News & Views

Citizen Advocacy Center

Third Quarter, 2015 – Health Care Public Policy Forum – Volume 27 Number 3

Announcements

***CAC is a membership organization** and we invite your board to join. Membership information and enrollment forms are at http://www.cacenter.org/cac/membership and on pages 21 and 22 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 23 of this newsletter.*

Our 2016 annual meeting will be held in Portland Oregon on Saturday afternoon and all day Sunday, September 17 and 18, 2016. The meeting will be co-sponsored by CLEAR, and will be devoted to regulatory issues regarding telehealth. It will take place immediately following the CLEAR meeting, which ends on noon on Saturday.

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SCOPE OF PRACTICE

Independent Practice for APRNs Promises Healthcare Cost Savings

A recent study projects that amending the physician supervision requirements for Advanced Nurse Practitioners could save Pennsylvania billions of dollars. According to a July 14, 2015, article in the *Pittsburgh Business Times*:

> Allowing advanced trained nurses to practice at the limits of their authority would generate at least $6.4 billion in health care savings for Pennsylvania over the next decade, a new study found.

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To practice in Pennsylvania, nurse practitioners must secure business contracts with two doctors. Researchers have shown that the mandate offers no patient health benefits while restricting access to care and correlating with worse patient health outcomes.

Read it at http://tinyurl.com/p4sx3wd. See also http://tinyurl.com/ofbc69s and this article about how physician assistants reduce costs and improve care at http://tinyurl.com/o6fn73r.

Expanded Scopes for Nurses Good for Value Based Care

An article in by Leslie Small in the online journal *Fierce Healthcare* summarizes financial and quality of care benefits of scope of practice changes for advanced practice nursing. She cites research published in *Healthcare Finance and Health Affairs*.

For more, see http://tinyurl.com/oo9nmwj. See also a report from the Robert Wood Johnson Foundation entitled, "The Value Proposition of Retail Clinics," at http://tinyurl.com/oztpjeo.

Illinois Considers Prescriptive Authority for APRNs

The Illinois legislature is considering a bill (HB421) that would allow Advanced Practice Registered Nurses to prescribe medications, including controlled substances, without physician involvement. The bill would eliminate the requirement for a written collaborative agreement for all advanced practice nurses and the requirement for an anesthesia plan for certified registered nurse anesthetists.

Medical societies in the state are waging write-in campaigns against the proposal.

The legislation is at http://tinyurl.com/po9684d.

Pennsylvania Considers End to Collaborative Practice Requirement

Pennsylvania House Bill 765, introduced in March 2015, would eliminate the current requirement that Nurse Practitioners have a collaborative practice agreement with a physician in order to practice. Sam Kennedy, reporter for *The Morning Call* newspaper in Allentown wrote on March 29, 2015, about the arguments for and against the legislation.

See http://tinyurl.com/q3e5z2l.

Missouri Board of Nursing Recommends Delegation Decision-Making Tree

In the February-April 2105 State Board of Nursing Newsletter, Missouri Board President Rhonda Shimmens explains the Delegation Decision-Making Tree recommended by the Board.

Delegation may be a difficult skill to develop among nurses. Although there is considerable variation in the language used to talk about delegation, the American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) both define delegation as the process for a nurse to direct another person to perform nursing tasks and activities. NCSBN describes this as the nurse transferring authority while ANA calls this a transfer of responsibility. Both mean that a registered nurse (RN) can direct another individual to perform a nursing task. Both stress that the nurse retains accountability for the delegation (Joint Statement, 2014).

The NCSBN has identified "Five Rights of Delegation." Briefly, these are:

1. Right Task: A task that is delegable for a specific patient.
2. Right Circumstances: Appropriate patient setting, available resources, and other relevant factors considered.
3. Right Person: The right person is delegating the right task to the right person to be performed on the right person.
4. Right Direction/Communication: Clear, concise description of the task, including its objective, limits, and expectations provided.
5. Right Supervision: Appropriate monitoring, evaluation, intervention as needed, and feedback.

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You can find a Delegation Decision-Making Tree as well as other resources on delegation on our web site at http://pr.mo.gov/nursing-focus.asp.

The Delegation Decision-Making Tree was a tool developed to assist nurses in making delegation decisions. Licensed nurses have ultimate accountability for the management and provision of nursing care, including all delegation decisions.

To use the Delegation Decision-Making Tree, start with a specific client, caregiver, and nursing activity. Beginning at the top of the tree, ask each question as presented in the box. If you answer "no" to the question, follow the instructions listed to the right of the box and arrow. If you answer "yes," proceed to the next box. If you answer "yes" for all questions, the task is delegable.

The grid can be used…

For nurses making delegation decisions.

For staff education regarding delegation.

For orientation of new staff, both nurse and unlicensed assistive personnel (UAP).

For nursing education programs providing basic managerial skills for students.

For nursing continuing education.

For Member Boards responding to questions about delegation. (Boards may consider including this tool as part of a delegation information packet).

For orientation of new board members and attorneys.

For Member Board workshops and presentations regarding delegation issues, and,

For evaluation of discipline complaints involving concerns regarding delegation.

The complete article and decision-making tree is at http://tinyurl.com/nc8cj87.

Maryland Authorizes Full Independent Practice for APRNs

In May 2013, Maryland became the twenty-first state to permit full practice by nurse practitioners. The legislation frees nurse practitioners from the obligation to enter into an "attestation agreement" with a physician in order to practice. The American Association of Nurse Practitioners applauded the development. See: http://tinyurl.com/oz2l39s.

California Considers Expanding Scope for Optometrists

In May 2015, the California Senate approved a bill (SB 622) that would authorize appropriately trained optometrists to perform some minor eye surgeries and administer vaccinations to adults. The bill awaits approval by the State Assembly.

For more, see: http://tinyurl.com/nl6wo4r.

California Considers Expanding Scope of Naturopathic Doctors

SB 538, sponsored by state Sen. Marty Block (D-San Diego), would authorize naturopathic doctors to order more kinds of imaging studies; perform certain operative procedures related to superficial abrasions, superficial lacerations and some superficial lesions; and prescribe, administer and order Schedule IV, Schedule V and unclassified prescription drugs without supervision.

For more, see http://tinyurl.com/oe5aq4m, and http://tinyurl.com/ola6daa. For an opposing argument, see http://tinyurl.com/pvngt85.

California Authorizes Pharmacists to Offer Some Primary Care

Legislation going into effect later this year gives California pharmacists authority to order lab tests, adjust medication regimens for patients with chronic conditions, prescribe birth control, and provide medication for smoking cessation and travel abroad.

See: http://tinyurl.com/nr2zukh. See also: http://tinyurl.com/nmgcf6b.

California Nixes Scope Expansion for Advanced Practice Nurses

On June 30, 2015, *California Healthline* reported that: "On Tuesday, the Assembly Committee on Business and Professions rejected a bill (SB 323) that aimed to allow nurse practitioners to treat patients without the supervision of a physician if certified by an authority such as a hospital, medical group, accountable care organization or clinic, the *Sacramento Bee*'s "Capitol Alert" reports

For more, see: http://tinyurl.com/p7gafbl.

Out-of-Hospital Births Said to Be Under Attack by Nursing Board

Reporter Brooke Purves reported on August 6, 2015, on newsreview.com that the California Board of Registered Nursing (BRN) has been accused by certified and licensed nurse midwives of falsely accusing them and dragging them through disciplinary proceedings because they perform out-of-hospital births. The affected caregivers also fault the board for not convening the board's Nurse-Midwifery Advisory Committee, even though midwives have been asking for guidance from the board about midwifery practice issues.

See more at http://tinyurl.com/nboyfuy.

Colorado Allows Pharmacists to Dispense Anti-Overdose Med Without Prescription

The National Association of Boards of Pharmacy reported in its July 15, 2015, *e-News* that:

> **Colorado Allows Pharmacies to Dispense Naloxone without a Prescription as Overdose Deaths Climb**
>
> Coming at a time when heroin and opioid overdoses are gripping the nation, a new Colorado law allows pharmacies to sell naloxone without a prescription. A number of states are allowing measures like Colorado's to combat increasing overdose death rates associated with prescription opioid and heroin abuse. See http://tinyurl.com/o5od6rm.
>
> NABP's AWARxE® Prescription Drug Safety Program is working to reduce opioid and heroin overdose deaths by educating the public on prescription drug abuse and misuse. The program's website offers resources such as facts on the dangers of prescription drug abuse at http://tinyurl.com/q3ex2hr, informational flyers and posters at http://tinyurl.com/psxqnor, and a Locator Tool at http://tinyurl.com/pgfc2e5 to help consumers find prescription drug disposal programs near them.

Two States Allow Pharmacists To Dispense Birth Control Without Prescription

On July 15, 2015, *Kaiser Health News* reported that California and Oregon would permit pharmacists to dispense birth control pills and other hormonal birth control without a doctor's prescription. The pharmacists must provide patients with a health screening before dispensing the medications. California's law was passed in 2013; Oregon's in 2015.

See http://tinyurl.com/puppv5s, http://tinyurl.com/o59yowa, and http://tinyurl.com/ozu3eoo.

Study Documents Scope of Nurse Anesthetists

The National Council of State Boards of Nursing carried this report in its June 19, 2015, *Good Morning Members:*

> It is often noted that Certified Nurse Anesthetists (CRNAs) are not allowed to practice to the full extent of their training and scope of practice. To address the lack of quantitative scope of practice information among CRNAs in the literature, study researchers investigated the impact of location and the absence of physician supervision on scope of practice. Surveys were mailed to a national sample of 1,202 actively practicing CRNAs who were members of the American Association of Nurse Anesthetists.
>
> The researchers found that CRNAs practicing in rural locations exhibit broader scope of practice to meet the needs in their communities, while those practicing in a hospital or surgery center reported greater restrictions on practice. Additionally, researchers found that those in states opting out of physician supervision had higher scope of practice scores, and CRNAs who had a change in practice after their state implemented opt-out legislation had the highest scope of practice scores of all groups.
>
> The Centers for Medicare and Medicaid Services offer an "opt out" of physician supervision of CRNAs option with 17 states currently participating, which allows full reimbursement from Medicare. This opt-out has enabled hospitals to recruit CRNAs and allowed CRNAs to work according to their full scope of practice.
>
> According to study researchers, this study highlights that CRNAs in opt-out states are experiencing changes in their practice as a result of policy modifications, leading to a broader scope of practice. Researchers note the changing practice patterns uncovered are not limited to the anesthesia specialty and they encourage further study among other advanced practice registered nurse (APRN) specialties to identify the impact of location of practice and ongoing legislative changes.

FDA Approves Device Enabling Non-Anesthesiologists to Sedate

On September 30, 2015, FDA approved a medical device that will enable properly trained non-anesthesia professionals to administer Propofol during colonoscopy and gastroenterology procedures provided an anesthesia professional is readily available.

See more: http://tinyurl.com/py9yzqp.

LICENSURE

White House Issues Report on Occupational Licensing

In July 2015, the White House issued a document entitled, *Occupational Licensing: A Framework for Policymakers*. Prepared by the Department of Treasury Office of Economic Policy, the Council of Economic Advisors, and the Department of Labor, the document outlines the growth of licensing over the past several decades, its costs and benefits, and its impacts on workers and work arrangements. The report recommends several best practices to ensure that licensure protects consumers without placing unnecessary restrictions on employment, innovation, or access to important goods and services. …

Licensing best practices include:

- Limiting licensing requirements to those that address legitimate public health and safety concerns to ease the burden of licensing on workers.
- Applying the results of comprehensive cost-benefit assessments of licensing laws to reduce the number of unnecessary or overly restrictive licenses.
- Within groups of States, harmonizing regulatory requirements as much as possible, and where appropriate entering into inter-State compacts that recognize licenses from other States to increase the mobility of skilled workers.
- Allowing practitioners to offer services to the full extent of their current competency, to ensure that all qualified workers are able to offer services.

As part of their research, the report's authors consulted with several experts in the field of licensure and regulation, including David Swankin, CAC's President and CEO.

Read the White House document at http://tinyurl.com/paj5gyl, and see also http://tinyurl.com/nvq5cbt.

Paper Recommends Licensure Changes

A discussion paper entitled "Reforming Occupational Licensing Policies" written by Morris M. Kleiner of the Humphrey School of Public Affairs, University of Minnesota and published by the Hamilton Project at the Brookings Institution recommends four structural changes in the regulatory system. The paper's abstract reads:

> Occupational licensing has been among the fastest growing labor market institutions in the United States since World War II. The evidence from the economics literature suggests that licensing has had an important influence on wage determination, benefits, employment, and prices in ways that impose net costs on society with little improvement to service quality, health, and safety. To improve occupational licensing practices, I propose four specific reforms. First, state agencies would make use of cost-benefit analysis to determine whether requests for additional occupational licensing requirements are warranted. Second, the federal government would promote the determination and adoption of best-practice models through financial incentives and

better information. Third, state licensing standards would allow workers to move across state lines with a minimal cost for retraining or residency requirements. Fourth, where politically feasible, certain occupations that are licensed would be reclassified to a system of certification or no regulation. If federal, state, and local governments were to undertake these proposals, evidence suggests that employment in these regulated occupations would grow, consumer access to goods and services would expand, and prices would fall.

See the discussion paper at http://tinyurl.com/p42lf9d.

Federal Trade Commission Issues Staff Guidance on FTC *North Carolina Dental* Decision

The Bureau of Competition at the Federal Trade Commission has issued a *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants*. Released on October 14, 2015, the document "addresses two basic questions:

When does a state regulatory board require active supervision in order to invoke the state action defense?

What factors are relevant to determining whether the active supervision requirement is satisfied?"

See the FTC Press release at http://tinyurl.com/ohgo897.

Demand for Travel Nurses Grows

In May 2015, the online *MEDPAGETODAY* reported that the demand for travel nurses has reached an all-time high, in part due to the Affordable Care Act. Research has found no association between travel nurses and patient safety problems. On the contrary, using travel nurses to meet seasonal demand or address staff shortages can improve patient care.

For more, see http://tinyurl.com/o69q2sa.

Tennessee Suspends Licenses For Failure to Repay Student Loans

According to the timesFreePress.com, 270 Tennessee healthcare professionals had their licenses suspended in 2014 for defaulting on their student loans. These professionals included nurses, EMTs. Physical therapists, social workers, massage therapists, doctors, and dentists.

For more, see http://tinyurl.com/nhkfv5q.

New Model Pharmacy Board Act Available

In September 2015, the National Association of Boards of Pharmacy announced a revised Model Act:

> Updated ***Model Act*** Now Available to Assist Boards of Pharmacy in Developing Laws and Rules to Protect Public Health
>
> The recently amended *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act)* is now available to provide the state boards of pharmacy with model language that may be used for developing state laws or board rules in their efforts to protect public health. The *Model Act* was revised to add a section on interoperability between state prescription monitoring programs (PMPs) and to include language that notes the board of pharmacy should be responsible for overseeing PMPs and establishing PMP policies to ensure the most effective and appropriate use of PMP information. In addition, the *Model Act* was updated to include a revised definition of medication synchronization that aims to recognize the authority of pharmacists to provide better patient-centered care through the implementation of medication synchronization programs. Further, a new security section was added to include information about facility security measures to ward against robberies/burglaries as well as internal security measures that protect drug inventory. A facility requirement for a veterinary drug therapy reference for pharmacies that engage in veterinary drug dispensing was also added. The *Model Act* was also amended to require that all pharmacy technicians be certified. Lastly, the *Model Act* was updated to provide licensure exemption for manufacturers that dispense dialysate, drugs, and devices to home dialysis patients.
>
> The changes to the *Model Act* were incorporated as a result of the NABP Executive Committee-approved recommendations made by the Task Force on Standards for the Use of PMP Data, the Task Force on Medication Synchronization, the Task Force to Examine Strategies for Preventing and Reacting to Pharmacy Robberies and Thefts, a resolution adopted at the NABP 110th Annual Meeting, and the recommendations of the 2014-2015 Committee on Law Enforcement/Legislation. The Model Act is available for download from the Members section of the NABP website. See http://tinyurl.com/p8n5ny4. A full summary of the *Model Act* changes can be found in the September 2015 issue of the NABP Newsletter (PDF, pages 157-158 and 162). http://tinyurl.com/pmlntxy.

Massachusetts Board Disciplines Nurses for Licensure Fraud

On September 13, 2015, reporters Kay Lazar and Felice J. Freyer revealed in the *Boston Globe* that the Massachusetts Board of Registration in Nursing had disciplined 13 nurses for misrepresenting their qualifications for licensure. Lazar and Freyer write that the situation raises concerns about the thoroughness of Professional Credentials Services of Nashville, the company retained by the board to conduct background checks.

Several instances of fraudulent credentials were discovered through the *Nursys* database maintained by the National Council of State Boards of Nursing. Other instances slipped through the cracks when nurses claimed to hold valid licenses from states that do not fully cooperate with *Nursys*.

Read the article at http://tinyurl.com/ojdjqfl.

Technology Enables DORA to Reduce Licensure Fees

Lauren Larson, director of Colorado's Department of Regulatory Affairs (DORA), had a 250,000 surplus at the end of FY 2014-15, leading it to drop some licensure fees. For example, it will reduce the price of licensure renewal for chiropractors, nurses, and psychologists.

See more at http://tinyurl.com/p3v68t3.

Australian Health Practitioner Regulatory Agency Releases Report

In July 2015, the Australian Health Practitioner Regulatory Agency released a report about its activities during the past five years:

> On 1 July 2015, we marked five years of the National Scheme (WA will mark this milestone on 18 October). Over the past five years, the National Boards and AHPRA have worked in partnership to implement the National Scheme to improve our regulatory effectiveness and efficiency and build our knowledge of the common regulatory challenges for all registered professions. We are continuing to implement our **Regulatory principles** to guide our decision-making, with a strong focus on responding in ways that are proportionate and effectively manage risk to the public.

State licensing boards may find some inspiration in regulatory standards and processes from other countries.

Read the full report at http://tinyurl.com/pt56umk.

PAIN MANAGEMENT AND END OF LIFE CARE

States Consider Right to Die Laws

Since January 2014, thirty-six states have considered and fourteen legislatures have passed "right to die" legislation. Eight of those laws have received gubernatorial approval. Most of the laws are based on a model that guarantees terminally ill patients a right to try experimental drugs. But the FDA controls access to these drugs, and physicians have discretion over whether to prescribe them.

For more see http://tinyurl.com/nubcg7m and http://tinyurl.com/pa7wn5j.

California Adopts End of Life Legislation

On October 5, 2015, Governor Jerry Brown signed an End of Life Options Act, the most recent iteration of legislation that failed to pass in the state during four attempts dating back to 1992. A former seminarian, Governor Brown signed the legislation after weighing religious and ethical arguments. He was persuaded, he said, when he realized that he would be comforted to have such an option if he, himself, were facing a painful terminal illness.

The Legislative Counsel's Digest explains that:

> Existing law authorizes an adult to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.
>
> This bill would enact the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, to make a request for a drug prescribed pursuant to these provisions for the purpose of ending his or her life. The bill would establish the procedures for making these requests. The bill would also establish the forms to request an aid-in-dying drug and, under specified circumstances, an interpreter declaration to be signed subject to penalty of perjury, thereby *creating* a crime and *imposing* state-mandated local program. This bill would require specified information to be documented in the individual's medical record, including, among other things, all oral and written requests for an aid-in-dying drug.

More information is available at http://tinyurl.com/na8ltb3, http://tinyurl.com/pqucz7j, and http://tinyurl.com/ow7rx5a.

The organization Compassion in Choices applauded the Senate's action. See http://tinyurl.com/ngs699u. And for information about underground physician-assisted death with dignity in California, see http://tinyurl.com/njk8kuy.

New Jersey Considers Bill To Promote Palliative Care

Legislation under consideration in New Jersey (A-39111/S-2931) would require healthcare professionals to make patients and family members aware of palliative care options, when appropriate. The objective is to build awareness and demand for palliative care, which treats symptoms, but does not attempt to cure underlying causes. The bill would create a Palliative Care and Hospice Care Advisory Council, which would work with the Rutgers Cancer Institute of New Jersey to develop information for hospitals to give to patients.

For more, see: http://tinyurl.com/otua9md.

CONSUMER INFORMATION

Consumers Union Petitions Medical Board to Require Doctors on Probation to Notify Their Patients

On October 8, 2015, Consumers Union, the policy and advocacy division of Consumer Reports, filed an administrative petition with the Medical Board of California urging it to require doctors who are on probation to notify their patients. Nearly 500 doctors in the state are on probation, but they are not required to disclose that information to the patients they treat. "Californians deserve the right to know whether their doctor is on probation for serious misconduct that could jeopardize their health," said Lisa McGiffert, manager of Consumers Union's Safe Patient Project. "But right now, most patients have no idea when their doctor has been disciplined and put on probation by the Medical Board."

See CU's press release at http://tinyurl.com/q37t53w, and see also http://tinyurl.com/q9ndflu.

Federation of State Medical Boards Launches "docinfo" Web Site

August 19, 2015, the Federation of State Medical Boards (FSMB) announced today that it has launched a free online resource to provide consumers with important background information on the more than 900,000 actively licensed physicians in the United States, including whether or not a physician has been disciplined by a state medical board.

See the press release announcing www.docinfo.org at http://tinyurl.com/of7boox.

Advocacy Group Issues Guide to Quality Long Term Care

The National Consumer Voice for Quality Long-Term Care has issued a fact sheet to help consumers distinguish good quality care in long-term care facilities.

The document is available at http://tinyurl.com/q7ujqtg.

QUALITY OF CARE

California Outpatient Surgery Law Gets Mixed Reviews

CaliforniaHealthline, a publication of the California HealthCare Foundation, reported on September 21, 2015, that new legislation affecting outpatient surgery centers. The Foundation sought the opinions of interested stakeholders who generally feel that the law does not go far enough.

Read more about it at http://tinyurl.com/ntpqspd.

CONTINUING PROFESSIONAL DEVELOPMENT

England Postpones New Revalidation System for Nurses

The National Council of State Boards of Nursing reported on May 29, 2015, in its *Good Morning Members* blog that:

The implementation of a new system of nurse competency checks, known as revalidation, may be delayed in England due to the size and complexity of the country. According to NMC chief executive and registrar Jackie Smith, an update will be provided in July by each U.K. country on the progress of being able to introduce the new system of competency checks. The launch date for the new system of competency checks has already been pushed back by three months to April 2016.

The revalidation system of nurse competency checks will replace the current system of PREP (post-registration education and practice). It introduces additional standards for revalidation of state registrants, which include: 1) obtaining feedback on the registrant's nursing practice; 2) the registrant recording a minimum of five written reflections on the code of conduct, on registrants' continuing professional development and on the registrant's practice related feedback; 3) completing 40 hours of continuing professional development (increased from 35 to 40 hours); and 4) obtaining third-party confirmation that the registrant has met all revalidation standards.

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

AMA Delegates Urge Modifications of MoC Requirements

At their June meeting, American Medical Association delegates asked for changes in the American Board of Medical Specialties' Maintenance of Certification requirements. They asked for more transparency about what is required and how much maintaining certification will cost individual practitioners. They also asked ABMS to develop fiduciary standards for its member boards.

For more, see http://tinyurl.com/nlc296x.

TELEHEALTH

Medical Board Compact Gains Traction

At press time, 11 states have signed on to the Federation of State Medical Board's Interstate Medical Licensure Compact (licenseportability.org). The parameters of the compact were finalized in September 2014. For more, see http://tinyurl.com/nd9fccl.

In June, Humayun Chaudhry, DO, CEO of the Federation of State Medical Boards spoke about the Compact to *His Talk Practice*. Read the interview at http://tinyurl.com/pe69vjy, and see also http://tinyurl.com/o2z83wz.

Judge Blocks Texas Medical Board Rule

In June 2015, a US District Judge issued an injunction blocking enforcement of Texas Medical Board rule 190.8, which would prevent Teledoc doctors from providing telehealth services to patients with whom they have not first met in person. The battle between the medical board and Telehealth has simmered for years and will now go to court.

For more, see http://tinyurl.com/om7xjwy.

Iowa Medical Board Issues Telehealth Rule

In a press release on June 3, 2015, the Iowa Board of Medicine announced a new rule:

> Iowa Administrative Code 653—13.11 defines telemedicine, explains how a valid physician- patient relationship can be established in a telemedicine setting, and identifies technology requirements for physicians who use electronic communications, information technology or other means of interaction with patients who are not physically present. The rule requires out-of- state physicians to have a valid Iowa medical license if they diagnose and treat patients located in Iowa.
>
> The rule recognizes that telemedicine can provide important benefits for patients, including increased access to health care, expanded use of medical specialty expertise, and prompt access to medical records.

See the press release at http://tinyurl.com/ondqkzd.

Editorial Note: Also in June 2015, the Iowa Supreme Court struck down a medical board rule prohibiting doctors from prescribing abortion-inducing drugs via telemedicine. The court concluded that the medical board's rule requiring doctors physically examine patients before prescribing the medication and watch the patients take the medication did "not provide any measurable gain in patient safety." See also in this issue that a judge in Texas stopped enforcement of a similar medical board rule in that state.

See http://tinyurl.com/nz2328h.

Telehealth Credited with Lower Healthcare Costs

The combination of telehealth and higher insurance deductibles is credited with slowing healthcare spending. Interviewed on July 3, 2015, by *MedPage Today*, Kulleni Gebreyes, MD "stressed the importance of telehealth or 'virtual care' by noting that underlying the ACA's triple aim of lower costs, improved outcomes, and better patient experiences is another significant factor: access. 'Whether it's getting you the right access to care when you leave a hospital after surgery, or if you live in a rural community and you don't have specialists easily available to you ... if you really want to deliver on lower cost, high-quality better experience, virtual care is a key way to do that.'"

For more, see http://tinyurl.com/nrlqao6 and http://tinyurl.com/puppv5s.

For expert opinion on the expansion of telehealth practice, see http://tinyurl.com/npbadl2.

Consumers Lack Knowledge About Telehealth

In a post by to the July 23, 2015, *HealthData Management,* Greg Slabodkin reported that consumers show scant awareness of telehealth:

> As the healthcare industry looks to take advantage of the benefits of telehealth, providers need to do a better job educating the public about the technology. Case in point: A new survey has found that an astonishing 41 percent of consumers have never heard of telemedicine. …
>
> However, when it comes to awareness and acceptance of telemedicine, survey results indicate that age might be a factor, particularly for the younger millennials compared to Baby Boomers. While only 37 percent of consumers age 55-64 said they would use telemedicine, 58 percent of 25- to 34-year-olds said they would do so. In addition, 52 percent of 25- to 34-year-olds believe they understand when it is best to use telemedicine versus just 34 percent of 45- to 54-year-olds.
>
> Still, a separate nationwide survey of 504 U.S. adults conducted by TechnologyAdvice Research found that nearly 56 percent of consumers would be uncomfortable conducting a doctor's appointment virtually and only about 35 percent of those surveyed indicated that they would choose a virtual appointment. And approximately 75 percent of those surveyed reported they either would not trust a diagnosis made via telemedicine, or would trust this method less than an in-doctor visit.

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

DISCIPLINE

Louisiana Medical Society Tries to Weaken Medical Board

HB 843 introduced in the Louisiana legislature at the urging of the state medical society would weaken the medical board's discipline powers. Among the changes proposed in the legislation is a prohibition against investigating most anonymous complaints, a three-year statute of limitations on investigating complaints and a requirement that the board notify a licensee within five days of beginning an investigation. The first two provisions were stripped from the bill by the senate committee, which feared it would excessively weaken the board. But the five-day notification requirement was allowed to remain.

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

ETHICS

Do Patients Need to Protect Themselves from Physician Conflicts of Interest?

In *Health Affairs Blog* on April 10, 2015, James Rickert queries, "What Can Patients Do in the Face of Physician Conflicts of Interest?" This is how he describes the situation:

> But more and more, a visit to the doctor can become a business meeting, and more specifically, a sales meeting where very expensive goods and services are sold to customers. While facing this fact can be emotionally difficult for patients making potentially life changing medical decisions, it allows us to navigate more effectively in this brave new world of American medicine. If our physicians are thinking and acting more like business people, so must patients.

Read the blog at http://tinyurl.com/oahtmmd. See also this report from the Office of the Inspector General of the Department of Health and Human Services advising healthcare providers to be cautious about compensation arrangements at http://tinyurl.com/pnu2wfv.

Editorial Note: To be sure, patients are wise to be alert to potential conflicts of interest. But, don't licensing boards have a responsibility to establish patient-centered ethical guidelines related to financial gain from prescribing certain medications, ordering certain tests ,and selling or renting equipment to hospitals, and so on?

IMPAIRED PRACTITIONERS

California Adopts Regulations for Monitoring Substance Abusing Docs

The Medical Board of California, which discontinued its physician health program several years ago after several audits slammed its effectiveness, has adopted new monitoring program regulations. In a June 12, 2015, press release, the board announced:

> **Regulations Adopted to Monitor Substance-Abusing Physicians**
>
> Sacramento – Regulations take effect July 1, 2015, to implement 2008 legislation from Senate Bill (SB) 1441 (Ridley-Thomas, Chapter 548), designed to protect the public by monitoring physicians (and other healing arts professionals) impaired by drug or alcohol abuse.
>
> The regulations spell out uniform standards for dealing with substance-abusing health care professionals. The regulations detail how physicians will be monitored during probation, including the mechanics of random biological fluid testing "on any day, at any time, including weekends and holidays." The physician, if permitted to work, may be monitored in the workplace and/or required to attend support group meetings. Violation of any of the new regulations can result in permanent loss of his or her license to practice medicine. All costs associated with disciplining the substance abuser will be borne by the licensee.

> Executive Director of the Medical Board of California Kimberly Kirchmeyer says, "These new regulations will ensure consistent standards are applied to all disciplinary orders issued against substance-abusing physicians and will further the Board's mission of consumer protection," Ms. Kirchmeyer served with other executive officers from the state's healing arts boards on the Substance Abuse Coordination Committee created by the Department of Consumer Affairs as a requirement of SB 1441.
>
> "The regulations also promote rehabilitation of the licensee," Kirchmeyer said.

See http://tinyurl.com/odsmm75.

Texas Medical Board Amends Rules for Physician Health Program

On June 25, 2015, the Texas Medical Board announced a change in the Physician Health Program and Rehabilitation Orders:

> The Amendments to §180.4, concerning Operation of Program, eliminate the prohibitions on eligibility for referrals made regarding individuals that have violated the standard of care as a result of the use or abuse of drugs or alcohol, committed a boundary violation with a patient or patient's family member(s), or been convicted of, or placed on deferred adjudication community supervision or deferred disposition for a felony. Further amendments add language providing that the Medical Board may refer such individuals publicly through the entry of an order that addresses the standard of care, boundary, and/or criminal law related violations. In the event of such a referral, the Medical Board retains the authority to discipline the individuals for the standard of care, boundary, and criminal law related violations.

IN DEPTH FEATURE: "WHY ARE THESE DOCTORS SO MAD? WHAT IT MEANS FOR YOU"

Editorial Note: This Quarter's In-Depth Feature by Rosemary Gibson is re-printed with her permission from the Huffington Post Blog (Posted 4/1/15 and Updated 6/1/15. Rosemary Gibson is the author of **Wall of Silence** ***and is the 2014 recipient of the American Medical Writers Association award for her writing on health care in the public interest. She is a founding member of the Consumers Union Safe Patient Network and is senior advisor at The Hastings Center. www.rosemarygibson.org.***

A vocal group of doctors is thumping mad. Is your doctor one of them?

Here's the backstory. If you live in Colorado, Indiana, Montana, New York, or South Dakota, your doctor could be practicing for 30 years and never be required to keep up-to-date as a condition of renewing his or her medical license every few years. Just fill out a form and send a check.

It's not much better if you live elsewhere. Other states require licensed doctors to do as little as 20 hours of self-study a year.

To raise the standard in a high-stakes profession, most doctors choose to become certified by a board of their peers in their specialty, say family medicine or surgery.

Maintaining this certification requires passing a knowledge exam every 10 years and demonstrating continuous learning and improvement in the care provided to patients.

A group of doctors has circulated a petition to do away with independent examinations of doctors' medical knowledge and requirements to improve their practice, saying it is too burdensome and not relevant to what they do every day. See http://tinyurl.com/ptkjf94.

Their solution? Continuing medical education, shorthand for no independent determination of whether a physician is keeping up-to-date.

Taking a page from Hillary Clinton's "Trust me" attitude in deciding which emails should be made public from her private account while Secretary of State, the doctors' stance is a "Trust me" too.

It doesn't fly. Here's why: First, the public wants to trust their doctor but also wants independent verification that their doctor meets a higher standard: "Trust, but verify."

Second, if the certification process is not well tailored to physician practice and too costly, don't throw it out. Fix it. Make it relevant. Make it better. Test competence as well as knowledge.

Here's an example: A University of Michigan study of physicians who perform bariatric surgery were videotaped while performing surgery. (See http://tinyurl.com/l82vcyy). Their surgical skill was independently assessed by their peers who were unaware of who was performing the procedure. Not surprising, patients whose surgeons had better skills fared better. Independent assessment pinpoints where a physician's competence can be improved.

Most people probably think this type of testing is already being done. It isn't. It should be. Raise the bar. Don't lower the floor.

Third, the public expects that doctors stay abreast of emerging health threats such as antibiotic-resistant superbugs and how to diagnose and treat them.

A gentleman I know in the Washington, D.C. area who had surgery noticed that the wound had become red and swollen. His doctor did not follow the standard protocol developed by physicians that has reduced these infections. The result? Months of painful and costly treatment of an antibiotic-resistant infection.

Doctors are like the rest of us. We don't know what we don't know. Fully free choice of continuing education is not a solution.

Take patient safety. Most doctors never learned patient safety in medical school. It was never taught, although that it beginning to change. Fortunately, future doctors in training are expected to learn how to identify common medical errors and unsafe situations, and how to reduce the chance of patient harm.

Physicians in 2015 should not practice cardiology or surgery as if it were the 1990's. Nor should they practice as if it were the 1990's when it comes to safety.

A cadre of dedicated physicians have been learning and applying safety science in patient care -- on top of their heavy workloads -- with promising results.

To bring more practicing doctors up to speed, the certification process has given greater emphasis to patient safety. Remarkably, opponents of certification have characterized patient safety as “busy work” in an article in the well-known New England Journal of Medicine. See http://tinyurl.com/ptkjf94.

There is a saying among professionals who go to work every day to ensure public safety whether on airplanes, in space flight, in nuclear power plants, on America's highways or in the doctor's office or hospital: anyone who is not trained to see how mistakes can happen, nor equipped to avoid them, is the most dangerous person in the room.

The public has the biggest stake in the outcome of whether physicians should be expected to have independent assessment of their knowledge and performance in practice. We have been left out of the debate.

The media should invite the public into the dialogue. Hopefully, it will be without some of the vitriol that has surfaced. Perhaps it is indicative of physician burnout, fueled by unrealistic demands by their employers and insurance companies to see too many patients in too little time in a system filled with opportunities for error. Whatever the etiology, a constructive tone would be consistent with the professionalism the public expects.

In the interest of full disclosure, three years ago I agreed to be an unpaid, independent public member of the public policy committee of the American Board of Medical Specialties. It works in collaboration with the 24 specialty boards that offer certification to physicians. My purpose has been to encourage patient safety as an integral part of ongoing assessment of physicians, an interest sparked 15 years ago while writing *Wall of Silence*, the first book to tell the human story behind the Institute of Medicine report, To Err is Human. (See http://tinyurl.com/pkvbxw2).

Recent estimates suggest that more than 400,000 Americans die from preventable health care harm annually. (See http://tinyurl.com/pk7f778). All hands on deck are needed to stem the mayhem. The patient on the gurney is counting on it. “Trust me” doesn't work.

MEMBERSHIP INFORMATION

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

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

We provide the following services to boards that become members:

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

The annual membership fees are 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 the remainder of 2015 and 2016, please complete this form and mail or fax it to:

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