**Proposed Changes to Board of Registration in Medicine Regulations - 2017**

[**243 CMR 1.00 Disciplinary Proceedings for Physicians**](http://www.mass.gov/eohhs/docs/borim/proposed-regs/243-cmr-1.docx)

[**243 CMR 3.00 Patient Care Assessment Programs**](http://www.mass.gov/eohhs/docs/borim/proposed-regs/243-cmr-3.docx)

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| **243 CMR 1.00 DISCIPLINARY PROCEEDINGS FOR PHYSICIANS** |
| **Section**  | **Description** | **Comments** |
| 1.01 (2) Definitions | * Complaint expanded to include info from “from any source” and expands the definition from “misconduct”
* Disciplinary Action - expanded to include remediation, probation and academic probation
 | *Any allegations or comments about a provider would be permitted into record w/o facts or source.**Remediation added w/o guidance on type.* *Hospital Bylaws allow for fair hearing- expanded reporting requirement will increase hosp hearings.**Academic probation should be limited to med school-too broad as written* |
| 1.03(5) Grounds for Complaint | * Gross and repeated negligence replaced with negligence
* New grounds for discipline added "conduct which is in violation of the ethical standards of the profession”
 | * *Too broad: “Any person, organization, or member may make a complaint to the Board”. Need to leave in “which charges a licensee with misconduct”.*
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| 1.05 Final Decision and Order and Miscellaneous Provisions | * Require the physician entering into a Probation Agreement as a condition of the stay of an indefinite suspension; and that failure to comply with the Probation Agreement may result in an immediate suspension.
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| **243 CMR 3.00 PATIENT CARE ASSESSMENT PROGRAMS** |
| **Section**  | **Description** | **Comments** |
| 3.01Scope and Purpose | * Removes applicability to office settings
* Removes reference to PCA regulations' role in assisting Board with its disciplinary function
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| 3.02 Definitions | * New Definitions
	+ Adverse Event any incident or variation in processes that causes or could potentially cause serious injury or an undesirable patient outcome.
	+ Close Call any adverse event that did not affect a patient’s outcome but for which a recurrence carries a significant chance of causing serious injury to a patient.
	+ Serious Reportable Event - those events required to be reported to DPH under [105 CMR 130.332](http://www.mass.gov/eohhs/docs/dph/regs/105cmr130.pdf).
* Allows a Medical Peer Review Committee to be a nonprofit established by a professional society whose primary purpose is evaluation of and assistance to impaired providers.
* Changes definition of “Patient Care Assessment Coordinator” to require the it to be a person in leadership (had previously allowed a Committee to fulfill the role)
 | * *Very broad use of the word adverse event; should reference natl’ std such as NQF*
* *Close Call as defined too broad and undefined > unnecessary reporting.*
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| 3.03 Establishment and Participating in Patient Care Assessment Programs | * Relates to nursing homes
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| 3.05 Patient Care Assessment Program - Credentialing  | * Requires physicians to include application for privileges all disciplinary proceedings and all criminal convictions (misdemeanor or felony and all medical malpractice claims in all jurisdictions at any time
* Removes 10 year malpractice look back to now be unlimited
* removes 10 year look back to other healthcare facilities where the applicant had privileges
* Adds telemedicine credentialing provision, allowing facility to follow the requirement of [42 CFR 482.12](https://www.law.cornell.edu/cfr/text/42/482.12) and [482.22](https://www.law.cornell.edu/cfr/text/42/482.22)
 | * *Extending beyond the 10 yr reporting period>admin burden. Slow credentialing process>delay pt care*
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| 3.06 Patient Care Assessment Program – Structure | * Eliminates option of having a committee fulfill the duties of the Patient Care Assessment Coordinator
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| 3.07 Patient Care Assessment Program - Internal Audits and Internal Incident Reporting | * QPSD of the Board may require facility to add additional incidents to its list of adverse events which must be reported
* Internal incident reporting system must allow for the reporting of close calls and other adverse events not on the facility's list of reportable events
* Extends retention time of incident reports, summary reports and recommendations to and from Patient Care Assessment Coordinator from 3 years to 10 years
 | * *Similar to comments about “adverse events” and “close calls”. Allows broad discretion to the Board w/o ability of provider to appeal or question the need to report. . No uniform definition or criteria*
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| 3.08 Patient Care Assessment Program- Reporting to the QPSD | * Adverse events that have not been reported to DPH as Serious Reportable Events have to be reported to QPSD of the Board:
* “serious injuries” that were unanticipated, including
	+ physical or mental impairment substantially limiting one or more major life activities in the short term, which may become a disability if extended long term; substantial change in the patient’s long term risk status
	+ loss of a body part
	+ major intervention for correction, such as surgery or transfer to a higher level of care.
* Name of patient and licensee is not required to be reported unless required by the Board
* Facility may report close calls and other events
 | * *Fact that pts may be sent to a higher level of care despite highest level of care and safety provided. No Natl’ evidence based stds to support proposed requirement; when is it inappropriate to transfer to a higher level of care?*
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| 3.10 Patient Care Assessment Program – Informed Consent and Patient Rights  | Extensive new requirements regarding informed consent* informed consent must be in writing and must be obtained before all diagnostic, therapeutic or invasive procedures, medical interventions or treatments
* Requires attending physician or primary operator to discuss the risks and obtain the written informed consent. Other facility personnel may assist in the completion of the written informed consent documentation.
* Requires attending physician/primary operator to inform the patient of who will be participating in the procedure, intervention, treatment including the names of all involved in the procedure/surgery
* Requires patient record to include documentation of the attending physician’s presence or absence during the procedure, intervention or treatment - including time of absence and who was supervising during the absence
 | * *Entire section needs to be rewritten. Will lead to legal confusion and increased admin time*
* *Each provider to perform informed consent if pt receiving multiple procedures w/in the same facility*
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| 3.13 Medical Care Quality – Reporting to the Board – Nursing Homes | * Relates to nursing homes
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| 3.14 Qualified Patient Care Assessment Program – Clinics | * Deletes PCA requirements related to clinics
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