News & Views

Citizen Advocacy Center

Third Quarter, 2013 - A Health Care Public Policy Forum - Volume 25 Number 3

We Want You!

CAC is now a membership organization *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership and on pages 27 – 28 of this newsletter.*

Although we encourage you to receive our newsletter by becoming a CAC member, ***you may still subscribe to our newsletter without becoming a member.*** *More information is at http://www.cacenter.org/view/newsletter and on pages 29 of this newsletter.*

With this issue of ***CAC*** **News & Views** *we have replaced most long URLs with short links to our source material. (In one case, a 241-character URL was shortened to 31 characters). Please let us know whether or not you think this is an improvement: feedback@cacenter.org.*

PATIENT SAFETY

Brigham and Women's Recounts Errors in Staff Newsletter

Reporter Liz Kowalczyk reported on April 9, 2013, in the *Boston Globe* that in January 2011 Brigham and Women's Hospital began publishing an online newsletter for its staff entitled "Safety Matters." It reports mistakes and medical errors occurring in the hospital, drawing them to the attention of caregivers and administrators who can take action to prevent a recurrence.

Kowalczyk writes of changes in emergency department procedures that reduce patient wait times. A medication error resulted in changes in hospital procedures to require pharmacists and doctors to discuss side effects before prescribing medications that may have dangerous interactions.

For details, see http://tinyurl.com/CAC2013-3-1.

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British National Health Service Imposes Legal Duty to be Honest about Mistakes

The British National Health Service has instituted a collection of reforms in response to tragic neglect and abuse at Stafford Hospital between 2005 and 2008. Among the reforms is a legal duty for NHS boards to be honest about mistakes. Health Secretary Jeremy Hunt said the goal is a "fundamental change to the system," intended to achieve a culture of "zero harm."

The report can be found at: http://tinyurl.com/CAC2013-3-2.

See also http://tinyurl.com/CAC2013-3-3.

Ohio Board of Nursing Promotes Course on Human Trafficking

On May 31, 2013, the Ohio Board of Nursing emailed this announcement:

> **OBN E*News 05/31/2013 - Human Trafficking training for school nurses – free CNEs**
>
> Human trafficking is a growing concern throughout the nation, and Ohio is at the center of the problem. Ohio Governor John Kasich has identified nurses working in the school setting as a key group to prevent and identify human trafficking among their students. At the Governor's direction, the Ohio Department of Health School Nursing program collaborated with the ODH Sexual Assault and Domestic Violence Prevention Program and others to develop a new protocol for Ohio school nurses (the first of its kind in the nation) to provide guidance to nurses on how to prevent, identify and appropriately intervene when trafficking of students is suspected.
>
> The introduction of this new protocol will be done at a summer 2013 ODH conference Human Trafficking: And Update for Nurses Working in Ohio Schools. This day-long training will provide nurses working in the school setting with information about the prevention, identification and intervention for students who are trafficked. It will include a presentation by a human trafficking survivor, introduction of the new protocol, definition of human trafficking, information

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about the national hotline and other resources available to help you understand human trafficking in Ohio.

This conference is free and 4.25 nursing contact hours will be awarded to nurses who attend all sessions. Further information may be found in the attached flyer or by going to: http://tinyurl.com/CAC2013-3-4.

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QUALITY OF CARE

CAC Signs Letter to CMS on Patient Experience Surveys

CAC was one of 29 signatories to a letter to the Centers for Medicare and Medicaid Services commenting on a planned survey of patient experiences in outpatient and ambulatory care settings. The letter reads in part:

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-4171-NC: Request for Information to Aid in the Design and Development of a Survey Regarding Patient Experiences with Hospital Outpatient Surgery Departments/Ambulatory Surgery Centers and Patient-Reported Outcomes from Surgeries and Procedures Performed in These Settings

Dear Ms. Tavenner:

The 29 undersigned organizations represent a collaboration of leading consumer, labor, and employer organizations committed to improving the quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. We appreciate the opportunity to respond to the Request for Information (RFI), the goal of which is development of a patient experience survey tool and patient-reported outcomes measures for assessing the quality of care provided in the hospital outpatient (HOPD) and Ambulatory Surgical Center (ASC) settings.

Consumers and purchasers have long applauded the use of the HCAHPS patient experience survey – and more recently, the addition of the Care Transition Measure 3-Question Survey (CTM-3) – in the Medicare Inpatient Quality Reporting Program. At the same time, we have highlighted the enormous gap that exists in the collection of similar data at the HOPD and ASC levels, particularly given the exponentially increasing volume of care delivered in these settings. We wholeheartedly support CMS' efforts to now create both a patient experience tool and Patient-Reported Outcome (PRO) measures that will address the unique mix of patients and type of care delivered in these two settings.

In response to CMS' request for information on topics, questions, and specific surveys that may already exist to fill the aforementioned gap in measurement, we offer comments on the following:

RFI Response: HOPD/ASC Patient Experience Tool March 26, 2013 Consumer-Purchaser Disclosure Project Page 2 of 7

- The importance of **expanding the patient experience survey beyond surgical procedures, to include patients that receive ambulatory care in the HOPD;**
- The importance of creating methods for quickly and efficiently collecting PRO data (including patient experience data) **that leverage innovative Health IT tools**, thus allowing for greater patient response rates and more rapid-cycle improvements; and
- Suggestions for specific topics and questions that will **best achieve the goals of a HOPD/ASC patient experience survey** and PRO measures, including topics that will provide more granular information on patients' experiences with their doctors and surgeons at the individual provider level.

We strongly support CMS' efforts to close the patient experience and PRO data collection gaps, and we look forward to working with you as this development work continues.

The entire letter can be found at http://tinyurl.com/CAC2013-3-5.

IN THE COURTS

Court of Appeals Rules for FTC in North Carolina Dental Board Case

The Fourth Circuit Court of Appeals ruled on May 31, 2013, that the North Carolina State Board of Dental Examiners engaged in anti-competitive activity when it determined that private teeth-whitening services were practicing dentistry without a license and effectively put them out of business in the state.

This ruling has potential implications for licensing boards across the country. In recent years, the Federal Trade Commission has issued complaints against other licensing boards for what it viewed as anti-trust violations. Significantly, the court found in this case that the dental board is a private entity, not covered by state action immunity.

See the court's ruling here: http://tinyurl.com/CAC2013-3-6.

Also see: http://tinyurl.com/CAC2013-3-7.

***Editorial Note: This case was discussed at length at the CAC Annual Meeting in Seattle, and that discussion will be summarized in the 2013 4th Quarter issue of CAC* News & Views.**

Judge Overrules Medical Board Discipline

In March 2013 a circuit court judge in Frederick County, Maryland ordered the state medical board to reinstate the license of a Middletown, Maryland doctor accused by a total of eleven patients of unwanted sexual touching. Circuit court judge G. Edward Dwyer ruled that the board must accept the June 2011 recommendation of ALJ Harriet Helfand, who found the testimony of all 11 accusers to be not credible. Helfand's recommendation is not public.

In February 2006 the board permitted Dr. Michael Rudman to resume practice under conditions (no massage therapy and chaperones), but revoked his license in December of that year when Rudman entered an Alford plea to an accusation of second-degree assault. The Alford plea was not an admission of guilt, but a concession that the board had sufficient evidence to obtain a conviction if the case were to go to court. Judge Dwyer's ruling was based in part on his finding that the board did not provide strong reasons for rejecting the ALJ's proposed resolution.

For more, see: http://tinyurl.com/CAC2013-3-8.

State Supreme Court Upholds Ohio Medical Board Discipline

The State Medical Board of Ohio revoked the license of doctor Larry Lee Smith based on sexual misconduct involving two patients. Smith appealed to the Ohio Supreme Court claiming that the board used inadmissible evidence obtained when one of the patients wore a wire to tape her encounters with the doctor on three occasions. He also alleged that the board improperly ordered him to undergo a psychological examination. The Court found that the medical board acted properly and upheld the revocation of Smith's license.

The Court's decision can be found at: http://tinyurl.com/CAC2013-3-9.

Court Rules New Jersey CRNAs Must Be Supervised

Writing in www.outpatientsurgery.net, Stephanie Wasek reports that a New Jersey appeals court has upheld a regulation requiring an anesthesiologist to be present when a certified registered nurse anesthesiologist performs certain procedures.

Wasek quotes Jay Horowitz, CRNA, of Quality Anesthesia Care Corp. in Sarasota, Florida, who said that:

> To depict (CRNAs) as assistants to anesthesiologists contradicts state and federal regulations for practice and reimbursement, CRNA practice in the military and within the Veterans Administration system," he continues. "Although anesthesia may be the practice of medicine when provided by doctors, it's well documented in the law that, when provided by nurses, it is the practice of nursing.

The entire article can be found at: http://tinyurl.com/CAC2013-3-10. Also see: http://tinyurl.com/CAC2013-3-63.

Court Okays Suit Alleging Violation of Chaperone Policy

A federal trial court ruled in February 2013 that Jane Doe, a patient at Montefiore Medical Center may sue the facility for negligence in enforcing its policy requiring a chaperone to be present when a male physician examines a female patient. However, the court dismissed the plaintiff's allegation of negligent hiring and supervision of the physician charged with sexual assault.

For details, see: http://tinyurl.com/CAC2013-3-11.

SCOPE OF PRACTICE

Pharmacists Integral to Quality Care

Including pharmacists actively in hospital based care teams has the effect of improving quality and reducing readmissions. The pharmacists' contribution includes ensuring that patients obtain prescribed medications upon discharge, educating patients about their medications, and so on.

See: http://tinyurl.com/CAC2013-3-14.

Pharmacy Specialties Present Five-Year Vision

The Board of Pharmacy Specialties (BPS) Board of Directors has approved a five-year vision statement explaining its approach and expectations for board certification of pharmacy specialties to "build the future of board certification activities for pharmacists."

The vision contains four main planks:

- The number of Board Certified Pharmacists will significantly increase to facilitate progress towards a future model where board certification will be the expectation for pharmacists engaged in direct patient care.
- BPS will recognize new pharmacy specialties and/or subspecialties in areas that are consistent with, but not limited to, the growth of accredited postgraduate year 2 (PGY2) residency programs. In addition, BPS will evaluate the current specialty recognition structure and process and consider potential modifications.
- BPS will routinely gather and publish statistics on the number of Board Certified Pharmacists and will facilitate research related to the value of BPS board certification. Board Certified Pharmacists will be recognized, valued and compensated within healthcare delivery systems worldwide for their contributions to direct patient care.
- BPS will continually assess its model for recertification based on the principles of continuing professional development that ensure current knowledge consistent with the scope of the specialty.

The entire document can be found at: http://tinyurl.com/CAC2013-3-13.

Legal Interpretation of Nursing Duty Evolves

An article by Marilyn L. Dollinger, DNS, FNP, BC, RN and Richard Dollinger, JD first published in the National Council of State Boards of Nursing's *Journal of Nursing Regulation* (Vo. 3, No. 1, April 2012) appeared in the February, March, April 2013 issue of the Missouri State Board of Nursing *Newsletter*. Entitled, "A New Legal Interpretation of Duty for Registered Nurses," the article begins with the following introduction:

> Today, the courts are placing new emphasis on patient safety by recognizing a stricter duty for nurses to evaluate and question medication orders and protocols. Thus, nurses may find that they are more frequently named in civil lawsuits involving medication errors, a safety problem facing nurses in all patient-care settings. In the face of these changes, boards of nursing will need to protect the public and nurses by ensuring that regulations governing nursing practice are consistent with the court's expanded definition of a nurse's duty. This article discusses new challenges to ensuring that regulations governing nursing practice are consistent with the court's definition of a nurse's duty and safe nursing practice.
>
> Registered nurses (RNs) soon may find that the courts are placing an increased emphasis on patient safety by expanding the duty of nurses to evaluate and question medication orders and protocols and, if necessary, to *refuse to administer prescribed drugs*. (Emphasis added) In *Applewhite v. Accuhealth Inc.* (2010), the Appellate Division, First Department in New York, held that an RN should not have administered an intravenous (I.V.) steroid in the home setting without having epinephrine available. The court held that the RN had a duty to the patient to withhold the medication because epinephrine was not provided by the home care agency or ordered by the physician, and the nurse was not authorized to prescribe it.
>
> This article discusses this lawsuit in depth and presents new challenges and implications for regulators regarding ensuring that regulations governing nursing practice are consistent with the court's definition of a nurse's duty and safe nursing practice…

The entire article can be found at: http://tinyurl.com/CAC2013-3-12.

Florida Reporter Characterizes Scope Battle as "Turf War"

Tallahassee Bureau reporter for the Fort Lauderdale *Sun Sentinel* Kathleen Haughney, wrote an article on February 11, 2013, entitled "All Eyes on Law Turf War; Optometrists, Ophthalmologists Battle Over Who Can Write an Rx." The article delves into a legislative battle over whether optometrists should be authorized to prescribe oral medication, a privilege that is allowed in 47 other states. The usual arguments have been advanced: the ophthalmologists contend that optometrists lack the necessary skills; the optometrists say they should be permitted to practice to the full extent of their training.

Editorial Note: What makes this article stand out is that Haughney reports the amount of campaign contributions made by the opposing parties. Interestingly, the optometrists gave more than the ophthalmologists. Houghton also uncovers some interesting subtext: the legislation expanding optometry's scope would also require disclosure of a Medicare rule permitting optometrists to provide post-surgical care for an ophthalmologist's cataract surgery patients for a portion of the MD's fee. It is alleged that some optometrists refer patients to selected ophthalmologists in return for an understanding that they will in turn get post-surgical care referrals.

Houghney's article can be found at: http://tinyurl.com/CAC2013-3-15.

California Considers Broad Changes in Scope of Practice

Editorial Note: The following article appeared in the February 11, 2013, California Healthline, a service of the California HealthCare Foundation.

State Considers Changing Non-Physicians' Scope of Practice

California lawmakers are considering expanding the scope of practice for non-physicians in an effort to address a shortage of doctors to treat individuals who will gain health insurance coverage under the Affordable Care Act, the *Los Angeles Time*s reports. See http://tinyurl.com/CAC2013-3-16.

Background

The *Los Angeles Times* reports that only 16 of the state's 58 counties have the supply of physicians recommended by the federal government.

In addition, the Association of American Medical Colleges says that nearly 30% of California's doctors are nearing retirement age.

Meanwhile, the state is preparing to expand Medi-Cal and require most residents to have health insurance under the ACA.

Legislation to Expand Scope of Practice

Sen. Ed Hernandez (D-West Covina), chair of the Senate Health Committee, plans to offer legislation that would allow physician assistants to treat more patients and nurse practitioners to establish independent practices. It also would allow pharmacists and optometrists to act as primary care providers and diagnose and manage certain chronic conditions.

Hernandez questioned what good expanding health care coverage is if patients "are going to have a health insurance card but no access to doctors."

Hernandez said he will introduce the legislation and hold a hearing on the matter next month.

Physicians Respond

Physicians say that giving non-physicians more autonomy and authority could negatively affect patient safety.

Paul Phinney, president of the California Medical Association, said, "Patient safety should always trump access concerns."

Doctors also argue that expanding non-physicians' scope of practice could increase health care costs because health care providers with less education and training tend to order more tests and prescribe more antibiotics.

Phinney said that physician assistants and other mid-level health care providers should be deployed in doctor-led teams, where they can consult with physicians while performing examinations and prescribing medications.

In an effort to address a shortage of physicians in certain areas, CMA has asked for more funding to expand participation in a loan repayment program for recent medical school graduates that provides them with up to $105,000 in return for practicing in underserved communities for three years.

Other Health Care Providers Respond

Physician assistants, nurse practitioners and other mid-level practitioners say that they have more training than they are allowed to use.

Beth Haney -- president of the California Association for Nurse Practitioners -- said, "We don't have enough providers… …so we should increase access to the ones that we have" (Mishak, *Los Angeles Times*, 2/9).

Read more: http://tinyurl.com/CAC2013-3-17, http://tinyurl.com/CAC2013-3-18, and http://tinyurl.com/CAC2013-3-19.

CMS Reimbursement Rule Upholds Supervision Concept

Editorial Note: On February 12, 2013, the National Council of State Boards of Nursing alerted its members to the following CMS rule related to enhanced reimbursement incentives for primary care:

CMS Rule Creates Issues for Advanced Practice Registered Nurses

A provision in the Affordable Care Act seeking to improve access to care for individuals on Medicaid provides enhanced reimbursement incentives for primary care. In November, CMS released the final rule implementing this part of the law. However, the rule and consequent documentation indicates that the higher reimbursement incentive only applies to primary-care services administered by practitioners working under the personal supervision of a qualifying physician. In other words, despite the significant number of states recognizing autonomous practice and billing by APRNs, these non-physician practitioners are excluded from the higher payment unless supervised. CMS reasons that the statute clearly specifies that services are furnished by physicians, which indicates that Congress clearly intended direct physician involvement.

For more, see: http://tinyurl.com/CAC2013-3-20.

Wharton Economists Make Case for Independent APRN Practice

A February 13, 2013, article in the *Health Economics* newsletter online at *Knowledge@Wharton* argues that the patchwork regulatory system under which the scope of APRN practice is determined state by state makes little economic sense.

For more, see: http://tinyurl.com/CAC2013-3-21.

Center for Health System Change Reviews Impact of Nurse Practitioner Scope Laws and Payment Policies

On February 28, 2013, the Center for Health System Change announced a new publication:

> **Primary Care Workforce Shortages:**
> *Nurse Practitioner Scope-of-Practice Laws and Payment Policies*
>
> While state scope-of practice laws don't typically restrict what primary care services nurse practitioners (NPs) can provide to patients, the laws do affect practice opportunities for NPs and appear to influence payer policies, according to a new qualitative study by the Center for Studying Health System Change (HSC) for the nonpartisan, nonprofit National Institute for Health Care Reform (NIHCR).
>
> Amid concerns about primary care provider shortages, especially in light of health reform coverage expansions in 2014, some believe that revising state laws governing nurse practitioners' scope of practice is a way to increase primary care capacity.

For more, see: http://tinyurl.com/CAC2013-3-22. For more discussion of Medicare reimbursement policies, see: http://tinyurl.com/CAC2013-3-23. See also this research into the divergent opinions of physicians and nurses about independent APRN practice and equal pay: http://tinyurl.com/CAC2013-3-24, http://tinyurl.com/CAC2013-3-25, and http://tinyurl.com/CAC2013-3-26. And for an interesting discussion of the impact of the Affordable Care Act on insurance reimbursement for massage therapy (and perhaps other professions), see: http://tinyurl.com/CAC2013-3-27.

Nevada Considers Removing APRN Supervision Requirement

In its 2013 session, the Nevada legislature considered Senate Bill 69, which would remove the requirement that advanced practice nurses must practice under the supervision of a physician. The legislation stalled in committee.

The bill can be found at: http://tinyurl.com/CAC2013-3-28.

Alabama Considers Expanding APRN Prescriptive Authority

The Alabama Senate passed a bill that would expand the medications that may be prescribed by advanced practice nurses practicing under a physician's supervision. The bill also expands the prescriptive authority of certified nurse midwives. The goal of the legislation is to improve access to care, especially in rural areas.

For more, see: http://tinyurl.com/CAC2013-3-29.

Dental Hygienist and Therapist Specialties Get More Attention

In March 2013 the daily blog *kaiserhealthnews* reported coverage in several media outlets about state-based efforts to broaden access to dental care by expanding the scope of practice of dental hygienists and/or creating a mid-level "dental therapist" specialty.

See: http://tinyurl.com/CAC2013-3-30.

Walgreen Clinics to Offer Diagnosis and Treatment

In a departure from the more common pattern of disease management, Walgreens announced in April 2013 that it will retain nurse practitioners and physician assistants in its "Take Care Clinics" to perform tests, diagnose conditions, prescribe medications and order additional tests. This move aroused disapproval from the American Academy of family physicians.

For more see: http://tinyurl.com/CAC2013-3-31, http://tinyurl.com/CAC2013-3-32, and http://tinyurl.com/CAC2013-3-33.

Retail Clinics Predicted to Increase Under Healthcare Reform

A new study anticipates a 20-25% growth in the number of walk-in retail clinics in coming years as the Affordable Care Act is implemented and thousands of currently uninsured consumers acquire health insurance.

For more, see: http://tinyurl.com/CAC2013-3-34.

Also see the following article about the use of telemedicine by retail clinics: http://tinyurl.com/CAC2013-3-35.

Study Suggests Home Birth Safer for Low-Risk Pregnancies

As reported in medpagetoday.com, Dutch researchers found fewer severe outcomes for planned home births vs. hospital births in low-risk patients. The authors note it is significant that the mothers had seen primary care providers throughout their pregnancies and planned the venue of delivery, reducing the odds of complications.

For more, see: http://tinyurl.com/CAC2013-3-36.

Indiana Legalizes Home Birth Midwifery

House Enrolled Act 1135, effective July 1, 2013, legalizes and regulates certified professional midwifery in Indiana. Prior to the enactment of this law, only licensed certified nurse-midwives were permitted to attend home births. Regulation of what will be called "certified direct entry midwives" will be the responsibility of the Indiana Medical Licensing Board, which will write implementing regulations.

For details, see: http://tinyurl.com/CAC2013-3-37. For public reaction, see: http://tinyurl.com/CAC2013-3-38.

DISCIPLINE

California Legislature Considers Bill to Take Powers from Medical Board

California Senate Bill 304, introduced in April 2013 and passed by the State Senate in May would remove the Medical Board of California's (MBC) authority to investigate physician misconduct. Proponents of the legislation are critical of the board for investigating but not disciplining physicians, in particular in cases involving prescription abuse. The legislation would give the Attorney General authority to investigate and discipline physicians and leave the board with the power to issue licenses.

For more, see: http://tinyurl.com/CAC2013-3-39.

The bill can be found at: http://tinyurl.com/CAC2013-3-40.

The MBC announced its support for several pieces of legislation to curb prescription drug abuse, but opposes SB 304. See: http://tinyurl.com/CAC2013-3-41.

Here is the take of one California consumer advocacy organization: http://tinyurl.com/CAC2013-3-42.

While the legislature considers the matter, a coalition of consumer advocacy organizations is working on drafting a voter ballot initiative aimed at curbing prescription drug abuse and holding doctors more accountable.

See: http://tinyurl.com/CAC2013-3-43.

National Council Introduces "Nursys e-Notify"

The National Council of State Boards of Nursing has introduced a system that provides automatic notices to employers about licensure and discipline actions reported to the national Nursys system. See: http://tinyurl.com/CAC2013-3-44. For a detailed explanation of the program, see page 5 of the Missouri State Board of Nursing newsletter: http://tinyurl.com/CAC2013-3-45.

CONSUMER INFORMATION

FARB Offers License Checking Service

The Federation of Associations of Regulatory Boards (FARB) issued the following announcement in April 2013:

> The Federation of Associations of Regulatory Boards (FARB) is pleased to announce the launch of www.lookupalicense.org, an online service to provide the public with easy online access to verify the licensure status of a wide range of practitioners and providers.
>
> FARB explores and undertakes initiatives intended to compliment the regulatory community and to protect the public. FARB's newest initiative, Look Up a License, is a universal logo and service that provides a recognizable mechanism to verify licensure status of selected professions.
>
> When you visit lookupalicense.org, you will see a list of FARB Governing Member professions. A simple click on the Look Up a License magnifying glass will direct you to each professions' association of regulatory board's website that delivers online verification of licensure status. Do you need to Look Up a Chiropractor? Or Social Worker? Please visit www.lookupalicense.org to try it today!
>
> FARB believes in the usefulness of lookupalicense.org to the public. "It is essential that members of the public are provided with a convenient mechanism to verify that practitioners are currently licensed and in good standing. Consumers may not always realize the importance of licensure and the public protection elements involved in providing practitioners with the authority to practice a

regulated profession. We look forward to the Look Up a License logo to be the recognized pathway to license verification," said Dale Atkinson, Executive Director of FARB.

FARB is a not for profit organization incorporated in 1974 to promote public protection and provide a forum for information exchange for associations of regulatory boards and their stakeholders with interests in professional regulation. The mission of FARB is to promote excellence in regulation for public protection by providing expertise and innovation from a multi-professional perspective.

Hospital Rating Systems Produce Conflicting Results

Jordan Rau, Senior Correspondent at *Kaiser Health News* wrote on March 18, 2013, about the differing results produced by various hospital rating systems. Writing about the hospital comparisons by the Leapfrog Group, the Joint Commission, Consumer Reports, the Centers for Medicare and Medicaid Services, and others, Rau asks and answers "Why are hospital ratings all over the map?"

For some answers, see: http://tinyurl.com/CAC2013-3-46.

More States Enact "Truth in Advertising" Laws

Maryland, Nevada and Texas recently enacted laws requiring medical personnel to wear badges making clear their identity and professional role. In an online post on June 10, 2013 to amednews.com, Tanya Albert Henry writes that "The AMA's Truth in Advertising campaign, launched in 2009, provides background information on the issue and model legislation to assist states in passing laws that help increase clarity and transparency in a system where patients mistake non-physicians for physicians and sometimes don't know that a certain specialist is actually a physician."

Read the article at: http://tinyurl.com/CAC2013-3-47.

CONTINUING PROFESSIONAL DEVELOPMENT

Professional Association Sues to End Maintenance of Competence

The Association of American Physicians and Surgeons (AAPS) has sued the American Board of Medical Specialties (ABMS) in an effort to end maintenance of competence (MOC) requirements, which the AAPS considers to be a "moneymaking scheme" which does not improve patient care.

AMA Delegates Opposes Continuing Competence Requirements

At the AMA's annual meeting in June 2013, the House of Delegates approved resolutions challenging the American Board of Medical Specialties' (ABMS) Maintenance of Competence (MOC) program. The resolutions:

- Oppose mandatory specialty recertification programs and support lifelong specialty certification;
- Oppose discrimination against doctors who don't recertify; and

- Ask for more transparency from ABMS, including information about revenue from certification and recertification.

The House of Delegates also voted to commission a study of the economic impact of MOC and prospective Maintenance of Licensure (MOL) requirements on physicians and their impact on patient outcomes and access to care.

For more, see: http://tinyurl.com/CAC2013-3-48.

Editorial Note: On June 17, 2013, the Executive Director of ABMS, Lois Nora, sent the following comment to all ABMS associate members:

> As promised, we are providing an update on the most recent development in the situation related to the antitrust lawsuit filed by the Association of American Physicians & Surgeons (AAPS) against the American Board of Medical Specialties regarding the ABMS Maintenance of Certification® program (ABMS MOC®).
>
> ABMS leadership and legal counsel have analyzed the claims brought by AAPS and concluded that they are without merit. Our legal counsel is moving forward with a Motion to Dismiss, which will be filed later today. ABMS also has prepared the following statement – which should be regarded as highly confidential until it is released at 5 p.m. ET on June 17 – to respond as needed when asked for public comment about the latest developments:
>
> > "The American Board of Medical Specialties (ABMS) has filed a Motion to Dismiss a lawsuit filed in April by the Association of American Physicians and Surgeons, Inc. (AAPS) regarding the ABMS Maintenance of Certification® program (ABMS MOC®). We believe the claims of the suit are without merit and we stand by our MOC process and the significant value it brings to patients, their families and the medical profession.
> >
> > MOC is a demonstration of a physician's ongoing commitment to a process of lifelong learning and assessment for those physicians who choose to be certified by an ABMS Member Board. We believe this is what patients expect and deserve from their doctors. ABMS and its 24 Member Boards will continue in their commitment to serve the public interest through programs designed to foster lifelong learning and continuous certification."
>
> Please continue to direct all media inquiries related to this matter to the ABMS' Communications team (Lori Boukas at (312) 436-2626 or lboukas@abms.org). If you have any non-media related questions or wish more information, please don't hesitate to call me.
>
> We will continue to share updates as appropriate.

See the AAPS announcement here: http://tinyurl.com/CAC2013-3-49, and see also: http://tinyurl.com/CAC2013-3-50.

British General Medical Council Issues Revalidation FAQ Document

Effective December, 2012, all doctors licensed to practice with the General Medical Council (GMC) are now required, by UK law, to regularly demonstrate, usually every five years, that they are up to date and fit to practice. The GMC has issued FAQs to provide further details on revalidation, the license to practice, and information for doctors who work wholly outside of the UK.

The document can be found at: http://tinyurl.com/CAC2013-3-51.

Star-Ledger Ponders the Evaluation of Aging Doctors

In the March 17, 2013, online edition of the Newark *Star-Ledger*, Reporter Dan Greenberg wrote a comprehensive and insightful article about measuring the current competence of aging physicians. His article is concerned with physical and mental competence as well as professional knowledge, skills and performance. The AMA and the American Board of Medical Specialties (ABMS) are considering ways to address the evaluation of aging practitioners.

The article can be found at: http://tinyurl.com/CAC2013-3-52.

SPOTLIGHT

Physical Therapy Boards Highlight Continuing Competence Online

This quarter, **CAC *News & Views*** shines a spotlight on the Federation of State Boards of Physical Therapy (FSBPT) for its excellent, user-friendly online link to materials that assert the Federation's commitment to the continuing competence of physical therapists and explain the resources it makes available to member boards. The site has links for licensees, states, and continuing professional development providers. Another link leads to a rich assortment of resources, including statements of philosophy and purpose, a practice review tool, a candid discussion of the Federation's relationship with the professional association as it concerns continuing competence, FAQs, and a link for consumers and patients.

Editorial Note: Because we are so impressed with this FSBPT treatment of continuing competence,* CAC *News & Views recommends the Federation include a link to this page within the "For Consumers" link on its main Web site home page.

PAIN MANAGEMENT AND END OF LIFE CARE

Advocacy Groups Ask FDA Not to Reschedule Hydrocodone Products

Editorial Note: CAC and several other patient and health professional groups signed on to the following letter to Margaret A. Hamburg, M.D. Commissioner of the Food and Drug Administration:

February 1, 2013

RE: Docket No. FDA-2012-N-0548

Dear Commissioner Hamburg:

On behalf of the patient and health professional groups listed below we would like to share our strong concerns about the January 25 vote of the Drug Safety and Risk Management Advisory Committee in favor of rescheduling combination hydrocodone products into Schedule II.

As patient advocacy and health professional organizations, we are committed to combating illegal use of prescription drugs. However, it is also important to consider the unintentional consequences of policy changes that can cause serious difficulties for patients, and even result in harm and further suffering.

Medications containing hydrocodone in combination with other pain relievers are often prescribed for acute pain, but these products also play a key role in helping patients manage chronic cancer and non-cancer pain over time. They are effective for a wide range of painful conditions and diseases. Often, these medications are the ones that allow patients to complete their disease-directed treatments, sleep through the night, or continue to work and otherwise engage in and enjoy activities of daily life.

The Institute of Medicine (IOM) has documented that there are 100 million Americans living with chronic pain. That number does not count Americans with acute pain annually estimated by the Centers for Disease Control and Prevention (CDC) to be 46 million from surgery alone. Rescheduling these medications is a drastic measure that would have far-reaching consequences; chief among them would be loss of pain control for millions of Americans.

No evidence currently exists to show that reclassifying hydrocodone will curb misuse and abuse of pain medications. In contrast, there is evidence that rescheduling medications to higher classifications can reduce patient access to medications and cause harm. Prescriptions for Schedule II medications cannot be transmitted by telephone or fax, nor can they be refilled. The proposed policy change would require patients to see their doctor for office visits with greater frequency simply to refill a prescription. This would impose burdens on patients and caregivers in terms of having to forego hours, days, or even weeks of work. There would be a much greater chance that patients with a legitimate clinical need would be unnecessarily forced to endure symptoms of pain for longer periods of time. This requirement also could impose hardship for patients in rural areas who travel long distances for doctor office visits.

There would be increased costs to patients, state and federal government healthcare expenditures, and to the healthcare delivery system for the much more frequent office visits. Rescheduling these medications would unnecessarily introduce inefficiencies and increase healthcare costs at a time when policymakers are seeking ways of increasing efficiencies and reducing costs.

Oxycodone is already a Schedule II medication, and it is one of the most heavily abused medications. It is difficult to believe that moving combination hydrocodone products into the same federal Schedule as oxycodone would have a measurable favorable impact.

Although we appreciate DEA's rule to allow a prescriber to issue multiple Schedule II prescriptions at the same time, up to a 90-day supply, pharmacies rarely encounter prescriptions that have been written pursuant to this DEA rule. Prescribers lack knowledge of the rule, are confused by differing state laws in this area, and fear law enforcement scrutiny.

We strongly support policy changes that strike the necessary balance to curb the misuse and abuse of pain medications in the U.S., while also preserving patient access to medications. Drug control policies should pursue equitable solutions such as targeting illegitimate drug sellers, better educating prescribers and youth, better utilizing prescription drug monitoring programs, and establishing permanent medication disposal programs.

The prescription drug abuse problem can be successfully curbed. However, we urge FDA not to recommend unworkable provisions, such as moving all combination hydrocodone products into Schedule II. Combating prescription drug abuse must take a holistic approach. All affected stakeholders must work proactively to tackle and resolve this complex problem.

Thank you for considering our views on this issue.

American Academy of Pain Management (AAPM)
American Association of Nurse Assessment Coordination (AANAC)
American Cancer Society Cancer Action Network (ACS CAN)
American Society of Consultant Pharmacists (ASCP)
Amputee Coalition
CarsonCompany, LLC
Citizen Advocacy Center (CAC)
Interstitial Cystitis Association
Long Term Care Pharmacy Alliance (LTCPA)
Massachusetts Pain Initiative
NADONA
National Association of Chain Drug Stores (NACDS)
National Community Pharmacists Association (NCPA)
National Fibromyalgia & Chronic Pain Association
National Hospice and Palliative Care Organization
Pain Treatment Topics
US Pain Foundation
Wisconsin Pain Initiative

For additional information, see http://tinyurl.com/CAC2013-3-53.

IN-DEPTH FEATURE

Rationale for Maintenance of Licensure Requirements

Editorial Note: The following In-Depth Feature is excerpted with permission from The Federation of State Medical Board's* Journal of Medical Regulation *Vol. 99, No. 1, 2013, p. 19. The complete article, with citations, can be found at: http://tinyurl.com/CAC2013-3-54.

CAC *News & Views* applauds the Federation of State Medical Boards for staking a position in favor of more meaningful requirements for licensure renewal and encouraging its member boards to experiment with methodologies. CAC has long advocated for continuing professional development requirements consumers can rely upon as valid measures and assurances of current competence. Progress toward this goal has been frustratingly slow in the decades since policy makers and advocacy organizations first focused attention upon it. CAC welcomes all signs of forward movement, including abandonment of sole reliance on CE as a surrogate for current competence and reforms to strengthen the relevance of CE to individual practitioners' learning needs and to improvements in clinical practice and patient outcomes.

The Evidence and Rationale for Maintenance of Licensure

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Humayun J. Chaudhry, DO, MS; Frances E. Cain, BA; Mark L. Staz, MA; Lance A. Talmage, MD; Janelle A. Rhyne, MD, MA; and Jon V. Thomas, MD, MBA

A B S T R A C T: Fulfilling a statutory responsibility to protect the public within their jurisdictions, state medical boards have been working with the Federation of State Medical Boards (FSMB) and collaborating organizations to thoughtfully explore pathways and procedures by which Maintenance of Licensure (MOL) may be implemented for physicians in the years ahead. As a better understanding emerges of the types of continuing medical education (CME) and continuous professional development (CPD) activities physicians already engage in, and the resources that may be necessary for state boards to meaningfully implement MOL, questions have sometimes arisen about the value of these activities in contributing to quality health care and improved patient outcomes. Though MOL has not yet been formally implemented, there is a growing body of compelling evidence and rationale for the educational activities that could meet a state board's requirements for MOL. This article summarizes the recent literature on the subject, including CME and CPD, and recent policy statements of organizations and thought leaders from the house of medicine.

The quality of health care delivered in the United States has an immediate and long-term impact on the quality of life, livelihood, morbidity and mortality of its residents and on the nation's economy and national security. There are many stakeholders (e.g., patients, physicians, hospitals, health insurance plans) within our costly health care system. At the most fundamental level of health care delivery, however, what matters most is the interaction that takes place between a licensed and qualified health care provider and a patient seeking health care.

As the sole entity charged with overseeing the licensure and regulation of physicians, state medical boards have long recognized their responsibility to protect the public and promote quality health care by ensuring that only qualified individuals receive a license to practice medicine and deliver health care. In further fulfillment of their responsibility to protect the public, most state boards adopted continuing medical education (CME) requirements for physicians beginning in 1971 as part of the license renewal process. Several boards are now considering Maintenance of Licensure (MOL), a system of continuous professional development (CPD) that includes practice-relevant CME, to better assure the public that only those physicians who remain up-to-date in their area of practice retain that privilege…

From Lifelong Licensure to Maintenance of Licensure

…When an applicant for initial licensure provides evidence of successfully meeting (mandated) requirements, state medical boards – and by extension, the public – can be confident that the physician has the requisite knowledge and skills to practice medicine competently and safely. Licensure renewal, by contrast, has long been an administrative function that assumes licensees are fit to practice medicine unless adverse events, complaints or negative outcomes indicate otherwise. While the licensure renewal processes carried out by state boards are a central component of public protection, they reflect a reactive, rather than a proactive, evaluation of physicians' continued fitness to practice.

FSMB Board Chair Henry Cramblett declared in 1980, "The Federation holds firm to the premise not only that a person must show evidence of being thoroughly educated, highly qualified, and staunchly ethical in order to receive a medical license, but that these characteristics must be displayed continuously throughout that physician's active career." Over the last quarter century or so there have been increasing calls from outside the state medical regulatory community in support of more robust requirements for renewal of medical licensure and more proactive evaluation of physicians' continued fitness to practice as part of the license renewal process.

The nature of the physician-patient relationship has also changed, in part because of the public's awareness that there are limitations of medical knowledge and the availability of multiple, if not conflicting, treatment options and pathways.

In 1995, the Pew Charitable Trust recommended that states "require each licensing board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals." Similarly, a series of Institute of Medicine (IOM) reports beginning in 2000 addressed the importance of quality health care and patient safety, stressing the need for better regulation (including licensure) across the continuum of medical education, training and practice. The IOM's 2012 report, *Best Care at Lower Cost*, recommended an expanded commitment to the goals of a "continuously learning health care system" from leaders in health care, advising them to "incorporate basic concepts and specialized applications of continuous learning and improvement into health professions education; continuing education; and licensing...requirements."

Recent studies of the quality of health care delivered in the United States and how it may be related to clinical experience and skills lend further support for more proactive

evaluation of physicians' continued fitness to practice as part of the license renewal process.

In a random sampling of adults living in 12 metropolitan areas about their health care experiences, a survey that included a review of these individuals' medical records, McGlynn and colleagues found that participants received only 55% of recommended health care, a finding that the authors said, "poses serious threats to the health of the American people." In a widely quoted article from 2005 by Niteesh Choudhry and colleagues, a systematic review of the relationship between clinical experience and quality of health care found that physicians who have been in practice longer may be at risk for providing lower-quality care and that this subgroup of physicians may benefit from quality improvement interventions. Similarly, Epstein and colleagues found that psychiatrists in practice for 11 to 20 years had mean accuracy scores in their ability to diagnose major depression 10.5% points lower than those in practice for 0-5 years, and psychiatrists in practice for more than 20 years had scores 12.5% points lower than those in practice 0-5 years.

In 1994, Paul Caulford and colleagues evaluated physicians referred to the Physician Assessment Center at McMaster University in Hamilton, Ontario. Thirteen physicians were evaluated in seven skill areas: knowledge, communication, interviewing skills, history taking, physical exam, problem solving, management and record-keeping. The results of the study found that age, graduation year, solo versus group practice, reported CME hours and specialty certification status had significant simple correlations with competence in these areas. A multivariate analysis found that the only significant predictors of competence were age and specialty certification status.

Thus, while the conventional wisdom holds that physicians get better at the practice of medicine with age and experience, this is not unequivocally borne out by the evidence. The aforementioned studies instead demonstrate that as the rate of expansion of medical knowledge and advancements in technology continue to increase exponentially, it becomes increasingly critical that physicians actively engage in lifelong learning in their area of practice. Throughout medical school and post- graduate training, the next generation of physicians is being encouraged to embrace lifelong learning as an integral part of professionalism. Such efforts are also becoming commonplace for physicians already in practice. In either case, failure to keep pace with advances in knowledge, skills and technology has the real potential to negatively impact healthcare quality and patient safety.

The Case for Continuing Medical Education (CME)

In order to address the need for physicians to stay abreast of changes in the practice of medicine, most state medical boards in the 1970's and 1980's implemented mandatory continuing education requirements for license renewal. Continuing medical education was first established as a national requirement for physicians by the American Academy of General Practice (now the American Academy of Family Physicians), which has required CME for membership since 1947. The organization today notes on its website that "the responsibility for providing comprehensive and continuing health care to patients carries with it the responsibility to continue learning" and that "the need to keep abreast of the rapid expansion of medical knowledge necessitates CME."

…The FSMB's MOL framework, as articulated by an MOL Implementation Group in 2011, recommends that as part of a state's adoption of MOL it require that a majority (i.e., at least half) of the required CME be in a physician's area of practice.

Early studies, including a systematic Cochrane review, examining the value of CME found that short courses and conferences have little direct impact on professional practice, though they suggested that more effective methods such as systematic practice-based interventions, interaction with opinion leaders and multifaceted activities could change physician performance. In the late 1990's, this observation was supported by studies that demonstrated evidence that "interactive CME sessions that enhanced participant activity and provided the opportunity to practice skills can effect change in professional practice and, on occasion, health care outcomes."

In a more recent review of more than 130 articles related to the effectiveness of CME, selected from 68,000 citations identified in a comprehensive literature search, Marinopoulos and colleagues determined that while the quality of the evidence was "low" and firm conclusions were not possible, "CME appears to be effective at the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical outcomes." A promising 10-year investigation of evidence-based clinical practice in primary care, utilizing educational materials provided to physicians about lipid- lowering recommendations and an intervention group of physicians who received periodic lectures and case-based training, demonstrated substantially decreased mortality in patients with coronary heart disease among the intervention group (22%) compared with patients whose physicians only received educational materials (44%).

Integrating CME into a System of Continuous Professional Development (CPD). Continuing medical education, especially when it is interactive and directly related to a physician's practice, is an important part of MOL and will likely remain so in the years ahead, as long as there continues to be evidence in support of its potential and its impact on quality health care delivery and patient outcomes. Maintenance of Licensure programs will rely on efforts by educators and regulators alike to apply evidence-based approaches to new types of CME, such as simulation-based CME, that support translating knowledge into practice…

There have been recent calls for the further reform of CME. For example, the IOM in its December 2009 report, *Redesigning Continuing Education in the Health Professions*, endorsed a new vision for CME based on CPD that emphasizes identification of learning needs, development of a learning plan and acquisition of lifelong learning and skills. This is consistent with the AMA's definition of CPD, which incorporates "the wider arena of skills and specialized education, including but not limited to cognitive knowledge that physicians employ in the delivery of patient care."

The National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ) have now also placed greater emphasis on translating scientific knowledge into clinical practice. The new models of CME share some of these same basic goals, particularly behavioral change and systems redesign to improve patient outcomes. For example, Performance Improvement Continuing Medical Education (PI CME) was introduced about a decade ago as an attempt to address quality- improvement concerns, and the model has expanded significantly since then…

While the FSMB's MOL framework does not mandate that physicians engage in such activities, it encourages state medical boards to include PI CME and CAP, which it mentions by name, as educational options by which a physician may be able to comply with one or more MOL components.

The interface between physician self-assessment and CME, which was part of the FSMB's MOL discussions, has also been explored recently. Most CME activities rely on the individual physician to determine gaps in his or her knowledge through a subjective self-assessment and to select the appropriate CME activities to remedy any perceived deficiencies. While physicians may find this type of self-assessment to be of value, research has shown that "physicians have a limited ability to accurately self-assess." Eva and Regehr argue that "it is time to move beyond the rhetoric that self-assessment as a general, personal, unguided judgment of ability should be taught and developed as a valid basis on which to direct performance improvements." Particularly relevant to the development of MOL is their conclusion that "for maintenance of competence efforts to be in any way meaningful, external feedback is essential." The FSMB's MOL recommendation is consistent with these conclusions and suggests a continuous feedback loop for physicians that helps them select educational activities…

Growing Emphasis on Continuous Improvement

The movement toward MOL is consistent with the increasing and ongoing efforts in recent years by organizations throughout the health care system, from those representing hospitals to specialty boards, to develop elaborate and meaningful new systems of quality measurement and improvement. While the MOL framework is also a new system, to the extent that it has not existed before, it differs from the others because it primarily seeks to recognize physicians already engaged in these new systems of quality measurement and improvement activities and to "raise the floor" of clinical competency rather than mandate an entirely new series of measurements. A brief overview of some of these new systems is provided below.

The American Board of Medical Specialties (ABMS) and all of its member specialty boards have now adopted its Maintenance of Certification (MOC) program, which requires specialty-certified physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain their specialty certification status: medical licensure and professional standing, lifelong learning and self- assessment, cognitive expertise and practice performance assessment. The ABMS and its specialty boards are actively conducting research to evaluate the impact of specialty board certification and participation in MOC activities on patient care, with growing evidence of its utility in improving patient outcomes.

The AOA's Bureau of Osteopathic Specialists implemented in January 2013 its Osteopathic Continuous Certification (OCC) program, which requires its specialty certified physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain specialty certification status: medical licensure, lifelong learning and CME, cognitive assessment, practice performance assessment and improvement and continuous AOA membership.

The FSMB's framework for MOL recommends to state boards that physicians already engaged in robust CPD and lifelong learning activities in their area of practice, such as

the ABMS's Maintenance of Certification (MOC) program or the AOA Bureau of Osteopathic Specialists' Osteopathic Continuous Certification (OCC) program, be recognized by state boards as being "substantially in compliance" with any MOL program. It is important to note, however, that state boards have not required specialty certification or participation in specialty recertification activities for medical licensure. The MOL framework, likewise, does not recommend that state boards mandate all actively licensed physicians to obtain, or maintain, specialty certification in order to maintain their license. Other CPD and educational activities acceptable to state boards for MOL have been and will continue to be identified, especially for the more than 230,000 actively licensed physicians who never were, or are no longer, specialty certified or who have lifetime specialty certification.

The National Commission on Certified Physician Assistants (NCCPA) and the American Academy of Physician Assistants (AAPA) are engaged in defining "certification maintenance" activities that all certified physician assistants (PA-C) will be required to complete every six years to maintain their certification.

The Accreditation Council on Graduate Medical Education (ACGME), as part of its mission to ensure and improve the quality of graduate medical education, began implementation in 1999 of its Outcomes Project. While the accreditation of its GME programs historically focused on the potential of the program to effectively educate and train its residents and fellows, the Outcomes Project focused on the actual accomplishments of the program through an assessment of its outcomes…

The Joint Commission, which accredits hospitals, implemented new credentialing and privileging standards in 2007 and 2008 which were intended to make the credentialing and privileging process more objective and evidence-based by facilitating continuous monitoring of physicians' performance and by providing a basis for intervening when quality-of-care concerns are identified. The American Hospital Association's (AHA) Physician Leadership Forum last year released a white paper, "Lifelong Learning – Physician Competency Development," that examines the core competencies needed to deliver coordinated, team-based, value-driven care and includes recommendations for hospitals and physician-associated organizations to develop these skills in the current and next generation of physicians. "Licensing boards," the report said, "should also consider stronger focus on the core competencies as part of the licensing process."

In 2008, the Council of Medical Specialty Societies (CMSS) released a primer, The Measurement of Health Care Performance, which summarizes recent discussions and interest in quality improvement, outcomes measures, practice measurement and the validity and integrity of physician performance. The National Committee for Quality Assurance (NCQA) has also dedicated itself to measuring, evaluating and improving the quality of health care in the United States through tools such as the Healthcare Effectiveness Data and Information Set (HEDIS) and health plan "report cards."

The recent growth of Patient-Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs) all have at their core a commitment to continuous improvement and evidence-based out- comes, with the ultimate goal of better serving the needs of patients. In addition, the IOM's To Err Is Human report specifically challenged state medical boards to do their part in making health care safer for patients by periodically assessing providers "based on both competence and knowledge of safety practices." An

additional impetus for state medical and osteopathic boards to embrace change and improvement in medical regulation is the concern that if they don't, others may do so on their behalf or in their place. Medical regulation outside the bounds of state licensing authority could in turn, as one observer notes, lead to damaging effects to patients and society.

Internationally, the College of Physicians and Surgeons of Ontario (CPSO) evaluates the continuing competence of its licensees through its Peer Assessment Program, which it initiated in 1981. As part of the program, physicians undergo an office-based evaluation of their facilities, medical records and quality of care once every 10 years. The General Medical Council (GMC) of the United Kingdom launched Revalidation, its version of MOL, for all of its physicians in December 2012, becoming the first nation in the world to formally implement such a program. Though Revalidation's goals are similar to MOL, it includes a very different set of requirements for physicians. Because MOL has not yet been implemented in the United States, and Revalidation has only recently been initiated in the U.K., formal outcomes data are not yet available for either program. However, the FSMB, GMC and medical regulators in other nations contemplating variations of MOL have pledged to share lessons learned alongside the opportunities and challenges that are identified as best practices in licensure renewal.

Finally, efforts by public and consumer-oriented organizations and websites such as Consumers Union, Healthgrades.com and Angieslist.com to disseminate consumer-focused information about physicians also highlight a growing interest on the part of the public for information about their physicians, including the status of their credentials and the quality of care they provide. In 2007 the American Association of Retired Persons (AARP), in collaboration with Citizen Advocacy Center (CAC), conducted a survey of the residents of Virginia who were 50 years of age or older to assess their understanding and knowledge of Virginia's existing state medical licensure requirements. More than 95 percent of respondents said they believe that health care professionals should be required to show they have up-to-date knowledge and skills needed to provide quality care as a condition of retaining their medical license.

MOL as a form of Continuous Professional Development (CPD).
The adoption by the House of Delegates of the FSMB of a framework for MOL in 2010 was an important milestone that recognized emerging research in the area of physician education and professional development, as well as the cultural shift that was already occurring across the house of medicine. The adoption of a framework for MOL set into motion a desire on the part of state medical boards, articulated in a policy statement in 2004, to better support their "obligation to the public" to ensure the continuing competence of physicians as a condition of license renewal.

The FSMB's MOL framework recommends that state boards require physicians seeking license renewal to provide evidence of participation in a program of continuous professional development that reflects the three major components of what is known about effective lifelong learning:

1. Reflective self-assessment,
2. Assessment of knowledge and skills, and
3. Performance in practice.

By design, the MOL framework does not specify the details of a continuous professional development program, instead suggesting a system that state boards may wish to consider that enables physicians in their jurisdiction to demonstrate through a selection of reasonable educational options in their area of practice that they are meaningfully engaged in these activities. The MOL framework also does not mandate a secure, high-stakes examination for compliance with any of its components, although a physician may elect such an option if desired.

While MOL is still years away from implementation by any state medical board, several state boards have been working with the FSMB and collaborating organizations to look at the operational and logistical aspects of a program that is designed to support a physician's commitment to lifelong learning and assure multiple stakeholders of the enduring value of the hard-earned license to practice medicine.

As MOL advances, state boards, the FSMB and collaborating organizations will need to be mindful of what adult learning theorist Marsha Speck has described as a basic principle to be considered when professional development activities are designed: "Adults will commit to learning when the goals and objectives are considered realistic and important to them. Application in the 'real world' is important and relevant to the adult learner's personal and professional needs."

This article was endorsed by the Board of Directors of the Federation of State Medical Boards on February 7, 2013.

We Want You!

CAC is now a membership organization *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership and on pages 27 – 28 of this newsletter.*

Although we encourage you to receive our newsletter by becoming a CAC member, ***you may still subscribe to our newsletter without becoming a member.*** *More information is at http://www.cacenter.org/view/newsletter and on pages 29 of this newsletter.*

With this issue of ***CAC*** **News & Views** *we have replaced most long URLs with short links to our source material. (In one case, a 241-character URL was shortened to 31 characters). Please let us know whether or not you think this is an improvement: feedback@cacenter.org.*

LETTERS

Dear **CAC *News & Views,***

I thought you would be interested in recently completed work that addresses what patients and family members should do if they have a concern about health care quality in South Carolina.

Here are links to the three Tip Sheets:

What to Do if You Have a Concern about Quality in a South Carolina Hospital: http://tinyurl.com/CAC2013-3-55.

What to Do if You Have a Concern about Quality in a South Carolina Nursing Home: http://tinyurl.com/CAC2013-3-56.

What to Do if You Have a Concern about the Quality of Care from a South Carolina Doctor: http://tinyurl.com/CAC2013-3-57.

Tip Sheets are also available in California, Maine, New York, and Pennsylvania, with more planned in 2013. You can access all of them in the Reports/Media section of the Informed Patient Institute (IPI) website: http://tinyurl.com/CAC2013-3-58. They are available in both an on-line and PDF format.

IPI is a non-profit organization dedicated to providing credible online information about health care quality and patient safety for consumers. In addition to Tip Sheets on Quality Concerns, IPI also provides information on health care report cards in every state.

Sincerely,

Carol Cronin
Executive Director
Informed Patient Institute
Annapolis, MD

Dear **CAC *News & Views,***

You may have already seen some of the press, but there are some interesting articles and a terrific new economic paper on nurse practitioners: http://tinyurl.com/CAC2013-3-59, http://tinyurl.com/CAC2013-3-60, http://tinyurl.com/CAC2013-3-61, and http://tinyurl.com/CAC2013-3-62

Sincerely,

Catherine Dower, JD
Associate Director
Center for the Health Professions, UCSF

MEMBERSHIP INFORMATION

CAC offers memberships to state health professional licensing boards and other organizations and individuals interested in our work**.** We invite your agency to become a **CAC** member, and request that you put this invitation on your board agenda at the earliest possible date.

CAC is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards**.** Over the years, it has become apparent that our programs, publications, meetings, and services are of as much value **to the boards themselves** as they are to the public members**.** Therefore, the **CAC** board has decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

1) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
2) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
3) A $20.00 discount for CAC webinars.
4) If requested, a **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;
5) **Discounted rates** for **CAC's on-site training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;
6) Assistance in **identifying qualified individuals** for service as public members.

We have set the annual membership fees as follows:

Individual Regulatory Board	$275.00
"Umbrella" Governmental Agency plus regulatory boards	$275.00 for the umbrella agency, plus $225.00 for each participating board
Non-Governmental organization	$375.00
Association of regulatory agencies or organizations	$450.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	$100.00

MEMBERSHIP ENROLLMENT FORM

TO BECOME A CAC MEMBER ORGANIZATION FOR 2014, PLEASE COMPLETE THIS FORM AND MAIL OR FAX IT TO:

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Payment Options:

1) Mail us a check payable to **CAC** for the appropriate amount;
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Credit card number:	
Expiration date and security code:	
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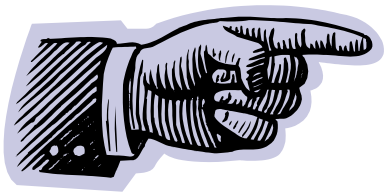

WE WANT YOU EITHER WAY!

We hope your board or agency decides to become a member of **CAC.** Membership includes a subscription to our newsletter for **all** of your board members and **all** of your staff, as well as many other benefits**.** But if you decide **not** to join **CAC**, we encourage you to subscribe to **CAC *News & Views*** by completing this form and mailing or faxing it to us.

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