News & Views

Citizen Advocacy Center

Second Quarter, 2014 - A Health Care Public Policy Forum - Volume 26 Number 2

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/citizen_advocacy_center_2014_annual_meeting*

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 23 and 24 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 25 of this newsletter.*

SCOPE OF PRACTICE

Government Accountability Office Reviews CMS Payment Policy for Nurse Anesthetists

The GAO released a study on March 10, 2014, of the implementation of CMS' payment policy for chronic pain procedures. The study found that:

> From 2009 through 2012, certified registered nurse anesthetists (CRNA) – a type of advanced-practice nurse specializing in anesthesia care – billed Medicare fee-for-service (FFS) for a minimal share of selected chronic pain procedures, less than ½ of 1 percent of these procedures in each year. Physicians without board certification in pain medicine billed for the majority of selected procedures each year, while pain

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physicians consistently billed for roughly 40 percent of selected procedures. Furthermore, although the number of chronic pain procedures billed by all rural providers increased from 2009 through 2012, the number of procedures billed by rural CRNAs declined over the period. Of all CRNA claims for selected procedures, the share billed by CRNAs in rural areas fell from 66 percent in 2009 to 39 percent in 2012.

The GAO recommends that "In order to ensure consistent implementation of CRNA payment policy, the Administrator of CMS should provide specific instructions to MACs on how to determine coverage with reference to a state's scope of practice laws, including instructions on how to proceed if the state scope of practice laws are not explicit."

For more, see: http://www.gao.gov/products/GAO-14-153.

Kansas Considers Expanded Nurse Practitioner Scope

Legislation under consideration in the Kansas House and Senate would permit nurse practitioners to perform more services without direct supervision by a physician. It would allow APRNs who have had 2,000 hours of supervision, and who carry malpractice insurance, to prescribe drugs independently, to execute a healthcare plan for patients, to provide counseling, and to lead a healthcare team. Eliminating supervision requirements is expected to help alleviate the shortage of primary care providers in the state.

See the legislation at:
http://www.kslegislature.org/li/b2013_14/measures/documents/sb326_00_0000.pdf.

Connecticut Expands APRN Scope

The Connecticut legislature passed a law that expands independent APRN practice. Under the law, APRNs would need a collaborative practice agreement with a physician for three years, after which they could practice independently.

For more, see: http://articles.courant.com/2014-04-28/health/hc-aprn-bill-20140428_1_aprns-practice-registered-nurses-health-care-system.

New York State Gives Nurse Practitioners More Independence

The Nurse Practitioners Modernization Act relieves nurse practitioners of the requirement that they have a written practice agreement with a doctor as a condition of practice. The law will take effect Jan. 1, 2015.

For details, see: http://tinyurl.com/14369po.

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PAIN MANAGEMENT AND END OF LIFE CARE

More Opioid Prescribing Not Linked to Improved Pain Care

Research sponsored by the Agency for Healthcare Research and Quality (AHRQ) reveals a two-thirds increase in prescriptions of opioids for non-cancer pain between 2000 and 2010. This increase in use was not accompanied by evidence showing that opioids are more effective or safer than other pain treatments.

For more, see: http://www.ahrq.gov/news/newsletters/research-activities/14jan/0114RA4.html.

CDC Points Finger at "Problem Prescribers"

Lisa Girion and Scott Glover of the *Los Angeles Times* reported on March 3, 2014 that a study conducted by the Centers for Disease Control and Prevention (CDC) found that doctors are the primary source of prescription pain meds used by drug abusers. The reporters write that:

> The new analysis found that for chronic abusers – people who took pills at least 200 days in the last year – doctors were the single most common source named,

27.3% of the cases. Friends and family members were still an important source at 26.4%. High-risk users also bought prescription drugs from friends and relatives (23.2%) and from dealers (15.2%).

The article can be found at: http://www.latimes.com/local/la-me-rx-source-20140304,0,3275352.story#axzz2uur8Lwbi. For additional information about prescribing patterns, see: http://tinyurl.com/qa2ltr9. See also: http://tinyurl.com/pquykpb.

Pain Care Academy Issues Statement on Delayed Release Opioid

On April 8, 2014, the American Academy of Pain Management issued a statement asking the Food and Drug Administration not to rescind its approval of Extended-Release Hydrocodone (Zohydro ER). The statement said, in part:

As an organization representing healthcare providers engaged in the management of pain, the American Academy of Pain Management (the Academy) is concerned about prescription drug abuse and related overdose deaths and is engaged in substantial efforts to address this public health crisis in ways that do not adversely affect individuals affected by an even larger public health crisis – that of uncontrolled chronic pain. The Academy appreciates the concerns of advocates calling for ZohydroTM ER's removal from the marketplace, but believes that ZohydroTM ER represents a valuable tool for many people with pain, and that much of the hysteria over its abuse potential overlooks a number of key facts and risk mitigation strategies that should render it as safe as any other opioid analgesic on the market.

The full statement can be found at: http://tinyurl.com/mysmh6z.

CONTINUING PROFESSIONAL DEVELOPMENT

Physician Organizations Oppose MOC / MOL Requirements

The American Medical Association (AMA) House of Delegates voted to oppose mandatory maintenance of certification (MOC) as a condition of relicensure and to continue to study MOC and maintenance of licensure (MOL) requirements, including their impact on physician practice.

Meanwhile, speaking for his organization, American College of Physicians president, David Fleming said the new MOC requirements "are not evidence-based, but are expensive, burdensome, and detract from the care of the patient." As many as 10,000 College members have signed a petition in favor of modifying what they consider to be onerous requirements.

For more, see: http://tinyurl.com/lesz44p and http://tinyurl.com/mrldarq.

TELEHEALTH

Federation of State Medical Boards Adopts Telehealth Policy

On April 26, 2001, the Federation of State Medical Boards (FSMB) adopted a Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine. Under the policy, caregivers must establish a "credible patient-physician relationship," including proper evaluation, patient privacy, informed consent, safe prescribing and other principles of safe medical practice. It includes the controversial requirement that doctors be licensed in the same state where the patient is located.

In June 2014, the American Medical Association adopted a similar policy statement about telehealth. The policy advocates pilot projects to validate the safety of telehealth practices.

Telehealth professional associations and some consumer advocates are not pleased with the policy.

For more, see: http://www.fiercehealthit.com/story/not-all-happy-telemedicine-model-policy-adopted/2014-04-29, http://www.fiercehealthit.com/story/ama-telemedicine-policy-emphasizes-state-licensure-person-visits/2014-06-12?utm_medium=nl&utm_source=internal, http://tinyurl.com/oqeskke, and http://tinyurl.com/p4p5uj6.

For an initiative to facilitate interstate licensure for telehealth see http://tinyurl.com/mapuj26.

Florida Legislature Tackles Telehealth Reimbursement

Reporters Jason Wilson and Janet Cruz write in the April 28, 2014, edition of the *Tampa Tribune* that Florida's legislature is considering licensure or certification by the board of medicine for telemedicine providers in the state. It is also aware of the need for third-party reimbursement for telehealth services on a par with in-person visits. The state medical association supports telemedicine, with appropriate accountability.

For more, see: http://tbo.com/list/news-opinion-commentary/telemedicine-puts-florida-out-in-front-of-patient-care-20140428/.

Tennessee Medical Board Debates "In-Person" Rules for Telehealth

The Tennessee Board of Medical Examiners held a hearing in May on its proposed regulation that would require that the first and fourth encounter with a patient take place in person. Rural health care providers and representatives of two major insurance companies argued in opposition to the proposal.

For details, see: http://nashvillepost.com/news/2014/5/20/tn_board_of_medical_examiners_faces_opposition_to_telemedicine_regulation.

HORROR STORY OF THE QUARTER

Doctor Sells Pain Pills at Fast Food Restaurants

In April 2014, Dr. Toni Daniels was indicted for several counts of conspiracy, distribution of controlled substances, and failure to pay taxes. She was charged with selling prescriptions for controlled substances without confirming that the individuals needed the painkillers. The sales took place at Burger King, Home of Chicken and waffles, Starbucks, Whole Foods, among other food purveyors. One report said Medical (California's Medicaid provider) paid $64,000 in false claims for the drugs.

http://blog.sfgate.com/crime/2014/04/11/berkeley-doctor-who-met-clients-at-starbucks-indicted/, and
http://www.justice.gov/usao/can/news/2014/2014_04_11_daniels.indicted.press.html.

ETHICS

Doctor Fined for Wrongful Conduct While on Medical Board

Ohio's Inspector General recommended that the state medical board develop policies specifying when per diem payments are appropriate. The recommendation came after the IG's office found that Dr. Lance Talmage, a physician member of the medical board, erred when he billed the board for time when he was also receiving money from the Federation of State Medical Boards (FSMB). Dr. Talmage ceased billing the board for per diem when he became chair of FSMB. He recently resigned from the Ohio board after serving 15 years.

For more, see: http://www.toledoblade.com/Medical/2014/05/22/Toledo-doctor-found-wrong-in-billing-state-medical-board.html.

PUBLIC MEMBER

Public Member Featured in Board Newsletter

The District of Columbia Board of Medicine Winter/Spring 2014 newsletter featured an interview with the board's public member, Terrence D. Straub.

Asked what perspective he brings to the board, Straub responded:

> I think health care delivery today is at a critical moment in our country, and in our history. It is becoming ever more sophisticated and technological and available, and as a consumer of medical services; like any other citizen, I am concerned about the quality of the care that is delivered. From a policy point of view, it has always been important to me.

Asked what board-related issues interest him most, he replied:

> Malpractice; the kind of doctors in the medical profession that may be potentially harming people when they are supposed to be healing them.

Asked what he would tell someone thinking of applying to serve on a board, Straub answered:

> It is a very rewarding and a worthwhile endeavor, supporting the mission of the board to protect the public.

Asked what message he would convey to licensees, he said:

> Hopefully, they are aware – should be aware – that the board is very active, and very vigilant, and makes every attempt to respond to complaints about medical practice in a timely and aggressive fashion.

For the entire interview, see page 8:
http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/BOM%20May%202014.pdf.

CONSUMER INFORMATION

Medicare Releases More Information About Participating Docs

In April 2014, the Centers for Medicare and Medicaid Services (CMS) posted on its website detailed information showing how many visits and procedures individual health professionals billed for and how much they were reimbursed in 2012. Under the Affordable Care Act (ACA), CMS will also release information about payments to doctors by pharmaceutical and medical device companies.

Consumers can use this information to ask questions of their caregivers, but should be cautious about jumping to conclusions. As Charles Ornstein of ProPublica comments, "There's a big difference between, say, a hospice doctor giving almost every patient a narcotic and a podiatrist doing the same thing."

This government release of information supplements numerous other Websites, include licensing board sites, most of which reveal information about doctor discipline.

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

http://tinyurl.com/n3ls6mb, http://www.healthleadersmedia.com/print/HEP-303330/AMA-Urges-Caution-with-Medicare-Doctor-Data, http://tinyurl.com/lmalrpk, http://tinyurl.com/n3mmzce, and http://tinyurl.com/nds2yon.

FSMB Publishes "Trends and Actions" Report

The Federation of State Medical Boards has published a meaty report entitled, "U.S. Medical Regulatory Trends and Actions Report." The first section covers 'State Medical Boards and Public Protection." It explains medical board structure and functions, describes "unprofessional conduct," and board information sharing.

It has several sections related to consumers including How State Medical Boards Serve the Public, The Consumer's Role, How to Check a Physician's Qualifications, How and When to File a Complaint, and How the Complaint Process Works.

Later sections of the report cover medical licensure and discipline information and contain tables of state medical board data.

See the report at: http://library.fsmb.org/pdf/us_medical_regulatory_trends_actions.pdf.

QUALITY OF CARE

CMS Revamps Quality Improvement Organization Program

In May 2014, the Centers for Medicare and Medicaid Services (CMS) announced major changes in its program for monitoring the quality of healthcare services for beneficiaries. Quality improvement activities will continue performed by Quality Improvement Organizations (QIO) belonging to the American Health Quality Association in collaboration with providers. Case review and monitoring will be performed by two contractors, rather than by the state-based QIOs.

For details, see: http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2014/may/may-12-2014/cms-adjusts-quality-improvement-organization-program.

MEDICAL MARIJUANA

Medical Board to Discipline Docs for Unjustified Marijuana Scrips

The California legislature is close to approval of new regulations governing medical marijuana, with enforcement authority residing in the Alcoholic Beverage Control Board. The medical board will be instructed to discipline doctors who recommend medical marijuana without adequate cause.

For more, see: http://www.huffingtonpost.com/2014/05/24/california-medical-marijuana-rules_n_5385902.html.

IN THE COURTS

NFL Players Sue Over Rampant Use of Prescription Painkillers

On May 20, 2014, a group of former football players filed suit alleging that the NFL routinely and illegally dispensed painkillers to keep them playing. The lawsuit seeks

financial damages and an injunction creating an NFL-funded testing and monitoring program to help prevent addiction, injuries and disabilities related to the use of painkillers.

For more, see: http://www.latimes.com/sports/nfl/la-sp-nfl-drugs-farmer-20140521-story.html.

CHEMICALLY DEPENDENT PRACTITIONERS

USAToday Publicizes Problem of Chemical Dependency

On April 17, 2014, *USAToday* posted a multi-media report on the incidence of chemical dependency among healthcare workers. Staff writer, Peter Eisler interviewed several caregivers about their chemical dependency and the danger it presented to patients.

He characterizes drug use by healthcare professionals "a pervasive problem, easily hidden, and poorly policed."

He interviewed law enforcement officials and checked healthcare professional board actions related to chemical dependency. He describes the experience in California, where the medical board abandoned its program for chemical dependency.

See the article at: http://www.usatoday.com/story/news/nation/2014/04/15/doctors-addicted-drugs-health-care-diversion/7588401/.

DISCIPLINE

Michigan Eliminates Board Chairs' Power to Curb Investigations

Michigan's governor signed new laws that prevent the chairs of the state's health professional licensing boards from unilaterally ending investigations. In the future, at least three board members must approve such a decision. The legislation gives the Department of Licensing and Regulatory Affairs authority to overrule disciplinary committee decisions.

For specifics, see: http://www.crainsdetroit.com/article/20140420/NEWS/304209978/new-state-rules-seek-to-tighten-doctor-discipline.

REGULATORY REFORM

Georgia Study Committee Recommends Regulatory Changes

A legislative study committee in Georgia issued a report in December 2013 recommending multiple changes in the operations of the state's professional licensing boards. The committee was charged with conducting what amounted to a "sunset review" of the Professional Licensing Board (PLB) Division.

Many of the committee's recommendations strive for efficiencies; others propose structural changes. For example, the committee recommends that:

- Boards should allow PLB Division Staff to handle minor investigations
- Boards should be required to maintain a Website
- Boards should consider meeting by videoconference
- PLB administrators should pursue all national organization testing/certification options and partnerships to minimize the need for state sponsored activities
- The Secretary of State should consider combining some boards
- Some boards should consider longer renewal periods

See the entire report here:
http://www.house.ga.gov/Documents/CommitteeDocuments/2013/ProfessionalLicensing_SC/HR549_FinalReport_2013.pdf.

LICENSURE

Physical Therapy Boards Consider Interstate Licensure Compact

In May 2014, the Federation of State Boards of Physical Therapy announced a decision to consider an interstate licensure compact. A task force has been working to develop a plan to proceed. It met in April and will reconvene in July 2014.

For more, see:
http://clients.cisend.com/vm.cfm?i=fa1267073d727766&jid=be83f2541e2ad1ed.

IN DEPTH FEATURE

Remarks at Connecticut Hospital Association 2014 Patient Safety Summit – Delivered by Rebecca LeBuhn, Board Chair, Citizen Advocacy Center

A Patient Perspective

The Citizen Advocacy Center, of which I am a co-founder and board chair, provides research, training and networking opportunities for the many public members on regulatory and credentialing boards, and for the organizations on which they serve.

CAC's Mission is to increase the accountability and effectiveness of health care regulatory, credentialing, oversight and governing boards by:

- Advocating for a significant number of public members;
- Improving the training and effectiveness of public and other board members;
- Developing and advancing positions on relevant administrative and policy issues;
- Providing training and discussion forums; and,
- Performing needed clearinghouse functions for public members and other interested parties.

Our Core Values include:

- *Collaboration* - Between consumers, health care providers, payers, regulators, and oversight organizations to support the delivery of ethical, safe, accessible quality health care; and
- *Meaningful consumer representation and participation*

Given this, I was delighted to learn that about 80% of Connecticut's hospitals have a Patient Advisory Board. I spoke last week with Shannon Grad, who staffs the advisory council at Connecticut Children's Medical Center and am impressed by the extent of family involvement in patient education and patient engagement activities, and in the top management's support for the activity. It is my personal opinion that it is good business for hospitals to involve your consumer / patient advisory committees (and, for that matter your community-based boards of directors) in instilling and enhancing a culture of patient centeredness and patient and family engagement.

I've been invited here to tell you about a personal story involving technology and error. In fact, I'm going to share several of my own and friends' experiences with the healthcare system to illustrate consumer attitudes and reactions, and to bring home the importance of patient empowerment and shared decision-making.

My Story

My story is about a costly, painful, anxiety-producing, questionably necessary chain of events following a false positive diagnostic test. You could say it is about both technical and technician error.

My sister and I have had annual mammograms from a fairly young age because of a family history of breast cancer. Several years ago, the individual who read my routine mammogram found something suspicious. Fortunately, as I have said, this turned out to be a false positive. But, of course no one knew it at the time.

Because of my family history, I agreed to take the next step recommended by my caregivers, which was a needle loc biopsy. Here's where I became a poster child for unintended consequences from diagnostic testing. The biopsy was scheduled, the OR was reserved, and I showed up at the imaging facility for the needle to be inserted to guide the surgeon to the suspicious tissue. Two technicians attempted repeatedly to insert the needle in the right location. After each try they took yet another image to see whether the needle was where they wanted it to be. All this while I was entrapped in the mammography machine compressor, counting my breaths and visualizing medieval torture chambers.

Time went by. The surgical team phoned asking where I was. The technicians inserted the needle again and took another image, which showed they still hadn't placed the needle correctly. The surgical team phoned again to say the OR reservation time was running out. The technicians took me down for surgery with a note pinned to my gown estimating for the surgeon how far off the mark the needle was so he could guess where to take tissue.

A follow up mammogram several months later showed that of course the surgeon had guessed wrong and the suspicious tissue was still there. The logic that made me agree to the biopsy in the first place hadn't changed, so I consented to go through the procedure again – so long as a more senior technician inserted the needle. The second surgery went smoothly and the biopsy was negative. The end result was a relief to me, but it was a long and expensive road to get there.

What do I take away from this experience?

It hasn't made me discontinue routine mammograms, given my family history. But I still have huge and important questions about the incident: Who was the person who read the image? Was the reading that set the sequence in motion an error in interpretation, a mistaken judgment, an excess of caution? I don't know the answer, but after the fact, I wish I'd had some guidance about what questions to ask.

> Should I have asked for still more professional opinions, or requested additional images from different perspectives?
>
> Should I have asked for – or more appropriately should I have been *offered* an ultrasound?
>
> Should I have asked to speak directly to the person who interpreted the image?
>
> Did he or she compare it to images from prior years?

What other explanations might there have been for the aberration?

Should I have asked for advice about the pros and cons of watchful waiting in my case?

When the first two technicians failed to place the needle properly, should I have refused to undergo the surgery at that time? Should I have complained to the hospital or the tech's licensing or certifying boards questioning their competence?

When I told a colleague about my experience, he recalled that about a decade ago the media reported that, nationally, as many as 50% of Pap Smears were read improperly. A creative hospital administrator in Colorado imposed a requirement that the people interpreting Pap Smears had to have their readings confirmed by a more seasoned clinician until they had read 1,000 tests. The percentage of correct readings improved as a result.

As patients we want to optimize the benefits and minimize the risks of screening tests, but experts tell me no test has 100% sensitivity and there will be variation and inconsistency between different clinicians who look at the same images or other test results.

As a society, we want to strike the right balance between using technology to advance public health and not spending precious healthcare dollars on tests or treatments that are unnecessary or of no value.

False positives and false negatives are inevitable consequences of screening and testing and hence the need for careful consideration of the harm that may occur when performing tests on healthy individuals. Should women with no family history or other risk factors be encouraged or discouraged from having mammograms? Are people like me who choose to screen because of a family history compounding their risk by repeated exposure?

The debate goes on, fueled by study results published a month ago finding that physical exams were as effective as mammograms in reducing cancer deaths among healthy middle aged women. Another study simulating the cost of various mammography screening strategies questioned whether the current approach is the best use of resources.

What should women think about mammograms? For that matter, what should men think about conflicting advice regarding PSA tests? How should coronary care patients react when their doctor recommends implanting a stent? These are the tip of the iceberg.

We've read a lot recently in the popular media about the *Choosing Wisely* campaign targeting the unsafe or unnecessary use of imaging and other medical services. Major newspapers have run articles and editorials, some frightening and some with suggestions for addressing the problems of unsafe use and overuse.

Joining the Choosing Wisely bandwagon

The American Association of Critical Care Nurses recently identified five common practices hospitals should reconsider,

The Agency for Healthcare Research and Quality finds a lack of evidence to support routine "per protocol" preoperative testing, and the US Preventative

Services Task Force reaffirmed its recommendation against carotid artery screening asymptomatic adults,

The American College of Anesthesiology Committee on Pain Medicine released a list of five areas if overuse of opioids, imaging and interventional procedures, and

Eight medical specialty societies in Canada will soon launch a "Think Twice" program modeled after Choosing Wisely.

These are just a few recent examples that show there is an effort underway to make the public aware of the importance of asking questions and exercising discretion when deciding whether to undergo a diagnostic procedure or a particular course of therapy. This opens the door even wider than before to hospitals desiring to establish a culture that helps patients and their families become better informed, fully engaged participants in decisions about their healthcare.

I want to mention some more of my own and friends' experiences to illustrate how at least some patients think about the healthcare system.

Many providers presume that patients want every available test and every possible therapy for illness or disease. This certainly isn't the case with end of life care, where public opinion polls show a strong preference for refusing heroic measures when they are unlikely to prolong a life of any reasonable quality

Also, a lot of patients suspect that the way we pay for healthcare provides incentives to overuse some technologies. More than once, I have suspected that tests or follow up tests were ordered because my insurance would cover an office visit or keep a hospital's high tech equipment occupied and paid for. For example, I was once referred for a stress test and lung CT scan despite the absence of symptoms other than slightly low oxygen saturation at night. At the time, I was playing tennis regularly at high altitude with no adverse effects, so I doubted the need for the tests, and in fact they showed no problems. Was there value in those tests? I don't think so. My feeling is that the providers involved were responding to the system's financial incentives more than my healthcare needs.

I've become more assertive about refusing tests, as I did recently when a hematologist suggested a bone marrow test to find out why I had a low white blood count. I opted instead to re-do the blood panel a few months later and those results were normal. When a recent echogram indicated moderate pulmonary hypertension, I declined more invasive follow up tests and chose instead to retake the echogram -- which was normal. The cardiologist was mystified as to why the two tests – a few months apart – revealed such divergent findings.

Two of my friends recently sought second opinions prior to knee surgery. Both carried the first doctor's x-ray to the second doctor's office only to be told that the price of admission to obtain the second opinion was to pay for another image. Was there value in these second images? Were they medically necessary, or were they perhaps a response to provider-centered rather than patient-centered financial incentives? Or, was there chauvinism at work here in the form of a belief that *our* imaging, *our* lab work, is better than anyone else's. There is probably no evidence for such an attitude and it subjects patients to multiple procedures, and perhaps harm. My friends weren't given any information to explain or justify the reasons for the additional images.

The ACA will alter reimbursement incentives, hopefully in ways that reward prudent choices involving minimal risk of patient harm, consistent with high quality results. We can expect patients to be asked to consider cost as one variable affecting their healthcare decisions. This means providers will need to be more transparent about costs. And, significantly, hospitals and other institutions will have to get a handle on what their *actual* costs are.

In addition to providing resources to public members, I've been a public member myself in several settings, most recently with the American Board of Radiology Foundation, which is facilitating the development and implementation of a National Strategy for Safe, Appropriate, Patient-Centered Imaging.

The ABRF's mission is to demonstrate and enhance accountability to the public in the use of radiation for medical imaging and treatment. Committed entirely to serving the public good, and without any other specific constituency, the ABRF has brought together leaders in the field of medical imaging and other stakeholder groups, including providers, delivery systems, payers, manufacturers, regulators, and the public to identify what is being done and what still needs to be done to optimize the use of imaging in the best interests of the public. Key themes of this initiative are quality, safety, value (affordability/cost), patient engagement, and appropriate use. The National Strategy is an evolving document, which I recommend you take a look at www.abrf.org.

Today, I want to point out a couple of aspects of the strategy:

In connection with patient engagement and shared decision-making, here is one workgroup's definition of an "empowered patient:"

> A patient whose opinion and input is respected, who possesses complete information about the risks and benefits of their various diagnostic and treatment options (including doing nothing), participates meaningfully in collaborative decisions about these options, is satisfied with his/her encounter with the healthcare delivery system, has all of their questions and concerns listened to and addressed, and has no barriers to obtaining his or her records.

Strategy elements related to this definition might be to encourage hospitals and other provider institutions

> to foster better communication between radiologists and ordering physicians,
>
> to involve radiologists in shared decision-making conversations with patients, and
>
> to let radiologists explain imaging results to patients.

These same institutions are also encouraged to buy into the recommendations of Image Gently and Image Wisely.

Another National Strategy workgroup recommends that the patient centeredness goal would be advanced if essential elements of the National Strategy were embedded in certification and accreditation standards and if the public, referring providers, and payers were motivated to seek services only from providers and facilities that conform to these standards. (I am told that the Joint Commission is emphasizing radiation safety and may become an important change agent.) This same ABRF workgroup recommends that aggregate public reporting of facility safety records and histories of adverse events would

help referring providers, payers, and patients select among facilities and enable those facilities to compare their performance to others as an incentive to improve.

From a consumer point of view, it makes a lot of sense for the radiology profession to do what it can to educate referring physicians. Research reported in the *Journal of the American College of Cardiology* found that this kind of education works. Physicians engaged in a 2-year continuing quality improvement program reduced inappropriate orders for coronary CT angiography by 60.2% and increased the number of appropriate scans by 23.4%. (Source: "Impact of a Continuous Quality Improvement Initiative on Appropriate Use of Coronary Computed Tomography Angiography: Results from a Multicenter Statewide Registry, the Advanced Cardiovascular Imaging Consortium," Online Journal of the American College of Cardiology, August, 2012.)

Also, there is growing evidence that practitioners learn from and adapt their behavior in response to data comparing the appropriateness of their choices and performance to those of others in their specialty.

One promising effort to implement the National Strategy is the 100K Children campaign that hopes to publicly document 100,000 good decisions about imaging children by June 30, 2015. 100K Children endeavors to teach parents the questions to ask and to equip healthcare professionals to make safer, more appropriate children's imaging decisions. For example:

> Careful observation is just as effective as a CT scan for detecting serious injuries.
>
> There is no need to routinely order CT scans both before and after injecting a dye.
>
> Child-sized scanner settings don't expose children to unnecessarily high adult radiation doses.

More on the subject of patient engagement and shared decision-making

I can't overemphasize importance of public education and helping patients and their families become better-informed participants in making decisions about our own or a family member's care.

Basic information about pros and cons of various technologies should be widely available to teach the public to be discriminating when they are confronted with a decision about a medical intervention. It is not easy to "educate" the public that harms may outweigh benefits and they need to think about tradeoffs. We have not been very successful in dealing with patient demand for antibiotics, or imaging, or other interventions when they are not medically indicated.

But the rewards that flow from a knowledgeable and engaged population can be great. Consider just these recent headlines:

> "Study Highlights Important Role That Patients Play in Determining Outcomes,"
>
> "New Rule Allows Patients To Get Test Results Directly From Labs, Without Doctor's Clearance,"
>
> "Patient Portals Increase Access and Reduce Misinformation,"
>
> "Patient Education Factors Into Decline of MRI Utilization,"

"Auto TXTing May Boost Diabetes Self-Care,"

"Health Literacy: A Prescription to End Confusion,"

"Once They Start Sharing Notes With Patients, Docs Don't Want to Stop."

In addition to general background information and healthcare literacy, patients also need decision aids at the time they are being referred for diagnostic testing or have a choice to make about treatment. A doctor friend of mine thinks patients need a script or checklist consisting of the 10 or 12 most important questions to ask – presented in the form of a decision tree that includes follow up questions.

This script should be available at a time and place when it is going to be most useful. That would be in advance for people who like to do research before meeting with a doctor and also at places where decisions are made and care is delivered -- doctors' offices, hospitals, and imaging centers.

The decision aids created by the Informed Medical Decisions Foundation are a good starting point. (See http://www.informedmedicaldecisions.org/shared-decision-making-in-practice/decision-aids/).

A script, or checklist, would not only inform, but could also empower patients. Researchers have found that a majority of patients prefer shared decision-making, where they and their physicians contribute equally. But, fewer than ¼ of those surveyed, thought disagreeing with a physician was socially acceptable or would lead to a good outcome.

Researchers recently surveyed 1340 online patients about the decision making model they prefer in situations where there are multiple options, but no single correct choice. Seventy percent prefer shared decision-making where patients and physicians contribute equally. But, only 14% and 15.2% respectively thought disagreeing with a physician was socially acceptable or would lead to good outcomes. (Source: Dr. Jared R. Adams of the Palo Alto Medical Foundation Research Institute, "Communicating with Physicians About Medical Decisions: A reluctance to Disagree," Online Archives of Internal Medicine, July 9, 2012.)

Remember, I doubted the necessity of the stress test and lung scan, but didn't decline them. My friends whose providers insisted on performing duplicate x-rays doubted their necessity but went along with the program in order to get a second opinion.

So, patients need their clinicians to be trained and willing to engage in shared decision-making and to be respectful of the patient's choices. It needn't always be a specialist; it could be a qualified nurse or technician who walks through alternative options. They have to be willing to commit the time to do it right.

I personally think that shared decision-making should be part of the curriculum at every school that educates healthcare professionals and it should be a continuing education offering for physicians, nurses, pharmacists, technicians, and others who interact directly with patients. Possessing the skills and actually engaging with patients should be a required part of demonstrating continuing competence in order to maintain a license or certification.

Patients also need help digesting the information gleaned from an image or other test. It's one thing when a diagnosis is clear, but what about ambiguous readings and conflicting advice.

What is a patient to do if a second opinion is directly contrary to the first? I think of a friend who underwent treatment for kidney stones and asked two clinicians whether continuing his calcium pill regimen prescribed to improve bone density would increase the chances of a recurrence of kidney stones. One doctor said, absolutely continue to take your calcium pills and the other said absolutely don't.

Conclusion

What are the "take aways" from these patient experiences?

> Shared decision-making is desirable, but the decisions aren't always easy.
>
> Healthcare experts, educators, and the media need to cultivate a substantial level of baseline consumer awareness about the importance of patient engagement and about the evolving science that influences our healthcare choices.
>
> And, then, when patients are confronted with making decisions about their care, providers need to supply enough pertinent information to help patients reach conclusions – sometimes reconciling second or third opinions – and they need to respect what the patient decides.
>
> Hospitals should nourish a culture of safety, patient engagement, and shared decision-making, guided by the Choosing Wisely frame of mind and respecting the adage "Do as much as possible *for* the patient and as little as possible *to* the patient."
>
> When providers oversell diagnostic testing and technology it can undermine patient trust, which is essential to shared decision-making.

On the topic of patient oriented cultures, I want to congratulate the CT Hospital Association for convening this annual Patient Safety Summit. (the twelfth, I believe) I have another suggestion for you: Why not invite your member hospitals to submit stories on an annual or biennial basis about the ways in which they have achieved a culture of safety and patient centeredness. You could publish these stories and give awards for the best and most impactful initiatives. And these award-winners could be chosen not by the association but by a citizen jury. CAC has had experience with citizen juries and can attest that their selections are taken with special seriousness.

I will close by reading from an op-ed piece entitled "Why I Never Got a Mammogram," which appeared on Valentine's Day 2014 in the New York Times. In it Marie Myung-Ok Lee writes:

> Patients want reassurances. We feel we have to test, so we can find out if we're sick. We rarely consider that the test itself might make us sick – perhaps through repeated exposure to radiation – or that there are health advantages for the non-tester like me, who gains time, sheds stress and potentially dodges the harm of a false positive or unnecessary treatment.

This isn't the answer for everyone. But, as parents and patients, we have no choice but to try to become conversant in medicine, even if it makes some doctors bristle. Our medical experts are an invaluable resource, but in the end, it's up to each of us how we want to proceed.

Thank you for your attention.

LETTERS

Editorial Note: CAC signed on to the Consumer-Purchaser Alliance's comments on a proposed CMS rule affecting hospital Inpatient Prospective Payment System. (See excerpt below) CAC and the other signatories received the following communication anticipating more comments in coming months.

From: Emma Kopleff [mailto:ekopleff@nationalpartnership.org]

Sent: Tuesday, July 01, 2014 10:19 AM

Subject: Consumer-Purchaser Alliance comments on CMS' Hospital Quality and Payment Programs have been submitted

Dear Colleagues,

Thank you for your support in signing-on to Consumer-Purchaser Alliance's annual feedback to CMS on the Hospital Inpatient Prospective Payment System (IPPS) proposed rule. Our comments have been submitted and the final version, including signatures from fellow consumers and purchasers, is attached.

Best,

Emma Kopleff
Senior Policy Advisor, Consumer-Purchaser Alliance
National Partnership for Women and Families

Excerpt from comments to CMS:

TO: Marilyn Tavenner, Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

RE: CMS-1607-P: Proposed Changes to FY 2015 Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; and Quality Reporting Requirements for Specific Providers.

Dear Ms. Tavenner:

The undersigned organizations represent a collaboration of leading consumer, labor, and employer organizations, committed to improving 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 submit comments to CMS on the proposed changes to the FY 2015 Medicare Inpatient Prospective Payment System (IPPS) rule. The detailed comments that follow this letter pertain to the following sections of the Notice of Proposed Rule Making (NPRM):

- Non-Payment for Preventable Hospital-Acquired Conditions (HACs), Including Infections, from the Deficit Reduction Act of 2005
- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- Hospital-Acquired Conditions Reduction Program
- Hospital Inpatient Quality Reporting Program
- Electronic Health Record Incentive Program
- Long-Term Care Hospital Quality Reporting Program
- PPS-Exempt Cancer Hospital Quality Reporting Program
- Requirement for Transparency of Hospital Charges Under the Affordable Care Act

We commend CMS' leadership in its ongoing implementation and refinement of federal inpatient hospital programs that seek to achieve the goals of the National Quality Strategy through increased transparency and the promotion of a market that rewards quality over volume. In particular, we are pleased to see this proposal's emphasis on:

- Increasingly defining better, safer and more affordable care based on improved patient outcomes;
- Advancing electronic reporting systems to drive performance improvement; and
- Increasing accountability for improved maternity care.

Despite continued positive momentum, significant measure gaps remain in areas critical to consumers and purchasers - the ultimate "customers" or end-users in healthcare. We urge CMS to devote resources to measure development that can fill the most critical gaps, particularly in areas of care where patient-reported data provide insight on experience of care, outcomes and functional status. Towards that end, we are hopeful that CMS, the Office of the National Coordinator for Health Information Technology (ONC) and other federal partners will leverage the Patient Reported Outcomes Measurement Information System (PROMIS) to create patient-reported outcome measures that support patient, family and caregiver engagement. Furthermore, we hope that those devoting resources to building capacity for the collection of patient-generated data will use examples of success (e.g., Dartmouth, Geisinger, California Joint Replacement Registry, U.K.'s National

Health Service, and Sweden's Rheumatoid Arthritis Registry), to support swift adoption of best practices, such as:

- Fitting patient-reported measures into the flow of care
- Educating consumers, clinicians and support staff on the advantages of collecting patient- reported data
- Merging patient-reported measurement with data from other sources (e.g., claims, medical records, registries, etc.)
- Continuously improving patient-reported measurement systems based on users' experiences and new technology

In the meantime, we also hope that CMS will take a timely approach to implementing existing measures that address gap areas in the short-term, prioritizing those recommended within the Measure Applications Partnership's (MAP) "families of measures." We believe this work offers important guidance to CMS about which measures should be prioritized for inclusion on the list of Measures Under Consideration and immediately adopted for use across multiple programs in both the public and private sectors…

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments on the proposed changes to the IPPS rule.

Sincerely,

American Benefits Council

American Cancer Society Cancer Action Network

American Federation of Teachers

American Hospice Foundation

Business Healthcare Group

Center for Healthcare Decisions

Citizen Advocacy Center

Consumers' CHECKBOOK/Center for the Study of Services

Consumers Union

Equity Healthcare

Group Insurance Commission, Commonwealth of Massachusetts

Health Policy Corporation of Iowa

Iowa Health Buyers Alliance

Lehigh Valley Business Coalition on Healthcare

Maine Health Management Coalition

Mothers Against Medical Error

National Coalition for Cancer Survivorship

National Partnership for Women & Families

Pacific Business Group on Health

Partnership for Patient Safety

Project Patient Care

St. Louis Area Business Health Coalition The Alliance

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/citizen_advocacy_center_2014_annual_meeting*

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 23 and 24 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 25 of this newsletter.*

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

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

Payment Options:

1) Mail us a check payable to **CAC** for the appropriate amount;
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card;
3) Provide us with a purchase order number so that we can bill you;

Purchase Order Number:

or

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

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature Date

Our Federal Identification Number is 52-1856543.

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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3) Provide us with a purchase order number so that we can bill you;

Purchase Order Number:

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Signature Date

Our Federal Identification Number is 52-1856543.