

MINUTES



July 19 – 21, 2017

**1203 Front Street
Raleigh, North Carolina**

General Session Minutes of the North Carolina Medical Board Meeting held July 19-21, 2017.

The July 2017 meeting of the North Carolina Medical Board was held at 1203 Front Street, Raleigh, NC 27609. Eleanor E. Greene, MD, President, called the meeting to order. Board members in attendance were: Pascal O. Udekwu, MD, Immediate Past-President; Timothy E. Lietz, MD, President-Elect; Mr. Shawn P. Parker; Mr. A. Wayne Holloman; Bryant A. Murphy, MD; Debra A. Bolick, MD; Judge Ralph A. Walker; Venkata R. Jonnalagadda, MD; Ms. Jerri L. Patterson, NP and Ms. Varnell McDonald-Fletcher, PA-C. Board members absent were: Cheryl L. Walker-McGill, MD, Past President and Barbara E. Walker, DO, Secretary/Treasurer.

Presidential Remarks

Dr. Greene reminded the Board members of their duty to avoid conflicts of interest with respect to any matters coming before the Board as required by the State Government Ethics Act. No conflicts were reported.

Minutes Approval

Motion: A motion passed to approve the May 17-19, 2017 Board Minute. There was not a Board Hearing in June, therefore there were no minutes for that month.

Announcement

Dr. Greene congratulated Dr. Debra Bolick on being elected to the position of Deputy Representative for Area 5 at the American Psychiatric Association Assembly Meeting.

The Legal department introduced a new staff member

Dr. Greene introduced guest speakers from Blue Cross Blue Shield, Brian Caveney, MD, JD, MPH; Chief Medical Officer and Anuradha Rao-Patel, MD, Associate Medical Director.

North Carolina Physician Health Program Reports (NCPHP)

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Dr. Joe Jordan, CEO, North Carolina Physicians Health Program (NCPHP), gave the following Reports: PHP Compliance Committee report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

Dr. Bolick presented the NCPHP Board of Directors Report.

NCMB Attorney's Report

Mr. Thomas W. Mansfield, Chief Legal Officer and Mr. Brian Blankenship, Deputy General Counsel, gave the Attorney's Report on Friday, July 21, 2017.

A motion passed to close the session pursuant to N.C. Gen Stat. §143-318.11(a) to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

A written report on 50 pending cases and 42 executed cases was reviewed by the Board. The specifics of these matters are not included as they are non-public. The Board accepted the report as presented. Additionally, the Board reviewed information regarding 3 matters involving outside litigation. The specifics of this report are not included because these matters are not public information.

A motion was passed to return to open session.

Mr. Mansfield presented a legislative update to the Board.

Executed Cases - Public Actions:

The following actions were executed since the Board's last regularly scheduled meeting. The Board voted to accept these as information.

Acosta, Daniel MD

Relief of Consent Order Obligations executed 06/28/2017

Artis, Daniellee Lynettee MD

Relief of Consent Order Obligations executed 05/24/2017

Cracker, Andrew John-Edward MD

Public Letter of Concern executed on 06/01/2017

Dahners, Laurence Earl MD

Public Letter of Concern executed on 05/30/2017

Dastous, Linh MD

Consent Order executed 05/09/2017

Fernandez, Sander MD

Public Letter of Concern executed on 06/01/2017

Fernz, Miriam Minu MD

Relief of Consent Order Obligations 06/06/2017

Folashade, Charles Olufemi MD

Consent Order executed on 06/15/2017

Gerlach, David Campbell MD

Relief of Consent Order Obligations executed 05/23/2017

Guffey, Neal Hamilton MD

Interim Public Non-Practice Agreement executed on 06/15/2017

Harris, John Joel MD

Consent Order executed on 06/09/2017

Headen, Kenneth Jay MD

Public Letter of Concern executed 06/29/2017

Heckman, Eric Christopher PA

Consent Order executed 06/26/2017

Howard, Chad Daniel MD

Public Letter of Concern executed 05/15/2017

Lee, Chee Yan MD

Reentry Agreement executed 06/01/2017

Liebman, Zachary Jay PA

Consent Order executed 06/05/2017

Lovin, Jeffrey Douglas MD

Public Letter of Concern executed on 05/25/2017

Pitts, Venus Idette MD

Non-Disciplinary Consent Order executed on 06/02/2017

Reilly, Preston Scott MD

Consent Order executed 06/26/2017

Rich, Preston Berkeley MD

Public Letter of Concern executed 06/29/2017

Roberts, Virginia Salyer MD

Consent Order executed on 05/24/2017

Shuck, Linda Michele MD

Reentry Agreement executed 05/09/2017

Vanarthos, Jill Chandelle PA
Consent Order executed 05/15/2017

Verdin, Thomas Marion MD
Consent Order executed on 06/09/2017

NCMB Committee Reports

EXECUTIVE COMMITTEE REPORT

Members present were: Eleanor E. Greene, MD, Chairperson; Timothy E. Lietz, MD; Pascal O. Udekwa, MD and A. Wayne Holloman. Members absent were: Barbara E. Walker, DO

Strategic Plan

a. Strategic Priorities Update

The Committee reviewed the updated Strategic Priorities Tracker.

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

Financial Statements

a. Monthly Accounting

The Committee reviewed the compiled financial statements for April 2017 and May 2017. May is the seven fifth month of fiscal year 2017.

Committee Recommendation: Accept the financial statements as reported.

Board Action: Accept Committee recommendation. Accept the financial statements as reported.

b. Investment Account Statements

The Committee reviewed the investment statements for May and June 2017

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

Old Business

a. FSMB Annual Meeting/Hearing

Current Board policy limits the number of Board members who can attend the FSMB Annual Meeting. However, those who don't attend miss out on educational sessions, interacting with colleagues from around the country, and getting to know their fellow Board members better. The Committee asked staff to determine the additional cost of all Board members attending the FSMB Annual Meeting. If all the Board members attend the FSMB Annual Meeting (which rarely occurs), the additional cost will be \$17,750.

The Committee also asked staff to calculate how much money is saved when the Board does not hold hearings. The average cost of a two-day hearing is \$8,500. Currently, there are six hearing dates each year; however, staff has determined (1) only four hearings are needed each year, and (2) historically there are very few hearings in April and August.

Committee Recommendation: 1) Modify NCMB policy to permit all Board members to attend the FSMB Annual meeting. (2) Beginning in 2018, cancel the April and August hearings.

Board Action: Accept Committee recommendation. 1) Modify NCMB policy to permit all Board members to attend the FSMB Annual meeting. (2) Beginning in 2018, cancel the April and August hearings.

New Business

a. Building Update

Mr. Gupta informed the Board we have received preliminary inquiries from a prospective buyer of the building.

Committee Recommendation: Accept as information. Staff will continue to monitor and provide periodic updates.

Board Action: Accept Committee recommendation. Staff will continue to monitor and provide periodic updates.

b. Proposed Changes to Rule 32R.0103 CS CME

It's not clear whether these licensees are required to complete the new CS CME requirement set out in the Board's rule 21 NCAC 32R.0101:

- Residents who have a full license rather than a RTL, and
- Physicians getting their initial board certification or doing MOC who are deemed to have satisfied the general CME requirements

Staff has submitted proposed rule changes to clarify that licensees in both groups, who prescribe controlled substances, are required to complete the new CS CME.

Committee Recommendation: Not discussed due to time constraints. Defer to full Board.

Board Action: Accept proposed changes to Rule 32R.0103 CS CME. Both groups are required to complete the new CS CME:

- Residents who have a full license rather than a RTL, and
- Physicians getting their initial board certification or doing MOC who are deemed to have the general CME requirements

c. Proposed Changes to the Code of Conduct:

Staff has reviewed the Board's Code of Conduct and submitted proposed changes to reflect model language. Mr. Jimison provided an overview to the Committee and answered questions.

Committee Recommendation: Adopt all changes except proposed paragraph 20 (concurrent leadership in state or national professional associations). Staff will revise paragraph 20 and submit it for further consideration at the September meeting.

Board Action: Tabled so that staff can make changes to paragraph 20 (leadership in state or national professional associations prohibited) and bring it back to the Committee for further consideration at the September meeting.

d. Board Meeting Schedule

Currently, the Board meets six times a year in the odd-numbered months. Three meetings (March, July and November) are two-day meetings that start at 1:00 p.m. on Wednesday and end around noon Friday.

Some Board members have expressed an interest in modifying the schedule to begin at 8:00 a.m. on Wednesday and end around 4:00 on Thursday. All Board members could return home Thursday evening or, if necessary, stay Thursday night and return home Friday morning. All non-local members of the Disciplinary Committee would need to travel to/stay in Raleigh Tuesday night for 8:00 a.m. meeting on Wednesday.

Committee Recommendation: Defer to Board.

Board Action: Beginning with the November 2017 meeting, the March, July and November meetings will start at 8:00 a.m. Wednesday and end Thursday afternoon by 5:00 p.m.

e. NCMB Review Panel

Mr. Henderson provided an update regarding the NCMB Review Panel process including a list of the 16 applicants for the two open Review Panel positions.

Committee Recommendation: Accept as Information.

Board Action: Accept Committee recommendation. Accept as information.

f. Nomination of Officers and Executive Committee Members

Pursuant to the NCMB Bylaws, the Executive Committee must nominate to the Board a slate of officers and an at-large member for the upcoming year (beginning November 1). The positions open for election are President-Elect, Secretary/ Treasurer and Member at Large.

Committee Recommendation:

President-Elect: Barbara E. Walker, DO

Secretary/Treasurer: Bryant A. Murphy, MD

Member-at-Large: A. Wayne Holloman

Board Action: Accept Committee recommendation. The nominations for the positions open for election are President-Elect, Barbara E. Walker, DO, Secretary/Treasurer, Bryant A. Murphy, MD, and Member-at-Large, A. Wayne Holloman.

POLICY COMMITTEE REPORT

Members Present were: Pascal O. Udekwu, M.D., Chairperson; Bryant A. Murphy, M.D.; Jerri L. Patterson, NP; Venkata R. Jonnalagadda, M.D.; and Shawn P. Parker

Old Business:

a. Use of Photography in the Examination Room (Appendix A)

At the July 2016 Committee meeting, there was discussion regarding the Disciplinary Committee's referral of a new position statement addressing use of recording equipment in the examination room. The Board instructed staff to draft a position statement for consideration by the Committee at the November 2016 Board meeting. The Board considered a draft of the position statement at the November 2016 Board meeting and made suggested changes and asked that the latest draft be submitted to Board stakeholders. A draft was submitted to stakeholders and comments were received and considered by the Board at the March 2017 Board meeting. At the May 2017 Committee meeting, it was discussed that the most recent draft of the position statement was published in the Forum and on the NCMB website in order to gather feedback from licensees before final consideration and adoption at the July 2017 Board meeting.

The committee discussed the feedback received from licensees and whether there needed to be clarification regarding the intent of recording (i.e. "Non-Medical Use"), and whether the Position Statement should be modified to only include certain language or should remain as proposed.

Committee Recommendation: Revise the proposed position statement to end after the second sentence of the “Informed Consent” section, deleting the numbered paragraphs of the “Informed Consent” section and deleting the “Post-recording Responsibilities” section.

Board Action: Accept Committee recommendation. Revise the proposed position statement to end after the second sentence of the “Informed Consent” section, deleting the numbered paragraphs of the “Informed Consent” section and deleting the “Post-recording Responsibilities” section. Additionally, remove emphasis from paragraph two, add emphasis to the last sentence of paragraph one, and reorder paragraphs two and three.

b. Treatment of Obesity (Appendix B)

At the March and May 2017 Committee meetings, there was discussion of the current relevance of the position statement and whether it should be modified or deleted. At both meetings, the Committee discussed methods of determining whether the position statement still served a useful purpose. At the May 2017 Committee meeting, after a consensus that the position statement is still relevant, it was suggested that in addition to mentioning hCG, the position statement should also include language addressing the inappropriate use of phentermine.

The position statement, as revised in the May 2017 Board meeting, was reviewed favorably.

Committee Recommendation: Accept proposed position statement.

Board Action: Accept Committee recommendation. Accept proposed position statement.

c. Medical Record Documentation (Appendix C)

The position statement, which was revised to include a section on Electronic Health Records, was favorably reviewed overall. There was discussion as to whether the position statement needed simplification and more conciseness. However, after further dialogue it was determined that the level of information provided was instructive at this time, but could be modified in future reviews of this position statement.

Committee Recommendation: Accept proposed position statement.

Board Action: Accept Committee recommendation. Accept proposed position statement.

d. Retention of Medical Records (Appendix D)

At the May 2017 Committee meeting, it was discussed that the Board’s position statement reflects the expectations of other entities regarding retention of records, but it might be helpful for the Board to articulate its own expectations to the Board’s licensees. The Committee instructed staff to draft a position statement for consideration by the Committee at the July 2017 Board meeting.

The Board's staff presented the proposed position statement. Concerns were raised that there still needed to be a decision on the exact number of years the Board expects for a physician to retain records. Mr. Brosius expressed the need for a possible rule on the number and not just a position statement so as to be an enforceable standard. OMD presented that in the case of a physician closing their practice or dying, that physician or the physician's family should only be expected to retain the records for 2 years after adequate notice is given to patients. Discussion ensued about the need for clarity in the Board's position statement.

Committee Recommendation: Assign Mr. Brosius, Dr. Kirby, and Dr. Udekwu the task of attempting to further revise the position statement to incorporate a specific Board standard. Bring back for review and consideration at September 2017 Board meeting.

Board Action: Accept Committee recommendation. Assign Mr. Brosius, Dr. Kirby, and Dr. Udekwu the task of attempting to further revise the position statement to incorporate a specific Board standard. Bring back for review and consideration at September 2017 Board meeting.

New Business

a. Capital Punishment

The committee did not have time to address the Capital Punishment position statement.

Committee Recommendation: Bring back for discussion at September meeting.

Board Action: Accept Committee recommendation. Bring back for discussion at September meeting.

LICENSE COMMITTEE REPORT

Members present were: Timothy E. Lietz, MD, Chairperson; Ralph A. Walker and Varnell McDonald-Fletcher, PA-C. Members absent were: Barbara E. Walker, DO and Cheryl L. Walker-McGill, MD

Old Business

a. Procedure to process license applications with misdemeanor charges or convictions.

At the July, 2016 License Committee, the Legal Department requested the licensing staff be permitted to process clean applications without Legal/OMD or Board Member review where the applicant truthfully reports two or less misdemeanors charges and/or convictions that (1) occurred more than twenty years ago and (2) prior to professional school. The Board Action was to allow the licensing section to process otherwise clean applications where the applicant truthfully reports two or less misdemeanor charges and/or convictions that:

- 1 – occurred more than twenty years ago, and
- 2 – prior to professional school.

Without the need for the application to be reviewed by the Legal Department or Senior Staff Review Committee. Additionally, these applications would not be reviewed by a Board Member. Licensing to track the number of applications that would fall into this category and report back to the license committee in six months.

At the January, 2017 Board meeting the licensing committee reviewed this again. The licensing section did not recall processing an application that met the criteria. The Board Action was for licensing to continue to track applications and report back to the license committee in 6 months.

The licensing section has reviewed 5 applications that met the above criteria since January 2017.

Committee Recommendation: Accept as information.

Board Action: Accept Committee Recommendation. Accept as information.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The License Committee reviewed **two** cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

ADVANCED PRACTICE PROVIDERS AND ALLIED HEALTH COMMITTEE REPORT

Committee Members present were: Jerri L. Patterson, NP, Chairperson, Timothy E. Lietz, MD, A. Wayne Holloman and Varnell McDonald-Fletcher, PA-C

PHYSICIAN ASSISTANTS ADVISORY MEETING

Staff discussed the Strengthen Opioid Misuse Prevention (STOP) Act and the need for rule-making. Draft of proposed rules will be presented at the September board meeting.

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

NURSE PRACTITIONERS

The Joint Sub Committee approved all recommendations from the May JSC Panel meeting.

Committee Recommendation: Receive as information.

Board Action: Accept Committee recommendation. Receive as information.

DISCIPLINARY (COMPLAINTS) COMMITTEE REPORT

Members present were: Bryant Murphy, MD, Chairperson; Debra Bolick, MD; Venkata Jonnalagadda, MD; Jerri Patterson, NP and Ralph Walker, JD. Members absent were: Barbara Walker, DO

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Complaints) Committee reported on 25 complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

DISCIPLINARY (MALPRACTICE) COMMITTEE REPORT

Members present were: Bryant A. Murphy, MD, Chairperson; Debra A. Bolick, MD; Venkata R. Jonnalagadda, MD; Jerri L. Patterson, NP and Ralph A. Walker, JD. Members absent were: Barbara E. Walker, DO.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Malpractice) Committee reported on 39 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (Medical Examiner) COMMITTEE REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-

8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Medical Examiner) Committee reported on two cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (DHHS) COMMITTEE REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (DHHS) Committee reported on 11 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

INVESTIGATIVE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

7 investigative interviews were conducted. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (INVESTIGATIVE) COMMITTEE REPORT

Members present were: Bryant A. Murphy, MD (chairperson), Debra A. Bolick, MD, Venkata R. Jonnalagadda, MD, Jerri L. Patterson, NP and Ralph A. Walker, JD. Members absent were: Barbara E. Walker, DO

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Thirty-seven investigative cases were reviewed. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

CONTROLLED SUBSTANCES CME PLANNING COMMITTEE

Board Members present were: Chairperson, Bryant A. Murphy, MD, Jerri Patterson, NP.

Overview of 2017 CS CME Panel Sessions

Four sessions were held during the months of April and May. 400 prescribers attended the panel sessions, and the webinar has had over 1,800 viewers. The overall feedback was very positive and we are working on making changes for future sessions. Wake AHEC is finalizing the reporting requirement for their grants.

New Business

a. Changes to 2017-2018 Program

The committee recommends the following changes to the CS CME panel sessions:

- Train the trainer program vs. managing content development for each session
 - Develop core presentation to be delivered at each session
 - Train core group of moderators to lead panel sessions in their region
- Reduce the number of presenters to 1 moderator + 2-3 panelists for each panel
- Continue holding panels on rural areas; partner with hospitals to cover urban areas/large prescriber groups

b. Next Steps

- ID counties for sessions
- ID core group of moderators
- Develop core content power point

Committee Recommendation: Accept as Information.

Board action: Accept Committee recommendation. Accept as information.

OUTREACH COMMITTEE

Members present were: Debra A. Bolick, MD, Chairperson; Bryant A. Murphy, MD; Shawn Parker and Pascal O. Udekwu, MD. Members absent were: Barbara E. Walker, DO

Old Business

a. Overview of Outreach Activities (Presentations)

The Communications Director provided an update on professional outreach to date. To date, NCMB has scheduled 35 talks to professional audiences, 26 of which have been completed. The Board remains on track to meet or exceed last year's outreach efforts. Opioid prescribing remains the most requested topic. The Committee discussed the importance of retaining key information about the Board, its mission and guidance on how to avoid regulatory problems in the slide deck, even when the audience requests a specific topic, such as opioids. The Committee also asked for a review of how information contained in presentations is vetted prior to talks to ensure accuracy. The Committee also encouraged the Communications Department to maintain the momentum the Board has created with Outreach in recent years so that NCMB retains the ability to regularly communicate important policy matters to licensee audiences across the state.

Committee recommendation: Accept as information

Board action: Accept Committee recommendation. Accept as information.

b. Public presentations to consumer audiences

The Chief Communications Officer (CCO) gave an update on public outreach so far this year. To date, NCMB Communications staff have presented to six consumer groups. Staff members approach each talk as an opportunity to learn more about patient/consumer interests and concerns, which may help guide future outreach or inform the Board's efforts to develop resources for patients and the public. The Committee discussed ways to ensure that NCMB provides content of interest to the public in its online Licensee Information pages. The CCO noted that NCMB will soon implement changes to the annual renewal questionnaire that may result in more licensees providing supplemental content, such as practice philosophy, insurance plans accepted and languages spoken, to their pages.

Committee recommendation: Accept as information

Board action: Accept Committee recommendation. Accept as information.

New Business

a. Introduction of new staff person

The Communications Director introduced the new Communications Coordinator, Sylvia French-Hodges, to the Committee.

Committee recommendation: Accept as information.

Board action: Accept Committee recommendation. Accept as information.

b. Forum newsletter digital supplement

The Communications Director discussed plans to introduce an email-only supplement to the quarterly Forum newsletter to provide readers with more timely information and updates between issues. Currently about 80 percent of Forum readers elect to receive the email version of the newsletter. The email supplement would be promoted in the printed edition of the Forum to give interested print readers the opportunity to opt in for the digital Forum supplement. The Committee discussed the value of maintaining a printed edition of the newsletter and asked that the Communications Department monitor the performance of the digital Forum supplement to assess its value to licensees. The Committee discussed the importance of limiting the number of email communications from the Board, to avoid having licensees become fatigued by NCMB content.

Committee recommendation: Proceed with a digital supplement to the Forum on a trial basis; The Communications Department shall produce two digital supplements and report back to the Committee after the trial issues are distributed.

Board action: Accept Committee recommendation: Communications staff to proceed with a digital supplement to the Forum on a trial basis; The Communications Department shall produce two digital supplements and report back to the Committee after the trial issues are distributed.

c. Public e-newsletter

The Communications Director outlined plans for an e-newsletter aimed at the consumer/patient audience. The idea came out of recent public market research that documented 10 percent awareness of the Board among the general public in NC, and also indicated consumer interest in receiving practical information and resources from the Board. The Committee discussed a variety of issues related to a consumer focused e-newsletter, including the importance of reaching all racial and socioeconomic groups, providing foreign-language versions (such as Spanish) of the newsletter, and ensuring that content remains within the scope of NCMB's mission. The Committee also discussed the desirability and feasibility of having a multi-pronged approach to reaching the public.

Committee recommendation: Bring to the full Board for further discussion.

Board action: Communications staff to proceed with plans to develop a patient/consumer focused e-newsletter to educate patients and the public about the Board.

Barbara E. Walker, DO; Secretary/Treasurer

PROPOSED POSITION STATEMENT:

Policy for the Use of Audio or Visual Recordings in Patient Care

The Board recognizes that there may be valid reasons for licensees to make audio or visual recordings of patients during a healthcare encounter. However, such recordings must be made for appropriate professional reasons and should employ safeguards that protect a patient's autonomy, privacy, confidentiality, and dignity. **In instances where a patient may be asked to disrobe, the patient should be provided an opportunity to disrobe beyond the view of any camera.**

Prior to an audio or visual recording being made of a patient, licensees should ensure that they have obtained the patient's informed consent. The informed consent should be documented in the medical record and should allow the patient an opportunity to discuss any concerns before and after the recording.

Recordings that could lead to disclosure of the patient's identity constitute protected health information and must be managed and transmitted in a manner that complies with HIPAA requirements.

(Adopted July 2017)

Treatment of Obesity

It is the position of the North Carolina Medical Board that the cornerstones of the treatment of obesity are diet (caloric control) and exercise. Medications and surgery should only be used to treat obesity when the benefits outweigh the risks of the chosen modality.

The treatment of obesity should be based on sound scientific evidence and principles. Treatment modalities and prescription medications that have not been proven to have beneficial effects should not be used. For example, it is the Board's position that it is inappropriate to: (1) prescribe hCG for the treatment of obesity; or (2) to prescribe phentermine at excessive dosages, for inappropriate durations, or to patients that are not overweight.

Adequate medical documentation must be kept so that progress as well as the success or failure of any modality is easily ascertained.

(Adopted [as The Use of Anorectics in Treatment of Obesity] October 1987; Amended March 1996; Amended January 2005 [retitled]; Reviewed November 2010; Amended May 2013; Amended July 2017)

Medical Record Documentation

The North Carolina Medical Board takes the position that an accurate, current and complete medical record is an essential component of patient care. Licensees should maintain a medical record for each patient to whom they provide care. The medical record should contain an appropriate history and physical examination, results of ancillary studies, diagnoses, and any plan for treatment. The medical record should be legible. When the care giver does not handwrite legibly, notes should be dictated, transcribed, reviewed, and signed within a reasonable time. The Board recognizes and encourages the trend towards the use of electronic medical records (“EMR”). However, the Board cautions against relying upon software that pre-populates particular fields in the EMR without updating those fields in order to create a medical record that accurately reflects the elements delineated in this Position Statement.

The medical record is a chronological document that:

- records pertinent facts about an individual's health and wellness;
- enables the treating care provider to plan and evaluate treatments or interventions;
- enhances communication between professionals, assuring the patient optimum continuity of care;
- assists both patient and physician to communicate to third party participants;
- allows the physician to develop an ongoing quality assurance program;
- provides a legal document to verify the delivery of care; and
- is available as a source of clinical data for research and education.

The following required elements should be present in all medical records:

1. The record reflects the purpose of each patient encounter and appropriate information about the patient's history and examination, and the care and treatment provided are described.
2. The patient's past medical history is easily identified and includes serious accidents, operations, significant illnesses and other appropriate information.
3. Medication and other significant allergies, or a statement of their absence, are prominently noted in the record.
4. When appropriate, informed consent obtained from the patient is clearly documented.
5. All entries are dated.

The following additional elements reflect commonly accepted standards for medical record documentation.

1. Each page in the medical record contains the patient's name or ID number.
2. Personal biographical information such as home address, employer, marital status, and all telephone numbers, including home, work, and mobile phone numbers.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier.

4. All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescriptions refilled by phone should be recorded.
5. Encounter notes should include appropriate arrangements and specified times for follow-up care.
6. All consultation, laboratory and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken.
7. An appropriate immunization record is evident and kept up to date.
8. Appropriate preventive screening and services are offered in accordance with the accepted practice guidelines.

Electronic Health Records

The promise and potential of information technology in health care, particularly the use of electronic health records (EHR), presents providers with distinct challenges. While the Board encourages the adoption and appropriate use of various forms of EHR there are some unique aspects and problems that have been repeatedly encountered by the Board, some of which are discussed below. This subsection does not identify all of the issues and problems encountered by providers using EHR. Rather it is meant to identify issues which the Board has repeatedly found to be problematic in malpractice cases and complaints coming to the Board's attention. It is important to recognize that this, and other Board position statements, are not comprehensive and do not describe exhaustively every standard that might apply in every circumstance. Basic, well-established principles of medical record documentation, as outlined above, apply to all forms of medical record documentation, including EHR.

The following guidelines are offered to assist licensees in meeting their ethical and legal obligations:

- EHR Deficiencies. Providers, on occasion, attribute errors or lack of follow-up, such as missed or lost abnormal laboratory results or x-ray reports, to deficiencies in their EHR. This is not acceptable. Providers must be aware of the idiosyncrasies and weaknesses of the EHR system they are using and adjust their practice accordingly. Providers are ultimately responsible for the adequate oversight and monitoring of the EHR.
- Responsibility of Licensees. EHR are becoming increasingly sophisticated and may provide flags for follow-up care or other clinical decision-making support, such as health maintenance recommendations. While an EHR system may assist in the clinical decision-making process, it is not responsible for decision making. For example, it is not acceptable to blame an EHR because it failed to recommend particular testing. Increasingly elaborate documentation, clinical management, and productivity tools may also result in increased opportunities for errors or omissions. These errors are a failure of the provider to assume appropriate responsibility for the care of the patient. In the end, decision-making responsibility rests solely with the provider; regardless of the information or notices provided by the EHR.
- Use of Templates. The Board cautions against overuse of template content or reliance on EHR software which pre-populates, carries forward, or clones information from one

encounter to the next, or from different providers, without the provider carefully reviewing and updating all information. Documentation of clinical findings for each patient encounter must accurately and contemporaneously reflect the actual care provided.

- Availability of, or Access to, Medical Records. Physicians must be able to provide patient medical records in a timely manner for various situations, such as consultations, transfer of care to another provider, or practice closure. The Board has encountered situations where providers were unable to access their patients' medical records due to fee or other disputes with the EHR vendor. This is particularly true when the medical records are maintained off site (cloud storage). Providers must understand provisions of their contract with the EHR vendor in this regard. These principles of medical record access apply as well to telemedicine providers.
- Breakdown of Patient-Provider Communication. Misunderstandings and miscommunications between patients, patient family members, practitioners, and office staff generate a substantial percentage of complaints received by the Board. Many EHR systems allow direct patient-provider communication (i.e. "patient portal"). While this form of communication can facilitate communication, such as follow-up of lab or x-ray results or medication refills, they also place a responsibility on the provider to provide timely responses to legitimate requests from patients for feedback or information.

(Adopted May 1994; Amended May 1996; Amended May 2009; Reviewed May 2013; Amended July 2017)

CURRENT POSITION STATEMENT:

Retention of Medical Records

Licenses have both a legal and ethical obligation to retain patient records. The Board, therefore, recognizes the necessity and importance of a licensee's proper maintenance, retention, and disposition of medical records. The following guidelines are offered to assist licensees in meeting their ethical and legal obligations*:

- State and federal laws require that records be kept for a minimum length of time including but not limited to:
 1. Medicare and Medicaid Investigations (up to 7 years);
 2. HIPAA (up to 6 years);
 3. Medical Malpractice (varies depending on the case but should be measured from the date of the last professional contact with the patient)—licensees should check with their medical malpractice insurer; North Carolina has no statute relating specifically to the retention of medical records;
 4. Immunization records always must be kept.
- In addition to existing state and federal laws, medical considerations may also provide the basis for deciding how long to retain medical records. Patients should be notified regarding how long the licensee will retain medical records.
- In deciding whether to keep certain parts of the record, an appropriate criterion is whether a licensee would want the information if he or she were seeing the patient for the first time. The Board, therefore, recognizes that the retention policies of licensees giving one-time, brief episodic care may differ from those of licensees providing continuing care for patients.
- In order to preserve confidentiality when discarding old records, all records should be destroyed, including both paper and electronic medical records.
- Those licensees providing episodic care should attempt to provide a copy of the patient's record to the patient, the patient's primary care provider, or, if applicable, the referring licensee.
- If it is feasible, patients should be given an opportunity to claim the records or have them sent to another licensee before old records are discarded.
- The licensee should respond in a timely manner to requests from patients for copies of their medical records or to access to their medical records.

- Licensees should notify patients of the amount, and under what circumstances, the licensee will charge for copies of a patient's medical record, keeping in mind that N.C. Gen. Stat. 90-411 provides limits on the fee a licensee can charge for copying of medical records.

**Licensees should retain medical records as long as needed not only to serve and protect patients, but also to protect themselves against adverse actions. The times stated may fall below the community standard for retention in their communities and practice settings and for the specific needs. Licensees are encouraged (may want to) seek advice from private counsel and/or their malpractice insurance carrier.*

(Adopted May 1998; Amended May 2009; Reviewed July 2013)

PROPOSED POSITION STATEMENT:

Retention of Medical Records

Licensees have both a legal and ethical obligation to retain patient medical records. The Board, therefore, recognizes the necessity and importance of a licensee's proper maintenance, retention, and disposition of medical records.

Patient interests related to present and future healthcare needs should be a licensee's primary consideration when determining how long to retain medical records.

Although North Carolina law does not specifically require the retention of medical records for a certain period of time, it is the Board's expectation that its licensees will retain patient medical records for a minimum of _____ years from the last date of treatment. It should be noted that this expectation relates solely to Board inquiries and does not preempt other legal or ethical record retention requirements.

There are a variety of other factors impacting a licensee's consideration of how long medical records should be retained. The following guidelines are offered to assist licensees in meeting their ethical and legal obligations:

- Federal laws applying to Medicare and Medicaid patients have varying requirements of record retention and may require record retention for up to seven (7) years;
- Medical Malpractice (varies depending on the case but should be measured from the date of the last professional contact with the patient)—licensees should check with their medical malpractice insurer or private legal counsel;
- Patient records gathered in the context of a hospital setting or large institutional environments are under the primary jurisdiction of their governing bodies;
- Immunization data has life-long relevance and special care should be taken to preserve it and its availability. Licensees are encouraged to utilize the North Carolina Immunization Registry ("NCIR") for documentation of all vaccines given. The states registry is an appropriate repository for this data; and
- In deciding whether to keep certain parts of the record, an appropriate criterion is whether a licensee would want the information if he or she were seeing the patient for the first time. The Board, therefore, recognizes that the retention policies of licensees giving one-time, brief episodic care may differ from those of licensees providing continuing care for patients.

Other Considerations and Board Expectations:

- Patients should be notified regarding how long the licensee will retain medical records.
- If it is feasible, patients should be given an opportunity to claim the records or have them sent to another care provider before old records are discarded.

- In order to preserve confidentiality when discarding old records, all records should be retained and destroyed in a HIPAA compliant manner, including both paper and electronic health records.
- Those licensees providing episodic care should attempt to provide a copy of the patient's record to the patient, the patient's primary care provider, or, if applicable, the referring licensee.
- The licensee should respond in a timely manner to requests from patients for access to, or copies of, their medical records.
- Licensees should notify patients of the amount, and under what circumstances, the licensee will charge for copies of a patient's medical record, keeping in mind that N.C. Gen. Stat. 90-411 provides limits on the fee a licensee can charge for copying of medical records.

*NOTE: Refer also to the Board's Position Statement on Departures from or Closings of Medical Practices.