



News & Views

Citizen Advocacy Center

Second Quarter 2017 – Health Care Public Policy Forum – Volume 29 Number 2

Announcement

CAC is pleased to announce that our 2017 Annual Meeting will be incorporated into CLEAR’s Annual Educational Conference in Denver, Colorado on September 13, 2017 – September 16, 2017. One registration will entitle CAC Annual Meeting registrants to attend sessions sponsored by CLEAR in addition to CAC’s activities that are oriented towards public members.

[View CAC’s Annual Meeting Program](#) (UPDATED TO INCLUDE INFORMATION ABOUT THE SPEAKERS)

[View CLEAR’s Annual Educational Conference Program](#)

[Register to Attend the CAC/CLEAR Annual Meeting And Conference](#)

IN DEPTH FEATURE

North Carolina Foundation for Nursing Excellence Celebrates Accomplishments

Editorial Note: This feature contains excerpts from the North Carolina Foundation for Nursing Excellence’s Report 2002-2016. The Foundation’s mission is, “to improve health outcomes for citizens of North Carolina through the support of leadership development, research and demonstration projects intended to enhance the practice of nursing.” The Foundation’s vision is, “to become a significant conduit through which innovative ideas related to health and healthcare can be evaluated and disseminated to the principal arenas of professional nursing and healthcare practice in North Carolina.”

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A letter from the Foundation’s CEO, Polly Johnson (formerly a CAC Board member), introduces the report:

...Our foundation has focused its efforts on nursing workforce development through a variety of initiatives at both the academic preparation and practice levels of our profession. In this respect, we wish to share an overview of projects that we have undertaken in our commitment to improving the health of all North Carolinians...

The Foundation’s work has fallen into three major areas: Evidence-Based Transition to Practice; Regionally Increasing Baccalaureate Nurses (RIBN), and Nurse Practitioner Transition to Practice.

The Evidence Based Transition to Practice Project took place from 2005 to 2012. Its goals were to develop core competencies needed by new nurses regardless of practice setting and reliable measures to assess competence.

“Transitioning new graduates to a practice setting has always been a challenge,” Polly Johnson told CAC News & Views. “Employers want new grads to be prepared to hit the ground running, but that is difficult to accomplish in an academic setting. Hospital representatives often serve on academic committees that have input into nursing curricula, but the committees are only advisory and their influence depends on the quality of the advice and the willingness of academicians to act on good recommendations.”

This multi-year three-phase project was designed to ensure that newly licensed nurses are afforded the opportunity to gain confidence and competence as they enter the workforce, thus enhancing patient safety and increasing retention in the workplace...

Newly licensed nurses and their preceptors from twenty-nine North Carolina hospitals, ranging from small rural hospitals to major medical centers, participated in the next phase of this project to determine those elements in transition experiences that contributed most significantly to competence and confidence development in the newly licensed nurse. **Key findings were that the quality of the new nurse/preceptor partnership had a direct relationship with how competent a new RN felt about his/her nursing practice and that higher competency scores correlated with fewer reported practice errors at both four and six months into employment.** (Emphasis added).

With further input from clinical nurse leaders across the state related to current preceptor preparation, it became clear that *the preceptor was a critical component of the successful transition of a new nurse, that there was no consistent preparation for preceptors across the state and that learning opportunities for preceptor development needed to be readily available to users.* (Emphasis added). With the help of many nurse educators in both academic and practice settings across the state, online learning modules as well as simulation scenarios were developed, piloted, and then refined for distribution to the broader nursing community.

“Gone are the days when people attend organized classes,” Johnson told us. Now they want to complete modules online at their own convenience. They receive continuing education credit for doing so, which is an added incentive to complete the modules.”

The Foundation developed three nursing preceptor training modules

- **Module 1: The Role of the Preceptor** introduces the preceptor roles of advocate, role model, coach, evaluator and socializer and how to appropriately use these roles with the new nurse.
- **Module 2: Communication in the Preceptor Role** focuses on the factors that influence communication such as learning styles, gender, generational issues and personality styles.
- **Module 3: The Transition Process:** Assessment to Evaluation focuses on the preceptor’s role in supporting the new nurse’s transition from novice to competent, confident care provider using a competency-based performance plan that includes quality and safety competencies, daily planning, communication, documentation and modifying plans.

The on-line training modules also include simulated scenarios which participants can use to practice their roles and receive individual feedback on their performance in managing preceptor-preceptee situations in a threat-free learning environment. The Nursing Preceptor Success Program modules and simulated scenarios are available through the NC Area Health Education Centers virtual library at www.aheconnect.com/newahec/courses.asp.

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As a major contributor to transforming our health care system and improving our nation's health, nursing is being challenged to significantly increase the educational preparation of its workforce over the next decade. As early as 2004, visionary North Carolina health care leaders concerned about the impact of our changing demographics on health care delivery, recommended an increase in number of RNs educated at the baccalaureate (BSN) level from less than 40% to 60%. In 2010 the Institute of Medicine's *Future of Nursing: Leading Change, Advancing Health* Report called for the nationwide proportion of BSN educated nurses to be 80% by 2020...

In 2008 we began the RIBN journey by creating a new partnership between Asheville Buncombe Technical Community College (AB Tech) and Western Carolina University (WCU) to dually enroll students in a seamless four-year nursing curriculum leading to a BSN degree. Adapted from a program developed by the Oregon Consortium for Nursing Education, this model provides an economically feasible BSN pathway that enables students to remain in their home communities while progressing toward a baccalaureate degree at the beginning of their nursing career. The goal of the Regionally Increasing Baccalaureate Nurses (RIBN) Project is "to create additional and more streamlined pathways and partnerships between two levels of nursing education (associate degree v. baccalaureate) in order to significantly increase both the diversity and proportion of BSN-prepared nurses in North Carolina."

What began with a small cohort of 16 students admitted to this Western NC RIBN pathway in 2010, has expanded across the state to include 8 universities and 31 community or private colleges offering the RIBN pathway. As of June 2016, 45 RIBN students have been awarded BSN degrees with Fall 2016 enrollment at 507! With continued expansion, our goal is to have an annual addition of 150-175 BSN-prepared nurses entering the NC workforce beginning in 2020...

Developing strong partnerships between academic institutions as well as major employers in each region was essential to the successful implementation of this pathway. Successful implementation has required a commitment from all involved stakeholders as well as a passionate leader to "make it happen!" Bringing admission and financial aid personnel together within each region to better understand and facilitate this new administrative arrangement was key to helping students navigate the system. Having a Student Success Advocate as the point person to help guide students through these administrative processes as well as coaching and making individual referrals for students with needs ranging from time management skill development to improving writing and or study skills was ranked as the most important aspect of the program by RIBN students, especially in the first 2-3 years of the program.

Polly Johnson told us, "Our overall goal has been to more effectively link community colleges with the state university system. We have 58 community colleges in the state, most of which have nursing programs. These are the educational access points for two-thirds of the nurses in the state. They don't have to leave home, courses are affordable and academic progression to a baccalaureate or higher degree can be completed in a flexible timeframe. In 2015, the State Board of Community Colleges and the University of North Carolina Board of Governors signed a RN to BSN Articulation Agreement to further facilitate academic progression by establishing standardized curriculum requirements for RN graduates of any NC community college to enter BSN completion programs at any one of the state-funded universities."

“We had tried for years to link community colleges and baccalaureate programs in this more streamlined manner,” Johnson continued, “but were able to accomplish this only after the Robert Wood Johnson Foundation and the Institute of Medicine recommended that 80% of the nursing workforce have baccalaureate preparation. Perhaps, the most exciting thing to happen in North Carolina is that the Community College System has taken the lead in promoting academic progression, when at one time they were the ones who felt most threatened by the move toward requiring a baccalaureate degree. That is a huge win for nursing education in North Carolina!”

The third major focus of the Foundation has been the Nurse Practitioner Transition to Practice Project. This project aims to maintain a strong primary care workforce by strengthening the competency and confidence development of novice nurse practitioners entering practice at a time when more experienced nurse practitioners are retiring.

The Foundation for Nursing Excellence (FFNE) convened a planning task force to explore those factors which contribute to the competency development of the novice nurse practitioner and to propose an economically-feasible transition to practice framework for those entering practice in primary care settings, particularly in the more rural areas of our state where resources are limited. Based on the information gathered by this multi-disciplinary group, a transition to practice framework has been proposed that leverages technology and a blended and tiered approach to onsite, regional and broad-based support and resource availability to address both the need to increase the competence and confidence of the novice practitioner as well as accommodate the resource limitations of employing organizations. Next steps will be for an entity with the passion, leadership and capacity to move this work forward by assuming coordination for piloting and refining this transition framework in two or three practice sites, preferably in the more rural areas of our state.

“The biggest thing we learned along the way is that it’s the quality of the support services that makes or breaks a program,” Johnson recalled. That is true for both preceptors in the transition to practice program and the Student Success Advocates in the RIBN program. “I believe the Foundation has made a difference,” says Johnson. “We created sustainable programs to strengthen our nursing workforce and, thereby, contribute to improved health outcomes for those we serve. That’s what it’s all about.”

More information about the Foundation programs is available at: www.ffne.org.

SCOPE OF PRACTICE

Controversial North Carolina Optometry Legislation Sent to Study Committee

North Carolina House Bill 36 began as legislation that would define the practice of optometry to include any one or combination of the following:

The examination of the human eye by any method to diagnose, to treat, or to refer for consultation or treatment any abnormal condition of the human eye and its adnexa; or the employment of instruments, devices, pharmaceutical agents and procedures intended for

the purposes of investigating, examining, treating, diagnosing or correcting visual defects or abnormal conditions of the human eye or its adnexa; or

The prescribing and application of lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision training, pharmaceutical agents, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

The original legislation deleted the phrase “other than surgery” from the optometry scope of practice and would, therefore, have permitted optometrists to perform three types of surgery: removing skin tags from around the eyes and two procedures involving lasers, including laser treatments used to relieve pressure in the eyeballs of glaucoma patients.

Ophthalmologists balked at permitting optometrists to perform any type of eye surgery and the second reading of the bill reinserted the “other than surgery” language and went on to list multiple forms of eye surgery considered to be beyond the scope of optometric practice.

Optometrists countered by pointing out to legislators that schools of optometry teach the types of surgery permitted in the original bill. The House decided to rewrite the legislation to refer the dispute to the North Carolina Institute of Medicine for independent analysis and advice:

Pursuant to G.S. 90-470(b), the North Carolina Institute of Medicine (NC IOM) is organized to be concerned with the health of the people of North Carolina, to monitor and study health matters, to respond authoritatively when found advisable, and to respond to requests from outside sources for analysis and advice when it will aid in forming a basis for health policy decisions. As such, the NC IOM is directed to study the issues addressed in House Bill 36 Enact Enhanced Access to Eye Care Act, as introduced during the 2017 Regular Session of the 2017 General Assembly.

The NC IOM shall report findings and recommendations pertaining to enhanced access to eye care, including draft legislation if appropriate, to the Joint Legislative Oversight Committee on Health and Human Services on or before October 1, 2018.

For more, see: www.wral.com/doctors-don-t-see-eye-to-eye-on-laser-surgery-legislation-/16559553/.

ANA Publishes Recommendations on Scope of Practice

The National Council of State Boards of Nursing online *Good Morning Members* posted the following item on March 3, 2017:

Evidence-based Recommendations Released to Address Registered Nurse (RN) Scope of Practice Barriers

The American Nurses Association (ANA) recently published six new articles in the *Online Journal of Issues in Nursing* that contain evidence-based recommendations that address RN scope of practice barriers. Many of the recommendations were made by an ANA-convened panel that explored factors that both promote and inhibit the ability of nurses to practice to the full potential of their licensure. Five of the six articles include evidence-based recommendations that address barriers identified by the panel that prevent RN practice to the full extent of education and scope.

The first four articles are based on key roles of RNs (professional, advocate, innovator and collaborative leader) that emerged from the panel work and demonstrate the value of RNs to the health care delivery system. An executive summary of the panel work is provided in the fifth article and the sixth article discusses a research study that analyzed variables important to full scope of practice, such as nurse educational level and organizational factors.

Ontario to Allow RNs to Diagnose and Prescribe

In May the College of Nurses of Ontario announced a change in the Province's Nursing Act:

On May 17, 2017, the Ontario government approved changes to the *Nursing Act* to permit RNs to prescribe medication according to a list, and to communicate a diagnosis for the purpose of prescribing medication.

Although the government has approved changes, RNs do not have the authority to perform either of these activities until the College makes regulations under the Nursing Act.

Diagnosing and prescribing are high-risk activities; the College is accountable for providing proper regulatory oversight that protects the public's right to safe nursing care. We will be working on ensuring there are regulatory mechanisms in place to promote safe nursing practice. We will define the scope of this new authority for RN practice and develop regulations that will implement this change safely, while supporting the government's goal of improving public access to medication.

As part of our work, we will consult with a broad range of stakeholders. As well, Council will review the evidence and feedback to make decisions about:

- the new RN scope of practice and how it fits, in the context of other nursing roles (such as NPs)
- practice requirements, including the drugs that RNs are authorized to prescribe
- requirements RNs must meet before gaining access to the new controlled acts (such as education)
- requirements for maintaining ongoing competence through the College's Quality Assurance program
- professional liability protection, and more.

See: www.cno.org/en/news/2017/may-2017/government-changes-will-eventually-lead-to-rn-prescribing/.

West Virginia Considers Special License for Retirees

In March 2017 the West Virginia Senate passed the West Virginia Medical Practice Act, SB 4, which would establish special volunteer medical licenses for retired/retiring health care professionals. The license would authorize them to donate their services to care for indigent and low-income patients from their own offices. They would be covered by the existing liability protections of the state's free clinics. Out-of-state doctors in good standing would be permitted to practice in the state under a seven-day license.

For more, see: www.register-herald.com/news/senate-bill-lets-health-care-retirees-donate-services/article_c8f78b5f-cf44-5b29-bbc6-4e2eba564ea1.html.

CONSUMER INFORMATION

Physician Rating Websites Get Bad Grades

HealthLeaders Media reported in March 2017 that researchers from Baystate Medical Center in Springfield MA evaluated 28 websites containing reviews of 600 physicians. The researchers found many of the websites difficult to use and many reviews difficult to read. They concluded that, “it is difficult for a prospective patient to find (for any given physician on any commercial physician-rating website) a quantity of reviews that would accurately relay the experience of care with that physician.”

For more see: www.healthleadersmedia.com/marketing/physician-rating-sites-get-low-marks#.

DISCIPLINE

Consumers Unhappy with California Medical Board Complaint Handling

At the Sunset Review hearings for the California Medical Board in February 2017 consumers and consumer advocates criticized the board’s handling of consumer complaints. Advocacy group, Consumer Watchdog called the system “broken.” For example, the board interviews doctors against whom complaints are filed, but may dismiss a complaint without consulting with the person who filed the complaint. Polls conducted by the board found that 88% are dissatisfied with the way the board responds to complaints and the length of time it takes to complete investigations.

For more, see: www.prnewswire.com/news-releases/medical-board-oversight-of-california-doctors-remains-broken-consumer-watchdog-will-testify-today-at-legislative-hearing-into-boards-future-300413905.html.

Read the letter here: www.consumerwatchdog.org/resources/cwmbcsunset2-6-17.pdf.

Read the Medical Board of California’s Sunset Report here: www.mbc.ca.gov/About_Us/Meetings/2016/Materials/materials_20161027_brd-9.pdf

Illinois Revisits Policy on Felony Convictions and Licensure

In March 2017 *JDSupra* posted the following update on Illinois legislation modifying the regulatory agency’s position on issuing licenses to individuals previously convicted of a felony:

A felony conviction can prohibit an individual from obtaining or maintaining a professional license to practice in the health care field. In an effort to minimize the impact of prior felony convictions on a person’s ability to obtain professional licensure, the State of Illinois recently enacted a new law (Public Act 099-0886), which amends the Department of Professional Regulation Law (20 ILCS 2105/2105-1 et seq) (the DPR Law). The DPR Law expands the opportunities for individuals with prior felony

convictions to practice a health care profession regulated by the Illinois Department of Financial Regulation (IDFPR), while still maintaining safeguards to ensure the safety of patients and health care consumers.

Prior to the DPR Law, the IDFPR would not issue a professional license to, or would permanently revoke the license of, individuals who were convicted of (i) a crime requiring registration as a sex offender; (ii) battery against a patient; or (iii) a forcible felony, defined as “treason, first degree murder, second degree murder, predatory criminal sexual assault of a child, aggravated criminal sexual assault, criminal sexual assault, robbery, burglary, residential burglary, aggravated arson, arson, aggravated kidnaping, kidnaping, aggravated battery resulting in great bodily harm or permanent disability or disfigurement, and any other felony which involves the use or threat of physical force or violence against any individual” (see 720 ILCS 5/2-8).

With enactment of the DPR Law, a forcible felony now will not be a permanent bar to obtaining a professional license, unless the conviction requires registration as a sex offender or relates to involuntary sexual servitude of a minor. For all other forcible felony convictions, an individual can petition the IDFPR for licensure beginning the later of (i) five years since the conviction; or (ii) three years since the individual was released from confinement related to the conviction.

Upon receiving the petition, the IDFPR will review the following factors to determine whether a license should be issued:

1. Seriousness of the offense;
2. Presence of multiple offenses;
3. Prior disciplinary history;
4. Impact of the offense on any injured party;
5. Vulnerability of any injured party;
6. Motive for the offense;
7. Contrition (or the lack of contrition) for the offense;
8. Cooperation (or lack of cooperation) with IDFPR or other investigative authorities;
9. Lack of prior disciplinary action;
10. Restitution to injured parties;
11. Whether the misconduct was self-reported;
12. Any voluntary remedial actions taken or other evidence of rehabilitation; and
13. Date of conviction.

For individuals with past felony convictions, the DPR Law provides an opportunity to practice a health care profession in Illinois. For businesses that employ health care workers in Illinois, the DPR Law means employers can no longer rely on the fact that if someone holds a license, they have no history of felony convictions.

See the post here: www.jdsupra.com/legalnews/prior-felony-convictions-may-no-longer-60577/#FollowSection.

See also: <http://cookcountyrecord.com/stories/511098786-new-illinois-law-allows-convicted-felons-to-get-health-care-related-professional-licenses>.

OPENNOTES

Editorial Note: CAC has entered into a collaboration with OpenNotes, a growing movement that promotes the sharing of healthcare practitioners' clinical notes with their patients. OpenNotes does not sell any products but rather is a foundation-supported initiative headquartered in Boston. The objective of this collaboration is to acquaint CAC's audiences with the benefits of OpenNotes and thereby inspire consumers to ask their doctors, nurses and other health care professionals to adopt open notes and inspire healthcare institutions and practitioners to support the practice. In furtherance of this objective we are introducing a new regular section in CAC News & Views on OpenNotes.

OpenNotes refers to the notes healthcare professionals include in medical records to describe their interactions with patients. In 2010 hospital systems in Massachusetts, Pennsylvania and Washington State joined in an exploratory study allowing 20,000 patients to read their clinicians' notes. The results of the study were positive; physicians reported little change in workload and patients overwhelmingly embraced the practice. Since then, multiple hospital systems all over the country have joined the OpenNotes movement and experienced improved practitioner/patient relations, greater patient empowerment and compliance with treatment regimens, a reduction in errors in medical records, and other benefits. Fears that note writing would become more burdensome for practitioners or that patients would be frightened by the content of the notes have not materialized.

CAC endorses OpenNotes' mission of "spreading and exploring the effects of open notes" and believes we can help advance this mission by acquainting the consumers, regulators, certifiers, and others in our orbit with the benefits of open notes and encouraging them to embrace and promote the OpenNotes movement.

For more information, visit: www.opennotes.org and www.opennotes.org/tools-resources/for-health-care-providers/implementation-toolkit/#5.

Family-Reported Errors and Adverse Reactions Not Always Mentioned in Children's Hospital Records

Research conducted by Dr. Alisa Khan, a researcher at Harvard Medical School and Boston Children's Hospital and Dr. Irimi Kolaitis of the Ann and Robert H. Lurie Children's Hospital of Chicago and Northwestern University Feinberg School of Medicine found that errors and adverse events reported by family members of hospitalized children and teens and by clinicians who treat them often did not get reported in hospital records.

The researchers found that error rates were close to 16% higher and adverse events were 10% higher with family reporting than without. Nearly half of family-reported errors and nearly a quarter of family reported adverse events were not recorded in patient medical records. Hospital incident reports were also fewer than incident and adverse event reports by families.

Dr. Kahn observed that "Our results suggest that whether we are talking about safety surveillance research or operational hospital quality improvement and safety tracking efforts, families should be included in safety reporting."

For more, see: www.reuters.com/article/us-health-hospitals-errors-idUSKBN16629K.

Editorial Note: This research is further evidence of the value of OpenNotes, a movement which advocates routinely giving patients and their designated proxies access to clinical notes allowing them to verify the accuracy and completeness of the information in the record. Not only would this enable patients to discover errors or omissions in their records, it would help with quality improvement.

Doctors Advised How to Communicate Bad News

Writing in the February 28, 2017, issue of *The DO*, Rose Raymond gives five tips for breaking bad news to patients. She emphasizes preparation and empathy. She advises doctors to find out first how much the patient and family members already know. She also underscores the importance of making sure the patient understands the diagnosis and treatment options.

Editorial Note: Notably, no mention is made of putting diagnostic or treatment information in writing. Nor is there any mention of the role sharing clinical notes with patients could have in facilitating communication, especially in difficult situations. Furthermore, it's probably common that when people hear bad news they don't hear much after that. This is all the more reason to give them access to the notes from the conversation with their clinician.

See the article here: <http://thedo.osteopathic.org/2017/02/how-to-break-bad-news-to-patients-experts-offer-best-practices/>.

See also this article recommending that physicians use health literacy guidelines in communicating with patients: <https://wire.ama-assn.org/delivering-care/medspeak-can-shut-down-effective-communication-patients>.

Research Reveals Strategies for Avoiding Diagnostic Errors

As reported in the October 19, 2016, *Annals of Internal Medicine – Annals for Hospitalists*, Inpatient Notes – Reducing Diagnostic Error – A New Horizon of Opportunities for Hospital Medicine, researchers Hardeep Singh, MD, MPH; Laura Zwaan, PhD recommend strategies for avoiding diagnostic errors in hospitals. The recommendations are based on literature and experience. The five major recommendations are:

1. Allocate time to communicate effectively with patients.
2. Work closely with lab personnel and radiologists to interpret complex test results or a difficult diagnosis.
3. Clarify whose responsibility it is to follow up on abnormal test results.
4. Make sure all members of the healthcare team are on the same page about a diagnosis when multiple constituents are involved.
5. Encourage patients to engage in the diagnostic process and look at their own medical notes for inconsistencies.

Editorial Note: The recommendations hinge on accurate communication between practitioners and between practitioners and patients. The fifth recommendation is startling in that it assumes patients have to rely on their own medical notes to find inconsistencies. In healthcare systems that have integrated OpenNotes into their procedures, patients can review clinicians' notes for accuracy and inconsistencies, a much more patient-centered approach.

For more, see: www.beckershospitalreview.com/quality/5-misdiagnosis-prevention-strategies-for-physicians.html.

See also: <https://psnet.ahrq.gov/resources/resource/30607/35500/2>.

AMA Advises on Mitigating the Consequences of Poor Communication

An article in the March 2017 issue of the *AMA Journal of Ethics* entitled, “Strategies for Acing the Fundamentals and Mitigating Legal and Ethical Consequences of Poor Physician-Patient Communication”

explores how the absence of effective verbal and nonverbal communication in the physician-patient encounter can lead to poor outcomes for patients and physicians alike. The article discusses legal and ethical topics physicians should consider during a medical encounter and provides educational and practical suggestions for improving effective communication between physicians and their patients.

The article addresses the ethical, legal and quality of care dimensions of poor doctor-patient communication because of the use of medical jargon. The article concludes that “physicians’ investment in communicating effectively can pay off in several dimensions of their practice, legally and ethically, and also contribute to providing quality care for their patients.”

Editorial Note: The article recommends following the principles of patient-centered communication and notes that the AMA Code of Ethics includes the concept that “a physician should be actively engaged in assessing a patient’s ability to understand and process information (to the best of his or her ability), presenting relevant information accurately and sensitively, and documenting the conversation.” Documenting patient-centered conversations is perfectly consistent with the goals of OpenNotes. When patients have access to their notes, they can revisit the conversation they had with their clinician at any time to remember details and ensure they understand the care plan.

See the article here: <http://journalofethics.ama-assn.org/2017/03/hlaw1-1703.html>.

Nurse Practitioners Encouraged to Use Electronic Records Wisely

The National Council of State Boards of Nursing April 6, 2017, *Good Morning Members* contained the following item:

Article Discusses the Ethical and Legal Implications of Nurse Practitioners (NPs) Using Electronic Health Records (EHRs) in Patient Care.

Although EHRs can improve the quality of patient care, increase efficiency and reduce costs, current EHRs require time-consuming data entry, can interfere with patient interactions and can cause medical errors. A recent article in *The Journal for Nurse Practitioners* states that NPs balancing heavy patient loads with data entry and reporting requirements must protect themselves and their patients when using EHRs. According to the article, “NPs should implement practical tips and best practices for navigating and

successfully using EHRs, as well as risk management strategies to ensure better patient care and avoid malpractice litigation or licensing issues.” When working with EHRs, the article recommends that NPs:

- Take advantage of all training that supports the EHR in their practice or hospital;
- Ensure accuracy in the record and learn how to work with the systems as they were intended; and
- Be aware of hidden liabilities associated with EHRs and follow best practices when entering information, especially with annotations, addenda and corrections after patient visits.

The author notes that “By incorporating these recommendations into their practices, NPs can help ensure quality patient care and increased efficiency, and help protect themselves against a malpractice claim or board of nursing complaint that could affect their ability to practice medicine.”

See the article here: [www.npjjournal.org/article/S1555-4155\(16\)30510-4/pdf](http://www.npjjournal.org/article/S1555-4155(16)30510-4/pdf), especially the section entitled, “Tips for Navigating an EHR.”

ETHICS

Medical Board of California Chair Challenged on Discipline Vote

In 2012 Dr. Dev GnanaDev, now the chairman of the Medical Board of California, cast a vote in favor of reinstating the license of a doctor who had been disciplined for sexual misconduct. Subsequently, Dr. GnanaDev accepted a \$40 million donation from a relative of the reinstated doctor toward the formation of a medical school in California. After this sequence of events, Dr. GnanaDev faced questions about whether his vote and the contribution to his medical school were related.

For more, see: <http://californiahealthline.org/news/california-medical-board-president-faces-questions-over-vote-in-sexual-misconduct-case/>.

Licensing Boards and Governor Spar Over Anti-Discrimination Language

The Nebraska boards of Psychology and Mental Health Practice are unable to agree with each other and with the governor about language barring discrimination against patients based on a practitioner’s strongly held beliefs. The position of the Nebraska Catholic Conference is also a factor in the debate. At issue also is the way practitioners make referrals when their strongly held beliefs interfere with their willingness to treat a patient.

For more, see: http://journalstar.com/news/local/govt-and-politics/two-licensing-boards-for-psychologists-and-counselors-at-impasse-with/article_2ae2a247-a4ad-5b3f-9f3c-23afae9981da.html.

See also http://journalstar.com/news/opinion/editorial/columnists/local-view-what-s-behind-the-licensing-impasse/article_88876ae9-de32-5b61-9b94-123eadd13005.html.

And also: http://journalstar.com/news/opinion/editorial/columnists/local-view-ethics-and-politics-at-odds/article_72a04734-7fd9-572c-abd3-22e2916bfa6b.html.

TELEHEALTH

Teladoc Compromise Enacted in Texas Legislature

On May 27, 2017, Governor Abbott signed SB1107 which resolves the Teladoc case. The bill moved rapidly through the legislative process, from introduction in February to enactment in just three short months. In March 2017 the Center for Connected Health Policy wrote the following detailed description of SB 1107 right after the bill was introduced:

The court case battle between Teladoc and the Texas Medical Board (TMB) may soon find a resolution, as a new piece of legislation, SB 1107 was introduced last week that would address issues on both sides. The first hint of such a bill came in early February when mHealthIntelligence reported that legislation was being drafted that would represent a compromise between telemedicine stakeholders and Texas regulators. The original suit, filed by Teladoc in April 2015 (*Teladoc, Inc. et al, v. Texas Medical Board*) alleged that the Texas medical board's face-to-face consultation requirement, needed to establish a physician-patient relationship and issue prescriptions, illegally limited competition from telemedicine companies. Teladoc's argument cited the Supreme Court decision in *North Carolina Board of Dental Examiners v. Federal Trade Commission (FTC)* which ruled that medical boards comprised of private professionals are not exempt from federal anti-trust laws unless there is direct supervision by the state. However, the Texas Attorney General claimed that the TMB satisfied the "active supervision" requirement cited in the Supreme Court case because the Board is subject to judicial review.

A description of the key elements of SB 1107 is provided below.

Definitions

SB 1107 eliminates previous definitions in the state of Texas for a "telemedicine medical service" and "telehealth service" and replaces them with the following:

Telemedicine medical service means a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Telehealth service means a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified or otherwise entitled to practice in the state and acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location than the health professional using telecommunications information technology.

The clear difference between these two definitions is that a telemedicine medical service is limited to physicians, or health professionals acting under the physician, while a telehealth service applies to other health professionals, such as physical therapists, audiologists, etc.

Practitioner-Patient Relationship

Under SB 1107, a valid practitioner-patient relationship would be present during a telemedicine interaction as long as the practitioner complies with the same standard of care that would apply to the provision of the same health care service or procedure in an in-person setting. In addition, the practitioner must:

1. Have a preexisting practitioner-patient relationship with the patient, in accordance with rules adopted under Section 111.006 (see below for section on a valid prescription);
2. Communicates, regardless of the method of communication, with the patient pursuant to a call coverage agreement established in accordance with the Texas Medical Board rules with a physician requesting coverage of medical care for the patient; **OR**
3. Provides telemedicine medical services through one of the following methods, as long as the practitioner complies with the proper follow-up requirements and the method allows the practitioner to have access to, and use the relevant clinical information, as they would had the service been delivered in-person. **The acceptable methods include the following:**
 - Synchronous audiovisual interaction;
 - Asynchronous store and forward technology as long as the practitioner uses clinical information from clinically relevant photographic or video images, including diagnostic images or the patient's relevant medical records; **OR**
 - Another form of audiovisual telecommunication technology that allows the practitioner to comply with the appropriate standard of care.

A practitioner can only establish a valid practitioner-patient relationship over telemedicine (as outlined in #3) if they provide the patient with guidance on appropriate follow-up care, and (if the patient consents and has a primary care physician (PCP)) provide to the patient's PCP within 72 hours, a medical record or other report containing an explanation of the treatment provided along with the practitioner's evaluation, analysis or diagnosis as appropriate.

The requirements outlined in this section do not apply to mental health services. The rule also states that a practitioner-patient relationship is not present if a practitioner prescribes any abortion-inducing drug or device.

Valid Prescription

SB 1107 requires the adoption of joint rules by the Texas Medical Board, Board of Nursing, Physician Assistant Board and Board of Pharmacy that establish the determination of a valid prescription. Those rules must allow for the establishment of a practitioner-patient relationship by telemedicine as outlined in #3 above. These professional boards must publish on their websites responses to frequently asked questions related to the determination of a valid prescription issued as a result of a telemedicine medical service.

Insurance Coverage

Under SB 1107 health plans would still be prohibited from excluding a telemedicine medical service or telehealth service from coverage solely because it was not provided through a face-to-face consultation, however they would not be required to provide coverage for services provided by only synchronous or asynchronous audio interaction or a facsimile.

Health plans would also be required to adopt and conspicuously display on their website their telehealth/telemedicine payment policies.

Read the full text of the bill at <http://cchpca.us9.list-manage1.com/track/click> and stay tuned for more updates as SB 1107 moves through Texas' legislative process.

Arkansas Updates Telehealth Regulations

The National Council of State Boards of Nursing's March 16, 2017, Good Morning Members contained the following item:

A new law in Arkansas redefines the term "originating site" to permit telemedicine services to be provided to a patient at their home or other remote location. The law updates a September 2016 telemedicine law in Arkansas, which removed the requirement for an initial in-person visit in order to establish a provider-patient relationship and allowed for a face-to-face examination using real time audio and visual technology. The law also makes clear that a patient-provider relationship can't be formed solely through an internet questionnaire, email, patient-generated medical history, audio-only communication, text messaging, fax or any combination thereof.

See the law here: www.arkleg.state.ar.us/assembly/2017/2017R/Acts/Act203.pdf.

Study Questions Savings from Telehealth

Rand Corporation researchers found that the availability of virtual doctor visits has the effect of raising healthcare expenditures. This is because "the researchers found that only 12 percent of telemedicine visits replaced an in-person provider visit, while 88 percent represented new demand." True, a telehealth visit costs less than an in-office visit (\$79 vs \$146), but the availability of telehealth generates more use. Researcher Lori Uscher-Pines said:

To achieve cost savings, telehealth services would have to replace costlier visits, the researcher said. Insurers could increase telehealth visit costs for patients to deter unnecessary use. Another way to increase the health system value of virtual doctor visits is to target specific groups of patients — such as those who often use emergency rooms for less severe illnesses. An emergency room visit costs an estimated \$1,734.00.

For more, see: <http://californiahealthline.org/news/are-virtual-doctor-visits-really-cost-effective-not-so-much-study-says>.

REGULATORY REFORM

FTC Chair Makes Case for “Economic Liberty”

In a speech on February 23, 2017, at the George Mason Law Review's 20th Annual Antitrust Symposium, Acting FTC Chair Maureen K. Ohlhausen announced:

As Acting Chairman of the FTC, I have committed to make economic liberty and regulatory humility touchstones of my leadership of the agency. Today, I'd like to tell you more about how I plan to carry out that commitment, with a particular focus on the problem of occupational licensing regulation...

Occupational licensing stands out as a particularly egregious example of this erosion of economic liberty. In the 1950's, less than five percent of jobs required a license. Estimates today place that figure between 25 and 30 percent. Today, licensing requirements reach far beyond doctors, electricians, and other fields where public health and safety issues are clearer. Instead, licensing requirements extend to auctioneers, interior designers, make-up artists, hair braiders and numerous other occupations...

See the entire speech here:

www.ftc.gov/system/files/documents/public_statements/1098513/ohlhausen_-_advancing_economic_liberty_2-23-17.pdf.

See also: www.ftc.gov/news-events/press-releases/2017/03/ftc-launches-new-website-dedicated-economic-liberty.

Tennessee Enacts “Right to Earn a Living” Law and Considers Measures to Conform to U.S. Supreme Court NC Dental Ruling

In 2016 the Tennessee Legislature enacted a “Right to Earn a Living” law calling for a review by government operations committees of rules and regulations related to licensure adopted by the state's boards and commissions. In 2017 the legislature enacted HB 326 which mandates a similar review of rules and regulations that could give rise to an antitrust action foreseen by the U.S. Supreme Court's ruling in NC Dental.

For more, see: www.knoxnews.com/story/money/business/journal/2017/04/01/licenses-needed-shampoo-hair-and-massage-horses/99162048/.

See HB 326 here: www.capitol.tn.gov/Bills/110/Bill/HB0326.pdf.

Arizona was the first state to enact a Right to Earn a Living Law:

sonorannews.com/2017/04/07/arizona-becomes-first-state-protect-right-earn-living/.

Letter to the Editor Questions Eliminating Iowa Licensing Boards

The following letter to the editor published in the *Des Moines Register* on March 13, 2017, challenges Governor's proposals to eliminate licensing boards:

Professional licensing reform is an agenda item in the push for smaller government by conservative think-tanks such as Institute for Justice and Goldwater Institute. Their concern is that strict professional licensing regulations decrease low-income entrepreneurs and stymie economic growth. However, the professional licensing boards that Gov. Terry Branstad proposed eliminating are not solely low-income occupations.

While some occupations do not protect the public (e.g., landscaping and interior design), this bill proposes eliminating licensing boards for professions that require a high degree of knowledge to provide competent care services to the public. These proposed cuts include boards for social workers, respiratory care and mental health counselors. The boards for these professions provide a check and balance system to ensure quality services are being provided.

The current system can be assessed with the intent of improving it rather than eliminating it. Entrepreneurship in low-income occupations can be a way to overcome poverty and should be a bipartisan issue. Increasing small business tax credits or micro-financing are just two opportunities that can help grow the local economy while also maintaining a competent professional workforce.

— Bryon Little, *Des Moines*

Source: www.desmoinesregister.com/story/opinion/readers/2017/03/13/professional-licensing-reform-agenda-item/99131464/.

The following day, the Register published this comment by Bruce Buchanan, a licensed social worker:

House Study Bill 138, proposed by Gov. Terry Branstad was defeated in subcommittee recently. This study bill would have done away with licensure requirements not only for mental health professionals but for other licensed professionals. Mental health professionals across the state were pleased with the defeat of this bill. However, now we are concerned again because the governor stated he still believes the state should remove professional licensing requirements for social workers, mental health therapists and other licensed professionals.

I am a licensed independent social worker. I served as the chair of the Iowa Board of Social Work in the mid-1990's. I also served as the president of the Association of Social Work Boards for the United States and Canada. State boards across the country license more than 400,000 social workers. The association maintains four levels of exams for social work licensure in all of the states. These exams assure the public that social workers have passed a national exam to document their ability to practice competent social work. This is important, as social workers provide more than 60 percent of all mental health treatment in the United States.

Social workers provide hospital treatment, treatment for the physically disabled, intellectually disabled and the list goes on and on. Every state licenses social workers at the highest level of licensure. If Iowa drops licensure, it would be the only state to just have a registry at the highest level of clinical practice.

This creates huge problems because there are numerous federal programs that require licensure in order to reimburse for mental health services. This would also create problems for private insurance companies, including the MCOs that run Iowa's Medicaid services, which require licensure to reimburse for mental health treatment.

In Iowa there are 3,990 actively licensed social workers at all levels of practice. There are 1,667 actively licensed mental health counselors and marriage and family therapists, as well. Therefore, it is critically important that this group of care providers complies with the highest possible competency standards in order to assure that vulnerable persons with mental health conditions receive the optimal care they deserve and need. The very reason for licensure is to protect public health by ensuring standards and oversight for practitioners.

Social workers provide services for the most vulnerable people in our state. In the eight years that I was the chair of the board, we investigated numerous complaints and took action against unethical or incompetent social workers.

Today, as I watch the current board it continues to investigate complaints and take action protecting mental health consumers in Iowa. People who utilize social work services want and deserve assurances that ethical and competent standards will be followed when they are dealing with some of the most confidential information kept in their heart, which may indeed be breaking.

Small business owners such as myself and my partners, who employ more than 40 people in greater Des Moines, like many other private mental health providers could potentially be put out of business. This would be reckless, severely straining already insufficient services.

We as a profession want people to feel safe and to know that they are working with competent, highly trained professionals. A registry would not protect this vulnerable population and may indeed stop people from seeking out mental health care. That would be a tragic result, hurting many Iowans.

Source: www.desmoinesregister.com/story/opinion/columnists/iowa-view/2017/03/14/ending-social-worker-licensure-would-reckless/99160194/.

QUALITY OF CARE

Quality of Care Measures and Patient Satisfaction May Not Coincide

A white paper from the HCPro newsletter Patient Safety Monitor Journal analyzes the similarities and differences between patient satisfaction data and healthcare institutions' measures of quality of care – both process measures and outcomes measures.

See the white paper here: <http://promos.hcpro.com/pdf/patient-safety-vs-quality.pdf>.

MEMBERSHIP INFORMATION

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

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

We provide the following services to boards that become members:

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

The annual membership fees are as follows:

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

MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for 2017 please complete this form and email, mail or fax it to:

CAC

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