D.C. Board of Medicine

INFORMATION FOR THE MEDICAL COMMUNITY AND THE PUBLIC FROM THE D.C. BOARD OF MEDICINE

DC BOARD OF MEDICINE GOES GREEN

INSIDE THIS ISSUE

Verification of Licensure 2

Loan Repayment 2

Licensure Status Online 2

Update Your Profile 3

In The News 3

Counsel's Column 4

HIV/AIDS in the District 6

Academic Detailing Program for Physicians 10

Cultural Confidence 12

Meet Board Member Miriam Markowitz 13

Postgraduate Physician Annual Enrollment 14

Communication Issues 14

Supply of LTC Physicians 15

Board Welcomes Dr. Jacqueline Watson 16

Jim Granger Retires 17

Board Orders 18

Filing a Complaint 19

Online Profiles 19

Board Members, Board Staff and Contact Information 20

YOUR MAILING ADDRESS

Changing your mailing address? Send your name, mailing address, and license number to:

DC Board of Medicine
Processing Department
Address/Name Change
717 14th Street, NW
Suite 600
Washington, DC 20005

Government of the District of Columbia
Adrian M. Fenty, Mayor

DEPARTMENT OF HEALTH
Promote. Prevent. Protect

May 2009

Letter from the Chair

HIV/AIDS RATE IN DC HITS 3%: "SERIOUS TIMES CALL FOR SERIOUS MEASURES."

Frederick C. Finelli, M.D., J.D.

It was splattered all over the papers and hit the national news shows. I read that at least 3% of our city's residents have HIV or AIDS. And that 3% is an underestimate, because so many cases are not diagnosed. And some referred to our HIV problem as a severe epidemic. Others said that our rates are higher than West Africa. You must have read or heard the news. Are you like me? Did you stop and think, "Somebody should do something about this!"

When it comes to healthcare in DC, that "somebody" is you, the doctors of DC. As doctors, we order the tests, make the diagnoses, and prescribe the treatment. If there is a serious disease that we are underdiagnosing, we need to step it up. It's our job. It's our duty.

What can we do? Start by reading Dr. Shannon Hader's article on page 7 of this newsletter. You may be surprised at what you learn. For example, did you know that you do not need to obtain a special consent or give pretest counseling to test for HIV? And did you know the CDC [Centers for Disease Control and Prevention] recommends routine HIV testing of everyone, that's everyone, age 13 and over, at least once, even if there are no risk factors? Are we doing all we can?

Of course, it is not all on our shoulders. Some clinics and hospitals are already using routine "opt-out" HIV testing. And the Department of Health is working hard to assist all healthcare practitioners and organizations in diagnosing, treating and preventing HIV/AIDS. But as the ultimate caretakers of the city's health, we, the doctors, need to take the lead.

— Frederick C. Finelli, MD, JD
Chairperson
DC Board of Medicine

REPORTS OF ADVERSE EVENTS DUE WITHIN 60 DAYS OF OCCURRENCE

Formerly, adverse events were reported on January 1 and July 1 of each calendar year. The law has now changed and all adverse events must be reported within sixty (60) days of the event's occurrence.

See the Board Counsel's article on page 4.

DEA AND DISTRICT CS REGISTRATIONS REQUIRED

A physician who prescribes controlled substances in the District of Columbia must have both a federal Drug Enforcement Agency (DEA) registration number and a District of Columbia controlled substance registration number. Pharmacies are prohibited from accepting prescriptions for controlled substances without a local registration number on the prescription. This is not a new law. Controlled substance registration numbers expire simultaneously with your medical license and can be renewed as part of your biennial medical license renewal. For more information see 22 District of Columbia Municipal Regulation Chapters 10 and 13. If you need a local registration number please contact DC Controlled Substances, Yvonne Briscoe Hall, Program Specialist, with the Pharmaceutical Control Division at (202) 724 - 7338/4900.

Upcoming Board Meetings

THE BOARD MEETS ON THE LAST WEDNESDAY OF THE MONTH

**at 717 14th St., NW
10th Floor
Washington, DC 20005**

Open Session is at 9:00 a.m.

Please call (202) 724-8800 to confirm meeting date.

Continuing Medical Education

The Board reminds all licensees that the continuing medical education (CME) requirement for renewal in 2010 is fifty (50) hours of Category I continuing education. The courses must be accredited by the Accreditation Council for Continuing Medical Education, the American Osteopathic Association, a state medical society, or the American Medical Association. The Board recommends that licensees accumulate CME credits throughout the renewal period in order to avoid last minute cramming and possible renewal issues.

(Physicians can gain CME credits by participating in the District's iDiS Academic Detailing Program. See pages 10-11.)

STOP MEDICAID FRAUD.

CALL THE DC MEDICAID FRAUD LINE AT:
1-877-632-2873

VERIFICATION OF LICENSURE

Licensing authorities and some health facilities often require a letter of verification of the licenses you currently hold or have held in the past. These letters of verification are sometimes called "letters of good standing," even though your DC license may have expired.

If the jurisdiction or institution to which you wish the letter sent gave you a form, simply forward the form, with a check or money order payable to "DC Treasurer" in the amount of thirty-four dollars ($34.00) to:

DC Board of Medicine
717 14th Street, NW
Suite 600
Washington, DC 20005

On the form, be sure to include your name and the address where the form is to be sent.

If the jurisdiction or institution to which you wish the letter sent did not give you a form, send the payment referenced above and a short note requesting a letter of verification. The note should include your name, and the name and address of where you want the letter of verification sent.

LOAN REPAYMENT PROGRAM REMINDER

The District of Columbia has established a loan repayment program for health care professionals. The program's main goal is to aid in the recruitment and retention of health care professionals to provide services to medically underserved residents. Participation will be approved on a case-by-case basis and each applicant is required, among other requirements, to:

- Be a United States Citizen.
- Be a physician who has completed post-graduate training in family practice medicine, general internal medicine, general pediatrics, obstetrics/gynecology, psychiatry or osteopathic general practice.

For more information, please contact Ms. Katina R. Green of the Community Health Administration Primary Health Program at:

Phone: (202) 442-9168
Email: katina.green@dc.gov

CHECK LICENSURE STATUS ONLINE

The status of an applicant's licensure application can now be checked online. Go online at:

https://app.hpla.doh.dc.gov/mylicense/

A MUST READ: HIV TESTING

"ROUTINE OPT-OUT HIV TESTING" by S. L. Hader, MD, MPH, Senior Deputy Director of the HIV/AIDS Administration, page 7.

HIV-Test FAQs on page 9.

TIPS FOR EXPEDITING YOUR LICENSE

Make sure to have your entire application filled out and signed.

- Provide official court documents of final case dispositions for any felonies or misdemeanors that you incurred (i.e., a defendant in any state or country).
- Malpractice case dispositions should include a case number, jurisdiction, year, all the defendant names, all plaintiff names, a brief summary of the case, and final disposition, such as judgment dollar amount, dismissed with or without prejudice, or settlement dollar amount—this information must be sent with your application.

EACH PHYSICIAN IS REQUIRED TO UPDATE HIS OR HER ONLINE PHYSICIAN PROFILE.

SANCTIONS WILL BE IMPOSED ON PHYSICIANS WHO DO NOT REPORT CHANGES WITHIN 30 DAYS.

Physicians must report changes related to:

- Settlements, judgments, and convictions
- Disciplinary actions by other jurisdictions
- Final orders of any regulatory board of another jurisdiction
- Restriction or termination of privileges as a result of a peer review action
- Disciplinary action taken by a federal health institution or federal agency.

Please see "Counsel's Column" in this issue (page 4, item #3) for a detailed list of actions which must be reported.

To update your profile, login to our online system at: https://app.hpla.doh.dc.gov/mylicense/
Questions? Call the Board of Medicine at (202) 724-8800.

IN THE NEWS

DC BOARD #22 ON PUBLIC CITIZEN'S 2008 RANKING

The consumer advocacy group Public Citizen has named the DC Board of Medicine as one of the top ten states with the largest improvement in the number of serious disciplinary actions per 1,000 physicians for the period of 2001 to 2007. According to their report entitled *Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2005-2007 (HRG Publication #1837)*, "Ten states have accomplished at least a 10-place improvement in ranking between the 2001-2003 ranking and the 2005-2007 ranking: Arkansas from 29 to 16; Delaware from 50 to 29; District of Columbia from 42 to 22; Hawaii from 51 to 21; Illinois from 35 to 12; Maine from 34 to 24; Nebraska from 28 to 5; Rhode Island from 46 to 23; Tennessee from 44 to 28 and Vermont from 19 to 8." Public Citizen's rankings are based on disciplinary data provided by the Federation of State Medical Boards (FSMB).

THE LACK OF COMMUNICATION BETWEEN PHYSICIANS

The problem of "noncommunication among physicians" was the focus of *Physicians Behaving Badly,* an article published in JAMA (Journal of the American Medical Association, 7/2/08, page 21-22). The author, primary care physician Michael D. Stillman, MD, recounts an incident where a patient of his had been admitted, treated and prescribed new medications within a 3-week timeframe, yet he was not informed of these events until after his patient had been discharged. He also recounts another instance, when a patient of his was admitted to the hospital, but the hospital staff never informed Dr. Stillman that the patient had died. Dr. Stillman only obtained this information two weeks later when he called the patient's home to inquire about his condition. Without collaboration between physicians, he says: "we miss critical pieces of [patient] histories and thus either perform redundant workups or fail to address important medical issues." Dr. Stillman proposes that this issue be addressed by medical educational institutions and that curriculum reinforce the need for physician-to-physician communication, so that collaboration between physicians can be "taught, role modeled, and even enforced" for future physicians.

PHYSICIAN OVERCONFIDENCE LEADS TO DIAGNOSIS ERRORS

In the article *The Startling Truth About Doctors and Diagnostic Errors* (www.alternet.org), the authors conclude that physician overconfidence accounts for the high rate of misdiagnosis: "The belief that 'I know all I need to know,' may help explain what researchers describe as a 'pervasive disinterest in any decision support or feedback...'." Authors Mahar and Karvounis also note that autopsy results from 1998 and 1999 reveal that autopsies "turn up a major misdiagnosis in roughly 40 percent of all cases." *The article was originally published online at www.healthbeatblog.org.*

DISRUPTIVE BEHAVIORS SENTINEL EVENT ALERT

The Joint Commission has issued an alert (*Behaviors that undermine a culture of safety,* Issue 40, 7/9/08), to draw attention to the destructive and unacceptable behavior which has traditionally been tolerated in medical settings: "...overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions." Or "throwing instruments across the operating room" as one Board member noted at the September 2008 board meeting.

Although disruptive outbursts are not sentinel events (death, serious physical or psychological injury, loss of limb), disruptive behaviors, according to the Joint Commission "can foster medical errors... [and] preventable adverse outcomes..." Recommendations for eliminating such behaviors include establishing a "Zero Tolerance" policy for disruptive behavior, educating medical staff, encouraging casual cup-of-coffee discussions with those exhibiting unacceptable behaviors and enforcing appropriate disciplinary actions.

For full list of recommendations, go online at: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm

Counsel's Column

1. **Be transparent in what you report to the Board of Medicine.**
2. **Reporting Adverse Events: Know what they are, who does the reporting and when they must be reported.**
3. **You now have a profile on-line. Keep it current.**
4. **If you prescribe controlled substances, you need to have a local CS registration number.**
5. **If you currently practice medicine in the District and do not have a license to do so, check to make sure you are covered by the rules.**
6. **The Board of Medicine has as one of its primary oversight responsibilities the investigation of complaints against physicians. Be sure to respond to the Board when you are asked for your side of the story.**

THINGS I WISHED I HAD KNOWN BEFORE I GOT IN TROUBLE WITH THE BOARD OF MEDICINE

By John C. Greenhaugh, Esq.
Senior Assistant Attorney General & Board Legal Advisor

From time to time, I think it is helpful for those who practice medicine to focus on matters that routinely come before the Board. Physicians would want to know about "incidents" that could lead to sanction and avoid those errors. Most are errors of omission. Here are my top six:

1. **Be transparent in what you report to the Board of Medicine.** When you renew, you will go on-line and answer a number of questions. Most of those questions are "screening questions." Do not complete the form too quickly. Give the renewal form the time and attention it deserves. For instance, if you respond to the screening question asking if since your last renewal have you been investigated "by any authority or peer review board for any violation of state, federal or local law", and you check the "No" box and the Board finds out you were investigated by "any authority", you have committed a violation of law and may be sanctioned by the Board. What makes it even more important to be accurate is that the law does not require that the Government prove the physician knew about the investigation. The standard is that one knew or *should have known* that they were being investigated when they responded with a wrong response. *(emphasis added)* On all of the screening questions on the renewal form be sure that you do not inadvertently check the wrong box.

2. **You have to report adverse events that occur in your treatment of a patient unless you are practicing in a medical facility at the time**, in which case the facility has to report the adverse event. See District of Columbia Municipal Regulation Title 17, § 4017 and D.C. Official Code § 7-161 (2007). If the adverse event occurs in your private office, you need to report it. The law requires you to report adverse events within sixty (60) days of their occurrence. Formerly, healthcare providers were required to report twice a year, on January 1 and on July 1 of each calendar year. However, that reporting period changed with the Adverse Event Reporting Requirement Amendment Act of 2008, effective March 20, 2009. The reporting period is now a "rolling 60 day" reporting period. If you cannot complete the entire report within 60 days, submit what you can on time and supplement it as soon as possible.

Know what adverse events need to be reported. Post the list in your administrative office and make sure everyone is aware of the adverse events to be reported. Unless it is one of the twenty-eight (28) "never events" specified by the National Quality Forum, or a central line associated bloodstream infection (CLABSI), it does not have to be reported for purposes of adverse event reporting. An event may have to be reported elsewhere for other purposes, but if the event meets the definition of an adverse event it has to be reported to the Health Regulation and Licensing Administration, part of DOH for the District of Columbia. The mailing address is at the top of the form. The twenty-nine (29) events that need to be reported are found on our website at: http//www.hpla.doh.dc.gov. They are listed on the last several pages of the report format. You need to print the report and fill it out

manually. The Department is expecting to move to a Web-based reporting system this calendar year.

3. **You now have a profile on-line. Keep it current.** You need to keep that profile updated, either by updating it yourself or by reporting items to the Board of Medicine when the changes relate to settlements, judgments, conviction of a crime, or any disciplinary action by other jurisdictions. The changes to your profile need to be reported at the time your application is approved for licensure, within thirty (30) days of renewal or within thirty days of a change to the data in your profile. Know what has to be reported for your profile. This includes any settlement of a case filed against you, whether you paid the settlement or someone else did on your behalf. It includes judgments in civil suits. It includes information on any misdemeanor and felony convictions. Finally, report to the Board any final orders of any regulatory board of another jurisdiction that resulted in the denial, probation, revocation, suspension, or restriction of any license or that resulted in the reprimand or censure of any licensure, fines imposed, or the voluntary surrender of a license while under investigation in a jurisdiction other than the District of Columbia, restriction or termination of privileges at a healthcare facility as a result of a peer review action, as well as any disciplinary action taken by a federal health institution or federal agency. The regulation requires all disciplinary actions in the past ten (10) years be reported, as well as the date, amount, and description of any medical malpractice payout made within the last ten (10) years. See District of Columbia Municipal Regulation Title 17, § 4609 (Physician's Profile).

4. **If you prescribe controlled substances, you need to have a local CS registration number.** You can renew the number at the same time as you renew your license. There is an alert on the first page of this newsletter that provides you the contact information for local registration numbers. Please read it and, if you prescribe controlled substances, acquire the number. Pharmacies are increasingly not filling CS prescriptions unless they see both the DEA number and the local registration number on the prescription.

5. **If you currently practice medicine in the District and do not have a license to do so, check to make sure you are covered by the rules.** See Title 17, § 4611 for the rules governing pre-licensure practice by students and postgraduate physicians. For instance, if you are in a residency program you generally do not need a medical license. However, postgraduate physicians in training need to know there is an exception to this rule. Many postgraduate physicians in training moonlight outside the District. As soon as you acquire a license in a neighboring state to work nights and weekends, you lose the exemption to work without a license in the District even if in a residency program. You are in effect practicing medicine without a license. The fine for this violation increases with the passing of each month that you do not have the license but need one. So if this applies to you, get that application in. If you are in a residency program, you need to "enroll" with the Board of Medicine via the online Postgraduate Physician Trainee Enrollment Form. The Board calls it the PPT program. *[See page 14 of this newsletter.]* It costs $50 each year, payable to the hospital at the time of enrollment and reenrollment. This enrollment is required by law, so please read the regulations. You need to reenroll each year. The purpose of registration is to gather data via the questionnaire, and to allow the Board to track physicians practicing medicine without a license in the District, e.g. at what hospital, and under what clinical program. Contact your Program Director, Residency Coordinator, GME Director, or medical licensing staff in the Health Regulation and Licensing Administration if you have any questions. Lastly, keep in mind that the PPT exemption from licensure lasts five (5) years from the date of medical school graduation. You have five years to complete your residency program and obtain a medical license. The PPT enrollment is only good while you are in a residency program during that five years. A period of fellowship does not count. If you completed the residency program, you need a license to practice in the District, unless if in a fellowship program you are not practicing medicine, e.g. doing research.

6. **The Board of Medicine has as one of its primary oversight responsibilities the investigation of complaints against physicians.** Those complaints, if there is the potential for a violation of the laws and regulations that govern the practice of medicine, are forwarded to the physician for a response to the Board. The legal document that is used to seek the response is called an Order to Answer, which orders the physician to respond to the Board within ten (10) days of receipt of the Order to Answer. If the response to the Board is not returned within ten days, the lateness of the response is itself a violation of regulation and may result in disciplinary action against the physician.

■ ■ ■

These six points to remember are not intended to be all-inclusive, but the main point is to be accurate and timely in all reporting requirements. For starters in maintaining a clean record and responding appropriately and on time to Board queries, these six "danger" areas are a good place to start.

BOARD OF MEDICINE FORMS MAY BE ACCESSED ONLINE AT WWW.HPLA.DOH.DC.GOV.
Click on Professional Licensing Boards/Registrations, then click on Medicine. Links to forms are below and at left.

HIV/AIDS ADMINISTRATION'S SHANNON HADER, MD, SPEAKS TO THE BOARD OF MEDICINE

By Nancy Kofie

The District HIV/AIDS Administration's Senior Deputy Director Shannon L. Hader, MD, MPH, spoke with the Board of Medicine in 2008 and urged members to encourage physicians to make oral-swab opt-out HIV testing a routine part of their practice. Oral swab results are available in 20 minutes. *(For test kits, see contact information at right.)*

It Should Be Easy

We need to make it as routine and easy to get as a blood pressure test, Dr. Hader told Board members. "It is time to treat it like the medical disease it is." Describing routine testing as a "core initiative," Dr. Hader noted that most patients don't opt out, and that many mistakenly believe that HIV testing is already a routine part of their medical care.

"Recent data indicates that 3/4ths-to-4/5ths of clients with new HIV diagnoses in the District had contact with the healthcare system in the last 12 months," Dr. Hader told board members.

DC has an infection rate that is twice as high as New York City, and four times the infection rate in Detroit, Hader noted. "HIV/AIDS is the number one cause of premature mortality in the District."

No Consent Form Needed

Board Chair Frederick Finelli, MD, JD, asked about the regs as related to HIV testing. "We are lucky," Dr. Hader said. "There are no regs, no requirement for a special HIV consent form. HIPPA *[Health Insurance Portability and Accountability Act of 1996]* governs everything."

Dr. Finelli voiced concern that DC physicians may have about reporting requirements. "We do encourage people to comply with reporting requirements," Dr. Hader told board members so that the District will have the numbers for planning purposes and for the data needed to gain federal funding.

Emergency Department Testing

DC hospital emergency departments are currently offering the rapid test. George Washington University is reporting 2-3 new positives a week; Howard University Hospital reports 8 new positives a week.

The District Council has passed a bill which requires Medicare reimbursement.

Roadmap for Your Practice

Physicians do not have to do precounseling, but should have a "roadmap for practice" when diagnosing HIV—expert back up. "Walk your patient through to continue the care. Talk to colleagues who do a lot of HIV testing. How do they handle it?" Refer your HIV+ patients to a practitioner currently treating at least 20 HIV patients.

Do not feel reticent to test for HIV. "Draw on your skills as a physician. We diagnose serious medical conditions every day," Dr. Hader said.

Board member John J. Lynch, MD, voiced concern that some patients may fear disclosing their status to a partner or their parents. Dr. Hader conceded that, for some, the diagnosis could cause the patient to be confronted with rejection or anger from family members or partners. In DC, teenage patients have the right to be tested: "Teens decide if they want to get tested. No parental consent needed."

Partner Notification Program

"Tell your patients: 'I think it is really important for you to disclose [your HIV status], and we can help you'," Dr. Hader said.

The HIV/AIDS Administration offers a service for HIV+ patients in which past sexual partners are notified that they have been exposed and are at risk.

According to Dr. Hader, 40% of infections in the District are transmitted by heterosexual contact, 20% are transmitted via men having sex with men, and 15% are transmitted through drug use [25% undetermined].

Although the most common age of diagnosis occurs for persons in their 30s or 40s, Hader said, clients in their 50s have the same chance of diagnosis as those under 30.

Dr. Hader seeks to dispel the myth that high-risk patients engage in high-risk activities. Many persons who are infected have only one sexual partner: "You don't need to be a 3x-risk-individual to be 'at risk'."

CONTACT THE HIV/AIDS ADMINISTRATION FOR RAPID HIV TESTS AND TRAINING

Phone	**202-671-4900**
Address	**64 New York Ave., NE Suite 5001 Washington, DC 20002**
Web	**www.doh.dc.gov/hiv**

DC APPLESEED REPORT LAUDS DISTRICT'S IMPROVEMENT IN THE TREATMENT AND PREVENTION OF HIV/AIDS

In 2008, Mayor Fenty and DC Appleseed Director Walter Smith released a fourth "report card" noting that the District government's performance in 11 areas around HIV/AIDS had substantially improved.

"[Appleseed's] report card confirms that the District has the know-how and plans in place to reverse the HIV epidemic," Mayor Fenty said.

The District leads the nation with the boldest initiatives to reduce the impact of HIV. DC is the first and only jurisdiction working to implement routine HIV testing in its medical settings. DC Appleseed recognized this by improving DC's grade to "A-".

"Able leadership, strong collaborative ties, a focus on performance and improved outcomes all combine to put the District in a great position to continue to combat the HIV/AIDS epidemic," said Dr. Pierre N.D. Vigilance, Director of the Department of Health. More of the District's promising approaches include:

- Working to ensure that all labor and delivery suites and OB/GYNs are offering routine HIV testing by 2009.
- Launching new public information programs to reduce stigma, promote routine testing, reduce risky behavior, and access available services.
- Expanding the new youth initiative – including a national model of text messaging HIV/STD information.
- Working on interagency coordination with stronger agreements with sister District government agencies.
- Other areas that were highlighted include improvement in reduced barriers to substance abuse treatment and HIV testing at the DC Jail.

ROUTINE OPT-OUT HIV TESTING IN MEDICAL SETTINGS

BY SHANNON L. HADER, MD, MPH
Senior Deputy Director, HIV/AIDS Administration, DC Department of Health

"I can't have AIDS – I go to the doctor and get pap smears and blood drawn every year, and they've always told me I check out fine."

I can't count the number of times I've heard those statements, or others like them, when taking care of a hospitalized patient with an opportunistic infection (AIDS) who is also getting their very first HIV diagnosis. And it never gets less upsetting to hear. The belief among people that their health care provider will take care of them, tell them what they need to know (whether they want to hear it or not), keep them on track for health, and know what health threats pertain to them, are not bad expectations. Health care must do its best to deliver on those expectations.

Although the District of Columbia has gone further than most jurisdictions in increasing access to HIV testing, we can and must do better still. Our surveillance data show that almost 70 percent of new AIDS cases are 'late testers,' or persons who were just diagnosed with HIV within 12 months of their AIDS diagnosis, often concurrently during a life-threatening opportunistic infection. This is nearly twice the national rate of 39 percent. And while we must continue to talk of HIV being a preventable infection, we must also remember to talk about AIDS being a preventable condition – the vast majority of persons diagnosed early in the course of HIV need not progress to AIDS.

We will never entirely eliminate 'late testing' until all people are universally accessing health services. However, more detailed data suggest that a good portion of persons newly diagnosed with HIV in DC have been accessing medical services without being offered testing. Preliminary data from the soon-to-be-released 2007 National Behavioral Risk Factor Survey showed that 73 percent of persons testing positive as part of the survey had seen a health care provider within the past year without receiving an HIV diagnosis. Early diagnosis not only saves lives of those infected with HIV, but it also prevents HIV transmission: most people diagnosed with HIV take precautions to help prevent transmission to others. Thus, District primary care providers offering HIV testing as routine opt-out care is a major strategy for immediately increasing the number of persons who know their HIV status, and potentially decreasing the proportion of late 'testers' and further transmission.

What does 'routine opt-out testing' really mean? Routine means HIV testing is offered automatically, and requires no extensive pre-test risk assessment or counseling. Opt-out means that patients have the right to refuse—just like they do for all blood draws or medical procedures. This strategy recognizes that traditional risk-based and opt-in screening can be barriers to testing, and that in our current high-risk environment it is ineffective as the only approach—it will miss a large number of HIV-infected or HIV-exposed persons. It also responds to what experience and studies have shown—that being offered a test by their medical provider is one of the most common reasons people give for having been tested. Also, it responds to the often silent expectation that patients have of their providers: that if something is an important health threat, their provider will be sure to address it. After all, think of how few prostate exams we would do if patients had to specifically request them during their physicals!

The Centers for Disease Control and Prevention now recommend that all persons aged 13-64 be tested at least once in their lifetime, with additional testing based on risk screening for possible new exposures. In DC, due to the high rates of HIV, we've taken those recommendations one step further and recommend that everyone aged 14-84 get tested annually as the new standard of care.

Practically speaking, what does it take to move to routine opt-out HIV testing in a primary care setting? It can be as simple as working out a plan that covers the basics.

- Physicians can let patients (and staff) know that their practice routinely screens for HIV. We recommend incorporating HIV testing along with all other information into any general consent form a practice uses. Note that in the District, there is no special documentation requirement for HIV testing consent. Doctors can decide how else they may want to let patients know—Is it posted? Do staff mention this at check-in? During vital signs? During the exam? During blood draw?—and how will doctors and staff document and adhere to patients' refusal if they decide to 'opt-out' during that visit.

- Doctors can decide how to incorporate testing into their normal patient-care flow. One approach is to add HIV to the basic blood panel and send it off with all other labs. Another approach is to use oral fluid or blood-based rapid tests that can give a preliminary result during the office visit – but note that rapid testing is not required for routine testing.

- Providers can identify protocol and care plan for new positive findings. If a primary care provider (PCP) has not done a lot of HIV testing before, often the best thing a physician can do is to speak with a colleague who has. A colleague may be able to better prepare a fellow doctor for what to expect, and may agree to be an 'on call' back-up if questions arise. Most importantly, a provider can figure out which HIV care provider(s) will be the 'next stop' for positive patients. Like other serious diagnoses, PCPs need to provide patients with sufficient basic information, support, and connection to specialized services. This doesn't mean every provider should or needs to take on HIV treatment themselves.

Originally published in DC Primary Care Reformer, May 2008

(continued on bottom of page 8)

MAYOR FENTY RELEASES UPDATED HIV/AIDS STATISTICS: NEW STUDY ON HETEROSEXUALS & RELATIONSHIPS

INCREASED HIV/AIDS TESTING HAS LED TO REDUCTION IN BABIES BORN WITH HIV; STUDY REVEALS SEX OUTSIDE OF RELATIONSHIPS AND LOW CONDOM USE

(March 16, 2009) Mayor Adrian M. Fenty, along with Department of Health Director Pierre N.D. Vigilance, MD, and HIV/AIDS Administration Director Shannon Hader, MD, released two reports on the state of HIV/AIDS in the District of Columbia. The reports are a part of the District's overall effort to enhance data collection and analysis in an effort to provide effective public health programming for all health issues facing DC residents.

"Past studies have highlighted the HIV/AIDS problem in the District, but these reports detail how individuals are putting themselves at risk for the disease," said Mayor Fenty. These reports will "allow us to improve how we prevent HIV and better serve people living with the virus."

Recently, the Centers for Disease Control (CDC) recognized the District as one of the top three jurisdictions in the country in conducting the most HIV tests and identifying the greatest number of persons with HIV under its Expanded HIV Testing Initiative.

DISTRICT OF COLUMBIA HIV/AIDS EPIDEMIOLOGY REPORT 2008

The District of Columbia HIV/AIDS Epidemiology report highlights that the District's HIV testing programs have greatly increased early diagnosis among residents, thus reducing the number of babies born with HIV. In 2005, 10 babies were born with HIV, by 2007 only one baby was born with the infection. The report also confirms that the District has seen a 70-percent increase in the number of people tested. Four years ago only 40,000 residents were tested, however by 2007 the number of residents tested increased to 70,000. Additionally, the report reveals that three percent of adults and adolescents are living with HIV/AIDS in the District, with seven percent of those infected between the ages of 40 and 49. At 6.5 percent, statistics were highest among African-American males.

HETEROSEXUAL RELATIONSHIPS AND HIV IN DC

This new report is the first-ever study conducted to assess the behavioral risks of HIV among heterosexuals. The report reveals that heterosexuals are at risk of HIV because of sex outside of relationships and low condom use. This study is the first part of a new series on DC HIV Health Behavior. The study found:

- Approximately 75 percent reported being in a committed relationship.
- Nearly half believed their last sexual partner was having sex with someone outside of the relationship.
- Nearly half reported they had sex outside of the relationship.
- Nearly half did not know their last sex partner's HIV status.
- More than 70 percent of participants did not use condoms.

Through the Expanded HIV Testing Initiative, the District tested more than 70,000 individuals and found 464 persons with HIV. The Administration announced several steps the District is taking to address these new statistics:

- The District is funding a community partner and working with the CDC to make couples counseling training and testing available. This action is the first-of-its-kind in the nation.
- In 2008, three out of the seven birthing centers in the District were routinely testing pregnant women for HIV; the goal for 2009 is to make screening available at all District birthing centers.
- The District distributed 1.5 million free condoms in 2008, making progress toward the goal of 3 million per year.
- The Administration will continue to expand routine testing in medical settings, as three-quarters of the heterosexual participants who tested HIV-positive didn't know their status and had seen a healthcare provider in the past 12 months.

"Some people may think they've been tested for HIV just because they've been seen by a doctor or had blood taken, but that does not mean they have actually been checked for HIV. Our study shows that many doctors are not routinely offering or doing HIV tests," said Dr. Pierre N.D. Vigilance, Director of the Department of Health. "This year, the District will be doing extensive outreach among our health care providers to ensure that we fully implement routine testing."

The District recently received improved grades from the DC Appleseed Center of "A" for Surveillance, "A-" for HIV testing and "B" for condom distribution. The Fenty administration's goal remains that no baby will be born with HIV in DC by the year 2010.

ROUTINE OPT-OUT HIV TESTING (continued from page 7)

"HIV-positive" is a serious diagnosis of a serious disease. When an AIDS presentation is the first diagnosis of HIV, this is beyond serious – it is tragic. It signals that some opportunities for preventing transmission and preserving health, survival, and quality of life may have been lost. The core competencies of PCPs [primary care providers]—being able to both help keep people healthy and also to help diagnose and deal with serious diseases—make providers a highly qualified front-line in the modern response to our modern HIV epidemic. With the help of DC's primary care providers, the many people who are accessing health care in the District need never be 'late testers.'

LETTER FROM SHANNON HADER, MD (WITH FAQs)

Dear Colleague: [3/6/09]

I am writing to ask for your help in eliminating HIV transmission in the District of Columbia, and to re-affirm the District's Routine HIV Testing Policy. Mayor Adrian Fenty has made HIV his number one public health priority.

The District has a "modern" HIV epidemic—"modern" in both its scale and complexity. The DC Department of Health's 2008 Epidemiology Annual Report Update shows that 3% of District adults and adolescents are diagnosed and living with HIV/AIDS. To put that in context, the U.S. Centers for Disease Control and Prevention defines a generalized and severe epidemic when more than 1% of the population is impacted by disease. In addition, local studies suggest that between one-third to one-half of HIV-infected District residents may be unaware of their positive status. This is because missed opportunities for regular HIV testing abound: the new DC HIV Health Behavior study reports that 75% of study participants newly diagnosed with HIV had been to at least one medical provider within the last 12 months.

One of the most effective measures that we can take to combat HIV/AIDS is to increase routine voluntary HIV screening in all health care settings, which will in turn foster earlier detection of HIV infection, link patients to care and prevention services, and reduce perinatal HIV transmission.

In June 2006, in keeping with now current CDC guidelines, the DC Department of Health implemented a policy of a routine opt-out HIV testing in medical settings. Routine opt-out HIV testing means that all persons 14-84 years old, should be regularly offered HIV testing each year, and given the option of 'opting out' or refusing if they wish. **Separate written consent specifically for HIV testing is NOT required.** Pre-test risk assessment and extensive counseling are neither required nor recommended.

The DC Department of Health **HIV/AIDS Administration offers healthcare providers training and technical assistance** to implement routine screening in their medical settings. There are several operational models that have been successful among District providers in implementing routine HIV testing in outpatient, emergency room, inpatient, and labor & delivery settings. To support medical providers and community partners, the Department has hired a HIV testing expansion coordinator dedicated to increasing the number of routine HIV testing providers throughout the District.

For additional information regarding routine HIV screening, please **contact Avemaria Smith, HIV Testing Expansion Coordinator, at 202.671.5061 or Avemaria.Smith@dc.gov.**

We know that the DC medical community is up to the challenge of reducing HIV transmissions by making HIV screening a routine part of medical care.

Thank you for your help in the response,

Shannon L. Hader, MD MPH
Senior Deputy Director, DC Department of Health
HIV/AIDS Administration

FREQUENTLY ASKED QUESTIONS

What does the DC law state as requirements for consent around HIV testing?

There is no separate law or regulation governing HIV testing consents (or requirement for written consent). The same protocol of informing patients of medical testing applies.

How are medical providers incorporating informing clients about routine opt-out HIV testing into their care practice?

There are a variety of models that are being used. Some facilities specifically include that routine HIV testing will be offered in the overall general medical care consent. Others have clerks inform patients during check in or nurses offer testing during vital signs. Others post signs or pamphlets that explain the availability and routine offer of screening. Others inform the clients during blood draws or blood orders. Still others are asking clients to sign "refusals" if they refuse HIV testing.

Since no separate HIV-specific written consent is required, does this mean that I don't need to inform the client that testing is routinely offered?

No. Testing is voluntary, and although the offer should be routine, the client can refuse, just like they can refuse other medical assessments that are part of care. Regular testing—not "invisible, mandatory, or uninformed testing"—is the goal.

Why isn't pre-test risk-assessment recommended?

Because of the high rate of HIV in DC, many persons being exposed to and infected with HIV do not have 'traditional' high risk factors. Thus, basing the offer of HIV testing on risk assessment will miss a large number of persons who are infected with HIV.

My hospital/medical corporation has its own policy that still requires separate written informed consent for HIV—what should I do?

Some facilities/corporations still have outdated policies in place. Often they are based on the false assumptions that clients don't want to be tested, that HIV testing is a "bad" and "abnormal" thing, and that there is "no risk" to medical providers avoiding or ignoring HIV testing. DC DOH is happy to meet with hospital leadership to discuss the current updated policies and new standards of care. We have found Risk Management Teams to be especially effective in implementing facility-level practice updates.

What is the policy about offering HIV testing to minors—do we need parental consent?

As with all STD and reproductive health services, minors are considered emancipated/able to assent and consent for their own services. Clinical judgment should be used to be sure that minors are competent to participate in/truly assent or consent to testing services.

What is the policy regarding HIV testing for patients who are unable to consent, due to issues such as severe medical illness/altered mental status/etc.?

This situation goes beyond HIV screening policy to medical testing and evaluation policies and procedures. If a client is unable to consent and does not have a health care proxy providing consent for medical procedures, the same clinical judgment should be used to provide HIV testing as is used to provide other medical services. Specifically, if HIV testing is an important part of the evaluation and treatment of the client's current medical status and condition—such that NOT testing would inhibit appropriate medical evaluation and treatment, then testing for medical need should be considered.

What are the next steps for HIV positive patients?

The goal of routine HIV screening is to link HIV positive individuals into care and treatment, regardless of whether they are newly diagnosed or previously identified positives that are not in care. The next step is immediate linkage to HIV care. Any subsequent tests and treatment will be completed in the initial HIV medical visit.

ACADEMIC DETAILING: DISTRICT TO OFFER PROGRAM FOR PHYSICIANS

LETTER FROM HPLA SENIOR DEPUTY DIRECTOR

The program, called the *Independent Drug Information Service (iDiS)*, will focus on providing optimal patient care and disease management resources. iDiS will offer helpful resources and tools so physicians can make the best decisions for their patients about therapeutic benefits, risks, and costs.

The District of Columbia Health Professional Licensing Administration (HPLA) is pleased to announce that we will be coordinating an effort, on behalf of the DC Department of Health, to offer an academic detailing program to physicians practicing in the District. This program, called the Independent Drug Information Service (iDiS), will focus on providing optimal patient care and disease management resources. iDiS will offer helpful resources and tools so physicians can make the best decisions for their patients about therapeutic benefits, risks, and costs.

- iDiS develops health resources for patients, so physicians and other health care professionals can help educate patients about the medical and therapeutic decisions they've made, and to help improve adherence to treatment regimens. iDiS is a program provided by the nonprofit Alosa Foundation, which is comprised of physicians and researchers on the faculty at Harvard Medical School. The program will offer evidence-based, non-commercial information about medications and other therapeutic options commonly used in primary care.
- The program is wholly financed by the District of Columbia through the Department of Health as mandated by SafeRx (D.C. Law 17-0364, the SafeRx Amendment Act of 2008, Title IV Pharmaceutical Education Sec. 401 "Pharmaceutical Education Program Establishment Act of 2008"), which was passed by the District Council to: address pharmaceutical detailing; require detailers to abide by a code of ethics; and establish a pharmaceutical education program for physicians and other health care providers in the District.
- The iDiS team of Harvard-affiliated faculty, physicians and researchers comprehensively evaluate biomedical journals and other data sources to pull together the best available evidence about drug safety, efficacy, and cost-effectiveness. They then synthesize this material into convenient, clinically-relevant summaries. These materials are presented to physicians in their offices by a team of specially-trained physicians, nurses, and pharmacists.
- No pharmaceutical companies are associated with this program. Program facilitators will present evidence-based data from the most current medical literature. The materials are written by faculty who accept no personal compensation from any pharmaceutical manufacturer for any purpose.

Each DC physician's participation is significant and appreciated. Continuing medical education (CME) credits shall be provided to participating District physicians. The program is free and voluntary. If you are a physician interested in participating in this program, please contact iDiS. *Please see page 11 of this newsletter for the company's contact information and their answers to frequently asked questions.*

Through this, and other efforts, HPLA and the physicians of the District can join together to work collectively to ensure quality care for the citizens of the District of Columbia, and for all of the visitors who come to the nation's capital as well.

Sincerely,
Feseha Woldu, PhD, Senior Deputy Director
Health Professional Licensing Administration
HEALTH REGULATION AND LICENSING ADMINISTRATION

Q & A FROM IDIS
ABOUT THE NEW DISTRICT OF COLUMBIA "ACADEMIC DETAILING" PROGRAM

Where did this idea come from?

The Independent Drug Information Service (iDiS) program is designed to meet physicians' need for current, unbiased, non-commercial drug information that is free of all influence by any pharmaceutical company. Manufacturers' sales reps may provide convenient, user-friendly material, but it's all about selling their company's products. Academic sources of information may be more balanced, but are often dry and hard to access. The concept of "academic detailing" was developed to assemble rigorous, evidence-based, non-commercial overviews of the latest information about prescribing options, and bring it to the doctor in his or her office—in a convenient and time-efficient manner. The program is funded by the District of Columbia Department of Health, but it has no control over any of its content.

Why now?

Physicians, patients, and government programs face growing concerns about drug safety and affordability. Many physicians question the usefulness and balance of the information offered by sales reps, and worry whether it contains all the relevant negatives as well as positives about the drugs being promoted. Costly new products are vigorously marketed to clinicians and patients, while equally-good established drugs, no longer covered by patents, get much less attention. With medication co-pays a major problem for patients, many of them are having an increasingly hard time paying for what you prescribe. Doctors in practice need an "honest broker" source of information about medications so they can make the best decisions for their patients about benefits, risks, and costs. Ideally, it would be delivered to them in their offices with the same convenience as commercial "detailing," and that is just what we propose to do.

Who's really behind this?

What you see is what you get. The program is wholly financed by the District of Columbia through the Department of Health. No drug companies are involved. The materials are written by faculty at Harvard Medical School who accept no personal compensation from any pharmaceutical manufacturer for any purpose.

Why is the District spending money on this?

District of Columbia patients and taxpayers will spend tens of millions of dollars this year on prescription drugs. Some of this will represent the best possible investment in health, but some of it will go for products that are not the most efficacious, safe, and cost-effective options. Giving you the data you need to help inform these critical decisions will cost a tiny fraction of the District's drug expenditures, making it a very reasonable investment. Experience in other states indicates that such programs can help pay for themselves through more appropriate prescribing.

What do I have to do?

A drug information consultant who is a nurse or physician will contact you soon to offer to meet with you in your office briefly (for 10 - 20 minutes) at a time of your choosing, to describe the program. She will also be prepared to present the first clinical module: the management of type 2 diabetes. This topic was chosen because of the enormous importance of this condition, and the major new clinical trials published in the past year that have greatly expanded our knowledge about treatment strategies. Subsequent topics will be available throughout the year and will cover topics such as: lipid-lowering therapy, anti-hypertensives, anti-platelet therapy, and management of depression in the elderly. The program will offer continuing education credits from Harvard Medical School for physicians participating in the program.

The service is completely voluntary, but we hope you'll agree to have at least the first meeting with your "academic detailer" to tell her how we can best meet your needs.

Why would I want to do this?

As you know, it takes an enormous amount of time and work to stay current on all the latest information about drug choices and drug risks, especially for new products. The goal of the Independent Drug Information Service is to be just that—a service—that will provide a time-efficient way for you to get the unbiased, non-commercial information you need as a prescriber, quickly and effectively, in your own office.

"We hope you'll find this new service useful in your practice, and welcome your feedback."—iDiS

PROGRAM

iDiS Independent Drug Information Service

The Independent Drug Information Service (iDiS) is an innovative program designed to provide physicians with an evidence-based, non-commerical source of the latest findings about the drugs they prescribe.

TOLL FREE NUMBER
1-877-410-5750

WEB SITE
www.RxFacts.org

EMAIL ADDRESS
info@RxFacts.org

Please contact iDiS if you have questions, or if you would like to set up a time and date for your first training session at your office.

PROVIDING MEDICAL CARE WITH CULTURAL CONFIDENCE

DIRECTOR OF CENTER FOR MINORITY HEALTH SPEAKS TO BOARD OF MEDICINE

By Nancy Kofie

Health disparities between racial and ethnic minorities and the non-minority population exist, and we must address the problem "in ways that do not polarize us," according to Stephen B. Thomas, PhD, Director of the Center for Minority Health (CMH) at the University of Pittsburgh Graduate School of Public Health.

Race and Class

Do you feel culturally confident when offering care to patients from a minority or lower-income population? Dr. Thomas told Board members about the Institute of Medicine's 2000 report entitled "Unequal Treatment." The report cites research that has found that—even when a minority patient has the same insurance, income, and severity of condition as his or her white counterpart—they are less likely to receive an appropriate treatment (like a transplant) and more likely to receive an undesirable treatment (such as lower limb amputation for diabetes).

Some white physicians may feel "outside of their comfort zone" when in the presence of minority patients. Similarly, some minority physicians may feel the same way when communicating with patients who have a lower educational and economic status.

Stephen B. Thomas, PhD, Director of the Center for Minority Health

"I Treat Everyone the Same"

Some physicians simply refuse to believe that there is a disparity. According to Dr. Thomas, physicians often tell him: "We treat everybody the same." This view is understandable because disparity in treatment does not occur because a physician or nurse is deliberately being racist or classist, Dr. Thomas said. Yet it happens, due to deeply-ingrained beliefs about minorities or lower income individuals.

"I am not Incompetent"

Physicians often feel insulted when their objectivity and basic competence is questioned. Dr. Thomas has found it more effective to offer physicians the opportunity to become more culturally "confident" rather than saying culturally "competent." Physicians can become more aware of the problem through the use of scenarios and other tools.

Marketing Wellness

Part of the problem in health disparities, Dr. Thomas said, is that some African Americans do not trust the healthcare system because of historical incidents like the infamous Tuskegee syphilis study (which occurred 1932 through 1972).

Dr. Thomas's Center has broken down some of that medical mistrust, in Pittsburgh, through its Healthy Black Family™ program, which reaches out to the community with events such as health screenings, held in barber shops and other nonmedical settings.

Outreach in the District

"The National Institutes of Health and the Robert Wood Johnson Foundation are expecting us to replicate our models in other cities, and that is part of why I am here as well," Dr. Thomas told Board members. "We are looking for a partnership in the District to replicate the Healthy Black Family™ project model. Not just in barber shops, but that people are being identified and driven to culturally-competent interventions."

The problem cannot be eliminated by blaming people or by instituting new rules, he said. It must be an effort which draws people together.

You may contact Dr. Thomas via email at sbthomas@cmh.pitt.edu

PAID INACTIVE STATUS

If you intend to retire your license, or if you would like to place your license on Inactive Status, you must explicitly inform the Board of your intention before the renewal date expires. If you fail to pay renewal fees on time, your license is not inactive; it is delinquent (expired). It is unlawful to practice while your license is delinquent/expired.

MEET THE BOARD OF MEDICINE'S NEW CONSUMER MEMBER MIRIAM A. MARKOWITZ, MSc

Miriam A. Markowitz, MSc

When were you appointed to serve on the Board of Medicine?

I was appointed to the Board and sworn in by Mayor Fenty in June 2008. I attended my first Board of Medicine meeting in July 2008.

Why and how did you initially become involved with the Board? What sparked your interest in serving as a Board member?

My entire professional career has been in the health care provider sector, with my background in health economics and health policy and management. I wanted to identify a program or services within the District that [would allow me to] continue to learn from my peers and develop advanced knowledge with respect to the challenges facing our city to attract and oversee the medical providers that serve all of us. The role of protecting the public and also seeking creative solutions to problem solve issues, such as the ongoing shortage of licensed professionals, is exciting to me. Likewise, I am hopeful that the Board of Medicine will remain a forum where new clinical applications, technology, and interventions are debated and brought forward to the public.

Is there any aspect of your service as a new Board member thus far that has surprised you (or has the experience been what you expected it to be)?

Not a surprise, but clearly validated: This is a hard working Board! There is easily 6 to 10 hours of prep work for Board meetings, which run for the majority of the day.

Please tell us about your background. What do you think are the life experiences and/or career experiences you have had that will enable you to become an effective Board Member?

I moved to the District over six years ago, drawn by the diversity, the new possibilities emerging, and the great cultural riches here in the District. I am very committed to DC and believe it has a strong health care provider community.

My academic training includes economics, health policy and management as well as women's studies. My professional career encompasses a wide range of professional duties within large academic medical centers, focusing on management information, ambulatory services to running a large hospice program in rural Michigan, and leading the strategic planning and business development efforts for several organizations.

Understanding the provider side of health care balances my experiences as a consumer, and hopefully allows me to appreciate the nuances that arise when the Board is called on to take action.

I am a big proponent of access to care and safety initiatives, and hope these interests will allow me to be a strong contributor on the Board.

What would you tell someone who is thinking about applying to serve on the Board?

I would encourage others to find something that really motivates them and research the level of commitment well before agreeing to serve!

This Board does require a strong understanding of the medical community.

From your observations as a Board member thus far, do you have any words of advice for licensees?

My only advice is that it is important to tell your story clearly and concisely so that Board members can fully appreciate the unique circumstances that may exist regarding a request under consideration. Likewise, I would encourage licensees to forward relevant materials or developments that they want the Board to understand as we experience such rapid adoption of clinical care changes.

What skills do you think you will develop as a Board member that you have not previously developed?

One never has enough skills in the area of consensus building and the ability to listen. These are traits often underused. This forum gives me an opportunity to exercise both well.

BOARD CHAIR GOES HOLLYWOOD

Dr. Frederick Finelli, Chairperson of the DC Board of Medicine, recently traveled to Chicago where he was interviewed for a video being produced by the Federation of State Medical Boards Foundation. The video highlights the importance of research, education, volunteerism and leadership. Congrats, Dr. Finelli!

POSTGRADUATE PHYSICIAN TRAINING ANNUAL ENROLLMENT PROGRAM

The Board of Medicine's mandatory Postgraduate Physician Training Enrollment Program (PPTEP) tracks postgraduate physicians practicing in the District. This program requires annual enrollment; it is NOT a one-time enrollment, and it is not a license. The District does not issue temporary or training licenses.

1) Each year, submit a PPTEP form electronically via our website at: **www.hpla.doh.dc.gov**
   - Click 'Professional Licensing Boards/Registrations', then 'Medicine', then 'Postgraduate Physician Enrollment'.
   - Please jot down the ID and Passwords you create the first year, so you can use them in subsequent years.

2) Then also submit the PPTEP form, printed out on paper, to the residency program Graduate Medical Education Director, along with the annual fee of $50.00. The program director will sign your form and submit the form to the Board of Medicine.
   - Any 'YES' answers on the questionnaire must be accompanied by supporting documentation and explanation. Failure to do so will delay approval.
   - Enrollment is not complete until the application is reviewed and approved by the DC Board of Medicine.

Questions about the PPTEP?
Call Board Licensing Specialist Lisa Robinson at (202) 724-8802

MOST FREQUENT CAUSE OF COMPLAINTS AGAINST DC PHYSICIANS: COMMUNICATION ISSUES

A significant number of complaints that are received by the DC Board of Medicine can be attributed to poor communications skills. These complaints often include claims of: "rudeness"; alleged failure to return telephone calls; or alleged failure to explain matters thoroughly to a patient or a patient's family.

Most of the communication complaints that the Board receives are not egregious and do not warrant formal disciplinary action, but they may have an impact on doctor-patient relationships. Communications problems can produce less-than-satisfied patients and ultimately can result in the deterioration of a medical practice. There are several principles that promote good communications: candor, compassion, listening, and documentation.

CANDOR

The first principle is candor. Licensees should be completely honest with patients about medical matters. Communicating with candor regarding possible courses of treatment and possible outcomes is required.

COMPASSION

A second essential ingredient to good communication is compassion. In some cases, physicians have the unpleasant task of being the bearer of bad news. Physicians should strive to be as tactful as possible without sacrificing candor.

LISTENING

Communication should be a two-way street. Listening to patients' questions and addressing them fully is important. To ensure that patient issues have been addressed, a physician should consider ending a dialogue with the question: "Do you have any more questions?"

DOCUMENTATION

Documentation is also an important principle of good communication. Patient records should reflect what the physician discussed with the patient or the patient's family, and it might prove helpful to note the time spent on the discussion.

SUPERVISION OF OFFICE STAFF: Many of the communications complaints that are received by the Board are complaints about the physicians' office staff. When a staff person has a sub-optimum communications experience, the physician should instruct the staffer how such matters should be handled in the future.

INCREASING THE SUPPLY OF LONG TERM CARE PHYSICIANS

By Elizabeth Nolte, MD

Any nursing home administrator or medical director knows how difficult it is to recruit and retain good Long Term Care (LTC) physicians. LTC physicians are not only scarce, they also don't compete heavily for job openings at chronic care facilities. Moreover, their overall numbers are decreasing. I believe that it is essential for nursing homes to play a more active role in increasing the supply of LTC physicians.

According to the American Geriatrics Society, there were more than 9,000 geriatricians practicing in the US in 1998. Currently, there are only 7,128 certified geriatricians and 1,596 geriatric psychiatrists. This translates to a supply of one geriatrician for every 2,546 Americans aged 75 or older and one geropsychiatrist for every 11,372 older Americans. As our population ages and mental health issues increase, by the year 2030, this ratio is expected to drop to one geriatrician for every 4,254 older Americans, and one geropsychiatrist for every 20,195 Americans aged 75 and older.

Unfilled Fellowship Slots

The shortage of LTC physicians is compounded not only by increasing demand by an aging population, but also by a low demand for geriatric fellowship programs by trainees in primary care residency programs. The Association of Directors of Geriatric Academic Programs (ADGAP) reported that in 2006-2007, there were 468 geriatric medicine first-year fellowship training slots, but only 253, or 54%, were filled. For the same year, there were 136 geriatric psychiatry fellowship first-year training slots, and only 68, or 50%, were filled.

Barriers for Generalists

Given the paucity of geriatricians and geropsychiatrists, nursing homes should actively recruit general internists, family practitioners and general psychiatrists. These generalists are also well equipped to manage seniors in the acute care setting and in long term care facilities. Unfortunately, many generalists are not interested in treating large volumes of geriatric patients. The reasons are multifold: low reimbursement rates, high malpractice costs for nursing home practices, high poverty among seniors, high mortality rates and the large time investment needed to complete a patient visit. But even the percentage of medical school graduates pursuing primary care residencies is diminishing. In 2005, only 20% of third-year internal medicine residents in the US planned to pursue careers in general internal medicine, compared with 54% in 1998, according to a report of the American College of Physicians.

Creating Incentives

As the educator member of the Nursing Home Administration Board, I find these statistics worrisome. While there is nothing that long term care facilities can do to increase the number of geriatric or primary care training slots, I believe there are strategies that can be implemented to encourage physician interest in careers in long term care.

First, incentives for practicing physicians could be offered to include assistance with malpractice insurance coverage and patient billing, continuing medical education (CME) allowances for attendance at workshops related to long term care, and evening and weekend coverage by an on-call nurse practitioner or licensed medical resident.

Opening Doors to Trainees

Secondly, nursing homes can foster relationships with medical schools to introduce medical students to long term care. Although most medical schools don't require students to take a course in geriatrics, all students are exposed to geriatric patients during their primary care clerkships—but this usually takes place in an acute care setting. There exists an opportunity for nursing homes to permit students to rotate through their facilities under the supervision of the medical director or attending physician.

Thirdly, nursing homes could open their doors to internal medicine, family practice and psychiatry residents to learn how to manage the unique problems of residents in a chronic care setting. These could take the form of performing medical assessments for specific problems such as falls, weight loss, aspiration, incontinence and agitation; shadowing the attending physician or medical director on wound rounds, performing medication reviews, doing chart reviews for proper use of restraints and attending in-service training seminars. Additionally, nursing homes could offer rotations for trainees in dentistry, ophthalmology, podiatry, and physiatry. These training opportunities would serve not only to increase trainee exposure to LTC, but also to improve the quality of care for nursing home residents.

I have worked at four nursing homes (NH) in the District and wondered why there were no medical students or residents, even though many of the nursing home attending physicians are medical school faculty or practice at teaching hospitals. Possibly, NH administrators are concerned that teaching trainees would increase the nursing home's liability. However, as long as the medical school or hospital provides malpractice insurance coverage for their trainees, and they are adequately supervised, this should not pose a problem.

Early Experiences at NH

I believe that if more trainees were exposed to nursing homes early in the educational process, this would create a greater interest in careers in LTC and improved quality of care for NH residents. Moreover, trainees that have a good experience at the nursing homes where they rotate may be more likely to seek employment at that nursing home when they enter practice. Using myself as an example, my first nursing home experience did not occur until my third year of clinical practice when I was hired as an attending physician at DC Village. Following that experience, I was hooked. To this day, I remain involved in the LTC industry after 16 years of clinical practice.

Dr. Nolte is a member of the DC Board of Nursing Home Administration.

BOARD WELCOMES NEW EXECUTIVE DIRECTOR JACQUELINE A. WATSON, DO, MBA

Dr. Jacqueline (Jacqui) Watson, was recently appointed to serve as the new Executive Director of the District of Columbia Board of Medicine.

Dr. Watson, a family practice physician by clinical training, with an MBA in health management and policy, served for the past ten years as the president & CEO of Health Concepts International, LLC (HCI), a solution-focused health care management and strategy consulting firm in Washington, DC. Dr. Watson has spent her career working with a diverse group of clients within the District of Columbia and the Caribbean region, including the Blue Cross and Blue Shield Association, DC Department of Health, National Institutes of Health, and Pharmaceutical Research and Manufacturers of America.

Dr. Watson, a graduate of Leadership Greater Washington (LGW), is an active member of her community and serves on several advisory boards. Dr. Watson is a member of the board of directors of National Rehabilitation Hospital (NRH), and an advisory council board member of the Georgetown University Lombardi/ Capital Breast Care Center (CBCC), among other activities. In 2001, she single-handedly spearheaded the formation of the first DC Chamber of Commerce Health & Wellness Committee, served as a member of the board of directors, and developed the successful 10:10:10 Corporate Wellness Challenge workplace wellness initiative. In addition, Dr. Watson is the founder of the Caribbean philanthropic organization, Jamaican Women of Washington, Inc. (JWoW), a non-profit organization, that supports underserved women and children in the Caribbean and the District.

Dr. Jacqueline A. Watson

Dr. Watson is a graduate of Howard University, Washington, DC (BSc); New York College of Osteopathic Medicine, Long Island, NY (DO); Georgetown University School of Medicine/Providence Hospital Family Medicine Residency Program, Washington, DC; and The George Washington University School of Business and Public Management, Washington, DC (MBA). Publications include Telemedicine: Its Role in Disease Management and the Future of Health Care Delivery *(Georgia State Medical Association Magazine, Volume 16: 14-18. May 1999) and* Complementary and Alternative Health Practices in the Black Community: Existing and Emergent Trends *(Praeger Handbook of Black American Health, Policies and Issues Behind Disparities In Health, Volume 2, Chapter 3). Dr. Watson lives in the District of Columbia with her husband, a local dentist, and their thirteen year old son. Her hobbies include tennis and traveling.*

When did you become the new Executive Director of the DC Board of Medicine (BOM)?

I assumed the position of Executive Director (ED) on March 16, 2009.

What are your top priorities in your new position?

As you know, the ED has oversight over the BOM, Board of Chiropractic (BOC) and the assigned health professional advisory committees under the purview of the BOM. I work under the authority of the Boards, and the Boards and committees are responsible for regulating the practice of their respective professions. My first and foremost responsibility is to make sure that we protect the health, safety and welfare of our citizens.

My top 5 priorities, in no particular order, are to:

I. Direct the BOM staff to provide the necessary administrative support to the board members, who take time out of their very busy work schedules and volunteer for this important service to the public.

II. Continue to support the use of innovative web-based technologies to improve the experience for doctors and applicable health professionals seeking licensure in the District. I want to make sure that we do all within our powers to facilitate making registration, certification and processing of licenses for qualified health care professionals seamless, expedient and friendly.

III. Work earnestly to ensure that the appropriate checks and balances and policies and procedures are in place to fairly and swiftly identify and take appropriate action against the privileges of physicians and other health professionals who pose a threat to the safety of patients seeking care in the District of Columbia and thus minimize the incidence of adverse events.

IV. Analyze data we collect and share with respective agencies to help influence informed decision-making for the city with respect to building an adequate health care workforce and improving access to care.

V. Enhance the visibility of the BOM and explore new ways to expand our public outreach and education efforts and identify new stakeholders to engage in the process so that we are sufficiently accountable to the public and inspire public confidence and support.

The Board's former ED was not a physician; what insights do you bring as a physician?

Being a physician is not a requirement for this job as you know, but the fact that my professional background includes training as a family practice physician provides me with an intimate knowledge and personal insight into the medical profession and perhaps a heightened sensitivity and appreciation for the joys and unique challenges faced by physicians and health care providers in this radically changing health care environment.

What lessons did you learn as president & CEO of a health care management and consulting firm that will enable you to tackle the challenges of your new position?

Organizational management and strategic planning and the flexibility to adapt to new environments and successfully work with diverse groups to achieve measurable results.

Did earning your MBA change your perspective regarding our health care system, the practice of medicine, or business? If so, how?

The answer is YES to all the above. I completed my MBA ten years ago and doing

an MBA allowed me to gain a better appreciation for the complexities of the health care delivery system rather than being limited to understanding just the practice of medicine. The health care delivery system is the large umbrella under which health care professionals and providers of all types operate. This system is heavily influenced by big business, powerful interest groups and policy makers and today, more than ever, practicing good medicine also means practicing good business. In my opinion, an overhaul of the American medical school curriculum and residency training programs needs to be done to include both business management and health policy instruction, among other things, so that providers, who are the ones on the front line of delivering care, will possess the skills necessary to practice in the current environment and be able to provide meaningful solutions for reforming health care.

You have spent your career thus far in both the Caribbean region and the District. What special health challenges do you see in the Caribbean and DC? Any outstanding commonalities or differences?

There are numerous similarities, with respect to challenges, particularly with respect to the increasing costs associated with treating the leading chronic non-communicable diseases—cardiovascular disease, hypertension, diabetes, obesity, cancer, HIV—that we know are often preventable, and providing access to quality health care for all citizens.

What are the major challenges facing the DC Board in 2009?

I have observed three big ones and the last one is actually an opportunity.

I. Currently, the board does not have an adequate number of members with diverse specialty backgrounds. We need to move rapidly to fill vacant slots and bring doctors on with specialty areas that frequently come before the board—OB/GYN, Psychiatry, Emergency Medicine, to name a few. In addition, I strongly recommend amending the statute so that the number board members can be expanded from 11 to 15. This would allow the case load to be more widely distributed among the physician and consumer members who volunteer to serve and allow us to be more efficient.

II. Have the DC Municipal Regulations keep up to pace with the changes and expectations of the health care consumer and environment. Telehealth, Medispas, Complementary/Alternative Medicine, Retail Medicine, Comparative Effectiveness Research are just a few of the areas that will need focused attention and leadership with respect to practical regulatory policy development and clinical guidance.

III. Lastly, with healthcare reform being a major priority of the new administration, and the District of Columbia being the nation's capital, with some of the worst health statistics in the country, we will be expected to contribute to shaping the direction and influencing the role healthcare providers must play in lowering costs, expanding access and raising the quality of care delivered to all Americans.

FORMER EXECUTIVE DIRECTOR JAMES R. GRANGER RETIRES

The Board is saddened to announce the retirement of our long-standing executive director, Mr. James Granger. The Board benefited from Mr. Granger's regulatory expertise and calm demeanor since he accepted the position in 1994. "With his strong work ethic, deep intellect and phenomenal organizational skills, he would have shined in any position he chose. I am glad he chose us," says Board Chair Dr. Frederick Finelli. "Jim Granger has been a great asset to the Board of Medicine. His expertise, insight and support will be missed." In April of 2008, Mr. Granger received the Distinguished Service Award during the Administrators in Medicine's Federation of State Medical Boards Meeting, recognizing his "distinguished service and special accomplishments." His award reads: "ADMINISTRATORS IN MEDICINE, The National Organization for State Medical and Osteopathic Board Executives, hereby presents James R. Granger, Jr., D.C. Board of Medicine Executive Director, with the Distinguished Service Award in recognition of his Distinguished Career as a Medical Board Executive, Presented April 30, 2008, 2008 AIM Annual Meeting, San Antonio, Texas."

Jim Granger

How long were you the Executive Director of the Board of Medicine? I was Executive Director from December 1994 until February 2000, and again from May 2001 until September 2008.

What led you to this job? What was your previous position?

I worked in professional regulation in the Department of Consumer and Regulatory Affairs from 1986 until 1994. The former ED retired, and I was assigned to the Board of Medicine. The health regulatory Boards were subsequently transferred to the Department of Health.

What was your biggest challenge during your tenure as Executive Director?

The biggest challenge was lack of resources. Until 2005, we had two investigators for all health licensing boards (approximately 50,000 licensees), insufficient administrative staff, office equipment (especially computers) and supplies. Indeed, there were times when the District's financial situation was such that we had to bring our own toilet paper to work. After 2005, the resource situation improved dramatically.

What was your biggest accomplishment (if you don't mind saying)?

I cannot think of one individual accomplishment that I would mention. I think I am proud of the overall performance of the staff that I supervise. Applications are processed in a timely manner as are disciplinary actions.

What is the most important quality or personality trait that a job candidate should bring to the job of Executive Director?

Well, there are many factors that contribute to success in this position. In terms of personality, you have to be even tempered. In terms of skills, you must be fairly organized or the tide of work will overwhelm you. You must also be equipped to communicate with the professional community and the public at large. In terms of knowledge, you must be knowledgeable of the statute and the regulations.

Now that you are retiring, is there anything you will miss?

Yes, I will miss working with the staff and the many excellent board members that we have and have had over the years. I have enjoyed the professionalism and the personalities.

Do you have comments regarding the current state of or the future of the Board?

There are always new issues arising in medical regulation, and I expect that those issues will continue to arise as the practice of medicine continues to evolve. However, I am proud of the fact that the administrative aspects of support to the Board are in order.

BOARD ORDERS

March 7, 2008 - December 31, 2008

Revoked

Pierotti, Aldino L. III (6/3/08) The physician's D.C. medical license was revoked as result of disciplinary action (denial) in Ohio for an inaccurate application and for filing inaccurate renewal applications with the D.C. Board of Medicine. [Internal Medicine]

Udebiuwa, Oparaugo I. (8/21/08) The physician's D.C. medical license was revoked as a result of practicing medicine while his license was suspended. [Psychiatry]

Figueroa, Armando B. (8/25/08) The physician's D.C. medical license was revoked as a result of prescribing violations. The physician failed to conform to accepted standards of conduct and prevailing practice in the practice of medicine, prescribing drugs when not authorized to do so, and wrote prescriptions for controlled substances and other drugs without putting the date of issuance on the prescriptions in violation of D.C. statutes. [Internal Medicine]

Summarily Suspended

Acevedo, Paul (4/28/08) The physician's D.C. medical license was summarily suspended as a result of relapsed alcohol abuse. [Neurology]

Suspended

Wolde-Tsadik, Seife Meshesha (5/23/08) The physician's D.C. medical license was suspended for substance abuse and prescription violations in Virginia until such time as he has an unencumbered Virginia medical license. [Internal Medicine]

Peal, Rhoda (6/9/08) The physician's D.C. medical license was suspended for charges related to abandonment and failure to provide a copy of a patient's records. [Internal Medicine]

Liberman, Joseph (10/21/08) The physician's D.C. medical license was suspended for his failure to comply with a previous order's CME requirements. [Psychiatry]

Probation and Reporting Requirements

Greene, Peter (8/11/08) The physician's D.C. medical license was reinstated and placed on probation with reporting requirements indefinitely as long as he is in treatment for his addiction to alcohol. [Dermatology]

Acevedo, Paul (12/2/08) The physician's previous summary suspension is lifted and his D.C. medical license was placed on probation with indefinite treatment and reporting requirements.

Greer, Douglas (12/29/08) The physician's medical license was reinstated and placed on indefinite probation with reporting requirements for as long as he is under federal parole. [Opthalmology]

Probation and Remediation

Fisher, Edward G. (9/24/08) The physician's D.C. medical license was placed on probation and reprimand by Consent Order for at least one year and he was required to take a course in boundary issues as a result of inappropriate contact and relationship with a patient. [Surgery and Family Medicine]

Probation

Negussie, Yeheyis T. (6/9/08) The physician's D.C. medical license was placed on probation pending the outcome of an investigation into a malpractice suit, and the order of revocation of September 26, 2007 was withdrawn. [Internal Medicine]

Reprimanded

Zebrak, Ryszard (5/19/08) The physician was reprimanded and required to comply his Virginia order with reporting requirements. The physician was disciplined in Virginia for prescription irregularities and substance abuse. [Psychiatry]

Gay, Dionne (8/7/08) The physician was reprimanded and required to pay a fine for failure to respond to a Board Order To Answer. [Family Medicine]

Griffin, Leslie C. (8/21/08) The physician was reprimanded and required, should she return to practice in D.C., to notify the Board of Medicine sixty (60) days prior to the start of any such employment. [Radiology]

Fox, Michelle (10/29/08) The physician assistant was reprimanded and fined for filing a false application. The physician assistant must also obtain a Fitness-To-Practice evaluation and possibly remain in treatment. [Physician Assistant]

Fined

Dormu, Jeffrey J. (4/21/08) The physician was fined by consent order for not completing a Physician Profile form. [Surgery]

BOARD ORDERS
(continued)

Drakes, Duan A. (5/8/08) The physician was fined by consent order for not replying to an Order to Answer in a timely manner. [Thoracic Surgery]

Solomon, Barbara (10/6/08) The physician was fined by consent order for not updating her physician profile to report an action by another jurisdiction. [Internal Medicine]

Gillian, Lorraine (10/8/08) The physician was fined by consent order for not replying to an Order to Answer in a timely manner. [Obstetrics & Gynecology]

Casey, Sean O. (11/18/08) The physician was fined by consent order for failing to update his physician profile to report an action by another jurisdiction. [Radiology]

Mitikiri, Nirupama D. (11/24/08) The physician was fined by consent order for failing to complete a physician profile. [Internal Medicine]

Charabaty, Samar (12/2/08) The physician was fined by consent order for failing to complete a physician profile. [Internal Medicine]

Probation Terminated

Negussie, Yeheyis T. (11/18/08) The physician satisfied the terms of his prior interim order dated June 9, 2008. [Internal Medicine]

Other

Liberman, Joseph (12/19/08) Suspension lifted, retroactive to 11/20/08. The physician satisfied the requirements of the previous 10/21/08 Order, which imposed a suspension until compliance with CME and a fine of $5,000.00. [Psychiatry]

Kashif, Fahim (12/23/08) License reinstated, retroactive to 10/30/08, after the revocation of 12/6/07. The physician petitioned the Board and the request for reinstatement was granted. [Physician Assistant]

FILING A COMPLAINT WITH THE BOARD

To file a complaint against a licensed DC physician or physician assistant, simply write a letter that describes your complaint. The letter must be signed, and you should attach copies of any pertinent documents that you may have. The letter must also include your address, so we may contact you as necessary and notify you of any findings.

Please note: You can print a complaint form from our website at www.hpla.doh.dc.gov

You should mail the complaint to:

DC Board of Medicine
717 14th Street, NW
Suite 600
Washington, DC 20005

You can also fax the complaint to the Board at (202) 724-8677.

If your complaint alleges unlicensed activity, you should address your complaint to:

Supervisory Investigator
717 14th Street, NW
Suite 1000
Washington, DC 20005

You can also fax your complaint about unlicensed activity to (202) 724-8677.

Please be advised that the health professional licensing boards do not have jurisdiction over fee disputes, except for billing for services that were not provided. If you have a fee dispute with a health professional, you can seek redress through the civil courts.

ONLINE PROFILES

Need information about a District physician?

Go online at www.hpla.doh.dc.gov and, in the left column (blue), click on

Physician Profile Search

This site provides the public with information about physicians licensed to practice medicine in the District of Columbia. It contains information that is provided by the DC Medical Board and information that is self-reported by physicians.

D.C. BOARD OF MEDICINE
717 14th Street, NW
Suite 600
Washington, DC 20005

PRSRT STD
U.S. POSTAGE
PAID
LAUREL, MD
PERMIT NO. 6326

Printed on Environmentally Friendly Paper

Government of the District of Columbia
Adrian M. Fenty, Mayor

Health Professional Licensing Administration

Address
DC Board of Medicine
717 14th Street, NW
Suite 600
Washington, DC 20005

Board phone number
(202) 724-8800

Fax number
(202) 724-8677

DC Government website
www.dc.gov

HPLA webpage
www.hpla.doh.dc.gov

Current Members of The District of Columbia Board of Medicine

Frederick C. Finelli, MD, JD,
Physician Member and Chairperson

Robert B. Vowels, MD, MPH, representing
Pierre N. D. Vigilance, MD, MPH,
Statutory Member

John J. Lynch, MD, Physician Member

Lawrence A. Manning, MD, Physician Member

Peter G. Shields, MD, Physician Member

Ronald Simmons, PhD, Consumer Member

Miriam A. Markowitz, MSc, Consumer Member

Raymond K. Tu, MD, Physician Member

Cheryl R. Williams, MD, Physician Member

Director, Department of Health
Pierre N.D. Vigilance, MD, MPH

Board Staff

Executive Director
Jacqueline A. Watson, DO, MBA

Health Licensing Specialists
Lisa Robinson
Antoinette Stokes
Aisha Williams

Health Licensing Assistant
Lena Cameron

Senior Assistant Attorney General
John C. Greenhaugh, Esq.

Newsletter Editor/Layout/Photos
Nancy Kofie

To use HPLA's website to check and verify a license, go to: www.hpla.doh.dc.gov