



News & Views

Citizen Advocacy Center

Second Quarter 2018 – Health Care Public Policy Forum – Volume 30 Number 2

Announcement

Our 2018 annual meeting will be held on October 16, 2018, and October 17, 2018, at Washington Plaza Hotel in Washington, DC. The theme is “Teams: Training, Practice, Evaluation, and Enforcement.” More details will be available soon, and we will add that information to our website and send announcements to everybody on our contact list.

Please note our new office address:

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DISCIPLINE

Media Exposes Sexual Misconduct Cases

In the January 28, 2018, edition of the *Post and Courier*, Mary Katherine Wildeman reported about “How South Carolina doctors’ sexual misconduct flies under the radar, and why patients may never know.” She writes that the newspaper identified at least 26 doctors brought before the medical board for sexual misconduct within the past 5 years. Only four were disciplined; fifteen remain in practice. Wildeman reports that information about these cases is not made public unless and until the board decides to impose discipline.

A post on January 28, 2018, on the website *cleveland.com* reported that credential checks by Ohio hospitals might miss a history of

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sexual misconduct. This information does not appear in the search engines hospitals consult unless there has been a formal action by a former hospital employer or a medical board.

Meanwhile, at least two women have sued medical centers in Utah for failing to report sexual misconduct allegations against a male nurse accused of multiple sexual assaults.

See more at <http://tinyurl.com/ycj8sszz>, <http://tinyurl.com/ya2jhtuo>, <http://tinyurl.com/yc5fwv3y>, <http://tinyurl.com/y8fhmb7j>, and <http://tinyurl.com/ybzgtngz>.

Medical Board Not Taking Advantage of Practitioner Data Bank

An investigation by MedPage Today and the Milwaukee Journal Sentinel discovered that medical licensing boards are not checking the National Practitioner Data Bank before making licensing decisions. They found that 13 boards didn't check the NPDB even once in 2017. Several of the boards said that reporters are often their source of information about doctors with records in the bank.

See more at <http://tinyurl.com/y8pwj2tg> and <http://tinyurl.com/y8djsfoo>.

OPEN NOTES CMS to Encourage Patient Access to Medical Records

On March 9, 2018, *JD Supra* reported that the Centers for Medicare and Medicaid Services announced some changes in its policies toward health information management. One change will affect electronic health records requirements. Other changes are intended to improve patient access to their medical records. According to *JD Supra*:

The first initiative, MyHealthEData, focuses on breaking down barriers that prevent patients from having electronic access to their health records on an application or device of their

choice. The initiative will seek to ensure that patients have access to their entire health record, so patients can actively seek out health care service providers that meet their health needs.

The second initiative, Medicare Blue Button 2.0 is a new tool that will allow patients to access and share their health care information in a secure and universal digital format. The tool will enable Medicare patients to connect their claims data to secure applications and providers they trust and will allow patients to access and share their information with new health care providers. CMS hopes that the new tool will lead to less duplication in testing and will promote increased competition among technology innovators who serve the Medicare population.

See more at <http://tinyurl.com/y8nmtc5w>.

OpenNotes Helpful to Caregivers

In March 2018, the Agency for Healthcare Research and Quality released a study entitled, *Empowering Informal Caregivers with Health Information: OpenNotes as a Safety Strategy*, by Chimowitz H., Gerard M., Fossa M., Bourgeois F, Bell SK. The abstract reads:

Patients frequently depend on informal caregivers (e.g., family, friends, or paid workers) to assist with various aspects of medical care, such as medication administration and travel to medical appointments. OpenNotes seeks to share clinicians’ notes with patients through patient portals. Although patients frequently grant portal access to caregivers, the impact of this improved access to health information on the safety of care

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provided by caregivers remains unknown. Researchers sent a survey to 24,722 patients participating in OpenNotes who had at least one available visit note during the study period. The surveys were sent through the patient portal. Out of the 7058 surveys returned, 150 respondents self-identified as caregivers. Analysis of survey data revealed that access to patient notes enhanced caregiver understanding of recommended medical care including tests and referrals, reminded them about necessary testing, helped them understand results, reminded them about appointments, and improved caregiver ability to assist patients with medications. An Annual Perspective discussed the potential of health information technology to improve patient and caregiver engagement in safety.

See more at

<https://psnet.ahrq.gov/resources/resource/31800/35500/2>,
<https://psnet.ahrq.gov/resources/resource/30094>, and
<https://psnet.ahrq.gov/perspectives/perspective/243>.

Poor Health Literacy Undermines Coronary Patient Recovery

Researchers from the Mayo Clinic have found that the weaker a patient's health literacy, the greater the risk that patients with heart failure will be hospitalized and die. The article by Natalie Grover entitled, "Poor Health Literacy Can Be Dangerous for Heart Failure Patients" quotes Dr. Gregg Fonarow, co-chief of University of California, Los Angeles' division of cardiology, who said "This study points to an important need to address low health literacy in heart failure and find effective strategies that can help overcome the risk."

Grover references the National Academy of Medicine's definition of health literacy: the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Slightly more than 10% of the patients studied had poor health literacy, which coincided with nearly twice as great a chance of death and a 30% increased likelihood of hospitalization.

Editorial Note: Clinicians sharing their notes with patients could help elevate health literacy. At a minimum, it would address the lack of "capacity to obtain" health information. Followed up by in-person conversations with clinicians, the availability of OpenNotes could also improve rates of understanding and applying health information.

See more at <http://tinyurl.com/yac6uz92>.

Researchers Study Patient Response to Ambivalent Diagnoses

In January 2018, the Agency for Healthcare Research and Quality (AHRQ) published a study entitled, “Patient perspectives on how physicians communicate diagnostic uncertainty: an experimental vignette study.” The study’s abstract reads:

Reducing diagnostic error is an area of increasing focus within patient safety. However, little is known about how patients perceive physician communication regarding diagnostic uncertainty. In this study, participants (parents of pediatric patients) were assigned to read one of three clinical vignettes each describing a different approach to a physician communicating diagnostic uncertainty; they were then asked to answer a questionnaire. Researchers found that explicit expression of diagnostic uncertainty by a physician was associated with negative perceptions of physician competence as well as diminished trust and satisfaction with care, whereas more implicit language was not. A past Annual Perspective highlighted some of the challenges associated with diagnostic error.

See more at <http://tinyurl.com/yc636ob5>.

Health IT Underutilized in Ambulatory Care

Research sponsored by the Agency for Healthcare Research and Quality found that ambulatory care practices underuse electronic medical records:

Study: Ambulatory Care Practices Underuse Health Information Technology

Ambulatory care practices are not utilizing many functions available with health information technology (IT), according to new AHRQ-funded research. The study, published in The American Journal of Managed Care and based on 2014 Health Information and Management Systems Society (HIMSS) Analytics survey data, was developed to measure the levels of implementation and use of health IT among ambulatory care practices. Researchers found that as of 2014, 73 percent of practices were not using electronic health record (EHR) technologies to their full capability. Nearly 40 percent of the surveyed practices made minimal or no use of health IT. Researchers said that underuse of health IT in ambulatory care could affect a health system’s ability to provide coordinated and efficient care. The authors concluded that efforts to increase the use of health IT functionalities should focus on practices that are small, located in nonmetropolitan areas and provide specialty care.

Editorial Note: Adopting IT would not only affect a health systems’ ability to provide coordinated and efficient care, incorporating an OpenNotes protocol into the IT mix would promote trust, improve conformance with treatment regimens, and bring other benefits associated with the use of OpenNotes.

See the abstract at <https://www.ncbi.nlm.nih.gov/pubmed/29350506>.

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Incomplete Medical Records Problem for Patients

According to a report posted February 7, 2018, by WSOCTV, missing or incomplete medical records are a problem familiar to the North Carolina Medical Board. Medical records figure in cases before the board 25% of the time. The board updated its medical records requirements last year.

Editorial Note: The report gives patients this advice: 1) Ask for a summary after every visit; 2) use online patient portals to review records and access tests; 3) request an amendment with your version of care if you disagree with the records. A fourth recommendation is to ask your doctor or health plan to embrace the OpenNotes philosophy and give patients access to their clinicians' notes.

See more at <http://tinyurl.com/y7oajqqj>, <http://tinyurl.com/ya4rowdl>, and <http://tinyurl.com/yc2t63kr>.

SCOPE OF PRACTICE

New Tools to Help Legislators Evaluate Scope Proposals

The State of Minnesota posted links to two tools created by the National Conference of Governors and the National Council of State Legislatures to help make scope of practice decisions. One tool is a “framework to assist policymakers in the objective analysis of legislative proposals relating to scope of practice changes for regulated health professions/occupations.” The second is “a tool to assess barriers to the enacted scope of practice laws and identify strategies and action steps to mitigate the barriers.”

See more at <http://tinyurl.com/y9n8xcfw>.

Nursing Organization Issues Statement on Full Scope of Practice

On January 19, 2018, the American Academy of Nursing issued a press release entitled “Allowing APRNs to Practice to Full Extent of Education and Training is Essential to Improving Primary Care in the United States.” The press release announcing the position statement reads in part:

The American Academy of Nursing today announced its position statement that full practice authority for advanced practice registered nurses (APRNs) is necessary to transform primary care, and that practice restrictions on APRNs should be removed so that they may practice to the full extent of their education and training.

Lack of full practice authority for APRNs is a barrier to the provision of efficient, cost-effective, high- quality, and comprehensive health care services for some of the nation’s most vulnerable populations. APRNs are a ready workforce, ideally positioned to improve access to care. However, barriers at the state and national levels continue to prevent APRNs from practicing to the full extent of their capabilities.

See more at <http://tinyurl.com/yaaj7nwu>. See also the American Medical Association resolution opposing the National Council of State Boards of Nursing’s APRN Compact, which allows APRNs to practice in any Compact state without applying for an additional license, at <https://www.ama-assn.org/sites/default/files/media-browser/public/hod/i17-214.pdf>.

Algorithm Distinguishes Between Physician and Nursing Care

Researchers at the University of Chicago have developed an algorithm that shows how nursing care is parallel and independent from physician care. The summary of the study published in the March 8, 2018, *Science Daily* reads:

A multidisciplinary team of researchers has published the first quantitative study on the divergent scopes of practice for nurses and doctors. The study uniquely leveraged computer science technology to compare individual-level patient care provided by nurses and doctors using information routinely documented in the electronic health record.

Co-author Karen Dunn Lopez told *Science Daily* that, “Without documentation from nurses, health records only show part of the whole. I hope this study is viewed as a first step in identifying how the combination of nursing care and medical care work together to improve patient outcomes.”

See more at <http://tinyurl.com/yqs4uwwd>.

DEA Expands Authority to Treat Opioid Addiction

On January 23, 2018, the Drug Enforcement agency announced a new policy permitting Nurse Practitioners and Physician Assistants to treat opioid addiction. The agency’s press release reads, in part:

As published today in the Federal Register, nurse practitioners and physician assistants can now become DATA-Waived qualifying practitioners, which gives them authority to prescribe and dispense the opioid maintenance drug buprenorphine from their offices. Prior to the enactment of the Drug Abuse Treatment Act of 2000, only physicians could treat opioid addicts and had to register with DEA as both physicians and operators of Narcotic Treatment Programs. Waiving this second registration prompted more physicians to offer treatment services.

See more at <http://tinyurl.com/yb9ghuxg> and <http://tinyurl.com/ycqvwycl>.

Physical Therapists Try Again for Dry Needling Authority

Legislation introduced into the New Jersey Senate (SB 431) would permit physical therapists (PTs) in the state to provide patients the service known as “dry needling.” In 2017 then Governor Chris Christy signed a measure that expanded PT scope of practice, but omitted mention of dry needling.

Acupuncturists contend that PTs lack the necessary training to perform invasive treatments such as dry needling. PTs point out that only PTs who can document specific training would be permitted under the proposed legislation to provide the service. They argue further that permitting PTs to administer dry needles would broaden public access to a non-drug pain control methodology and help alleviate the opioid abuse crisis.

See more at <http://tinyurl.com/yafylk6q>.

Heartland Institute Favors Expanded Scope for Mid-Level Dental Workers

Writing in a February 20 online post by the Heartland Institute, Charles Katebi, State Government Relations Manager, describes legislation that would expand the scope of practice of dental therapists in the state. The need for an expanded scope, he writes...

...is stronger now than it has ever been. In the coming years, a growing number of Kansans will be reaching retirement age and demanding an increasing amount of dental treatments. At the same time, a growing number of dentists will also be reaching retirement age and hanging up their lab coats.

Read the article at <http://tinyurl.com/yd6haz6t>.

Midwives Improve Maternal Care

Research highlighted by *ProPublica* in February 2018 provides evidence that maternal and neonatal health is improved when midwives are involved in obstetrical care. According to its abstract, a new study found:

Poor coordination of care across providers and birth settings has been associated with adverse maternal-newborn outcomes. Research suggests that integration of midwives into regional health systems is a key determinant of optimal maternal-newborn outcomes, yet, to date, the characteristics of an integrated system have not been described, nor linked to health disparities.

See more at <http://tinyurl.com/ycg9554g> and <http://tinyurl.com/ya6ohrmp>.

Naturopaths Seek Licensure in Illinois

On March 6, 2018, WTTW ran a story on *Chicago Tonight* about the quest for licensure by naturopathic physicians in the state. Licensure legislation ([HB2530](#) and [SB0708](#)) was introduced in 2017. Naturopaths contend that licensure would enable patients to be sure their providers are qualified. The medical association argues that naturopaths do not receive the same training as allopathic physicians.

Read about it at <http://tinyurl.com/ybb9ulmr>.

Nova Scotia Releases New Nurse Standards of Practice

The National Council of State Boards of Nursing *Good Morning Members* reported March 9, 2018, that the College of Registered Nurses of Nova Scotia:

...recently introduced the Nurse Practitioner Standards of Practice 2018 which includes a new set of standards intended to guide the practice of NPs in Nova Scotia and aid in the delivery of safe care to patients. The new standards are a shorter and more concise outline of the updated legal and professional expectations required of NPs. The new standards also include an additional emphasis on the autonomous role of the NP provider.

The changes in the new standards were based on stakeholder feedback, a relational approach to regulation and the public's confidence in the knowledge, skills and abilities of NPs in Nova Scotia. Sue Smith, CRNNS chief executive officer and registrar, states, "The introduction of new standards into the nursing profession is a milestone moment because it marks a time in history when the status quo is adapted to reflect and include new evidence, new changes in practice and new expectations from the public."

See more at <http://tinyurl.com/ydf8k3lj>.

PAIN MANAGEMENT AND END OF LIFE CARE

Some Clinicians Worry Opioid Crisis Threatens Proper Pain Care

In the February 21, 2018, *News Beat* Michael Haederle asks, “Will the Pendulum Swing Too Far? Push to Curb Opioid Abuse May Leave Chronic Pain Sufferers with Fewer Options.” He writes that pain care experts at the University of New Mexico worry that a backlash among physicians and nurse practitioners has caused some clinicians to refuse to prescribe opioids at all. He refers to an article in the *New England Journal of Medicine* which points out that:

The fallout from those decisions is a growing pool of patients who are forced to navigate their transition off prescribed opioids, often with little or no assistance or guidance, with the potential for disastrous results.

See more at <http://tinyurl.com/y7au55bv> and <http://tinyurl.com/ycepax8u>.

TELEHEALTH

Missouri House Recommends Amending Telehealth Rules

On April 5, 2018, the Missouri House of Delegates recommended passage of legislation that would modernize telehealth rules in the state. It would allow reimbursement for telehealth services that meet the same standard of care as in-person clinical visits. It would also allow “store and forward” technologies which the Center for Connected Health Policy defines as “the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email transmission.” This would, for example, permit a patient to forward to their clinician a photograph showing a wound or rash or other condition for diagnosis via telehealth. The bill would also eliminate mileage limitations for telehealth reimbursement and requirements for “telepresenters” to interpret for patients.

See more at <http://tinyurl.com/ya5e6knl> and <https://legiscan.com/MO/text/HB1617/2018>.

Federal Funding Bill Expands Medicare Funding for Telehealth

The Center for Connected Health Policy reported on February 13, 2018, that:

The new short-term funding bill introduced by the House on Tuesday and signed by the President on Friday morning incorporates language from the CHRONIC Act which expands the use of telehealth under Medicare Advantage plans, the End Stage Renal Disease (ESRD) Program, applicable Accountable Care Organizations (ACOs), and for individuals with stroke. Specifically, the CHRONIC Act eliminates the geographic requirements for ACOs delivering services via telehealth as well as for the treatment of ESRD and acute stroke. It also removes the facility type requirement for ACOs and stroke treatment and expands eligible sites for ESRD treatment to include the home and renal dialysis facilities. However, restrictions related to the type of provider delivering the service and the allowable services (CPT codes) would still be applicable. The bill also adds the option for Medicare Advantage plans to offer “additional telehealth benefits” for its enrollees.

For more information, see: <http://tinyurl.com/y8lhnjay>, <http://tinyurl.com/yc3kj832>, and <http://tinyurl.com/ybvt dxvg>.

State Telehealth Laws and Regulations Differ Greatly

The February 14, 2018, edition of Patient Safety and Quality Insider contains a helpful guide to navigating the patchwork of state laws related to telehealth. The article but Brian Ward begins this way:

As of 2017, all 50 states have adopted some form of telemedicine coverage.

Telemedicine is the remote diagnosis and treatment of patients using an audiovisual platform—a doctor’s appointment over Skype, remotely monitoring a patient’s vitals, messaging pictures of rashes and illnesses, etc. And while certain issues will still require an in-person examination (e.g., setting a broken arm), the field is opening several new options for treatment.

Because telemedicine is still so new, the laws pertaining to it have yet to keep pace with the technology. The rules surrounding telemedicine vary greatly between states, and wading through the list of best practices and guidelines can be difficult.

So why should hospitals set up a telemedicine program? And what do they need to navigate the disparate laws and regulations around telemedicine?

See the entire article at <http://tinyurl.com/y7sp7rcp>. See also the Center for Connected Health Policy’s update on barriers to telehealth at <http://tinyurl.com/y9dzsah4>, and a comparison of reimbursement policies at <http://tinyurl.com/y8wv8767>.

See another review of telehealth legislation at <http://tinyurl.com/yce25nlm>.

Michigan Lawmakers Debate Entry into Interstate Compact

Mark Sanchez wrote in the March 4, 2018, *MiBiz* blog about the Michigan State Medical Society’s opposition to legislation intended to make it easier for Michigan doctors to obtain licenses in other states in order to practice using telehealth modalities. The sticking point was language defining a physician as someone who “holds specialty certification or a time-limited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association’s Bureau of Osteopathic Specialists.” The objection is over the steps the American Board of Medical Specialties requires to maintain certification.

See more at <http://tinyurl.com/yd8wunpx>.

Veterinarian Association Supports Telehealth

The American Veterinary Medicine Association has issued a statement in support of the use of telehealth modalities. It reads in part:

Telemedicine is a tool that may be utilized to augment the practice of veterinary medicine. The AVMA is committed to ensuring access to the convenience and benefits afforded by telemedicine, while promoting the responsible provision of high quality veterinary medical care. Veterinary care, whether delivered through electronic or other means, should be provided with professionalism.

See the entire statement at <http://tinyurl.com/y8db94ou>.

NORTH CAROLINA DENTAL AND ANTI-TRUST Nursing Journal Tracks Aftermath of Supreme Court North Carolina Dental Decision

The *Journal of Nursing Regulation* January 2018 issue contains an article entitled, “Antitrust and Regulatory Boards: Where Do We Go from Here?” by Nathan Standley, JD. The article catalogues legislation and litigation since the Supreme Court’s decision and has the following recommendation to regulatory boards for avoiding the risk of anti-trust interventions:

Antitrust risk management has become, and should continue to be, a topic regularly discussed at the state level and the state regulatory board level. At the state level, it is important to ensure that sufficient statutory protections are in place to attract and retain the best public servants on state boards. These statutes can include immunity, indemnification, and defense provisions, with provisions that apply to the range of official actions a board and board members take, including those with antitrust implications. As a cautionary note, none of these statutes has yet to be tested in any of the litigation sparked by North Carolina Dental. Beyond immunity, indemnification, and defense provisions, states that develop an active supervision regime should do so with the experience and insights offered by the initial wave of legislation and litigation in response to North Carolina Dental. In addition, legislators analyzing potential active supervision regimes should tailor supervision requirements together with a comprehensive evaluation of whether clear articulation exists without jeopardizing the board’s capacity to protect the public.

See more at <http://tinyurl.com/yce42vme>.

LICENSURE

“Right to Earn a Living” Legislation Explained

While more and more states consider or enact “Right to Earn a Living” legislation, the John Locke Foundation adds to the literature examining the rationale for occupational licensure by publishing a Research Brief in March 2018 entitled, “The Right to Earn a Living Act: Licensing Should Serve a Legitimate Public Purpose.” The Brief points out that:

Occupational licensing is the most extreme form of occupational regulation by the state. It’s the only one that blocks entry into a field of labor unless and until a person satisfies all the state’s requirements, which can be quite costly. It’d be a big deal any time a decision to subject an occupation to licensing were made arbitrarily.

See more at <http://tinyurl.com/y9lv5d4g>.

CONTINUING PROFESSIONAL DEVELOPMENT

Neurosurgeons See Need to Evaluate Older Members of the Profession

A survey of neurosurgeons revealed that most believe there should not be a cutoff date after which neurosurgeons should be required to cease practice, but 50 percent believe that neurosurgeons over the age of 65 should undergo rigorous evaluation. In addition to

maintenance of certification examinations, this group recommended such things as case review and analysis of patient outcomes. Forty-two percent believe there should be a maintenance of certification exam tailored for older surgeons.

See more at <http://tinyurl.com/y7r4cgp8>.

Internists who participate in MOC Less Likely to Be Disciplined

On March 8, 2018, the American Board of Internal Medicine issued a press release entitled, “Doctors who pass a periodic assessment of medical knowledge to maintain ABIM board certification have fewer state medical board disciplinary actions.” This data was reported in the *Journal of General Internal Medicine*. The release concludes:

“These findings have significant implications for a vast number of patients seeking safe, quality care from general internists,” said Dr. Furman S. McDonald, Senior Vice President of Academic and Medical Affairs at ABIM and the lead author of the study. “Though most internists will never face disciplinary actions, the study revealed an important association between medical knowledge as demonstrated on the MOC exam and lower risk of disciplinary actions. This adds to the growing body of evidence demonstrating that MOC is an important factor that can inform the public’s choice of physicians.”

See more at <http://tinyurl.com/yb8fagcr> and <http://tinyurl.com/y7lr86dh>.

CONSUMER INFORMATION

Blog Advises Consumers How to Select a Doctor

A blog sponsored by “the Good Men Project” recently posted a piece entitled, “A New Resident’s Guide to Choosing the Right Doctor.” Fourth out of five bits of advice is the recommendation to consult the government website to “check out the doctor’s license.” The second tip (after “check with the locals”) is to read online reviews. This observation particularly stands out: “Remember that these reviews were left by previous clients. Therefore, you can guarantee that they’re accurate, honest and worth your time.”

Editorial Note: CAC News & Views believes blogs such as this underscore the importance of medical boards engaging in consumer education. While it is advisable to consult with friends and neighbors and to read online reviews of healthcare providers, it may not be a public service to elevate the information from these sources over the information available from a licensing board. It is certainly not true that online reviews are guaranteed to be “accurate and honest.” It is impossible to know who has posted the review and with what motivation.

See more at <https://goodmenproject.com/health/new-residents-guide-choosing-right-doctor-spnsr/>.

Media Exposes State-by-State Differences in Physician Profiles

A study by *MedPage Today* and the *Milwaukee Journal Sentinel* posted on February 28, 2018, is part of a major investigation of doctors disciplined in one state but able to continue practicing in another jurisdiction(s). The article concentrates on doctors with disciplinary records in North Carolina, but no record of discipline in neighboring state, Georgia.

See more at <http://tinyurl.com/y73vt44l>, <http://tinyurl.com/ya6tymr4>, and <http://tinyurl.com/y8u9hajq>. Be sure to visit the links to the related articles.

QUALITY OF CARE

Federal Officials Move to Elevate Provider Conscience over Patient Care

On February 7, 2018, the National Council of State Boards of Nursing's *Good Morning Members* contained two items about federal policy vis a vis the conscience of healthcare practitioners. Here they are in full:

New Conscience and Religious Freedom Office Announced

The U.S. Department of Health and Human Services (HHS) recently announced the creation of the new Conscience and Religious Freedom Division, under the HHS Office for Civil Rights (OCR). According to the OCR website, the new division will enforce "laws and regulations that protect conscience and protect coercion on issues such as abortion and assisted suicide." The new division will be responsible for investigating complaints filed by health care workers claiming that their employers violated their religious rights. The division is intended to protect doctors, nurses and other health care clinicians who refuse to perform medical procedures such as abortion, sex-reassignment surgery, or fertility treatment to lesbian couples based on religious and moral objections.

Proposed Rule Expands Religious Protections for Health Care Providers

HHS' Centers for Medicare and Medicaid Services (CMS) recently proposed a rule that will require Medicare and Medicaid providers to create standards and procedures to protect their employees' religious and moral beliefs. The proposed rule includes new standards that providers will be required to follow, including notifying the public, patients and employees on how federal conscience and associated anti-discrimination statutes apply to them. In addition, the proposed rule outlines new standards that define if a provider is participating in an abortion and would allow providers to decline to give abortion referrals to patients or inform them about available funding for abortion.

If finalized, the rule will require Medicare and Medicaid providers to maintain records, cooperate with HHS investigations, submit written assurances and certifications of compliance to faith and moral-based anti-discrimination laws and regulations. Additionally, CMS issued a notice to Medicaid directors rescinding a 2016 Medicaid guidance that prohibits states from withholding funds from health care providers that perform abortions. Comments will be accepted on the proposed rule through March 26.

Editorial Note: CAC News & Views hopes that Federal policies and rules do as much to protect the rights and clinical needs of patients as it proposes to do for clinicians who believe it is appropriate for their religious beliefs to affect their patients' access to care. See this article about a patient who was denied needed care <http://tinyurl.com/yc7bmmj6>, and see <http://tinyurl.com/ybruqx8t>.

American Academy of Nurses Issues Statement on Nurse Fatigue

On February 14, 2018, the National Council of State Boards of Nursing's *Good Morning Members* reported:

The American Academy of Nursing recently released a position statement that recommends policies and practices that promote adequate, high-quality sleep for nurses to contribute to safe nursing practice and patient care. The American Academy of Nursing recognizes that long and irregular shift hours, such as a 12-hour work day,

disrupt the natural sleep cycle and may “affect nurses’ health, readiness, their ability to function in the delivery of patient care, and may lead to more medical errors.”

The statement, Reducing Fatigue Associated with Sleep Deficiency and Work Hours in Nurses, includes the following recommendations:

- Nurses and employers of health care organizations should educate themselves about the health risks of working long shift hours and the evidence-based strategies to reduce those risks;
- Employers of health care organizations should incorporate evidence-based practices in the design of their employees’ work schedules and establish policies, programs, practices and systems at work that promote sleep health;
- Employers should promote a workplace culture that promotes sleep health;
- Employers should recognize the role of shift work, long shifts and nurse fatigue on turnover, absenteeism, patient safety and related costs; and
- Experts should develop continuing education courses for nurses and nursing managers that relay evidence-based personal practices and workplace interventions to maximize sleep health and alertness in nurses.

See more at <http://tinyurl.com/yc2jp5v5>.

UK Researchers Study Use of Patient Feedback by Hospital Boards

The Agency for Healthcare Quality and improvement reported on its Patient Safety Network that:

Health care leaders increasingly recognize the importance of engaging patients in quality and safety initiatives. Researchers examined how boards of directors at two National Health System hospitals in England gathered and operationalized patient feedback. Patient input informed strategic priorities and inspired initiatives but was underutilized to ensure improvement.

See the research report at <http://qualitysafety.bmj.com/content/27/2/103>.

IMPAIRED PRACTITIONERS

State Supreme Court Denies Physician Safe Harbor Protection

On March 7, 2018, the National Council of State Boards of Nursing’s Good Morning Members reported that a California appellate court ruled that the state medical board could use a physician’s DUI record for discipline. Here is the report:

A California appellate court recently ruled that the Medical Board of California could use arrest report evidence to justify censuring a doctor accused of cocaine possession. The appellate court ruled that, “state law provided a blanket exception to the usual safe harbor for people who completed drug diversion programs when the person in question was a doctor.”

The District Court originally overruled the Medical Board of California’s decision against the doctor, stating that Penal Code 1000.4 “forbids the use of evidence in an arrest report in an employment of licensing action if the person has completed a drug diversion program,” which the doctor had in January 2016. The appellate court disagreed, ruling that while most citizens would have been protected under Penal Code

1000.4, the Business and Professional Code 492 creates an exception for doctors. Business and Professional Code 492 was passed with the “explicit purpose of assuring public safety,” and “was intended to protect the public from doctors who were addicted to controlled substances, a risk increased by doctor’s access to controlled substances and their potential to cause harm to patients.”

PATIENT SAFETY

ECRI Institute Names Top Patient Safety Concerns

Each year, the ECRI Institute develops a list of hospital safety concerns based on a review of event reports and root-cause analyses from its members. The list is intended for hospitals to use to help them identify and mitigate patient safety issues. The top ten concerns in order of importance are:

- Diagnostic errors
- Opioid safety across the continuum of care
- Care coordination within a setting
- Workarounds
- Incorporating health IT into patient safety programs
- Management of behavioral health needs in acute care settings
- All-hazards emergency preparedness
- Device cleaning, disinfection and sterilization
- Patient engagement and health literacy
- Leadership engagement in patient safety

See more at <http://tinyurl.com/yd7zr22u>.

IN DEPTH

Iowan’s Views on Medical Errors – Iowa Patient Safety Study – Heartland Health Research Institute – December 2017

Editorial Note: This Quarter’s In-Depth Feature is based on an excellent, comprehensive survey of Iowan’s attitudes toward medical errors and some aspects of healthcare decision-making. Readers are encouraged to read the entire study at: https://hhri.net/wp-content/uploads/2017/11/2017_IowaPatientSafety-Study-FINAL.pdf. See also this case study about training clinicians to communicate about errors at <http://tinyurl.com/ybnyqrqh>.

This study follows up on a report issued in 2016 entitled, *Silently Harmed: Hospital Medical Errors in the Heartland*, which included information on medical errors in Illinois, Iowa, Minnesota, Missouri, Nebraska, South Dakota, and Wisconsin. This study focusing on Iowa used a survey instrument developed by the Harvard School of Public Health and administered in Massachusetts in 2014. To gather the data, slightly more than 1,000 Iowans were surveyed by phone between May 6 and June 11, 2017.

Explaining the reasons for doing the study, the authors point out that:

If medical errors remain under-reported y providers to the public, other methods must be explored to learn the extent of this problem. One method is to ask the general public about their experiences with the health care they've received in the past... Moving forward from this report, the challenge for all stakeholders will be mustering the courage, ethical commitment, and political will to pursue new standards and approaches to improve patient safety and quality of care. Avoidable suffering can be reduced by improving evidence-based statistics on medical errors that will allow for meaningful measurements to gauge future progress.

The respondents were almost equally male and female and ranged in age from 18 to 65+. They were predominantly Caucasian and half had at least some college. A quarter completed high school and 15% had post-graduate education. More than half earned at least \$50,000, with nearly 20% earning more than \$100,000.

Respondents reported that within the past five years, 18.8% have themselves or someone close to them has experienced a medical error, most frequently in a hospital. Slightly more than half of those reporting an error are female. Almost two-thirds considered the medical consequences of the medical error to be "serious." One-third reported "serious" financial consequences as a result of the error.

One-third of the respondents said they experienced the error personally. Nearly 60% said the error was made in the care of someone close; seven percent had experienced an error themselves and someone close had also experienced an error. Almost 60% reported an error in a hospital; almost 30% reported an error in a physician's office or clinic. Interestingly, only 4% reported an error in a nursing home.

The types of medical errors reported Iowans probably won't surprise readers of CAC News & Views:

- Mistake during test, surgery or treatment (60.2%)
- Misdiagnosis (55.1%)
- Wrong test, surgery, or treatment (43.9%)
- Incorrect medication: wrong dosage (37.3%)
- Wrong or unclear instructions about follow-up care (31.7%)
- Wrong prescription from doctor (19.9%)
- Infection as a result of test, surgery or treatment (19.1%)
- Test results lost or not delivered to patient (17.8%)
- Fall in hospital or nursing home (8.8%)
- Bed sore in hospital or nursing home (6.2%)

As to the seriousness of the medical error, 59.5% of respondents reported that they experienced "serious" health consequences. Almost one-third reported serious financial consequences.

Respondents were asked whether the person who experienced the error was informed that a medical error had occurred. Nearly 60% were not informed; almost 40% learned of the medical error because the healthcare provider informed them. Considerably more men (49.4%) were informed of the error than were women (30.7%).

Researchers asked a series of questions about the affected person’s decision whether to report the medical error to a doctor, a nurse, a hospital or clinic, or to an official agency. About 62 did report the error while nearly 33% did not.

The data showing to whom the error was reported should make regulators think carefully about the need to do more to make the public aware of the existence and authority of licensing boards.

Errors were reported to:

- Medical staff where the error occurred (78.8%)
- Administration where the error occurred (36.1%)
- Patient satisfaction questionnaire (23.7%)
- Health insurance company (23.1%)
- A lawyer (14.0%)
- A government agency (12.2%)
- Healthcare consumer organization (8.0%)

Asked what they hoped to achieve by reporting the error, respondents told the researchers:

- To prevent the same error from happening to someone else (88.9%)
- To get help coping with problems caused by the medical error (50.5%)
- To get anger about the error off the respondent’s chest (40.2%)
- To have the responsible person punished (31.5%)
- To receive compensation for the harm caused by the error (24.6%)

Those who did not report the error decided this way because:

- They didn’t think it would do any good (65.7%)
- They thought they couldn’t report an error affecting someone else (45.4%)
- They didn’t know how to report the error (40.5%)
- There was no way to report anonymously (28.1%)
- They didn’t want to get anyone in trouble (27.0%)
- They didn’t think the error was important (21.2%)
- They didn’t want to offend anyone (19.2%)
- They were afraid the doctor would stop seeing them (10.5%)

An impressive 89.6% thought the error they or someone close to them experienced was preventable. Three percent thought the error was not preventable, and 7.4% didn’t know.

The remaining questions have to do with Iowans’ healthcare decision making whether or not they experienced a medical error. Researchers asked whether respondents had ever searched for information about the safety or quality of care provided by doctors or hospitals. Fewer than a third (27.8%) answered affirmatively. More than 70% had never looked for safety or quality information. Of those individuals, 62.3% assumed such information would be difficult to find and two-thirds think it would be difficult to understand.

Of those who did seek out information, 65.2% were able to find what they were looking for. Ninety-six percent of these people were able to understand the information they found and 83% used the information to make decisions about where to get healthcare.

Using a scale of 1 (no confidence) to 4 (great confidence) respondents rated various sources of information:

- Primary care doctor (3.45)
- Friends and family (3.22)
- Local hospital (3.00)
- State government agency (2.97)
- Independent, non-governmental experts (2.95)
- A federal agency (2.77)
- Health insurance company (2.67)
- Employer (2.63)

Respondents were asked, “If you were to look for information about the safety or quality of medical care provided by doctors or hospitals in Iowa, would it be helpful to have easy-to-understand information on patient safety culture perceptions by physician and hospital staff about their own safety policies?” Nearly 90% responded in the affirmative.

The authors of the report explained the significance of this question:

Nine in 10 Iowans thought it would be helpful to have information on safety culture-perceptions of medical staff members. Having public information about how medical staff perceive their own organization and department on safety protocol would be important to Iowans when assessing whether to use a particular hospital or clinic.

To learn how hospital staffs view the quality of service inherent within each hospital unit, hundreds of U.S. hospitals use the Agency for Healthcare Research and Quality (AHRQ) survey on patient-safety culture. Yet the federal government hasn’t made the public reporting of the survey results mandatory for hospitals or clinics. Currently, this information is seldom provided to patients, as hospital and other providers take the survey under the agreement that the results will remain “top secret,” only to be used for internal purposes by the government and hospital administration.

The next set of questions had to do with opinions about the degree of difference in the likelihood of medical errors at various hospitals in the state and among various physicians in the state. Those who had experienced a medical error or had a close associate who had done so were more likely to think that there is a big difference between hospitals and doctors in the likelihood that patients would experience a medical error.

Asked what variables enter into their choice of a hospital, respondents placed the greatest weight on “reputation” and the least weight on hospital advertising. On a scale of 1 to 4, these were the responses:

- Reputation (3.21)
- Large number of the type of treatments needed (3.18)
- Proximity to home (3.13)
- Previously used by friends and family without issues (3.12)
- Health insurance would pay full or larger cost (3.03)
- Recommended by primary care doctor (2.96)
- Where doctor admits patients (2.97)
- Lower out-of-pocket cost (2.63)
- Rated higher by experts (2.56)

- Fewer reported medical errors (2.52)
- Recommended by health insurance (2.21)
- Associated with a medical school (1.92)
- Advertising about the hospital (1.58)

Moving to attitudes about patient safety and medical errors in Iowa, the researchers asked questions about respondents' understanding of the term "medical errors." Nearly 40% claimed familiarity with the term, with the percentage increasing with the age of the respondent.

Approximately half of respondents thought the likelihood of medical errors is "not too likely" (46.6%). An even higher percentage (48.1%) believe medical errors are "not a problem" in Iowa. These findings dwarf the comparable figures for respondents who believe errors are "very likely" (6.6%) and that the problem of errors is "very serious" (6.8%).

About one-quarter of Iowans believe there are fewer medical errors in the state than there were five years ago. Interestingly, the percentage of respondents who have received medical care during the past five years believe the frequency of errors has increased (21.3%). Those with an experience of a medical error are even more inclined to believe the prevalence of medical errors has increased (39.8%).

Asked about the likely causes of medical errors, respondents attribute responsibility to individual doctors/nurses (48.3%) more than hospitals/clinics (32.9%). About 18% expressed no opinion.

Asked what percentage of medical errors are preventable, 16.3% of respondents believe all medical errors are preventable; 38% of respondents think three quarters are preventable; 10.5% think one quarter are preventable; 1.4% believe none are preventable.

On a scale of 1 to 4, respondents were asked to choose from 19 options that they believe are the most important causes of medical errors. The range is very small – the cause considered most important (overworked medical staff) received a score of 3.65 and the cause considered least important (not seeing own medical record) received a score of 3.03. In descending order of perceived importance, the nineteen possible causes are:

- Overworked medical staff
- Not knowing about care received elsewhere
- Poor staff communication or inadequate teamwork
- Disorganization leading to wrong drug or dose
- Medical staff not listening
- Not discussion treatment options
- Poorly training medical staff
- Not spending enough time with patients
- Complicated medical care
- Not speaking the patient's native language
- Medical staff not washing hands
- Out-of-date medical records
- Overcrowded ER
- Careless medical staff
- Poor follow-up care instructions

- Too many tests or drugs
- Medical staff not checking in after being sent home
- Medical staff who don't care
- Not seeing own medical record

The report concludes with a series of questions about the kind of medical error reporting Iowans would like to see in their state. Respondents were presented with five options for error reporting. They strongly agreed with all reporting scenarios in this order of preference:

- Doctors, hospitals and clinics should be required to tell patients if a medical error is made during their treatment
- Nursing homes should be required to report all medical errors to a state agency
- Hospitals should be required to report all medical errors to a state agency
- Individual doctors should be required to report all medical errors to a state agency
- The general public should be able to find out about medical errors in Iowa

Dialing in further, 63.1% of respondents strongly agree and 29.8% of respondents agree with the following statement, “the general public should be able to find out about the number and types of medical errors made by different hospitals and doctors in Iowa.” Iowans who had experienced a medical error were even more likely (77.2%) to strongly agree with the statement.

Nearly 80% strongly agree that hospitals should be required to report all medical errors to a state agency and nearly 75% believe doctors should have the same requirement. More than 80% believe nursing homes should also be required to report all medical errors to a state agency.

Nearly 90% strongly agree that providers should be required to tell patients of any medical error made in their treatment, but slightly fewer than 60% believe the doctors they currently see would tell them about a medical error. Delving more deeply into this line of questioning, the researchers comment that:

Quite alarmingly, when dissecting this question further between Iowans who had experienced a medical error versus those who had not, Iowans with a medical error history were more likely to believe their personal doctor would NOT reveal the error to them (45%). This contrasts with the responses of Iowans who have not experienced a medical error, 61.2 % of whom believe their personal doctor would tell them if a medical error had occurred. Obviously, experiencing a medical error seriously erodes trust between patients and providers. As mentioned earlier in this report, only 39% of Iowans who experienced a medical error in the past five years were informed of the error.

In their conclusion, the researchers write:

...preventable medical errors occur much too frequently. Because of the millions of medical procedures Iowans and Americans undergo each year, preventable harm due to medical errors is a public health crisis...

To address these issues, Iowa can carefully assess and initiate stringent guidelines for healthcare providers to mandatorily report medical errors to a state-based agency. Such a reporting system can be utilized not as a means to punish facilities for these medical errors, but rather, to hold providers accountable for correcting system weaknesses to ensure the same error does not happen again. Realistically, relying solely on provider-reported errors will likely fall short of reflecting the magnitude of actual medical error

incidents. Therefore, to achieve accurate data for error analysis, Iowa could also employ a two-pronged process of obtaining medical error occurrence information through a patient incident reporting system, supplemented by an on-going random sampling patient survey. Together these approaches can measure whether progress is being made on reducing or eliminating medical errors occurring in Iowa....

Pursuing this two-pronged approach of obtaining patient-reported errors, in addition to statewide mandatory reporting, will yield information on medical errors in Iowa that are based on both factual and scientific processes that include patient experience and perspective. As shown in this survey, it is critical that all medical error information be made available to the public and done so in a way that is specific, easy to locate and easy to understand.

Much too often, arguments are made that we must have perfect measurement tools before we can begin to solve this egregious problem. The aphorism attributed to Voltaire, “perfect is the enemy of good,” suggests that perfection is not necessary, so long as incremental improvements are being made. We need to begin making incremental improvements for the sake of all Iowans.

Finally, with the release of this survey – the first of its kind in Iowa – the next steps taken will define out ethical commitment to this public health crisis. Iowa can lead the nation on patient safety practices and desired health outcomes, but for this to happen, public opinion will play a vital role in shaping how policymakers and other stakeholders respond. This all begins with the general public and policymakers becoming aware of the problem of medical errors in Iowa, and insisting on more transparency from our medical care problems.

LETTERS

Dear CAC,

I’m seeing more and more activity related to occupational licensing. Here’s an article from the Economist:

Occupational licensing blunts competition and boosts inequality: *How high earning professions lock their competitors out of the market.*

<https://www.economist.com/news/united-states/21737053-how-high-earning-professions-lock-their-competitors-out-market-occupational>.

The FTC held a roundtable to discuss “economic liberty” and how “Unnecessary licensing restrictions erect significant barriers and impose costs that cause real harm to American workers, employers, consumers, and our economy as a whole, with no measurable benefits to consumers or society.”

Economic Liberty Task Force hosted a roundtable on November 7, 2017 in Washington, DC, to examine empirical evidence on the effects of occupational licensure.

<https://www.ftc.gov/policy/advocacy/economic-liberty>.

NCSL, CSG, and NGA recently issued a report on licensing with an interesting conclusion related to the economic impact of licensing.

The State of Occupational Licensing – Research, State Policies and Trends

<http://www.ncsl.org/research/labor-and-employment/report-the-state-of-occupational-licensing.aspx>.

Conclusion

The last several decades have seen a dramatic growth in the number of licensed occupations and the share of workers who have a license to perform their work. The growth in licensure could influence worker wages, consumer prices, employment in licensed occupations, disadvantaged, or populations with challenges who want to work in a licensed occupations, and mobility for workers who want to take their skills across state lines. Moreover, research suggests that licensing policies do not always achieve intended quality, public health or safety outcomes. At the center of these crucial conversations are state policymakers, who establish most occupational licensure requirements and for whom the goals of consumer protection and economic opportunity and growth are paramount concerns. Moving forward, states will continue to learn from one another as they adopt and refine regulatory practices that seek to remove barriers to work and improve portability across state lines.

I'm growing concerned that the economic arguments are pushing aside the consumer protection aspects of licensing, especially for health professions.

Chuck Willmarth, CAE
Associate Chief Officer, Health Policy and State Affairs
American Occupational Therapy Association

Dear Pain Care Forum Members:

Please see comments submitted to Senate Finance Committee by US Pain Foundation and AIPM in answer to the Committee's request for policy recommendations from a pain management perspective regarding what the Committee and CMS can do to ameliorate the opioid crisis. Also see statement from HHS Sec. Azar about President's proposed budget and **"Tackling the Opioid Epidemic,"** which calls for \$10B in HHS funding, \$126 M support CDC and \$500M NIH accelerate development of new treatments:

<http://docs.house.gov/meetings/IF/IF14/20180215/106869/HHRG-115-IF14-Wstate-AzarA-20180215.pdf>.

Finally, links to two articles that may be of interest and a press release, **"E&C Readies Two-Track Push to Combat the Opioid Crisis:"**

"Congress Doesn't Know what to do about Opioids:" <https://www.axios.com/washington-slow-response-opioid-crisis-d469d089-8f15-4ced-a85b-a6865eb474a5.html>.

"Do Alternatives to Opioids Really Exist?" <https://morningconsult.com/opinions/do-alternatives-to-opioids-really-exist/>.

Best,

Steve LaPierre
Vice President Government Affairs at Boston Scientific

Dear Friends,

Joining a distinguished group of colleagues for a news conference at the University of Illinois School of Public Health, we announced the new **Chicago Declaration to End Dental Industry Mercury Use** – a statement by 50 organizations calling for action on amalgam.

The signers are among the leading national environment, public health, and children’s rights groups in America, such as Sierra Club, Greenpeace, Health Care Without Harm, Clean Water Action, Learning Disabilities Association of America, International Indian Treaty Council, Organic Consumers Association, Environmental Working Group, Regeneration International, Mercury Policy Project, Organic and Natural Health Association, Los Jardines Institute, and Ecology Center.

Signers of the Chicago Declaration also include important state-based nonprofit groups from half the states, such as Physicians for Social Responsibility-Chicago, Texas Campaign for the Environment, Connecticut Coalition for Environmental Justice, Clean and Healthy New York, the California-based Coalition for Clean Air, Pennsylvania Council of Churches, and the Ohio Environmental Council.

The Chicago Declaration calls for...

- matching the European Union by ending amalgam use in children, pregnant women, and breastfeeding mothers in 2018, based on the precautionary principle;
- phasing out new amalgam placement by the end of 2020 with time-limited specified exceptions; and,
- action by FDA to bring its policies in line with the Minamata Convention on Mercury and to publicly advise a phase down of the use of amalgam with the goal of phasing out entirely.

While FDA action is urged, we shall not wait for FDA to act! As explained by Beth McGaw, President, Learning Disabilities Association of America, “Today, every parent in America needs to insist their dentists only use mercury-free dental fillings for their child.” And why not? To quote Jessica Saepoff, DDS, former Commissioner of the Washington State Dental Quality Assurance Commission, “Mercury-free dentistry is practical, it is a superior technology and it is tooth-friendly – minimally invasive – while amalgam is not.”

After all, as I told the news conference on Monday, “Twenty-first century dentistry is mercury-free dentistry.”

Charlie Brown
Consumers for Dental Choice
18 April 2018

MEMBERSHIP INFORMATION

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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 our 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

Assistance in **identifying qualified individuals** for service as public members.

Fee Schedule:

The annual membership fees are as follows:

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

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To become a CAC Member Organization for 2018 please complete this form and email, mail or fax it to:

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