



News & Views

Citizen Advocacy Center

First Quarter 2019 – Health Care Public Policy Forum – Volume 31 Number 1

CONTINUING COMPETENCE

ABMS Vision Commission Issues Recommendations on Continuing Certification

On February 13, 2019, the American Board of Medical Specialties released the final report of its Vision for the Future Commission:

The Continuing Board Certification: Vision for the Future Commission (Commission) submitted its final report to the American Board of Medical Specialties (ABMS) Board of Directors. The Commission’s final set of recommendations marks the end of the Commission’s work.

Over the past 12 months, it has been our pleasure to work with the talented and dedicated members of the Commission. Their insights and perspectives helped create a report that supports and reinforces the important role that continuing certification plays in today’s health care system and offers recommendations to improve its value to all stakeholders.

On behalf of the Commission, we want to recognize the Vision Initiative Planning Committee for their leadership in establishing and informing the Commission’s framework and gathering invaluable background information. We also want to thank the representatives of

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stakeholders from within the medical profession, including practicing physicians, medical associations, and professional societies, as well as the representatives who use the credential, including hospitals and health systems, members of the credentialing community and the public, for their testimony and shared best practices. And, we especially want to acknowledge those who participated in the stakeholder survey, offered ideas and commentary, and were engaged throughout the Vision Initiative process. Your combined contributions were of great value and had an enormous impact in forming the Commission's final report.

See the report at <https://visioninitiative.org/commission/final-report/>

Department of Justice Weighs in on Maintenance of Certification

Legislation under consideration in Maryland would affect how hospitals factor in specialty certification status when they make privileging decisions (HB857). The legislation was proposed by a physician who serves on the board of directors of an organization that certifies physicians, the National Board of Physicians and Surgeons, which has been critical of the Maintenance of Certification (MOC) requirements of the member boards of the American Board of Medical Specialties (ABMS) which have been in place for the past decade or so, but which are now being significantly modified. (See previous article). This same legislator solicited an advisory opinion from the Antitrust Division of the U.S. Department of Justice (DOJ) about whether ABMS "may harm competition by imposing overly burdensome conditions on physicians who wish to maintain their certification." He also asked the DOJ to comment on policy options available to the legislature to correct for any anti-competitive consequences from ABMS requirements. In essence, the three policy

options under consideration were, 1) do nothing; 2) prohibit hospitals from requiring physicians to maintain board certification; or 3) promote competition between “legitimate” certifying bodies. On the policy options, the DOJ wrote:

The Division encourages the Maryland legislature to consider ways to facilitate competition by legitimate certifying bodies, consistent with patient health and safety. Physicians, hospitals, healthcare consumers, insurers, and others can benefit from competition to provide cost-effective, high-quality certification services. Toward that end, the Division encourages drafters of the Bill to consider ways to allow for entry by additional, legitimate certifying bodies.

At the same time, the Division encourages the Maryland legislature to continue allowing hospitals and insurers independently to decide whether to consider a physician’s MOC status when making business decisions, such as granting hospital privileges. The Division is concerned that the second approach outlined above could unnecessarily interfere with hospitals’ and others’ unilateral business decisions and thereby harm, not improve, the competitive landscape of healthcare in Maryland. If hospitals and insurers are free to decide whether Maintenance of Certification or another recertification program is a useful tool to identify skilled and qualified physicians, then use of such programs can promote competition and provide benefits for patients. To avoid unnecessary, unintended, or overbroad restrictions on competition, the Division recommends that the legislature not restrict such competitive benefits unless a restriction is determined to be necessary and narrowly tailored to redress well- founded consumer harms or risks.

The ABMS issued a statement in reaction to the DOJ advisory opinion. It reads in part:

ABMS is pleased that the DOJ letter encourages the Maryland legislature “to continue allowing hospitals and insurers independently to decide whether to consider a physician’s MOC status when making business decisions, such as granting hospital privileges” and ABMS strongly agrees with the conclusion of the DOJ that enactment of the Maryland bill could “harm, not improve, the competitive landscape of healthcare in Maryland.” ABMS applauds the recognition by the DOJ of the value to consumers and health systems of “certifying that a provider has demonstrated a certain level of training, testing, or experience over and above other providers.”

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Like the DOJ, ABMS supports and encourages a competitive marketplace for specialty certification. At the same time, however, we are concerned about deception of patients if physicians are permitted to market themselves as “Board Certified” based on certification by a Board whose standards do not rigorously assess medical knowledge and maintenance of skills. After all, most consumers do not have the experience to differentiate between a claim of Board Certification based on the exacting standards of ABMS Boards and a claim of Board Certification not based on such standards.

For that reason, we believe that claims of Board certification should be based on transparent standards that will genuinely advance the interests of patients and avoid deception. We are confident that, when compared to any other specialty certification programs, ABMS Boards can clearly demonstrate the superiority of their certification programs in giving useful information to hospitals, payers, and patients. It is for this reason that hospitals, health plans, consumers, and even providers themselves, overwhelmingly select ABMS certification as the gold standard of specialty care.

While we continue to work with physicians and specialty and medical societies to ensure our programs do not become overly burdensome, we are proud that our certificate represents the highest standard of knowledge and assessment currently available. Accordingly, ABMS continues to welcome an accurate comparison of our programs to other certification programs currently in the marketplace, and we continue to support the right of patients and health systems to determine which program best meets their expectations for high quality specialty care.

See more at <http://tinyurl.com/y3ckx6vp>.

Stakeholders Opine about Aging Physicians

An article in the BMJ entitled “Patient safety and the ageing physician: a qualitative study of key stakeholder attitudes and experiences” addresses the safety and political dimensions of late-career physician (LCP) practice. (White AA, Sage WM, Osinska PH, *et al*, Patient safety and the ageing physician: a qualitative study of key stakeholder attitudes and experiences, *BMJ Qual Saf* Published Online First: 20 September 2018. doi:10.1136/bmjqs-2018-008276).

The abstract reports these results and conclusions:

Results Stakeholders describe lax professional self-regulation of LCPs and believe this represents an important unsolved challenge. Patient safety and attention to physician well-being emerged as key organizing principles for policy development. Stakeholders believe that healthcare institutions rather than state or certifying boards should lead implementation of policies related to LCPs, yet expressed concerns about resistance by physicians and the ability of institutions to address politically complex medical staff challenges. Respondents recommended a coaching and professional development framework, with environmental changes, to maximize safety and career longevity of physicians as they age.

Conclusions Key stakeholders express a desire for wider adoption of LCP standards, but foresee significant culture change and practical challenges ahead. Participants recommended that institutions lead this work, with support from regulatory stakeholders that endorse standards and create frameworks for policy adoption.

See more at <http://dx.doi.org/10.1136/bmjqs-2018-008276>

AMA Declines to Adopt Standards for Testing Older Doctors

On November 14, 2018, MedPage Today reported that:

A set of guiding principles from an American Medical Association council on assessing the competency of senior/late career physicians failed to gain adoption at the AMA's interim meeting.

In a floor vote of 281-222 on Tuesday, delegates sent the report back to the Council on Medical Education, which issued the guiding principles. Some hospitals and health systems already require competency testing by older physicians, but there are currently no standards for these tests.

Read more at <http://tinyurl.com/yyo3zeba>.

Ontario Nurses Grapple with Definitions of Competence and Competency

The National Council of State Boards of Nursing's *Good Morning Members* reported on October 19, 2018 about an article in the *Journal of Nursing Regulation*:

According to an article in the *Journal of Nursing Regulation*, the College of Nurses of Ontario identified inconsistencies in the use of the terms competency and competence within the college. To support the organization's assessment frameworks and operational

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activities, consistent definitions of the two terms were needed. The article “describes the process used to develop the definitions for competency and competence used by the College of Nurses of Ontario, as well as implications for regulators.”

The College of Nurses of Ontario developed the following definitions:

- Competency: a component of knowledge, skill and/or judgement demonstrated by an individual for safe, ethical and effective nursing practice.
- Competence: an individual’s capability for consistently integrating the required knowledge, skill and judgement for safe, ethical and effective nursing practice.

The article notes that the “integration of clear definitions of competency and competence support the work of regulatory functions in protecting the public interest.”

Read the article at <http://tinyurl.com/y33llgdk>.

QUALITY OF CARE

Health Affairs Recommends Patient Engagement to Reduce Diagnostic Errors

Researchers from *Health Affairs* magazine examined causes of diagnostic errors and found that failure to pay attention to patients is a significant contributor. Christopher Cheney writes in “Tapping Patient Engagement to Reduce Diagnostic Errors” that:

- In outpatient care, diagnostic errors impact about 12 million adults annually.
- In a new database, patients report a range of substandard clinician behavior tied to diagnostic errors such as manipulation and disrespect.
- Proposals to reduce diagnostic errors through patient engagement include lifelong communication training for clinicians.

The researchers recommend several methods to improve patient engagement.

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

Study Finds Academicians Under-Report Students’ Lapses in Professionalism

A study reported in November 2018 in *Academic Medicine* sought to explain the reasons academicians fail to report lapses in professionalism by medical students. Failure to report these lapses is significant because physicians who had lapses in professionalism while students are more likely to accumulate a disciplinary record during their careers. The study’s authors concluded:

The findings from this study suggest several next steps. First, the failure to report professionalism lapses is both an individual and a systems problem and should be addressed as such. At the individual level, it will be important to ensure that policies and procedures are clearly stated and that there are sufficient faculty development programs to help implement and sustain these efforts. At the systems level, crafting effective reporting programs, developing and pilot testing systems approaches (similar to error reporting), and engaging faculty will be important. Finally, dialogue among faculty, students, and administrators about definitions, expectations, and the evaluation of professionalism, including the criteria for reporting lapses and the consequences that follow, would help clarify the process for all concerned. Placing the challenges of

reporting on more empirical footing represents a first step in designing interventions that clarify and strengthen faculty and institutional commitment to professionalism as a cornerstone of medical education and practice.

See more at <http://tinyurl.com/yyswap4d>.

DISCIPLINE

Year-long Investigation Concludes Medical Licensing System “Broken”

On November 30, 2018, *USA TODAY* published a summary of the results of its yearlong investigation of medical licensing in the US conducted in collaboration with the *Milwaukee Journal Sentinel* and *MedPage Today*. The article identifies seven takeaways from the investigation, most of which are related to the disciplinary function. This article contains links to investigative reports published throughout the year.

Read the article at <http://tinyurl.com/yyf7ff7l>.

TELEHEALTH

Telehealth Enlisted in Opioid Crisis

On October 2, 2018, the Center for Connected Health Policy reported that:

Congress continues with legislation designed to combat the national opioid epidemic with the introduction of H.R. 6781, the Mental Health Telemedicine Expansion Act, sponsored by Rep. Suzan DelBane (D-WA). The bill was introduced mid-September, almost a week prior to the Senate passing of the comprehensive opioid package, H.R. 6. H.R. 6781 would amend the Social Security Act by removing Medicare originating site location requirements for mental health telehealth services. These requirements restrict telehealth originating sites to areas designated as rural health professional shortage areas, counties that are not included in a Metropolitan Statistical Area, and entities that participate in a Federal telemedicine demonstration project.

The bill adds mental health telehealth services as CPT codes 90834 and 90837, which are both for individual psychotherapy services. It also includes the home as an eligible originating site for mental health telehealth services.

Additionally, the new originating sites added by this bill would be ineligible to receive a facility fee. Payment for the services would require a physician or practitioner to provide an in-person assessment of the patient’s needs prior to the delivery of telehealth services and to reassess those needs at a frequency specified by the Secretary.

See the legislation at <http://tinyurl.com/y2ze7879>.

Compilation of State Telehealth Laws Updated

In October 2018, the Center for Connected Health Policy announced the availability of an “Updated & Redesigned Fall 2018 Edition of the 50 State Telehealth Laws and Reimbursement Policies Report.” The announcement highlighted the following significant findings from the update:

Forty-nine states and Washington, DC provide reimbursement for some form of live video in Medicaid fee-for-service. This number has not changed since Spring 2018.

Eleven states provide reimbursement for store-and-forward. Four states that were previously on the list were removed, due to clarification that their store-and-forward reimbursement only includes teleradiology (which CCHP does not count) and/or lack of information indicating a Medicaid reimbursement law providing for store-and-forward reimbursement has been implemented by the state's Medicaid program.

Twenty state Medicaid programs provide reimbursement for remote patient monitoring (RPM). This number has remained unchanged since Spring 2018.

Twenty-three states limit the type of facility that can serve as an originating site. While some states removed their list of eligible facilities, others added specific facility lists, resulting in this number remaining steady since Spring 2018.

Thirty-four state Medicaid programs offer a transmission or facility fee when telehealth is used. This number is up two since CCHP's Spring 2018 update.

Thirty-nine states and DC currently have a law that governs private payer telehealth reimbursement policy. This is an increase of one (Kansas) since Spring 2018, although three state laws don't go into effect until 2019.

Read the report at <http://tinyurl.com/yysmsd8t>. See a Legislative Roundup at <http://tinyurl.com/y2b6oznt>.

Rural Areas Use Telehealth Less Than Urban Areas

A study by the U.S. Department of Agriculture found that urban dwellers use telehealth services more than people in rural areas, regardless of other factors like level of educational attainment, household income, and employment status. Although, according to the Center for Connected Health Policy:

In some instances, these other factors appeared to more strongly predict the use of telehealth than rural-urban residency. As an example, rural residency appeared to only marginally influence the use of online health research which was more strongly determined by level of educational attainment. When factoring by level of education, rural populations appeared to conduct online health research only slightly less than their urban counterparts.

Researchers looked at three types of services:

1. Online health research – Personal research related to health such as the use of websites including WebMD
2. Online health maintenance – Using internet-connected technology to make appointments, examine and maintain medical records and accounts, pay medical bills, and communicate with health providers and staff
3. Online health monitoring – The use of internet-connected devices such as alert devices and monitoring implants.

See more at <http://tinyurl.com/yxk7sto5>.

CMS Issues Mandated Report on Telehealth Use

On November 28, 2018, the Center for Connected Health Policy reported that:

In response to a requirement in the 21st Century Cures Act to issue a report on telehealth use, barriers and opportunities in Medicare, CMS released an informational report on November 15th addressing the four required elements, including the following:

1. Identification of Medicare beneficiaries whose care may be improved most by telehealth services;
2. Activities by the Center for Medicare and Medicaid Innovation that examines the use of telehealth;
3. The types of high-volume services that might be suitable to be furnished using telehealth; and
4. The barriers that are preventing telehealth's expansion.

The document employs data from Medicare Fee for Service (FFS) between 2014 and 2016, reporting that although overall use of telehealth has increased, the rate of adoption is still limited.

See the report at <http://tinyurl.com/yxa6rsjn>.

Telehealth Use Increasing, but Still Rare

Reuters' new service reported on a JAMA study of the frequency of telehealth use, which found:

Overall, annual telemedicine visits increased from 206 visits in 2005, or less than one per 1,000 people in the study, to more than 202,000 visits in 2017, or more than seven per 1,000. Most of this increase happened over the last few years of the study, with an average annual compound growth rate of 52 percent from 2005 to 2014 and an annual average compound growth rate of 261 percent from 2015 to 2017.

See more at <http://tinyurl.com/y5kr86kr>.

See this for data on which specialties use Telehealth most: <http://tinyurl.com/y269wk93>.

See this 2018 trends analysis: <http://tinyurl.com/y6bkf95f>.

See these forecasts for 2019: <http://tinyurl.com/yyqmauk4> and <http://tinyurl.com/y322zm9p>.

See a proposal to expand access to telementalhealth in New York: <http://tinyurl.com/yxowkbgg> and Medicaid expansions in California: <http://tinyurl.com/y2mu25os>.

ETHICS

Medscape Asks Doctors about Their Ethical Dilemmas

December 10, 2018, *Beckers Hospital Review* posted the following:

Medscape surveyed more than 5,200 physicians in more than 29 specialties to discover how they feel about the ethical issues they face in the medical field.

The annual "[Medscape Ethics Report 2018](#)" surveyed physicians on key ethical issues concerning money, romance in the workplace and patients' well-being.

Here are six findings from the report:

1. Almost 3 in 4 of those surveyed (69 percent) said physicians should be required to get an annual flu shot if they are in direct contact with patient.
2. The majority of respondents (86 percent) said they would refer patients to physicians outside of their health system despite increasing pressure to keep referrals in-house.
3. Approximately 63 percent of those surveyed said they would not cherry-pick patients to avoid those with comorbid disease. However, 44 percent of plastic surgeons, 38 percent of orthopedic surgeons, and 31 percent of orthopedists said "yes" to cherry-picking patients.
4. Among those surveyed, 72 percent of female physicians and 59 percent of male physicians said it is not acceptable to engage in a romantic or sexual relationship with a patient.
5. Roughly 39 percent of respondents said physicians should be subjected to random testing for drug and alcohol misuse, while 42 percent of those surveyed said they should not.
6. Medscape asked physicians to describe their toughest ethical dilemmas in open-ended responses. Among the responses were issues with vaccinations and moderating disputes between terminal patients and their families. One physician said their toughest ethical dilemma involved "trying to convince a parent their child needed treatment for meningitis, when the parent wanted to try homeopathic treatments. Hospital lawyer was involved; the parents went home; the child died."

See the report at <http://tinyurl.com/y5rw2wzt>.

CONSUMER INFORMATION

California Medical Board Specialist Praises Public Information

Medical Board of California Public Member and Board Chair wrote the following message in the Fall 2018 board newsletter:

It is an honor to be elected as the president of the Medical Board of California (Board). Concurrently, I recognize what tremendous responsibility this role entails. The Board members and the Board's staff are often called upon to do things that are uncomfortable, and I think that is a good thing. When we are uncomfortable, we must think outside the box and open ourselves to new perspectives, and ultimately, I believe, find our way to new solutions.

As the Board begins this new term, I will take a "Consumers First" approach and will challenge the Board's staff with the question: "If you are living the mission, what would you do better?"

I will challenge them to identify areas in which the Board can improve and, perhaps more important, come up with creative solutions.

We will shift our "Check Up on Your Doctor's License" from a campaign to an initiative. We will strive to include a broader range of partners in our outreach efforts and we will commit to transparency in all our interactions with legislators, licensees and consumers.

Five years ago, our team's targeted outreach efforts began with teleconferencing. We will continue to expand those efforts, utilizing technological enhancements in everything from our web platforms to the license alert app.

We will work with stakeholders to identify areas in which we can improve the Board's vital licensing and enforcement functions, including reducing enforcement timelines.

Earlier this year we celebrated the passing of the Patient Notification Bill and the mandatory consultation of CURES. We have achieved much, and we have more to do. I look forward to working alongside my fellow Board members to implement a physician's health program and explore more ways in which we can combat the opioid epidemic gripping the nation.

You have a very strong team working for you. Our commitment is demonstrated by the fact that 90 percent of our current Board members will remain on the Board for the next two years, and I look forward to working with my fellow Board members and the Board's staff to strengthen and enhance consumer protection in California.

See the newsletter at <http://tinyurl.com/y4yr4h8k>.

Federation of State Medical Boards Publishes 2018 Regulatory Trends Report

The Federation of State Medical Boards (FSMB) has published a report entitled, "U.S. Medical Regulatory Trends and Actions 2018." The first section covers topics such as, board structure, the licensure and regulation processes, unprofessional conduct, due process, discipline information sharing, the consumer role, how to contact a medical board, and how to file a complaint, and the difference between board discipline and malpractice.

The second section contains 2017 aggregate discipline statistics for the entire country rather than state-by-state. The statistics include the number of physicians with a board action, actions by board action categories, number of first-time offenders, and number of reciprocal actions.

See the full report at <http://tinyurl.com/yydyqeag/>

REGULATORY REFORM

White House Advocates Choice and Competition in Healthcare System

In November 2018, the U. S. Departments of Health and Human Services, Treasury, and Labor issued a report to the President entitled "Reforming America's Healthcare System through Choice and Competition." The report offers recommendations in four areas, including healthcare workforce and labor markets:

Reduced competition among clinicians leads to higher prices for health care services, reduces choice, and negatively impacts overall health care quality and the efficient allocation of resources. Government policies have suppressed competition by reducing the available supply of providers and restricting the range of services that they can offer. This report recommends policies that will broaden providers' scope of practice while improving workforce mobility, including telehealth, to encourage innovation and to allow providers more easily to meet patients' needs. The report also recommends that the Federal Government streamline funding for graduate medical education to allocate taxpayer dollars efficiently and to address physician supply shortages.

Among the recommendation made in the report are these:

Broaden Scope of Practice

- States should consider changes to their scope-of-practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set.
- The federal government and states should consider accompanying legislative and administrative proposals to allow non-physician and non-dentist providers to be paid directly for their services where evidence supports that the provider can safely and effectively provide that care.
- States should consider eliminating requirements for rigid collaborative practice and supervision agreements between physicians and dentists and their care extenders (e.g., physician assistants, hygienists) that are not justified by legitimate health and safety concerns.
- States should evaluate emerging healthcare occupations, such as dental therapy, and consider ways in which their licensure and scope of practice can increase access and drive down consumer costs while still ensuring safe, effective care.

Improve Workforce Mobility

- States should consider adopting interstate compacts and model laws that improve license portability, either by granting practitioners licensed in one state a privilege to practice elsewhere, or by expediting the process for obtaining licensure in multiple states.
- The federal government should consider legislative and administrative proposals to encourage the formation of interstate compacts or model laws that would allow practitioners to more easily move across state lines, thereby encouraging greater mobility of healthcare service providers.

Facilitate Telehealth to Improve Patient Access

- States should consider adopting licensure compacts or model laws that improve license portability by allowing healthcare providers to more easily practice in multiple states, thereby creating additional opportunities for telehealth practice. Interstate licensure compacts and model laws should foster the harmonization of state licensure standards and approaches to telehealth.
- States and the federal government should explore legislative and administrative proposals modifying reimbursement policies that prohibit or impede alternatives to in-person services, including covering telehealth services when they are an appropriate form of care delivery. In particular, Congress should consider proposals modifying geographic location and originating site requirements in Medicare fee-for-service that restrict the availability of telehealth services to Medicare beneficiaries in their homes and in most geographic areas.
- States generally should consider allowing individual healthcare providers and payers to mutually determine whether and when it is safe and appropriate to provide telehealth services, including when there has not been a prior in-person visit.

- Congress and other policymakers should increase opportunities for license portability through policies that maintain accountability and disciplinary mechanisms, including permitting licensed professionals to provide telehealth service to out-of-state patients.

Ease Restrictions on Foreign-Trained Doctors

- The Department of Health and Human Services, in coordination with the Accreditation Council for Graduate Medical Education (ACGME), should identify foreign medical residency programs comparable in quality and rigor to American programs. Graduates of such equivalent programs should be granted “residency waivers,” allowing them to forgo completing an American residency and instead apply directly for state licensure.
- States should create an expedited pathway for highly qualified, foreign-trained doctors seeking licensure who have completed a residency program equivalent to an American GME program.

See the entire report at <http://tinyurl.com/yayzvc4f>. See more at <http://tinyurl.com/y2xmdrtk> and at <http://tinyurl.com/y5934413>.

FTC Issues Publication on License Portability

On September 24, 2018, the Federal Trade Commission (FTC) posted the following press release: about a new document from the Economic Liberty Task Force:

The Federal Trade Commission today released a staff report examining ways to reduce the burden on licensed workers moving to new states or wishing to market services across state lines.

The Report, entitled, “Options to Enhance Occupational License Portability” is part of the FTC’s Economic Liberty Task Force initiative. This initiative, begun last year, aims to reduce hurdles to job growth and labor mobility by encouraging states to reduce unnecessary and overbroad occupational licensing regulation. Occupational licensing, when not necessary to further legitimate public health and safety concerns, can impose real and lasting costs on both American workers and American consumers. These burdens often fall disproportionately on lower income Americans trying to break into the workforce and on military families who must move frequently. In recent decades, the number of occupations subject to state licensing requirements has increased dramatically, increasing the burdens on workers.

The Report released today builds on a roundtable held by the Task Force last year that examined ways to mitigate the negative effects of state-based occupational licensing requirements. The Report looks at interstate compacts and model laws that states can use to improve the portability of occupational licenses. It examines procedures that might be adopted to facilitate multistate practice by those who already hold a valid license in one state. It also considers specific initiatives to reduce the burden of state relicensing on military spouses.

Commissioner Maureen K. Ohlhausen has long championed reform in this area. She stated, “Most occupations are licensed state-by-state, meaning that a valid license in one

state often will not easily transfer to a new state. This can create real hardships for those who cannot easily bear the costs of being relicensed, and can also reduce public access to trained professionals in rural areas who might otherwise be served by telehealth services or multistate practitioners. Today’s FTC staff report provides important, useful guidance to help state policymakers find ways of reducing these burdens.”

See the report at <http://tinyurl.com/y68fxv4y>.

U.S. Congress Legislates Licensure Protection for Sports Medicine

The bipartisan Sports Medicine Licensure Clarity Act passed in October 2018 by Congress protects sports medicine providers who travel across state lines with sports teams.

See more at <http://tinyurl.com/y3lxw38u>, <http://tinyurl.com/y3csobd6>, and <http://tinyurl.com/y5otrokw>.

Heartland Institute Joins Chorus against Licensure Overreach

In a December 2018 Research and Commentary entitled, “Occupational Licensing Laws Hurt State Economies,” Matthew Glans concludes:

Burdensome occupational licensing laws often produce negative economic effects such as less competition and higher costs. Even worse, these onerous rules rarely yield better or safer services. In many instances, licensing laws are unnecessary, which is why many states are passing reforms to reduce state licensing boards’ authority.

See the report at <http://tinyurl.com/yy559brn>. See also activity in Ohio, Idaho, and Florida at <http://tinyurl.com/y3xxuhwv> and <http://tinyurl.com/y75pngun>.

Some Professions Question Opposition to Licensure

The anti-regulatory atmosphere in states that are questioning the increase in licensure requirements in recent decades is getting pushback from some professions that want to be licensed. For example, Melissa Jackowski, president of the American Society of Radiologic Technologists (ASRT) told Matt O’Connor of *HealthImaging* that:

We’re now seeing an occupational license reform movement that’s essentially a movement to deregulate licensure in general. That’s the battle we’re fighting. And it’s not just us. Many other groups are involved such as respiratory therapists, dental hygienists, occupational therapists and others. We’re watching several bills that mandate state-by-state investigation of licensure laws to determine which do not need regulation. We’re just not sure how they are going to determine which professions get de-licensed.

See more at <http://tinyurl.com/y2y4yjtp>. See also this debate in Connecticut over licensure for manicurists at <http://tinyurl.com/yxsoaasd>.

IN DEPTH FEATURE

Address by Denise Roosendaal, CAE, Accepting the 2018 Ben Schimberg Public Service Award

Thank you, Becky. I am grateful and humbled to accept the Ben Schimberg award. The list of past recipients contains some of my professional heroes and I hardly feel worthy of such distinguished recognition. I did not know Mr. Schimberg but I have crossed paths with many who did. I've heard numerous accounts of his passion, his intellect, and his approach to life, and these remembrances make this award even more meaningful.

In 2011, just a few months after assuming the Executive Director role at Institute for Credentialing Excellence (ICE), Becky LeBuhn appeared in my office with a copy of Mr. Schimberg's book, Occupational Licensing: A Public Perspective. With her hands on her hips-- in that simultaneously sweet and commanding way that is completely Becky-- she said, "If you know what's good for you, you'll read this." Over the years, I may have overdramatized that memory but I am certain I accurately recall her respect and admiration for this man and his work. I did read that book and I continue to keep it within easy reach in my office.

Shortly thereafter, David Swankin and I began our tradition of having breakfast in DuPont Circle. He taught me so much about public members and licensure ... and fighting for what's right. I knew I was learning from a great mind and from a man with incredible experience. So I listened. Plus we've had a lot of fun.

I've had the privilege of working alongside so many wise and passionate leaders in my career. But what I have learned about the importance of public member service I have learned from these two powerhouse individuals, the "dynamic duo," as I refer to them. And I would like to publicly thank them for their contributions to this cause. They have guided me and believed in me over the past seven years. You are both role models to this community and to me. Thank you for your service.

It's nice to be in a room with individuals who understand what I do and why I do it. For as long as I've been married (eleven years now), I've tried to explain my job to my mother-in-law. I throw around words like "credentialing" and "competencies." I talk about the importance of regulation, enforcement of standards and public protection. I opine about scope of practice and psychometrics. She finally confessed that it would be easier to tell people that I work for the CIA!

I am proud to lead an organization like ICE that recognizes the value of the role of the public member. ICE has a public member on each of our governing bodies – the board of directors, the NCCA Commission and the newly established Accreditation Services Council. ICE also supports public members by offering them complimentary registration to our annual conference when the Executive Director of their organization also attends. We have established the Public Member Working Group, led by Becky LeBuhn, that reaches out to public members and develops valuable services to support their efforts. Becky is also highlighting the role and importance of public members through a series of interviews in the ICE Credentialing Insights online journal. We are collecting data on the current public members in our community and plan to collect information on prospective public members, as well. It is my vision that ICE will

become a conduit for connecting those willing to serve with those organizations that need public members.

I wish I could stand here today and say our work in protecting the public is done. But we are far from done. With legislative threats at the state level, we must stand guard and challenge efforts that could damage consumer protection and patient safety. Our work is not done. As I ponder the North Carolina Dental Board Supreme Court case, I see that our work is not done. When misunderstanding of maintenance of certification is written into licensure law or hospital credentialing practices, it is clear that our work is not done.

I'm not a pessimist ... and I'm not an alarmist ... and I'm not opposed to common sense reform. I'm always seeking ways to move forward and create a better tomorrow. But I am concerned.

I'm also curious. I'd like to know who is now in possession of the crystal ball. Apparently, some in this room have had access to a crystal ball over the years, because they have predicted a future that, in some ways, is now coming true.

Allow me to share two specific examples of what I mean.

In 2012, David brought me a copy of an article from the New York Times about hair-braiding licensure. He said, "This is going to be a problem." The hair-braiding example has been raised in more credentialing meetings I've attended in the past year than any other. It seems to be the fuel for those seeking drastic restrictions on occupational licensure.

The second example is from, Paul Grace, a two-time past president of ICE. In his lecture for the Ben Schimberg award in 2012, he said, "If the public and private entities that make up this industry are to be successful in their public service mission, the number one need is focused, informed, and courageous leadership."

I couldn't agree more. With these two wise predictions in mind, I'd like to engage in a few predictions myself.

*The first has to do with recent legislative activities. Legislative conversations and inquiries about occupational reform will continue and will require more outcome measures. Since that hair-braiding article, we've seen a dozen states consider or enact some kind of occupational licensure reform with varying degrees of success. I'm not necessarily critical of reform. It's always a good idea in the name of public protection and even economic progress to examine the impact of regulation. These conversations **should** attempt to find that balance between the public's and the occupation's best interest; the balance between economic health and public protection; the balance between barriers to entry (perceived or real) and the need for qualified workers. I say **should**, because sometimes finding that balance is nowhere in the conversation. Well, until we remind them, of course!*

The occupational reform legislation we saw this past year had continual problems with ill-defined terminology, which led to confusion for the lawmakers. The Louisiana legislation originally included language that would have prohibited the use of the term "certified" unless the individual was also licensed. This would have wiped out the ability of individuals with voluntary certifications from being recognized in that state. After the bill was appropriately amended, one of the sponsoring legislators confessed to not understanding the impact of the language.

ICE is now part of a coalition, the Professional Certification Coalition (PCC), which is a joint partnership between ICE and the American Society of Association Executives. This coalition is comprised of 100 professional societies and credentialing organizations with a mutual goal of monitoring and amending, when necessary, various state legislative attempts to reform occupational licensing. We are not debating the reform initiatives on the merit of the intent. Rather, we are monitoring the proposed legislation to determine whether they contain damaging misunderstandings or misinterpretations of how certification works, or onerous evidentiary requirements for sunrise or sunset review of licensure, or if those reviews appropriately balance economic concerns with public safety or consumer protection.

ICE is part of another coalition: The Right to Safe Care Coalition (RTSCC). This group of associations and credentialing bodies is addressing the proliferation of limitations or outright prohibitions on mandatory demonstration of continued competence. This coalition is focusing on educating the public about the importance of continuing competence requirements.

These initiatives have resulted in conversations about the role and importance of credentialing, public safety and consumer protection, and the recognition of competence. However, while there is good research available, the highest goal of preventing harm to the public can be difficult to quantify. How do you prove that injury did not happen as a result of an individual being regulated or certified?

ICE now has a research agenda for the next several years, and we will be reaching out to universities, third-party research entities and other professional organizations to assist. Many fine organizations have engaged in dynamic research endeavors, too. But we must become more focused in sharing this information more widely with external audiences.

Now, let's move on to governance. *My prediction is that governance models will need to continue to evolve in the future.* I teach a governance workshop for our non-profit staff and I have to admit that governance is not a sexy topic. It's a bit difficult to get entry-level associates excited about the topic even when I tell them that governance is where the magic happens. But I do see a glimmer in their eyes when I tell them how amazing it is when a group of volunteers from all walks of life come together with a serious focus on protecting the public or shaping a profession or creating change or enabling a vision of the future.

In the shadow of the North Carolina Dental Board decision, we are starting to see some legislative attempts to address concerns about governance. Some are tackling it from the anti-trust aspect; others are addressing representation-related issues.

At a recent CLEAR conference, the Council on Licensure, Enforcement and Regulation, I learned of three independent Canadian studies about the state of licensure (McMaster Health Forum report; CNO Vision 20/20; PSA Review). Several common themes are clear. More public representation on professional licensing bodies is needed; some studies recommend as much as 50% public representation. There is a call for more training for public members. Also advisable are fewer popularly elected or politically connected board members and more member selections based on merit and experience.

While figuring out new governance models can feel a bit mundane, when it's structured well and focuses on what's important, governance need not be an obstacle but source of empowerment and innovation.

Finally, let's look at changing demographics. *My prediction is that understanding the needs of consumers, patients and the future workforce will become even more relevant and challenging.*

The Millennials are not coming – they're here. This next gen professional is speaking loudly as a consumer and as a member of the workforce. You've heard this before, I'm certain. With an expectation to change careers – not just jobs, but careers – six times in their lifetime, the next gen professional is thinking carefully about ROI. If they graduated college with enormous debt, they are rightfully wondering whether the time and expense needed to be invested in a credential will pay off in the estimated 7.5 years they'll be engaged in that profession before moving on to the next.

In the workplace, the question has focused on whether or not this generation is adequately prepared for work. This next generation has already changed how universities and professional associations approach education and continued professional development. These future professionals are not expecting recognition or advancement without the learning as some have cynically suggested. But they are demanding to understand how their learning connects with how they will advance in their field. This generation has always had wide and deep access to technology and they will not settle for cookie-cutter approaches to the delivery of education. The eligibility requirements for certification bodies will also need to reflect those various demands and new perspectives.

The good news? As consumers and citizens, this generation is demanding transparency from government, their employers, and those in positions of authority. I think they would make great public members. I just learned last week of a certification body that intentionally sought out a millennial as their public member for all the reasons I just stated.

Perhaps the most disconcerting of the millennial trends is the threat on established knowledge as expressed in the book "Death of Expertise" by Tom Nichols. This book outlines how society now values the opinion of reviewers over traditionally demonstrated expertise. This is the Yelp generation. In addition, with the amount of information at our fingertips and the trend to self-inform or self-diagnose, the means to evaluating the value of a product or program or a professional is now turned upside down.

Despite all of these changes and challenges, I am encouraged by what is ahead of us. I am encouraged by the conversations we're having with various stakeholders. I am encouraged by the continued dedication of the professionals and volunteers in the credentialing community. I am encouraged by you and your dedication to this field.

In the introduction of Mr. Schimberg's book, he states, "The air is filled with charges and countercharge about who benefits the most from licensing..." (Benjamin Schimberg. Occupational Licensing: A Public Perspective (Princeton: Educational Testing Service, 1982).

That was 1982. I believe it is equally true today. Finding the right balance for the highest public benefit is critical.

The next time I talk with my mother-in-law about my field of work I'm simply going to tell her that I help protect the public by making sure that professionals have demonstrated they know what they're doing.

You all know the important role of public members for public protection. But you are the choir. So, I say to you today, Choir, sing. Sing loudly and sing powerfully and sing outside these walls to the many stakeholders who have not yet heard your song about protecting the public. Stay

vigilant, stay focused, stay centered on the importance of public members and in this crazy political and regulatory environment we find ourselves in, I say “sing on and lead on.”

I thank you again, for this distinguished honor. Mr. Schimberg continues to cast a long and powerful shadow in the credentialing community and I pledge to work hard to honor his legacy.

Thank you

SCOPE OF PRACTICE

South Carolina Extends Telehealth Privileges to Advanced Practice Providers

As of July 1, 2018, Advanced Practice Providers, including Physician Assistants and Advanced Practice Registered Nurses have been permitted to establish a relationship with patients for delivering telehealth services so long as they follow the same standards that apply to medical doctors.

See more at <http://tinyurl.com/y6d3sv6a>.

American Enterprise Institute Hosts Discussion of Physicians and NPs

Peter Buerhaus, PhD, director of the Center for Interdisciplinary Health Workforce Studies at Montana State University, in Bozeman told a gathering assembled by the American Enterprise Institute that, in his opinion, physicians needn't worry about competition from nurse practitioners because the vast majority of them work with physicians. Furthermore, more providers are needed to meet the demand for primary care. Buerhaus recommended eliminating scope of practice restriction on nurse practitioners to help relieve the shortage of primary care providers.

The American Enterprise Institute subsequently adopted a policy position in favor of removing scope of practice restrictions.

Read more about Dr. Buerhaus' presentation at <http://tinyurl.com/y6cd8o5t>, <http://tinyurl.com/y65rjdbx>, and <http://tinyurl.com/yyajcd5l>.

See more about the recommendation adopted by the American Enterprise Institute at <https://www.medscape.com/viewarticle/904384> and <http://tinyurl.com/y6tzga5t>.

Read more here about the decrease in primary care physician visits and increase in visits to nurse practitioners and physician assistants at <http://tinyurl.com/y5mur57h>.

Study Finds Nurse Practitioners Well Prepared for Primary Care Role

On November 21, 2018, the National Council of State Boards of Nursing's *Good Morning Members* reported that:

A new study found that although NPs are well prepared to help fill health care gaps arising from a shortage of primary care physicians in California, many face employment and practice barriers. Researchers examined data from California's 2017 Survey of Nurse Practitioners and Certified Nurse Midwives and found that “counties with high density of primary care physicians tended to also have high density of nurse practitioners.”

According to the study's lead author Joanne Spetz, the two major barriers to NPs filling the primary care gap in California are the scarcity of NP education training programs in underserved areas and that “California is the only Western state that requires written

standardized procedures for nurse practitioners to practice and prescribe.” To maximize the impact that NPs can have in meeting care needs, the study calls for expanding education programs in underserved areas, increasing the diversity of the NP workforce and ensuring that NPs feel empowered to fully use their skills.

See more at <http://tinyurl.com/y2229vgj>.

North Carolina Court Affirms Physical Therapy’s Claim to Dry Needling

In another decision in the long-standing battle between physical therapy and acupuncture over which profession is authorized to practice dry needling, the Supreme Court of North Carolina affirmed a lower court decision that dry needling is within the scope of physical therapy.

Read the decision at <http://tinyurl.com/yxv26eee>.

New Nurse Practitioner Census Released

The American Association of Nurse Practitioners (AANP) released new statistics in January 2019 showing an increase in NPs providing primary care. According to AANP:

NPs work in a variety of settings, including private practice (24.2 percent), hospital outpatient clinics (14.5 percent), inpatient hospital units (12.1 percent), emergency rooms (3.1 percent), urgent care (4.3 percent) and community health centers and Federally Qualified Health Centers (8.1 percent). An estimated 72.6 percent of NPs reported they deliver primary care in their main NP work site/setting.

The latest data shows 89.0 percent of the NP workforce worked as full-/part-time staff or faculty. In addition to clinical practice, 14.3 percent of NPs had administrative roles at their main NP practice sites, described as “professional-level” (director, manager or supervisor) and one in five held “executive-level” positions (CEO, CNO or owner).

See more at <http://tinyurl.com/y4vfaehm>.

PATIENT SAFETY

Assesses Progress toward Patient Safety Goals

On October 8, 2018, the National Council of State Boards of Nursing’s *Good Morning Members* reported that:

In 2009, the NPSF’s Lucian Leape Institute (LLI) identified five areas of health care that require system-level attention and action to improve patient safety:

- Medical education must be redesigned to prepare new physicians and other health professionals to function in new cultures;
- Care must be delivered by multidisciplinary teams working in integrated care platforms;
- Health care workers need to work in safe environments and find joy and meaning in their work;
- Patients must become full partners in all aspects of designing and delivering health care; and
- Transparency must be a practiced value in everything health care workers do.

In a new article, members of the LLI assess the implementation progress of these five concepts in the U.S. and identify ongoing challenges. The authors note that it is critical that national professional organizations, foundations and the government support these strategies as they are “as critical now as when first described and are key to advancing the LLI’s mission to have a world where patients and those who care for them are free from harm.”

See the article at <http://tinyurl.com/yxvnnvlo>.

OPEN NOTES

Patient Engagement Found to Improve Care

In an article entitled, “Open Notes, Patient Narratives, and Their Transformative Effects on Patient-Centered Care,” posted on the *NEJM Catalyst* on October 4, 2018, researchers report that Patient education and self-tracking can help patients contribute significantly to health care improvements, particularly through their assessment of non-clinical aspects of care, their assessment of the care environment, and their observations and experience with the care process.

See the article at <http://tinyurl.com/y9jsvmvf>.

Patients Should Check the Accuracy of Their Medical Records

On November 21, 2018, J Graham of *Kaiser Health News* wrote an article advising patients to check their medical records for errors:

Patients can identify errors in their medical records that health care providers may not recognize. This news article highlights the importance of patients correcting seemingly simple mistakes such as name misspellings and phone numbers as these errors can contribute to situations that result in patient harm.

Read the article at <http://tinyurl.com/yasa7oue>.

OpenNotes Announces Campaign for More Effective Implementation

In February 2019, OpenNotes’ Executive Director announced that:

As we begin 2019, we are glad to report that more than 36 million Americans can access their visit notes through patient portals. But that’s only 10% of the U.S. population. It does look as if “rules” that are emerging from the bipartisan 21st Century Cures Act passed two years ago will help stimulate further spread aggressively, but the fact is that simply “turning on” note sharing does not mean that patients can find, read, and benefit from their notes easily. So we are focusing increasingly on finding ways to implement OpenNotes more effectively. Only then can a large number of patients in a given practice access and benefit from note-sharing.

For more see <http://tinyurl.com/y29laxgn>.

ROLE OF PUBLIC MEMBERS

Healthcare Thought Leaders Write About Value of Public Members

In the October 25, 2018 ACCME *Announcement*, the Accreditation Council for Continuing Medical Education referred readers to an article in *Academic Medicine* entitled, “The Role of Public Members in Health Care Regulatory Governance.” The authors are authors David Johnson, MA; Katie Arnhart, PhD; Humayun Chaudhry, DO, MS; David Johnson, MD; and Graham McMahon, MD, MMSc. The article’s Abstract reads:

American medicine has progressively embraced transparency and accountability in professional self-regulation. While public members serving on health care regulatory boards involved with the accreditation, assessment, certification, education, and licensing of physicians provide formal opportunities for voicing public interests, their presence has not been deeply explored. Using 2016 survey and interview data from health care organizations and public members, the authors explore the value and challenges of public members. Public members were often defined as individuals who did not have a background in health care and provided a patient perspective, but in some instances prior health care experience did not automatically exclude these individuals from serving as public members. Public members served on the majority of national health care regulatory boards and constituted an average 9% to 15% of board composition, depending on how rigidly the organizations defined “public member.” Public members were valued for their commitment to the priorities and interests of the public, ability to help boards maintain that public focus, and various professional skills they offer to boards. A main challenge that public members faced was their lack of familiarity with and knowledge of the health care field. The authors suggest several considerations for improved public member integration into health care regulatory organizations: clearly defined roles of public members, including evaluating whether or not previous health care experience either contributes or hinders their role within the organization; greater visibility of opportunities for the public to serve on these boards; and potentially a more intensive orientation for public members.

See more at <http://tinyurl.com/y2m228fu>.

PAIN MANAGEMENT AND END OF LIFE CARE

ANA Enumerates Nursing’s Ethics Related to Pain Management

The National Council of State Boards of Nursing’s Good Morning Members reported December 7, 2018 that:

The ANA published a new position statement in *The Online Journal of Issues in Nursing*. The purpose of the position statement is to “provide ethical guidance and support to nurses as they fulfill their responsibility to provide optimal care to persons experiencing pain.”

The statement includes the following position of the ANA regarding pain management:

- Nurses have an ethical responsibility to relieve pain and the suffering it causes;
- Nurses should provide individualized nursing interventions;

- The nursing process should guide the nurse's actions to improve pain management;
- Multimodal and interprofessional approaches are necessary to achieve pain relief;
- Pain management modalities should be informed by evidence;
- Nurses must advocate for policies to assure access to all effective modalities; and
- Nurse leadership is necessary for society to appropriately address the opioid epidemic.

See the position statement at <http://tinyurl.com/y3xl9vxh>.

2019 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 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.

The annual membership fees are as follows:

Individual Regulatory Board	\$325.00
“Umbrella” Governmental Agency plus regulatory boards	\$325.00 for the umbrella agency, plus \$275.00 for each participating board.
Non-Governmental organization	\$425.00
Association of regulatory agencies or organizations	\$500.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	\$100.00

2019 MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for 2019, please complete this form and email, mail, or fax it us.

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- Mail us a check payable to Citizen Advocacy Center for the appropriate amount (see Fee Schedule on previous page);
- Provide us with your email address so that we can send you an invoice and a payment link that will allow you to pay using any major credit card; or
- Provide the following information to pay by credit card:

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