



# News & Views

## Citizen Advocacy Center

First Quarter 2018 – Health Care Public Policy Forum – Volume 30 Number 1

### Announcement

*Our 2018 annual meeting will be held on October 16, 2018, and October 17, 2018, at Washington Plaza Hotel in Washington, DC. The theme is “Teams: Training, Practice, Evaluation, Enforcement.” More details will be available soon, and we will add that information to our website and send announcements to everybody on our contact list.*

*Please note our new office address:*

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Suite #4  
Washington, DC 20009*

### 2017 – COUNCIL ON LICENSURE, ENFORCEMENT AND REGULATION (CLEAR)

#### Remarks Upon Receipt of the 2017 Ben Shimberg Public Service Award

**Delivered by Steve Hart who was at the time the Executive Director, Kentucky Board of Pharmacy, and the President of the Council on Licensure, Enforcement and Regulation (CLEAR)**

On behalf of CLEAR, thank you to David, Becky, and all at CAC for the great honor of receiving this award, given in the name of Dr. Ben Shimberg. Dr. Shimberg was instrumental in founding both of our

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organizations and dedicated much of his professional life to ensuring that the work of professional regulators focused - and indeed continues to focus - upon three things:

- 1) Ensuring that the public is protected from unscrupulous, incompetent and unethical practice;
- 2) Offering some assurance that those regulated are competent to practice in a safe and effective manner, and;
- 3) Providing for efficient disciplinary procedures where wrongdoing has occurred.

At a time when there is such considerable discussion about regulatory reform at the highest levels of state and federal government in the United States, almost all of which centers upon an economic perspective, Ben's clarity of thought and focus upon public protection is a timely – and timeless – reminder of what should be underpinning our discussions and every action we take as regulators. Little wonder that Dr. Shimberg was appointed an honorary CLEAR Board Member in June 2001.

Like CAC, CLEAR places its public protection role at the heart of all that it does. Part of CLEAR's mission is to serve as "a dynamic forum for improving the quality and understanding of regulation in order to enhance public protection."

There are four distinct areas of substantive inquiry that CLEAR supports on an ongoing basis. In fact, its annual conference program is divided into four corresponding tracks: Compliance and Discipline; Testing and Examinations; Entry to Practice and Beyond; and Administration, Legislation and Policy. Approximately 100 committee members, drawn from CLEAR's broad membership,

ensure the organization’s resources meet the needs of professional and occupational regulators, and it is with them that this award is shared. Their extraordinary contribution and expertise ensures that all of CLEAR’s output is created by regulators, for regulators.

It is the desire to improve the quality and understanding of regulation that has led CLEAR to focus so heavily upon its training and educational efforts, which have now involved more than 20,000 regulatory investigators and inspectors, and numerous regulatory leaders and board members. Recent additions to the stable of programming offered by the organization include a two-day course for those interested in Advanced Concepts in Regulatory Governance and a further two-day offering related to Administrative Law and the Regulatory Process. CLEAR continues to offer certified training for regulatory investigators and inspectors via its NCIT programming, Executive Leadership for Regulators for those in senior positions, and Introduction to Regulatory Governance, for Board and Council Members. Recognizing that it is not always possible for Board and Council Members to attend in-person meetings, the Introduction to Regulatory Governance program is also offered via webinar, on-demand, and online. Given the important role that regulation plays in the life of our communities, it is imperative that those charged with administering, crafting, overseeing and ensuring compliance, are well-versed in best practices.

While there are certainly similarities between CLEAR and CAC, CLEAR has historically taken a markedly different path when it comes to adopting a formal position about a matter of controversy or interest. CLEAR has instead, quite deliberately, established itself as the forum in which a range of differing viewpoints can be discussed and explored<sup>1</sup>. CLEAR is particularly well-placed to hear from a diverse range of stakeholders about the approaches they have taken, or those areas that may be of particular concern, given broad-based international involvement and members in North America, Europe, Asia and Australasia.

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<sup>1</sup> *Editorial note from CAC: It is true that CAC occasionally takes a formal position on public policies (such as advocating for meaningful assurances of professionals’ current competence rather than sole reliance on mandatory continuing education hours, removal of unjustifiable scope of practice restrictions facilitating the dissemination of telehealth services, etc...) CAC also prides itself as a “forum in which a range of differing viewpoints can be discussed and explored.”*

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By looking broadly for, and at, regulatory innovation, CLEAR's stakeholders are exposed to the latest thinking in the sector. Recent areas of focus have included the role of risk, as it relates to regulators' role in protecting the public interest, safeguarding its welfare and preventing harm. A risk-based perspective on professional regulation has emerged over the past decade – most notably in the form of “Right-Touch Regulation” as espoused by the Professional Standards Authority in the United Kingdom—as a leading approach to dealing with the question of whether or not to regulate or to change the way regulation is enacted. A risk-based approach ensures that regulatory authority is applied only in proportion to the identified risk, and is mindful of the socio-economic realities within which the regulated profession operates. Risk-based regulation acknowledges the trade-offs a regulator faces in determining how best to protect the consumer. For example, a regulator may choose to focus resources on criminal background audits rather than continuing education audits.

The success of risk-based regulation is wholly dependent upon the proper identification, quantification and analysis of risks. Without this, any subsequent regulatory effort is doomed to failure. While the risk of public harm is of paramount concern,

regulators also must consider the financial and reputational risks associated with the programs they plan to introduce and the actions they take – or choose to forego. In addressing risk issues, it is critical that the regulator identify and deal with the root causes and not be distracted by things that are merely symptoms of a greater underlying problem.

In addition, there is increasing interest in ensuring that regulators are seen to be more effectively engaged with, and more representative of, the wider community. To this end, CLEAR has recently offered sessions concerning Community Reference Groups (CRGs), which have been pioneered in Australia and Canada, among other jurisdictions.

Such groups can assist in designing outreach campaigns and with customer service initiatives, provide input into standards reviews, and feed into strategies that address critical issues of concern. Similarly, CRGs have also participated in responses to formal consultations initiated by governments.

CRGs have also provided regulators with additional expertise related to communication and messaging and improved the likelihood that outreach efforts will be successful. The groups also provide regulators with access to the networks of individual CRG members, which might not have otherwise been available to the regulator. Further, the groups have sometimes also offered a means by which critics of a regulator can be meaningfully engaged and brought into the regulatory process.

As we look forward, CLEAR will continue to focus on the role technology plays, and will play, in ensuring regulation is both effective and efficient. We are particularly interested in learning more about Blockchain Technology and the future role it might play in the field, particularly in light of the work that has been undertaken in financial regulation.

As efforts continue to explore regulatory reform, CLEAR is pleased to have a seat on the Expert Panel of the National Conference of State Legislators (NCSL)-led Occupational Licensing Project. The project, which also involves the National Governors Association (NGA) and the Council of State Governments (CSG) focuses on the effect occupational licensing has on several populations: skilled immigrants; people with criminal records; active duty military and veterans and their spouses; and unemployed and/or dislocated workers. CLEAR looks forward to engaging further with this diverse group and to serving as a resource, as needed, for the potential reform efforts that will be undertaken by the eleven participating states.

As regulators we seldom receive recognition – other than critical headlines – and so CAC’s decision to recognize CLEAR’s work is particularly appreciated and welcome. CLEAR looks forward to continuing its quest to promote regulatory excellence and deeply appreciates the encouragement receiving the Ben Shimberg Public Service Award provides.

## **ROLE OF LICENSING BOARDS**

### **Medical Boards Encouraged to Address Physician Burnout**

Dr. Arthur Hengerer, past chair of the Federation of State Medical Boards (FSMB), is urging medical boards to play a role in identifying and remediating physician burnout. In a commentary published by the National Academy of Medicine in August 2017, Dr. Hengerer and Sandeep Kishore introduce three lines of discussion on this topic:

First, there is the critical role of state medical boards in identifying mental health challenges and physical impairments, particularly during licensure and re-licensure... How might we proactively address these challenges? One option is to ask physicians about the symptoms, signs, and cues to burnout in licensure questionnaires by state

medical boards or by some other methodology... physicians experiencing depression or any mental health challenge do not feel their confidentiality would be protected if they were honest about what they are experiencing... One must wonder, are licensing requirements actually causing physicians to hide their own burnout?

Second, the FSMB and state medical boards are experiencing a tension of needing to prioritize wellness and health of physicians – to reduce clinical errors – and also balancing this with concerns of transparency with patients and ensuring a robust health workforce. How open should we be?...

Third, there is the issue of self-regulation. In the medical profession, it is our duty to report and self-regulate. However, it is very clear that the medical profession does not do this effectively.

Dr. Hengerer invites interested parties to comment.

See the full article here: <http://nam.edu/breaking-a-culture-of-silence-the-role-of-state-medical-boards/>.

See also: <https://thedo.osteopathic.org/2017/10/fearing-license-issues-depressed-doctors-dont-get-help/>, and <http://tinyurl.com/yal9a43e>, and <https://psnet.ahrq.gov/resources/resource/31655/35500/2>.

## **CONTINUING PROFESSIONAL DEVELOPMENT**

### **ABMS Appoints Commission to Envision Future of Re-Certification**

The American Board of Medical Specialties (ABMS) announced in September 2017 the creation of a commission charged with making recommendations for the future of the 24-member board's Maintenance of Certification (MOC) requirements:

CHICAGO, IL – September 25, 2017 – The American Board of Medical Specialties (ABMS) and its 24 Member Boards have launched a major initiative, “Continuing Board Certification: Vision for the Future” (Commission). A collaborative process, the Commission will bring together multiple partners to vision a system of continuing board certification that is meaningful, relevant and of value, while remaining responsive to the patients, hospitals and others who expect that physician specialists are maintaining their knowledge and skills to provide quality specialty care.

***Editorial Note: David Swankin, CAC President and CEO, has been appointed as a public member on the commission.***

This initiative is in response to pushback against MOC requirements on the part of Diplomates who believe they are too costly and not germane to actual clinical practice. This pushback has recently taken the form of legislative proposals in as many as 14 states that would prohibit hospitals, insurer, or medical boards from using conformance with MOC to differentiate one physician from another.

See the ABMS press release here: <http://tinyurl.com/yd2zpdck>.

*Editorial Note: CAC is a founding member of the Right to Safe Care Coalition, which was created to educate the public about these legislative threats to rigorous, periodic third-party assessment of the current competence of healthcare practitioners. See <http://righttosafecare.org>.*

## **Workshop Examines Business Case for High Value Continuing Professional Development**

The National Academies of Sciences, Engineering and Medicine has released proceedings from a workshop entitled, “Exploring a Business Case for High-Value Continuing Professional Development: Proceedings of a Workshop.” The proceedings are described as follows:

Continuing education, continuing professional development, and high-value continuing professional development exist along a continuum. The Global Forum on Innovation in Health Professional Education (Global Forum) hosted a workshop on April 6–7, 2017, to explore the value proposition for CPD. Forum members and workshop participants gathered in Washington, DC, to learn about innovative CPD programs around the world, to consider the perspectives of those who invest in CPD, and to discuss the businesses case for CPD. The workshop rapporteurs have prepared these proceedings as a factual summation of the session discussions.

See the proceedings here: <http://tinyurl.com/y7csmr34>.

## **Board-Certified Physicians Less Likely to Be Disciplined**

Dave Kovalski posted in the November 20, 2017, *Life Science Daily* that the American Board of Medical Specialties released data in response to an October 18 article in the *Florida Sun-Sentinel* reporting that some doctors in the state are allowed to continue to practice after harming patients.

ABMS said that board-certified physicians are five times less likely to have been disciplined by state medical licensing boards than those that are not certified. Equally important, ABMS data show that physicians who participate in Maintenance of Certification (MOC) activities are better at adhering to practice guidelines and improved care processes. They also lower the cost of care compared to physicians who do not complete MOC.

For more, see: <http://tinyurl.com/yb9xv3c5>.

## **Neurosurgeons Recommend Testing for Older Colleagues**

A Mayo clinic survey of neurosurgeons found that most don’t think there should be a mandatory retirement age, but that neurosurgeons older than 65 years should undergo extra testing. In a November 15 report on the Mayo clinic *News Network* Frederic Meyer, MD, Executive Director of the American Board of Neurological Surgery was quoted to say:

It’s important to focus on patient safety and also assess a neurosurgeon’s capacity over time,” Dr. Meyer says. “In the future, surgical simulator training and testing may become essential in continuing assessment of a surgeon’s technical and cognitive competency.

The article goes on to explain about the survey responses:

Asked how to fairly evaluate aging neurosurgeons, respondents said:

- There should be no absolute age cutoff, 956 (66%).
- Neurosurgeons 65 and older should undergo additional testing, including cognitive assessment or a review of cases, in addition to a standard Maintenance of Certification exam, 718 (50%).
- A Maintenance of Certification exam should include individual case log and patient outcome review, 766 (59%).
- A Maintenance of Certification exam should be tailored to accommodate the aging neurosurgeon, 606 (42%).

For more, see: <http://tinyurl.com/yd85urjy>. See also this report that ophthalmologists over age 70 receive fewer complaints than do younger practitioners: <http://tinyurl.com/ycz56g68>. See Australia's approach to assessment for practitioners over the age of 70: <http://tinyurl.com/yayhuprp>.

### **Article Explores Barriers to Simulation for Training and Assessment**

An article in the November 2017 issue of Academic Emergency Medicine entitled, "Simulation-based Education to Ensure Provider Competency Within the Health Care System," explains a consensus working group's deliberations on this topic. The article abstract says:

The acquisition and maintenance of individual competency is a critical component of effective emergency care systems. This article summarizes consensus working group deliberations and recommendations focusing on the topic "Simulation-based education to ensure provider competency within the healthcare system." The authors presented this work for discussion and feedback at the 2017 Academic Emergency Medicine Consensus Conference on "Catalyzing System Change Through Healthcare Simulation: Systems, Competency, and Outcomes," held on May 16, 2017, in Orlando, Florida. Although simulation-based training is a quality and safety imperative in other high-reliability professions such as aviation, nuclear power, and the military, health care professions still lag behind in applying simulation more broadly. This is likely a result of a number of factors, including cost, assessment challenges, and resistance to change. This consensus subgroup focused on identifying current gaps in knowledge and process related to the use of simulation for developing, enhancing, and maintaining individual provider competency. The resulting product is a research agenda informed by expert consensus and literature review.

See the article here: <http://tinyurl.com/ybxvh8co>.



# TELEHEALTH

## CCHPR Issues 2017 Update of Telehealth Laws and Reimbursement Policies

- On November 7, 2017, the Center for Connected Health Policy released its annual update of state telehealth laws and reimbursement policies. Among the trends noted in the update are these:
- Forty-eight states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service. This number has remained relatively consistent over the past two and a half years.
- Fifteen state Medicaid programs reimburse for store and forward, an increase of two states (MD and OK) since the April 2017 edition.
- Twenty-one state Medicaid programs provide reimbursement for Remote Patient Monitoring (RPM). While Oklahoma Medicaid added RPM reimbursement since April 2017, Hawaii and Kentucky were removed from the list due to no evidence of implementation of requirements in statute to reimburse for RPM within their Medicaid programs.
- Nine state Medicaid programs (Alaska, Arizona, Illinois, Minnesota, Mississippi, Missouri, Oklahoma Virginia and Washington) reimburse for all three, although certain limitations apply.

See the update here: <http://tinyurl.com/y7sakdst>. See this article on the impact of telehealth on the growth of micro-hospitals: <http://tinyurl.com/ybzw6qes>.

## Update on Telehealth Laws Related to Mental Healthcare

The national law firm Epstein Becker Green updated its 50-state survey of telehealth laws related to mental and behavior healthcare delivery.

In June 2016, Epstein Becker Green (EBG) published its *50-State Survey of Telemental / Telebehavioral Health* (“Survey”), a comprehensive and extensive compilation of research regarding the laws, regulations, and regulatory policies affecting the practice of telemental / telebehavioral health in all 50 states and the District of Columbia. Since EBG’s publication of the Survey, states have been incredibly active as far as legislating with respect to the provision of telehealth services. For this reason, EBG’s latest release, the *2017 Appendix to the 50-State Survey of Telemental/Telebehavioral Health* (“Appendix”), is a summary of the recent changes to the laws, regulations, and policies discussed in the Survey. The Appendix, like the Survey, includes hyperlinks to original source materials (e.g., relevant laws, regulations, and agency guidance).

See the appendix here:

<https://www.ebglaw.com/content/uploads/2017/10/EPSTEIN-BECKER-GREEN-2017-APPENDIX-50-STATE-TELEMENTAL-HEALTH-SURVEY.pdf>.

And this: <http://www.mobihealthnews.com/content/report-nearly-every-state-has-updated-its-telehealth-legislation-last-year>.

## **Telehealth Needed in Urban as well as Rural Areas**

The Center for Connected Health Policy, the National Telehealth Policy Resource Center, recently published a commentary on a blog in *Health Affairs*, which noted that telehealth services are needed in rural areas because of a lack of practitioners and are needed in urban areas because of a shortage of appointments.

See more here: <http://mailchi.mp/cchpca/issue-in-focus-access-to-care-can-be-challenging-for-urban-patients-too?e=d903860d49>, and <http://tinyurl.com/ycmedzox>.

See also this article on “websites” manner: <https://www.wired.com/story/telemedicine-is-forcing-doctors-to-learn-webside-manner/>, and on telehealth and Medicaid: <https://wamu.org/story/17/11/13/technology-opens-new-possibilities-medicare-patients/>.

## **Veterans Administration Proposes to Preempt State Restrictions on Telehealth**

A proposed Veterans Administration rule entitled Authority of Health Care Providers to Practice Telehealth is summarized like this:

The Department of Veterans Affairs (VA) proposes to amend its medical regulations by standardizing the delivery of care by VA health care providers through telehealth. This rule would ensure that VA health care providers provide the same level of care to all beneficiaries, irrespective of the State or location in a State of the VA health care provider or the beneficiary. This proposed rule would achieve important Federal interests by increasing the availability of mental health, specialty, and general clinical care for all beneficiaries.

The proposed rule contains the following language related to state licensure restrictions:

In an effort to furnish care to all beneficiaries and use its resources most efficiently, VA needs to operate its telehealth program with health care providers who will provide services via telehealth to beneficiaries in States in which they are not licensed, registered, certified, or located, or where they are not authorized to furnish care using telehealth. Currently, doing so may jeopardize these providers’ credentials, including fines and imprisonment for unauthorized practice of medicine, because of conflicts between VA’s need to provide telehealth across the VA system and some States’ laws or licensure, registration, certification, or other requirements that restrict or limit the practice of telehealth. A number of States have already enacted legislation or regulations that restrict the practice of interstate telehealth, as discussed below in the Administrative Procedure Act section.

To protect VA health care providers from potential adverse actions by States, many VA medical centers (VAMC) are currently not expanding some critical telehealth services if the health care service is provided outside Federal property (such as when the beneficiary is receiving telehealth care in his or her home or when the VA provider is delivering telehealth care from his or her home) or across State lines. In addition, many individual VA health care providers refuse to practice telehealth because of concerns over States

taking action against the health care provider's State license, State laws, or the shifting regulatory landscape that creates legal ambiguity and unacceptable State licensing risk. The current disparities between VA health care practice in telehealth and State laws have effectively stopped or inhibited VA's expansion of telehealth services to certain locations, thereby reducing the availability and accessibility of care for beneficiaries.

See the proposed rule here: <https://www.gpo.gov/fdsys/pkg/FR-2017-10-02/pdf/2017-20951.pdf>. See also: <https://www.aafp.org/news/government-medicine/20171106vatelehealth.html>.

See information on passage by the US House of Representative of legislation expanding VA Telehealth: <https://www.healthdatamanagement.com/news/house-passes-bill-expanding-va-telehealth-across-state-lines>, and <https://www.medscape.com/viewarticle/888327>, and <http://tinyurl.com/ycmer7vm>.

## **Physician Makes a Case for Telehealth Specialty Certification**

Michael Nochomovitz, MD, chief clinical integration and network development officer at New York Presbyterian, makes a case in a December 7, 2017 interview with *Health Leaders Media* that telehealth is maturing and soon it will be advisable to establish a specialty certification for telehealth practitioners:

Telemedicine started out with coughs, colds, rashes – easy things. But now with the technology improving and remote monitoring expanding, the need for a more sophisticated approach has become apparent.

A telemedicine visit isn't the same as FaceTiming your cousin. It involves a true medical interaction that needs to be defined and categorized, and there are a number of people around the country who have set standards of their own, but they haven't made any consensus because it's too early.

Having said that, there are going to be people who do this for a living. There will be a career where you don't touch a patient, and there will have to be a set of core competencies that will need to be codified.

See the entire interview here: <http://tinyurl.com/y75nwk6a>.

## **DISCIPLINE**

### **State Audit Critiques Nursing Board; Legislature Considers Fixes**

The New York State Board of Nursing was found by state auditors to be too slow to investigate complaints and too lax on nurses with criminal records. Legislation which passed the state senate but is stalled in the house would have attempted to correct weaknesses in the regulator's authority. In New York, nurses are regulated by the Department of Education. Among the fixes would give regulators summary suspension authority.

For more, see: <http://www.healthleadersmedia.com/nurse-leaders/state-audit-slams-new-yorks-oversight-nurses>.

## **Physician Files Anti-Trust Suit Against Board that Disciplined Him**

In January 2017, Dr. Allibone, a physician subject to discipline by the Texas Medical Board, filed an anti-trust lawsuit alleging that board members conspired against him and other alternative medicine providers to protect allopathic physicians in the state. For example, the board used conventional medical practitioners to evaluate complaints against Dr. Allibone. The court ruled that the board was immune from the anti-trust suit:

In an October 20th Order, a federal district court in the Western District of Texas granted a motion, by members of the Texas Medical Board (TMB) and the TMB itself, to dismiss a physician's Sherman Act claims because the TMB is a state agency entitled to sovereign immunity under the Eleventh Amendment. The court also held that sovereign immunity extended to the individual board members of TMB because they were sued in their official capacities as state officials. In addition, the district court determined that the board members were further protected from plaintiff's claims for prospective declaratory and injunctive relief due to Parker immunity, also known as state action immunity, and an affirmative defense to anticompetitive behavior, per the Supreme Court's decision in *Parker v. Brown*, 317 U.S. 341 (1943).

See a full explanation from Foley & Lardner LLP here: <https://www.foley.com/texas-medical-board-immune-from-antitrust-suit-over-alternative-medicine-services-11-03-2017/>.

## **Senate Bill Would Force VA to Report Discipline**

Bipartisan legislation introduced in the U.S. Senate in November 2017 would require the Department of Veterans Affairs to report disciplinary actions taken against VA practitioners to the National Practitioner Data Bank and to state medical boards. It would also prevent the VA from removing disciplinary records from personnel files when practitioners leave VA employment. The bill was a response to an expose in *USA Today* alleging that the VA was concealing information about disciplinary actions taken by the agency.

For more, see: <http://tinyurl.com/y88gwg5z>., and <http://tinyurl.com/y8jxj5jy>. See the GAO confirmation that the VA failed to report here: <http://tinyurl.com/y8z96k64>, and here: <http://tinyurl.com/ya23cb2v>. See the VA's promise to improve: <http://tinyurl.com/y7cpxw3o>. The Federation of State Medical Boards urges better reporting from the VA to medical boards: <http://tinyurl.com/y7a4uon5>.

## **OPEN NOTES**

### **Privacy Concerns Major Reason Patients Hesitate to Share Medical Records**

In the November 29, 2017, *Health IO and CIO Review*, Jessica Kim Cohen wrote about research into why patients hesitate to share medical records online. Cohen writes:

There are four key factors that predict a patient's likelihood to want to share online medical records with their healthcare providers, according to a study in the *Journal of Medical Internet Research*.

The researchers – led by Mohamed Abdelhamid, PhD, an assistant professor of information systems at the California State University Long Beach College of Business

Administration, and Joana Gaia, PhD, a clinical assistant professor of management science and systems at the University at Buffalo (N.Y.) School of Management – conducted a survey of 1,600-plus participants to investigate their interest in electronically sharing their medical records.

The researchers determined privacy concerns held the most influence over whether patients intended to electronically share medical with their providers. Additional predictors of an individual's intention to share information included patient activation, issue involvement and patient-physician relationship.

See more here: <http://tinyurl.com/y722jynh>.

***Editorial Note: Study co-author, G. Lawrence Sanders, PhD, recommends that healthcare providers inform patients of measures to protect the security of electronic medical records. He points out that, "When a patient decides not to share their records electronically, it can result in increased costs, medical errors and undesired health outcomes." CAC News & Views believes this is a powerful case in support of system-wide OpenNotes policies accompanied by patient education and trust-building.***

## **Electronic Medical Record Systems Still Don't Communicate Well**

An article in the October 25, 2017, issue of *Medical Economics* entitled “Inability to share information across systems remains major EHR failure” describes the frustrations encountered by physicians who try to send and receive electronic medical records within and between institutions. The article observes:

This is why a cloud-based infrastructure is so critical for our nation's healthcare industry. Too many doctors document care within disconnected software systems that aren't wired for intelligence. They can't tell you if a patient saw a specialist last month, had an out-of-network MRI for similar symptoms, or had an adverse reaction to a medicine prescribed by the orthopedist in the next town.

***Editorial Note: If it is frustrating to physicians not to have a complete record of patient care easily accessible electronically, it should be even more frustrating for patients not to have a readily available and complete record of care by all of their different caregivers.***

See the article here: <http://tinyurl.com/ydb8et8k>.

## **Triggers in Electronic Medical Records Prompt Follow up Care**

***The November 21, 2017, AHQR News Now cited an article in Clinical Gastroenterology and Hepatology about triggers in electronic medical records:***

Triggers developed and tested in electronic health records effectively identified delayed follow-up evaluations in patients with suspected colorectal and hepatocellular cancers, according to an AHRQ-funded study. The triggers are based on algorithms that use data from laboratory testing, diagnosis, procedure and referral codes to determine patients at a higher risk for developing these cancers. Researchers reported that the algorithm accurately predicted delayed follow-up in 56% of colorectal cancer patients and 82% of

hepatocellular cancer patients. The approach offers a more efficient method to identify delayed diagnostic evaluation of gastrointestinal cancers, researchers concluded.

See the article here: <https://www.ncbi.nlm.nih.gov/pubmed/28804030>.

See also this use of the EHR trigger tool to identify preventable adverse events: <https://www.ncbi.nlm.nih.gov/pubmed/28935832>.

***Editorial Note: The OpenNotes initiative represents an opportunity to enlist patients in the monitoring of their own risk factors and timely follow up testing and or treatment.***

## **Researchers Find Inconsistent Use of Health Literacy Tools**

Research described in the November 21, 2017, *AHRQ News Now* found that many healthcare providers neglect to adopt health literacy universal precautions:

A new AHRQ study found that most health care providers did not always adopt “health literacy universal precautions,” such as checking that their instructions were clear enough for patients to understand. The study, published in *Health Literacy Research and Practice*, analyzed AHRQ Medical Expenditure Panel Survey data to determine the extent to which providers were adopting precautions such as clear instructions, “teach back” methods and help with filling out forms. People who were older, less educated or members of racial or ethnic minority groups were more likely to be asked to confirm their understanding or be offered help with forms.

See the article here: <http://tinyurl.com/ybsukc2w>.

***Editorial Note: Practitioners who embrace OpenNotes in practice or philosophy would by definition be checking whether all of their notes, including instructions, are understandable to their patients. Patients with access to their records through OpenNotes can help by notifying their providers when entries in their records are not clear.***

## **SCOPE OF PRACTICE**

### **Two Reports Examine Role of Nursing in Healthcare Workforce**

The National Council of State Boards of Nursing blog, *Good Morning Members* reported on November 10, 2017 about two reports related to the role of nursing in community healthcare. The first was generated by the Nebraska Action Coalition:

According to a recent study, although “the nursing profession has a long and credible history of developing the workforce to meet health needs of the population, one area where nurses have been curiously silent is the changing workforce, particularly in development of the community health worker role.” The Nebraska Action Coalition – Future of Nursing and the Robert Wood Johnson Foundation Public Health Nurse Leader in Nebraska initiated a project where a team of nurse leaders convened to examine the emerging role of the community health worker both nationally and in Nebraska.



The team employed a dialectic approach to produce “a set of 10 consensus recommendations reflecting nursing expertise and inputs into the development of the community health worker role in a transforming health system.” In addition, recommendations for the Future of Nursing – Nebraska Action Coalition were developed. The study notes, “Nurses have critical assets to offer in the continuing development of the health care workforce. Through this project work, the project team hopes to illuminate the possibilities and potential of nurses and of community health workers.”

See the study here: <http://neactioncoalition.org/wp-content/uploads/2017/08/CHW-Project-Report-FINAL-July-2017-ed-8-21-2017.pdf>.

The second report comes from the Brookings Institution;

A recent report from The Brookings Institution suggests that “nurses are, and can be even more, a solution to the fragmented health care landscape.” According to the report, intermediaries are needed in health care to bridge the gap between health facilities and nonmedical institutions, such as schools. The report notes that “nurses are among the most important of such intermediaries” by not only providing skilled health care services, but because nurses tend to be closest to the patient and their family and “the most aware of their broader psychosocial and health care needs.”

For the report, researchers reviewed the roles of a variety of nurse specialties and detailed the ways in which nurses function as intermediaries and the obstacles they face, in addition to suggesting steps to address those obstacles:

- Address data silos, which can make it difficult for nurses to gain access to the information they need;
- Review scope-of-practice rules and other professional barriers that prevent nurses from maximizing their effectiveness, and design appropriate training; and
- Budgets and payment systems, which often frustrate efforts to use nurses strategically, should be aligned to encourage the more effective use of nurses and intermediaries.

For more, see: [https://www.brookings.edu/wp-content/uploads/2017/09/es\\_20170921\\_nurses\\_as\\_intermediaries.pdf](https://www.brookings.edu/wp-content/uploads/2017/09/es_20170921_nurses_as_intermediaries.pdf).

## **Rule Change Would Encourage APRNs in Long Term Care Facilities**

The National Council of State Boards of Nursing’s *Good Morning Members* blog reported on December 13, 2017, that:

An article published in *Nursing Outlook* calls for “changes in specific federal regulations which are needed to sustain and encourage the use of APRNs in nursing homes nationwide.” Specifically, the article notes that the Code of Federal Regulation (CFR 483.40) should be revised to “allow APRNs employed by long-term care facilities to conduct necessary visits in nursing facilities” so as to “expedite and improve resident’s access to care while enhancing physician productivity.”

The recommendation follows the successful implementation of the Missouri Quality Initiative (MOQI) designed interprofessional model in nursing homes with APRNs. The CMS sponsored initiative to reduce avoidable hospitalizations among nursing facility residents was implemented for four years in 16 nursing homes in Missouri. The initiative was associated with “consistent and significant” reductions in outcome measures – hospitalizations, emergency room visits, Medicare expenditures for hospitalizations and Medicare expenditures for emergency room visits – for long-stay nursing home residents. The article notes that the success of the MOQI initiative demonstrates that nursing homes can benefit by implementing the model and hiring APRNs, but that changes to CFR 483.40 “are necessary to improve patient access to care and encourage hiring APRNs in U.S. nursing homes.”

See the article here: <http://tinyurl.com/yalkym9k>.

### **Nurses Say AMA Fighting Direct Patient Access**

According to a November 20, 2017, article by Bruce Japsen published in Forbes.com, nurses are fighting back against a resolution adopted by the AMA House of Delegates opposing independent practice by non-physician practitioners, including Advanced Practice Registered Nurses. According to Japsen, the American Nurses Association accused the AMA of perpetuating “the dangerous and erroneous narrative that APRNs are trying to ‘act’ as physicians and are unqualified to provide timely, effective and efficient care.”

See the entire article here: <http://tinyurl.com/y8zve45n>. See also: <http://www.smartbrief.com/s/2017/11/aanp-responds-medical-groups-position-aprns-0>.

### **FTC Staff Comment Favors Allowing Non-Veterinarian Animal Massage**

Responding to a request for its opinion, the Federal Trade Commission staff told the Tennessee Legislature that it supports making permanent an exception to licensure for animal massage. The statement reads in part:

We strongly urge the Tennessee Legislature to consider making the 2017 exemption permanent, absent evidence of a credible threat of harm that requires either licensing of animal massage therapists, or allowing only veterinarians to perform or supervise the practice of animal massage therapy. Indeed, letting the exemption expire appears inconsistent with current animal health training protocols.

More generally, FTC staff have long encouraged legislatures and regulators to avoid unnecessary occupational regulations that do not address well-evidenced public policy concerns... When citizens would be at risk of harm from services provided by unqualified professionals, occupational regulation can ensure that professionals maintain minimum competency levels and can be effectively disciplined for misconduct. Still, licensing erects barriers to entry in a profession, which means it can significantly raise prices for consumers and prevent otherwise qualified individuals from using their skills to earn a living. When professional services involve little risk of harm to public health or



safety, states might safely forgo licensing and rely instead on competitive market forces to protect the public from unqualified providers.

See the entire letter here: <http://tinyurl.com/y9wgc8j7>.

## **National EMS Scope of Practice Updated**

A work group including the National Highway Traffic Administration, Office of EMS, and the National Association of EMS Officials released an updated version of The Emergency Medical Responder and Emergency Medical Technician National EMS Scope of Practice Model Guidelines. The new guidelines include narcotic antagonists, tourniquet application and the use of wound packing.

For more, see: <http://tinyurl.com/y9zz9nce>.

## **LICENSURE AND WORKFORCE**

### **Missouri Board of Nursing Facilitates Licensure for Military Personnel**

On November 17, 2017, the National Council of State Boards of Nursing's *Good Morning Members* reported:

The Missouri State Board of Nursing voted unanimously to approve Air Force BMTCP 4N051 as a PN program, making the state the first in the nation to formally approve the program. For service members, veterans and families in Missouri, the program approval provides an increase in educational and job opportunities. Military personnel and veterans who have completed the Air Force BMTCP 4N051 program (5 Skill Level or above) are now able to apply for a PN license in Missouri.

Executive Director Lori Scheidt, MBA-HCM, stated, "We are honored to work with all military branches to strengthen access to quality health care to the citizens of Missouri and to assisting veterans in transitioning into civilian careers."

For more, see: <https://difp.mo.gov/news/newsitem/uuid/332c684c-1cb1-4576-856e-6c560ebb9f70>.

### **Illinois Report Highlights Questionable Licensure Requirements**

Writing in *Illinois Policy* on December 5, 2017, Amy Korte points out "How Licensing Puts the Hurt on Lower Income Illinoisans, Entrepreneurs." She cites a report by the Institute for Justice that examined licensure requirements in the 50 states. The report ranks the states according to the severity of restrictions to entry into 102 lower-income occupations, such as athletic trainers, dental assistants, barbers, bus drivers, cosmetologists, emergency medical technicians, and more. In Illinois, cosmetologists are required to take nearly ten-times as much education as emergency medical technicians in order to qualify for licensure.

For more, see: <http://tinyurl.com/y84w66c3>.

See the Institute for Justice report here: <http://ij.org/report/license-work-2/>.

See also: <http://files.constantcontact.com/4ac009d3101/2f0e01ab-5a6b-41e4-930b-e8dbff4d9f99.pdf>.

## **Nurse Group Disappointed Not to Be Considered APRN**

Jennifer Thew wrote in *Health Leaders Media* that the OMB declined to re-classify clinical nurse specialists:

Clinical nurse specialists are disappointed with the U.S. Government's Office of Management and Budget. The office released its 2018 revisions to the Standard Occupational Classification System, and once again, CNSs are classified as general registered nurses rather than advanced practice registered nurses, despite a request for change from the National Association of Clinical Nurse Specialists.

For more, see: <http://tinyurl.com/y9kmptl9>.

## **Australia's Regulatory Agency Issues 2016-2017 Annual Report**

The Australian Health Practitioner Regulation Agency and the National Boards have released its annual report on the National Registration and Accreditation Scheme during 2016 – 2017.

See the report here: <http://www.ahpra.gov.au/annualreport/2017/downloads.html>.

See also: <http://www.ahpra.gov.au/Publications/AHPRA-newsletter/december-2017.aspx>.

## **IN THE COURTS**

### **NCSBN Creates Tool Kit Around Supreme Court *NC Dental* Ruling**

The National Council of State Boards of Nursing *Good Morning Members* blog reported that:

In an effort to educate and inform boards of nursing about the U.S. Supreme Court's decision in the North Carolina State Board of Dental Examiners v. Federal Trade Commission (FTC) case, NCSBN has created a useful online North Carolina Dental Guidance Toolkit.

The toolkit contains:

- A guidance document entitled "Navigating North Carolina State Board of Dental Examiners v. Federal Trade Commission";
- The North Carolina State Board of Dental Examiners v. Federal Trade Commission U.S. Supreme Court opinion;
- An FTC document titled "FTC staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants";
- Two *Journal of Nursing Regulation* articles related to the case: "North Carolina Board of Dental Examiners v. Federal Trade Commission: State Boards of Nursing Face Increased Exposure to Antitrust Claims" and "State Board Shake-Up: Legislative Action in the Wake of North Carolina Board of Dental Examiners v. Federal Trade Commission;" and

- Two Discipline Case Management conference presentations: “Antitrust & Regulatory Boards: Where Do We Go from Here?” and “State Board Shake-Up: Legislative Action in the Wake of North Carolina Board of Dental Examiners v. Federal Trade Commission.”

The toolkit is available for members on the NCSBN website.

## **CONSUMER INFORMATION**

### **CAC Signs Letter Supporting Hospital Accreditation Transparency**

CAC is one of more than 30 signatories to a letter to Iowa Senator Grassley supporting disclosure of the findings of hospital and ambulatory surgical center accreditation surveys. The letter reads in part:

Release of this information would promote hospital quality and also would reveal the quality of the inspections that Medicare enrollees depend on to ensure safe care. Currently, only summary information is released after remediation activities between Accrediting Organizations and healthcare providers have occurred.

Section 1865 of the Social Security Act prohibits the release of survey reports conducted by Accrediting Organizations and that prohibition should be removed. This law is not in the best interest of consumers and deprives them of valuable information that could help them in choosing health care providers...

Accrediting Organizations are required by law to demonstrate the ability to effectively evaluate a facility’s compliance that meet or exceed Medicare conditions of participation and use processes that are comparable to federal survey methods. In recent years, the Centers for Medicare & Medicaid Services (CMS) has reported its follow-up surveys found at least one major patient safety problem in approximately 40% of the institutions reviewed by Accrediting Organizations... The questions must be then asked: Did the accreditation survey miss the problem or was the remediation not effective or did the facility shift resources, which created other safety problems? Without the underlying survey information, there is no way for the public to know why these patient safety problems continue. Despite the above concerns, data derived from the surveys is extremely important, since the identified lapses in patient safety are reliable and need to be readily available to the public...

### **Florida Supreme Court Facilitates Access to Peer Review Records**

In October, 2017, Florida’s Supreme Court reversed a lower court decision and gave patients access to peer review records. According to an analysis by Buchanan, Ingersoll, Rooney published in *JD Supra*:

The case represents major change for Florida patients, health care providers and attorneys, because it facilitates the public disclosure of formerly privileged peer review documents, even those that are expressly prepared for litigation purposes.

See more here: <https://www.jdsupra.com/legalnews/florida-supreme-court-broadly-construes-81828/>.

## ETHICS

### AMA Approves New Ethics Statement

Tanya Albert Henry wrote in the November 20, 2017, *AMA Wire* that the AMA approved a global physician ethics pledge. This pledge modernizes the Declaration of Geneva adopted in 1948.

According to Henry, the new pledge;

- References respecting the autonomy and dignity of the patient, which was not previously recognized in the declaration.
- Adds that the “well-being” of a patient will be a physician’s first consideration, amending a clause to state that the “health and well-being of my patient will be my first consideration.”
- Creates an obligation for respect between teachers, colleagues and students. Previously, it called for students to respect their teachers, but included no reciprocity.
- Establishes an obligation for physicians to share medical knowledge for the benefit of their patients and the advancement of health care.
- Requires physicians to attend to their own health, well-being and ability so they can provide the highest standard of care. This comes at a time when physicians have seen an increase in workload and a rise in occupational stress.
- Augments an existing clause that calls for a physician to practice with conscience and dignity by having physicians pledge to practice with conscience and dignity “in accordance with good medical practice.” This was done to more explicitly invoke the standards of ethical and professional conduct that patients and physicians’ peers expect.

For more, see: <http://tinyurl.com/y7q6fqbc>.

## LETTERS

*Editorial Note: On December 13, 2017, CAC and many other interested parties received this email from Catherine Britain, Executive Director of the Telehealth Alliance of Oregon and speaker at CAC’s 2016 Annual meeting in Portland, Oregon. As readers may be aware, the FCC decided to overrule net neutrality rules, making all the more real concerns about the effect of such a decision on the future of telehealth practice in the U.S.*

Greetings,

As many of you know, the FCC will be deciding whether or not to suspend the current net neutrality rules in favor of a free market approach to the internet. The decision will be announced tomorrow December 14th.

The impact of this decision has raised a lot of concern from the telehealth community, and there are many arguments being put forward. One of the biggest concerns is that we don’t really know how telehealth would fare in a free market environment, as telehealth has never really existed without net neutrality rules.

I have included several links to articles that represent the thinking of some of telehealth's advocates contrasted with the thinking of Ajit Pai, the FCC Chair:

<https://mhealthintelligence.com/news/telemedicine-advocates-cry-foul-over-fccs-net-neutrality-plan?elqTrackId=031dba224ccf47c4a30443695219c12f&elq=476c8d3d08bf49c7a8d8d503e93acbbf&elqaid=4212&elqat=1&elqCampaignId=3898>.

<https://us9.campaign-archive.com/?u=c9fa99b7520aedfca5c453103&id=e061ac583b>.

<https://www.fiercetelecom.com/telecom/fcc-s-pai-circulates-draft-order-to-overturn-net-neutrality-rules>.

Please read and consider sending your thoughts/comments to the FCC.

Thank you,

Cathy

--

Catherine S. Britain, Executive Director

Telehealth Alliance of Oregon

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[www.ortelehealth.org](http://www.ortelehealth.org)

***Editorial Note: The FCC did indeed abolish the net neutrality rules.***

## 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 **onsite 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; and
- 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

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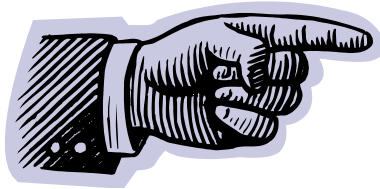
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