News & Views

Citizen Advocacy Center

First Quarter, 2014 - A Health Care Public Policy Forum - Volume 26 Number 1

Save the Dates!

Our 2014 annual meeting will be held on October 23 and 24, 2014, in Baltimore, Maryland. *More information is at http://www.cacenter.org/cac/meetings.*

CAC is a membership organization *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership and on pages 28 and 29 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 page 30 of this newsletter.*

SCOPE OF PRACTICE

FTC Comments on Massachusetts Scope of Practice Bill

On January 17, 2014, the Federal Trade Commission responded to a request by Congresswoman Kay Khan (D-Mass) for comment on Massachusetts House Bill 2009, which would permit nurse practitioners to order tests and therapeutics and issue written prescriptions without a supervisory agreement with a physician. The FTC's comment read in part:

> APRN supervision requirements raise several related competitive concerns. By restricting APRNs' access to the marketplace, supervision requirements may

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deprive health care consumers of some of the benefits that provider competition can offer. Undue impediments to competition can affect the cost and quality of available health care services and restrict provider innovation in health care delivery. Excessive supervision requirements also can exacerbate provider shortages and access problems, particularly for underserved populations that already lack adequate and cost-effective primary care services.

We recognize that patient health and safety concerns are of critical importance when states regulate the scope of practice of health care professionals, and FTC staff defer to Massachusetts on the ultimate health and safety standards that the Commonwealth may choose to establish. We recommend, however, that the legislature seek to maintain only those NA and NP supervision requirements that advance patient protection…

For more, see http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician.

Editorial Note: On March, 2014, the FTC released a policy paper saying that "limiting the range of services APRNs may provide and the extent to which they can practice independently… may reduce competition that benefits consumers." In its report the Commission recommends that state legislators exercise caution when evaluating proposals that would limit nurse practitioner practice and direct patient access to nurse practitioner services.

The American Association of Nurse Practitioners (AANP) urged legislators to take the FTC's report to heart and consider the consequences of undue restrictions. In particular the AANP points out that the FTC paper included additional statements in support of nurse practitioners, such as:

- ***research demonstrates that nurse practitioners provide safe and effective care;***
- ***nurse practitioners might help alleviate health care access problems across the U.S. if undue regulatory burdens on their practice are reduced;***
- ***effective collaboration among health care providers, including team-based care, does not always require physician supervision of nurse practitioners; and***
- ***fewer restrictions on nurse practitioners would be good for competition and America's health care consumers.***

The AANP press release is at http://www.aanp.org/press-room/press-releases/136-press-room/2013-press-releases/1489-nurse-practitioners-urge-legislators-to-follow-ftc-lead-against-practice-restrictions.

The FTC report is at http://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

See also http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2384948 for the abstract of an article querying whether licensed occupations should face anti-trust scrutiny.

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Citizen Advocacy Center
1400 Sixteenth Street NW
Suite #101
Washington, DC 20036
Phone: (202) 462-1174 Fax: (202) 354-5372
Email: cac@cacenter.org

Editor-in-Chief: Rebecca LeBuhn
Contributing Editor: David Swankin
Newsletter Layout / Subscription Manager: Steven Papier

CONTINUING PROFESSIONAL DEVELOPMENT

American Medical Association Dislikes Maintenance of Licensure and Maintenance of Certification Programs

At its June 2013 meeting, the American Medical Association House of Delegates passed several resolutions opposing the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) program. One resolution opposed mandatory specialty board recertification programs and discrimination by hospitals and other entities against physicians who do not recertify. Another resolution supported continuing medical education and lifelong specialty certification. Another implied the ABMS would profit

from its MOC requirements by asking for published reports on ABMS revenue, expenses and compensation. Finally, the delegates voted to create an AMA commission to evaluate the impact of the maintenance of certification program on physician workforce, practice costs, patient outcomes, patient safety and patient access.

CAC Comments on FSMB's Latest Maintenance of Licensure Document

CAC sent the following letter to the Federation of State Medical Boards commenting on the Draft Report of the Maintenance of Licensure Task Force on Continuous Professional Development issued January 28, 2014:

Thank you for the opportunity to comment on the above referenced draft report. When finalized, the report should be very helpful to state medical boards in deciding whether to "approve" particular learning tools and activities submitted by physicians for purposes of meeting MOL requirements in the future.

Overall, the draft document contains useful and helpful guidelines for FSMB member boards. There is one glaring exception, which is the subject of these comments. On page 9, lines 314-317, the following recommendation is made to state medical boards:

> State boards **should not** (emphasis added) require or ask for demonstration of improvement in practice but rather rely on licensees' continuing, active participation in approved CPD activities and processes, recognizing that improvement in physician knowledge and practice will be facilitated over time as a result of the physician's participation.

The rationale for this recommendation appears on page 7, lines 212-219, of the draft, which reads:

> A state board's determination of whether a physician has complied with MOL should be based on participation in a CPD activity, rather than the specific result or outcome of that activity. The fundamental purpose of any quality CPD program is to improve physician performance. Therefore, over time, the physician's practice would be expected to improve by virtue of participation in the CPD activity, even if the physician is unable to practically demonstrate specific improvement outcomes at the start of the activity or at the specific time of licensure renewal. It is the fact that the physician is actively engaged in an approved CPD activity or process that ought to be sufficient in aggregate to meet most MOL requirements.

In our opinion, the above-quoted draft recommendation and its rationale need to be turned on their heads. Instead of saying, "State boards **should not** (emphasis added) require or ask for demonstrations of improvement in practice…" the recommendation should say, "State boards **should** (emphasis added) require such demonstrations of improvement in practice…" The rationale for this recommendation should be changed accordingly.

As written, the recommendation runs 180 degrees counter to the positions of at least two other well-respected medical organizations regarding demonstrations that CPD has a positive impact on clinical practice:

--The newly revised "Standards for the ABMS Program for Maintenance of Competence (MOC) (approved by the ABMS Board of Directors on January 15, 2014, for Implementation in January 2015) contains a new standard IMP-1, under the heading "Improvement in Medical Practice." It reads:

> IMP-1, Each ABMS Member Board will incorporate practice assessment and improvement activities into its program for MOC requirements throughout diplomates' careers. Each ABMS Member Board Program for MOC will incorporate ways in which diplomates may engage in specialty-relevant, performance-in-practice assessment followed by improvement activities when practice gaps are identified.

The rationale for this and other standards in the "Improvement in Medical Practice" is explained as follows:

> Part IV of the Program for MOC focuses on Improvement in Medical Practice (IMP) by the diplomates. These standards contribute to improved patient care through ongoing assessment and improvement in the quality of care provided by diplomats in their individual practices and/or in the larger hospital, health system, or community setting in which the diplomates practice medicine.

--The American Council for Continuing Medical Education (ACCME) has standards (called criteria) CME providers must meet in order to be accredited. **(Disclosure: CAC President David Swankin, one of the authors of this comment, serves as a public member on the ACCME Board of Directors. The remarks in this comment are CAC's and do not imply the agreement of ACCME.)** Currently, the ACCME criteria (standards) are in the process of being simplified. One criterion which will <u>not</u> be changed is Criterion 11, which reads:

> The provider analyzes changes in learners (competence, performance, or patient outcomes) achieved as a result of the overall program's activities/educational interventions.

This is the note that accompanies (explains) Criterion 11:

> The provider is asked to analyze the overall changes in competence, performance, or patient outcomes facilitated by their CME program using data and information from each CME activity. Providers who only measure change in knowledge in all their activities will not have any data on change in competence, performance, or patient outcomes to analyze.

Also relevant is ACCME Criterion 1, "Mission Statement," which will read as follows in the revised version:

> The provider has a CME mission statement that includes "expected results" articulated in terms of changes in competence, performance or patient outcomes that will be the result of the program.

Taken together, ABMS and ACCME are clearly committed to the proposition that CPD must be concerned with physician performance, not simply physician knowledge. CAC recognizes, as do many others, that we have not yet developed evidence based measures for performance. That does not negate the need to develop and promulgate standards addressing performance. The draft FSMB rationale for the recommendation addressed in

this comment is in effect a statement of hope ("Over time," it reads, "the physician's practice **would be expected to improve by virtue of participation in the CPD activity**" (emphasis added). Everyone hopes that is true, but hope is not sufficient.

In a preface to its new standards document, ABMS states:

> Because the Program for MOC has transformed certification from an early career event to an ongoing program of continuing learning and assessment, it can help diplomates remain current in an increasingly complex practice environment. **Furthermore, the program improves patient care through practice improvement activities. MOC requirements align with other quality improvement, educational, and regulatory activities in which diplomats engage. Thus, these standards outline a relevant and meaningful mechanism for continuing professional development for diplomates while helping support the social compact between the Public and the profession.** (Emphasis added)

The third component of FSMB's Maintenance of Licensure Framework is entitled "Performance in Practice (How Am I Doing?)" It reads:

> Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

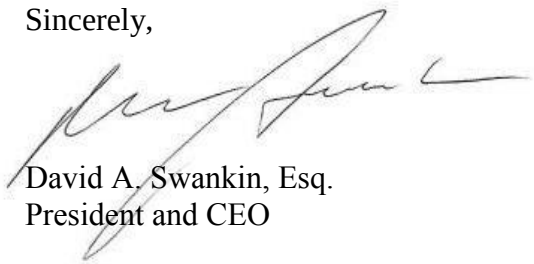
The DRAFT recommendation to State medical boards that they **should not** (emphasis added) require or ask for demonstration of improvement in practice…" negates component 3, "How Am I Doing?"

On page 6, lines 196-198, of the FSMB DRAFT this terrific statement appears:

> The ultimate goal of MOL is to facilitate physician participation in learning activities that are relevant to their daily practice **and that result in performance improvement, and, ultimately, better patient outcomes.**

The draft recommendation we challenge in this comment undermines rather than advances this ultimate goal. We urge FSMB to join ABMS in adopting policies to enhance public protection by linking CPD requirements to performance in practice. Over the years CAC has praised FSMB for its leadership in promoting meaningful continuing competence requirements as a condition of re-licensure. We would be saddened to see FSMB abandon this leadership role.

Sincerely,



David A. Swankin, Esq.
President and CEO

Rebecca LeBuhn
CAC Board Chair

Certified Midwifery Challenged by New Delaware Law

House Bill 194 enacted by the Delaware legislature in July 2013 calls for fines up to $1,000.00 for practicing midwifery without a permit – the equivalent of practicing medicine illegally. The permit, which has been required since 2001, involves entering into a collaborative agreement with a licensed physician.

Karen Webster, a certified midwife who had practiced in Delaware and Maryland for a quarter century, was accused of practicing medicine without a license in both states. She is contesting the charges and fighting the permit requirement.

For more, see http://delaware.newszap.com/centraldelaware/127459-70/law-hinders-del-non-nurse-midwives.

Editorial Note: Meanwhile, Indiana adopted HB 1135, which creates a licensure board and authorizes certified professional midwives to assist at home births. See http://www.in.gov/legislative/bills/2013/IN/IN1135.1.html.

California Legislation Recognizes Certified Geriatric Pharmacist Credential

On October 4, 2013, the Commission for Certification in Geriatric Pharmacy (CCGP) announced that:

> Governor Jerry Brown of California signed legislation on October 1, 2013, to recognize advanced practice pharmacists, authorized to conduct patient assessments and participate with health care providers in evaluation and management of diseases and health conditions of patients. The Certified Geriatric Pharmacist credential, offered by the Commission for Certification in Geriatric Pharmacy, is one of the qualifications used in recognition of advanced practice pharmacists. View the full text of the legislation.
>
> "We are very pleased that California has taken this important step forward," said Chris Alderman, BPharm, PhD, CGP, FSHP, BCPP, Chair of the CCGP Board of Commissioners. "It is the people of California who will benefit from greater involvement of qualified pharmacists in their health care. Older adults are at particular high risk for medication-related problems because they often have multiple medical conditions and take numerous medications. The Certified Geriatric Pharmacist is the ideal person to collaborate with other health care providers in managing their drug therapy."

Read the full story at http://www.prweb.com/releases/2013/10/prweb11190142.htm.

Read more at http://www.digitaljournal.com/pr/1507196#ixzz2uZeSQHXL.

UCSF Research Takes On Primary Care Provider Shortage

The following is excerpted in part from November 4, 2013, *Science Codex*:

> Thanks to a wave of aging baby boomers, epidemics of diabetes and obesity, and the Affordable Care Act, which aims to bring health care coverage to millions more Americans, the United States faces a severe shortage of primary health care providers.
>
> In a series of papers published in the November 2013 issue of *Health Affairs*, researchers at UC San Francisco advocated a number of potential solutions to the problem.
>
> In an analysis and commentary, Thomas S. Bodenheimer, MD, MPH, a UCSF professor of family and community medicine, and Mark D. Smith, MD, MBA, president and CEO of the California HealthCare Foundation, cited estimates that the U.S. will have a shortage of 52,000 primary care physicians by 2025. To meet the shortage, they suggested the creation of physician-led patient care teams of licensed and unlicensed health care personnel who have been empowered to provide an expanded scope of care. They also advocated increased participation by patients in providing more of their own care…
>
> The authors' recommendations include:
>
> - Empower registered nurses, pharmacists and physical therapists to provide care for "uncomplicated" medical problems such as respiratory and urinary tract infections, low back pain, diabetes and high blood pressure.
> - Let unlicensed medical assistants assume responsibility for preventive care needs and patient coaching for chronic conditions such as diabetes, high cholesterol, and high blood pressure.
> - Use new diagnostic technologies to permit patients to perform self-diagnosis and administer their own medications for chronic conditions such as diabetes, high blood pressure and cardiovascular diseases requiring anticoagulation agents, while encouraging patients to serve as peer coaches for other patients with the same conditions…
>
> In another analysis and commentary, a group of authors led by Catherine Dower, JD, Health Policy and Law Director of the UCSF Center for the Health Professions, reinforced the conclusions of Bodenheimer and Smith from a legal perspective.
>
> Dower and her team analyzed current laws governing scope of practice, which they defined as "what services may be provided by which health professions under what conditions." They concluded that existing laws and regulations, which are determined on a state-by-state basis, prevent most health professionals from providing the full scope of health care services that they have been trained and are qualified to provide. This mismatch between professional competence and scope of practice, said the authors, results in higher health care costs and needless inefficiencies.

“Our licensing laws have not kept pace with increasingly higher levels of education and better technology,” said Dower. “For example, many state laws don't allow nurse practitioners [NPs] to see patients without physician supervision, even though NPs are educated, trained and tested to do so.”

Furthermore, she said, the existing “patchwork approach” to the regulation of health professions, with each state passing its own set of laws, is a disservice to patients, professionals and health care employers alike…

The authors recommended a number of legal and regulatory reforms, including:

- Align scopes of practice with professional competence.
- Make regulations easier to update, to better reflect professional advancement.
- Recognize and accommodate overlapping scopes of practice between different health professions.
- Mandate public participation in regulatory bodies that determine scope of practice, thus ensuring a voice for consumers and patients.
- Use best available evidence in setting regulatory policies.
- Create a national clearinghouse that provides up-to-date information and research about emerging health professions and scope-of-practice expansions for use by states in creating policy.

A research team led by Joanne Spetz, PhD, professor of economics at the UCSF Philip R. Lee Institute for Health Policy Studies and associate director of research strategy at the UCSF Center for the Health Professions and Stephen T. Parente, PhD, MPH, MS, of the University of Minnesota presented evidence that liberalization of scope-of-practice laws for nurse practitioners could potentially achieve significant savings in the cost of visits to retail clinics.

According to the authors, NPs are the primary health care providers in such clinics, which offer diagnosis and treatment for common, non-life-threatening health conditions. They are located in settings such as pharmacies, grocery stores and big-box retailers.

The team compared the two-week cost associated with a clinic visit for 9,503 patients in 27 states who visited retail and non-retail clinics at some point between 2004 (and) 2007. In 13 of the states, NPs were allowed to practice independently, without the supervision of a physician; in six of the 13, they were also permitted to prescribe independently. The remaining 14 states required NPs to be supervised by or collaborate with a physician.

Adjusted to 2013 dollars, the average two-week cost for a non-retail clinic visit was $704.00. In states where NPs required physician supervision or collaboration, the cost was $543.00. In states where NPs were allowed the practice independently, the cost was $484.00; it was $509.00 in states where they both practiced and prescribed independently…

For more, see

http://www.sciencecodex.com/ucsf_researchers_offer_solutions_to_looming_healthcare_provider_shortage-122350.

See also http://www.chcf.org/publications/2013/11/ha-physician-shortage.

Walgreen Clinics to Use Software to Guide Patient Checkups

Walgreens plans to introduce software called ePass to prompt caregivers in its clinics to ask certain questions and recommend certain interventions depending on a patient's electronic medical record and algorithms that predict the likelihood of certain medical conditions.

At the conclusion of the exam, the software makes a SOAP note (subjective, objective assessment plan) which updates the patient's medical record. Each such entry contributes to the volume of data within ePass on which to base future predictions.

Public Supports Expanded Role for Nurse Practitioners

On November 6, 2013, Michael Ollove of the Pew Charitable Trusts' Stateline Dispatch reported on a survey showing that:

> More than six in 10 Americans support giving nurse practitioners more leeway to provide health care services, including prescribing medicines and ordering diagnostic tests without the need for supervision by a physician.
>
> Seven out of 10 oppose laws that prevent people from selecting nurse practitioners as their primary care providers, according to a poll commissioned by the American Association of Nurse Practitioners.
>
> The poll, conducted by the Mellman Group, is intended to buttress lobbying by the AANP to convince state legislatures to allow nurses to work as primary care providers. The AANP argues that giving more responsibility to nurse practitioners is particularly important because of the shortage of primary care doctors, a scarcity likely to worsen as the Affordable Care Act ushers 32 million currently uninsured Americans into health plans.
>
> At least 17 states now allow nurse practitioners to work without a supervising physician, and similar measures are under consideration in other states.
>
> Most health advocates agree that allowing nurse practitioners to fill in for doctors makes sense for basic services. But doctors' groups oppose any changes, saying nurses lack the training to safely diagnose, treat, refer to specialists, admit to hospitals and prescribe medications, without a doctor's oversight.
>
> The survey size was 1,000 adults. Interviews were conducted by telephone from Sept. 12-15. The margin of error is +/-3.1 percent.

See also http://www.pewstates.org/research/analysis/survey-americans-support-more-medical-duties-for-nurse-practitioners-85899518133.

Australia Enacts Health Professionals' Pathway to Prescribing

Australia's Health Professionals Prescribing Pathway (HPPP) provides a "nationally consistent approach to the prescribing of medicines by health professionals registered under the National Registration and Accreditation Scheme other than medical professionals." The HPPP is part of Australia's National Strategy for the Quality Use of Medicines. The strategy means selecting medication management options wisely; choosing suitable medicines if a medicine is considered necessary; and using medicines safely and effectively to achieve the best possible outcomes.

Under the HPPP, health professionals must complete five steps to safely and competently prescribe. The steps are:

1) Complete education and training
2) Recognition by the National Board of competence to prescribe
3) Legal authorization to prescribe
4) Prescribing within the professional's scope of practice

For more detail about the HPPP see http://www.hwa.gov.au/news-and-events/news/14-11-2013/final-health-professionals-prescribing-pathway-approved.

PAIN MANAGEMENT AND END OF LIFE CARE

Indiana Medical Board Adopts New Prescribing Rules

On October, 25, 2013, Indiana's Attorney General announced:

> The Medical Licensing Board of Indiana voted Thursday to adopt a new rule concerning physicians who prescribe addictive pain medications to nonterminal patients.
>
> Indiana Attorney General Greg Zoeller said the rule aims to ensure patients are well informed about their prescriptions and physicians closely monitor patients to identify cases of misuse and abuse. A recent study by Trust for America's Health revealed the number of deaths caused by overdoses in Indiana has quadrupled since 1999.
>
> This year, the Indiana General Assembly passed legislation charging the board with developing new rules regarding prescribing controlled substances and strengthening the authority of the Attorney General's office to inspect physician records in overprescribing cases. The two emergency rules stem in part from recommendations made by the Indiana Prescription Drug Abuse Task Force, which Zoeller launched last year…
>
> Beginning Dec. 15, physicians will be required to monitor certain patient's history via the state's drug monitoring system called INSPECT which reveals what medications have been prescribed to a patient. Zoeller said this check can prevent someone from

> "doctor shopping" or obtaining multiple prescriptions for the same drug from different physicians.
>
> The board also adopted a new rule giving the Attorney General's office the ability to more efficiently review physician records regarding controlled substances. Zoeller said this helps his office during investigations of physicians who may be overprescribing.
>
> Since January of last year, Zoeller's office has filed complaints or summary suspensions against more than 15 doctors for overprescribing.

For the complete announcement, see http://www.in.gov/activecalendar/EventList.aspx?view=EventDetails&eventidn=139121&information_id=189744&type=&syndicate=syndicate.

Palliative Caregivers Face Accusations

Crystal Phend, Senior Staff Writer at *MedPage Today*, wrote on February 4, 2014, about palliative care providers being accused of murder or euthanasia for practicing their specialty. Notably, the primary source of complaints is other healthcare providers.

For more, see http://tinyurl.com/ljv4l9j.

TELEHEALTH

Legislation Introduced to Permit Telehealth under Medicare

In an effort to overcome barriers to practicing telemedicine across state lines resulting from our system of state based licensure, Representative Devin Nunes (R-CA) introduced the TELEmedicine for MEDicare Act of 2013.

In broad brush, the bill says:

> In the case of a Medicare participating physician or practitioner who is licensed or otherwise legally authorized to provide a health care service in a State, such physician or practitioner may provide such a service as a telemedicine service to a Medicare beneficiary who is in a different State, and any requirement that such physician or practitioner obtain a comparable license or other comparable legal authorization from such different State with respect to the provision of such health care service by such physician or practitioner to such beneficiary shall not apply.

The text of the bill can be found at https://www.govtrack.us/congress/bills/113/hr3077/text.

Editorial Note: Also in 2013, Representative Peter Welch of Vermont introduced the Telehealth Enhancement Act of 2013, which would make it easier for people to take advantage of telemedicine by electronically linking patients to physicians. The bill would also provide for home-based video services for hospice care, home dialysis, and homebound beneficiaries. It would also permit states to expand Medicaid coverage to

include telemedicine services for women with high-risk pregnancies. There is growing support for Telehealth legislation on Capitol Hill.

See http://www.healthleadersmedia.com/print/MAR-302930/Show-Dont-Tell-Telehealth-Benefits.

See also Andis Robeznieks' reporting in Modern Healthcare about licensure issues and a Federation of State Medical Board's initiative on the subject at http://www.modernhealthcare.com/article/20140320/NEWS/303209952/proposed-patient-centered-telemedicine-policy-raises-licensing, and http://www.modernhealthcare.com/article/20140322/MAGAZINE/303229962/state-boards-policy-for-telemedicine-may-present-roadblocks.

Telehealth Found to Help Nursing Home Residents

A Commonwealth Fund announcement of a study of the issue of telehealth in long term care facilities begins with this:

> Nursing home residents in need of medical care after regular hours or on weekends are often sent to the hospital, where they face a great risk of serious health complications. These hospitalizations also cost Medicare more than a billion dollars a year.
>
> Results from a new Commonwealth Fund supported study reported in *Health Affairs* led by Harvard Medical School's David C. Grabowski confirm that telemedicine can be a cost-effective alternative to a trip to the hospital.

See the study at http://www.commonwealthfund.org/Publications/In-the-Literature/2014/Feb/Use-of-Telemedicine.aspx?omnicid=20.

PATIENT SAFETY AND MEDICAL ERRORS

Heavy Incidence of Harm in Long-Term Care Facilities

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) is calling for minimum nursing home staffing standards in response to a recently released Department of Health and Human Services Office of Inspector General (OIG) report, "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries." The OIG investigation found that one third of skilled nursing home residents are being harmed, and in some cases, even dying, as a result of "adverse or temporary harm events" - instances where harm results due to the care provided - or not provided - by the facility. Examples of such events include excessive bleeding due to medication, falls, infections, pressure ulcers, blood clots, acute kidney injury and worsening of preexisting conditions due to lack of care.

See the complete press release from Consumer Voice, which includes a link to the OIG report at http://www.theconsumervoice.org/sites/default/files/OIGReportCVStatement3-14.pdf.

See also http://www.propublica.org/article/one-third-of-skilled-nursing-patients-harmed-in-treatment?utm_source=et&utm_medium=email&utm_campaign=dailynewsletter.

Study Examines Why Doctors Stay Silent About Colleagues' Errors

In its October 31, 2013, issue, the *New England Journal of Medicine* published a report entitled, "Talking With Patients About Other Clinicians' Errors." Lead author Dr. Thomas Gallagher of the University of Washington School of Medicine told ProPublica reporter Marshall Allen that more than half of the doctors he surveyed (number unknown) said they had witnessed at least one error by a colleague in the previous year.

For the *New England Journal of Medicine* article, Gallagher and 14 other experts discuss the many reasons why doctors don't report errors by their peers. Examples of unreported errors range from misreading diagnostic tests to errors that result in patient harm.

Dr. Humayun Chaudhry, President and CEO of the Federation of State Medical Boards told Allen that physicians and healthcare organizations should be more assertive about reporting errors. Failure to do so "makes patients wonder if they can trust their own physicians and the profession of medicine."

See the *New England Journal of Medicine* article at https://www.documentcloud.org/documents/813486-talking-with-patients-about-other-clinicians.html.

See also http://www.propublica.org/article/why-doctors-stay-mum-about-mistakes-their-colleagues-make?utm_source=et&utm_medium=email&utm_campaign=dailynewsletter.

See this link for research into barriers to physician transparency about errors in which they are personally involved http://www.ncbi.nlm.nih.gov/pubmed/24553443.

Cardiology Association Changes Wording of Guidance on Appropriateness

Reporter Peter Waldman of *Bloomberg News* reported on October 30, 2013, that "Doctors Use Euphemism for $2.4 Billion in Needless Stents." He writes that the American College of Cardiology (ACC) will no longer use the term "inappropriate" in its guidelines for implanting coronary stents. The ACC will now use the term "rarely appropriate; they will replace the term "uncertain" to "may be appropriate."

Experts estimate that as many as half the 7 million stents implanted in the last decade may have been "inappropriate" under ACC guidelines. Waldman points out that several medical boards (Texas, Maryland, Missouri, and Kentucky are mentioned) have disciplined doctors for implanting stents that were not needed.

Find Waldman's article at http://www.bloomberg.com/news/2013-10-30/doctors-use-euphemism-for-2-4-billion-in-needless-stents.html.

Editorial Note: This move by the American College of Cardiology runs against the spirit of the Choosing Wisely campaign which encourages careful deliberation and shared decision-making between patients and their clinicians. See http://www.choosingwisely.org.

U.S. Congress Passes Law on Pharmacy Compounding

A year after the outbreak of fungal meningitis traced to faulting drug compounding, the U.S. Congress passed the Drug Quality and Security and Accountability Act. The legislation distinguishes between traditional pharmacies and entities making large quantities of compounded drugs without individual prescriptions. The former will continue to be regulated by state pharmacy boards. The larger compounders will be required to register as outsourcing firms and will fall under FDA oversight.

For more, see http://thomas.loc.gov/cgi-bin/bdquery/z?d113:S.959

Oregon Medical Board Issues Office-Based Surgery Rules

The Oregon Medical Board's Fall 2013 *Report* opens with a story about "Patient Safety in Office-Based Surgery:"

> On October 3, 2013, the Board voted to adopt the proposed rules on office-based surgery. These rules became effective upon filing on October 15, 2013.
>
> Dr. Shirin Sukumar, Board Secretary and Chair of the Administrative Affairs Committee, summarized the rules in three parts: "patient safety, physician education, and accountability."
>
> The rules classify levels of office-based surgeries and set forth the corresponding requirements. Specifically, the rules establish a standard of practice for licensees performing office-based surgery and set forth the requirements for when performing (sic) such procedures. The rules also clarify the assessment and informed consent procedures, clarify the requirements for patient medical records, expand the emergency care and transfer protocol requirements, and require reporting of specified office-based surgical adverse events.
>
> The adoption of these rules is the culmination of a deliberate process of research and collaboration with the public as well as local, state and national associations, which began in mid-2011. The research included examining other states' laws, national standards, professional association recommendations and medical literature. Public input was critical during each stage of development.
>
> As a result of the two-year process, Dr. Sukumar stated that she "is confident that other states will look to Oregon as a model" for office-based surgery regulations.

See the new regulations at http://www.oregon.gov/omb/Topics-of-Interest/Pages/Office-Based-Surgery-Proposed-Rules.aspx.

CMS to Take Action Against "Abusive Prescribers"

On January 14, 2014, *ProPublica* reporters Charles Ornstein and Tracy Weber wrote up CMS's plan to take action against prescribers whose performance jeopardizes patient safety. The agency will decide which prescribers are "abusive" on a case-by-case basis. *ProPublica* published a series of articles in 2013 about the laxity of CMS oversight over Medicare's Part D prescription drug program.

See *ProPublica's* coverage at http://tinyurl.com/lbvvxak.

IN-DEPTH FEATURE

This Quarter's In-Depth Feature is the Kathy Apple's Shimberg Memorial Lecture delivered at CAC's 2013 Annual Meeting in Seattle, Washington. Kathy received the Ben Shimberg Public Service Award "for promoting best practices in nursing regulation and motivating boards of nursing to regularly evaluate and improve their performance as protectors of the public interest."

The Reluctant Regulator: Lessons Learned on the Importance of Public Protection

Thank you for that kind introduction. I have to start by saying how humbled and honored I am to receive the Ben Shimberg Public Service Award. I am overwhelmed to be acknowledged with this award and in awe of its past recipients, for all of whom I have great admiration and respect. I want to thank the CAC Board of Directors for their consideration, with a special thank you to David Swankin and Becky LeBuhn who have had a positive and substantial impact on my regulatory career.

I know I am supposed to provide a lecture at this juncture. I did prepare by reviewing all of the previous award lectures and noted that Art Levin said that he would not give a lecture but then went on to give an outstanding one. I would like to do something a little different by sharing the experiences and lessons that have shaped my regulatory career and the beliefs I hold today about the importance of public protection through licensure and the proper role of the regulator. I have titled my lecture: The Reluctant Regulator: Lessons Learned on the Importance of Public Protection.

In my educational endeavors and throughout my professional career, I have always sought experiences that were challenging, stimulating, and in one way or another, gave back to the community at large. Seeking those opportunities did not always mean I knew everything I was supposed to know. At least I knew that I did not know, and so I always sought out new knowledge. Somewhere early in my regulatory career, I obtained a copy of Ben Shimberg's book, *Occupational Licensing: Practices and Policies*. I also had the privilege of meeting Dr. Shimberg. I wish I had known him longer. I wish that I could sit down with him now, knowing what I know today.

I started my regulatory career not as a regulator but as a regulated professional. In 1989, I moved from Alaska to Nevada. I thought I was being a responsible registered nurse by applying for both my registered nurse and advanced practice registered nurse (APRN) licenses prior to my move. The Nevada State Board of Nursing issued a RN license but

denied the APRN license. I remember wondering why I was okay to practice and be licensed in one state but not another. On the surface, it did not make sense. I appealed the denial of the APRN license three times appearing before the board of nursing three times. I don't know if that is stubborn determination but in the end, after completing a second master's degree as recommended by the board of nursing, they offered me a job. Looking back, I am not sure exactly how that happened. I was told I did such a good job during my appeals, that the board of nursing was impressed, even if they could not give me what I wanted. However, what I know now is that as a professional nurse, I did not really understand the public protection purpose of licensing and the professional obligation under law, let alone administrative law and the construct of law.

What I came to understand later was that the state nurse practice act was not clear on how to regulate advanced practice in psychiatric-mental health nursing. This lack of clarity was one of the first things I helped make clear through changes in law and regulation once I was hired. I learned how to change the law to protect the public while at the same time providing access to qualified providers. It was my first lesson on how to evolve nursing regulation and the importance of regulatory evolution.

There would be many other lessons along the way regarding regulatory evolution including arguing the public protection case in the five-year discussion that resulted in the first nationally standardized regulatory model for APRNs known as the Consensus Model for APRN Regulation. This model which is currently being implemented in all states, protects the public, while at the same time provides increased access to care and improves the mobility of ARPNs.

The original position I was offered by the Nevada State Board of Nursing was the Associate Director for Discipline. I remember thinking how hard could this job be? After all, nurses are good people. Year after year Gallup Polls reveal that nurses are the public's number one most trusted profession. However, little did I know the types of unprofessional conduct and incompetence that could threaten or actually harm patients.

Now I want to share a story that may appear at first glance not to connect to what I just said but bear with me, it will. Prior to starting this new position, my husband and I went on a four-day river rafting trip with several other couples from his place of employment. We all met at an agreed upon location and began setting up camp for the night. Someone built a campfire which brought everyone together, as campfires do. I was sitting next to a woman who during the course of introducing each other, discovered we were both nurses. This is always an energizing moment when in a group of strangers you find commonality. I found out she worked at a local acute care facility. When she asked me where I worked, I said I was about to start a new position with the Nevada State Board of Nursing running their discipline program. Well, so much for commonality, the first thing she did was get a horrified look on her face, and then promptly got up and left. I hardly saw her during the rest of the trip. I wondered what I had gotten myself into with this new position.

A year after I started with the board of nursing, I was going through some old investigative files and low and behold, there she was, the same nurse I shared a campfire with. There had been a complaint of possible drug diversion filed against her. That investigation had been closed for lack of evidence but a year after that she was reported to the board of nursing for falsifying prescriptions for controlled substances. At least I

had now understood her initial reaction when we met on the banks of the American River.

Lesson number two: I realized later that it is human nature at play in this framework of public protection. After all, if all human beings were ethical and law abiding, there would be little need for regulation.

Managing the state board discipline program was my first visceral insight and lesson on how professional licensing protects the public. At the time I started, the board of nursing had a backlog of discipline cases and the Attorney General had been asked to assign a deputy attorney who was a skilled litigator to assist in aggressively moving this backlog. The first case the new deputy and I reviewed was about a new nurse who after being fired at a local hospital for a pattern of medication errors, had threatened to "blow away the unit" where he worked. The deputy and I became immersed in a very heated debate about the merits of the case and public safety. While the deputy thought the nurse was just blowing off steam, I knew that this was a credible threat. In the end, we came to an agreed upon action plan, which included the deputy teaching me administrative law and me teaching him about nursing practice with a special focus on mental health issues. Through the course of our working relationship we had a clear sense of the boundaries of our roles and how they complemented one another.

Lesson number three: After years of seeing one horrific complaint after another, I came to believe that the disciplinary function of licensing boards is critical, vital, and as needed today as it will continue to be in the future. The experience also taught me how respecting and acknowledging legal scopes of practice between and among professionals works for the benefit of all.

Later, after I was offered the position of executive director for the Nevada State Board of Nursing, I decided to contact a previous executive director who had been well respected in the state. Because she was elderly, I offered to come to her home explaining that I was seeking her seasoned advice on the role. She immediately and forcefully said no, that she would be in my office at 9:00 a.m. sharp the following morning. And she was. Her opening comment to me was about power; who has it, who doesn't, how to respect it, how to use it, and how not to be corrupted by it. It was a conversation I was not expecting; however it was the most important advice I have ever received.

Lesson number four: It is a powerful position to implement law, with the force of law, but it must be done respectfully, judiciously and fairly.

This brings me back to the individual for whom this honor is named. Here is what I learned from Ben Shimberg: ask questions; all kinds of questions, fundamental questions, even questions for which you think you know the answer. Why is there licensing? Who should do the licensing? How are licensing requirements determined? How is competence determined? What is the best way to determine competence? And my favorite, where is the evidence that licensing works?

Lesson number five: Asking the right questions often is the answer to evolving licensure regulation.

Dr. Shimberg was an expert on competency testing. He challenged us all to ensure competence assessments meet the highest psychometric and ethical standards. He urged

licensing boards to continuously examine how to improve testing procedures. Dr. Shimberg challenged licensing boards to improve communication to applicants and consumers, to keep data and accurate records on all board business and be accountable for their own performance. He advocated for research conducted by licensing boards in all aspects of regulatory functions. He encouraged collaboration between and among licensing agencies. He challenged all regulators to have and follow their own code of ethics.

Dr. Shimberg influenced many nurse regulators and I think he would be pleased with the many accomplishments of NCSBN such as the emphasis on evidence-based regulation, commitment to ongoing regulatory excellence through the collection of performance data, research related to nursing regulation, psychometrically sound and legally defensible competence assessments, an organizational value of collaboration especially with regulatory bodies of other health care disciplines, and learning through interaction with regulatory bodies from other countries.

Here is what I continue to learn from CAC: ask more questions. I heard about the Citizen Advocacy Center early in my regulatory career; I knew it was a consumer advocacy organization and provided education for consumer members of licensing boards. I attended annual meetings, listened, learned, and was stimulated by the sophisticated dialogue. I learned about the critical importance for the role of consumer members on licensing boards.

When David Swankin asked me to sit on a discussion panel, I was unprepared for what would unfold. This is where I learned about the true genius of CAC. The panel discussion was on collaboration between health care licensing boards. David did not ask the panelists to discuss collaboration; he did not ask us to share why health care licensing boards do not get along. He simply asked us to share how our respective regulatory bodies work positively together. I shared the panel with a representative from the Federation of State Medical Boards. I have to confess that I was scrambling; how did we work positively together? It was an awkward panel discussion at best. Today however, I am happy to report that NCSBN led the way to the formation of the Tri-Regulator Leadership Collaborative with the Federation of State Medical Boards and the National Association of Boards of Pharmacy. This collaborative is working in a very positive, collegial manner on issues of mutual concern and modeling interprofessional collaboration at the national level for our members at the state level.

Lesson number six: Collaboration is powerful and necessary.

There is still much work to be done in our field of regulating occupations and professions through the concept of licensure. I recently read a new study published in the Journal of Patient Safety in September of this year titled, "A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care." The conclusion of this study was that the number of premature deaths associated with preventable harm to patients in this country was estimated at 210,000 to 400,000 per year. This is two to four times the estimate cited in the Institute of Medicine report, *To Err is Human – Building a Safer Health System,* published in the year 2000.

Here is my question. What happened? Why have all the efforts for improvement made by so many appeared to not have the desired impact? One of the comments from the report

was that "the lack of a well-integrated and comprehensive continuing education system in the health professions is a major contributing factor to knowledge and performance deficiencies at the individual and system level." Clearly preventing adverse events is a complex subject that includes both system and individual errors. Regarding individual errors, I do find it interesting that this report readily identifies what I believe to be the unanswered question of our generation of regulators: how should the licensee demonstrate competence over time in order to maintain the privilege of licensure?

This question was raised 10 years ago in the 2003 Institute of Medicine report, *Health Professions Education: A Bridge to Quality*. This report recommended that all health profession boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care through direct measures of technical competence, patient assessment, evaluation of patient outcomes and other evidence-based assessment methods. So why is this such a hard question? What stops the regulatory community from taking decisive action? Should not the public and regulatory bodies demand the same standard of competence assessment of the licensee from the beginning, and throughout the lifetime of active practice? Should we be rethinking how health care professionals are licensed? Is the generalist licensure model still the right model? Now see, this is where I think Ben Shimberg would be proud that all of us keep asking questions.

In closing, I have had the honor to learn many lessons; that collaboration is an absolute necessity; that the essence of human nature influences regulation; that the law must be clear, just, decisive and must evolve; to be aware of power and use it wisely; and most importantly, keep asking questions.

I would like to end by expressing my gratitude to the CAC Board of Directors for this honor, to my many colleagues at the National Council of State Boards of Nursing, to my many mentors, some of whom are in this room, and lastly and most importantly to Ben Shimberg who urged us all to do our best in protecting the public.

REGULATION

Tri-Regulator Collaborative Sets 2014 Agenda

Leaders of the National Council of State Boards of Nursing (NCSBN), the National Association of Boards of Pharmacy (NABP), and the Federation of State Medical Boards (FSMB) met in October 2013 to discuss matters of mutual concern and agree upon an agenda for 2014. The agenda includes:

- Preparation for a historic, joint meeting of the governing boards of each organization on February 5, 2014;
- A proposed position statement on interprofessional team-based care for adoption by each organization;
- Assessing the public protection issues related to practice between and among countries and other international issues related to the regulation of healthcare practice;

- Encouraging regular dialogue between U.S. medical, pharmacy and nurse licensing boards, including facilitation of dialogue with board members of each respective organization; and
- Planning for the second Tri-Regulator Symposium to be held in 2015.

For more, see https://www.ncsbn.org/4691.htm.

DISCIPLINE

Chicago Tribune Says State Medical Board Relies Heavily on Reciprocal Actions

On January 7, 2014, *Chicago Tribune* reporter Karisa King wrote an article entitled, "Doctor Investigations Often Start Elsewhere; Data Show Illinois Leans Heavily on Other States' Work." The article, which quoted both David Swankin and CAC Board member Art Levin, faults the Illinois Department of Financial and Professional Regulation (IDFPR) for failure to initiate disciplinary action against a doctor accused of committing a medical error and then attempting to cover it up. King goes on to write that except for Pennsylvania, Illinois was the state that relied most on cases brought first in other jurisdictions – about 50% of its case load.

Spokespersons from the IDFPR claim that the source of the data, the National Practitioner Data Bank, inaccurately categorizes some of Illinois' cases because the state does not license by specialty.

See the entire article at http://articles.chicagotribune.com/2014-01-07/news/ct-doctor-discipline-met-20140107_1_other-states-chicago-doctor-physicians.

Court Upholds Board Enforcement Actions

The Iowa Medical Board announced in January 2014 that the Iowa Court of Appeals upheld the board's actions to enforce a board order against an ophthalmologist. The court rejected the doctor's argument that he was in compliance with the court order, that the sanctions were unreasonable, and that the board's processes violated his due process rights.

See the court's decision here http://judicialview.com/State-Cases/iowa/Health_Care/Tobin-v-Iowa-Board-of-Medicine/29/596624.

Michigan Considers Limiting Power of Board Chairs

Bills working their way through the Michigan legislature would increase regulatory oversight and transparency. One (SB 575) would require a minimum of three board members to review every allegation that comes before the board. This is in response to an incident a few years ago when the board chair dismissed allegations against a practitioner friend without investigating or consultation with others on the board. If signed into law, the legislation will also prohibit board members from testifying as paid expert witnesses in cases that may subsequently come before the board.

FSMB Offers Resources to Improve Physician-Patient Communication

Noting that many complaints to its member boards stem from communication breakdowns, the Federation of State Medical Boards (FSMB) has developed resources for licensees to improve their communication skills.

See the Federation's Spring 2014 *Newsline* at http://www.fsmb.org/pdf/nl-spring2014.pdf.

See also http://www.fsmb.org/physician_patient_communications_resource_center.html.

CHEMICALLY DEPENDENT PRACTITIONERS

Star Tribune Critiques Minnesota Board of Nursing Monitoring Program

In a special report, entitled "Addicted Nurses Keep Licenses," *Star Tribune* reporter Brandon Stahl faults the Minnesota Board of Nursing for permitting nurses to continue to practice even though they do not conform to the conditions of the state-run monitoring program, or even though they have been kicked out of the program. In a particularly egregious case, one nurse diverted liquid Hydromorphone and replaced the medication with tainted saline solution. As a result, one patient died, three required surgery, and six needed intensive care.

Some of the problem rests with the state-run monitoring program, which does not report to the board until there have been three or four problem bodily fluid screens. Program participants are also allowed to miss screens. Also, employers are not currently required to inform the board about cases of diversion at their establishments.

For more, see http://www.startribune.com/local/230376611.html.

Since Mr. Stahl began his series on the board of nursing, legislation has been introduced to strengthen the board's disciplinary powers. See http://www.startribune.com/politics/statelocal/249656891.html for the latest on reform legislation and for links to other articles in the series.

See also http://www.mondaq.com/unitedstates/x/287168/employee+rights+labour+relations/Minnesota+Bill+Would+Require+Immediate+Suspension+for+Nurses+Failing+a+State+Diversion+Program.

PUBLIC MEMBERS

National Patient Safety Foundation Endorses Patient Engagement

"Enabling patients and families to be respected partners in health care—from the exam room to the policy arena—is essential if the U.S. health care system is to continue to make progress in patient safety." So begins a press release announcing a report released on March 19, 2014, by the National Patient Safety Foundation's Lucian Leape Institute. The announcement goes on to say:

> *Safety Is Personal: Partnering with Patients and Families for the Safest Care*, advocates for patients and families to be active partners in all aspects of their care, as well as in health care design and delivery and in policy development and research efforts. The report identifies specific action items for health leaders, clinicians, and policy makers to pursue in making patient and family engagement a core value in the provision of health care.

For more, see http://www.npsf.org/about-us/lucian-leape-institute-at-npsf/lli-reports-and-statements/safety-is-personal-partnering-with-patients-and-families-for-the-safest-care/.

LICENSURE

States Consider Fast-Track Medical Education

Kathy Robertson, reporter for the online *Sacramento Business Journal* posted an article on March 12, 2014, reporting that legislation under consideration in California would permit students to earn medical degrees in three years. The bill, Assembly Bill 1838, was introduced by Assemblywoman Susan Bonilla and is co-sponsored by the University of California and the California Medical Board. Medical schools in New York and Texas already offer accelerated degree programs for medical students.

See the entire article at http://www.bizjournals.com/sacramento/blog/morning-roundup/2014/03/calif-legis-education-doctors-accelerate.html.

See also http://www.fsmb.org/pdf/interstate_compact_senators_january13C.pdf.

Missouri Considers Deregulation of Some Professions

Legislation under consideration in Missouri would remove licensure requirements for several professions and permit their members to practice so long as they do not claim to be licensed. Among the professions potentially affected by the bill are massage therapists, barbers, cosmetologists, and embalmers.

The text of the bill can be found at http://legiscan.com/MO/text/HB1891/2014.

Florida Considers Licensure for Telemedicine Providers

Bills in the Florida House (HB 751) and Senate (SB 7028) would provide for licensure for telemedicine providers from other states. Supporters of the legislation believe it would help relieve provider shortages in the state. The Senate bill includes reimbursement regulations in addition to licensure and registration requirements. For more, see http://www.myfloridahouse.gov/Sections/Bills/billsdetail.aspx?BillId=51847 and http://www.myfloridahouse.gov/Sections/Bills/billsdetail.aspx?BillId=51861.

Editorial Note: The Federal Trade Commission is examining whether restrictions on the delivery of telemedicine services in jurisdictions where providers are not licensed is anti-competitive.

According to David Pittman, Washington Correspondent, MedPage Today, "Medical groups, including the American Medical Association (AMA) and state physician societies, have opposed the interstate licensure of physicians, saying states have a right to determine that providers meet certain standards. But telemedicine backers say those groups are only protecting their financial interests and are not interested in increasing patient access to care."

For more, see http://www.medpagetoday.com/MeetingCoverage/HIMSS/44551?xid=nl_mpt_DHE_2014-03-03&utm_content=&utm_medium=email&utm_campaign=DailyHeadlines&utm_source=WC&eun=g504008d0r&userid=504008&email=rebeccalebuhn@cacenter.org&mu_id=5629123.

SPOTLIGHT

Two Web Sites Excel on Consumer Information

This issue of **CAC** ***News & Views*** shines the Spotlight on two Web sites that contain excellent consumer information. The National Consumer Voice for Quality Long Term Care (The Consumer Voice) for its Web Site, which is full of links to valuable consumer information for long term care facility residents and their families and advocates. Check it out at http://www.theconsumervoice.org/resident/nursinghomes/fact-sheets.

The American Academy of Orthopedic Surgeons' Web site has an excellent link to a page on "Patient Safety," which describes orthopedic surgeons as part of a healthcare team and offers valuable information and advice to consumers about what to expect at an office visit and surgical encounter at http://orthoinfo.aaos.org/topic.cfm?topic=A00684.

CONSUMER INFORMATION

HCI3 Issues Report Card on State Practitioner Performance Data

The Health Care Incentives Improvement Institute (HCI3) issued a "State Report Card on Transparency of Physician Quality Information" in December 2013. The report finds fault with the information available from government agencies and private sources, saying that, "The Aligning Forces For Quality (AF4Q) effort has, to-date, remained one of the few bright spots across the U.S. in providing transparent quality information to consumers."

For more, see http://www.hci3.org/content/physician-quality-transparency-report.

CMS Adds Quality Information to "Physician Compare"

In February 2014 the Centers for Medicare and Medicaid Services (CMS) announced the addition of quality information to its Web site with information for consumers about health care professionals. "Physician Compare" was created under the Affordable Care Act. For more on its content, see http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-02-21.html.

Editorial Note: See also HealthLeaders Media reporter Cheryl Clark's article about changes she would make in CMS's Hospital Compare at http://www.healthleadersmedia.com/print/QUA-299834/12-Things-Id-Change-On-Hospital-Compare.

California *Healthline* Reports Consumers Use Physician Web Sites

On February 19, 2014, California *Healthline*, the online Daily Digest of News, Policy & Opinion published by the California Healthcare Foundation, reported on several studies showing that patients consider online physician ratings to be a valuable resource. To read the article and access links to the studies, see http://www.californiahealthline.org/articles/2014/2/19/study-online-physician-ratings-valuable-to-patients.

Public Interest Groups Release Consumer Ratings of Group Practices

In January 2014 Consumer Reports, the California Healthcare Foundation and the California Healthcare Performance Information System released consumer rankings of their experiences with 170 physician group practices in California. Similar projects are underway in Massachusetts, Minnesota and Wisconsin.

California patients were asked to rank group practices (not yet individual physicians) on a graduated scale in response to nineteen questions about such variables as how well physicians explained things to patients, how courteous support personnel were, and the frequency of follow up care.

For more, see http://www.healthleadersmedia.com/print/QUA-299811/NFP-Groups-Release-CA-Patient-Experience-Rankings.

CMS Release of Medicare Payment Data Elicits Multiple Reactions

On April 9, 2014, CMS released a database showing the dollar amounts Medicare reimbursed 888,000 different practitioners (physicians and others) for clinical services, pharmaceuticals, medical devices, etc. The release was welcomed by many, including those looking for ways to curb the growth of healthcare expenditures without compromising quality of care. Others greeted hesitantly, including professional associations, some of which lamented that their members had not been given an opportunity to verify the accuracy of the data. Here are links to some of the reporting on the data release:

http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2014/Apr/April-14-2014/Release-of-Doctor-Billing-Data-May-Help-Insurers.aspx?omnicid=16

http://www.washingtonpost.com/opinions/a-needed-look-into-the-cost-of-medicare/2014/04/12/09dc3198-c1b3-11e3-bcec-b71ee10e9bc3_story.html?wpisrc=nl_headlines

http://www.propublica.org/article/beyond-ratings-more-tools-coming-to-pick-your-doctor?utm_source=et&utm_medium=email&utm_campaign=dailynewsletter

http://www.healthleadersmedia.com/print/HEP-303330/AMA-Urges-Caution-with-Medicare-Doctor-Data

http://www.medpagetoday.com/PublicHealthPolicy/Medicare/45221?isalert=1&uun=g504008d1105R5629123u&utm_source=breaking-news&utm_medium=email&utm_campaign=breaking-news&xid=NL_breakingnews_2014-04-11

Editorial Note: This database will be used by CMS to help identify waste, fraud, and abuse, but its significance is much broader. It is a huge advance in the transparency of our healthcare system that will enlighten policy makers, insurers, consumers, regulators, and others. Significantly, the data will inform efforts to change the way healthcare is paid for, and these changes will reverberate and impact education, continuing professional development, scope of practice and other aspects of care delivery that regulators deal with. It will take time before researchers, investigative reporters, and others can digest the data and understand its strengths and limitations, but meanwhile, we applaud the government for making it public.

QUALITY OF CARE

Medical Board of California Takes Proactive Approach to Public Health

The message from Dr. Sharon Levine, Board President, in the Medical Board of California's Fall 2013 newsletter, commends State Senator Roderick Wright for sponsoring legislation instructing the medical board to begin "the conversation within the profession about the role of lifestyle choices on our individual and collective health." In fulfilling this assignment, the board will be "incorporating into specialty-relevant Continuing Medical Education, medical education, and residency training the best available science about the role of diet, exposure to environmental toxins, and a sedentary lifestyle in causing and exacerbating illness…"

See the entire message at http://www.mbc.ca.gov/publications/newsletters/newsletter_2013_11.pdf.

MEMBERSHIP INFORMATION

CAC is a not-for-profit, 501(c)(3) tax-exempt service organization founded to support 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, **CAC** has decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our services.

We provide the following services to member boards:

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:

CAC

1400 16th Street NW ● Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 ● FAX: (202) 354-5372

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City:	State:	Zip:
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Purchase Order Number:

or

4) Provide the following information to pay by credit card:

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Expiration date and security code:	
Billing Address:	

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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 <u>all</u> of your board members and <u>all</u> of your staff, as well as many other benefits. But if you decide <u>not</u> to join CAC, we encourage you to subscribe to CAC News & Views by completing this form and mailing or faxing it to us.

NEWSLETTER SUBSCRIPTION FORM

Downloaded from our website: **Calendar year 2014 and back-issues for $240.00.**

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Credit card number:	
Expiration date and security code:	
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Signature Date

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