FORUM
NORTH CAROLINA MEDICAL BOARD
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Pg. 6 — Time for EHR?

When doctors "drift," questions of competency and ethics are key

NCMB President Donald E. Jablonski, DO, says "it is the physician's professional responsibility to make sure they are competent to practice in a particular area."

Physicians complete four years of medical or osteopathic school and, upon graduation, we may legitimately call ourselves doctors. But most physicians would readily acknowledge that residency training is what really prepares them to practice medicine. Most doctors, whether they are MDs or DOs, complete a residency of between three and five years—longer for certain surgical subspecialties.

It is during this all-important training that pediatricians learn to take care of kids, and neurosurgeons gather the knowledge and experience to do delicate brain surgery. Residency is the gateway to competent specialty practice. To be sure, medicine evolves and physicians can and do learn new skills and modalities through numerous legitimate training courses. Still, few physicians would consider it prudent, or ethical, to practice too far outside their area(s) of residency training.

However, various factors, including economic pressures, have resulted in a small but increasing number of physicians "drifting" into areas of practice that fall well outside their formal training. Examples might include the enterprising OB/GYN who has expanded his or her practice to include Botox injections and cosmetic laser procedures, or a family doctor who primarily practices dermatology. Another variation the Board has seen is the "pain specialist" whose qualifications consist of little more than a willingness to write prescriptions for Schedule II drugs.

Licensure in North Carolina, like all other states, grants the licensee the privilege to practice the full scope of medicine. This type of licensure (often referred to in regulatory circles as "GUMP"—general undifferentiated medical practice) has historic roots that precede the pervasive specialization of today's modern medical practice. As Dr. Jim Thompson, former president and CEO of the Federation of State Medical Boards and a licensee of this Board, has written, no physicians in the 21st century are expected to practice, nor are they capable of practicing, all the disciplines of medicine. Yet, licensure puts no restrictions on what an individual may practice. Licensees are not even limited to practicing either medicine *or* surgery. (Check your wall license: you are licensed by the Board to practice "medicine *and* surgery.")

That said, it is the physician's professional responsibility to make sure he or she is competent to practice in a particular area. As long as the licensee is competent

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through appropriate training, the Board has no issues with "drift." This allows some flexibility in the practice of medicine, avoids specialty-specific licenses and acknowledges the overlap that occurs in many similar specialties.

By the same token, the Board has a duty under the law to act when a licensee demonstrates he or she is not competent in a particular area of practice. Complaints of substandard care involving an area of practice in which the physician is not trained will, understandably, get closer scrutiny than others.

As a physician who has practiced for nearly 30 years, I can understand and empathize with any colleague who turns to well compensated, primarily cash-based services to maximize earnings and/or minimize contact with insurance bureaucracy. I have been in practice since 1981, arriving on the scene at the end of the 'Golden Years' of medicine. Since then, physician fees have remained flat, office visits have gotten shorter, the number of patients seen per day has gotten larger and practice overhead has gone one direction—up.

As a regulator, however, the phenomenon of practice drift concerns me.

While most physicians refrain from practicing in areas where they simply aren't competent, some do not. In a recent disciplinary case before the Board, a surgeon trained in one discipline (not plastics) built the majority of his practice around doing full-body plastic surgery procedures. The Board fielded numerous complaints from patients who were unhappy with their results, and outside expert reviews confirmed that care was below standards. Worse, upon further examination, the Board found that the self-reported information on the licensee's page on the NCMB's public website was misleading and, in some cases, incorrect. It would have been impossible for a patient viewing the licensee's information online to tell that this physician had not completed residency training in plastic surgery. In fact, based on incorrect board certification information on the licensee's page, patients might reasonably conclude that the licensee was indeed a trained and board certified plastic surgeon.

Of course, some licensees who practice outside their areas of formal training do provide care that meets accepted and prevailing clinical standards. In these cases, it is still essential that the licensee clearly represent his or her areas of training and other credentials. For example, it would not be ethical for someone who is board certified in family medicine to mention that certification in advertising or signage that promotes cosmetic procedures, for reasons I hope are obvious. Such advertising could lead the public to conclude that the licensee's board certification refers to their cosmetic treatments.

The Board has taken steps to provide greater transparency to patients and others who use its website to find information about physicians. As you may recall, changes to North Carolina law authorized the Board to expand the information it provides to the public regarding its licensees. Before this law took effect, the Board published the licensees' training institution and board certifications. However, the Board did not show the specific area of training (pages would simply state that residency training was at UNC Hospitals in Chapel Hill, not that the residency was in family medicine at UNC Hospitals in Chapel Hill).

The Board's expanded information pages, which went live in December, ask licensees to state their specific areas of training, as well as their board certifications (see the Licensee Information update article on page four for more information and please report your training information if you have not already done so.) This should help patients understand if a physician they are considering is practicing outside his or her area of residency training and prepare patients to ask appropriate questions about the licensee's training and qualifications to do a particular treatment or procedure.

We should continue to look at "practice drift." I will be appointing a special task force to evaluate this phenomenon and provide guidance to help licensees determine whether they have "drifted" too far.

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A quicker path to an NC physician license

The NC Medical Board has developed an expedited path to licensure for experienced physicians, answering concerns raised by North Carolina hospitals and others that the Board's licensing process takes too long. The Board's Licensing Department currently advises applicants that it may take four to six months to process their applications.

The NC Rules Review Commission approved rules establishing the expedited physician license application in July and they are in effect as of August 1. The new application is intended to make it faster and easier for out-of-state physicians to obtain a North Carolina license, while ensuring the same high quality standards for admission to practice.

Applicants who qualify for the expedited license application will not have to document their medical or osteopathic education, their postgraduate medical training or USMLE or other examination scores, among other things. In addition, qualified applicants will not need to submit letters of recommendation.

It is anticipated that about 20 percent of the approximately 2,000 physicians who seek licensure in North Carolina each year will qualify to use the new process. Diverting qualified applicants to the streamlined application also should expedite the licensing process for all other applicants by reducing the workload of the Board's licensing staff.

The Board is working on an expedited licensure process for physician assistants, which could be in effect by this fall.

21 NCAC 32B .2001 is adopted, with changes, as published in 24:19 NCR 1694 as follows:

SECTION .2000 – EXPEDITED APPLICATION FOR PHYSICIAN LICENSE
21 NCAC 32B .2001 EXPEDITED APPLICATION FOR PHYSICIAN LICENSE

(a) A specialty board-certified physician who has been licensed in at least one other state, the District of Columbia, U.S. ~~Territory~~ territory or Canadian province for at least five years, has been in active clinical practice the past two years; and who has a clean license application, as defined in paragraph (c) below may apply for a license on an expedited basis.

(b) An applicant for an expedited Physician License shall:

(1) complete the Board's application form, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) submit documentation of a legal name change, if applicable;

(3) on the Board's form, submit a photograph taken within the past year, at least two inches by two inches, certified as a true likeness of the applicant by a notary public;

(4) supply a certified copy of applicant's birth certificate ~~if the applicant was born in the United States~~ or a certified copy of a valid and unexpired U.S. passport ~~if the applicant was born in the United States.~~ If the applicant ~~was not born in the United States,~~ does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States; *(Note: there may be some applicants who are not present in the U.S. and who do not plan to practice physically in the U.S. Those applicants shall submit a statement to ~~the~~ that effect);*

(5) provide proof that applicant has held an active license to practice medicine in at least one other state, the District of Columbia, U.S. Territory or Canadian province for at least five years immediately preceding this application;

(6) provide proof of clinical practice providing patient care for an average of 20 hours or more per week, for at least the last two years;

(7) provide proof of certification or recertification by an ABMS, CCFP, FRCP, FRCS, or AOA approved specialty board within the past ten years;

(8) submit an AMA Physician Profile; and, if applicant is an osteopathic physician, submit an AOA Physician Profile;

(9) submit a NPDB/HIPDB report dated within 60 days of the applicant's oath;

(10) submit a FSMB Board Action Data Bank report;

(11) submit two completed fingerprint record cards supplied by the Board;

(12) submit a signed consent form allowing a search of local, state and national files to disclose any criminal record;

(13) pay to the Board a non-refundable fee of three hundred fifty dollars ($350.00), plus the cost of a criminal background check; and

(14) upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.

(c) A clean license application means that the physician has none of the following:

(1) professional liability insurance claim(s) or payment(s);

(2) criminal record;

(3) medical condition(s) which could affect the physician's ability to practice safely;

(4) regulatory board complaint(s), investigation(s), or action(s) (including applicant's withdrawal of a license application);

(5) adverse action taken by a health care institution;

(6) investigation(s) or action(s) taken by a federal agency, the U.S. military, medical societies or associations;

(7) suspension or expulsion from any school, including medical school.

(8) graduation from any United States or Canadian medical school that is not LCME or CACMS approved; or

(9) has passed no licensing examination other than Puerto Rico Written Examination/Revalida.

(d) All reports must be submitted directly to the Board from the primary source, when possible.

(e) The application process must be completed within one year of the date on which the application fee is paid. If not, the applicant shall be charged a new applicant fee.

History Note: Authority G.S. 90-9.1; 90-5; 90-11; 90-13.1 Eff. August 1, 2010.

NCMB Public Affairs Department receives national recognition

The NCMB's Public Affairs Department recently won two awards of excellence from the National Association of Government Communicators (NAGC) for redesigning the *Forum* newsletter and certain other Board marketing materials, including the website, in 2009.

The NAGC is a national professional association whose members include local, state and federal government agencies. The awards competition salutes superior communications efforts of government agencies of all sizes and types.

Licensee Information Pages: An update

It's been nearly a year since the NCMB called on physicians and physician assistants to help with the enormous task of expanding the licensee information available to the public on the Board's website. The expanded Licensee Information Pages, authorized by a 2007 state law, went live at *www.ncmedboard.org* in early December. The pages, which allow users to call up information on individual licensees by clicking "Look Up a Licensee" and typing in a licensee's name, are the most popular feature on the Board's website.

Below is a review of selected data collected through the Licensee Information Pages initiative and some clarifications about licensees' obligations to report certain information.

The Board appreciates its licensees' continued participation with this initiative.

Participation

As of June 2010—six months after the public launch of the expanded pages—about 84 percent of the Board's more than 31,000 MD/DO licensees had logged in to the online portal that the NCMB built to allow licensees to report their expanded information. To date, about 5,000 of the Board's physician licensees have not responded to the NCMB's requests to update and expand their information.

A closer look at the numbers is more encouraging: More than 90 percent of the more than 21,000 physician licensees who are based in NC (the rest of the 31,000 hold NC licenses but practice elsewhere) have logged in. While the Board would like to see 100 percent participation from in-state physicians, it is pleased to see such a strong response rate among its NC-based licensees. About 90 percent of the Board's nearly 4,000 physician assistant licensees have logged in. The vast majority of the Board's PA licensees practice in-state.

Review of selected data: A critical information gap

As you may recall, the expansion of the Board's Licensee Information Pages included both new required and new optional information. This article deals only with required information.

As expected, relatively few licensees have reported required information of a prejudicial nature, such as hospital privilege suspensions, malpractice payments or certain criminal convictions (See the box on page five for an account of specific types of information reported.) Data for these new categories of public information are consistent with the Board's historical information (The Board has tracked malpractice payments, changes to hospital staff privileges and criminal charges/convictions for non-public investigative purposes for some time).

Reporting of new required information of a non-prejudicial nature, such as hospital affiliations or area(s) of practice, appears to have been appropriately robust, with one notable exception. As of June 2010, only about 19,586 licensees have reported their residency and fellowship training information. In other words, more than 7,000 of the physician licensees who have logged in to provide their information to the Board did not provide this important information as required by North Carolina law.

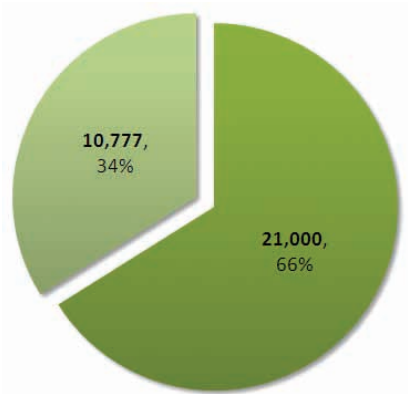
Residency training was one of the categories of information displayed on the Board's website prior to the recent update and expansion of information, so it may be that these licensees assumed their training information would automatically be transferred into the new system. This is not the case. As part of the recent changes, the Board changed how it captures and displays postgraduate training information to provide details about the specific area of training. As a result, all licensees must update their information for their training to appear. Those who have not provided updated information have no residency training on the Board's website. This creates a conspicuous gap in the information available to the public. Patients may look up their physician's information page, see "None Reported" under residency training and mistakenly conclude that their doctor did not complete postgraduate training.

The Board is in the process of amending its annual license renewal process so that all licensees will be prompted to update their training information if they have not already done so. However, a faster way to ensure that your residency training information is complete and accurate is to login to the Licensee Information system on the Board's website now.

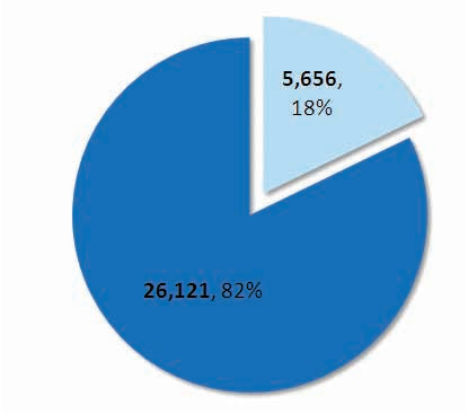
NEED TO UPDATE YOUR INFORMATION PAGE?

- Go to *www.ncmedboard.org* and click on "Update Licensee Info Page" (second item in Quick Links list at right)
- Click on Training to enter your internship, residency and fellowship training (enter all that apply)
- Once you are done, take a moment to see what the public sees. From the Board's Home Page, click on "Look up a Licensee" and enter your name to pull up your info page.
- Remember to update your page regularly, especially if you have new "required" information.
- Encourage your colleagues to do all of the above.

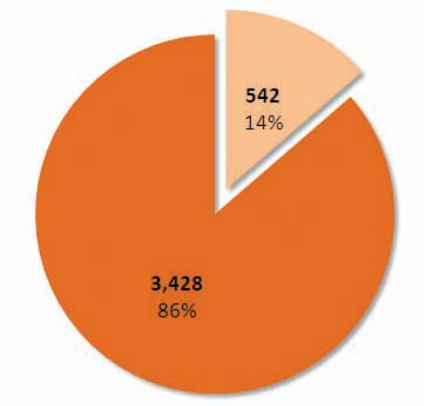
LICENSEE INFORMATION: BY THE NUMBERS



Total number of licensed MD/DOs: 31,777
Practicing in NC: 21,000
Practicing out-of-state: 10,777



As of June 2010, MD/DOs who have:
Logged in to report data: **26,121**
Have not logged in to report data: 5,656



Total number of licensed PAs: 3,970
PAs that have logged in to report data: 3,428
PAs that have not logged in to report data: 542

*Approximate percentage of MD/DOs and PAs practicing in NC who logged in: 90 percent

The NC Medical Board unveiled expanded licensee information pages on its website in December. Here is a snapshot of participation and reporting in selected required categories of information as of June 2010. (Source: NCMB data)

Physicians reporting information about postgraduate medical training	19,586
Physicians reporting Board Certification information	25,956
Physicians reporting hospital affiliations	18,318
Licensees reporting information about areas of practice (includes PAs)	33,550
Licensees reporting actions by out-of-state medical boards or other regulatory agencies	477
Licensees reporting professional liability settlements	341
Licensees reporting judgments in professional liability cases	14
Licensees reporting misdemeanor convictions	222
Licensees reporting felony convictions	47
Licensees reporting final actions to revoke/suspend hospital privileges	49

Changes in the Office of the Medical Director

Recent months have seen changes in the NCMB's Office of the Medical Director. Effective July 1, C. Michael Sheppa, MD, transitioned to part-time hours at his request, stepping down as the Board's medical director. He will continue working as associate medical director. Meanwhile, Scott G. Kirby, MD, previously the Board's assistant medical director, has been appointed medical director.

Among other things, the OMD reviews all cases related to quality of care and makes recommendations for Board action as part of the Board's internal case review process.

Dr. Sheppa first came to the Board as assistant medical director in February 2006, assuming the role of medical director in September of the same year. Before joining the Board's staff, Dr. Sheppa was a partner in and president of Raleigh Emergency Medical Associates in Raleigh.

Dr. Kirby came to the Board as assistant medical director in November 2006. Prior to joining Board staff, he was an emergency department physician at Raleigh Community Hospital, now Duke Health Raleigh Hospital, and partner in Capital Emergency Physicians in Raleigh.

Scott G. Kirby
Medical Director, NCMB

Finally, the OMD expanded its staff in April to include a physician assistant, Katharine Kovacs, PA-C. Ms. Kovacs helps the OMD review license applications and disciplinary cases related to quality of care. Prior to coming to the Board, Ms. Kovacs worked in a variety of care settings, including nursing homes, and most recently was on the clinical staff of Raleigh Neurology.

Electronic Health Records:

Is now the time for your practice?

Margie Satinsky, MBA, President, Satinsky Consulting, LLC

Over the past decade, more and more medical practices have implemented electronic health records (EHR). Now even holdouts have a tempting reason to take the plunge.

Under changes authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, part of the American Recovery and Reinvestment Act (ARRA), physicians and certain other practitioners may receive financial incentives for using electronic health records (EHR). Eligible practitioners may qualify for up to $44,000 over five years in incentive payments from Medicare, or they may receive up to $63,750 over six years from Medicaid. Practitioners may participate in one incentive program; enrollment in both programs is not permitted. Incentive payments for eligible practitioners will start sometime in 2011.

The U.S. Department of Health and Human Services (DHHS) released two final rules on July 13, 2010. One rule, issued by the Centers for Medicare & Medicaid Services (CMS), defines the minimum requirements that providers must meet in order to qualify for EHR incentive payments. The second rule, issued by the Office of the National Coordinator for Health Information Technology (ONC), identifies the standards and criteria for the certification of EHR technology.

EHR vendors have seen medical practices lining up for both new product implementations and product upgrades needed to meet incentive requirements. Is your practice among them? Should it be?

What can you do to ensure that your implementation is a success, and not the disaster that occurs in so many medical practices? The physicians in one Philadelphia internal medicine practice compared their conversion from paper to electronic health records to flying an airplane without a pilot! You can have a positive experience through careful planning.

Here are a dozen practical suggestions.

1 Be honest about your technology readiness and receptivity

In most practices, physicians' attitudes toward technology vary greatly. Some love it, and others hope they will never have to fiddle with it. Structure your software selection, staff training and implementation to accommodate your workforce. The primary purpose for introducing EHR into your practice is to provide better patient care and enhance outcomes; it's not simply to claim incentive payments or buy the hottest new gizmo. Make enhancement of practice value the goal. New associates who have recently completed their training seek environments with EHR and the ability to exchange information within referral networks. Physicians who plan to retire within a few years can enhance the attractiveness of their practices by adding these capabilities.

2 Designate the right leader(s)

Identify the appropriate individual(s) to lead the decision and implementation processes. The leader should have both an interest in IT and the ability to manage people and change. In some situations, a physician can do the job—provided that he or she is given adequate time to accomplish the task. In other situations, an administrative person may be better suited to the role. Or, a physician/administrator team may work best.

3 Involve employees at all levels of the practice

Your EHR will impact staff at all levels of your practice, so physicians and other clinicians, as well as administrative and clerical staff, should be part of your implementation team. People who are involved from the outset are more likely to support your ultimate decision and make it work. Be sure to include IT skeptics in the mix. The speed of your success as an organization will be measured by the progress of its slowest learners. You may be surprised to find your skeptic transformed into an IT advocate.

4 Identify your needs

Clarify your own mission and goals before investing in expensive technology. A small practice with one location has different needs than a large practice with multiple sites and aggressive growth plans. Do you receive or send large images and files? What are your communication needs? Reach

consensus on your future direction and choose technology that supports you.

5 Fix problems in your current workflow

If you assume that automating specific aspects of your practice operations will correct current problems in your workflow, think again. You cannot computerize chaos. Transitioning from paper to electronic health records won't fix human resource problems or poor financial management. If you automate malfunctioning processes, you'll compound the problems. Fix what doesn't work before you automate.

6 Consider EHR as part of your total IT strategy

For maximum benefit, your EHR should interface with the other major components of your practice's IT system, such as the practice management system (PMS) and patient Web portal, if you have one. Select an EHR vendor with the total picture in mind. Here's an example from a family practice physician who wants to purchase EHR and replace his current PMS. The physician likes the software from two different vendors, and if he decides on this option, he must pay for a two-way interface of several data sets both at the outset and on an ongoing basis. From a financial perspective, a better option is to select a single vendor that can provide an integrated solution, where software for two or more applications is built off the same operating platform. With the integrated solution, there are no cost add-ons and there's no question about where to seek technical assistance when it's needed. E-prescribe is another good example. If you select an EHR that includes an e-prescribe feature (as opposed to buying a separate e-prescribing application) prescription information automatically links to your EHR without your having to take extra steps to enter it into the patient record. Taking the time to make EHR work harmoniously with all your systems from the outset will save your practice headaches—and money—over the long haul.

7 Educate yourself about recent legislative changes

To qualify for incentive payments from Medicare or Medicaid, a practice must use EHR, meet requirements for submitting information on clinical and health information quality measures, and be able to demonstrate interoperability with other healthcare facilities. Practices will also be required to demonstrate they meet requirements for "meaningful use" of EHR in the practice. That may sound

Q&A Term to know: Interoperability

A quick conversation with Holt Anderson

In order to fully realize the promise of electronic health records, medical practices must be able to exchange patient records with other practitioners and care settings treating a common patient. It's a concept known as interoperability. *Forum* Editor Jean Fisher Brinkley asked Holt Anderson, executive director of the NC Healthcare Information and Communications Alliance in RTP, to explain it in plain terms.

Holt Anderson, Executive director, NCHICA

Q: What is interoperability?

A: In the healthcare context, interoperability is when you have the ability to share information about a patient between different care settings so that the data that is sent, is received and interpreted as it was originally intended. There is no loss in translation between systems.

Q: Why should physicians and other practitioners care about interoperability?

A: Physicians are driven professionally to provide the best care possible. In today's world, where information is dispersed among different care settings, making a clinical decision without complete information is not giving the best care possible. The only way clinical decisions can be informed is if they can get the information from other systems. And unless these other systems have the ability to talk to each other the information is not going to be there when it's needed.

Q: How close is that to being reality?

A: I think we've made great progress over the last few years with the establishment of the Office of the National Coordinator for Health Information

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simple, but practices must meet very specific criteria set by the federal government in order to qualify. Look at the new CMS website that contains current information on the EHR incentives —*www.cms.gov/EHRIncentivePrograms/*.

8 Seek outside help when you need it

Most practices don't select and implement IT solutions on a regular basis, so they are less experienced in the process than they are in other aspects of practice management. Independent practice management consultants without financial ties to vendors can guide you, introduce you to vendors, set up site visits to practices that use different products, provide criteria for vendor selection, and review proposed vendor contracts. The Carolinas Center for Medical Excellence in Cary offers an excellent series of webinars on ARRA and the stimulus package. The North Carolina AHEC Program recently received federal funding to provide on-site consulting to primary care practices that need to prepare for, select and implement certified electronic health records. The NC AHEC Program will also assist primary care practices using electronic health records and ensure that they meet criteria to qualify for the financial incentives. For information on AHEC services in your community, go to *www.ncahec.net* and click on the county in which your practice is located. Finally, the High Performance Physician Institute (HPPI) offers multi-day CME seminars throughout the country on information technology for practicing physicians. HPPI also provides programs that are customized for communities and medical associations. For more information, visit *www.highperformancephysician.com*

9 Do your homework before bringing in vendors

Research the big picture about EHR systems you are interested in before talking with specific vendors. Then specify exactly what you want each vendor to tell you so you can easily compare. Give the vendors background information on your practice, a list of questions about the software, the company, training and technical support, and the criteria that you will use to make your selection. Having guided many practices in their selection of various IT solutions, I put training and technical support—not cost—at the top of my list. Avoid vendors that want to provide a quote without taking the time to listen to and understand your needs.

10 Select a vendor(s) appropriate for your practice's needs

Independent national organizations such as the AC Group or KLAS regularly test and rank EHR vendors according to specific criteria. Professional associations can be good resources too. For example, the website of the American Academy of Family Practice (*www.aafp.org*) includes a section with feedback from practitioners who have shared their experiences, both positive and negative, using EHR and other IT systems.

11 Make the most of site visits

Ask each vendor to provide the names of three practices that match your size and specialty. Contact each practice and offer a stipend of a few hundred dollars (they are likely to refuse) to observe their workflow for a few hours. Visit the practice without the vendor present, and be willing to travel as far as you need to go. Ask both the lead champion and most vocal skeptic physicians to participate in your visit. Bring examples of common scenarios in your practice and ask your hosts to show you how the equivalent situation is handled in a digital environment. "The site visit is absolutely the most important part of the vendor selection," says Allen Wenner, MD, of West Columbia Family Medicine and a principal with High Performance Physician Institute, a group that trains physicians on the use of EHR.

12 Don't skimp on training

My clients' experiences with EHR have taught me an important lesson regarding training. Many vendors offer Web-based training as a way of reducing costs. But remote learning doesn't work for everybody. If you need on-site training for both the super-users and everybody else in your practice, buy it—even if you have to pay a premium. You are already spending a significant amount of money on the software, so learn how to make it work for you. Don't be like a surgical practice I know that was one of the first to purchase EHR so it could be ahead of its competitors. When I asked this group how it uses data, the physicians confided to me that they had no idea how to use the software and, in fact, continued to use paper records!

Acknowledgments

Thanks to the following for their input and assistance with this article: Holt Anderson, Executive Director, North Carolina Healthcare Information and Communications Alliance, Inc., and State of North Carolina lead for the Nationwide Health Information Network (NHIN); Ann Lefebvre, Associate Director, Statewide Quality Improvement, North Carolina AHEC Program; and Allen Wenner, MD, West Columbia Family Medicine, West Columbia, SC, and High Performance Physician Institute.

> The speed of your success as an organization will be measured by the progress of its slowest learners.

RESOURCES

Centers for Medicare and Medicaid Services
CMS has created a Web page on its Internet site to help healthcare professionals interested in receiving financial incentives for using certified EHR systems. *www.cms.gov/EHRIncentivePrograms/*

Carolinas Center for Medical Excellence
Offering a series of webinars on the federal stimulus package as it pertains to healthcare professionals. *www.thecarolinascenter.org*

NC Area Health Education Centers
NC AHEC received grant funding to provide on-site consulting to primary care practices preparing for, selecting and implementing certified electronic health records. NC AHEC will also help primary care practices already using EHR ensure that they meet criteria for incentive payments. *www.ncahec.net*

High Performance Physician Institute
Offers multi-day CME seminars nationwide on information technology for practicing physicians; also provides customized programs for communities and medical societies. *www.highperformancephysician.com*

American Academy of Family Physicians
AAFP's website includes feedback from physician practices already using EHR systems, and other information technology. *www.aafp.org*

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Continued from page (7)

Technology (ONC). Its role is to establish standards that can be adopted by companies that develop and sell electronic health records and by companies that focus on exchanging information between systems. Those standards are now established and they are beginning to emerge. The ability to exchange information is based on being built on the same standards. In order to receive stimulus money for EHR, physicians must purchase a system that is certified to be interoperable. The government is now beginning to certify certifying entities so that physicians making decisions can be assured that they are purchasing a system that is interoperable.

Q: Where are we today in North Carolina?
A: In comparison to other states I think we're very fortunate in having five academic medical center-based integrated delivery networks with very robust physician referral networks. I'm thinking of the UNCs, the Dukes, the East Carolinas. They're very automated and they're all totally integrated. Then we have the Novants and the WakeMeds and the other health systems in the state that are also very good and very automated. We have practices and large clinics that are also very automated, so that's at one end of the spectrum. At the other end of the spectrum we have many solo practitioners and small practices, primarily in rural settings. We have pediatricians and family medicine doctors, who have very slim margins in the first place, who can't afford, necessarily, the investment that's required for getting EHR. The new stimulus funding is an opportunity to get that.

Q: What do physician practices have to do in order to be interoperable, other than buy a certified system?
A: There have to be agreements among a practice or physician's office and the organizations they want to do business with and trade records with. The expectations and responsibilities of partners who want to exchange information need to be memorialized. If I'm going to exchange records with you and you're going to make decisions based on the information I'm sending you, where is my liability and where is your liability? What is your responsibility for responding to me if I request records? Can I charge you? What can I expect from you, now that we're sharing a patient? It's actually much more complex. The technology piece is the easy piece.

Federal EHR incentives: A quick guide

President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) in February 2009. The part of the law known as the HITECH Act promotes the meaningful use of electronic health records (EHR) by providing financial incentives to certain healthcare professionals. Below is a review of the incentive programs' key components.

What agencies are providing financial incentives?

Medicare and Medicaid will each have separate incentive programs.

What types of healthcare professionals may receive incentive payments?

For the Medicare program, physicians (whether MDs or DOs), podiatrists, optometrists and chiropractors may all claim incentives. For the Medicaid program, eligible professionals include physicians (pediatricians have special eligibility and payment rules), dentists, nurse practitioners and physician assistants who treat patients in a rural health clinic or Federally Qualified Health Center that is led by a PA.

Can I claim incentives through both programs?

No. Eligible healthcare professionals may participate in only one incentive program.

How much money can an eligible professional receive?

Participants who meet all requirements for EHR incentives can receive up to $44,000 over five years in payments from Medicare, or they may receive up to $63,750 over six years from Medicaid.

Can any physician receive incentive payments?

No. Hospital-based physicians who perform substantially all of their services in an inpatient hospital setting or emergency room only do not qualify. The final meaningful use rule clarifies questions about hospital-based providers in ambulatory settings.

When will incentive payments begin?

Registration by eligible providers who wish to receive the Medicare or Medicaid payments will begin in January 2011. A registration link will be available at *www.cms.gov/EHRIncentivePrograms/*. Attestations for the Medicare program will start in April 2011, and Medicare incentive payments will begin in mid-May 2011. States will initiate their incentive programs on a rolling basis pending CMS approval of the State Medicaid HIT plan.

When will incentive payments stop?

Medicare will make no incentive payments for EHR use after 2016, so apply ASAP if you intend to claim the maximum incentive under Medicare. Medicaid will make incentive payments beyond 2016, but eligible professionals may not receive payments for more than six years.

What must a medical practice do to qualify for incentives, other than adopt EHR?

Practices must demonstrate "meaningful use" of EHR, meet requirements for submitting information on clinical and health information quality measures and be able to demonstrate interoperability with other healthcare facilities to receive payments. All of these criteria must be met to receive payments. The final rule on meaningful use sets up a two track approach that divides objectives into required core objectives on which all providers must report and a menu of set objectives from which providers can choose to report what is most important to them.

I'm not sure what "meaningful use" entails. How can I ensure I qualify for payments?

DHHS finalized the rules governing the EHR incentive programs on July 13, 2010. The final rule defines meaningful use and specifies the steps that healthcare professionals must take to qualify. CMS has created a fact sheet on the rules and program standards at *www.cms.gov/EHRIncentivePrograms/*

I can't afford to invest in EHR right now, even with incentive payments. Are there consequences for sticking with paper records?

Yes. Incentive payments are a carrot to encourage adoption of certified EHR systems, but there's also a stick for those who don't. Healthcare professionals who do not demonstrate "meaningful use" of EHR by 2015 will receive a Medicare fee cut of up to 5 percent.

Source: Centers for Medicare & Medicaid Services

DID YOU KNOW ?

The NCMB recently amended its position statements titled Medical Record Documentation and Retention of Medical Records to address electronic medical records (EMR).

The changes include language that advises licensees to be sure records accurately reflect elements of proper documentation and that confidentiality is preserved when EMRs are discarded or destroyed.

To view these statements go to *www.ncmedboard.org* and click on "Find a Position Statement" in the green Quick Links menu on the right.

Recommendations for X-ray follow-up

Beginning with this issue of the *Forum*, the Office of the Medical Director will contribute periodic columns aimed at educating licensees about some common areas of concern. Columns are inspired by actual cases under review by the Board. However, suggested topics are welcome. If you would like to see a specific issue discussed in this space, you may request a topic by emailing the *Forum* editor at *forum@ncmedboard.org* Do keep in mind that the Board cannot give advice on specific cases or situations.

From the Office of the Medical Director

SCOTT G. KIRBY, MD

In this column, I will discuss problems with follow-up care after X-rays or other diagnostic imaging studies. Both of the cases described below are actual deidentified cases. Both resulted in malpractice payments that meet criteria for posting on the Board's public website.

Example 1

A 65-year-old female was seen in an emergency department for evaluation of "palpitations." A chest X-ray was obtained as a matter of routine and read by the Emergency Department physician as "negative." The radiologist identified a lung mass on the same X-ray and submitted his written report to the ED within hours of its completion. The ED physician's earlier and inaccurate interpretation of the examination was not available to the radiologist, and there was no documentation the finding of a lung mass by the radiologist was communicated to the ED physician or to the patient. The ED physician did not provide further care for the patient and did not follow-up on the final radiology report. The patient was discharged without an appointment for a CT scan as recommended by the radiologist. Several months later the patient was diagnosed with lung cancer that was ultimately fatal. A malpractice payment of $100,000 was made in the ED physician's name.

Example 2

A 46-year-old male in overall good health was scheduled for elective hernia repair. Although the patient did not meet criteria for a pre-operative chest X-ray, it was inadvertently included by office staff in the surgeon's pre-operative orders. The surgeon, not realizing the chest X-ray was done, did not look for the results. The chest X-ray showed an (asymptomatic) atypical lung mass not present on a previous film from five years earlier. The radiology report, with a notation that the mass was suspicious for cancer and needed follow-up, was placed in the patient's hospital medical record. This finding was not communicated to the surgeon and, by inadvertent neglect, the written report was not seen. Office follow-up records did not include the X-ray report and it did not come to a physician's attention until six months later, when the chest X-ray report was found in the patient's hospital chart and follow-up was arranged for what proved to be inoperable cancer. A malpractice payment totalling $750,000 was made in the names of both the surgeon and the radiologist.

Discussion

The Board uses the Accreditation Council for Graduate Medical Education's "Six Core Competencies" as a framework for evaluating disciplinary and malpractice cases. One of the competencies is "systems-based practice." What does this mean and how does it apply to the examples above? In short, physicians must demonstrate the ability to effectively and efficiently use resources in the health care system to provide optimal care. In both case examples, systems-process failures resulted in the delayed diagnosis of cancer—currently one of the most active and expensive areas of malpractice.

Physicians have an individual responsibility to appropriately follow-up on diagnostic tests they order, or those that are ordered on their behalf. Physicians have a general responsibility to ensure that they work in an environment that has reliable systems in place that eliminate, to the greatest extent possible, the types of errors noted earlier. Any medical professional who thinks patient safety is compromised by inadequate policies or systems should bring concerns to the attention of administration and work with others to correct the deficiencies, if possible.

Failure to adequately follow-up on X-rays and other diagnostic tests regularly contributes to bad outcomes. Radiologists have a professional responsibility to communicate significant findings—particularly those suggesting cancer—to the ordering or referring physician, and to clearly document that this communication has occurred. The time, method of communication and identification of the person to whom the findings were communicated should be documented. If there is a discrepancy between a preliminary X-ray reading and the final interpretation, this discrepancy should be communicated in a manner that ensures receipt by the referring or treating physicians. Documentation of the discrepancy and its communication to the ordering physician should be included in the final report. The patient's office medical record should include a copy of the final X-ray report, an indication of physician review of the report and notation of follow-up plans and actions taken, including documentation that the patient was notified of the findings.

Establishing these practices on a routine basis should help prevent errors and improve the quality of care, as well as eliminate numerous claims of malpractice and/or complaints to this Board.

North Carolina Medical Board

Quarterly Disciplinary Report | February-April 2010

Board actions are now published in an abbreviated format. The report no longer includes non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. If you prefer the previous method of reporting Board actions, you may access an expanded disciplinary report by visiting the Board's website at *www.ncmedboard.org* Readers who prefer the more comprehensive version may sign up on the website to be notified when a new report is posted. Go to "Professional Resources" and select "Subscriptions" to sign up for an RSS Feed to be notified. Be sure to select the feed for "Bimonthly Disciplinary Report."

Name/license#/location	Date of action	Cause of action	Board action
ANNULMENTS			
FARRELL, Edwin Gayle, MD (000017345) Wilmington, NC	03/17/2010	MD consumed alcohol while under NCPHP contract; Arrested for DWI in 2008 and 2006 (conviction in 2007); Provided false information during licensing interview and on annual renewal; Inappropriate conversation with a minor patient's sibling	MD's NC medical license is annulled
REVOCATIONS			
BERKOWITZ, Howard Martin, MD (000023174) Atlanta, GA	03/10/2010	MD entered a guilty plea to felony health care fraud in NY	Notice of Revocation
FARRELL, Edwin Gayle, MD (000017345) Wilmington, NC	03/17/2010	MD consumed alcohol while under NCPHP contract; Arrested for DWI in 2008 and 2006 (conviction in 2007); Provided false information during licensing interview and on MD annual renewal; Inappropriate conversation with a minor patient's sibling	MD's NC medical license is revoked
ROBERTSON, ELISABETH M., MD (000034107) Statesville, NC	02/22/2010	Wrote narcotic prescriptions for family and diverted for self use; Forged another MD's signature to obtain controlled substances	MD's NC medical license is revoked via consent order
SUSPENSIONS			
BLACK, Steven Ray, MD (200500976) Sylva, NC	03/02/2010	Arrested for marijuana possession; Assessment determined MD was abusing cannabis	Indefinite suspension of NC medical license
CRUMMIE, Robert Gwinn, MD (000014636) Rutherfordton, NC	03/17/2010	Care of six patients was below acceptable standards	Indefinite suspension of NC medical license
SMALL, Fairleigh David, MD (000024710) Abingdon, VA	03/17/2010	MD's license suspended in VA for felony conviction and malicious wounding	Indefinite suspension of NC medical license
Suspension via Consent Order:			
ALFORD, Todd Michael, MD (200701869) Kings Mountain, NC	02/18/2010	MD committed a boundary violation with a patient	Indefinite suspension of NC medical license
BOTHE, Brian Michael, MD (200201433) Arden, NC	02/18/2010	Several patient charts were illegible and incomplete; Prescribing for self and family	Six-month suspension; immediately stayed/placed on probation
BRADY, Joseph Lawrence, Jr., MD (000028822) Charlotte, NC	02/26/2010	MD admitted he used an illegal controlled substance; Voluntarily entered NCPHP contract	Six-month suspension; immediately stayed
CALDWELL, Chad Cameron, PA (000103163) Winston-Salem, NC	03/24/2010	Arrested for aggravated assault/damage to business property; Admitted to abusing alcohol	Indefinite suspension of NC medical license
CHASE, Bradford Alan, PA (000103564) High Point, NC	03/11/2010	PA inappropriately obtained and abused pain medication	Indefinite suspension of NC physician assistant license
HARIHAN, Thomas Francis, PA (000101609) Elizabeth City, NC	04/11/2010	Inappropriate comments to patient; touching patients in an uncomfortable way	Indefinite suspension of NC medical license
KRAMER, James Scott, MD (000039438) Greensboro, NC	04/16/2010	Treated patient with whom he had a personal relationship; Didn't document patient care	Six-month suspension; immediately stayed/placed on probation
MISTRI, Kamlesh Krishna, PA (001000799) Hickory, NC	02/19/2010	Treated patients for opioid abuse; Neither MD nor clinic were certified as an Opioid Treatment Program	Six-month suspension; immediately stayed/placed on probation
NISBETT, Donald A., MD (000046332) Laurinburg, NC	04/15/2010	Care of four patients fell below standard; Assessment shows need for improvement; MD agrees to participate in education program	MD's license is suspended for 90 days; stayed immediately on probationary conditions

Name/license#/location	Date of action	Cause of action	Board action
PARKER, Gregory Dean, MD (000029713) Charlotte, NC	03/10/2010	MD made, and later admitted making, false representation to Board investigator	MD's license is suspended for six months; stayed immediately
RIVERA-ORTIZ, Epifanio, MD (009900123) Charlotte, NC	04/16/2010	Boundary violation; Inappropriately touching patients during examination	Indefinite suspension of NC medical license
SIEGEL, Drew Kevin, MD (000039999) Burlington, NC	03/09/2010	MD suffers from a medical condition that affects ability to practice	Indefinite suspension of NC medical license
SILVERMAN, David Louis, MD (009900349) Martinsville, VA	02/24/2010	Disciplined in VA; Impaired—alcohol and substance abuse	Indefinite suspension of NC medical license
SINGH, Vinod, MD (000038690) Benson, NC	03/10/2010	MD abusing alcohol and benzodiazepines; Currently in treatment program	Indefinite suspension of NC medical license
THOMPSON, Robert Bruce, MD (000040006) Charlotte, NC	03/02/2010	History of substance abuse/psychiatric health problems; Admitted to relapsing in recovery	Indefinite suspension f NC medical license
WHITE, Dale E., PA (000101583) Knightdale, NC	02/19/2010	PA did not appropriately manage care of chronic pain patients	One-year suspension; Stayed all but 30 days; Probation for the remainder of suspension period
WILSON, Wayne Vincent, MD (000033444) Hickory, NC	02/18/2010	Treated patients for opioid abuse; Neither MD nor the clinic were certified as an Opioid Treatment Program; Records lack appropriate documentation for patient on potentially lethal dose of Methadone	MD's NC medical license is suspended for six months; Stayed and license is placed on probation for six months with several conditions
DENIAL OF LICENSE/APPROVAL			
LIN, Jefferson Bo-Zin, MD (NA) Tempe, AZ	02/17/2010	Provided false information on NC license application	Application for NC medical license is denied
SURRENDERS			
OGILVIE, James William, PA (00010326) Raeford, NC	02/23/2010		Voluntary surrender of NC medical license
QUILLEN, Rocky C., PA (000102450) Supply, NC	02/08/2010		Voluntary surrender of NC medical license
YORK, David Allan, MD (200401357) Augusta, ME	03/26/2010		Voluntary surrender of NC medical license
TOOLE, James Eugene, PA (001000071) Franklin, NC	02/18/2010	Prescribing for patient fell below acceptable standards	PA surrenders his NC medical license via consent order
PUBLIC LETTERS OF CONCERN			
ADAMS, George Liell, MD (200301437) Raleigh, NC	02/17/2010	Prescribing for family without maintaining proper medical records	Public letter of concern issued
BODEN, Scott Adam, MD (200500872) Wethersfield, CT	03/30/2010	Disciplined in CT for using unlicensed individual to administer anesthesia	Public letter of concern issued
BREWER, Thomas Edmund, Jr., MD (000028141) High Point, NC	02/24/2010	Owned a medical center with a non-physician in violation of Board rule	Public letter of concern issued
BRUHA, Paul Joseph, MD (000036664) Fort Walton Beach, FL	04/06/2010	Disciplined in FL for wrong site surgery	Public letter of concern issued
BUCKLAND, David Nelson, PA 000101879) Star, NC	03/24/2010	Prescribing to family in violation of Board position statement	Public letter of concern issued
CARLSON, James Lennart, MD (201000170) Beachwood, OH	02/04/2010	MD did not accurately answer a question on NC license application	Public letter of concern issued
CHAO, Ronald Philip, MD (200900329) Beverly Hills, CA	04/21/2010	MD did not accurately answer a question on NC license application	Public letter of concern issued
DANIEL, Michael Page, MD (000034967) Burlington, NC	02/17/2010	Failed to provide full and complete medical records to patients in a timely manner	Public letter of concern issued
DUBINSKI, Mark Anthony, MD (000035114) Henderson, NC	02/16/2010	Prescribing to family in violation of Board position statement	Public letter of concern issued
GILLIS, John Francis, MD (009500354) Mooresville, NC	04/01/2010	MD arrested for DWI and failed to report it during his annual license renewal	Public letter of concern issued
HALLBERG, John Andrew, MD (201000313) Lumberton, NC	03/03/2010	MD disciplined by RI and West VA for failure to report hospital privileges on probation	Public letter of concern issued

Name/license#/location	Date of action	Cause of action	Board action
HATCH, David Matthew, MD (201001879) Winston-Salem, NC	04/20/2010	MD did not accurately answer a question on NC license application	Public letter of concern issued
JENKINS, Larry Parker, MD (000017874) Albermarle, NC	02/10/2010	MD did not refer patient to appropriate specialist until after patient's second visit. Records do not reflect referral	Public letter of concern issued
LAPP, Kathleen Green, MD (200000250) Chapel Hill, NC	02/16/2010	MD inappropriately affixed a patient's signature on a Release of Information form	Public letter of concern issued
LEHMAN, William Louis, MD (200600954) Raleigh, NC	02/02/2010	MD performed surgery at the wrong site	Public letter of concern issued
NORRIS, Clarence Eugene, MD (009401288) Matthew, NC	02/22/2010	Board is concerned about MD's record keeping/selling supplements from office	Public letter of concern issued
OLDROYD, Robert G., MD (009900313) Pinehurst, NC	03/10/2010	MD arrested/charged with DWI and failed to report on license renewal	Public letter of concern issued
RUSSELL, David Norman, MD (000025525) Salisbury, NC	04/07/2010	Inappropriate supervision of a PA and PA's prescribing	Public letter of concern issued
SHAPIRO, Mark Thomas, MD (000020509) Greensboro, NC	02/22/2010	Prescribing to family in violation of Board position statement	Public letter of concern issued
SMITH, Ronnie Dale, MD (000023878) Florence, SC	02/16/2010	Failed to maintain continuity of care	Public letter of concern issued
TANO, Benoit Deki Kovame, MD (200301297) Fort Blevoir, VA	02/24/2010	Disciplined by TX; Inadequate medical records	Public letter of concern issued
THOMPSON, Marcel Dwaine, MD (200501535) Round Rock, TX	04/07/2010	Disciplined by TX; Agreed to take course on professional boundaries	Public letter of concern issued
WAGNER, Paul Dean, MD (200001325) Charleston, WV	03/02/2010	Failed to timely respond to Board inquiries	Public letter of concern issued
REPRIMAND			
BOWMAN, Karolen R. Church, MD (000021756) North Wilkesboro, NC	03/22/2010	MD's care of four patients departed from standards of accepted/prevailing practice	MD is reprimanded; May not prescribe Schedule II, IIN, III and IIIN to patients over 21
BUTTAR, Rashid Ali, DO (009500528) Huntersville, NC	03/26/2010	MD treated patient without performing a physical exam, violating Medical Practice Act	Reprimanded; Must provide informed consent to treatment form to all patients
CHUNG, Kevin Robert, MD (000039999) Morganton, NC	03/04/2010	MD care of patient found to be below acceptable standard	MD is reprimanded
HOFFERT, Marvin Jay, MD (201000195) Charlotte, NC	02/11/2010	Failed to disclose certain information on application	MD is reprimanded
KEYES, Booker T., Jr. , MD (000032127) Jacksonville, NC	04/16/2010	MD prescribing of controlled substances to four patients fell below standard of care	MD is reprimanded; Shall not prescribe controlled substances for pain treatment
LANGSTON, Jonathan Lawrence, PA (000100214) Shallotte, NC	02/18/2010	Board requests PA take CME and implement EMR system	PA is reprimanded
MACK, Barbara Ann, MD (000034388) Southern Pines, NC	02/05/2010	Aided and abetted the unlicensed practice of medicine; Several patient charts show care below standard	MD is reprimanded
MULLINS, Christopher Edwards, DO (009800101) Clarksville, VA	02/19/2010	MD prescribed medication without proper physical exam	MD is reprimanded
OKSANEN, Owen David, MD (201000229) Port St. Joe, FL	02/12/2010	Did not accurately answer a question on NC license application	MD is reprimanded
PANDIT, Subodh Kumar, MD (200001234) Hendersonville, NC	02/15/2010	Care of patient in ER fell below acceptable standards; Hospital privileges were suspended, later reinstated	MD is reprimanded
SCALLION, Ralph Michael, MD (000023664) Durham, NC	02/18/2010	Ordered for assessment by NCPHP and Acumen; MD delayed assessment at Acumen	MD is reprimanded
WISE, Daniel Edwin, MD (000017813) Charlotte, NC	4/22/2010	Prescribing without proper physical exam; Poor medical record documentation and prescribing to self and person with who MD had a significant relationship	MD is reprimanded

Name/license#/location	Date of action	Cause of action	Board action
WINN, Michael John, PA (0010000472) Fayetteville, NC	02/02/2010	PA aided and abetted the unlicensed practice of medicine; Several patient charts show care below standard	PA is reprimanded
PROBATION			
BOTHE, Brian Michael, MD (200201433) Arden, NC	02/18/2010	Several patient charts are illegible and incomplete; Prescribing for self and family	MD's license is suspended for six months; suspension immediately stayed/placed on probation
KRAMER, James Scott, MD (000039438) Greensboro, NC	04/16/2010	MD treated patient with whom he had a personal relationship; Did not document patient care	MD license is suspended for six months; stayed immediately on probationary conditions
MISTRI, Kamlesh Krishna, PA (001000799) Hickory, NC	02/19/2010	Treated patients for opioid abuse; Neither MD nor the clinic were certified as an Opioid Treatment Program	MD's license is suspended for six months; immediately stayed and placed on probation
MITCHELL, James Alistair, MD (200400921) Fayetteville, NC	02/22/2010	Prescribing to family in violation of Board position statement; MD did not keep records or perform exam	MD's license is placed on probation for one year
NISBETT, Donald A., MD (000046332) Laurinburg, NC	04/15/2010	Care of four patients fell below acceptable standards; CPEP assessment shows need for improvement; MD agrees to participate in education program	MD license suspended for 90 days; stayed immediately on probationary conditions
OSMAN, Mohamed Buwe Sidi, MD (200201142) St. Pauls, NC	03/04/2010	MD prescribed Methodone to patients without registration as a DEA Narcotic Treatment Program	MD is reprimanded; must complete CME in prescribing/record keeping
WHITE, Dale E., PA	02/19/2010	PA did not appropriately manage care of chronic pain patients	PA license suspended for one year; Stayed all but 30 days; Probation for the remainder of suspension period
WILSON, Wayne Vincent, MD (000033444) Hickory, NC	02/18/2010	Treated patients for opioid abuse; Neither MD nor the clinic were certified as an Opioid Treatment Program; Records lack appropriate documentation for patient on potentially lethal dose of Methadone	MD's NC medical license is suspended for six months; Stayed and license is placed on probation for six months with several conditions
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED OR REPLACED BY FULL LICENSES			
DUGLISS, Malcolm Andrew John, PA (009001628) Asheville, NC	04/06/2010	PA diverted pain medication for his own use; Complying with NCPHP contract	Issued temp license; Shall undertake a program of reentry
PERRY, Robert Francis, MD (009401472) Carolina Beach, NC	03/23/2010	Previous discipline for boundary violations; MD under and has complied with NCPHP contract	Issued a temp license; Must maintain contract with NCPHP/comply with other conditions
WRENN, Cynthia Helen, PA (000102752) Fayetteville, NC	04/08/2010	Prescribed to a patient with whom she had a significant relationship; Diverted controlled substances; Prescribed without proper physical exam and provided false information on license renewal	PA is issued a temporary license; PA shall maintain a contract with NCPHP
MISCELLANEOUS DISCIPLINARY ACTIONS			
SPATARO, Joseph David, MD (200300091) Charlotte, NC	04/16/2010	Treating patients for obstetrical care without having obstetrical hospital privileges; Care of five patients fell below standards	May not practice obstetrics or provide prenatal care and will refer patients requiring such care to appropriate physicians
OVERTON, Dolphin Henry, III, MD (000039313) Wilson, NC	04/26/2010	NCPHP participant for alcohol dependency and mental health issues	MD's license must remain inactive
OWENS, James Lee, MD (000038159) Jarvisburg, NC	02/16/2010	CPEP assessment showed recommendations for improvement; Five patient charts show deficiencies in prescribing and medical documentation	MD to obtain a practice monitor and submit practice monitoring agreements to the Boards for approval

North Carolina Medical Board
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This publication is printed on 70# Flo Dull Text. It is a Forest Stewardship Council paper.
Environmental savings realized by using this paper are summarized below:
4,096 lbs of paper used | 952 lbs of wood saved | 2,811 gallons of water saved | Landfill waste reduced by 952 lbs

EXAMINATIONS

Residents Please Note USMLE Information

United States Medical Licensing Examination
Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at *www.fsmb.org*.

Special Purpose Examination (SPEX)
The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

BOARD MEETING DATES

August 19-20, 2010 (Hearings)
September 15-17, 2010 (Full Board)
October 14-15, 2010 (Hearings)
November 17-19 (Full Board)

Meeting agendas, minutes and a full list of meeting dates can be found on the Board's Web site
ncmedboard.org

Visit the Board's website at *www.ncmedboard.org* to change your address online. The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 30 days of a move.

DEA rules allow e-prescribing of controlled substances

The U.S. Drug Enforcement Administration now provides registered prescribers with the option of issuing prescriptions for controlled substances electronically, pursuant to federal rules that took effect June 1.

The new rules also permit pharmacies to receive, dispense and archive these electronic prescriptions. Rules regarding the electronic prescribing of controlled substances are an addition to, not a replacement of, existing rules pertaining to the prescribing of controlled substances. Prescribers who wish to continue to issue paper prescriptions for controlled substances may do so. The new rules simply provide those who want to use modern technology for controlled substance prescriptions with a framework for doing so while maintaining the closed system of controls on these prescriptions.

The NCMB encourages authorized prescribers who are interested in e-prescribing and controlled substances to educate themselves about the new rules. Please note that the rules were issued by the federal government. The NCMB is not able to answer questions about them. The DEA's Office of Drug Diversion has established a website to provide information and resources on the new rules at *www.deadiversion.usdoj.gov/ecomm/e_rx/*