News & Views

Citizen Advocacy Center

First Quarter, 2016 – Health Care Public Policy Forum – Volume 28 Number 1

Announcement

Our 2016 annual meeting will be held in Portland Oregon on Saturday afternoon and all day Sunday, September 17 and 18, 2016. The meeting will be co-sponsored by CLEAR. The theme will be "Modernizing the Regulatory Framework for Telehealthcare Delivery." It will take place immediately following the CLEAR meeting, which ends at noon on Saturday. A preliminary program and meeting registration form can be accessed from www.cacenter.org.

IN DEPTH FEATURE

Transparency in Patient Safety: Seeing is Believing

The 2015 Ben Shimberg Public Service Award was given to Lisa McGiffert, Director, Consumers Union Safe Patient Project, for her advocacy and success in mobilizing consumers and patients to represent the public interest before licensing boards and in other settings. The text of Ms. McGiffert's Ben Shimberg Memorial Lecture appears here:

I am so honored to be singled out for the Ben Shimberg award among the many people who work across the country to try to keep patients safe by improving the oversight of health professionals. It is a particular privilege to be listed with those I admire personally and have had the opportunity to work beside such as Art Levin and Julie D'Angelo Fellmeth.

I met Art more than 20 years ago when I joined a committee of consumer organizations that vetted candidates for consumer representatives on FDA advisory committees. We immediately connected as

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fellow travelers on this path of including the public interest voice in all facets of our nation's health regulatory system.

And, Julie entered my orbit about six years ago when we began monitoring the Medical Board of California (MBC). We were quickly introduced to her extraordinary body of work – years of persistently and intelligently monitoring the board. The board respects her opinion, they listen to her, and often they do what she asks because they know she is solidly committed to ensuring they are accountable to the people of California. I wish every state had a Julie Fellmeth.

And, thank you for the opportunity to "meet" Ben Shimberg, who was fundamentally about regulation in the public interest and spent his life working toward that purpose. I am so honored to be introduced to and connected to his work in this way.

As you heard, I work for Consumer Reports – we are a nonprofit organization that tests and rates products and publishes the results. Through our advocacy and policy arm – Consumers Union – we push for changes in the marketplace and in laws so they tilt more in the favor of consumers. For the past 14 years, I have directed the Safe Patient Project. We work on an array of issues – health care-acquired infections, medical errors, safety of medical devices and physician accountability.

Our ultimate goal is to eliminate preventable patient and we do so by seeking policy changes that make medical errors and the risk of harm more transparent to the public. That in turn motivates health care providers, and sometimes their regulators, to act differently. Working alongside of me to meet these goals are Consumers Union staffers Suzanne Henry and Daniela Nunez – their research, tweeting, organizing, story collecting and analyzing is what makes the wheels of our Safe Patient Project turn. I want you to recognize that I share this award with them. And, with consultant Maryann O'Sullivan, an extraordinary combo of organizer/policy wonk, who has been instrumental in keeping us moving forward on California medical board work.

I am especially pleased to be recognized for my work mobilizing consumers and patients to speak up for the public before medical boards. Over the years we have collected more than 6000 stories from people who have experienced medical errors up close and personal. These story sharers have helped us build a network of citizen activists from all over the country – now called the Patient Safety Action Network. This is an amazing and remarkable group. They are members of a club that none of them wanted to join and they are passionate about preventing others from experiencing what they did. At least one of them is speaking out and taking action every day to make our health care system safer. They are involved in all of our work and we are often involved in their efforts. For example, last year they formed an ad hoc Medical Board Roundtable – we meet monthly to share information and ideas about how to make our states' licensing boards more responsive to the needs of consumers and patients.

Working with this network is the best part of my job. They keep me focused on what is really important: staying on the side of patients and not getting distracted by the much more visible and ubiquitous issues concerning doctors and hospitals. Health care providers do have issues that I might be sympathetic to and there is a lot needed to be done to improve their experiences working in the health care system. But they have other people to advocate for them. My job is to advocate for what patients and the broader consuming public needs and that sometimes conflicts with what health care providers need and want. I get really peeved when consumer advocates are lured away from the focus on patients – often through funding sources that direct them to work on provider issues. There are simply not enough of us. So we have to stay focused. As public members of occupational licensing boards – you have a similar responsibility.

My first introduction to physician accountability issues was in the late 1980's. I was a staffer for the Texas Senate Committee on Health and Human Services. My boss was one of the sponsors of a bill to incorporate changes required by the federal Health Care Quality Improvement Act – the law that created the National Practitioner Data Bank. This bill allowed the Medical Practices Act to be completely opened for debate. The negotiations

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

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

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were intense and I learned a lot about occupational regulation that year. In subsequent years I worked on many issues relating to the whole array of state oversight boards – nurses, pharmacists, dentists.

When I moved over to Consumers Union's Austin based Southwest Office in 1991 I took these regulatory accountability issues with me and continued to monitor and work to improve how boards interact with the public and to make their work more transparent to the public. In 2003 I turned my attention to public reporting of hospital-acquired infections – we were instrumental in passing 30 state laws, after which the federal government required all US hospitals to report certain infections. Without knowing where these problems are, we cannot address them. We are now seeing some of these infection rates coming down. And one of the major factors in making that happen was transparency. The pressure brought by public awareness can be great. In 2009 physician accountability issues returned to my repertoire – and transparency is a major part of that work.

An early lesson learned in my life as an advocate was that information is power. And without information, the public is powerless. I think ultimately transparency is a primary issue in patient safety, including oversight of health professionals. In its truest form, transparency requires making the information easily available to the public without arbitrary barriers – the Internet has really helped us there. But to achieve real transparency also requires promoting to consumers where to find information, translating what the information means and how they can use it.

We recently filed an administrative petition asking the Medical Board of California (MBC) to require all physicians on probation to inform their patients of their probationary status. The board does this sometimes in probation orders, but not consistently. We wanted this notice to be a standard part of probation orders.

For several years we had been asking the board to discuss this issue that had actually been raised by board staff as a 2012 Sunset review recommendation, but rejected by the board. Unfortunately, the board wouldn't put this issue on their agenda, which is the only way they could discuss it. So we filed this petition – California law requires state agencies to respond to such a petition within 30 days. That's how we got our day before the Medical Board.

I realized that this proposal and the board's response highlights many common frustrations that consumers and patients have with health licensing agencies in general and medical boards in particular.

The first basic issue raised: What does "public information" look like and what does it mean to board members who are directed to serve the public? These days, health licensing boards embrace the public's right to know and are proud of the information they have posted on their websites.

I have to take a minute to say that there is much to be proud of. It is much easier to get public information today than when I began working on these issues. It was a huge victory when the Texas Medical Board finally posted disciplinary orders on the website. But the documents were in some obscure and difficult format, instead of the universally used pdf format.

In general, these websites could be a lot more consumer friendly and we know that is not always under board control. But, boards seem to be okay with people having to work at "knowing." They don't make it easy and often create unnecessary barriers, for example: the link to many states' profiles is labeled "verify a license" or "look up a license" – when "look up your doctor" would be so much more understandable. Many websites have legal disclaimers that would make the average consumer think that the information was not correct, even information created by the board. And, there is typically no plain English summary about why a physician is on probation. So, even when consumers find their way to the medical board website, they face a complicated array of pages and links to get to a profile and then they have to wade through long legal documents that are nearly impossible for them to interpret. I don't believe this scenario fulfills the mission of truly informing the public.

We asked the California Medical Board for the list of all 500 physicians on probation. We sorted the spreadsheet by county and posted it on our website. We sent a news release out to the media and they really responded. The spreadsheet included a link to each physician's probationary order so reporters could read for themselves what led to this disciplinary action. And they were shocked that some of these doctors were still practicing on patients who had no knowledge of these actions. This didn't really surprise us because Consumer Reports had surveyed the public several years ago and found that 79% of respondents thought that when physicians' licenses are limited, suspended or revoked, they should be restricted to work that does not require patient care or treatment until their licenses are in good standing again. Clearly an opinion that contradicts the California Medical Board's practices.

Consumers Union made it easy for the media and the public to see which doctors in their community were on probation. The media coverage before the board meeting was off the charts – with newspapers editorializing in support, radio talk shows and interviews with consumers and board members about the patients' right to know. As a consequence, many more people discovered that the medical board website was a source of important information.

Another issue: The board seemed more concerned about the burden on a few doctors to disclose their probationary status due to their behavior than for the potential risk to their patients who may be harmed. The board was concerned that this would interfere with the doctor-patient relationship. If a doctor on probation for repeated gross negligence or serious substance abuse issues harms a patient, it is the ultimate betrayal of trust if that patient was unaware of the doctor's prior discipline.

A license is a privilege. Doctors on probation have violated that privilege. This involves a very slim minority of doctors – why are boards and the overwhelming majority of physicians who never would have these problems shielding these doctors?

The board was concerned that if patients were told about a doctor's probation, they would no longer want to see that doctor. But this was insultingly flawed reasoning because the board openly stated that all patients had to do was to go to the website and find this information. We thought it was certainly more efficient for the patients of a very small percentage of licensed doctors to be informed than to expect millions of people to check on more than 100,000 doctors' backgrounds every few weeks to keep up with the medical board's actions.

Misinformation. The board members and the medical community didn't seem well informed about common behavior that lands a doctor on probation. Instead, they focused on doctors on probation for minor issues such as recordkeeping and tax issues (in reviewing orders, we have found none of those). Their focus should have been on the ones who have substantially violated medical practice standards or committed egregious acts that any patient would want to know about, has a right to know and can know if only they have a computer to look it up and the tenacity to wade through the maze of pages and documents. We were so concerned about this misinformation being provided to the public by the so-called experts that we asked the Board to analyze their probation orders and report on how many are on probation for serious issues like sexual misconduct or repeated gross negligence.

In addition to the concerns already mentioned, the medical board thought our petition was too prescriptive – it outlined how notice should be given, some of which we took directly from Board orders – and they voted to deny our petition. But they got the message that the public wants to know about these things. They adopted motions to continue working on this with Consumers Union and other stakeholders. So, we feel real progress was made toward patient and board awareness. The Board is also doing more outreach to inform the public about who they are and what they do – and plans to expand that in the future. We are very happy to see these efforts and will be working with the board to get the word out.

We will be going back to the board to ask them to require doctors to inform their patients when their probation is due to serious issues like sexual misconduct, serious substance abuse, and repeated gross negligence.

One last outcome from this action: Julie Fellmeth commented in support of our petition but voiced concerns that probation orders are not being properly monitored and responses to probation violations are too slow and too mild. The board agreed to look into this matter, which we also think is very important.

Finally, I want to touch on the role of public members. An issue that was near and dear to Ben Shimberg. While certainly all board members should represent the public interest, public members have a super-responsibility to do so. Too often, the public members are indistinguishable from the physician members in their questions and their votes. And when they are not, they're always out numbered. We want to see public members who are advocates for patients, just as physician members are advocates for doctors. You know what I'm talking about.

Recently the Federation of State Medical Boards issued a statement defining public members for its board but couched it in terms of what they should not be (e.g., a retired health care provider) rather than the attributes they are seeking in a person. Several years ago, we wrote California Governor Jerry Brown encouraging him to appoint public members who have "demonstrated a historic commitment to working on behalf of consumers and who have no conflicts of interest…. Who should have a commitment to making the medical board transparent in its decision-making process and actions" and whose "backgrounds should reflect an unflagging commitment to the health and safety of health care consumers."

Two patient safety advocates who we have worked with have been appointed to serve on state medical boards: Jean Rexford in Connecticut and Yanling Yu in Washington. These advocates were chosen because of their work on behalf of harmed patients. They are the type of public representatives we would like to see appointed to all occupational boards. The fact that you are here at this meeting indicates that you are serious about your public responsibilities. But there are many others who may never even think about it.

So, think about how you can take steps in every meeting to ask questions and pro-actively suggest changes that are specifically in the public's interest. Even one provocative public interest question could make a significant difference. Ask for more transparency, more analysis of the boards' work; give respect and attention to the few consumers and patients who make their way to your meetings; engage them in seeking solutions and suggest platforms where board members can get feedback directly from patients about their experience with the investigations of their complaints.

Thank you again to the Citizen Advocacy Center for all of the good work you do and for bestowing on me this recognition for the work that I love doing.

SPOTLIGHT

Certification Board Bylaws Enhance Public Member Role

The National Board for Certification in Occupational Therapy (NBCOT) has adopted a new bylaw significantly empowering the public members serving on its board of directors. See especially new Section 8.3.3 below, which in effect gives veto power to the public members regarding any proposed initial and renewal certification eligibility requirements, standards, and policies that are under consideration for adoption by NBCOT. CAC is not aware of any other licensing or certification entity that has so dramatically empowered their public board member(s). The new bylaw reads in full:

NBCOT Bylaws Section on Voting and Adopting Certification Standards

Section 8.3 The action of a majority of the Directors present at a meeting at which a quorum is present is the action of the Board of Directors.

Section 8.3.1 Actions approved by a majority vote of the Directors that are specific to the following certification standards: initial certification eligibility; certification examination policies; certification renewal requirements; adopting practice analysis results; and standard setting recommendation must be reaffirmed by a majority vote of the Public Directors prior to becoming effective.

Section 8.3.2 The provisions of Section 8.3.1 will be applicable whenever the Board of Directors considers modifications, additions or deletions to certification standards described in Section 8.3.1.

Section 8.3.3 **Initial and renewal certification eligibility requirements, standards, and policies that are not affirmed by a majority of the Public Directors will be referred back to the appropriate Board Committee with comment for consideration.**

SCOPE OF PRACTICE

California Law Improves Access to Licensed Midwives

SB 407, signed by California Governor Jerry Brown in September 2015, allows licensed midwives to provide services to the state's Medi-Cal (Medicaid) patients. Home births or birth center births using a midwife are as much as 80% less expensive that hospital births, so the state expects to save money while giving Medi-Cal patients greater choice.

For more, see: http://tinyurl.com/zbghh6w.

Literature Search Confirms Quality and Cost-Effectiveness of APRN Care

Martin-Misener (R), et al wrote in the *British Medical Journal* November 25, 2015, that "Patient outcomes were equivalent or better when seeing nurse practitioners in place of general practitioners within specialized ambulatory primary care settings, according to recently published data." This conclusion is based on 11 randomized studies conducted in the United States, United Kingdom and the Netherlands.

For more, see: http://tinyurl.com/hw3ym82. See also: http://tinyurl.com/gpnhfnu.

Editorial Note: See also this study which found that "removing restrictions on NP SOP regulations could be a viable and effective strategy to increase primary care capacity": http://www.nursingoutlook.org/article/S0029-6554(15)00268-7/abstract.

Institute of Medicine Updates *Future of Nursing* Report

In 2010 the Institute of Medicine (IOM) released a report entitled, *The Future of Nursing: Leading Change, Advancing Health* which forecast the role of nursing in the evolving healthcare delivery environment. In December 2015 the IOM released a follow-up report documenting what has happened with its 2010 recommendations in the intervening five years.

See: http://tinyurl.com/h9qf8gq.

Editorial Note: In an article in the Case Western Reserve Health Matrix: The Journal of Law-Medicine, vol. 24, 2015, Daniel J. Gilman and Julie Fairman look back at the IOM's Future of Nursing report recommendations on scope of practice in the context of some Federal Trade Commission initiatives to protect competition.

See a link to the article here: http://scholarlycommons.law.case.edu/healthmatrix/vol24/iss1/8/.

VA Proposes Full Practice for APRNs

The Veterans Administration has submitted proposed rules to the Office of Management and Budget which would give advanced practice nurses full practice authority in VA facilities. See: http://tinyurl.com/ha974n7.

Clinical Nurse Specialists Gain Independent Practice

The National Association of Clinical Nurse Specialists issued a press release in December 2015 to announce that:

> A review of state laws and regulations reveals that since 2010, eight states have granted clinical nurse specialists (CNSs) the authority to practice without a physician's supervision and six have given CNSs independent authority to prescribe drugs and durable medical equipment. These represent 32 percent and 40 percent increases, respectively, in the number of states that grant such authority; CNSs can now practice to the full extent of their education and training in 28 states and prescribe without supervision in 19.

See the full press release here: http://www.nacns.org/docs/PR-PrescriptiveAuthority1512.pdf.

Texas Pharmacists May Now Administer Emergency Epinephrine

Pharmacy regulation in Texas has been amended to permit pharmacists to administer epinephrine in emergency situations. They must notify 911 and have the patient evaluated by EMTs and also notify the patient's physician within 72 hours.

See the legislation here: http://tinyurl.com/jsvwavm.

Study Confirms Value of Doctor/Pharmacist Collaborative Practice

The National Council of State Boards of Nursing's *Good Morning* Members reported on February 16, 2016, that:

> A new study found that the collaborative physician-community pharmacist agreement can be successful in providing antivirals for low-risk patients without the need for a physician's office visit. To examine the effectiveness of collaborative physician-community pharmacist programs to treat influenza-like illness, adult patients with influenza symptoms were screened by a pharmacist in 55 community pharmacies in Michigan, Minnesota and Nebraska from Oct. 1, 2013, to May 30, 2014.
>
> Pharmacists completed a physical assessment, performed a rapid influenza diagnostic test and provided appropriate referral or treatment according to an established collaborative practice agreement with a licensed prescriber. Pharmacists followed up with patients 24 to 48 hours after the encounter to assess patient status.
>
> Researchers found that by using an evidence-based collaborative practice agreement, pharmacists were able to provide timely treatment to patients with and without influenza. Researchers conclude that this collaborative model could reduce the number of patients seeking care for causes that require only symptomatic management.

Find the study here: http://www.japha.org/article/S1544-3191%2815%2900009-6/fulltext.

ETHICS

HIPAA Violations Exposed by ProPublica

Charles Ornstein of ProPublica reported on December 10, 2015, that "Small Violations of Medical Privacy Can Hurt Patients and Erode Trust." The story was co-produced by National Public Radio. Ornstein catalogues a series of small violations of privacy that caused embarrassment and worse for the patients affected.

He points out that the federal agency responsible for enforcing HIPAA, the Office of Civil Rights (OCR), rarely disciplines practitioners for violations considered to be "small." Most of what OCR concerns itself with are large-scale data breaches, which must be reported to the agency if they affect 500 or more people. Some small-scale privacy violation victims have won jury awards. Ornstein interviews Neal Eggerson, an attorney who has filed several such lawsuits.

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

QUALITY OF CARE

New Regulations for California Ambulatory Surgery Centers

SB 396, which went into effect January 1, 2016, requires ambulatory surgery centers (ASCs) and office-based surgical practices in California to meet new requirements aimed at ensuring that the facilities and those who work there are properly credentialed. Among other things, the law requires ASCs and office-based surgery practices to conduct peer review, to update medical staff bylaws, policies and procedures to be consistent with the peer review process, to undergo unannounced accreditation inspections, and to conduct background checks on current and prospective staff to learn of any prior denials or restrictions of staff privileges.

For more, see: http://tinyurl.com/jtyy93n.

Medical Board Acts to Curb Concurrent Surgeries

The Massachusetts Board of Registration in Medicine passed a rule requiring surgeons to sign in and out of operating rooms and to identify the backup surgeon who will fill in when the primary surgeon leaves the room. The action was taken in the wake of a *Boston Globe Spotlight* expose revealing the controversial but not uncommon practice of surgeons conducting more than one surgery simultaneously.

See: http://tinyurl.com/zcco9t5.

LICENSURE

Professions Differ Over License Portability

An article by Michael Ollove in the Pew Charitable Trust's *Stateline* reviews how different professions are addressing license mobility. Nursing pioneered the Interstate Compact, to which 25 states now belong. Medicine takes a more conservative approach which still

requires physicians to be licensed in every state in which they practice, but expedites the application process. Other professions – psychology, social work, physical therapy, occupational therapy, and mental health counselors are in various stages of developing their approaches to licensure portability.

For details see: http://tinyurl.com/htsdrpa.

CAC Endorses Physical Therapy Compact

On February 23, 2016, CAC transmitted the following letter in support of the Federation of State Boards of Physical Therapy initiative to create an interstate licensure compact:

William Hatherill, CEO
Federation of State Boards of Physical Therapy
124 West Street South
Suite 300
Alexandria, VA 22314

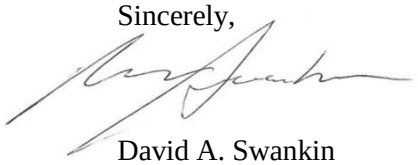
Dear Bill:

The Citizen Advocacy Center (CAC) is pleased to enthusiastically support the new Physical Therapy Licensure Compact (PTLC). We believe this interstate licensing agreement will meet the needs of patients and licensees while preserving the regulatory authority of the individual states. The compact will benefit patients by promoting improved access to physical therapy services.

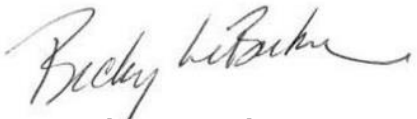
We are pleased to see that the Physical Therapy Compact Commission will seek public comment as it develops rules and regulations for the promulgation of the compact. CAC looks forward to participating in this rule development process.

We urge the Federation to include at least one public member on the new commission and its executive board.

Sincerely,



David A. Swankin
President and CEO



Rebecca LeBuhn
Board Chair

Medical Boards Join Licensure Compact

As of January 21, 2016, twenty-six states have enacted or introduced legislation to join the Federation of State Medical Board's compact to expedite licensure application. For details, see:
https://www.fsmb.org/Media/Default/PDF/Advocacy/NewCompactIntroductions_Jan2016_FINAL.pdf.

"Assistant Physician" License Aims to Address Physician Shortage

Several states (Missouri, Arkansas, Kansas, and potentially Oklahoma) have enacted legislation that would permit medical school graduates to treat patients before they have completed residencies. The objective is to relieve the physician shortage. Many professional organizations, including the AMA, the Association of American Medical Colleges, and the American Association of Colleges of Osteopathic Medicine oppose the idea.

The law in Missouri creates a license for an "assistant physician," who can provide primary care services in underserved areas when supervised by a physician. For a variety of reasons, this program is not yet operational. Similar legislation in Arkansas creates a "graduate resident physician" and in Kansas, a "physician in training."

Read more at: http://tinyurl.com/hzwm4k4.

Value of Licensure Questioned

An editorial in the *Orange County Register* on February 12, 2016, challenges occupational licensing laws because, as stated in the headline "Occupational licensing laws harm consumers, suppress jobs." The editorial was prompted by a hearing on February 4, 2016 before California's Little Hoover Commission called to examine the social and competitive effects of licensure.

See the editorial here: http://www.pe.com/articles/licensing-794219-economic-licensed.html. See testimony before the Little Hoover Commission here: http://tinyurl.com/gu9aogc.

Survey of Pharmacy Laws Updated

The National Association of Boards of Pharmacy has released an updated survey of pharmacy regulatory law in the US:

> Serving as a convenient reference for individuals seeking an overview of the laws and regulations that govern pharmacy practice in 53 jurisdictions, the updated 2016 Survey of Pharmacy Law is now available.
>
> The Survey, produced in CD format, consists of four sections including a state-by-state overview of organizational law, licensing law, drug law, and census data. Newly added this year:
>
> - A question in Section 16, Pharmacy Licensure Requirements, asks if states recognize the NABP Verified Pharmacy Program®.
> - Two questions in Section 20, Prescription Requirements, ask if states require identification for Schedule II controlled substance (CS) prescriptions and for CS prescriptions other than Schedule II.
> - Four questions added to the new section, Section 27, Independent Pharmacy Practice, ask if pharmacists may administer tests, interpret tests, prescribe based upon test outcomes, and prescribe naloxone.

Updates for the 2016 Survey were graciously provided by the state boards of pharmacy. In addition to the boards' support, NABP requested data from relevant health care associations for the Survey's prescribing authority and dispensing authority laws in Sections 23 and 24, and laws pertaining to the possession of non-controlled legend drugs and possession of CS in Sections 25 and 26. Additional updates to the Survey are described in the November-December 2015 (PDF) issue of the NABP Newsletter at http://nabp.net.bmetrack.com/c/l?u=5CDC10C&e=89C322&c=8AB9&t=0&l=193A29E6&email=ykfSJIUqLGX%2FpmSHZOtaW%2FANyf4zh32MmMYADqvCF08%3D&seq=1.

The *Survey* can be purchased online for $195 by visiting the Publications section of the NABP website at http://nabp.net.bmetrack.com/c/l?u=5CDC10D&e=89C322&c=8AB9&t=0&l=193A29E6&email=ykfSJIUqLGX%2FpmSHZOtaW%2FANyf4zh32MmMYADqvCF08%3D&seq=1. NABP provides the *Survey* free of charge to schools and colleges of pharmacy for distribution to their final-year pharmacy students. This is made possible through the generous grant of Purdue Pharma L.P.

For more information on the *Survey*, please contact Customer Service via phone at 847/391-4406 or via email at custserv@nabp.net.

ENFORCEMENT

Los Angeles County to Require Chaperones for Sensitive Exams

In the aftermath of a legal settlement with a patient who alleged sexual abuse in a Los Angeles County clinic, the Board of Supervisors ruled that all county clinics must have chaperones during sensitive medical exams.

County Supervisor Sheila Kuehl wants the Department of Health Services also to empower nurses and other hospital workers to report cases of suspected abuse. Nurses and others hesitate to do so out of fear of retaliation.

For more, see: http://tinyurl.com/hkc54ed.

DISCIPLINE

Study Finds Many Doctors Not Disciplined for Sexual Misconduct

"Seventy percent of U.S. physicians – 177 out of 253 – who had engaged in sexual misconduct that led to sanctions by hospitals or other health care organizations or a malpractice payment were not disciplined by state medical boards for their unethical behavior…" This is according to research released February 3, 2016 by Public Citizen's Health Research Group. Interestingly, the research showed that when licensing boards do take action against doctors found to have sexually abused patients, the actions tend to be more severe than disciplinary measures for other types of offenses.

For more see: http://tinyurl.com/j46xgam.

New Jersey Found to Have Inconsistent Handling of Sexual Abuse Cases

In a lengthy article in the Passaic County *Herald News* on October 25, 2015, staff writer Jean Rimbach explores how the State Board of Medical Examiners handles cases alleging sexual abuse. An important element is the extent to which the public is informed of the fact that there has been discipline and chaperone requirements and other restrictions.

Editorial Note: See also the section on CONSUMER INFORMATION in this issue for more about advocacy in favor of public disclosure when doctors are on probation.

The Director of New Jersey's Division of Consumer Affairs is working with the medical board to strengthen the disciplinary measures imposed in sexual abuse cases and improve transparency.

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

CONTINUING PROFESSIONAL DEVELOPMENT

Florida Board of Medicine Prevails in Dispute with Electrologists

In 2014 the Society for Clinical and Medical Hair Removal (SCMHR) asked the Florida Board of Medicine for a decision related to the requirement that electrologists who use laser and light-based devices earn certification. The medical board determined that the affected group of electrologists need only to obtain initial certification and do not need to re-certify every five years as required by the certification program offered by the trade association. The SCMHR challenged the board's decision in court.

A state appeals court ruled in January 2016 in favor of the medical board. "…(T)here appear," the court wrote, "to be valid policy arguments for and against such a requirement. However, these policy arguments are more appropriately directed to the board in the rulemaking process because this court does not have the authority to make policy or to second-guess the wisdom of the policy embodied in the board's rules."

Editorial Note: It will not surprise readers of CAC News & Views that we believe the medical board and the appeals court came down on the wrong side of this issue. If there is value in requiring certification in the first place, there is merit in requiring those certified to conform with the certifier's requirements for maintaining that certification in good standing.

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

Call for Hospitals to Monitor Aging Clinicians

In a post on *HealthLeadersMedia*, November 10, 2015, Alexandra Wilson Pecci describes initiatives taken by hospitals to strike a balance between taking advantage of older practitioners' valuable years of experience and protecting patients from risks associated with older practitioners' declining faculties. See: http://tinyurl.com/z49lh4c.

Editorial Note: CAC has long recommended that licensing boards, healthcare delivery institutions, and specialty certification bodies collaborate in assessing and verifying the current competence of healthcare practitioners. CAC News & Views urges licensing boards to reach out to hospitals and other institutions that have instituted or are considering procedures for monitoring the ongoing competence of their workforce.

Informal Poll of Physical Therapists About Continuing Competence

An article in the Federation of State Boards of Physical Therapy (FSBPT) Winter 2015 *Federation Forum*, entitled Consumer Awareness: Are we doing enough? explores the views of physical therapists in attending the FSBPT annual meeting about how well PTs and their licensing boards do when it comes to ensuring patients of PT's current competence.

See: http://tinyurl.com/zmlv37f.

PAIN MANAGEMENT AND END OF LIFE CARE

Experts Recommend Ways of Curbing Opioid Abuse

With the expanding epidemic of prescription opioid abuse, experts recommend ways to address the problem. A guest column by the American Society of Anesthesiologists takes the position that doctors can help curb abuse by engaging in "serious discussion" with patients and caregivers when opioids are prescribed. See: http://tinyurl.com/gpsnhhn.

An article in the *Journal of the American Medical Association* makes the case that efforts to control the problem need to be addressed by all prescribers. Recent research found that instead of a small subset of doctors, pain meds are prescribed by a "broad cross-section of medical professionals…. That means overprescribing opioids, they suggested, is a problem to which a majority of health professionals are contributing, not the work of a small minority." See: http://tinyurl.com/zvc72mp. An article in the New England Journal of Medicine advocates that prescriber education is a the most promising approach to curb overprescribing. See: http://tinyurl.com/hmgpde2.

The White House has assigned the Department of Agriculture to head an interagency task force to tackle opioid abuse in rural areas: http://tinyurl.com/gs7x4nv. The Food and Drug Administration has announced a plan for developing a multidimensional proactive response to the opioid crisis: http://tinyurl.com/hsgvx89.

The Centers for Disease Control and Prevention (CDC) has issued draft guidelines to reduce opioid abuse and addiction which include such measures as urine testing and limits on the amount of opioids that can be prescribed to a single patient. This approach is being challenged by advocates for those patients who suffer from chronic, unmitigated pain. See: http://tinyurl.com/zu33fhv. The Drug Enforcement Agency recommends a 360 degree approach. See: http://www.dea.gov/divisions/hq/2015/hq111015.shtml. Legislation introduced in the U.S. Congress proposes a comprehensive approach. See: http://tinyurl.com/zskwk6h.

Johns Hopkins University issued a report entitled, *The Prescription Opioid Epidemic: An Evidence-Based Approach*, which recommends a multi-disciplinary comprehensive approach to treating addiction and preventing new cases of addiction. See: http://tinyurl.com/ojkmfun.

Published in the March-April 2016 issue of *Research in Social and Administrative Pharmacy*, another report by Onoor W. Norwood and Eric R. Wright entitled, *Integration of prescription drug monitoring programs (PDMP) in pharmacy practice: Improving clinical*

decision-making and supporting a pharmacist's professional judgment explores how to more effectively integrate pharmacists in efforts to prevent prescription drug abuse. (http://tinyurl.com/gsrq4hv).The National Association of Boards of Pharmacy (NABP) is aggressively fighting illegal online sellers which "contribute to the nation's prescription opioid epidemic." (http://tinyurl.com/gwvt3u8). A blog published by the AAFP contends that e-prescribing offers protections against prescription abuse by providing a direct link between prescriber and pharmacy: http://tinyurl.com/hvnckdp.

States Take Varied Approaches to Curbing Opioid Abuse

Michigan relies on the Michigan Automated Prescription System which a governor's task force has recommended be updated or replaced to remove deficiencies. See: http://tinyurl.com/zp76mx7. California has taken steps to fix technical glitches in its prescription monitoring program which doctors and pharmacists say have discouraged them from using the system. See: http://tinyurl.com/zdw2488. In Maryland, the medical board mandated continuing medical education courses in opioid prescribing. See: http://tinyurl.com/j4hon2s. South Dakota is considering permitting emergency responders to carry naloxone. See: http://tinyurl.com/h3jgsx2. See also: http://tinyurl.com/zvc72mp. Ohio adopted guidelines to curb abuse: http://www.med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/Publications/E-News-NewsLetters/Med%20Bd%20E-News%20-%20Acute%20Pain%20Prescribing%20Guidelines%20-%20.pdf. Massachusetts is going after illegal prescribing: http://tinyurl.com/ztydnh8. The Federation of State Medical Boards has published a directory of state prescription monitoring programs: https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_pmp_overview_by_state.pdf. In Minnesota, the boards of medicine, nursing and pharmacy have updated their joint statement on pain management: https://mn.gov/boards/assets/Joint%20statement%20PR%202015_tcm21-90719.pdf. The National Governors' Association has signed on with the AMA to a statement calling for action: http://tinyurl.com/hcsczsq.

Medical Association Issues Guidelines Related to Aid in Dying Law

In response to requests from its membership the California Medical Association has issued a Q and A guide to how to comply with the state's new End of Life Option Act.

For more, see: http://tinyurl.com/j8uq4uo.

California Group Assesses End of Life Care

The Coalition for Compassionate Care of California has released an assessment of end of life care in the state compared to recommendations by the Institute of Medicine. The report notes progress that has been made, but says more need to be done:

> The growing need for palliative care far outpaces the capacity of services in California. In particular, palliative care specialists are in short supply, and certification programs are limited. Reliable funding streams do not yet exist. While knowledge is growing about best practices and quality standards, they have not yet

been broadly implemented. And so far, consumer demand for better care at the end of life has not created the type of powerful change seen with the experience of childbirth.

Read the report at: http://tinyurl.com/jm5ex3m.

NORTH CAROLINA DENTAL CASE

AMA Comments on Implications of Supreme Court's North Carolina Dental Decision

The American Medical Association was disappointed in the Supreme Court's decision in the North Carolina dental case, having warned in a brief before the Court that "requiring active state supervision of licensing boards as a condition of antitrust immunity would subordinate public health to antitrust considerations, discourage service on regulatory boards, and disrupt a 150-year tradition of regulating professionals." Nevertheless, in September 2015, the AMA issued a document suggesting ways states might attempt to comply with the decision.

For details, see: http://www.cms.org/communications/ama-legal-brief.

States React to Supreme Court Decision in North Carolina Dental Case

Several states are preparing to take steps to make their regulatory framework consistent with the requirements laid down in the Supreme Court's decision. Among them is Ohio, where state Senator and antitrust lawyer Bill Seitz warns that regulatory boards could be sued if the system isn't modified. He plans to draft legislation once he receives recommendations from Governor Kasich's office. See: http://tinyurl.com/hfcjkyy.

Arizona is considering legislation that would consolidate the administrative and investigative functions of health professional boards in one agency, the Arizona Department of Health Services. See: http://tinyurl.com/jcspxp8.

CONSUMER INFORMATION

Medical Board Asked to Require Doctors to Inform Patients of Probation

In October 2015 Consumers Union (CU) petitioned the Medical Board of California to require doctors on probation to so inform their patients. Lisa McGiffert, Director of CU's Safe Patient Project, says about 500 of California's 102,000 physicians are currently under probation. The medical board denied CU's petition, but agreed to create a Patient Notification Task Force to look at how the board can improve transparency on its website and explore launching a public information campaign. See the petition here: http://tinyurl.com/hp5dxdc.

In January 2016 CU submitted a modified proposal to the Patient Notification Task Force which would require doctors to disclose to patients when the offense for which they are on probation is "serious" and exposes patients to risk, such as sexual misconduct, gross negligence and chemical dependency.

Subsequently, State Senator Jerry Hill proposed legislation (SB 1033) that would require doctors to inform their patients when they are on probation for a serious disciplinary action.

For more see: http://tinyurl.com/h2g4jo3. See also this editorial in the *Los Angeles Daily News*: http://tinyurl.com/jxpqrg4. Learn more about SB 1033 here: http://tinyurl.com/zmtk38h. See also: http://tinyurl.com/zeerunf.

Editorial Note: In connection with New Jersey Division of Consumer Affairs' review of how boards handle discipline and transparency related to sexual abuse cases, Patricia Klemar, Senior policy advisor to the New Jersey Healthcare Quality Institute expressed the opinion that if a board considers a practitioner to be enough of a threat to restrict the license, patients should be notified. See: http://tinyurl.com/zvov7nf.

CAC News and Views applauds Consumers Union for its advocacy in favor of doctors informing patients when they are under probation. We believe that this requirement should not apply solely to doctors but should apply to all healthcare professions.

Iowa Board Publishes Consumer Information Brochure

The Iowa Board of Medicine has posted on its website a guide to help consumers understand how the board handles complaints. The guide explains what the board does, including what professions it does not regulate. It then explains the investigative and disciplinary process.

See the guide at http://tinyurl.com/j8g46p7.

TELEHEALTH

NCSL Publishes *Telehealth: Policy Trends and Considerations*

The National Conference of State Legislatures has published policy guidance for state legislators considering telehealth legislation in their states. This excerpt from the document's executive summary explains that:

> Policymakers are working to craft frameworks that capitalize on the bene ts of telehealth, while maintaining an appropriate level of oversight to safeguard state investments and ensure effective health care delivery and health outcomes.
>
> Legislators can ask questions to learn more about bene ts, opportunities and challenges related to telehealth in their states. Leaders can guide policy discussions that center on telehealth as a way to extend existing health care services.
>
> In considering telehealth policies, legislators may want to convene a variety of stakeholders from all sectors and perspectives. Policymakers modifying or creating policies may consider the level of oversight needed to ensure that services are effective in terms of costs and outcomes, and balance those needs with potential unintended consequences or future hurdles as tele-health continues to develop. Reimbursement, licensure and patient safety – along with new challenges and opportunities – will continue to be issues for state leaders to consider.

Read the document here: http://www.ncsl.org/documents/health/telehealth2015.pdf.

AHRQ to Conduct Literature Review on Results of Telehealth

Responding to a Congressional request, the Agency for Healthcare Research and Quality will develop an evidence map related to telehealth. In this technical brief AHRQ explains its goals and methodology: https://effectivehealthcare.ahrq.gov/ehc/products/624/2110/Telehealth-Protocol-150811.pdf.

New Apps for Ordering House Calls

Cellphone Apps, such as *Pager*, *Heal*, and *Medcast* enable consumers to request a house call from a participating doctor. Benefits include convenience and lower cost.

For more, see: http://tinyurl.com/htstmog and http://tinyurl.com/hnj5g6v.

CMS Model Facilitates Telehealth

The Centers for Medicare and Medicaid Services (CMS) issued a new model in January 2016 allowing Accountable Care Organizations (ACOs) more latitude for using telehealth to serve beneficiaries. The New Generation ACO (NGACO) model is intended to advance the Obama Administration's goals of experimentation with innovations including telehealth and alternative payment models to provide beneficiaries with better care.

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

Editorial Note: Legislation introduced in the U.S. Congress would expand Medicare coverage of telehealth services in rural areas. See: http://tinyurl.com/h4dxl3r and http://tinyurl.com/j27xtlv. Also in January 2016, Humana added telehealth to its Medicare Advantage plans in 12 states (AZ, IL, IN, KS, KY, MI, MO, OH, PA, VA, WA, and WV). See: http://tinyurl.com/qstqshf. The United States Senate Committee on Finance is also considering policy guidance that would expand the use of telehealth for beneficiaries with chronic conditions. See: http://tinyurl.com/ztybfqh

Texas Medical Board President Defends Board Position on Telehealth

Under pressure when a court overruled the medical board's position vis a vis telemedicine provider, *Teledoc*, Texas Medical Board president, Dr. Michael Arambula, contributed a guest commentary in the November 13, 2015, online *American Statesman* to explain that telemedicine is permitted in many settings in the state.

See the entire column here: http://tinyurl.com/zqa6urw.

American College of Physicians Takes Stand on Telehealth

Hilary Daniel, BS; Lois Snyder Sulmasy, JD, for the Health and Public Policy Committee of the American College of Physicians co-authored an article in the November 17, 2015, issue of the *Annals of Internal Medicine* setting forth telehealth policy recommendations of the Health and Public Policy Committee of the American College of Physicians (ACP). According to the article abstract:

> Telemedicine – the use of technology to deliver care at a distance – is rapidly growing and can potentially expand access for patients, enhance patient–physician collaboration, improve health outcomes, and reduce medical costs. However, the

potential benefits of telemedicine must be measured against the risks and challenges associated with its use, including the absence of the physical examination, variation in state practice and licensing regulations, and issues surrounding the establishment of the patient–physician relationship. This paper offers policy recommendations for the practice and use of telemedicine in primary care and reimbursement policies associated with telemedicine use. The positions put forward by the American College of Physicians highlight a meaningful approach to telemedicine policies and regulations that will have lasting positive effects for patients and physicians.

For more, see: http://annals.org/article.aspx?articleid=2434625.

Florida Medical Board Allows Telehealth Prescribing

The Florida Board of Medicine voted in February 2016 to uphold a rule permitting the use of telemedicine to prescribe controlled substances for the treatment of psychiatric disorders. The board acted after three experimental telehealth prescribing programs authorized in 2015 concluded successfully.

For more, see: http://tinyurl.com/zvc7mvs and http://tinyurl.com/jnv9r4s.

Editorial Note: Among the states considering teleprescribing, Indiana's House of Representatives passed HB 1263 in February 2016 which would permit physicians, physician assistants, and APRNs to prescribe remotely to patients with whom they have an established relationship. (http://medcitynews.com/2016/02/indiana-telemedicine-prescriptions/.)

Telehealth in the ICU Shown to be Cost-Effective

Researchers at the University of California Davis publish study in the journal *Critical Cere Medicine* entitled, "Economic Evaluation of Telemedicine for Patients in ICUs. Mathematical modeling by the researchers found that the benefits of using telehealth technologies can be worth the significant investment involved. ICU telehealth includes monitoring patients and providing access to specialists not available at the ICU site.

For more see: http://www.ucdmc.ucdavis.edu/publish/news/newsroom/10673.

Employee Benefit Association Participates in Telehealth Rulemaking

ERIC, the ERISA Industry Committee, submitted testimony to the Wisconsin Medical Board rulemaking proceeding on telehealth policy. A national trade association advocating for employee benefit and compensation interests of America's largest employers, ERIC promotes policies that facilitate the use of telehealth. ERIC's recommendations to Wisconsin are to adopt flexible policies and avoid unnecessary restrictions.

See the recommendations here: http://www.eric.org/health/eric-participates-in-wisconsins-telemedicine-rulemaking/.

MEMBERSHIP INFORMATION

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

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

We provide the following services to boards that become members:

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

The annual membership fees are as follows:

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

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There are three ways to pay for your membership:

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