Ohio Nurse

The Official Publication of the Ohio Nurses Foundation

ONF Ohio Nurses Foundation

Volume 6, Number 1 December 2012

Quarterly circulation approximately 222,000 to all RNs, LPNs, and student nurses in Ohio.

Whistleblowing–How to Ensure That The Law Protects You

This independent study was developed by: Kathleen M. Blickenstaff, JD, MS, RN, CS, and updated by Jan Lanier, JD, RN

This independent study has been developed to help nurses understand their rights and responsibilities regarding the provisions in the Nurse Practice Act and the law that protects nurses who blow the whistle from employer retaliation.

The authors and planning committee members have declared no conflict of interest. There is no commercial support for this independent study. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

1.57 contact hours of Law and Rules (Category A) will be awarded for successful completion of this independent study.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

OBJECTIVES

1. Discuss the meaning of the term "whistleblowing."
2. Describe the provisions in the Nurse Practice Act that protect nurses who blow the whistle from employer retaliation.
3. Identify the steps that the nurse whistleblower must take in order to be afforded the protection of the law.

Introduction:

With the passage of House Bill 511 in the 123rd General Assembly, several new provisions were added to the Nurse Practice Act ("NPA"), which is Chapter 4723 of the Ohio Revised Code ("ORC"). One of these provisions is "whistleblower protection" for nurses who report a person or a business entity for a violation of the NPA or any other provision of the ORC, as long as the nurse makes the report in good faith. These new provisions are contained in Sections ("§") 4723.33 and 4723.341 of the Ohio Revised Code.

This article will discuss the provisions of the whistleblower protection laws, as well as the responsibilities of the nurse in making a report to assure that the nurse is afforded the protection that these laws provide. These laws read as follows:

ORC Section 4723.33: Protection Against Retaliatory Action.

A registered nurse, licensed practical nurse, or dialysis technician who in good faith makes a report under this chapter or any other provision of the Revised Code regarding a violation of this chapter or any other provision of the Revised Code, or participates in any investigation, administrative proceeding, or judicial proceeding resulting from the report, has the full protection against retaliatory action provided by sections 4113.51 to 4113.53 [general Ohio whistleblower protection laws] of the Revised Code.

ORC Section 4723.341: Immunity for reporting.

(A) As used in this section, "person" has the same meaning as in section 1.59 of the Revised Code and also includes the board of nursing and its members and employees; health care facilities, associations, and societies; insurers; and individuals.

(B) In the absence of fraud or bad faith, no person reporting to the board of nursing or testifying in an adjudication [a legal proceeding to make a final decision related to certain facts; a court proceeding] conducted under Chapter 119 of the Revised Code with regard to alleged incidents of negligence or malpractice or matters subject to sections 3123.41 to 3123.50 [laws regarding a licensed professional defaulting on child support obligation] of the Revised Code and any applicable rules adopted under section 3123.63 [default on child support obligation by a licensed professional] of the Revised Code or this chapter or section of the Revised Code shall be subject to either of the following based on making the report or testifying:

(1) Liability in damages in a civil action for injury, death, or loss to person or property;

(2) Discipline or dismissal by an employer.

(C) An individual who is disciplined or dismissed in violation of division (B)(2) of this section has the same rights and duties accorded an employee under sections 4113.52 and 4113.53 [general Ohio whistleblower protection laws] of the Revised Code.

(D) In the absence of fraud or bad faith, no professional association of registered nurses, licensed practical nurses, or dialysis technicians that sponsors a committee or program to provide peer assistance to individuals with substance abuse problems, no representative or agent of such a committee or program, and no member of the board of nursing shall be liable to any person for damages in a civil action by reason of actions taken to refer a nurse or dialysis technician to a treatment provider or actions or omissions of the provider in treating a nurse or dialysis technician.

What do the laws mean?

The above provisions were added to the NPA and became effective on April 10, 2001. The basic meaning of § 4723.33 is that a licensed nurse or dialysis technician who makes a report, or "blows the whistle," on a person, business, or company who is acting in violation of any part of Ohio law, including the NPA, or who testifies in a court proceeding or investigation related to that violation is provided with the full protection against retaliation provided for under the laws of Ohio, as long as the report was made in good faith. Section 4723.341 applies protection from retaliation for reporting a violation of the law, not only to RNs, LPNs, and dialysis technicians, but also to other individuals, organizations, health care facilities and employers and insurers, as long as the report is made in good faith and with no fraudulent intent.

What does it mean to make a report in good faith and what are the protections provided for by the laws of the State of Ohio?

According to the 6th edition of Black's Law Dictionary ("Black's"), the term "good faith" is an abstract term referencing a person's state of mind at the time that an action or a statement is made. Black's says that to act in "good faith" means to act with an honest belief, purpose and intention, and with the absence of malice, the absence of an intent to defraud; an absence of intent to provide false information or information for which the informant has little or no regard as to whether or not it is true; and with an absence of intent to seek an unconscionable or unreasonable advantage. (Black, H.C. (1999). *Black's law dictionary* (7thmed.), St. Paul, Minn.: West Publishing Co.)

Therefore, in order to be afforded protection from retaliation under Ohio law for reporting an individual, an employer, etc. for violating any provision in Ohio law or for testifying or otherwise participating in an investigation or court proceeding against that individual or employer, the nurse must make the report with honest intentions and without any intention to provide false, potentially false, or misleading information. Good faith also encompasses the lack of a retaliatory intention on the part of the nurse making the report.

Section 4723.341 of the ORC affords protection for a nurse (or other individual, organization, employer, etc.) who reports to the Board of Nursing or testifies in an investigation or court proceeding about alleged incidences of negligence, malpractice, or other acts in violation of the Nurse Practice Act. This section states that if the nurse (or

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Published by:
Arthur L. Davis Publishing Agency, Inc.

OHIO NURSE

The official publication of the Ohio Nurses Foundation, 4000 East Main St., Columbus, OH 43213-2983, (614) 237-5414.

Web site: www.ohnurses.org

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Questions
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other individual, organization, employer, etc.) makes the report and/or testifies in good faith, the nurse will not be responsible for any payment of money associated with the court proceeding in which that nurse testified, nor can the nurse be disciplined or terminated from employment by his/her employer as a result of his/her involvement in this situation. If the employer disciplines or discharges the nurse in violation of this provision, the nurse has the legal right to sue the employer for reinstatement of employment, fringe benefits, seniority rights, position, back pay, etc. The nurse has one hundred eighty (180) days after the discipline or termination in which to file a law suit for wrongful termination against the employer.

What are the other criteria for reporting to obtain the protection of the law?

In addition to the requirement of making the report in good faith, a nurse must follow the provisions in §4113.52 of the Ohio Revised Code. This section of the Revised Code relates to the rights of an employee to report a violation of the law by the employer or a fellow employee and it provides further procedural guidance for the nurse in making a report. This law is more general and applies to any kind of employee/employer situation in the state of Ohio. Section 4113.52 states that if an employee becomes aware of a situation in the course of the employee's employment that the employee reasonably believes is a violation of a municipal, state, or federal law and is likely to cause physical harm to a person or persons or is a public health hazard and the employee believes that the employer has the ability and/or authority to correct the situation, that employee must first orally notify his/her supervisor or other authority in the organization. The employee must then follow up the oral notification with a written description of the alleged violation. The written description must contain enough detail that the employer is able to identify the problem. If the employer does not correct the situation or at least make a reasonable and good faith effort to remedy or begin to correct the situation within twenty-four (24) hours of either the oral or the written notification (whichever is sooner), then the employee may make a written report describing the violation to an appropriate official, agency, department, or other authority having regulatory control over the employer or the employer's business, such as the Ohio Environmental Protection Agency, the Ohio Department of Health, the Ohio Attorney General, the Ohio Board of Nursing, or a municipal or county department of health. The employer has an obligation to notify the employee, in writing, of action taken to remedy or begin to remedy the violation.

Section 4113.52 of the ORC also prohibits the employer from taking any retaliatory or disciplinary action against the employee who makes a report in compliance with the law. Disciplinary and retaliatory actions include, but are not limited to, transferring or reassigning the employee, reducing the pay of the employee, denying an otherwise deserved promotion or pay raise and firing or suspending the employee.

There are some violations of the law that are so outrageous and potentially destructive that the employee need not give the employer time to remedy the situation. The employee is protected if, in the course of employment, he/she becomes aware of a violation and makes a good-faith report of the violation directly to the appropriate authorities. These types of violations are described in Sections 3704, 3734, 6109, and 6111 of the Revised Code and include violations related to air quality, handling of solid and hazardous waste, safe drinking water, and water pollution control. Before making a report of this nature directly to a reporting agency, it would be wise for a nurse employee to consult an attorney and/or to inform the employer first, orally and in writing, of the alleged violation. In this way the nurse can be assured of protecting his/her rights.

It is also important to note that when the law states that the nurse must first make a report to his/her employer about the alleged violation, this means that the nurse must follow the chain of command and the procedural mechanisms in the institution which outline the method for filing a grievance or complaint with the employer. This information should be readily available in the employer's policy and procedure manual, employee handbook or other such document. If the grievance procedure is not readily available to the nurse, the nurse should go to his/her immediate supervisor and ask about the process.

In the absence of an employment contract or a specific policy in the employee handbook to the contrary, employees in Ohio are considered to be employed "at will." This term means that the employee has no obligation to remain employed with the employer and need only provide reasonable notice before terminating employment and that the employer can terminate the employee for any reason, or no reason at all, as long as it is not a reason that is prohibited by law. Therefore, if a nurse blows the whistle according to the appropriate protocols as defined by the law, the employer may not fire the nurse because termination of the nurse for appropriately executed whistleblowing is prohibited by law. Prior to the passage of these new whistleblower protections in the NPA, it would have been much more difficult for the nurse to have any protection from employer discipline or firing as a result of the nurse's whistleblowing.

What exactly must a nurse do to receive whistleblower protection under the law?

In simple terms, the whistleblower protection laws mean that if a nurse or an employee, in the course of his/her employment, makes a discovery or becomes aware of a violation of the NPA or other laws of the state of Ohio, which may cause harm to individuals or the public in general, the nurse or employee will be protected from retaliation for reporting the employer, if the nurse or employee follows the procedural rules laid out in the law. These rules can be summed up as follows:

1. The nurse or employee must have become aware of this situation in the course of his/her employment.
2. The nurse must have a good faith belief that the employer is violating a law or a regulation, evidenced by having researched the law and any relevant institutional policies, etc.
3. The nurse must believe that the employer is able to control the situation and has the authority and the power to refrain from the violation.
4. The nurse must be acting in good faith with no ulterior motives and no retaliatory or malicious intent. In other words, the nurse must act out of concern for the welfare of individuals or the general public and not with the idea of "getting back at" or punishing an employer.
5. The nurse must make an attempt, again in good faith, to determine that the activity of the employer that she/he believes is a reportable violation, is, in fact, what it seems.
6. The nurse must first notify the employer, orally and in writing, through the appropriate procedural process for his/her institution and must give the employer a chance to remedy the situation.
7. The nurse should put the notification to the employer as well as the subsequent notification to the legal authority in writing and keep a copy for herself or himself. Oral communications do not provide the same protection as written communications because oral communications are more subject to individual interpretation and validation.
8. The nurse should present all information to the employer and to the reporting agency in a professional manner and should refrain from having the communication appear to be "gossip."
9. If the nurse is called to testify about the alleged violation that he/she reported or about an alleged violation reported by another nurse or employee, the nurse must again be certain to represent himself/herself professionally and refrain from testifying about activities that the nurse has "heard" or "thinks" are occurring. The nurse's testimony should contain the nurse's observations only.
10. The nurse should refrain from speaking to others inside or outside of the employment situation about the alleged violation lest it appear that the nurse has a motive other than the safety and welfare of individuals and the public.
11. The nurse should document in writing everything that she observes related to the violation, as well as documenting any retaliation from the employer after the report is made.

Failure to follow the steps listed above can be extremely detrimental, both personally and professionally, to the nurse who blows the whistle on his/her employer. If whistleblowing is done effectively, the nurse can protect patients and the public from illegal and potentially harmful practices of the employer, making the nurse a sort of "hero" or "heroine." If whistleblowing is done improperly, the nurse may end up not only losing his/her job, but may lose credibility as a professional making it difficult to obtain subsequent employment. In addition, if it appears that the whistleblower's motives are more for revenge or other bad faith, the nurse may subject him/herself to allegations of fraud, which, if proven, can result in fines, discipline by the Board of Nursing, and perhaps even jail time.

Other state and Federal whistleblower protection laws.

The Federal government and many other states have similar whistleblower protections in place. The same procedures as discussed above should be followed if a nurse becomes aware of an employer's violation or potential violation of a Federal law. The Federal laws in which nurses become aware of employer violations are most commonly those laws having to do with Medicare or Medicaid fraud and abuse or an employer receiving monetary kickbacks or other kinds of benefits for making patient referrals to a certain agency or facility. These laws are extremely complicated and complex and are constantly changing. If a nurse becomes aware of an employer's potential violation of a Federal law, it would be wise for the nurse to consult an attorney who specializes in health care to assure that the situation is likely to be a violation of Federal law and to assure that the nurse receives appropriate protection from retaliation by the employer. To find a health care attorney, the nurse should consult his/her professional association to see if the association has such a listing and talk with other health care professionals, particularly physicians, who often have a relationship with a health care attorney. (For more information on whistleblowing under the Federal False Claims Act, see: Polsten, M. (1999). Whistleblowing: Does the law protect you? *American Journal of Nursing, 99* (1):26-32.)

Case examples

Nurses who report "violations" of the law and who do so in bad faith, with ulterior motives, or without adequately investigating whether the employer's act is actually or likely to be a violation, not only will not receive legal protection against retaliation by the employer, but may incur penalties such as fines, jail time, loss of employment, and similar consequences. Since the whistleblower protection laws are new provisions for the NPA, there are no examples in Ohio.

However, there are situations where nurses have blown the whistle for "violations" of Federal law, but have done so in bad faith. One such case involves Scott Slemp, a home health nurse who filed a whistleblower suit against his employer, Country Style Health Care. Slemp alleged that his employer falsified his signature on nursing notes for home visits that he (Slemp) had not made and then billed Medicare for those visits. Slemp's employer won the case because the agency was able to show that it had never submitted claims (bills) to Medicare for the alleged fraudulent visits and that Slemp had fabricated the entire story to cover up his poor nursing care. (Hansen, D. & Leewenburgh, T. (2001). Whistleblowers get nothing in 2 HHA cases. *Medicare Compliance Alert, 13*(16): 1-4.)

Another situation with a different outcome occurred in Texas where an emergency department nurse suffered retaliation after making a good faith report that her employer, the University of Texas Medical Branch, was forcing unwanted procedures on patients who came to the emergency department. The nurse, along with another nurse who also witnessed the violations, reported their concerns about the hospital under the state whistleblower law and the whistleblower clause of the Texas Nurse Practice Act. The jury found that the nurses had made their report in good faith, however only one of the nurses received any compensation for the hospital's retaliation. This nurse was able to prove that the hospital retaliated against her by subjecting her to abrupt schedule changes, verbal harassment and criticism for which she was awarded a total of five hundred thousand dollars ($500,000.00) in damages and three hundred ten thousand dollars ($310,000.00) for legal fees.

The other nurse was not able to prove that she had been subjected to retaliatory action by the hospital and consequently did not receive a monetary award. The difference was that the first nurse documented everything that happened to her after reporting the violation and the second nurse did not. (American Nurses Association. *The American Nurse.* Available online at http://www.nursingworld.org/tan/sepoct00/txnurse.htm, accessed August 17, 2001.)

Case study

Angela and Nora are both registered nurses at Very Big Oncology Practice, Inc. (the "Practice"), which employs a total of four (4) registered nurses, in addition to the clinical manager, Sara, who is also a registered nurse. Sara tells Angela and Nora that profits have been down in the Practice and that at the last business meeting, she and the physicians determined that much of the cost was due to nurses' salaries. Sara and the physicians decided to lay off two nurses and to hire two "assistant nurses" to take their places. Sara explains that the assistant nurses she has hired are unlicensed, but have experience in a hospital cancer unit. Sara also tells Angela and Nora that they will be responsible for teaching the assistant nurses to start the intravenous lines and to administer the chemo agents for the patients in the Practice. Angela and Nora are not sure that this is a good idea and tell Sara that they do not think this is appropriate and that they are concerned about the safety of the patients. Sara tells them that she has thought about this and has determined that as long as Angela and Nora are available for questions, the assistant nurses should have no problem and the patients' safety will not be compromised. Sara also tells them that they both can be easily replaced, should they decide that they do not want to work with the assistant nurses.

The assistant nurses report to work the next day and Sara tells Angela and Nora to begin their training by letting them observe for the first few days how to start an IV and how to administer the chemo agents. Angela and Nora go about their duties in the office that day while the two assistant nurses are observing them. After work, Angela and Nora talk with Sara and again express their concern about the situation being illegal and unsafe for patients. Sara tells them that the doctors allegedly checked with the Board of Medicine and have been told that it is perfectly legal and ethical to have assistant nurses starting intravenous lines and administering chemotherapeutic agents as long as they have been adequately trained by registered nurses. Sara emphasizes that Angela and Nora must be certain to train the assistant nurses appropriately or they may be fired.

The next day during her lunch break Angela contacts the Board of Nursing and finds out that unlicensed individuals, and even LPNs, are not permitted to administer chemotherapeutic agents regardless of who trains them. After lunch, Angela tells Sara what she learned from her call to the Board of Nursing. Sara laughs and tells her that the Board of Nursing has nothing to do with how a physician's practice is run and that the Practice needs to answer only to the Board of Medicine.

After work that day, Angela speaks with Dr. Blank, the senior physician in the practice; she reports to him her conversation with the Board of Nursing and expresses her concern about the safety of the patients in the practice if unlicensed people were permitted to handle the intravenous administration of chemo. Dr. Blank admits to her that no

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one had called the Board of Medicine to request an opinion on the issue. He also tells Angela that having unlicensed people administering chemotherapy was a bit "off the beaten path," but he felt that it was an extremely prudent fiscal decision and that if the Practice did not cut its costs in order to increase its revenues, they would "all be in the unemployment line"!

That evening, Angela puts her concerns in writing, including the information that she obtained from the Board of Nursing. The following day, Angela presents Dr. Blank with the written documentation about her concerns and gives copies of her memo to the other physicians and to Sara. Sara takes her aside and tells her that if she continues to "make trouble" that she would be "very sorry." Two days pass and Sara tells Angela and Nora that the assistant nurses have observed enough and it is time for them to begin to practice starting IVs. Sara volunteers to be a "guinea pig" at lunch time if Nora or Angela agree to talk the assistant nurses through the process of starting IVs on her. Angela states that she will have no part of this process and refuses to participate. Sara and Nora go into the lounge at lunch time and begin to teach the assistant nurses to start IVs. Angela eats by herself in her car.

During the following days Sara and Nora resume their teaching activities with Angela refusing to participate. During this time, Angela talks to two of the other physicians asking them if they had read her memo about her concerns. They said that they had read the memo, but were unwilling to go against the wishes of Dr. Blank and Sara. The following week, the two assistant nurses start their first IVs on a patient with Nora and Sara supervising. Angela calls the Board of Nursing and reports Sara and Nora for violation of the NPA; she also calls the Board of Medicine and reports the physicians in the practice. She follows up her verbal reports with written memos to the Boards detailing the activities.

The following week, Sara and the physicians are contacted by the Boards of Nursing and Medicine and are informed that there will be an investigation related to the delegation of nursing activities to unlicensed personnel. Angela receives an envelope with a check for a week's worth of pay as severance and is told not to return to the Practice.

The following week, Nora observes one of the assistant nurses hang the wrong chemotherapy agent with a patient. Nora is able to correct the situation before any of it is administered to the patient. Nora tells Sara that she is beginning to think that Angela was correct and that she plans to testify against Sara and the physicians, if the matter comes to that. Nora is fired that day without severance pay.

Angela and Nora both contact attorneys and file law suits against the Practice alleging retaliatory discharge and protection under the whistleblower protection laws in the State of Ohio. Angela is likely to prevail in her suit and be awarded monetary damages related to the termination of her employment. Nora is likely not to prevail and is likely not to receive any compensation for her retaliatory termination. Angela followed all the steps that needed to be followed to evidence her good faith reporting of the violation of state law. Nora did not follow the necessary steps for protection under the whistleblower protection laws.

Conclusion

It is very important for nurses to be able to report an employer's activities that are illegal and potentially harmful to patients or to the public in general and to advocate for the welfare and safety of patients. This type of activity is commonly called "whistleblowing" or "blowing the whistle." In order to encourage nurses to advocate for the safety and wellbeing of patients and the public, legal protection must be in place for the nurse in order to safeguard against retaliatory action by the employer. Ohio added whistleblower protection for nurses to the Nurse Practice Act. A nurse is afforded this protection from retaliation by her employer as long as she follows the provisions of the law for reporting the violations. In general, these provisions require that the nurse must have become aware of the potential or alleged violation through the course of his/her employment with the employer, he/she must make an effort to determine that the activity is in fact a violation, the nurse must make the report in good faith without any selfish or retaliatory motive, and (except in certain cases) must give the employer written notice of the violation and allow the employer twenty-four (24) hours to make an effort to remedy the situation. The nurse must report the violation first through the employer's internal grievance procedures and if the employer does nothing to remedy the situation, the nurse should make the report to the appropriate regulatory agency. The nurse should document his/her knowledge about the violation, all efforts made to verify the information, all activities related to reporting the information, and any retaliatory actions taken by the employer after the report has been made.

It is important for a nurse to follow the procedures outlined in the law exactly to be afforded protection from retaliation. To ensure that the nurse receives the full protection of the law, it would be wise for the nurse to seek the assistance of a health care attorney and/or the Ohio Nurses Association before reporting a violation.

OSHA Launches New Whistleblower Protection Site
Posted By Mike Hall On July 16, 2010 @ 3:45 pm
In Legislation & Politics

The Occupational Safety and Health Administration (OSHA) says that workers who blow the whistle on safety violations and other unlawful practices "play an important role in assuring compliance with federal laws."

But, say workplace safety advocates, too many times workers don't speak up about safety and health problems on the job because they fear retaliation from their employers, even though it's illegal.

OSHA now has a new website specifically dedicated to its whistleblower protection program, www.whistleblowers.gov. The site is designed to provide workers, employers and the public with easily accessible information about the 18 federal whistleblower protection statutes that OSHA currently administers. OSHA chief David Michaels says:

OSHA doesn't work unless workers feel secure in exercising their rights. This Web page is part of OSHA's promise to stand by those workers who have the courage to come forward when they know their employer is cutting corners on safety and health.

The new site provides information about workers' rights and provisions under each of the whistleblower statutes and regulations that OSHA enforces. It also has program fact sheets and information on how a worker can file a retaliation complaint with OSHA. Along with the direct URL, the site can be accessed at www.osha.gov by clicking on the "Whistleblower Protection" link.

Federal workplace safety laws allow workers to file discrimination complaints with OSHA if they believe their employer has retaliated against them for exercising a broad range of rights protected by law. These rights include filing safety or health complaints with OSHA and seeking an OSHA inspection, participating in an OSHA inspection, participating or testifying in any proceeding related to occupational safety or health, or reporting an injury or illness to their employer.

The Miner Safety and Health Act (H.R. 5663) now before Congress would strengthen whistleblower protections for miners covered by the Mine Safety and Health Administration and workers covered by OSHA.

Whistleblowing–How to Ensure That The Law Protects you

Post Test and Evaluation

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name:_____

Date:_____ **Final Score:** _____

Circle the one that best answers each question.

1. To what does the term "whistleblower protection" refer?
   A. Protection that the nurse receives to prevent him or her from losing his/her nursing license.
   B. Protection that the nurse receives that prevents him/her from being sued.
   C. Protection that the nurse receives from employer retaliation as a result of his/her reporting an employer's violation of state law.
   D. Protection that the nurse receives that eliminates the need for the nurse to carry her own malpractice liability insurance.

2. What is another way to describe Chapter 4723 of the Ohio Revised Code?
   A. The Whistleblower Protection Act
   B. The Nurse Protection Act
   C. The Retaliatory Prevention Act
   D. The Nurse Practice Act

3. Which of the following can "disqualify" a nurse for protection from retaliation by an employer for whistleblowing?
   A. Consulting an attorney prior to reporting the violation.
   B. Making a report to seek revenge on the employer.
   C. Making a report with a fellow employee.
   D. Notifying the employer of the alleged violation prior to making the report.

4. What does it mean "to act in good faith"?
   A. To act with an honest belief and with the absence of malice.
   B. To act with the betterment of the nursing profession in mind.
   C. To act with a retaliatory frame of mind.
   D. To act without contacting an attorney or other legal representative.

5. Will the law protect a nurse from retaliation by her employer if the information reported by the nurse as a violation is eventually proven to be false?
   A. Yes, but only if the nurse has used an attorney to help her with the case.
   B. No, because the information is false.
   C. No, because reporting information that is proven false proves bad faith on the part of the nurse.
   D. Yes, if the nurse has made the report in good faith, having made reasonable efforts to determine the veracity of the information.

6. How long does an employer have to make a good faith effort to correct the violation after the nurse has notified the employer of his/her belief that the employer is violating the law?
   A. Twenty-four (24) hours.
   B. One hundred eighty (180) days.
   C. The employer has no time to correct the situation because the employer should have realized that there was a violation.
   D. Thirty (30) days.

7. If an employer retaliates against a nurse employee who blows the whistle, how long does the nurse have to file a law suit against the employer?
   A. Twenty-four (24) hours.
   B. One hundred eighty (180) days.
   C. There is no limit since the employer violated the law.
   D. Thirty (30) days.

8. What is the employer's obligation to the whistleblowing employee after that employee has notified the employer of an alleged violation?
   A. Give the employee a paid leave of absence while the employer investigates the claim to prevent possible harassment of the whistleblowing employee.
   B. Provide the employee with a raise to thank him/her for the notification.
   C. Provide the employee with written notification of the employer's action to remedy the situation.
   D. The employer owes the employee nothing except not to fire the employee.

9. What is the primary reason that the nurse whistleblower should refrain from speaking about the alleged violation to the nurse's fellow employees?
   A. To prevent the appearance that the nurse's motives are for reasons other than to prevent harm to patients or the public.
   B. To prevent other employees from knowing about the violation to "save face" for the employer.
   C. To prevent another employee from making a similar report and sharing in any monetary award with the nurse.
   D. To prevent the nurse from possible harassment from fellow employees.

10. A nurse who blows the whistle without bothering to check the veracity and validity of the alleged violation may suffer which of the following negative consequences?
   A. There will be no negative consequences to the nurse because mistakes such as this can happen to anyone.
   B. The law protects the nurse from any negative consequences as long as the report was made orally and not in writing.
   C. The law protects the nurse from any negative consequences as long as the report was made in writing and not orally.
   D. The nurse may be charged with fraud and be required to pay fines, go to jail, and may lose his/her license to practice.

11. Are there "whistleblower protection" laws, at the level of the Federal government, as well as in states other than Ohio?
   A. Yes, for the Federal government, but no as to other states.
   B. No, for both the Federal government and for other states.
   C. Yes, for both the Federal government and other states.
   D. No, for the Federal government, but yes as to other state governments.

12. In order to receive compensation for and prove retaliation by the employer following a nurse's good faith report of a violation, the nurse should do which of the following?
   A. Request that the employer turn over the nurse's employment record.
   B. Document all actions taken by the employer related to the nurse's employment following the nurse's reporting of the violation.
   C. Enlist the assistance of others who are employed by the employer to look for and report other potential violations of the employer.
   D. Terminate his/her employment with that employer to prevent any sort of retaliation by the employer.

13. Which of the following actions is most appropriate for the nurse to take, if the nurse has made a good faith report of an employer's violation of the law and is subsequently disciplined or terminated by the employer?
   A. Hire an attorney to file suit on the employer within one hundred eighty (180) days of the termination.
   B. Make a written demand that the employer reinstate the nurse with a raise in salary.
   C. Encourage others who remain employed with the employer to quit their jobs in retaliation.
   D. Report the employer to the Ohio Department of Health.

14. What legal protections are in place for a nurse who is called to testify in court about an alleged violation reported by another nurse?
   A. The testifying nurse is afforded no legal protection since it was not that nurse who blew the whistle.
   B. The testifying nurse receives the same protection as the nurse who blew the whistle as long as the nurse makes his/her testimony in good faith.
   C. The testifying nurse will receive legal protection, but only if the employer is shown to have actually been in violation of the law.
   D. The testifying nurse receives protection only if she has been employed with the employer for at least one hundred eighty (180) days.

15. Nursing organizations, such as the Ohio Nurses Association, can provide assistance to nurses who suspect that their employers are violating the law.
   A. True
   B. False

Evaluation

1. Were you able to achieve the following objective?	Yes	No
a. Discuss the meaning of the term "whistleblowing."	__Yes	__No
b. Describe the provisions in the Nurse Practice Act that protect nurses who blow the whistle from employer retaliation.	__Yes	__No
c. Identify the steps that the nurse whistleblower must take in order to be afforded the protection of the law.	__Yes	__No
2. Was this independent study an effective method of learning?	__Yes	__No

If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?
   _____

4. What other topics would you like to see addressed in an independent study?

Fraud and Abuse in the Medicare and Medicaid Programs

Developed by: Beatrix Maitland, BS, RN, HCM

This independent study has been designed to enhance the nurse's knowledge of some of the aspects of abuse and fraud in the Medicaid/Medicare Programs. The author and planning committee members have declared no conflict of interest. There is no commercial support for this independent study. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

1.45 contact hours will be awarded for successful completion of this independent study.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

OBJECTIVE

Describe how to identify fraud and abuse in the Medicare and Medicaid Programs and how to report it.

STUDY

The topic of health care fraud and abuse is complex. Health care fraud costs the taxpayers between $60 and $90 billion annually. The scope of the problem is widespread throughout the United States with certain geographic areas of intense activity known as high risk zones (Miami, Chicago, Detroit, New York, Los Angeles, Houston, Baton Rouge, Tampa, and Brooklyn). Efforts to combat this enormous problem consist of a multidisciplinary approach to include the efforts of law enforcement, benefit integrity contractors, state agencies, the beneficiary community, citizens, providers and other allied health care personnel.

This article will define what constitutes fraud and how it differs from abuse. Additionally, the reader will have the ability to discuss how criminal and civil cases against health care providers who commit fraud are determined, what penalties may be imposed, why the problem of health care fraud continues to grow throughout the country and what is being done to protect our precious tax payer dollars now and in the future.

At the conclusion of this offering the reader will be able to report suspected fraud and abuse in the Medicare and Medicaid Programs to the appropriate authority and will have the ability to cite specific cases of fraud which have occurred across the country.

The problem defined: Health care fraud poses a risk to the solvency of the Medicare Trust Fund. Additionally, the cost is high in terms of future health care benefits, consumer safety and the delivery of quality health care.

The Centers for Medicare and Medicaid Services (CMS) currently spends $525.6 billion annually for Medicare benefits, $403.9 billion for Medicaid benefits and $11.4 billion for the Children's Health Insurance Program (CHIP) benefits. These figures grow on an annual basis.

To understand the scope of the problem one must understand the complexity of the administration of the Medicare and Medicaid Trust Fund. There are over 100 million beneficiaries who use the dollars allocated to the Trust Fund. These health benefit programs cover 1 in 4 Americans. Every day 4.8 million claims are processed.

The cost of these federal and state health care programs adds up to consume 19% of the Federal budget. In the Medicare Program alone, every working day Medicare pays over 4.4 million claims to 1.5 million providers worth $1.1 billion dollars. Each month Medicare receives almost 19,000 provider enrollment applications and each year Medicare pays over $430 billion for more than 45 million beneficiaries. Management of this enormous program is a daunting task.

Through the **Affordable Care Act (ACA) Title VI,** the Transparency and Program Integrity was created. It is to ensure the integrity of federally financed and sponsored health programs. It includes new requirements to provide information to the public on the health system and promotes a newly invigorated set of requirements to combat fraud and abuse in public and private programs.

The governing body for Program Integrity (PI) is the Department of Health and Human Services (DHHS). DHHS also oversees CMS and the Office of Inspector General (OIG) for health care fraud related crimes. Additionally there are private contractors who work in collaboration with OIG/CMS/HHS regarding program integrity efforts. These private contractors are called Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC).

Who are they and what do these contractors do? The PSC and ZPIC contracts were designed to ensure the integrity of the Medicare and Medicaid Programs. Originally CMS awarded contracts to Program Safeguard Contractors (PSCs) whose role was to protect the Medicare Trust Fund. The PSCs were created out of the Health Insurance Portability and Accountability Act (HIPAA) in 1996.

Since the onset of an independent program integrity function, CMS changed the way PI is structured based on the Affordable Care Act (ACA) and the Medicare Modernization Act (MMA). The new structure of PI consists of 7 Zones called Zone Program Integrity Contractors (ZPICs). The ZPICs are responsible for the oversight of all claim payer types to include: the prescription drug plan, Medicare Part A, Medicare Part B, Medicare Part C, Home Health, Hospice and durable medical equipment. The transition to ZPICs is not completed to date, but the majority of the contracts have been awarded. The rationale behind this change is to allow for better cross claims analysis for identification of criminals committing fraud across multiple claim payer types.

It is important to point out that, although fraud and abuse are a huge problem, the numbers of health care providers that are cheating the system are small.

What is fraud? Fraud is defined as willingly and knowingly executing or attempting to execute a scheme to obtain an unauthorized benefit. Simply put, fraud is an intentional act. The individual knows they are doing something wrong but choose to ignore this fact because they know they will receive a payout. The payout is taxpayer dollars. The intentional deception of individuals that undermine the integrity of the Medicare and Medicaid Trust Fund dollars are at the very core of The Benefit Integrity Program responsibilities.

One example of fraud is billing for services that are unnecessary or never provided. In regard to this example: a provider might bill for a procedure (debridement of a wound when in reality a dressing change was performed) that was never provided to a beneficiary. Another common fraud scheme is to up-code services provided. For example, if a patient were admitted to the hospital with pneumonia but the admission was coded and intentionally billed as respiratory failure, which carries a higher DRG payment, fraud is committed. Using another provider's identity is an act of fraud, which is also referred to as identity theft. Additionally, changing, duplicating or altering a medical record after an audit has been announced, or at any other time in order to meet billing requirements, is considered fraud. Failure to provide care is not only a cause of patient harm but has been pursued as fraud. Case examples may include a patient in a Skilled Nursing Facility (SNF) developing multiple bed sores over a short period and losing their life because of such failure of care. The list goes on and on.

Later in this offering, we will review some actual examples of cases that were investigated and we will discuss the outcomes of each.

What is abuse? Abuse is defined, as it applies to the Medicare Program, as incidences or practices of providers that are inconsistent with accepted sound medical, business or fiscal practices. These practices can, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services which fail to meet professionally recognized standards of care or are medically unnecessary.

Some common examples of abuse are: billing patients for greater than the allowed coinsurance amount of 20%, submitting claims for services that are not medically necessary to the extent that they are furnished and violations of the Medicare participation agreement.

To understand what is meant by abuse we will review an example. Suppose you visit your family doctor for a productive cough and chest congestion with a fever. Perhaps he writes a prescription for antibiotics to treat what has been diagnosed as a respiratory infection. Now, suppose you return in 10 days with complaints of feeling worse than your initial visit and you include chest pain and increased blood tinged mucus production with wheezing and shortness of breath. The accepted standard of practice could warrant a CAT scan of your chest. However, if the physician also orders a CAT scan of your pelvis without a medical indication for doing so (he indicates he is just being cautious), he could be abusing the system. To take this scenario one step further, if this same physician has ownership in an out-patient CAT scanning facility where he reaps profits for any testing done and he routinely orders multiple CAT scans on the majority of his patients, fraud might be indicated, not to mention patient harm from overexposure to harmful radiation. My point is that abuse can be gray and can cross the line into the fraud arena if repeated violations occur. Remember fraud equals intent, willingly and knowingly scheming to obtain an unauthorized benefit.

The Penalty for Fraud: If fraud is committed, several administrative sanctions may be imposed on the offender. For example, in less extreme cases, there can be overpayments identified and collected by the Program Integrity contractors that serve CMS. Additionally, providers may have their payments suspended. Education regarding

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proper billing practices always accompanies such penalties. When law enforcement becomes involved, depending on whether a civil or criminal conviction is pursued, penalties become more severe. Let's differentiate between what determines whether a criminal or a civil prosecution will occur.

In criminal cases the evidence must prove guilt beyond a reasonable doubt. Criminal cases carry penalties which include imprisonment, fines, restitution, loss of licensure in some cases and the potential of exclusion from the Medicare and Medicaid Programs.

Exclusion from the Medicare and Medicaid Programs prevents the offender from billing state and federal health care programs. There are two types of exclusions: Mandatory Exclusion which is a minimum of five years exclusion from the Medicare and Medicaid Programs. Offenses that result in a Mandatory Exclusion include drug related offenses, submitting false claims or conviction in a felony health care fraud related offense.

Once a Mandatory Exclusion has expired reinstatement into the Program is not automatic.

Exclusion is nationwide in scope and applies to all health care professions and occupations.

For example, if a nurse is excluded, he or she will be precluded from many types of employment in the health care field. Items or services furnished by the excluded nurse cannot be reimbursed, either directly or indirectly, by a Federal health care program. A nurse cannot work at a hospital, nursing home, or other institutional provider if the nurse's salary or fringe benefits are paid directly to the nurse or indirectly through the employer on a Federal health care program's cost report. These prohibitions apply regardless of whether the person excluded as a nurse now has a different license within the nursing field (e.g., LPN instead of RN), or changes fields and is now employed as a physician, secretary, administrator, information clerk, cafeteria worker, or any other position where the salary is reimbursed by Federal health care programs directly or on a cost report.

Once excluded, an individual or entity is not able to participate in Federal procurement and non-procurement programs and activities. For example, an excluded person cannot be granted Federal student loans or housing loans, nor will any excluded party be able to enter into any contract with the Federal government.

For example: If Nancy Nurse participates in recruiting Medicare patients for home health care (HHC) when they are not homebound, knowing that the beneficiary does not need HHC means fraud has occurred and she can be excluded from the Program. The full impact of this mandatory exclusion would make it essentially impossible for the nurse to find any employment within her field of licensure for a period of 5 years. Nurses need to be aware of administrators offering big bonuses for participating in such schemes. Not only is exclusion a reality but you could also find yourself (wearing an orange jumpsuit in an 8X10 housing development with bars on the doors and windows) in prison!

Additionally there can be a Permissive Exclusion which implicates anyone that was aware of the fraud during the commission of the offenses. As a health care worker it is important to know about new regulations related to Permissive Exclusions.

Background on Permissive Exclusion Authority

- An entity that has been convicted of certain offenses, such as patient abuse, fraud or program-related crimes such as kickbacks and false claims, may be excluded from participation in federal health care programs. By virtue of their role or interest in an excluded entity, an individual owner, officer, or managing employee of a sanctioned entity may also be excluded from participation through their association with the entity. Such exclusions are subject to the discretion of the Secretary, and by delegation, the OIG. The standards for exclusions vary significantly depending on the individual's status as (1) an owner or (2) an officer or managing employee.

Exclusion of Owners

- Individuals with a direct or indirect ownership or controlling interest in a sanctioned entity may be excluded only if they knew or should have known of the conduct that formed the basis of the sanction. In general, if the evidence supports a finding that an owner knew or should have known of the prohibited conduct, OIG will operate with a presumption in favor of exclusion. This presumption may be overcome if the OIG finds that significant factors weigh against exclusion. The OIG does not describe those factors that are sufficiently significant to weigh against exclusion of an owner, and the factors described below *do not* affect the determination of whether an owner may be permissively excluded.

Exclusion of Officers and Managing Employees

- In contrast, officers and managing employees of a sanctioned entity may be excluded based on their position within the entity alone. Officers and managing employees need *not* have knowledge of the conduct that led to sanction of the entity. Because there is no required showing of knowledge to be subject to exclusion, officers and managing employees are at much greater risk of being excluded than owners. In its guidance, the OIG indicates that it will operate with a presumption in favor of exclusion where the evidence indicates that an owner knew or should have known of the prohibited conduct. Again, the presumption may be overcome if the OIG finds that significant factors weigh against exclusion.

Civil cases: Civil cases are based on the preponderance of the evidence. In all civil settlements the offender will pay back money to the Trust Fund. This refund is known as a Civil Monetary Penalty (CMP). The offender often will make a public statement of no wrongdoing. I don't want the reader to assume that these Civil Settlements are less beneficial to The Medicare and Medicaid Programs. On the contrary, this is where some of the greatest recoveries to the Trust Fund occur.

A perfect example of this is the most recent recovery of $2.3 billion (the largest health care settlement in history) from Pfizer Pharmaceutical Company. Pfizer was marketing a drug called Bextra for off label use, which is strictly prohibited by the Food and Drug Administration. The case was brought to the attention of the US Department of Justice by former employees through a qui tam or whistleblower action.

Whistleblowers are current or former employees of an organization that have knowledge of wrongdoing. Through a qui tam action (attorney guided litigation), the whistleblowers are entitled to receive a portion of the money recovered from the settlement. In the Pfizer case, the reward was $102 million, which was split between six individuals.

What is happening regarding fraudulent activity right now? Fraud has moved from what has been called a white collar crime to the world of organized crime. Criminals realize through their information network that penalties for health care related crimes are far less severe than drug related offenses with the payoff being far more lucrative. For example, a drug related crime carries a long prison sentence and less monetary profit during the commission of the crime. Health care related offenses carry far less prison time and the ability to reap huge profits in a short period.

With the introduction of organized crime to the health care industry, violence has also been reported. In the Miami area, for example, there have been murders linked to health care fraud. Due to reasons I cited earlier in this module, such as the volume of work related to administering the program, law enforcement officials, program integrity contractors, beneficiaries, citizens, state agencies and CMS have their hands full in fighting this battle.

Specific Case Examples: Let's begin with some criminal case history. This first criminal case discussion resulted in a precedent setting sentence and conviction. The case involves a physician named Dr. Jorge Martinez. Dr Martinez was a pain management specialist with practices in the Boardman and Parma areas of Ohio.

Dr. Martinez became the focus of an investigation after an astute beneficiary called to complain about the Medicare Summary Notice (MSN) they received. The call was received by the Program Safeguard Contractor (PSC) AdvanceMed. PSCs are hired by CMS to protect the Medicare and Medicaid Trust Fund by performing data analysis, responding to complaints and conducting investigations.

The complainant stated that they had seen Dr. Martinez two times and had received an injection in their neck on the first visit and another two injections in their neck on the second visit. The MSN received by the beneficiary reflected a bill for three injections on the first visit and five injections on the second visit. Based on this type of complaint, AdvanceMed was prompted to conduct an investigation.

AdvanceMed initiated data research, which indicated that Dr. Martinez was billing for multiple injections on a single date of service for many of his patients. In one case he billed 19 injections on behalf of one beneficiary on a single date of service. Further investigation showed that Dr. Martinez was extremely aberrant for the injection code that he was billing in comparison to his peer group. Additional investigation uncovered a narcotic prescription pattern that was also aberrant to his peer group. In fact, every seven days Dr. Martinez was prescribing 28 pills of various narcotic and sedative medications, which if taken in combination could have been harmful to the beneficiary.

The time-period under review, which was two years, revealed that Dr. Martinez billed Medicare, Medicaid, commercial insurance companies and the Bureau of Workmen's Compensation for $60 million. Dr. Martinez actually received $12 million in compensation for this fraudulent behavior. Most of the money came from the Bureau of Workmen's Compensation.

A referral was made to the Office of Inspector General by AdvanceMed who in collaboration with the Federal Bureau of Investigation and other state agencies were able to garner further convicting evidence. A surveillance video obtained of Dr. Martinez's office practice proved both disturbing and powerful in the prosecution of this case. On video surveillance, Dr. Martinez was captured administering injections into a patient's back without fluoroscopic guidance, which is outside the medical standard of care required in the administration of such injections.

Additional evidence in this case included interviews of both past and present patients, which revealed that Dr. Martinez would coerce patients to have unnecessary and dangerous injections into their backs in order to receive the prescription medications they were seeking. During the development of the investigation two patients died under his care. The criminal Assistant United States Attorney assigned to this case was seeking a 20 year prison sentence. Dr. Martinez was found guilty on 56 charges brought against him including health care fraud resulting in the death of two patients. He received a life sentence, which was a precedent setting outcome to this health care fraud case.

Another criminal case involved a podiatrist named Dr. Lawrence Harris. Dr. Harris defaulted on his federal medical education loan and was subsequently excluded from the Medicare Program. To circumvent this exclusion, Dr. Harris assumed the identity of one of his medical school colleagues who was currently homebound, sick and dying. Dr. Harris had access to the billing information required to use his friend's physician identifiers.

AdvanceMed first became involved in this investigation because of a beneficiary phone call. The beneficiary was confused by her MSN because it had a different podiatrist listed as the treating physician than the actual physician she saw. Dr. Lawrence Harris was the treating physician.

In the initial stages of the AdvanceMed investigation, data research was completed and phone interviews were conducted. The phone interviews involved a conversation with the Locum Tenens (substitute physician covering the ailing physician's practice) who stated that they were covering the practice of the billing physician because he was homebound, sick and in fact terminally ill. The Locum Tenens physician also stated they had no knowledge of any other physician who would be billing for services using the practice location they were hired to cover in the sick physician's absence.

After the evidence was gathered and Dr. Harris went to trial for alleged health care fraud, he testified on his own behalf. An example of Dr. Harris's attitude toward the seriousness of his crime was exhibited when he answered his ringing cell phone and began a conversation while on the witness stand. Dr. Harris was found guilty of health care fraud and was sentenced to seven years in prison.

Finally, I want to discuss a criminal case which occurred in Florida. The financial impact to the Medicare Program for this Florida case was over $100 million. Most of the fraudsters involved in this scam are already spending time in prison. As I mentioned earlier, PSCs are hired by Medicare to protect the Medicare Trust Fund. Part of this protection involves proactive data analysis. The PSC responsible for the state of Florida, TriCenturion, did some proactive data analysis and became concerned when they discovered that, although Miami- Dade, Broward and Palm Beach counties only accounted for 8% of the HIV Aids population, the money billed to the Medicare and Medicaid programs was 72% of the national average for two IV infusions called Rituximab and Ocreotide. This statistic begged the question, why are billings so high in Florida when the state accounts for a very small portion of the patient population involved?

After investigation of several South Florida HIV/AIDs Clinics, it was discovered that the scheme surrounding this fraud was created by three brothers, Jose, Carlos and Luis Benitez. The Benitez brothers recruited beneficiaries to come to their HIV clinics to receive unnecessary IV infusions. In some cases no medication was received, but the program was billed as if the drug had been administered. Additionally the beneficiaries allowed the clinic to use their health billing information to bill fraudulent claims to the Medicare and Medicaid programs.

For their cooperation, the beneficiary would receive $100.00 while thousands of dollars of medical claims were submitted by the HIV clinics in their names.

This fraud operation involved a total of 11 HIV clinics and resulted in $110 million taxpayer dollars lost to fraud. Several clinicians participated in this scheme. In fact the co-administrator, Aisa Perera, ended up facing a judge that imposed a 30 month prison sentence to Aisa for her part in the operation. A physician's assistant, Thomas McKenzie, received 14 years in prison for his part in the scheme. McKenzie was the trainer for all clinical staff regarding how to document fraudulently and bill for services that were never rendered.

Although most of the fraudsters have been caught, the masterminds behind the criminal activity remain at large. The Benetez brothers are believed to have fled the country. Additionally, it is believed that a large portion of the money was sent overseas, which makes the recovery of the dollars lost to the Trust Fund almost impossible.

During the trial Dr. Perera pled for leniency because she claimed to have done many good things for her community during her years as a practicing physician. The judge was not impressed. In fact he sentenced her to 30 months in prison and issued a strong message to her…"you are not in this courtroom for the wonderful things you have done in this community, you are here for committing fraud against the taxpayers across the country". Aisa did not help her cause when she lied on the witness stand during her testimony, which the judge also found to be discreditable.

Civil Cases Discussion: Now let's review some civil cases. Just to recap, a civil case is based on the preponderance of the evidence and results in recovery of money to the Trust Fund. In Ohio there have been some recent civil case recoveries. The first case we will discuss involves Christ Hospital in Cincinnati. This case began with a complaint from a whistleblower. The whistleblower was a physician, Dr. Harry Fry. The final settlement agreement resulted in Christ Hospital paying $108 million back to the federal government. Dr. Fry received $23.5 million for his help in this recovery.

The complaint alleged that Christ Hospital was limiting cardiologist's time in the heart station at Christ Hospital based on the volume of patient admissions that resulted in

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coronary bypass graft surgery (CABG). Physicians who did not have a large volume of CABG admissions were given little or no time in the heart station. It should be noted that the heart station at Christ Hospital is a floor dedicated to essentially non-invasive cardiac procedures like stress testing, electrocardiograms and echocardiograms. Seeing patients in this type of setting often results in lifelong physician/patient relationships. It is the bread and butter of developing a thriving cardiac practice. In other words, not having time in the cardiac station could severely impact the physician's practice viability.

This is a classic example of the Anti-Kickback Statute and the False Claims Act involving unlawful payments to physicians in exchange for patient referrals. A physician cannot be unjustly enriched because of money paid for referrals. In addition to the monetary settlement The Christ Hospital entered into a 5 year Corporate Integrity Agreement (CIA) with the government, which will ensure that the hospital corrects any further unlawful arrangements that they have with physicians.

Corporate Integrity Agreements are very costly to hospitals or other entities and are part of civil settlement agreements. During the term of the CIA, the hospital/entity would have to hire an outside auditing firm and pay them to monitor the hospitals/entities activity related to the settlement for five years. The Office of Inspector General may require the addition of staff to the hospitals/entities compliance department and an overhaul of current policies and procedures. As I said earlier, civil settlements may sound like a softer approach to fraud, but on close examination one realizes that these civil settlements are a harsh penalty for the offending entity without putting these large service centers out of business.

Merck & Co. agreed to pay $950 million in settlement of criminal and civil charges which resulted from the off label marketing of a drug called Vioxx. The drug was found to cause an increase in the risk of heart attack and stroke. Vioxx was used to treat certain types of pain, but not rheumatoid arthritis type pain, which is how Merck marketed the drug. Merck will pay back the $950 million and will be required to comply with a CIA to prevent future problems of this type.

What is being done to combat these issues we have discussed? The developments of new tools to fight this dilemma are a focus of the DHHS. One of the tools that has already been implemented is the Fraud Prevention System (FPS). The FPS provides law enforcement and the contractors a predictive modeling tool to identify potential fraud early enough to prevent dollars from being paid out from the Trust Fund. The ultimate goal of CMS is to stop the "pay and chase" recovery process of our taxpayer dollars. The early identification of potential schemes makes it easy to stop payment and averts the potential for money being spent or shipped out of the country before a recovery can be made.

Another tool that works well in the fight against health care fraud is the Health Care Fraud and Enforcement Action Team or "HEAT" strike force. Established in 2007, these teams have a proven record of success using a "data-driven" approach to identify unexplainable billing patterns and investigating these providers for possible fraudulent activity. The Medicare Fraud Strike Force team operating in South Florida already convicted 146 defendants and secured $186 million in criminal fines and civil recoveries. After the success of operations in South Florida, the Medicare Fraud Strike Force expanded in May 2008 to Phase II in Los Angeles, where 37 defendants have been charged with criminal health care fraud offenses. To date in the Los Angeles cases, more than $55 million has been ordered in restitution to the Medicare program.

Prevention is critical to reforming the system and the HEAT team focuses critical resources on preventing fraud from occurring in the first place. The team will build on demonstration projects by the HHS Inspector General and the Centers for Medicare & Medicaid Services (CMS) that focus on suppliers of durable medical equipment (DME). These projects increase site visits to potential suppliers to prevent imposters from posing as legitimate DME providers. Other initiatives include:

- Increasing training for providers on Medicare compliance, offering providers the resources and the knowledge they need to help identify and prevent fraud.
- Improving data sharing between CMS and law enforcement so we can identify patterns that lead to fraud.
- Strengthening program integrity activities to monitor and ensure Medicare Parts C (Medicare Advantage plans) and D (prescription drug programs) compliance and enforcement.

Fraud prevention efforts are also strengthened in President Obama's proposed Fiscal Year 2010 budget. The President's budget invests $311 million–a 50 percent increase from 2009 funding–to strengthen program integrity activities within the Medicare and Medicaid programs. The anti-fraud efforts in the President's budget could save $2.7 billion over five years by improving oversight and stopping fraud in the Medicare and Medicaid programs including the Medicare Advantage and Medicare prescription drug programs.

The results of the increased efforts by CMS and law enforcement have been excellent. Since the onset of HEAT and the realization that much of fraud related crimes in the Medicare and Medicaid Programs can be tied to bogus Durable Medical Equipment suppliers, the tally of suppliers expelled from the program increased by 50%.

Because of a HEAT sting operation, an organized ring of Armenian mobsters (73 individuals) committing health care fraud throughout the United States was broken and the fraudsters were taken into custody. The scheme the criminals were administrating involved 2,900 stolen Medicare numbers and stolen physician identifications, which were used to open 118 phantom clinics in 25 states. In New York alone, more than $100 million was billed to Medicare fraudulently and $25 million paid by the Program.

Still it needs to be said that one of the greatest tools that we have in this fight against health care fraud in the United States is the American taxpayer. As you read earlier, two of the criminal cases that went to trial and were successfully prosecuted were the result of a simple beneficiary phone call. Many of the large civil case settlements we discussed are the result of a concerned citizen who witnessed something that they knew was wrong and reported this information to the correct federal or state authority. We need your help as well.

As a practicing health care worker, if you see something or witness something that you believe is illegal, speak up!

While there is no quick fix to this enormous problem, everyone working together makes the efforts going forward that much more powerful. The results will be seen in the solvency of the Medicare and Medicaid Program in the future. All you need to do is listen to the news, where everyday there is talk of our Federal Deficit. Money lost to fraud waste and abuse in our nation's health care programs is a huge portion of that deficit. As I said before, 19% of the federal budget is spent on federal and state health care programs, so we need to work together to keep the taxpayer dollars where they belong.

Secretary of Health and Human Services, Kathleen Sebelius and Attorney General, Eric Holder were tasked by President Obama to dedicate more resources to solving this crisis. In fact in FY 2011 the Budget included $1.7 billion to fight fraud, waste and other improper payments. Over a 10 year period this investment is projected to save nearly $25 billion in Medicare and Medicaid expenditures.

On January 28, 2010, there was a National Summit on Health Care Fraud (can be viewed at http://www.stopmedicarefraud.gov/videos.html). The Summit brought together federal and state officials, law enforcement experts, private insurers, computer technology professionals, health care providers and beneficiaries for an unprecedented meeting to identify the scope of fraud, identify weaknesses in current systems and propose new solutions.

In conclusion: Fraud is not going away anytime soon. Criminals prey on the vulnerable and weak. This is not to say the Program is weak, but there are areas of vulnerability as we have already discussed. When you have enormous administrative programs, such as Medicare and Medicaid, you will find areas that are susceptible to attack.

The future of these federal and state health care programs is in our hands. The responsibility of protection of the Trust Fund must be viewed as a national priority for all Americans. America may not be able to solve this problem overnight, but as we move to the future and work together, we can make an impact on the issues of fraud and abuse in our health care industry.

Stay alert and use your intuition as a guide. If you think something does not seem right, bring that information to the appropriate administrative team leader. If you don't witness change after you make your initial report, take the information a step further without fear of retribution.

You are the key ingredient to helping eradicate fraud and abuse in the health care industry for yourself, your family and future generations. Thank you for participating in this offering. By doing so, you have already made a difference.

Special Note: *We recommend that you review Whistleblowing Protection laws when considering reporting potential fraud or abuse.*

Acronyms

ACA–Affordable Care Act
CHIP–Children's Health Insurance Program
CMP–Civil Monetary Penalty
CIA–Corporate Integrity Agreement
CMS–Centers for Medicare and Medicaid Services
DHHS–Department of Health and Human Services
DME–Durable Medical Equipment
FPS–Fraud Prevention System
HHC–Home Health Care
HIPAA–The Health Insurance Portability and Accountability Act
MMA–Medicare Modernization Act
MSN–Medicare Summary Notice
PI–Program Integrity
PSC–Program Safeguard Contracts
SNF–Skilled Nursing Facility
ZPIC–Zone Program Integrity Contractors

Fraud and Abuse in the Medicare and Medicaid Programs

Post Test and Evaluation

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name:_____

Date:_____ **Final Score:** _____

Circle the one that best answers each question.

1. Fraud is defined as:
   a. A crime that always involves a physician.
   b. Willingly and knowingly executing or attempting to execute a scheme to obtain an unauthorized benefit.
   c. A crime that costs the taxpayers millions of dollars annually.
   d. A crime that will always result in the imprisonment of the defendant.

2. Examples of fraud are: (choose all that apply)
   a. Billing for services that were never rendered.
   b. Altering documentation in the medical record to obtain payment.
   c. Receiving monetary reimbursement for referrals.
   d. Up-coding a diagnosis to receive higher reimbursement.
   e. Stealing another provider's identification and billing on their behalf.
   f. All are examples of fraud.

3. HHS is the highest federal entity that oversees the protection of the Medicare and Medicaid Trust Fund.
   a. True
   b. False

4. As a health care practitioner I am ethically obligated to report suspected fraud or abuse. I am protected from retribution by the Whistleblower Protection Act.
   a. True
   b. False

5. A nurse that participates in any fraud scheme to benefit financially could suffer the following penalties. (Check all that apply)
   a. A mandatory 5 year Exclusion from working in their field of licensure.
   b. Time in prison.
   c. Unable to work in any capacity for a health care system that bills Federal or state programs.
   d. A chance to re-establish their ability to work as a nurse after 5 years if the OIG allows it.

6. The Department of Justice can choose to take criminal or civil actions against a potential fraudster.
   a. True
   b. False

7. In a criminal proceeding all the following criteria must be met except which of the following before the attorney can proceed:
   a. Fraud must have occurred.
   b. A beneficiary must have died.
   c. The evidence proves quilt beyond a reasonable doubt.
   d. Money must have been paid in error.

8. As a physician I am entitled to receive $75.00 from the hospital where I see my patients for every patient I admit to that facility.
   a. True
   b. False

9. Patient harm as the result of failure to care is a criminal act under the false claims act.
   a. True
   b. False

10. A provider might face a Mandatory Exclusion if the following occurred. (Pick all that apply)
    a. He/she submitted a false claim.
    b. He/she was convicted of a felony health care fraud offense.
    c. He/she was convicted of a drug related offense.
    d. He/she was facing multiple malpractice charges.

11. Under the Mandatory Exclusion authority, a provider or entity is excluded from billing any federal health care insurance for a minimum of 5 years and reinstatement to the Program is not automatic once the 5 year exclusion has expired.
    a. True
    b. False

12. One in four Americans is covered by a state or federally funded health care plan.
    a. True
    b. False

13. Managing the problem of fraud and abuse in the Medicare and Medicaid program is complex because of the complexity of the administrative requirements of the Program and the numbers of claims, providers and beneficiaries involved in the Program.
    a. True
    b. False

14. Examples of abuse are: (choose all that apply)
    a. Falsifying medical records.
    b. Billing for services never rendered.
    c. Ordering a multitude of tests as a precaution even if the testing is not within the medical standards of care.
    d. Receiving or offering money for referrals.

15. Abuse can crossover into the fraud arena when multiple attempts to correct the error (such as education) go unheeded.
    a. True
    b. False

16. Fraud is an intentional act and this fact is the main differentiation between fraud and abuse.
    a. True
    b. False

17. Civil penalties are where some of the greatest recoveries to the Program are made.
    a. True
    b. False

18. The most powerful tool in the fight against health care fraud is an educated, concerned citizen.
    a. True
    b. False

Evaluation

1. Were you able to achieve the following objective? Yes No

   a. Describe how to identify fraud and abuse in the Medicare and Medicaid Programs and how to report it. __ Yes __No

2. Was this independent study an effective method of learning? __ Yes __No

   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?
   _____

4. What other topics would you like to see addressed in an independent study?

The Evolving Practice of Nursing

Developed by: Pamela S. Dickerson, PhD, RN-BC.

This independent study has been developed to enable the nurse to be proactive in advocating for the future of nursing.

The author and planning committee members have declared no conflict of interest. There is no commercial support for this independent study. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

0.8 contact hour will be awarded for successful completion of this independent study.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

OBJECTIVE:

1. Describe changes impacting the current and future practice of nursing.

Introduction

A number of factors have converged in the first decade of the 21st century to radically alter the environment in which health care is provided and change the nature of the role and responsibilities of the nurse. This study will explore these changes, with a focus on the current and potential impacts on the profession of nursing.

Setting the Stage

Changes in the *environment* in which health care is practiced have occurred more rapidly in the first decade of the 21st century than in the past. Hospital care, which used to be the "normal" and most common venue for the practice of nursing, is now only one of a myriad of opportunities for the nurse. Patients are in the hospital for shorter periods of time, and only the sickest patients are hospitalized. Consequently, hospitals are employing nurses who are experts in the type of care needed by hospital patients. Units which typically provided care for "medical-surgical" patients are often incorporating telemetry and other services that used to be reserved for critical care units. Many of the patients who used to be cared for on traditional medical-surgical units are now cared for either in rehabilitation centers or in their homes. Long-term acute care hospitals and/or units have been developed for those patients who need care for longer periods of time than the typical acute care facility can now handle. Reimbursement issues have driven many of these changes.

The *health care reform* provisions based on federal law passed in 2010 have yet to be fully determined. Some elements of the anticipated changes include more focus on preventive care, more persons having insurance to pay for primary care, and more focus on community-based care. The nurse is well positioned to be a provider for preventive care and services in the community. It is anticipated that resources for care in clinics, offices, and other community-based settings will need to increase to meet demand in the coming years.

Technological advances are impacting the types of services patients receive, where those services are provided, and the competencies of the personnel required to manage the technology. New equipment, telemedicine, use of electronic health records, and the impact of emerging fields such as genetics and genomics are altering the landscape of health care. Nurses must be competent in use of the technological "tools" without losing focus on the patient as the primary point of care.

Changes in funding from both private and government-related sources are dramatically impacting the practice of nursing and the services provided to patients. As an example, the Centers for Medicare and Medicaid Services (CMS) is no longer providing reimbursement for certain types of situations that occur in the acute care setting. For example, a patient who suffers a catheter-associated urinary tract infection, an injury related to a fall, or pressure ulcers during his/her hospital stay has been the recipient of something that CMS says should "never" happen (Modern Healthcare, 2009). "Never events" are described in an AHRQ (2010) patient safety document as "shocking medical errors that should never occur". Consequently, the hospital now is required to cover the cost of any additional care, medications, or other treatment the patient may require as a result of this complication.

The National Quality Forum (NQF), describes *serious reportable events* as "serious, largely preventable, and harmful clinical events" (NQF, 2011). A fact sheet published on the organization's web site (http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx) provides a detailed listing of these events. Efforts of NQF have included identification, reporting, and sharing of information about occurrences of these events for the purpose of education, leading to change in practice and safer patient care. Diverse examples include infant discharge to the wrong person, patient suicide during hospitalization, patient death or serious illness resulting from a medication error, and patient death or serious injury related to administration of incompatible blood or blood products (AHRQ, 2010). Many states now require hospitals to report these events, and increasingly, facilities are required to make this information available to the public on web sites such as http://www.hospitalcompare.hhs.gov/hospital-search.aspx?AspxAutoDetectCookieSupport=1.

Health Care Reform

Legislation passed by the US Congress in 2010 has the potential to significantly alter the landscape of healthcare in the United States. Some of the changes, such as parents' insurance covering college students through age 26, are already in place. Other changes are anticipated to be implemented within the next five years. Many of the recommendations do not currently have funding, so their implementation is in question.

Selected provisions of the legislation, named the 2010 Affordable Care Act, that affect nursing are summarized here. More detailed information about these provisions can be obtained from http://www.nursing.ohio.gov/PDFS/nursingandhealthreformlawtable.pdf.

1. Funding is to be provided for community-based education for advanced practice nurses, in partnership between accredited graduate nursing education programs and community-based healthcare centers.

2. Several programs offering loans, scholarships, or grants are to be established or maintained to promote education at all levels of nursing education.

3. A number of initiatives are aimed at increasing diversity in the healthcare workforce and deploying healthcare providers to work in underserved areas.

4. Several programs are targeted to provide education of healthcare providers and care for patients in high-need areas, particularly pediatrics, geriatrics, and community/public health.

5. A Patient-Centered Outcomes Institute would be established to focus on development, deployment, and implementation of evidence-based practice standards to enhance quality of patient care.

6. Accountable care organizations (ACOs) would be developed and implemented to focus on comprehensive care throughout an entire episode of illness. These organizations would potentially include physicians' offices, clinics, acute care hospitals, rehabilitation centers, and home health agencies. Services would be "bundled" and paid in relation to the entire episode of care, not individual services that are provided. Nurses would be key players in care coordination.

7. A National Health Care Workforce Commission / National Center for Workforce Analysis is to be created to lead the process of analyzing the existing workforce. This will enable policy makers and educators to determine areas of need and determine ways to most effectively deploy resources to meet those needs. There is currently no centralized data base that provides information about numbers of healthcare workers employed, their areas of employment, or the areas which are underserved.

The Current Landscape of Nursing Education

There are currently multiple routes for a person to take in order to become licensed as a registered nurse in the United States, ranging from associate degree preparation to graduate-entry programs. This diversity in the educational process has resulted in great confusion, both within the profession and in the eyes of the public. One of the key characteristics of a profession is that is has a clear educational path to prepare its practitioners. From time to time, there have been discussions within the nursing community about a core standard for "entry into practice" at the baccalaureate level, but this is not yet a reality.

Nursing education must be considered in two perspectives: preparation for licensure as a registered nurse, and advanced education in nursing. First, educational programs that prepare a person to sit for the National Council Licensure Examination (NCLEX-RN) will be discussed, followed by information regarding advanced academic education.

The associate degree in nursing is typically a two year program (ranging from 18-24 months reflecting either a two-academic year or two-calendar year program). Roots of the associate degree program are based in research conducted in the early 1950's at the time of emergence of the community college system in the United States. Dr. Mildred Montag, often known as the pioneer who began the ADN educational programs, was the project director for development of the model for this type of education. Results of the studies conducted at this time revealed that associate degree nurses were able to successfully pass licensure examinations and provide safe patient care (Mahaffey, 2002).

Initially, the associate degree was anticipated to be a "technical" degree while the baccalaureate degree was intended to be the "professional" degree. However, this differentiation never occurred in either licensure examination or practice.

From the early 1960s, the American Nurses Association (ANA) has advocated for a minimum of a baccalaureate degree as preparation for the professional practice of nursing. Approximately 20 years after ANA began its advocacy for BSN preparation, the National League for Nursing (NLN) also issued a position paper supporting the BSN as essential for professional nursing practice (Mahaffey, 2002). Both of these organizations' position statement initially met with great consternation within both the practice and academic communities. Those issues have not been resolved.

Increasingly, however, research data has supported the premise that nurses prepared at a minimum of a baccalaureate level are able to provide safer patient care (Aiken et al., 2003; Friese, et al., 2008; Van den Heede et al., 2009). With this evidence in hand, and with recommendations from several national organizations, there is now a movement toward requiring all nurses to have a baccalaureate degree within a certain number of years after licensure. To facilitate this process, recommendations call for better articulation between programs so that a nurse can begin his/her career as an LPN or Associate Degree nurse and more easily move through advanced academic programs to attain a BSN or higher degree.

Other options for entry into nursing currently exist. One, commonly referred to as an "accelerated" program, admits people into an undergraduate nursing major when they have already attained a minimum of a baccalaureate degree in another field of study. The student is then able to progress more quickly through the nursing courses and be prepared to sit for the National Council Licensure Examination (NCLEX).

Graduate entry programs are offered by some colleges of nursing. In these programs, the student with a minimum of a baccalaureate degree in another field of study is admitted directly to a master's degree program. This student takes a combination of basic nursing and master's level courses and sits for the NCLEX examination approximately one-half of the way through the curriculum. Once licensure has been attained, the nurse then continues to complete the master's degree program.

More traditional graduate programs exist to prepare the already-licensed registered nurse with educational and clinical preparation to practice at an advanced level. Some of the programs are designed to prepare nurse educators, clinical nurse leaders, administrators, or researchers; others focus on clinical practice to prepare the graduate to become certified as an advanced practice registered nurse (nurse practitioner, clinical nurse specialist, nurse midwife, or registered nurse anesthetist).

At the doctoral level, there are a number of programs that offer a Doctor of Philosophy (PhD) in nursing, typically focusing on nursing scholarship and research. More recently, there has been an initiative to move advanced practice nursing education to the doctoral level, creating the DNP (Doctor of Nursing Practice) as a clinician. (American Association of Colleges of Nursing, 2010)

For the remainder of this independent study, please refer to CE4Nurses.org and click on Ohio Nurse Independent Studies.

The Ohio Nurses Association Seeking Director of Health Policy

This person is responsible for the programming of the Health Policy Department. The Director will work cooperatively with ONA's outside lobbyists and others to assure optimum representation of the Association's legislative and political interests.

Commitment to work flexible hours, willing to travel, live in or near Columbus, have a current driver's license and be eligible for insurance coverage on company's automobile policy.

Desired education and experience:

- Bachelors degree in nursing.
- Masters degree in Public Policy Administration or related field and/or Juris Doctor.
- 3-5 years legislative and policy development experience.
- 3-5 years experience in a variety of nursing practice areas.
- Current Ohio RN license preferred.

Starting annual salary is $66,300. We provide an excellent benefits package which includes medical, dental, life insurance, long term disability insurance, retirement plan and leave time. To apply, email cover letter and resume to: jobs@ohnurses.org. Include "HPD Position" in the subject line.

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