News & Views

Citizen Advocacy Center

Third Quarter, 2014 - A Health Care Public Policy Forum - Volume 26 Number 3

We Want You!

CAC is a membership organization *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership and on pages 26 and 27 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 28 of this newsletter.*

SCOPE OF PRACTICE

Report Advocates Wider Use of Community Health Workers

In its February 2014 email *Newsletter*, The Center for the Health Professions features a Public Health Institute report entitled, "Taking Innovation to Scale: Community Health Workers, Promotores, and the Triple Aim." The report is published by the California Health Workforce Alliance, a program of the Public Health Institute. Authors of the report found that community health workers and promotores can reduce avoidable emergency department visits by 42%, deliver an impressive 4:1 return on investment, ensure that more patients keep their

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medical appointments, and improve health outcomes. It advocates for making these lay community workers regular members of0020primary care teams.

For more, see: http://www.phi.org/news-events/590/community-health-workers-an-answer-to-growing-us-health-care-needs-new-public-health-institute-report-finds.

Medical Board Considers Rules About the Use of the Title "Doctor"

Reporter Andrew Kitchenman of *NJSpotlight*, wrote an article in the February 18, 2014 edition entitled, " Board Asks: Are There Too Many 'Doctors' in Medical Profession In NJ?" Kitchenman reports that the New Jersey medical board is considering a proposal that would forbid physician assistants with doctoral degrees from using the title "doctor" in clinical settings. The board's physician assistant advisory board believes, "confusion results when physician assistants who hold doctoral degrees are referred to as "doctors" and patients believe they are medical doctors or doctors of osteopathic medicine." In contrast, an advanced practice nurse with a doctoral degree interviewed by Kitchenman says his patients have never been confused about this role, even when he uses the title, "doctor."

See the entire article at:

http://www.njspotlight.com/stories/14/02/17/board-asks-are-there-too-many-doctors-in-medical-profession-in-nj/.

Paper Reviews Economic Impact of APRN Scope of Practice

The National Bureau of Economic Research (NBER) released a paper (#19906) in February, 2014 which analyzes the economic and quality effects of expanding the scope of practice for nurse practitioners. The article, by Morris M. Kleiner, Allison Marier, Kyoung Won Park, Coady Wing is entitled "Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service." The paper's abstract explains that:

Occupational licensing laws have been relaxed in a large number of U.S. states to give nurse practitioners the ability to perform more tasks without the supervision of medical doctors. We investigate how these regulations may affect wages, employment, costs, and quality of providing certain types of medical services. We find that when only physicians are allowed to prescribe controlled substances that this is associated with a reduction in nurse practitioner wages, and increases in physician wages suggesting some substitution among these occupations. Furthermore, our estimates show that prescription restrictions lead to a reduction in hours worked by nurse practitioners and are associated with increases in physician hours worked. Our analysis of insurance claims data shows that the more rigid regulations increase the price of a well-child medical exam by 3 to 16 %. However, our analysis finds no evidence that the changes in regulatory policy are reflected in outcomes such as infant mortality rates or malpractice premiums. Overall, our results suggest that these more restrictive state licensing practices are associated with changes in wages and employment patterns, and also increase the costs of routine medical care, but do not seem to influence health care quality.

The full paper can be purchased at: http://www.nber.org/papers/w19906.

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Kentucky Expands Nurse Practitioner Scope

After a five-year legislative battle Kentucky nurse practitioners who have completed four years of prqactice in collaboration with a physician will be authorized to independently prescribe some medications. The new law also helps nurse practitioners find physicians willing to collaborate with them as they meet their four-year requirement.

For more, see: http://tinyurl.com/la5b73h.

Are Healthcare Practitioners Keeping Up With the Times?

A provocative commentary in the April 15, 2014, online *Health Leaders Media* post argues that healthcare consumers are choosing new methods of delivery – retail clinics, telemedicine and consumer-friendly uses of technology, extended hours, and more – and providers who do not adapt will be left behind. Editor at *Health Leaders Media*, interviewed Chris Wasden of PwC, whose company did the research and produced a report of their findings.

For more, see: http://tinyurl.com/lzux6v8, http://tinyurl.com/qdkhrcv and http://www.healthleadersmedia.com/print/TEC-303889/Telemedicines-Expanding-Options.

Illinois May Permit Psychologists to Prescribe

On June 18, 2014, Public Radio program *Here and Now* broadcast an interview with *Chicago Tribune* reporter Bonnie Miller Rubin about the state legislature's initiative to permit psychologists to prescribe. The legislation calls for special training and supervision by a physician.

Listen at: http://hereandnow.wbur.org/2014/06/18/illinois-psychologists-prescribe, and also see http://tinyurl.com/n4chgbv.

Virtual Dental Home Proposed to Expand Access to Care

In an interview in the Center for the Health Professionals online Newsletter, Paul Glassman, DDS, MA, MBA, Director for the Pacific Center for Special Care, University of the Pacific, Arthur A. Dugoni School of Dentistry makes a case for using technology and creative staffing to increase access to dental care, especially preventive care.

Responding to a question, Glassman says:

> One of my most important projects is the Virtual Dental Home. Like the medical home, the dental home is a system where care is coordinated to provide the patient with all the services he or she needs to stay healthy. The emphasis is on prevention, health promotion, and education so that patients only get surgery when they need it.

See the whole article at http://futurehealth.ucsf.edu/Public/Leadership-Highlight.aspx.

Michigan Expands Scope of Physical Therapists

A package of bills signed by Governor Snyder improves Michiganders' access to physical therapy services. See the governor's press release at http://tinyurl.com/q2kh6y2.

CAC Signs on to Amicus Brief

The Citizen Advocacy Center signed on to An Amicus Brief prepared by the American Nurses Association and submitted to the United States Supreme Court. The Court will hear an appeal of a decision by the Fourth Circuit Court of Appeals upholding a Federal Trade Commission holding that the North Carolina Board of Dental Examiners acted inappropriately in limiting the delivery of teeth whitening services by non-dentists in the state.

CAC President David Swankin explained that,

> CAC supports the 4th circuit decision because we believe the Federal Trade Commission plays an essential, non-partisan, public protection role by fulfilling its statutory responsibility to unearth and oppose rules and policies promulgated by state health professional licensing boards that establish unjustifiable anti-competitive business restrictions that do little if anything to protect and promote public health and safety.

The Amicus Brief can be found at: http://www.cacenter.org/files/AmicusBrief.pdf.

See the FTC's brief here:
http://www.ftc.gov/system/files/documents/cases/140730dentalexaminersbrief.pdf.

For a different perspective, see: http://tinyurl.com/ly2dnzs and
http://tinyurl.com/kuotvdn.

New Mexico Recruits APRNs on Cost of Collaboration Agreements

Unlike some neighboring states including Texas, New Mexico does not require nurse practitioners to pay for costly collaborative agreements with physicians. Governor Martinez is using this as a tool to recruit nurses from other jurisdictions.

For more, see: http://www.healthcarefinancenews.com/news/oversight-contracts-add-fuel-fire?single-page=true.

Healthcare System Puts Critical Care Nurses in Ambulances

Intermountain Healthcare in Utah has launched a program to put critical care nurses as well as EMTs in ambulances transporting patients needing critical care. This is expected to improve continuity of care, especially in situations where speedier helicopter transportation is not feasible.

For more, see: http://tinyurl.com/lwv8tsl.

Healthcare System Uses Pharmacists in Primary Care

Minnesota integrated health system HealthPartners uses clinical pharmacists to educate patients and consult with others on the healthcare team. The pharmacists are given special training in patient engagement and relieved of routine pharmaceutical duties to free them up to work with patients and other caregivers. Employing pharmacists in this way saves money and improves outcomes.

For more, see: http://www.healthleadersmedia.com/print/FIN-307273/Pharmacy-Optimization-Improves-Care-Lowers-Costs.

Study Warns that APRNs and PAs May Be Practicing Beyond Training

A study published in *JAMA Dermatology* says that Medicare billing codes submitted by APRNs and PAs (mostly involving dermatology) imply that these professionals may be undertaking surgical procedures, which the primary author, dermatologist, Dr. Brett Coldiron, suggests are beyond their training. Ken Miller, President of the American Association of Nurse Practitioners, says that APRNs refer patients to specialists when the needed care is beyond their scope of practice.

For more, see: http://tinyurl.com/nwrep7a and http://tinyurl.com/op8t2nr.

PAIN MANAGEMENT AND END OF LIFE CARE

NABP Video Advises Pharmacists to Look for "Red Flags"

The National Association of Boards of Pharmacy (NABP) and the Anti-Diversion Industry Working Group (ADIWG) have released a YouTube video for pharmacists with advice about behaviors that may indicate a patient is a doctor shopper, drug diverter, or abuser of prescription medications.

See the video at: https://www.youtube.com/watch?v=WY9BDgcdxaM&feature=youtube.

AHRQ Publishes Articles About States' Handling of End-of-Life Care

One category in the Agency for Healthcare Research and Quality's online Innovations Exchange is end-of-life care. Recent entries include one on Maryland's Advisory Council on Quality Care at the End of Life and Minneapolis' HealthPartners' approach to cultural sensitivity.

In Maryland, the legislature creased an independent, permanent government entity, the Maryland State Advisory Council on Quality Care at the End of Life, with responsibility for ongoing data-gathering, policy analysis, advocacy and education related to end-of-life policy issues.

In Minnesota, HealthPartners employs a culturally sensitive, tailored approach to care-coordinator discussion about advance directives with seniors enrolled in the managed care plan, Minnesota Senior Health Options. The initiative has increased the number of advance directives filed by minority patients.

For more, see: https://innovations.ahrq.gov/profiles/legislatively-mandated-permanent-council-serves-effective-catalyst-sustained-progress-end, and https://innovations.ahrq.gov/search/node/Minnesota%20HealthPartners.

See also this report from the Centers for Disease Control: http://tinyurl.com/lg6cvd7.

Pharmacy Boards Warn of Illegal Online Sellers

In April 2014, the National Association of Boards of Pharmacy issued a report entitled, "Internet Drug Outlet Identification Program Progress Report for State and Federal Regulators: April 2014." The report says that Internet drug outlets sell prescription drugs, including controlled substances, to consumers without a valid prescription.

The U.S. Government Accountability Office (GAO) has declared rogue Internet pharmacies a public health threat. GAO praised NABP's Verified Internet Pharmacy

Practice Sites (VIPPS) and generic Top-Level Domain (gTLD) programs for helping to reign in the problem.

For more, see: http://www.nabp.net/news/illegal-online-sellers-most-frequent-distributors-of-counterfeit-drugs-reports-nabp--2.

Coalition of Providers Strive to Improve End of Life Care

A coalition of health care institutions in California has agreed to guidelines to improve end of life care.

The coalition's guidelines recommend that health care providers:

> Encourage all patients to plan in advance for end-of-life care and make such an approach standard;
>
> Ensure that patients with chronic and progressive conditions have timely access to palliative care and other support services;
>
> Advise patients about the potential benefits and consequences of medical treatments as they relate to end-of-life care; and
>
> Work with patients to implement "shared-decision making" to decide what the most favorable care would be in specific scenarios.

For more, see: http://www.californiahealthline.org/articles/2014/5/22/calif-health-systems-issue-guidelines-to-improve-endoflife-care.

Iowa Board Reissues Statement on Pain Care

The Iowa boards of medicine, nursing, pharmacy, and physician assistants have reissued a 2009 statement on pain management to reassure caregivers that they will not face regulatory scrutiny if they treat patients pain responsibly.

See the press release and statement at http://tinyurl.com/mpmlnfz.

CONTINUING PROFESSIONAL DEVELOPMENT

Britain's General Medical Council Evaluates Revalidation

The National Health Service in Britain recently issued a report value of the General Medical Council's revalidation scheme for doctors. According to a March 18, 2014, post in *publicregulatoryblog*, the report concludes that:

> one year into implementation, medical revalidation is delivering value but that more needs to be done to maximise benefits in the future. Key points from the report include signs that concerns about a doctor's practice are being identified at

> an earlier stage, strong support for the system among responsible officers and appraisers and strong support from doctors, appraisers and responsible officers for medical appraisal… The report makes a number of key recommendations including, interestingly, the need for patients and the public to have a stronger role in revalidation.

Visit the blog for a link to the NHS report and to an earlier blog with an historical review of the Britain's revalidation process: http://publicregulatoryblog.ffw.com/2014/gmc-revalidation-early-benefits-and-impact.

AHRQ Research Evaluates Simulation Training in Surgery

The Agency for Healthcare Research and Quality (AHRQ) published the following story on its online Patient Safety Network. Although this study involved novice surgical trainees, simulation also has promise for continuing competency assessments.

Is the skillset obtained in surgical simulation transferable to the operating theatre?

Buckley CE, Kavanagh DO, Traynor O, Neary PC. Am J Surg. 2014;207:146-157.

Simulation training has taken hold as a key method for safely teaching procedural proficiency. Prior studies have found simulation to be superior to traditional didactics in improving skills and behaviors. This systematic review focused specifically on whether the skill set obtained from simulation is transferable to the operating room. The study was restricted to randomized controlled trials involving novice surgical trainees. The findings demonstrate a positive impact on operating competence, but the metrics used in studies thus far have been limited. The authors advocate for more robust assessment of operative performance. A recent systematic review, published as part of the AHRQ *Making Health Care Safer II* report, also found evidence that simulation training improved procedural competence and patient care outcomes. An AHRQ WebM&M perspective by Dr. David Cook reviews the literature on simulation training.

For more, see:
http://psnet.ahrq.gov/resource.aspx?resourceID=27598&sourceID=1&emailID=.

TELEHEALTH

Idaho Medical Board and Legislature Part Ways Over Telehealth

On April 28, 2014, Betsy Russell of the *Idaho Press-Tribune* wrote about the difference of opinion between the state medical board and the legislature over the merits of telemedicine. She cited legislators who view telemedicine as a tool to address provider shortages, particularly in rural areas. The legislature passed a bill in 2014 calling for state standards for the practice of telemedicine.

In the meantime, the medical board disciplined a physician for prescribing an antibiotic over the phone, putting her licensure in other states and board certification in jeopardy. Teladoc, a national provider of telemedicine services, pulled out of Idaho because of the regulatory atmosphere.

For more, see: http://www.idahopress.com/news/local/idaho-board-disapproves-of-telemedicine/article_48b66c1e-cea4-11e3-a0e7-001a4bcf887a.html.

Association of Physical Therapy Boards Urged to Embrace Telehealth

An article in the Federation of State Boards of Physical Therapy's spring 2014 *federation forum* based on a presentation at the 2013 annual meeting is very positive about the applicability of telehealth technologies to PT practice. Mike Billings, PT, MS, CEEAA and Mei Wa Kwong, JD describe Washington State's experience adopting telehealth for PT and urge other PT boards to do the same:

Telehealth is important to physical therapy because it addresses a different delivery system. Physical therapy should stay ahead of the curve and regulators should push hard to be included in all telehealth legislation. Telehealth is for everybody involved in health and physical therapy needs to be part of that equation. Currently, it's mostly about doctors and nurses.

Establishing telehealth legislation involves research and background (think long-term and flexible), finding the right partners and educating policy makers. Once it's legislated, the regulation work begins. Everything relies on the language. How the language is crafted for law will impact where telehealth goes.

See the article at:
http://clients.criticalimpact.com/newsletter/newslettercontentshow1.cfm?contentid=18012&id=2168.

CMS Proposes to Expand Telehealth Coverage

In July 2014 CMS proposed for comment new rules that would cover telehealth coverage for annual wellness visits and psychotherapy services. CMS expects these changes, if adopted, to improve access to care, especially in rural areas.

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

WORKFORCE

Nevada Board of Nursing Welcomes Military Medics to the Profession

An article in the March 2014 issue of the Nevada Board of Nursing's *Nursing News* celebrates the board's program for helping military veterans transition from military medicine to licensure or certification. Nevada was one of six states to receive a grant from the National Governors' Association, in this case to explore transition from military

to civilian practice as a licensed practical nurse, an emergency medical technician, or a law enforcement officer.

Read the article at http://epubs.democratprinting.com/publication/?i=202281.

ADMINISTRATION

Boards Hampered Because of Vacancies

Research by *Boston Globe* reporter Todd Wallack uncovered 919 vacancies on Massachusetts' boards and commissions and 867 holdover members whose terms had expired. The vacancies prevent some boards from holding meetings or achieving a quorum. Many of the boards and commissions identified in the article have little impact on consumer protection or safety. But, several regulate the healthcare professions. When they can't meet, or can't conduct official business for lack of a quorum, the effect can be denial of due process for licensees and/or complainants.

Editorial Note: See also the section on REGULATORY REFORM in this issue for an item about the possibility of reducing the number of boards and commissions.

For more, see: http://www.bostonglobe.com/metro/2014/05/18/massachusetts-legislators-explore-whether-hundreds-state-boards-should-abolished-redefined/kkFsJKN0YJhENLztKsjJeO/story.html.

ETHICS

Doctors Solicited by Pharmacies to Order Custom Drugs

On April 15, 2014, Staff Reporter Mary Ann Roser reported in the *Austin American-Statesman* that the state legislature was investigating ties between doctors and compounding pharmacies. Some pharmacies were allegedly approaching doctors to invest in their facilities and then refer patients to them. The executive director of the Texas State Board of Pharmacy told the legislative committee that more inspectors will be assigned to visit compounding pharmacies. She also reported that her board is working with the medical board to determine who has jurisdiction over the doctors involved in the arrangements.

Medical Board Member Accused of Conflict of Interest

Dr. Mary Carpenter, chair of the South Dakota Board of Medical and Osteopathic Examiners, has been accused of having a conflict of interest because she once served on the board of directors of a malpractice insurance company and continues to serve on the

board of an insurance holding company created by the malpractice company. The Governor and the medical board's executive director defend Carpenter against allegations of conflict of interest.

For a discussion of this debate see: http://www.argusleader.com/story/news/2014/05/10/critics-see-conflict-sd-doctor-multiple-boards/8958245/.

PUBLIC MEMBER

Public Member Honored for Achievement

Congratulations to Rev. O. Richard Bowyer, public member and former Chair of the West Virginia Board of Medicine and longtime friend to CAC, who received a Lifetime Achievement Award from the Federation of State Medical Boards (FSMB). The award "recognizes extraordinary and sustained service and commitment to the field of medical licensure and discipline." FSMB's announcement reads:

Rev. O. Richard Bowyer MDiv, ThM, has served several appointments for the West Virginia Board of Medicine over a span of more than 30 years. He was first appointed to the board in 1981 by now U.S. Senator John D. Rockefeller IV, who was Governor of West Virginia at the time. Rev. Bowyer was one of the first two public members ever to be appointed to the Board of Medicine under the newly minted Medical Practice Act heralding in the modern era of medical licensure and discipline. In 2010, he became the first public member ever elected president in the board's 130-year history. In 2012, he was elected for a second two-year term as president. During this tenure on the board, Rev. Bowyer's contributions have been most notable through his service as president, as well as his active role on the Complaints Committee and the Legislative and Executive/Management committees, all of which he has chaired. Rev. Bowyer's influence has helped shape medical licensure and discipline in West Virginia, as it exists today.

CONSUMER INFORMATION

NYPIRG Argues for More Disclosure About Sanctioned Doctors

A report from the New York Public Interest Group (NYPIRG) argues that consumers should be made aware of sanctions against doctors who continue to practice even after being disciplined by the medical board. NYPIRG argues that it isn't enough to post physician profiles online. They ask for a law requiring posting information about licensure restrictions at the place of practice.

For more, see: http://www.nypirg.org/health/questionabledocs/.

Oregon Dental Board Moves Backward on Consumer Information

Oregonian reporter Nick Budnick reported on July 11, 2014, that the state's Board of Dentistry voted to remove the names of disciplined dentists from its newsletter. Consumers will be able to find discipline information online – provided they enter the license number from the newsletter.

The board member who proposed eliminating disciplined dentists' names reportedly said, "All it does is pour salt in the wound," he said. "It's just mean, it's spiteful and it's fodder for gossip." Surprisingly, the board's public member supported the board's action, saying, revealing the names would "dilute the brand of licensees."

Other boards in the state support transparency. Ruby Jason, Executive Director of the nursing board, told Budnick that she finds the dental board's action "embarrassing… the state has given you your license. You have a public trust… I personally believe (naming) is a deterrent."

For details, see: http://tinyurl.com/q7sbcd9.

California Pharmacy Board Punts on Translation Rules

The California Pharmacy Board held a public hearing in July 2014 to discuss implementing a legislative requirement that non-English speaking patients be given translations of the instructions accompanying prescription drugs. Pharmacists in the state oppose the requirements while consumer advocates support it.

For more, see: http://tinyurl.com/q5kq5l3 and http://tinyurl.com/m4x65x5.

Public Knows Little About Evaluating Healthcare Providers

Americans do not think that information about the quality of health care providers is easy to come by, and they lack trust in information sources that tend to produce such indicators. When it comes to what being a quality health care provider means, there is a disconnect between how experts and consumers define it. Most Americans focus on the doctor-patient relationship and interactions in the doctor's office, with fewer thinking about the effectiveness of treatments or their own health outcomes. These are among the findings of a new survey conducted by the Associated Press-NORC Center for Public Affairs Research.

See more at: http://tinyurl.com/kb7x5m9, http://tinyurl.com/o9hx9no, and http://tinyurl.com/o9hx9no.

QUALITY OF CARE

Nurse Tenure Linked to Quality of Care

A study by Columbia University found a relationship between the length of time nurses worked in the same hospital unit was directly related to quality of care and length of stay. Longer tenures were also related to cost savings.

For more, see: http://www.hcpro.com/INF-303517-873/Study-Experienced-nurses-lead-to-better-quality-of-care.html.

Congress My Require 24-hour RN Presence in Long-Term Care

The National Consumer Voice for Quality Long-Term Care reported in its August 5, 2014, *Gazette* that Congress will consider requiring that an RN be on duty 24 hours in U.S. long-term care facilities. The organization endorses the proposed legislation:

> Legislation Requiring Round-the-Clock RN Coverage Introduced in Congress
>
> The Consumer Voice applauds the introduction of H.R. 5373, the Put a Registered Nurse in the Nursing Home Act, introduced in the U.S. House of Representatives by Congresswoman Jan Schakowsky on July 31st. The bill would require all nursing homes receiving Medicare and/or Medicaid reimbursement to have a registered nurse (RN) on duty twenty-four hours per day, seven days a week.
>
> Although most people believe RNs are already required round-the-clock, this is not the case. Under current federal law, nursing homes are only required to have a RN eight hours each day regardless of facility size – no matter how many residents they have or how sick they are. To read our full press release on this legislation, click here. Advocacy for increased RN staffing is part of Consumer Voice's Nursing Home Staffing Campaign. To learn more or join the Campaign, go to http://www.theconsumervoice.org/betterstaffing.

Care Teams Improve Access and Cut Costs

A new report from the Commonwealth Fund shows that:

> Care management programs that focus on patients with complex health and social needs are increasingly viewed by health systems and payers as essential to lowering the overall costs of care. In a new Commonwealth Fund issue brief, researchers Clemens S. Hong, M.D., Allison L. Siegel, and Timothy G. Ferris, M.D., compare the approaches of 18 successful programs to identify best practices to guide providers, payers, and policymakers across the U.S.
>
> In each of the complex care management programs highlighted, specially trained teams of physicians, nurses, pharmacists, mental health professionals, and others

coordinate closely with primary care providers. These teams address the needs of patients, most of whom have multiple chronic conditions or advanced illness and face social or economic barriers to accessing services.

For more, see: http://tinyurl.com/onzter3.

IN THE COURTS

Illinois Supreme Court Considers Automatic Licensure Revocation

The Illinois Supreme Court recently debated the merits of legislation calling for automatic revocation of a health professional's license after conviction of a crime requiring registration as a sex offender, forcible felony, or criminal battery in the course of care. Suits challenging the legislation were filed by several physicians whose licenses would be affected.

For a description of the case, see: http://www.jdsupra.com/legalnews/illinois-supreme-court-debates-automatic-36165/.

CHEMICALLY DEPENDENT PRACTITIONERS

California Voters to Decide On Doctor Drug Testing

A voter initiative that would raise the ceiling on malpractice lawsuits and require random drug testing for California's doctors has qualified for November ballot in that state. Proposed by advocacy group Consumer Watchdog, the measure would:

> Mandate random drug and alcohol testing of doctors modeled after the Federal Aviation Administration's testing of airline pilots, and testing after an adverse event in a hospital;
>
> Require that physicians check the state's existing prescription drug database before prescribing narcotics and other addictive drugs to first-time patients to curb doctor-shopping drug abusers;
>
> Promote justice for patients and legal deterrence to wrongdoing by adjusting the state's malpractice cap to account for 38 years of inflation, while maintaining the existing cap on attorneys' fees; and,
>
> Require physicians to report suspected drug or alcohol abuse at work by a colleague, as well as physicians' substandard care if it leads to an adverse event.

In the meantime, the California Medical Association (CMA) has proposed legislation that would revive the medical board's voluntary and confidential treatment program for chemically dependent practitioners, which was terminated in 2008 after numerous outside reviews found it to be ineffectual.

For more about these proposals see the following links: http://www.consumerwatchdog.org/newsrelease/consumer-watchdog-campaign-landmark-patient-safety-act-qualifies-november-california-bal;

http://www.latimes.com/business/hiltzik/la-fi-hiltzik-20140516-column.html#page=1;

http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_2301-2350/ab_2346_cfa_20140428_100129_asm_comm.html;

http://www.consumerwatchdog.org/newsrelease/greased-legislative-attempt-shield-drunk-and-high-doctors-passes-assembly-committee-decr;

and http://www.bakersfieldcalifornian.com/health/x1042360561/Ballot-initiative-seeks-drug-testing-for-doctors.

IMPAIRED PRACTITIONERS

Californians to Vote on Random Drug Testing for Doctors

In the fall, California voters will pass judgment on Proposition 46 which would require random testing of doctors for drug and alcohol use, with positive results reported to the state medical board. Polls show that as of now, the proposition has the support of a majority of Californians. At least one recovering physician supports the idea.

See his rationale at: http://www.vox.com/2014/8/23/6057669/why-doctors-should-face-mandatory-drug-tests.

DISCIPLINE

Medicare Fails to Monitor Doctor Discipline

Media outlets ProPublica, NPR, and Bloomberg News reported in April 2014 that Medicare continues to pay doctors who have been arrested, suspended by Medicaid, or lost their licenses to practice. ProPublica estimates that Medicare payments to sanctioned doctors exceeded $6 million in 2012.

Medicare published data about its payments to doctors for the year 2012 and invited researchers and the public to help identify instances of fraud. The Centers for Medicare and Medicaid Services and HHS' Office of the Inspector General have authority to remove doctors whose licenses have been revoked from Medicare eligibility, but neither agency is required to do so.

For more, see: http://www.propublica.org/article/even-after-doctors-are-sanctioned-or-arrested-medicare-keeps-paying and http://www.bloomberg.com/news/2014-04-28/doctors-get-millions-from-medicare-after-losing-their-licenses.html.

See also this follow-up article reporting on the incidence disciplinary actions among those who charge Medicare at the highest levels: http://tinyurl.com/nst7j7y.

Illinois Disciplines Doctor for Over-Prescribing Anti-Psychotic Meds

The Illinois medical board has suspended the license of Dr. Michael Reinstein, a psychiatrist who prescribed clozapine more often than any other physician in Medicare and Medicaid. It is alleged that the doctor received reimbursement from the manufacturer.

See ProPublica's coverage at: http://tinyurl.com/mw59bwr.

Nurse Loses License for Failure to Report Signs of Abuse

The *Portland Press Herald* reported in August about regulators' reaction to the death of an infant after abuse by its father. A visiting nurse lost her license for failure to report signs of abuse. On the other hand, the board of osteopathic medicine dismissed a complaint against a pediatrician who also saw the infant. The state's Child Protective Services officials visited the child a few days before his death, and concluded the child was not in danger.

For more, see: http://www.pressherald.com/2014/08/15/nurse-who-saw-ethan-henderson-loses-license/.

REGULATORY REFORM

Massachusetts Considers Deregulation

Following an article in the *Boston Globe* about vacancies on regulatory boards, a Massachusetts state senate panel plans to review 700 boards with the intention of recommending changes and possible elimination. The Governor may reintroduce a proposal to establish a formal sunset process for the state's boards.

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

Sunset Report Recommends Eliminating Licensure for Radiologic Technicians

The Texas Legislature's Sunset Advisory Commission has recommended discontinuing licensure for radiologic technicians. The Commission's rationale is that licensure is redundant, given other state and federal requirements and private certification and accreditation. In a post on May 16, 2014, Fierce Medical Imaging's Mike Bassett argues in favor of licensing.

For more, see: http://www.fiercemedicalimaging.com/node/1521/print.

LICENSURE

California Considers Easing Immigrants' Path to Licensure

Legislation passed by the state senate in California would permit licensure boards to require applicants to produce a tax ID number rather than a social security number for proof of identity. This change would enable professionals in the country illegally, and therefore unable to obtain a social security number, to apply for licensure.

For details, see: http://www.latimes.com/local/la-me-immigrants-doctors-20140512-story.html.

Maryland Considers Physician Background Checks

Maryland physician Dr. William Dando was prosecuted for sexual assault in May 2014. The investigation found that he had been convicted of rape in 1987 in Florida, but this had not been revealed when he applied for licensure in Maryland. Other professions in the state do require background checks, including chiropractors, counselors, and physical and mental health therapists.

For more, see: http://tinyurl.com/m2cjdrj.

Missouri Creates "Assistant Physician" Workforce Category

Legislation supported by the medical establishment in Missouri and signed into law by Governor Nixon will permit students who have not yet passed their final exams treat patients in primary care settings. These students must be supervised for the first 30-days of their practice.

Thomas Nasca, MD, CEO of the Accreditation Council for Graduate Medical Education says this approach to addressing the shortage of primary care providers is unwise because most of the students affected are graduates of schools outside the US.

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

See this report about fast-track education for physicians at one California University: http://tinyurl.com/p3rus6j.

See also this article about a medical school that accepts undocumented immigrants: http://tinyurl.com/ngnr674.

Texas Sunset Review Recommends Ending Licensure for Twelve Healthcare Professions

The Texas Sunset Review Commission staff report recommends discontinuing licensure for a dozen healthcare professions, including respiratory care and medical radiologic technologists. The Commission staff also recommends that all boards have as close as

possible to one-third public members and that public testimony be allowed at all board meetings.

Read the report here: https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Staff%20Report_0.pdf.

AMA Considers Resolutions Affecting Medical Boards

At its summer meeting, the AMA House of Delegates considered resolutions relevant to medical boards. The resolutions dealt with telemedicine, continuing competence, graduate education, and licensure of international graduates, among others.

See a summary published by the Federation of State Medical Boards' August 5, 2014, eNews: http://www.fsmb.org/Media/Default/PDF/Publications/AMA%20and%20AOA%20Actions%20for%20e-news.pdf.

PATIENT SAFETY

Safety Experts Want CDC to Track Patient Safety in Hospitals

At a hearing before the Senate Subcommittee on Primary Health and Aging, several patient safety experts lamented that patient safety has not improved significantly in the fifteen years since the Institute of Medicine published its first report on preventable errors in hospitals. They asked Congress to instruct the Centers for Disease Control to monitor and catalogue patient safety issues in the country's hospitals.

See ProPublica's coverage of this hearing at: http://www.propublica.org/article/were-still-not-tracking-patient-harm?utm_source=et&utm_medium=email&utm_campaign=dailynewsletter.

Newspaper Says "Maryland Hospital Reporting Inadequate"

According to an article by Meredith Cohn published July 26, 2014, in the *Baltimore Sun*, Maryland hospitals are failing to report medical errors to state regulators. The article cites several instances of preventable errors and explores some reasons for failure to report. One reason may be confusion about reporting requirements; another is fear of the consequences if errors are reported.

Editorial Note: Underreporting of medical errors is by no means unique to Maryland hospitals. This kind of underreporting inspired CAC to launch a project called PreP4patientsafety designed to help hospitals and health professional licensing boards work together to report errors to regulatory authorities.

See the *Sun* article here: http://www.baltimoresun.com/news/maryland/sun-investigates/bs-hs-medical-errors-20140726,0,5079647.story.

See also: http://www.baltimoresun.com/news/opinion/oped/bs-ed-patient-safety-20140807,0,2614635.story.

HORROR STORY OF THE QUARTER

Washington State Medical Board Revokes License of Sexting Surgeon

Washington State's Medical Quality Assurance Commission has revoked Dr. Arthur Zilberstein's license for sending sexually explicit text messages while performing surgeries, including appendectomies, cardiac probe insertions, and caesarean sections.

On one occasion, he exchanged 45 "sext" messages with a girlfriend during a 90-minute surgery.

For more, see: http://www.hcpro.com/INF-305607-873/Seattle-doctor-suspended-for-sexting-during-surgeries.html.

IN DEPTH

Opening Remarks at CAC's Conference Entitled, "Public Outreach: Promoting Awareness and Stimulating Community Involvement," May 2014

Delivered by David Swankin, President and CEO, Citizen Advocacy Center

MAY 20, 2014

Good Morning.

Thank all of you for coming today, and thanks to those of you participating electronically. As with all CAC meetings, extensive proceedings will be prepared to capture what transpires today and tomorrow. So, the work all of you do in the next two days will ultimately reach a wide audience.

Since our inception, CAC has repeatedly heard board executives express frustration about not only the lack of public understanding of regulatory boards, but also the absence of citizen support for the boards' mission before legislators and policymakers and citizen input into board activities, such as rulemaking proceedings and priority-setting. This is not for lack of effort on the part of some boards to bring about such public involvement.

Some boards schedule their meetings at various locations around the state to make it easier for members of the public to attend; some have excellent information on their websites explaining in plain English how the public can participate in the board's rule-making. We are aware of a few that have convened consumer focus groups on specific issues and others that have encouraged their public members to take it upon themselves to reach out to community groups. Some have organized speaker's bureaus and made speakers available at health fairs, community events and talk shows; some have distributed board related articles to community group newsletters. Clearly, significant effort has been expended, and the leadership of some boards is clearly committed to promoting citizen participation; but generally these efforts have been isolated and have yielded disappointing results.

For its part, CAC is just as frustrated as licensing board leadership at the dearth of community participation. We believe it is time to think outside of the box and experiment with new strategies and new initiatives to try to make it happen. We believe it would be productive to solicit ideas from community leaders about how to develop effective mechanisms to generate greater citizen involvement.

Public involvement in board activities could include keeping boards apprised of consumer priorities, concerns and aspirations for board accomplishments. It could also involve nominating public members, testifying at rulemaking proceedings and legislative hearings, and even petitioning boards to undertake initiatives of importance to the public. The payoff from the board's point of view would be to more closely align its agenda and priorities with those of the public it is mandated to serve. Boards would enhance their accountability and credibility by demonstrating emphatically that they are not focused primarily on the interests of the regulated profession, a commonly held perception.

Consumer awareness and involvement, or more precisely, the lack of it, is a problem for voluntary certification organizations as well as for licensing boards. In 2013, public member Dottie Jeffries wrote in the Nephrology Journal:

Unfortunately, consumers are not always aware of the certifications that exist or that they can seek out certified professionals. Many certification organizations invest their resources in promoting their programs to professionals and employers; the actual "end user" or consumer of the services provided is left out of the communication loop. The cause may be that consumers represent a very broad target audience that is difficult and expensive to reach.

At a CAC meeting last year entitled, "Public Outreach by Regulators and Certifiers," Institute for Credential Excellence Executive Director Denise Roosendaal emphasized the cost variable:

Reaching the consumer, en masse, is not only difficult for messaging; it is also very expensive. Because of information overload, it takes as many as three consistent messages just to get consumers' attention, and seven messages to get them to act. So, slicing up the mass audience is important. Credentialing organizations have had success focusing on employers rather than a mass audience.

One of the things we understand about our credentialing organization members is that the demands of marketing to their own certificant population leave very little left of

marketing to the public. Research shows that they now spend about 47% of their revenue for marketing, and this marketing is primarily for their certificant population.

Cost is a real issue, and it must be taken into account.

For both licensing boards and certification organizations, educating the public – including community groups and their leaders – is an essential first step if the goal is to get citizen support and community group advocacy in support of their work. At last year's outreach meeting, Nancy Kirsch, a member of the New Jersey Board of Physical Therapy and the board of directors of the Federation of State Boards of Physical Therapy, put it bluntly:

If our responsibility is to protect the public, we are responsible for educating the public what that protection represents. We are not doing as good a job at this as we could be doing. Consider our Web sites. Consumers have to click and click in order to find information, and even then, it may not be the information they want and need.

What can regulatory board associations do to help our member boards provide the right information to the public? If we are not providing information to the public about the services they should be getting, how will they know when they are not getting good services? How will they understand what to report, and how to file a complaint?

I believe that both licensing boards and certification organizations can learn from professional associations about the need to give a high priority to promoting consumer involvement. Another speaker at last year's meeting, Justin Elliott, the Director of State Government Affairs at the American Physical Therapy Association (APTA) explained why his organization believes citizen involvement is critical to carrying out its mission. He said:

> APTA educates the public about issues that impact them, including issues related to Medicare, scope of practice at the state level, and therapy caps. We also try to get the public involved in these issues. From our perspective, getting the public excited and involved is important because patient advocates provide a distinctive perspective to policy makers. It is one thing for a physical therapist to tell a legislator how he or she or the profession is affected as a provider of service. It is more effective when a patient tells their story about how physical therapy has helped them… While public policy affects the profession, it can have a bigger impact on the patients we serve.

Mr. Elliott also made the point that effective consumer education does not always mean drastically increasing the outreach budget or taking on a bunch of new projects. Sometimes it is a matter of doing a better job executing an existing program. He used the redesign of his organization's Web site as an example:

> We used to have just one Web site, with lots of information about PT. People complained that it was confusing and difficult to navigate. We retained an outside firm to do a Web site audit. We were told we needed to condense our information and focus on those areas people are interested in. We were told we were labeling things wrong. We were viewing our Web site from the perspective of APTA, rather than thinking about it as a caregiver or patient would.
>
> The audit revealed we needed two entry portals. So, we maintained http://www.apta.org and fixed it up. We also created another Web site,

> http://moveforwardpt.com, intended for patients. It contains information on conditions and situations a PT can treat. The two sites are interlinked with each other.

Not only can we learn from professional organizations like APTA, we can learn from licensing boards and certifying organizations in non-healthcare fields. In preparing for giving a talk last year at the annual meeting of the association of boards that license general contractors, I looked at the Web sites of the boards in states that had experienced a natural disaster – floods, forest fires, hurricanes, tornadoes, and the like. Was I ever impressed by some of these Web sites. Right on the home page, I found information that would be enormously helpful to a homeowner facing major repairs following a natural disaster. The FAQs when something like this: "How can I avoid getting ripped off by an unqualified repairperson?" Am I liable to a subcontractor even though I paid the entire bill to my general contractor but he did not pass the money along?" (the answer is Yes; something I did not know). The Web sites I looked at followed the advice of the APTA spokesperson: "Focus on those things people are interested in."

I will say one more thing about using Web sites to educate the public. Nancy Kirsch (NJ Board of Physical Therapy) related this story her board's Web site:

> New Jersey is trying to have good public outreach, but we're really not yet there. I asked a friend what he would do if he needed to find a physical therapist. He has enough computer savvy to negotiate the Web. He did a Google search. I was surprised to find that the New Jersey Board of Physical Therapy comes up first – before the professional association. A click on the licensing board link reveals a very congested, confusing Web site.
>
> My friend was hoping he would find an explanation of the practice of physical therapy. What he really wanted to know was how to choose a PT. What do PTs do? What are their qualifications? How do I know that the person I picked is any good? How do I find out? If I do have a complaint, what should I do? None of that is on the Web site.
>
> As board members, what would we want a consumer to know? What types of services should they expect? What is available to them if they suspect they are receiving substandard care?

Let me conclude these opening remarks by saying a few words about how we designed this meeting. As you know, we entitled it "Public Outreach: Promoting Awareness and Stimulating Community Involvement." Perhaps we should have titled in "Creating Consumer Demand."

Some years ago, CAC ran a program for the beneficiary members serving on the boards of directors of Medicare Quality Improvement Organizations (QIOs), known at one time as Peer Review Organizations (PROs). The mission of these groups was to "encourage" providers (physicians and hospitals) to follow best practices when treating Medicare beneficiaries with specific diseases. Initially, most QIOs created separate provider and consumer outreach programs. Subsequently, the outreach programs were merged.

How well did these programs work? At CAC, we recommended that the consumer outreach be evaluated, at least in part, according to what it contributed to improving

performance by providers. In other words, did this outreach create a demand (as drug companies do with their direct to consumer advertising) or instill incentives for providers to follow practice guidelines, for example, or spend more time answering questions and making sure patients understand the treatment regimen, or otherwise promote patient engagement?

In the program for today's meeting, we said:

> We will explore the possible reasons for the limited participation by community groups and members of the public. We will begin to develop novel and creative outreach strategies, taking into account the successes and failures of past efforts.
>
> An essential first step will be to ask community representatives what would motivate them to become involved. The meeting will begin with a focus group composed of community leaders who will take about their health care issues and concerns, and offer their thoughts on what it will take to get community groups interested and involved in the activities of licensing boards and voluntary certification agencies.

In just a moment, we will begin this meeting by hearing from community representatives. I am sure we will all learn a lot from this session.

Immediately following the focus group, we will hear descriptions of two efforts to engage community groups in the work of licensing boards in California. One effort was successful, the other disappointing. At our working lunch, two representatives from the North Carolina Board of Nursing will describe what they believe is a strong public outreach program.

After lunch, we return to California for a case study involving strong consumer participation in a rulemaking proceeding conducted by the board of pharmacy. This is a story I believe demonstrates the value of citizen participation.

The next session will feature four individuals who serve or have served in the past as public members on health professional licensing boards or voluntary certification agency boards of directors. The interaction between public board members and affected consumers and consumer groups will be one of the topics explored at this session.

The final session today explores effective messaging to community groups and the public. It will be presented as a case study from Ohio on the subject of tightening up on opioid prescribing.

Tomorrow morning we will reconvene at 9:00 am for four sessions, all moderated by CAC board member, Mark Yessian. First, we will discuss the merits of citizen advisory committees as a tool for facilitating communication to and from the public. Then we will hear about a successful effort by a citizen group to influence scope of practice legislation in Colorado. A national certification organization lent support to this and advocacy efforts in other states.

The following session will look in depth at ways in which social media can be employed to stimulate consumer awareness and involvement. Finally, we will close the conference with an interactive discussion among all attendees entitled, "The Voice of the Community: What Can Be Learned from Their Inquiries and Complaints."

LETTERS

From: Kathy Apple [mailto:kapple@ncsbn.org]

Sent: Tuesday, June 24, 2014 1:37 PM

To: David Swankin (DavidSwankin@cacenter.org)

Subject: RWJF Interview

David: Thought you would like to see this RWJF interview. I was happy to further recognize Ben's good work…

http://www.rwjf.org/en/blogs/human-capital-blog/2014/06/nurse_leader_honored.html?cid=xsh_rwjf_em#.U6mTX9Tf_1M.email.

Kathy

~~~~~~~~~~~~~

Dear Friends,

The mercury-free dentistry movement mourns the passing of two pioneers, Dr. Andy Landerman of California and Bob Jones of Texas. Bob Jones was the co-founder of Consumers for Dental Choice, along with Sue Ann Taylor of Atlanta. In 1996, the nascent movement for mercury-free dentistry was on the verge of being destroyed. Back then, dentists who spoke out against amalgam lost their dental licenses in this land of the free, home of the brave. Due to this notorious gag rule, hardly any consumers knew that "silver fillings" are really mercury fillings…

Dr. Landerman changed the paradigm again in 1999 with a petition to recover his dental license, which the state had taken away because he refused to use mercury fillings. I was honored to be serving as his attorney when Dr. Landerman boldly asserted his right to practice dentistry without amalgam. In response, the tyrannical chairman of the California Dental Board thundered: "A mercury-free dental practice does not fit the standard for dentistry in California" – a claim devoid of legal basis, but typical of dental boards at the time. Suddenly, the mercury-free dentistry movement was catapulted to the front page of *The Los Angeles Times*, which featured an article about the amalgam debate. Here is the supreme irony: two years later, Dr. Landerman was on his way back to practicing mercury-free dentistry… and the dental board was shut down by the California state legislature. California sneezes, America catches a cold; every dental board retreated on the gag rule. Momentum was shifting our way thanks to Dr. Landerman…

Today, 97 nations have signed the Minamata Convention on Mercury – the treaty that requires the phase down of amalgam use, lays out an amalgam phase down plan, and includes a mechanism for setting a phase-out date. And a new generation of dental consumers and dentists are joining forces to stop the use of dental mercury once and for all.

Charles G. Brown
National Counsel, Consumers for Dental Choice
President, World Alliance for Mercury-Free Dentistry
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MEMBERSHIP INFORMATION

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

We provide the following services to member boards:

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

We have set the annual membership fees as follows:

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

MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for 2015, please complete this form and mail or fax it to:

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

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or

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

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Signature Date

Our Federal Identification Number is 52-1856543.

WE WANT YOU EITHER WAY!

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