



News & Views

Citizen Advocacy Center

Third Quarter 2017 – Health Care Public Policy Forum – Volume 29 Number 3

Announcement

The PowerPoint slides from our 2017 Annual Meeting are now available on our website:
http://www.cacenter.org/cac/2017_annual_meeting.

Please note our new office address:

Citizen Advocacy Center
1601 18th Street NW
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Washington, DC 20009

SCOPE OF PRACTICE

Retail Clinics Expanding into Primary Care

An article in the March 25, 2017, *Medical Economics* ponders, “Will retail take over primary care?” The article by Stephen C. Schimpff describes the growth of pharmacy-based primary care delivery in CVS, QuadMed, Walgreens and Walmart. The popularity of retail clinics continues to grow because of lower costs, convenience, and a shortage of traditional primary care providers. Basic care is provided by nurse practitioners and physician assistants in consultation with physicians and the option to refer complicated cases to specialists.

For more see <http://medicaleconomics.modernmedicine.com/medical-economics/news/will-retail-take-over-primary-care>.

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Nurses Assume Hospitalist Role in Small Hospitals

Hospitals and Health Networks magazine reported in April 2017 that small hospitals that struggle to locate or compensate physician hospitalists are turning to nurses to perform the hospitalist role with improvements in patient outcomes and better retention of scarce physicians. Nurse hospitalists are credited with helping some small hospital survive.

For more, see:

<http://www.hhnmag.com/articles/8140-need-a-hospitalist-call-a-nurse>.

North Carolina Considers Modernization of Nursing Regulation

The North Carolina Nurses Association reported on February 14, 2017, that:

Lawmakers at the North Carolina General Assembly have introduced the Modernize Nursing Practice Act, a bill designed to reduce burdensome regulations and allow Full Practice Authority for Advanced Practice Registered Nurses (APRNs). Primary sponsors of House Bill 88 are Rep. Josh Dobson, Rep. Donny Lambeth, Rep. Sarah Stevens, and Rep. Gale Adcock. Primary sponsors of SB 73 are Sen. Ralph Hise, Sen. Louis Pate, and Sen. Joyce Krawiec.

“This legislation is long overdue for the patients of North Carolina. It allows some of the best nurses in healthcare to do exactly what they’ve been trained to do,” said North Carolina Nurses Association President Mary Graff. “North Carolina has a proud history of innovative nursing leadership, but this is one area where we are in catch-up mode to most of the rest of the country. These types of improved regulations have already proven to be safe and effective in dozens of other states.”

See the full press release at <https://ncnurses.org/about-ncna/latest-news/hb88-and-sb73-introduced/>, and see the bill at

<http://www.ncleg.net/Applications/BillLookUp/LoadBillDocument.aspx?SessionCode=2017,&DocNum=309&SeqNum=0>.

NCCPA Releases Physician Assistant Practice Data

The National Commission on Certification of Physician Assistants has released its “2016 Statistical Profile of Certified Physician Assistants.” Introducing the report, NCCPA President and CEO Dawn Morton-Rias wrote:

This year we mark the 50th anniversary of the PA profession, noting that it was in 1967 that the first class of three physician assistants graduated from the inaugural class of the first PA Program – Duke University.

The PA Profession has come a long way.

Today, we have over 115,500 Certified PAs working in every state in the U.S. and practicing in every specialty and clinical setting. Our numbers increased 44% in the last six years alone, and the future continues to be bright.

Physicians and employers depend on Certified PAs to provide expanded access to care, and patients rely on us for treatment during over 8.1 million visits every week. Certified PAs are valuable members of healthcare teams, and the demand for our services continues to grow.

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This 2016 Statistical Profile of Certified Physician Assistants provides information on current PA distribution, demographics and specialty and clinical settings in the United States.

With over 94% of Certified PAs contributing to this data set, you can be assured that the numbers are valid and that NCCPA is the most complete source for PA information. We hope that our stakeholders—*the public, employers, insurers, policymakers and PAs*, the media and others who need data about Certified PAs, will look to NCCPA. We trust that this report will contribute to greater understanding of the breadth, depth and positive impact of the PA profession.

Read the report here:

<http://www.nccpa.net/Uploads/docs/2016StatisticalProfileofCertifiedPhysicianAssistants.pdf>.

Physician Assistants Advised How to Navigate Scope of Practice Issues

On May 17, 2017, Shannon Firth, Washington Correspondent, MedPage Today posted a report about a session at the American Association of Physician Assistants' conference during which Stephanie Radix, JD, Senior Director for Outreach and Advocacy at the AAPA, and medical / legal consultant Jeffrey Nicholson, PhD, PA-C advised PAs that it is not necessarily enough to conform to the law. Avoiding scope of practice issues can also involve ethics and matters of patient safety.

For more, see: <https://www.medpagetoday.com/MeetingCoverage/AAPA/65362>.

APRNs Improve Care

An article in the June 1 edition of *HealthLeaders Media* documents the ways in which Advanced Practice Registered Nurses improve the quality and reduce the cost of care. Written by Jennifer Thew, RN, the article recounts the experience of Catholic Healthcare Initiatives in Colorado when the health system looked to APRNs and physician assistants to adapt to the demands of healthcare delivery in the future.

See more here: <http://www.healthleadersmedia.com/quality/aprns-improve-quality-outcomes-cost-care>.

Governor Vetoes Expansion of Psychologist Scope of Practice

Oregon Governor Kate Brown vetoed a bill that would have authorized state-licensed psychologists to prescribe. As reported by Chris Gray in the August 16, 2017, Lund Report, the governor's veto message cited her objections that the bill did not impose age restrictions on the patients that psychologists could treat, and that other states that have expanded psychologists' scope of practice have shown insufficient evidence that it improves access. She also noted that psychologists are regulated by a board that does not currently oversee drug prescribers, and that

giving psychologists this authority creates new liability concerns in case of malpractice or negative outcomes for the patient, including death. Brown was particularly concerned with the bill's impact on children.

For more, see: <https://www.thelundreport.org/content/brown-spikes-psychologist-prescriber-bill>.

REGULATORY REFORM

Mississippi Considers “Occupational Board Compliance Act”

The purpose of House Bill 1425 is stated to be “to ensure that occupational licensing boards and board members shall avoid liability under federal antitrust laws.” According to Mississippi Watchdog.org, “the bill would create an Occupational Licensing Review Commission to be composed of the governor, the secretary of state and the attorney general. The review commission would examine any regulation by an occupational licensing board before it could be placed on the secretary of state’s website and later adopted.”

For more, see: <http://billstatus.ls.state.ms.us/documents/2017/html/HB/1400-1499/HB1425SG.htm>.

Arizona Boards Ordered to Justify Regulatory Standards

By Executive Order, the governor of Arizona has required regulatory boards to review and justify their regulations and other actions to be sure they do not unnecessarily interfere with Arizonans’ entry into the workforce. Boards affected by the order include several healthcare boards, including nursing, chiropractic, medicine, massage therapy, optometry, physical therapy, occupational therapy, pharmacy, psychology, and respiratory care.

For more, see: https://azgovernor.gov/sites/default/files/executive_order_2017,-03.pdf, <http://freebeacon.com/politics/az-gov-cracks-down-occupational-licensing/>, and <http://www.azcentral.com/story/opinion/letters/2017,/04/13/barto-licensing-bill/100420200/>.

Missouri Bill Would Limit Professional Regulation

Missouri House Bill 480 passed by the Republicans in the state’s House of Representatives would require that any new regulations can be enacted only if the profession poses a risk of significant public harm, if the public would benefit from regulating individual practitioners, and if there is no alternative for accomplishing the desired end.

For more, see: <http://themissouritimes.com/38712/house-passes-bill-limiting-profession-registration-licensing/>.

Congress and States Consider Responses to NC Dental Decision

The August 4, 2017, issue of *FSMB Advocacy Network News* reported on federal and state legislative responses to the Supreme Court's decision in *North Carolina Board of Dental Examiners v. the Federal Trade Commission*:

Restoring Board Immunity Legislation

Sens. Mike Lee (R-UT), Ted Cruz (R-TX), Ben Sasse (R-NE), as well as **Rep. Darrell Issa (R-CA-49)** introduced **S. 1649, The Restoring Board Immunity Act**, which would create a limited antitrust exemption for state licensing boards, conditioned on whether a state adopts occupational regulation reforms tracking one of two frameworks. One track includes the creation of a State Office of Supervision of Occupational Boards, tasked with day-to-day board supervision of licensing authorities. To learn more about this bill, please see:

https://issa.house.gov/sites/issa.house.gov/files/Summary_RBI%20Act%5B1%5D.pdf.

The FSMB is closely monitoring this legislation, and welcomes feedback from its member medical boards. Please contact **Jonathan Jagoda**, FSMB Director of Federal Government Relations at jjagoda@fsmb.org.

Antitrust and Active Supervision

State legislatures are continuing to look at how to respond to *North Carolina Board of Dental Examiners v. Federal Trade Commission (FTC)*:

In **Ohio**, House Bill 289 <https://legiscan.com/OH/bill/HB289/2017> establishes a statewide policy on occupational regulation requiring standing committees of the General Assembly to periodically review occupational licensing boards regarding their sunset. The bill also requires the Common Sense Initiative Office to review certain actions taken by occupational licensing boards, and to require the Legislative Service Commission to perform assessments of occupational licensing bills and state regulation of occupations.

In **Wisconsin**, Assembly Bill 369 <https://docs.legis.wisconsin.gov/2015/proposals/ab369> and Senate Bill 288 <https://docs.legis.wisconsin.gov/2015/proposals/sb369> create the Occupational License Review Council within the Department of Safety and Professional Services. The Council is required to submit a report by December 31, 2018, that includes recommendations for the elimination of occupational licenses in this state, or the modification of laws and rules governing occupational licenses, and the reduction or elimination of occupational license continuing and other education requirements. The proposed recommendations shall be introduced in the legislature and must be acted upon no later than June 30, 2019. The bill provides that a new council convenes every ten years to repeat the process.

The FSMB State Legislative and Policy staff will continue to track and monitor legislation of interest to boards around the country. If there is legislation you would like us to assist with, please contact **John Bremer**, State Legislation and Policy Coordinator, at jbremmer@fsmb.org.

See also: <http://clear.blogs.com/clear/2017./08/us-restoring-board-immunity-act-introduced.html>, and <https://issa.house.gov/sites/issa.house.gov/files/Occupational%20Licensing%20Bill.pdf>.

ASWB Newsletter Features Article on Regulatory Reform

Association of Social Work Boards Director of Communications and Marketing Jayne Wood wrote in the August 2017 issue of *Association News* about a panel discussion of trends pointing toward changes in state licensing affecting multiple professions. She concludes:

With regulation coming under increased scrutiny and occupational licensing being viewed as a barrier to a mobile workforce, the threat of an imposed “one size fits all” solution reinforces the work of the Mobility Task Force to develop a Mobility Strategy that works for social work regulation. Whether describing compacts or model law-based mobility initiatives, the panelists at this roundtable shed light on ways that ASWB’s Mobility Task Force is making sound recommendations to help ASWB members achieve social work practice mobility. The Mobility Strategy framework, based in the model law, offers a commonsense approach.

Read the article here: <https://www.aswb.org/wp-content/uploads/2017./08/fromstaffAUG17.pdf>.

CONTINUING PROFESSIONAL DEVELOPMENT

Ontario Maintenance of Licensure for Pharmacists Cited as Model

The April 2017, *Journal of Medical Regulation* included an article entitled, “Standardized Assessment of Pharmacists’ Patient Care Competencies: A Model for Maintenance of Licensure (MOL) in the Health Professions,” by Zubin Austin, BScPhm, PhD; Deanna Williams, BScPhm; and Anthony Marini, PhD. The article’s abstract explains that:

Assessing the ongoing competence of practicing healthcare professionals requires regulators to balance complex demands of governments and the public, as well as interests and concerns of practitioners. A proliferation of models has evolved across professions and jurisdictions. In this article, we report on a model utilizing standardized assessment using best-practice measurement techniques and methods for evaluation of ongoing (i.e., post-registration) clinical competencies in the profession of pharmacy in Ontario, Canada. This model involves categorization of the profession into an active patient-facing and non-patient-facing register, implementation of a learning portfolio requirement to replace mandatory continuing education credit accumulation, and the use of standardized assessment techniques, such as a multiple-choice test of clinical knowledge and an objective structured clinical examination (OSCE) of clinical reasoning and interpersonal skills. Lessons learned from the development, implementation and retrospective analysis of almost two decades of data from this program can provide regulators in diverse professions and different jurisdictions with tools for standardized assessment of patient care competencies.

Read the article here: http://jmr.fsmb.org/wp-content/uploads/2017/04/StandardAssessment_JMR-102_4_FINAL-2.pdf.

Study Finds Physician Age Linked to Mortality Risk

An article by John Commins in the May 18, 2017, *HealthLeadersMedia* reports on a study published in *BMJ* about research at Harvard that found mortality rates of 10.8% among patients treated by hospitalists 40 and younger compared to rates of 12.1% among patients treated by hospitalists 60 and older. Lead author Anupam B. Jena, MD told Commins that a goal of the research is to help resolve the ongoing debate about what should be required of physicians in the way of continuing professional development as they age and go further out from residency.

See more: <http://www.healthleadersmedia.com/physician-leaders/physician-age-linked-clinically-significant-patient-mortality-risk>.

Assessing Aging Physicians

In July 2017, *JAMA Surgery* reviewed an article entitled, “The Aging Physician and the Medical Profession.” Authors E. Patchen Dellinger, MD, Carlos A. Pellegrini, MD and Thomas Gallagher, MD reached this conclusion:

As physicians age, a required cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and coworkers regarding wellness and competence would be beneficial both to physicians and their patients. While it is unlikely that this will become a national standard soon, individual health care organizations could develop policies similar to those present at a few US institutions. In addition, large professional organizations should identify a range of acceptable policies to address the aging physician while leaving institutions flexibility to customize the approach. Absent robust professional initiatives in this area, regulators and legislators may impose more draconian measures.

For more, see: <http://jamanetwork.com/journals/jamasurgery/article-abstract/2644000> and <http://www.reuters.com/article/us-healthcare-physician-retirement/should-older-doctors-be-examined-tested-or-forced-to-retire-idUSKBN1AR22K>.

Ensuring Objective Assessment of Current Competence

Christine Niero, PhD wrote in the May 19 *Professional Testing Blog* that the subject of recertification was discussed at a recent meeting of the International Laboratory Accreditation Cooperation (IAF-ILAC). The discussion revolved around the IOS/IEC standard 17024 conformity assessment requirements related to *General requirements for bodies operating certification of persons*. Niero wrote:

ISO/IEC 17024 requirement 9.6.5 stipulates that certification bodies consider several options for confirming continuing competence, including: a) on-site assessments; b) professional development; c) structured interviews; d) confirmation of continuing satisfactory work and work experience records; e) examination; and f) checks on physical capability in relation to the competence concerned. The responsibility of certification bodies electing any or a combination of these options is to provide evidence of impartiality in assessing continuing competence.

See more here: <http://www.proftesting.com/blog/2017./05/19/ensuring-impartial-assessment-recertification/>.

OPENNOTES

Study Finds Discrepancies in Diagnoses

The Agency for Healthcare Research and Quality published a study in April 2017 entitled “Extent of Diagnostic Agreement Among Medical Referrals” by M Van Such, R. Lohr, T Beckman and J. M. Naessens. The abstract reads:

Diagnostic uncertainty is common and can lead to missed or delayed diagnoses. This retrospective medical record review study examined cases where primary care providers sought diagnostic input from subspecialists. Investigators compared the final diagnosis from the subspecialty visit with the presumed diagnosis at the time of the initial subspecialty referral. They found that the diagnosis differed substantially in about one-fifth of cases following the subspecialty consultation. Costs were higher for cases with substantively different diagnoses compared to cases where subspecialists confirmed or further clarified diagnoses. The authors conclude that subspecialty access is critical to timely and accurate diagnosis. A recent WebM&M commentary discussed how cognition can influence diagnostic decision making.

Editorial Note: OpenNotes is a movement that promotes patient access to their clinician’s notes. This access is even more important in situations where two clinicians – in this case the referring primary care provider and the consulted sub-specialist – disagree about a diagnosis.

Physicians Better Prepared When Patients Enter Agenda in OpenNotes Prior to Visits

An article in the Annals of Family Medicine March/April 2017, entitled, “Patients Typing Their Own Visit Agendas into an Electronic Medical Record: Pilot in a Safety-Net Clinic,” documents the success of enabling patients to enter comments and questions into their OpenNotes records prior to visiting a clinician. The article abstract reads:

Collaborative visit agenda setting between patient and doctor is recommended. We assessed the feasibility, acceptability, and utility of patients attending a large primary care safety-net clinic typing their agendas into the electronic visit note before seeing their clinicians. One hundred and one patients and their 28 clinicians completed post-visit surveys. Patients and clinicians agreed that the agendas improved patient-clinician communication (patients 79%, clinician 74%), and wanted to continue having patients type agendas in the future (73%, 82%). Enabling patients to type visit agendas may enhance care by engaging patients and giving clinicians an efficient way to prioritize patients’ concerns.

For more, see: <http://www.annfammed.org/content/15/2/158.full> and <http://www.healthleadersmedia.com/technology/78-physicians-more-prepared-when-patients-enter-ehr-notes-ahead-appointments>.

Texas Telehealth Law Misses Opportunity

Following years of battling and lawsuits among telehealth providers and regulators, the Texas legislature enacted a telehealth law on May 12, 2017. The law defines the practice of telemedicine and addresses the doctor patient relationship, the standard of care, insurance coverage, remote prescribing and follow-up care, among other things.

On the subject of medical records, the law requires telemedicine practitioners to provide the patient's primary care provider with a medical record or other report within 72 hours that explains the treatment provided and the evaluation, analysis or diagnosis of the patient's condition.

Editorial Note: It is unfortunate that the legislators did not take this opportunity to mandate that patients be given direct access to the record from a telemedicine encounter. Patients would then be better informed in advance of their follow up appointment with their primary care provider.

Vermont Telehealth Law Misses Opportunity

Telehealth legislation enacted in Vermont expands patient access by, among other things, permitting patients to receive telehealth services at locations other than healthcare facilities. At the same time, the legislation prohibits recording telehealth encounters. It specifies, "neither a health care provider nor a patient shall create or cause to be created a recording of a provider's telemedicine consultation with a patient."

For details, see: <http://www.jdsupra.com/legalnews/vermont-s-new-telemedicine-law-expands-70182>.

Editorial Comment: This legislative language does not appear to prohibit clinicians participating in a virtual consultation from sharing their notes with referring physicians and patients. However, prohibiting recording the consultation potentially denies the patient any electronic record of what transpired. Such a record would be helpful to the patient in understanding a diagnosis and treatment options and could be helpful should the patient choose to seek a second or third opinion. Some state laws permit or encourage "store and forward" technologies which permit physicians and patients to use secure communications channels to share, study, and review records and video clips without having to have a real-time connection.

For more about recording clinical encounters, see: <http://www.aarp.org/health/healthy-living/info-2017/audio-recording-your-doctor-visit-fd.html>

Workshop on Health Literacy is Fodder for OpenNotes

The report from a workshop on communicating to patients contains valuable information about communicating information to patients about medications and treatment regimens. There is valuable guidance about how to improve health literacy, but no direct recommendation to provide patients with their practitioners' clinical notes to help them understand how to take their medications. "Communicating Clearly About Medicines – Proceedings of a Workshop – in Brief" was published in May 2017, by the National Academies Press

See the proceedings here: <https://www.nap.edu/read/24785/chapter/1>.

Study Finds Clinicians Use Cut and Paste in Clinical Notes

Research at the University of California San Francisco Medical Center cautioned about the problems associated with importing information into electronic medical records:

In the study, the results of which were recently published in *JAMA Internal Medicine*, the UCSF Medical Center researchers noted that electronic health records (EHRs) allow physicians writing progress notes to supplement traditional manual data entry with copied or imported text. “However, copying or importing text increases the risk of including outdated, inaccurate or unnecessary information, which can undermine the utility of notes and lead to a clinical error,” the study authors wrote...

Future analysis will examine how copied and imported text is used to fulfill the various functions of a note, such as billing or clinical history recall. This finding could spur EHR design that makes copied and imported information readily visible to clinicians as they are writing a note, but, ultimately, does not store that information in the note,” the study authors wrote.

See the article abstract at <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2629493>.

For more, see: <https://www.healthcare-informatics.com/news-item/ehr/study-clinicians-copy-and-paste-about-half-text-ehr-progress-notes>.

Editorial Note: The practice of importing text into electronic medical records adds weight to arguments in favor of sharing clinical notes with patients. Patients can spot and bring to clinicians’ attention information in their records which is incorrect or of questionable relevance to their symptoms and diagnosis.

Non-Profit Organizations Promote Improved Access to Digital Records

The July 3, 2017, edition of *MedCity News* online included an article about patient advocacy organizations working to improve patient access to their digital records and transmission of digital records among a patient’s multiple clinicians.

Among the challenges facing organizations are digital health tools with limited interoperability and patient portals that are all too often underused, or not accessed at all, by patients. Whether patients are able to access their information easily, and whether they’re accessing it in the first place, are the matters that have tripped up healthcare organizations.

One organization featured in the article is Share for Cures, “a Virginia nonprofit working to encourage patients to share their health data for cancer and other medical research...” Others are the National Association for Trusted Exchange and System for Health and Research Data Exchange (SHARE).

For more, see: <http://medcitynews.com/2017./07/overcoming-barriers-to-patients-gaining-access-to-health-records/>.

Should Patients Control Their Own Medical Records?

A blog by Dr. Joseph Schneider in *Blogged Arteries* makes the case that patients should control their own medical records. He recounts his own experience being mistaken for a different patient and cites these statistics:

Patients are misidentified 10 percent of the time, resulting in an inappropriate record merger or a duplicate record. Nine percent of these misidentifications result in medical errors. That's about one percent of all interactions resulting in errors. According to one study, a significant number of patients are harmed or die each year from identity errors.

Then he explains what he thinks would be a better approach:

Create a system that supports the right and the ability of individuals to be responsible for their own healthcare record and even to have control over it, with help as needed. With respect to interoperability, this means that some patients may even control what information is exchanged because they control their own records. This would augment, not replace, traditional physician/hospital controlled records for those patients who could not handle these responsibilities. The personal involvement that this engenders might be the most important step in getting accurate health information to the right place at the right time.

See the blog post at <http://bloggedarteries.texmed.org/2017./07/the-missing-link-patient-responsibility.html>.

Editorial Note: Short of giving patients control of their medical records, at a minimum they should be able to see, study, and if necessary correct records about their own health.

PUBLIC MEMBERS

Public Member Receives Award from FSMB

The Federation of State Medical Boards announced its 2017 award recipients in May 2017. Among the recipients is Carole Erickson, a public member who received an Award of Merit, which “recognizes activities and contributions that positively impact and strengthen the profession of medical licensure and discipline, and help enhance public protection.” The announcement says this about Ms. Erickson:

As a public member of the Montana Board of Medical Examiners, Ms. Erickson has been a catalyst for positive change for the board, its stakeholders and the state's citizens – a quality she has demonstrated again and again since joining the board more than a decade ago. The board's positive relationships with key stakeholder groups can be directly attributed to her outstanding engagement and leadership skills. Among her many accomplishments, Ms. Erickson worked with board staff to identify inefficiencies in the physician application process, resulting in a streamlined system that significantly reduced application times. She also led the formation of the board's Outreach Committee, and served as its liaison to external groups.

For more, see: https://www.fsmb.org/Media/Default/PDF/Publications/News%20release-FSMB%20Award%20Recipients_April%202017_FINAL.pdf.

CONSUMER INFORMATION

CAC Signs on to Letter Supporting Release of Facility Accreditation Reports

On August 3, the Centers for Medicare and Medicaid Services (CMS) withdrew a proposal to make healthcare facility accreditation reports available to the public. CAC had been one of more than 50 signatories to a letter to CMS supporting the proposed regulatory change that would require healthcare facility accrediting organizations to make their survey reports publicly available. The letter reads in part:

Survey reports are publicly available for schools and restaurants but not for healthcare facilities (hospitals and nursing homes). The public has the right to access these reports since healthcare is a vital service and knowing a healthcare facility's performance is imperative. In addition, a facility may elect to be surveyed by a State organization in lieu of a survey by an accrediting organization. Facility surveys which are performed by States are often publicly available and, thus, there appears to be a double standard regarding those performed by accrediting organizations.

The process and structure measures of accrediting organizations have been extensively researched, are often verified by onsite visits and are, thus, not subject to risk adjustment concerns that surround outcome measures.

The very high disparity rates of the accrediting organizations with follow-up governmental surveys makes transparency of utmost importance. One of two possibilities exist for this discrepancy:

1. The accrediting organization's survey can be substandard or in error. Concern exists that because there are multiple accreditation organizations and the facility chooses which organization performs the survey, that the less rigorous accreditation organization will be selected, producing an associated degradation in survey quality. In addition, the Joint Commission was also founded by the healthcare industry, including the American Hospital Association, and currently is funded by the organizations it accredits. Other accrediting organizations also receive funding by the healthcare facilities they survey.
2. The correction of the initial findings can be temporary or can be accomplished by pulling resources from other areas, creating other deficiencies.

Transparency of the initial and post remediation reports will help delineate these two possibilities.

We would also like to recommend that the final regulation requires that the initial report, before remediation, be readily available and posted on a public website.

In summary, we would like to reaffirm our support for the newly proposed CMS regulations as they relate to transparency of facility accreditation surveys.

For more, see: <https://www.psqh.com/news/accreditors-can-keep-hospital-inspection-reports-secret-feds-decide/>.

Medical Board of California Newsletter Features Board Website

The lead article in the Medical Board of California's Spring 2017, newsletter describes the evolution of the board's website since its initiation in 1996. Written by Susan Walvarst and Charlotte Clark and entitled, "The Medical Board's Website Then and Now," the article reads in part:

The Medical Board of California launched its first website in 1996, a simple web page with hyperlinks to information regarding Physician and Surgeon licensure in the state of California. It also provided consumers with information on how to choose a doctor or, if needed, how to file a complaint against a doctor.

While that early version seems primitive today, it represented a huge advantage for anyone who owned or had access to a computer. In the website's earliest days, the only way to check on a doctor's license was to call or write to the Board.

The Board's website has grown considerably in 21 years – incorporating new technology every step of the way – including a responsive design template, which adjusts the size of the website for viewing on mobile phones, tablets, laptops or desktops without losing functionality.

Read the article with links to the website here:

http://www.mbc.ca.gov/Publications/Newsletters/newsletter_2017_04.pdf.

IMPAIRED PRACTITIONERS

AMA Offers Module on Responding to Impaired Colleagues

Sara Berg, Senior Staff Writer for *AMA Wire* wrote on August 25, 2017, about a free module offered by the AMA entitled, "Understanding the Code of Medical Ethics: Physician Wellness and Professional Conduct." According to Berg, the module contains "information to help physicians identify and understand their ethical obligations to maintain their own wellness, help fellow colleagues in need who may be impaired, and promote a profession that places patient well-being and safety first."

For more, see: <https://wire.ama-assn.org/education/when-colleague-impaired-how-should-physicians-respond> and <https://cme.ama-assn.org/Activity/5585508/Detail.aspx>.

PATIENT SAFETY

Inter-Professional Practice Impacts Patient Safety

An article in the *Journal of Interprofessional Care* entitled "Patient Safety and Interprofessional Education: A Report of Key Issues from Two Interprofessional Workshops" by Elizabeth Anderson, Richard Gray and Kim Price examines the potential for interprofessional education to improve patient safety. The article's abstract says:

This article presents the outcomes of two workshops which explored historical and recent issues on patient safety that directly relate to leaders in the interprofessional field. The article considers the impact of flattened team-based structures where collaborative working constantly considers safe patient-centered high-quality care. These issues are mainly rooted in changes within a UK context, but the historical case studies present situations which could enlighten and enliven discussions of patient safety in an international context. The article was sparked by discussion of recurrent themes in healthcare that have undermined the abilities of medical practitioners to adequately manage hazard in clinical care settings throughout modern history. Examining the issues that confront healthcare practitioners and care workers in their dealings with patients and clients, such as the aged or the severely disabled, can reveal commonalities across global healthcare settings, in the past and present, that provide a useful tool in facilitating the goals of inter-professional education (IPE). The potential of IPE has links to both how professionals respond together to care situations and involve the general public in shared health understandings. The outcomes focus on how to ensure ministrations where optimal team-based collaborative care is recognized and constantly sought. We conclude that IPE has much to offer in this arena and more evidence of impact here is well worth pursuing.

Read the article here: <http://www.tandfonline.com/doi/full/10.1080/13561820.2016.1261816>.

Patients Impact Quality of Care

Research sponsored by the Agency for Healthcare Research and Quality and published in the *Journal of Hospital Medicine* found that:

Patients can play a crucial role in identifying safety events. Prior studies have shown that patient surveys can identify errors and adverse events that were not detected through other safety surveillance mechanisms. In this study, investigators conducted interviews with patients after hospitalizations at two urban tertiary care hospitals, specifically querying patients about perceived breakdowns in their care. Nearly 40% of patients perceived at least one breakdown, most commonly relating to communication with clinicians or issues with medications. Younger and more highly educated patients, as well as those who had a caregiver participate in the interview, were more likely to report a breakdown in care. This study highlights the importance of directly asking patients about perceived safety concerns as part of patient safety surveillance.

Approaches to engaging patients in patient safety are discussed in a Patient Safety Primer at <https://psnet.ahrq.gov/primers/primer/17>, and PSNet perspective is at <https://psnet.ahrq.gov/perspectives/perspective/136>.

For more, see:

https://psnet.ahrq.gov/resources/resource/31334?utm_source=ahrq&utm_medium=en6&utm_term=&utm_content=6&utm_campaign=ahrq_en8_29_2017.

Nurse Anesthetists Share Data with NCSBN

On July 19, 2017, the National Council of State Boards of Nursing's Good Morning Members announced:

NCSBN recently announced that NBCRNA (National Board of Certification and Recertification of Nurse Anesthetists) credentialing information is now being uploaded into the Nursys database, making it the first advanced practice registered nurse association to provide electronically primary source certificate information to boards of nursing via Nursys.

For more, see: <https://www.ncsbn.org/11059.htm>.

Editorial Note: CAC applauds this information sharing and encourages more of it between licensure authorities and certification bodies.

LICENSURE

Michigan Requires Licensure for Certified and Direct Entry Midwives

The May 17, 2017, edition of the National Council of State Boards of Nursing contained the following item:

A bill was recently signed into law requiring certified professional and direct entry midwives in Michigan to be licensed. The law requires midwives to apply for a license with the newly created Michigan Board of Licensed Midwifery, which operates through the Department of Licensing and Regulatory Affairs. The board consists of seven midwives, a certified nurse midwife, a gynecologist, a pediatrician and two public members, all subject to Senate approval.

Effective immediately, the new law establishes scope of practice requirements in addition to licensure requirements:

- Requires educational, credentialing and examination criteria for licensure as well as continuing education for license renewal;
- Requires a midwife to obtain informed consent from a patient at the inception of care and continuing throughout the patient's care;
- Requires a midwife to establish protocol for the transfer of care to a physician or hospital;
- Prohibits a midwife from using certain instruments, prescribing medications or performing surgical procedures other than episiotomies or repairs to perineal lacerations; and
- Requires the Department of Licensing and Regulatory Affairs, in consultation with the Michigan Board of Licensed Midwifery, to promulgate rules to establish and implement the midwifery licensure program, establish continuing education

requirements, delineate a midwife's scope of practice and create the process for obtaining informed consent from a patient within 24 months.

See the bill here: <http://www.legislature.mi.gov/documents/2015-2016/billenrolled/House/pdf/2015-HNB-4598.pdf>.

Doctors Get Licenses Under Interstate Compact

JD Supra reported on July 5, 2017, that physicians are beginning to earn out-of-state licensure through the Interstate Medical Licensure Compact, which at the time had eighteen state signatories. The blog post explains the process involved.

For more, see: <http://www.jdsupra.com/legalnews/physicians-begin-receiving-licenses-58756/>.

Growing Number of Nurses Earn College Degrees

A report from the Georgetown University Center on Education and the Workforce documents the increase in college educated nurses. Announcing the report, the Center wrote:

Dear Friends and Colleagues,

We released a new report that shows that a college education is increasingly the key to success in a nursing career, with 66 percent of registered nurses having a bachelor's degree or higher today compared with 32 percent in 1980. "Nursing: Can It Remain a Source of Upward Mobility Amidst Healthcare Turmoil?" also reveals a lack of diversity among nurses: 71 percent of RNs are White compared to only seven percent who are Latino and 12 percent who are Black.

The findings explore the educational barriers to upward mobility that low-income nurses and those from racial and ethnic minority groups face. The report also explores the knowledge and competencies that nursing requires.

For more, see: <https://cew.georgetown.edu/cew-reports/nursingcareers/>.

Editorial Comment: One of the authors of this new report, Artem Gulish, was an intern at CAC in 2009 and 2010. He researched and help write a number of CAC's publications on scope of practice reform. Congratulations, Artem!

DISCIPLINE

Discipline and Due Process

The National Council of State Boards of Nursing reported on May 26, 2017, that the *Journal of Nursing Regulation* published an article on discipline and due process in a digital age:

A recent JNR article discusses how board members' use of technology before, during and after a license disciplinary proceeding can affect the validity of the proceeding. The article advises that board members put aside personal electronic devices that are not necessary when participating in a hearing. The use of such devices raises suspicions that board members might be judging the matter improperly, communicating privately with others about the case or not paying sufficient attention.

According to the author, “Because of the risks inherent in the use of technology at a license disciplinary hearing, boards should investigate the governing statutes and rules of their state regarding their roles as hearing officers.” The author concludes that developing policies that are tailored to the requirements of the state and that give board members “a clear understanding of the expectations governing the use of technology in their roles as hearing officers will go a long way toward preventing problems.”

Find the article here: [http://www.journalofnursingregulation.com/article/S2155-8256\(17\)30070-4/pdf](http://www.journalofnursingregulation.com/article/S2155-8256(17)30070-4/pdf).

USMLE Scores Correlate with Chances of Disciplinary Action

A May 2017 article in the Journal of the Association of American Medical Colleges reports on research to ascertain whether USMLE test scores can predict the odds that a physician will face disciplinary action in the future. The abstract reads:

Purpose: Physicians must pass the United States Medical Licensing Examination (USMLE) to obtain an unrestricted license to practice allopathic medicine in the United States. Little is known, however, about how well USMLE performance relates to physician behavior in practice, particularly conduct inconsistent with safe, effective patient care. The authors examined the extent to which USMLE scores relate to the odds of receiving a disciplinary action from a U.S. state medical board.

Method: Controlling for multiple factors, the authors used non-nested multilevel logistic regression analyses to estimate the relationships between scores and receiving an action. The sample included 164,725 physicians who graduated from U.S. MD-granting medical schools between 1994 and 2006.

Results: Physicians had a mean Step 1 score of 214 (standard deviation [SD] = 21) and a mean Step 2 Clinical Knowledge (CK) score of 213 (SD = 23). Of the physicians, 2,205 (1.3%) received at least one action. Physicians with higher Step 2 CK scores had lower odds of receiving an action. A 1-SD increase in Step 2 CK scores corresponded to a decrease in the chance of disciplinary action by roughly 25% (odds ratio = 0.75; 95% CI = 0.70-0.80). After accounting for Step 2 CK scores, Step 1 scores were unrelated to the odds of receiving an action.

Conclusions: USMLE Step 2 CK scores provide useful information about the odds a physician will receive an official sanction for problematic practice behavior. These results provide validity evidence supporting current interpretation and use of Step 2 CK scores.

See more at:

http://journals.lww.com/academicmedicine/Abstract/publishahead/Exploring_the_Relationships_Between_USMLE.98203.aspx.

Georgia Medical Board to Review Handling of Sexual Misconduct Cases

On June 9, 2017, the medical board in Georgia issued the following statement:

On June 09, 2017, The Georgia Medical Board adopted a public statement regarding the Board's handling of sexual misconduct and boundary violations.

The Board, at the direction of Board Chairman Dr. John Antalis, began reviewing previous sexual misconduct/boundary violations cases in an effort to ensure the Board is following its mission to protect the health of Georgians through the proper licensing of physicians and certain members of the healing arts and through objective enforcement of the Medical Practice Act.

It is the intent of the Board to protect Georgia patients from physicians who use coercion or power for sex by:

- EDUCATING physicians about the importance of reporting colleagues who may be committing boundary violations
- INVESTIGATING every allegation and involving law enforcement when the investigation reveals criminal activity
- ENFORCING allegations that are proven by issuance of a Public Consent Order or Revocation of their medical license.

The board has been the subject of a series of newspaper exposes critical of its handling of sex abuse cases. See the *Atlanta Journal Constitution* series here:

http://doctors.ajc.com/doctors_sex_abuse/. See also <http://www.myajc.com/news/state--regional-govt--politics/with-brief-statement-medical-board-ends-sex-abuse-study/1aZgGHw3RSp6sVF7UDcPRM/>.

TELEHEALTH

Texas Enacts Telehealth Law

The Center for Connected Health Policy posted the following on May 23, 2017:

The Texas legislature has passed SB 1107, and Texas Governor Abbot is expected to sign the bill in the coming days. SB 1107 would allow for the establishment of a valid practitioner-patient relationship while using telemedicine. The passage of this bill comes after months of negotiations between the Texas Medical Board, regulatory agencies and industry groups. Previously, Texas required a patient to be located at an established medical site (i.e. a provider's office, hospital, etc.) in order to establish a practitioner-patient relationship with a patient that never received an in-person exam. This rule prompted protests from the telemedicine industry and culminated in the court case between TeleDoc and the Texas Medical Board, and led to an injunction being filed putting a temporary hold on the rule. The passage of SB 1107 effectively settles the dispute, allowing patients to be able to access their providers via apps on their smartphone, tablet or computer from their home, and follows a similar trend in other

states that have for the most part eliminated requirements for an initial in-person exam to establish physician-patient relationship.

Specifically, SB 1107 stipulates that to establish the relationship via telemedicine, the interaction must occur through synchronous audiovisual interaction, store and forward technology or another form of audiovisual telecommunication technology that allows the practitioner to comply with the appropriate standard of care. The provider would also be required to provide the patient with guidance on appropriate follow-up care and provide to the patient's primary care provider within 72 hours a medical record or report of the practitioner's evaluation, analysis or diagnosis.

SB 1107 also instructs the Texas Medical Board, Board of Nursing, Physician Assistant Board and Board of Pharmacy to establish rules pertaining to the determination of a valid prescription. Additionally, SB 1107 requires health plans to conspicuously display on their website their telehealth/telemedicine payment policies, although they would not be required to display the negotiated contract payment rates for health professionals who contract with the insurer.

See the bill here: <http://cchpca.us9.list-manage.com/track/click?u=c9fa99b7520aedfca5c453103&id=b03cb1c195&e=d903860d49>.

See also <https://www.psqh.com/news/caucus-pushes-for-telemedicine-expansion-in-congress/>, <http://www.jdsupra.com/legalnews/texas-telemedicine-law-finally-allows-87021/>, <http://www.jdsupra.com/legalnews/doc-can-you-hear-me-now-telehealth-85297/> and <http://www.star-telegram.com/opinion/opn-columns-blogs/other-voices/article168731522.html>.

Congress Considers Legislation for Medicare Telehealth

On May 24, 2017, *Patient Safety and Quality Healthcare* (PSQH) reported that:

The U.S. House of Representatives and Senate are considering both the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2017, and the Medicare Telehealth Parity Act (MTPA). The two bills are aimed at lowering CMS restrictions on telemedicine coverage and test the efficacy of telehealth services in Medicare healthcare delivery reform models. The Senate Finance Committee is also considering a bill called the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which includes a section that would allow greater use of telehealth.

Both CONNECT and MTPA had failed to advance during previous sessions of Congress, and were re-launched by members of the newly formed bipartisan Congressional Telehealth Caucus on May 19, 2017.

The four founding members of that caucus are Representatives Mike Thompson (D-Calif.), Gregg Harper (R-Mass.), Diane Black (R-Tenn.), and Peter Welch (D-Vt.)

See <https://mikethompson.house.gov/newsroom/press-releases/thompson-harper-black-welch-make-major-push-for-telehealth> and <https://www.psqh.com/news/caucus-pushes-for-telemedicine-expansion-in-congress/>.

Telehealth is a Two-Way Street

An article in the June 4, 2017, *Health Day News* describes new technology that enables cancer patients to communicate their symptoms electronically to their care providers in real time. This timely communication improves care because it enables practitioners to respond quickly between in-person visits. According to the article:

The new communication tool allows patients to use tablet technology to report 12 common symptoms experienced during chemotherapy -- things such as appetite loss, difficulty breathing, fatigue, hot flashes, nausea and pain -- in real time. That triggers an "alert" to health care providers.

The benefits can be significant, Basch's team found. The study of 766 patients found that those who used the tool regularly lived an average of five months longer than those who did not use the tool.

Read the article here: <https://consumer.healthday.com/cancer-information-5/mis-cancer-news-102/reporting-symptoms-online-to-docs-helps-cancer-patients-live-longer-723214.html>.

PAIN MANAGEMENT

FSMB Releases Opioid Use Guidelines

May 17, 2017, the Federation of State Medical Boards announced:

The Federation of State Medical Boards (FSMB) has released its updated “Guidelines for the Chronic Use of Opioid Analgesics.” The guidelines were officially adopted as policy by the FSMB House of Delegates at the FSMB’s Annual Meeting last month in Fort Worth, Texas.

The FSMB engaged with experts in pain medicine and addiction, government officials and other thought leaders over the past year and a half to conduct a thorough review and analysis of FSMB’s existing policy and other state and federal guidance documents on the prescribing of opioids in the treatment of pain. The workgroup, led by former FSMB Chair, J. Daniel Gifford, MD, FACP, identified its own recommendations as well as those included in recent advisories released by the FDA and the CDC’s March 2016.

“As our nation’s opioid epidemic worsens, it is critical that state medical and osteopathic boards - and the physicians and physician assistants they license and regulate - have updated guidance on the responsible management of chronic pain,” said FSMB President and CEO, Humayun Chaudhry, DO, MACP. “It is also critically important for clinicians to assess whether opioid analgesics, when prescribed by them, are not being abused, misused or diverted.”

“State medical boards play a crucial and unparalleled role in protecting the public,” said Gregory B. Snyder, MD, Chair of the FSMB Board of Directors. “These updated guidelines will provide the medical regulatory community with the knowledge and tools we need to help prevent this crisis from progressing in communities across our country.”

The guidelines feature updated criteria for use by state medical boards in the following areas:

- Patient assessments, evaluations and ongoing monitoring;
- Use of treatment agreements;
- Query to state prescription drug monitoring programs;
- Decision to initiate and discontinue opioid therapy;
- Concurrent use of benzodiazepines and opioids; and
- Prescribing naloxone and methadone.

QUALITY OF CARE

Quality of Care Superior at Teaching Hospitals

The Association of American Medical Colleges News reported May 23, 2017, on a JAMA study which found that mortality rates are significantly lower at teaching hospitals than at non-teaching hospitals. Author Jared Dashoff reported that:

The researchers stated that further investigation is necessary to determine the cause of the differences. However, they speculated that teaching hospitals may be earlier adopters of technologies and treatments that yield better outcomes.

“Academic medical centers provide a unique environment, with 24-hour availability of specialty services, advanced technologies, and some of the most expert physicians in the country,” said lead study author Laura Burke, MD, instructor of health policy and management at the Harvard Chan School and an emergency physician at Beth Israel Deaconess Medical Center. “This seems to pay off for patients. While obviously not all patients can receive care in major teaching hospitals, understanding which strategies and resources are particularly important to patient outcomes, and how they can be replicated among nonteaching hospitals, is critically important to improve care for all patients.”

For more, see: <https://news.aamc.org/patient-care/article/jama-study-finds-lower-mortality-rates-us-teaching/>.

Primary Care Decisions Often Lack Evidence Base

The June 27, 2017, HealthLeaders Media blog reported that:

Research-based evidence to help primary care physicians make decisions seems to be hard to come by, according to research from the University of Georgia.

Researchers, led by Mark Ebell, epidemiology professor at UGA’s College of Public Health, analyzed 721 topics from an online medical reference for generalists and found that only 18% of the clinical recommendations were based on high-quality, patient-oriented evidence. Their work appears in the journal *BMJ Evidence-Based Medicine*.

“The research done in the primary care setting, which is where most outpatients are seen, is woefully underfunded, and that’s part of the reason why there’s such a large number of recommendations that are not based on the highest level of evidence,” Ebell said in a statement.

For more, see <http://www.healthleadersmedia.com/quality/mediocre-evidence-behind-many-primary-care-decisions>.

IN DEPTH

The Right to Safe Care Coalition

CAC is a founding member of the Right to SAFE Care Coalition (RTSCC). RTSCC was formed to educate the public about the importance of lifelong learning programs for healthcare professionals administered by voluntary credentialing organizations, licensing boards, hospitals and other healthcare delivery institutions for the purpose of protecting the public, promoting patient safety and helping to ensure high quality healthcare services.

The organizations and individuals belonging to RTSCC are concerned about legislation aimed at weakening current systems for “Maintenance of Certification” (MOC) that has been considered by more than one-third of the states since January 2017. MOC systems are an important public protection because by satisfying MOC requirements, doctors and other health care professionals demonstrate to an external body that their knowledge and clinical skills are up-to-date. So far, most of the bills prohibiting hospitals, insurers, and / or licensing boards from differentiating among healthcare practitioners based on their MOC status have been directed at physicians and the MOC requirements of the American Board of Medical Specialties. A few states have also targeted physician assistant MOC, and coalition members believe it is only a matter of time until other health professions will be targeted as well. That is why organizations representing nurses, pharmacists, dietitians, occupational therapists and others have joined the coalition. Most of the legislation that alarms coalition members did not pass during the 2017, legislative session, but bills are certain to be reintroduced in 2018, which is why growing the coalition and enhancing public awareness of this threat to patient safety have urgency now.

RTSCC created a website that is being populated with an ever-growing library of educational resources. One page on the website debunks six commonly asserted myths about continuing competence: <http://righttosafecare.org/continuing-competence-myths/>. Another answers FAQs about the coalition: <http://righttosafecare.org/faq/>. The “News” link takes visitors to news and scholarly research related to MOC and assessing current competence: <http://righttosafecare.org/news/>.

Additional resources are available from other sources. The American Board of Medical Specialties (ABMS) whose member specialty certification boards are the primary target of the opponents of MOC wrote about anti-MOC legislation in its Summer 2017, *Insights*:

The ABMS Boards Community strongly believes that the assessment of current knowledge, judgment, and clinical skills makes an important contribution to patient health and safety and is essential to continuing certification. When patients and families don't have information about whether a physician is keeping up, they are at increased risk of selecting a less-than-competent doctor. Legislative mandates that establish a low bar

for specialty medical care also interfere with physician self-regulation. Additionally, they deny private health care organizations the freedom to set their own quality standards for credentialing and privileging physicians. Lastly, these bills are a disservice to the many physicians who place a high premium on providing quality care and are committed to practice improvement as demonstrated by their participation in MOC.

Board Certification is a peer-reviewed, physician-led process with more than 5,000 physician volunteers involved in developing certification and recertification programs. The complexity and rapid pace of change in medicine (with more than 10,000 studies published weekly), coupled with the slow uptake of medical advances (taking an average of 17 years for research evidence to reach clinical practice), and the substantial evidence that not only do knowledge and skills decline over time but that physicians cannot assess their own competence, all make a strong case for a systematic framework to help physicians keep current.

The medical profession bears a responsibility to set standards for specialty practice. Board Certification has been the profession's independent mechanism for doing that. Legislation that invites government interference into a physician-led, self-assessment process would undermine specialty standards and negatively affect patient care.

See the entire article here: http://www.abms.org/media/139499/story-3_state-legislation-puts-patients-at-riskfinal.pdf.

In the same issue of *Insight*, ABMS has this to say about how its member boards have responded to criticism by diplomats that maintenance of certification requirements need to be more relevant to actual practice:

(ABMS) and its 24 member boards, as well as many specialty societies, academic medical centers, and other continuing medical education (CME) stakeholders have taken several steps to help Board Certified physicians find quality accredited CME activities linked to components of the ABMS Program for Maintenance of Certification and simplify the approval process for CME providers.

In 2015, ABMS developed an online repository of MOC activities – the ABMS MOC Directory. The CME activities indexed in the MOC Directory have been approved by Member Boards to meet the *Lifelong Learning and Self-Assessment* requirements of the MOC program.

More than 16,500 physicians and other health care professionals have completed activities indexed in the MOC Directory. In a recent survey:

- 96 percent indicated they would recommend the MOC activity to one or more of their peers;
- 96 percent agreed that their engagement with the MOC activity would improve their care processes or clinical outcomes;
- 92 percent of all learners who completed an activity would recommend it to one of their colleagues; and
- 93 percent rated the MOC activity as “good to excellent” regarding its relevance to practice...

ABIM (American Board of Internal Medicine) and ACCME (Accreditation Council for Continuing Medical Education) recently expanded the types of activities that earn both CME credit and MOC points... This includes, but is not limited to, formal performance improvement (CME (PI-CME) activities...

See more here: http://www.abms.org/media/139496/story-4_increasing-access-to-moc-activitiesfinal.pdf.

David H. Johnson, MD wrote an opinion piece that appeared in the online The JAMA Network about anti-MOC legislation passed in Texas during 2017. It reads, in part:

During the 2017, legislative session Texas lawmakers voted to approve Senate bill (SB) 1148 entitled “Relating to Maintenance of Certification by a Physician or an Applicant for a License to Practice Medicine in This State.” SB 1148 was intended to restrict the use of maintenance of certification (MOC) as a credential for hospital privileging, to wit: “a hospital, institution, or program that is licensed by this state, is operated by this state or a political subdivision of this state, or directly or indirectly receives state financial assistance may not differentiate between physicians based solely on a physician's maintenance of certification.” The original bill was also written to prevent managed care plans from “differentiating between physicians based solely on a physician's maintenance of certification in regard to: (1) paying the physician; (2) reimbursing the physician; or (3) directly or indirectly contracting with the physician to provide services to enrollees.” SB 1148 was introduced by 2 physician-legislators, received support of the Texas Medical Association (ostensibly reflecting the temperament of its members), was vigorously debated and opposed by some academic and community physicians, and was signed into law by the governor on June 15, 2017.

A major impetus for the introduction of SB 1148 came from physician dissatisfaction with the MOC programs developed by the member boards of the American Board of Medical Specialties (ABMS). MOC critics argue the programs are excessively costly, are time consuming, are irrelevant to practicing physicians, and, most importantly, fail to improve patient care. Although criticism of recertification programs and MOC is not unprecedented, seeking legislative reprieve from state governments represents a significant departure from prior efforts to limit implementation of these programs, a course of action that may have unintended consequences.

...Specialty boards were created to develop the standards that define individual specialties. The standards are established by physicians for physicians. Initially many (but not all) boards granted lifetime certification based primarily on a single examination. However, over time it became increasingly clear that lifetime certification could not guarantee competence for the entirety of a physician's career. For this reason, ABMS and its member boards embraced the concept of recertification to improve the quality of patient care, set standards for clinical competence, and foster the continuing scholarship required for professional excellence over a lifetime of practice. Details of MOC programs were left to the discretion of member boards. In the past few years these programs have been subjected to intense scrutiny and criticism. In response, individual specialty boards have begun to transition from a strictly authoritative model to a more-collaborative model working in partnership with physicians and professional societies to ensure MOC programs remain meaningful and relevant.

Although critics often assert that there is no evidence that certification or MOC makes any difference in clinical care, some peer-reviewed literature refutes that claim. Board certification and recertification are associated with improved patient care, greater adherence to practice guidelines, fewer state board disciplinary actions, and, importantly in this era of rising health care costs, less-costly care. Moreover, patients seem to prefer board-certified physicians. They also expect their physicians to undergo periodic recertification...

Although the passage of SB 1148 may be viewed as a victory by those who stand opposed to the concept of MOC, it is a pyrrhic one. Beyond establishing criteria used for board certification, self-regulation also entails setting standards for admission to medical school, determining the content of medical school curriculum, establishing criteria for awarding medical degrees, determining standards for medical licensure, generating voluntary guidelines for acceptable clinical practice, and determining the criteria by which hospital privileges are granted to individual physicians. Although directed at MOC specifically, SB 1148 has potential consequences for all of these privileges and weakens the claim to self-regulation by establishing a precedent for additional governmental intervention into the practice of medicine that proponents of SB 1148 may find less agreeable.

Nearly 40 years ago, Relman (*Arnold Relman, former editor, New England Journal of Medicine*) commented on the controversy then surrounding recertification: “The development of an acceptable method of recertification ought to be an achievable goal for any specialty board that commits itself to the task; it is simply a question of will. The boards need to be pragmatic and flexible in their approach to this problem, but for a profession that takes such pride in its self-imposed discipline, total abandonment of the recertification idea would be a mistake. A retreat on this issue would not be well received by a public that has already begun to wonder whether medicine is more interested in defending its privileges than in maintaining its standards.” Relman was right on both accounts. Specialty boards must continue to work with their diplomates to ensure recertification programs maintain their relevance and rigor while minimizing redundancy. At the same time, efforts to limit or eradicate recertification programs through legislative action or other means may be seen by the public as nothing more than veiled attempts to lower professional standards.

See the entire article here: <http://jamanetwork.com/journals/jama/fullarticle/2648007>.

RTSCC is a loose coalition and is not a legal entity. There are no officers, bylaws, or dues, although some coalition members have donated funds to support the work of the coalition. The coalition is managed by a steering committee elected by all participating organizations and individuals. The current steering committee chair is Karen Plaus, CEO of the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA). RTSCC has signed an MOU with the Institute for Credentialing Excellence (ICE) to be the coalition’s Convener, which includes managing our funds.

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 2018 please complete this form and email, mail or fax it to:

CAC

1601 18th Street NW • Suite 4
 Washington, D.C. 20009
 Voice (202) 462-1174 • FAX: (202) 354-5372

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

Payment Options

- 1) Mail us a check payable to Citizen Advocacy Center for the appropriate amount;
- 2) Provide us with your email address so that we can send you an invoice, or;
- 3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature

Date

Our Federal Identification Number is 52-1856543.



WE WANT YOU EITHER WAY!

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

NEWSLETTER SUBSCRIPTION FORM

Download CAC News & Views for 2018 and all online back issues for \$240.00.

Name of Agency:	
Name of Contact Person:	
Title:	
Mailing Address:	
City, State, Zip:	
Direct Telephone Number:	
Email Address:	

Payment Options:

- 1) Mail us a check payable to **CAC** for the \$240.00;
- 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;

OR

- 3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature

Date

Our Federal Identification Number is 52-1856543.