News & Views

Citizen Advocacy Center

Third Quarter, 2016 – Health Care Public Policy Forum – Volume 28 Number 3

Announcement

CAC is pleased to announce that our 2017 Annual Meeting will be held in Denver, Colorado on September 13, 2017 – September 16, 2017. Our meeting will be incorporated into the 2017 CLEAR Annual Educational Conference. One registration will entitle CAC Annual Meeting registrants to attend a wide array of sessions offered by CLEAR in addition to CAC's public member-oriented sessions. Visit CAC's website in early spring for more details.

CONSUMER INFORMATION

Australian Regulatory Authority Issues Activity Report

The Australian Health Practitioner Regulatory Agency (AHPRA) issued an "Update" report in June, 2016. The introduction explains:

> **Health practitioner regulation exists to protect the public.** We all have the right to access safe, quality care from registered health practitioners. It is reassuring to know that the overwhelming majority of registered practitioners meet their legal obligations and provide safe care to patients and clients.
>
> The work of National Boards and AHPRA involves work on many fronts on a daily basis. Since the start of this year, we have:

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- answered 17,0625 phone calls and 18,826 email inquiries;
- registered 22,572 health practitioners for the first time;
- renewed the registration of 345,557 nurses and midwives (92% of the 376,902 due to renew by 31 May), and renewed 4,287 limited and provisional registrants for the other 13 professions;
- monitored 5,562 practitioners with imposed restrictions on their registration;
- investigated 377 practitioners;
- finalized 318 of those investigations, of which 54 led to restrictions on a practitioner's registration, and;
- referred 59 of the 377 matters to either a health or performance assessment, panel or tribunal hearing.

In this edition of *AHPRA report* we highlight a number of important initiatives to improve our services. One focus area is providing better and more comprehensive information on what the National Registration and Accreditation Scheme (National Scheme) does and its role in protecting all of us.

The first section of the Update describes activities devoted to enhancing patient safety.

See the entire report here: https://www.ahpra.gov.au/Publications/AHPRA-newsletter/june-2016.aspx#welcome.

Columnist Supports Disclosure of Doctors on Probation

On June 8, 2016, *Las Vegas Review-Journal* columnist Jane Ann Morrison made an effective case in support of Consumer Reports' Safe Patient Project's petition to the California Medical Board to require physicians on probation for serious infractions to so notify their patients. Using as a case in point the saga of a chemically dependent Nevada anesthesiologist and his disciplinary history with that state's medical board, Morrison writes, "This is not hypothetical, folks."

Editorial Note: Public members may want to use Morrison's column, entitled "Checking Out Your Docs Should Mean Full Disclosure," to help make the case for full disclosure before their boards.

See the column here: http://tinyurl.com/jdyxf38.

Patient Safety Group Evaluates Medical Board Websites

Consumer Reports Safe Patient Project and the Informed Patient Institute collaborated with an informal group of consumer advocates to evaluate the amount and quality of information available on medical board websites from a consumer perspective. The report's executive summary explains that:

> There are a variety of reasons that patients and families may need to find a new doctor—moving to a new town, getting new insurance, or receiving a diagnosis. Many of us turn to the Internet for information about doctors. One place to look in every state is a state medical board website. Medical boards are government agencies that protect the public from the unprofessional, improper and incompetent practice of medicine. In addition to licensing doctors, they accept and investigate complaints about doctors from the public.
>
> After evaluating 65 medical and osteopathic board websites, this report concludes that the information you find on these sites varies greatly – and all can be improved to provide the public with easier access to important information about their doctors. In some states, a site may be easy to use, but have little information about a doctor of interest. In others, the information may be comprehensive, but you cannot easily get to it, cannot tell where it comes from or how current it is.
>
> The highest rated websites had comprehensive information gathered in a "physician profile" for each licensee. But most sites were difficult to navigate, with a variety of user barriers such as confusing entry points ("verify a license"), long drop down menus, security codes, or information in multiple places.

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> We used 61 criteria to evaluate the sites based on: search capabilities, the types of information one could find about a doctor, instructions and ease of filing a complaint, and what general information was available about the medical board's operations. Weighted scores were applied to identify the best and worst websites.

See the complete report at: http://consumersunion.org/wp-content/uploads/2016/03/Final-report-for-posting-3-28-16-6PM-ET.pdf.

PATIENT SAFETY

AHRQ Study Confirms Feasibility of Patient Reporting of Safety Issues

A Rand Corporation report commissioned by the Agency for Healthcare Research and Quality "describes the development, testing, and evaluation of the Health Care Safety Hotline, a prototype system for collecting narrative and structured data from consumers and patients on their concerns about the safety of their health care. The Hotline allows patients, family members, and caregivers to report patient safety problems, including errors and adverse events, on a secure Web site or by calling a toll-free phone number. The Hotline also can provide data, with the consumer's permission, back to the health care provider or organization."

Read the report at: http://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/hotline/index.html.

See also: http://consumersunion.org/wp-content/uploads/2016/03/Final-report-for-posting-3-28-16-6PM-ET.pdf.

LICENSURE

Right to Earn a Living Act Passed in Tennessee

In June 2016, the Council on Licensure Enforcement and Regulation (CLEAR) online blog reported that:

> The Tennessee governor has signed into law HB 2201, the Right to Earn a Living Act. The bill requires all state agencies to limit entry regulations for professions and occupations to "those demonstrably necessary and carefully tailored to fulfill legitimate public health, safety or welfare objectives." State agencies will be required by July 1, 2017 and July 1 yearly thereafter to conduct a comprehensive review of their entry regulations to determine whether they serve a public health, safety or welfare objective and repeal or modify those that do not. The bill authorizes any person to petition an agency to repeal or modify an entry regulation. The agency would have 90 days to respond by repealing or modifying the regulation or specifically stating how the regulation serves a public health, safety or welfare objective. By December 31, 2016, all licensing agencies must submit a copy of all existing or pending entry regulations to the government operations committees, who may conduct a hearing regarding the regulations.

See the blog at: http://clear.blogs.com/clear/2016/05/tennessee-governor-signs-right-to-earn-a-living-act.html.

Movement to Lessen Licensure Requirements Spreads

An article posted on July 6, 2016, on *Watchdog.org* describes the push-back in numerous states against "onerous and often unnecessary" licensure requirements. Examples noted by the post's author, Eric Boehm, include hair braiding, non-commercial motor vehicle driving instructors, citrus packers, metallurgists, yoga teachers, and (remarkably) shampooers and individuals who collect coins from slot machines. He cites Michigan as one of the states aggressively pursuing repeal of licensure laws for occupations such as dietitians, interior designers, auctioneers, and carnival drive operators.

Read Boehm's article here: http://watchdog.org/269803/states-embrace-licensing-reform/print/.

See also this article about "right to work" in Illinois: https://www.illinoispolicy.org/illinois-entrepreneurs-deserve-the-right-to-earn-a-living/.

Students Challenge Step 2 Exam to Qualify for Licensure

Medical students across the country are challenging the need to take the Step 2 clinical skills examination required by the Federation of State Medical Boards and the National Board of Medical Examiners for all fourth year medical students. According to an article in the *Washington Post* by Danielle Douglas-Gabriel posted online August 6, 2016, students opposing the test feel that taking it is too expensive and redundant. They would prefer that their medical schools administer such a test at no charge.

Read more at the *Washington Post*: https://www.washingtonpost.com/local/education/thousands-of-medical-students-fight-against-pricey-required-skills-exam/2016/06/08/a5b64a56-2357-11e6-aa84-42391ba52c91_story.html.

FSMB Inaugurates Video Series on Physician Regulation

On July 28, 2016, the Federation of State Medical Boards announced that:

> The Federation of State Medical Boards (FSMB) has launched a new series of videos featuring interviews with health care leaders about issues impacting state medical boards and their mission of protecting the public.
>
> According to FSMB CEO Humayun Chaudhry, DO, MACP, the series titled "FSMB Spotlight," will educate health care providers, state and federal officials and the public about the work of state medical boards in protecting the public.
>
> "The series will feature conversations about health care – especially those with a nexus with state regulation of the nation's more than 900,000 physicians and 100,000 physician assistants," said Dr. Chaudhry, who will serve as host of the series.

For more, see the press release:
http://www.fsmb.org/Media/Default/PDF/Publications/FSMB_Spotlight_Launch.pdf.

NABP Releases Updated Model Act

The National Association of Boards of Pharmacy announced a revised model licensure act in September, 2016:

> Updated *Model Act* Now Available to Assist Boards of Pharmacy in Developing Laws and Rules to Protect Public Health

The recently amended *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act)* is now available to provide the state boards of pharmacy with model language that may be used for developing state laws or board rules in their efforts to protect public health. The *Model Act* was updated to include a revised definition of "Collaborative Pharmacy Practice Agreement" to remove restrictions that currently exist in the *Model Act*. Language was also changed to the definition of the "Practice of Pharmacy" to make it more general and relevant to the evolving practice. In addition, the *Model Act* was updated to change the term "Pharmacist Care" to "Pharmacist Care Services," and the definition was updated to make pharmacist clinical services more tangible and to include more than the dispensing of prescription drugs. Language was also added to specify that pharmacist care services outside of the premises of a licensed pharmacy should ensure the confidentiality of records and patient-specific information while still being relatively retrievable.

To align with federal requirements outlined in the Drug Quality and Security Act, *Model Act* definitions were added and revised to mirror those in the Drug Supply Chain Security Act (DSCSA). In addition, the Model Rules for Compounded or Repackaged Pharmaceuticals and the Model Rules for Outsourcing Facilities sections were updated. In the Model Rules for the Licensure of Manufacturers, Repackagers, Third-Party Logistics Providers, and Wholesale Distributors section, definitions associated with the Prescription Drug Marketing Act were removed from the *Model Act* and replaced with definitions outlined in the DSCSA. A reference to the Verified-Accredited Wholesale Distributors® program as a board-designated third party to conduct inspections for initial licensure and/or verification of regulatory compliance was added.

Lastly, the Model Inspection Form for Nuclear Pharmacies that was located in Appendix A of the *Model Act* was outdated, since Verified Pharmacy Program® (VPP®) surveyors use an updated nuclear pharmacy inspection form instead. To achieve universal inspection forms among state boards and VPP, the old nuclear pharmacy inspection form was removed. In addition, to provide the pharmacy community with full access to inspection standards, the Multistate Pharmacy Inspection Blueprint is now included in the *Model Act*.

The changes to the *Model Act* were incorporated as a result of the NABP Executive Committee-approved recommendations made by the Task Force on Pharmacist Prescriptive Authority, the Task Force on the Regulation of Pharmacist Care Services, and the 2015-2016 Committee on Law Enforcement/Legislation. The Model Act is available for download in the Members section of the NABP website. A full summary of the *Model Act* changes will soon be available in the September 2016 issue of NABP's newsletter, *Innovations*.

See the model act here: https://nabp.pharmacy/publications-reports/resource-documents/model-pharmacy-act-rules/

SCOPE OF PRACTICE

Another State Permits Pharmacists to Dispense Naloxone

On June 10, 2016, the National Council of State Boards of Nursing reported in its online *Good Morning Members* that:

> Beginning June 10, 2016, pharmacists in West Virginia will be able to dispense naloxone, an opioid overdose reversal drug. The new law authorizes a pharmacist or pharmacy intern to dispense an opioid antagonist pursuant to protocol. The new law states that the West Virginia Board of Pharmacy (WVBOP) is required to develop a protocol requiring patient counseling, education materials and documentation of distribution in the West Virginia Controlled Substances Monitoring Program database. Additionally, the law requires the WVBOP to revise existing reporting requirements, provide limited liability to pharmacists and pharmacy interns and reorganize existing code language.

Politico Convenes Discussion of Scope of Practice

In June 2016, Politico called together a group of experts to discuss scope of practice regulations and make recommendations for potential changes in the way scope is addressed to expand access to care:

> POLITICO convened a working group of high-level voices to look at changes in scope of practice. We chose to focus on the roles of physician assistants (PAs) and nurses, particularly nurse practitioners (NPs). Participants included primary and specialty doctors, nurses and NPs, PAs and researchers.
>
> In an on-the-record discussion moderated by POLITICO's executive editor for health care, Joanne Kenen, the group helped us identify trends and policy options around scope of practice, and to detect changes unfolding because of new health care delivery models.

Politico reported consensus on the following recommendations:

- CMS and where relevant private payers should authorize advanced practice registered nurses to perform admission assessments, as well as certification of patients for home health care services and for admission to hospice and skilled nursing facilities. PAs should also have a broader role in these areas, particularly home health.
- To encourage more primary care providers to take part in Medicaid, state Medicaid programs should raise reimbursement for NPs to match primary care physicians.
- Medicare should allow PAs to play an ongoing role in the care of an established patient who enters hospice, just as his or her physician can.
- Public and private payers, should allow NPs and PAs more latitude in ordering supplies such as diabetic shoes.
- Public and private payers should allow billing for behavioral and mental health on the same day.
- Provider organizations and neutral health policy researchers should analyze evidence of quality and savings associated with broader authority to practice to inform states that are still restrictive.

- Medicare should expand reimbursement of telemedicine (including for mental health.) Private payers are already moving in this direction.
- CMS's implementation of MACRA should pay careful attention to reducing barriers and encouraging more use of midlevel providers, including how not to run afoul of state law. States should be encouraged to update regulations that interfere with the move toward alternative payment models envisioned by MACRA.

Read more: http://www.politico.com/story/2016/06/scope-of-practice-health-care-224571#ixzz4LmiWiwCm.

Study Finds Pharmacy Technicians Improve Medication Safety

A study sponsored by the Agency for Healthcare Research and Quality and published in *Hospital Pharmacy* documents the value of pharmacy technicians in keeping medication histories. The study concluded:

> With high accuracy rates, pharmacy technicians proved to be a valuable asset to the medication history process and can enhance patient safety during care transitions. The results of this study further support the Pharmacy Practice Model Initiative vision to advance the pharmacy technician role to improve the process of medication history taking and reconciliation within the health care system.

For more, see: http://archive.hospital-pharmacy.com/doi/pdf/10.1310/hpj5105-396.

See also this study showing that Pharmacy review, adherence counseling during discharge, and ongoing telephone follow up identify safety concerns, prove cost-effective. See http://www.healthleadersmedia.com/leadership/medication-reconciliation-slashes-readmissions.

See also http://www.healthleadersmedia.com/community-rural/fewer-pharmacies-may-mean-more-readmissions.

And this report of pharmacists correcting prescriptions for older patients: https://www.washingtonpost.com/national/health-science/americas-other-drug-problem-giving-the-elderly-too-many-prescriptions/2016/08/15/e406843a-4d17-11e6-a7d8-13d06b37f256_story.html.

Physician Assistants Practice in Multiple Specialties

The National Commission on Certification of Physician Assistants (NCCPA) has released a report showing the distribution of the certified physician assistant workforce by specialty. The report provides detailed information about a variety of variables: the specialties PAs choose, the geographic location of practice, the services they provide in the clinical setting, and more. In her preface to the report, NCCPA President and CEO Dawn Morton-Rias, Ed. D, PA-C wrote:

> When I examine the data shared by PAs, in this first NCCPA report on the PA workforce by specialty, I see evidence that supports the notion that certified PAs are answering the call! PAs are meeting the needs of practices and patients throughout the medical and surgical specialties and subspecialties. These data reflect the tremendous role certified PAs fulfill in promoting healthcare equity, providing care to Medicare patients in cardiology, cardiovascular and thoracic surgery and Medicaid patients in general pediatrics and emergency medicine, to name a few.

> Our profession's story is about providing high quality care across the healthcare landscape; one of meeting needs, improving access, and making a difference. We hope that this report, like other statistical reports published by NCCPA, informs important dialogue within and outside the PA profession about opportunities to continue to grow and enhance the full utilization of certified PAs in all of the settings and specialties in which we work.

Read the entire report here: http://www.nccpa.net/Uploads/docs/2015StatisticalProfilebySpecialty.pdf.

Pennsylvania Senate Approves Nurse Practitioner Legislation

In July 2016, the Pennsylvania Senate approved legislation that would permit nurse practitioners to practice independently under the following conditions: nurse practitioners must practice for three years and 3,600 hours under a collaborative agreement with two physicians before they can practice on their own. A similar bill in the state House (H.B. 765) has not yet passed out of committee.

For more, see: http://www.cpbj.com/article/20160713/CPBJ01/160719923/senate-oks-nurse-practitioner-bill.

Midwives Practicing in More States to Meet Demand for Home Births

An article by Michael Ollove in the Pew Charitable Trusts' online *Stateline* on July 19, 2016 describes the growth in midwifery practice as the demand for home births grows. The article explains the differences between certified nurse midwives, certified professional midwives and certified midwives and describes the current regulatory structures, which vary from state to state.

Read more here: http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/07/19/with-uptick-in-home-births-midwives-seek-to-practice-in-more-states.

See also: http://khn.org/news/california-doctors-and-hospitals-tussle-over-role-of-nurse-midwives.

EMTS Fill Gaps in Healthcare Workforce

In its September 23, 2016, *Good Morning Members* blog, the National Council of State Boards of Nursing reported that:

> According to the Council of State Governments (CSG), a nonprofit U.S. organization that fosters the exchange of insights and ideas to help state officials shape public policy, states are increasingly turning to community paramedicine to help fill the gap in the health care workforce. CSG suggests that it can be cost-effective to expand the role of licensed or certified EMTs and paramedics to provide nonemergency preventive health care services directly to patients in their communities. In addition, expanding the role of emergency medical technicians can make up for health care workforce shortages.
>
> Currently, 16 states and the District of Columbia have passed legislation related to community paramedicine. Janet Haebler, senior associate director of state government affairs for the American Nurses Association, stated that community paramedicine "strives to fill in gaps in services that previously had been provided by public health and home care nurses but were lost with funding cuts." Haebler noted that a clear definition of the

> community paramedic role with patients is a necessity. For that reason, in states with new community paramedicine laws, nurses, EMTs and others held discussions to ensure that every patient has access to high-quality care from all health care providers.

See more here: http://knowledgecenter.csg.org/kc/content/states-using-emergency-medical-techs-expand-health-care-services.

ETHICS

AMA Updates Code of Ethics

AMA Wire reported on June 14, 2016 that the organization has updated its code of ethics:

> Physicians have just affirmed a comprehensive update of the nearly 170-year-old *AMA Code of Medical Ethics*, the conclusion of a meticulous project started eight years ago to ensure that this ethical guidance keeps pace with the demands of the changing world of medical practice.
>
> The modernized *Code*, approved Monday during the 2016 AMA Annual Meeting, is the first comprehensive review of this foundational document in more than half a century. For this undertaking, the AMA Council on Ethical and Judicial Affairs reviewed each individual ethical opinion for clarity, timeliness, ongoing relevance in today's health care environment and consistency across the *Code*.
>
> "Contemporary medicine must remain moral medicine during the current rapid pace of change in health care delivery system, and just as it did during its founding, the AMA has responded to this challenge by again putting ethics on center stage," AMA President Steven J. Stack, MD, said in a news release. "The comprehensive update to the *Code's* ethics guidance keeps pace with emerging demands physicians face with new technologies, changing patient expectations and shifting health care priorities."

For more, see: http://ama-assn.org/ama/ama-wire/post/code-of-medical-ethics-modernized-first-time-50-years.

ANA Publishes Code of Ethics with Interpretive Statements

The *Journal of Nursing Regulation* reported in July 2016 that:

> The American Nurses Association (ANA) *Code of Ethics for Nurses With Interpretive Statements* informs decision making about ethical violations by nurses and nursing education programs. The Code is the nursing profession's ethical standard of practice and nursing's contract with society. Nurse practice acts (NPAs) and the standards of practice are the profession's legal standard. This article describes the nine provisions of the Code and provides cases of ethical violations and the disciplinary actions that were taken. The intent of this article is to serve as an educational resource on how the Code can be used with NPAs to support nurse regulators in their decision making.

For more and a link to the Code of Ethics, see:
http://www.journalofnursingregulation.com/article/S2155-8256(16)31073-0/abstract.

Physician Admits Lying on Stand to Protect Colleague

On September 23, 2016, Marshall Allen of *ProPublica* reported that Dr. Lars Aanning admitted lying in a malpractice suit to protect a colleague. Dr. Aanning told Allen that he lied to protect his colleague from malpractice damages even though he, Aanning, had doubts about his colleague's skills. Aanning explained:

> I did it as a matter of course. And I did it because there was a cultural attitude I was immersed in: You viewed all attorneys as a threat and anything that you did was OK to thwart their efforts to sue your colleagues. I just accepted that as normal. It wasn't like, "I'm going to lie." It was, "I'm going to support my colleague."

In addition, Allen writes this about physicians talking to patients about medical errors:

> There's no way to tell how often doctors to lie to protect their colleagues, but ProPublica has found that patients are frequently not old the truth when they are harmed. Studies also show that many physicians do not have a favorable view of informing patients about mistakes and that health care workers are afraid to speak up if things don't seem right. Many doctors and nurses have told ProPublica that they fear retaliation if they speak out about patient safety problems.

See the article here: https://www.propublica.org/article/doctor-confesses-i-lied-to-protect-colleague-in-malpractice-suit.

QUALITY OF CARE

Sharing Doctor's Notes Found to Improve Satisfaction, Trust and Safety

Original research sponsored by the Agency for Healthcare Research and Quality published online in *BMJ Quality and Safety* in August 2016 found that several benefits flow from doctors and hospitals sharing doctors' notes with patients. The research was based on surveys with 99 doctors participating in OpenNotes and more than 4,500 of their patients. The article's abstract states the researchers' conclusions this way:

> Despite concerns about errors, offending language or defensive practice, transparent notes overall did not harm the patient–doctor relationship. Rather, doctors and patients perceived relational benefits. Traditionally more vulnerable populations—non-white, those with poorer self-reported health and those with fewer years of formal education—may be particularly likely to feel better about their doctor after reading their notes. Further informing debate about OpenNotes, the findings suggest transparent records may improve patient satisfaction, trust and safety.

Read the abstract here: http://qualitysafety.bmj.com/content/early/2016/05/26/bmjqs-2015-004697.

Learn more about OpenNotes here: http://www.opennotes.org.

Study Equates Care Provided by Advanced Practitioners and Physicians

The National Council of State Boards of Nursing posted the following on August 3, 2016 in its *Good Morning Members* blog:

> According to a new study, APCs (nurse practitioners and physician assistants) provide equivalent amounts of low-value health services in primary care in both hospital and office-based settings. The authors explain that this finding is important because, "according to a recent national survey, most physicians believe that APCs provide lower-quality care than they do, and nearly one quarter think that expanding their roles in U.S. practice would decrease the efficiency and value of health care."
>
> Using national data on ambulatory visits, researchers compared the use of potentially low-value health services, including use of antibiotics, plain radiography, advanced imaging and referrals to other physicians, between APCs and physicians in how they managed upper respiratory infections, back pain and headache. Researchers examined 12,170 physician and 473 APC office-based visits, and 13,359 physician and 2,947 APC hospital-based visits.
>
> According to researchers, the finding that "APCs order antibiotics, computed tomography or magnetic resonance imaging, radiography and referrals as frequently as physicians is reassuring given recent efforts to expand the number of APCs, as well as their role, to meet the increasing demand for primary care."

See more about the study here: http://annals.org/article.aspx?articleid=2529481.

Surgical Safety Improvements Since "To Err is Human"

In the August 8, 2016, issue of the *Harvard Business Review*, Amir A, Ghaferi and colleagues write about "The Next Wave of Hospital Innovation To Make Patients Safer:"

> Nearly 65 million surgical operations were performed last year in the U.S., resulting in an estimated 200,000 deaths from complications or other post-operative issues. Ongoing innovation is of tantamount importance to improving these patient outcomes, and over the past several decades, we have observed three distinct waves of surgical improvement.

The authors go on to describe technical advancements, standardizing procedures, and the upcoming third wave: high reliability organizing.

See more here: https://hbr.org/2016/08/the-next-wave-of-hospital-innovation-to-make-patients-safer.

DISCIPLINE

New York State Fails to Enact Legislation to Toughen Discipline

An investigation by ProPublica found that New York State lagged behind other states in swift licensure suspension and reporting of criminal convictions and misconduct. Citing examples of nurses who retained their licenses after being charged of convicted of violent crimes. Legislation

that would have tightened regulation of several professions passed the state Senate, but failed in the House before the 2016 legislative session closed.

For more, see: https://www.propublica.org/article/new-york-lawmakers-race-to-toughen-oversight-of-nurses-other-professionals.

Courts Rule Offenders Can't Escape Discipline by Surrendering License

Professional Licensing Report posted a story in July 2016 reporting that courts in two states ruled that licensees could not avoid disciplinary action by surrendering their licenses before the board finalizes discipline. The rulings affected doctors in Tennessee and Oklahoma.

Read more here: http://www.professionallicensingreport.org/you-cant-fire-me-i-quit-cuts-no-ice-in-professional-licensing/.

Sanctioned Doctors Paid to Promote Drugs and Devices

On August 23, 2016, *ProPublica* published a story entitled, "Drug and Device Makers Pay Thousands of Docs with Disciplinary Records:"

> Pharmaceutical and medical device companies are continuing to pay doctors as promotional speakers and expert advisers even after they've been disciplined for serious misconduct, according to an analysis by ProPublica… All told, the analysis identified at least 2,300 doctors who received industry payments between August 2013 and December 2015 despite histories of misconduct.

See the full article here: http://www.healthleadersmedia.com/physician-leaders/drug-and-device-makers-pay-thousands-docs-disciplinary-records.

PUBLIC MEMBERS

Iowa Medical Board Elects Public Member Chair

One of three public members of the Iowa Board of Medicine was elected board chair in April 2016. According to an article in the *Des Moines Register* written by medical board Executive Director Mark Bowden, public member and board chair Diane Clark "was trained as registered nurse and held several key administrative positions in health care settings. She has a master's degree in organizational management and was the primary recruiter for physician staff members of the Mayo Health System's Albert Lea, Minn., Medical Center, for several years until retiring in 2013."

For more, see: http://www.desmoinesregister.com/story/opinion/columnists/iowa-view/2016/06/30/first-non-physician-leads-medical-board/86451562/.

Researchers in Maryland Ask Public How to Ration Care

On August 21, 2016, Sheri Fink wrote in *The New York Times* about researchers in Maryland who have been asking the public to weigh in how policymakers should ration care in a national emergency. Fink writes that:

> In Maryland, participants in the forums, designed with the help of Carnegie Mellon University's program for deliberative democracy, tended to favor saving the most lives or years of life by prioritizing people who were expected to survive their current illness or live the longest after being treated. However, many also said that a lottery or first-come-first-served approach would be appropriate for patients who had roughly equal chances of benefiting.

See more here: http://www.nytimes.com/2016/08/22/us/whose-lives-should-be-saved-to-help-shape-policy-researchers-in-maryland-ask-the-public.html

TELEHEALTH

Florida Appoints Telehealth Advisory Council

Announcing the creation of a 13-member Telehealth Advisory Council, Florida's Secretary of the Agency for Health Care Administration Elizabeth Dudek and State Surgeon General and Department of Health Secretary Dr. Celeste Philip highlighted the potential benefits of telehealth for Florida's citizens:

> Secretary Dudek said, "I want to congratulate all of the members selected to serve on the Telehealth Advisory Council. The members of the council have a proven track record of innovation in the field of medicine, and I look forward to working with them over the next year to examine the best uses of telemedicine to provide healthcare for Floridians."
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> "Telehealth is an exciting, emerging area of medicine that will allow us to use new communication technology to improve access to care and bolster data about patient monitoring all over the world," said State Surgeon General and Secretary Dr. Celeste Philip. "As we move forward with the opportunities and advancements in this field, I am honored to commend, along with the Agency for Health Care Administration, the 13 newly appointed members of our Telehealth Advisory Council who will guide telehealth services in our state."

Members of the advisory council include representatives of insurers, healthcare facilities, telehealth providers, healthcare practitioners, and long term care facilities. The acting state president of AARP will represent telehealth stakeholders.

For more, see: https://leadingageflorida.site-ym.com/admin/email/get_custom_template.asp?guid=4C9D7B59-A9A2-40B8-A9D5-B4F6760F4AB7.

CONTINUING PROFESSIONAL DEVELOPMENT

Hospitals Advised to Evaluate Aging Surgeons

The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network (PSNet) published a review in July 2016 of an article in *Advances in Surgery* entitled "The Aging Surgeon." The summary reads:

> Senior clinicians often elicit respect from their junior colleagues. This respect can affect colleagues' willingness to intervene should they observe poor performance in their role models. This review discusses the need to manage aging surgeons appropriately as a matter of safety. The authors recommend that peer support, confidential skill assessments, and effective policy can help hospitals track changes in surgeon performance to mitigate potential safety problems while preserving the dignity of their clinical staff.

For more, see: https://psnet.ahrq.gov/resources/resource/29932/35500/2.

The October issue of the AMA Journal of Ethics contains an article which says fellow practitioners have an ethical responsibility to take action when they see an aging surgeon whose knowledge and skills may be diminished:

> When an esteemed elderly colleague needs assistance completing procedures safely, fellow health professionals have the responsibility to respond in order to mitigate risk to patients. There is a strong ethical basis for bringing the surgeon's declining capacity to his or her attention as well as to the attention of others. Ongoing capacity assessments could be one method for tracking diminished capacities among surgeons so that they can stop practicing surgery before putting patients at risk.

See: http://journalofethics.ama-assn.org/2016/10/ecas2-1610.html.

Physician Assistant Certification Body to Revamp Recertification Program

The Fall 2016 issue of the Washington State Medical Quality Commission *Update!* contains an article by its Physician Assistant member, Theresa Schimmels, PA-C, who participated in a workshop convened by the National Commission on Certification of Physician Assistants to review its recertification examination. This is her account of that experience and explanation of NCCPA's plans:

> I recently had the honor of being selected as one of 56 physician assistants out of 7,000 PAs nationwide, to participate in the NCCPA (National Commission on Certification of Physician Assistants) Core Medical Knowledge workshop for the proposed Physician Assistant National Recertifying Exam (PANRE) model in Atlanta, Ga. Our task: to review NCCPA "Blueprint Disease and Disorder List" knowledge areas. In other words, we were there to determine the core medical knowledge and skills that should be assessed on recertification exams. So, let's start at the beginning.
>
> The NCCPA is the certifying body for physician assistants. It is an independent, not-for-profit organization. Passing the certifying exam allows a PA to have a "C" (for Certification), after PA on a name badge. It's the equivalent of a physician passing a board exam. All states initially require PAs to have passed the NCCPA before they are licensed within that state. There have been 111,000 PAs certified by the NCCPA since 1975. As of December 31, 2015 there were 108,717 certified PAs in the U.S., 7,776 newly certified in 2015 alone. PAs are a fairly young profession, established in the early 1970's and young in age with 55 percent under the age of 40 years old, 67 percent female and 32 percent male, nationally.
>
> So what is core? Core medical knowledge and skill include the essential foundational knowledge and cognitive skills required for PAs to provide safe and effective care for

patients with a broad range of conditions and disorders, across the lifespan and across the spectrum of medicine. It's not the totality of knowledge and skills required for ALL specialties, rather what remains after removing all the specific knowledge and skill that are unique to a particular specialty. Core should be "walking around" knowledge.

So we, in essence, removed the "fluff" and extra information you might see on a PANCE (initial certification exam) and concentrated on those items that would be relevant to a PA in practice after six years, depending on if you are in the new 10-year cycle or the older six-year cycle as I am. These are items we determined to be:

1) Essential and critical to PA practice.
2) What you would expect PAs to know, regardless of specialty?
3) Knowledge and skill you would expect a PA to have to be able to transfer to ANY specialty area.

Since 2014, the NCCPA has been focused on a pivotal question: How can we maintain the generalist nature of the PA-C credential through a recertification model that serves the public interest and better reflects the current state of PA practice? The NCCPA recognizes that the knowledge and skill required to enter practice are somewhat different than those required to continue practice.

The model now under consideration:

- Improves the relevance and value of the assessment experience by addressing the content of the exam and the educational value of the recertification process;
- Maintains the integrity and appropriate rigor that the public and other stakeholders of this process expect

So, what did we do? The NCCPA utilized methodologies in new ways that have been vetted with other experts in the testing industry. The purpose of the meeting was to take the conceptual definition of core medical knowledge and operationalize it. We moved this knowledge from the abstract to the concrete, pointing to a list of core knowledge and skills believed to exemplify the definition of core principals of PA practice.

It was hard work, with immediate data returns on how we all ranked skills as "core," "undecided," or "not core." For example; is avascular necrosis core? Yes, it is. Is lichen planus core? No, it's not. Is normal labor and delivery core? We decided it wasn't but we did think that prenatal care was core. Discussion took place within groups of specialty PAs and primary care PAs, then we combined to evaluate and discuss again. Incredibly, those of us in specialty practice usually agreed with those in primary medicine practices.

So, what happens next? Over the next few months, NCCPA will use this data to start to change the core testing and updating the recertification exam process to reflect PAs' clear movement outside primary care, while maintaining the generalist nature of the PA-C credential. This model is expected to take 5 years to implement with this meeting being the first of several to get the proposed guideline changes established. It's an exciting process and one I was proud to be part of.

I thank the NCCPA for most of the above information taken from their presentations and their website. If you are interested in participating in the next steps of the process or would like more information, contact the NCCPA at www.nccpa.net.

Here is the NCCPA Fact Sheet: www.goo.gl/DijCQM.

The newsletter can be found here: http://www.doh.wa.gov/Portals/1/Documents/3000/MedicalCommissionUpdate!Fall2016.pdf.

IN-DEPTH FEATURE – 2016 Ben Shimberg Award Introduction by Barbara Safriet

Editorial Note: The presentations by Shimberg Award recipients are published each year in CAC News & Views *(Kathleen Haley's remarks will appear in the First Quarter 2017 issue and on www.cacenter.org). We don't usually reprint the introductions of the Shimberg award recipients, but we make an exception this year in order to share Barbara Safriet's observations about those qualities and actions that make both Kathleen Haley and the Oregon Medical Board exemplary in the world of healthcare professional regulation.*

I'm on the board of directors of CAC and I am very pleased to introduce Kathleen. I've known Kathleen for over a decade in her role as the Executive Director of the Oregon Medical Board. I've known of Kathleen for many years through her public service in Oregon and on national boards.

I suppose the question is: Why was Kathleen unanimously and enthusiastically selected for this award? There are many reasons. Let me note only a few. First and foremost for me, she has always understood and emphasized the principle that licensing boards exist to serve the public. That sounds simple, I know. But, let me assure you that often licensees and their professions think that the role of the licensing boards is to protect and promote the professional interest. Let's be very clear that professional and regulatory interests don't have to inevitably be in conflict, but I am convinced that the public's interest should always trump if there is a conflict.

Having worked with scores of licensing boards of many different professions in many different states, I can assure you that we still have a bit of work to do on this score – in enforcing this principle of separate, not inevitably incompatible, but separate roles. Kathleen has done that from the get go.

The second reason Kathleen should get this award is that when thorny health issues arise both as to practice and policy, some licensing boards are inert at best, or worse in my mind, too quick to act without thoughtful consideration of a variety of consequences that might result. Consequences that would affect health needs and consequences for the public and the profession.

This does not happen with Kathleen is involved.

For example, while I know it is hard to remember now, there was a time in this country when one of the most significant health services issues was the *under-treatment* of pain. Now it's overtreatment from pill mills and whatever else. Under-treatment was one of the most pressing public health and medical issues, especially the treatment of chronic pain in the community. Acute care in the hospital wasn't looked at so much, but in the community where most patients

with chronic pain, very competent practitioners fully recognized and understood the very real need for effective pain management for their patients, but they were fearful of being tagged by the DEA or the licensing board for overprescribing.

Well, the Oregon Medical Board, through Kathleen, worked the Federation of State Medical Boards to evaluate the issues and develop model guidelines for pain management. And, I think that OMB was the first medical licensing board to sanction a physician for demonstrable inappropriate *under-treatment* of a patient's chromic pain. That was really far out there. It was appropriate. It was absolutely right. And, Kathleen in many ways led that charge.

Another difficult regulatory issue presented itself when Oregon was the first state to enact the death with dignity provisions. This posed new and very difficult issues for physicians in the state and Kathleen and the OMB worked diligently with practitioners, the public and the legislature to assess and implement guidelines and policies to implement the act and inform physicians and terminally ill patients and their loved ones what the provisions and procedures were. Oregon's legislation and the OMB regulations and guidance have served as models for other states which have now chosen to enact death with dignity laws.

Finally, as Kathy's comments in the keynote indicated, Kathleen has been and continues to be an active collaborator with community groups, advocacy groups, providers (both institutional and individual), and payers in addressing questions and issues that need to be addressed to facilitate the implementation and delivery of much-needed care in new and innovative ways. I think the comments earlier about the role she plays in trying to accommodate telepractice and telehealth is a great example of that.

On a more personal note, Kathleen has lectured to my Lewis and Clark law school seminar on the regulation of healthcare providers almost every year since forever. And I have to be candid in saying my student evaluations benefit from that. She also has consistently taken on the added responsibility of mentoring a law student as a full-time extern in the OMB office. Hopefully, the OMB gets something out of this because I know the students do.

In sum, I and others could go on and on about how Kathleen's contributions have benefitted the public health by ensuring the OMB's is a progressive, active, diligent, well-informed and fair regulatory framework. Rather I will draw on an experience I had years ago when I was asked to give a commencement address at a health sciences school. I actually got the best advice I've ever had from talking with the cook before I spoke and asked "What would you say as a commencement speaker?" The cook said, here's what I would say: "Welcome. You did good. Goodbye."

I will slightly torque that by saying, Welcome to you all. Kathleen you done good. But, I won't say goodbye until you hear Kathleen's comments.

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
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Non-Governmental organization	$375.00
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There are three ways to pay for your membership:

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2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card;
3) Provide the following information to pay by credit card:

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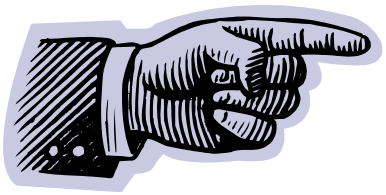

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We hope your board or agency decides to become a member of CAC. Membership includes a subscription to our newsletter for <u>all</u> of your board members and <u>all</u> of your staff, as well as many other benefits. But if you decide <u>not</u> to join CAC, we encourage you to subscribe to CAC News & Views by completing this form and mailing or faxing it to us.

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