# News & Views

## Citizen Advocacy Center

Second Quarter 2019 - Health Care Public Policy Forum - Volume 31 Number 2

# REGULATORY REFORM

## "Consumer Choice" Legislation Fails to Exempt Healthcare Professions

Legislation proposed in West Virginia, entitled The Occupational Licensing Consumer Choice Act" (HB 2697), was intended to "expand opportunities, promote innovation and increase competition by allowing consumers to make decisions in hiring and contracting with providers of their choice." According to the legislation, some professionals, such as barbers, would no longer be required to have a license in order to practice. Instead, they would disclose their unlicensed status and consumers would choose whether to patronize them.

The legislation exempted only a limited number of healthcare professions - physicians, nurses, dentists and pharmacists. The legislation would apply to other healthcare professions, such as physical and occupational therapy, and other high stakes professions such as engineering. The legislation's sponsor apologized, saying that there had been a drafting error and more professions should be exempted. Representatives of some affected professions worry that the bill as drafted sets a dangerous precedent for other states.

For more, see: **http://tinyurl.com/yy7vzv3e.** Read about the Arkansas legislature soundly defeating a bill that would have supported a study of scope of practice restrictions for health care professions here: **http://tinyurl.com/y3vxapqq.**

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### Kansas Considers Lowering Social Work Requirements

Advocates and employers in Kansas say a shortage of social workers in the state could be relieved by reducing work experience requirements that are more stringent in Kansas than in other states. SB 193 would modify current standards for licensure and certification of social workers in the state.

See more here: **http://tinyurl.com/y3nehyjc** and **http://tinyurl.com/yy66tn4k.**

### Certifiers Warn of Unintended Consequences of Pennsylvania Bill

Legislation under consideration in Pennsylvania would restrict the use of the title "certified" to those who hold a state-sanctioned credential. The American Society of Association Executives (ASAE), the Institute for Credentialing Excellence (ICE), and the Professional Certification Coalition (PCC) warn that, if passed, this legislation would harm the public by undercutting the use of credentials awarded by private, voluntary certification organizations.

See more here: **http://tinyurl.com/yywfk4po** and **http://tinyurl.com/y2s8tcoz.**

# LICENSURE AND CREDENTIALING

### Federation of State Medical Boards Evaluates Mini-Credentials

In a report released in June 2019, the Federation of State Medical Boards (FSMB) looks at new trends in credentialing professionals. According to the FSMB's release announcing the report,

The report specifically surveys three available technologies: digital signatures, Open Badges, and Blockchain-enabled credentials (Blockcerts). While no binding guidance is issued on what technology should be adopted, the report analyzes which of these technical solutions sufficiently meet existing legal and regulatory requirements of healthcare, while also delivering improved document portability, independence, and the level of trust patients expect in modern healthcare delivery models. Moreover, it provides descriptions of the unique technical features of each digital credential format and how these features align with the requirements for medical licensing and credentialing. Finally, the report calls for an industry-wide willingness to evaluate process and implement changes that specifically address existing inefficiencies and barriers. "Any organization or institution considering digital credentials can benefit from the research found in this report, and it is our hope that it sparks additional interest and collaboration that will modernize the licensure and credentialing process," said (FSMB Chief Information Officer Michael) Dugan.


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See more here: **http://tinyurl.com/y4vaz9sl.**

# TELEHEALTH

## Congress to Consider Expanding Availability of Mental Health Telehealth

On December 20, 2018, Senator Kamala Harris introduced legislation that would two bills, the *Mental Health Telemedicine Expansion Act* and the *Mental Health Professionals Workforce Shortage Loan Repayment Act*, to expand access to mental health services for millions of Americans experiencing mental illness, especially those in rural and medically underserved areas. Currently, more than 123 million Americans live in an area with a shortage of mental health professionals.

For more, see: **http://tinyurl.com/y65n6elu.**

**CAC *News & Views***
is published quarterly by

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## CMS Announces New Reimbursement Rules

The Center for Connected Health Policy reported on February 12, 2019, that CMS has new reimbursement policies related to communications technology:

> Beginning January 2019, the Centers for Medicare and Medicaid Services (CMS) began reimbursing for certain kinds of services furnished remotely using communications technology that are not considered "Medicare telehealth services." Because they are not defined specifically as telehealth, the limitations and restrictions generally applicable to telehealth in Medicare do not apply. These services include "virtual communication services" including communication technology-based services (HCPCS code G2012) and remote evaluation services (HCPCS code G2010). However, due to the unique rules that apply to federally qualified health centers (FQHCs) and rural health clinics (RHCs), CMS has assigned a new code (G0071) specifically for these safety-net clinics to utilize for virtual communication services as they are not eligible to bill G2010 or G2012. As a result of this policy change, CMS has released an FAQ document on the topic to help clarify any confusion around the use of the new code for FQHCs and RHCs. View the FAQs for the full scope of the questions and concerns answered through the document.

View the FAQ document here: **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf**

See more here: **http://tinyurl.com/yyvfot5x.**

## American Hospital Association Upbeat about Telehealth

The American Hospital Association (AHA) released several documents in February documenting the growth and value of telehealth services. These include a report entitled, "Telehealth: A Path to Virtual Integrated Care." According to AHA,

> This report from the AHA Center for Health Innovation examines how telehealth is part of a digital health revolution; the flexibility of delivery platforms and how they fit into virtual integrated care; why telehealth is critical to health care transformation; challenges to telehealth expansion; the current state of telehealth and opportunities for growth in hospitals; technology options and choosing the right vendor; and, most importantly, how hospitals and health systems can build capacity to expand access, improve outcomes and reduce costs.

See this report and other AHA materials here: **http://tinyurl.com/y5lln37p.** See also this report on several federal level actions affecting telehealth: **http://tinyurl.com/y24wbtz9.** See also: **http://tinyurl.com/y25fyf7c.**

### Economist Ponders Legal Obstacles to Telehealth

Robert Graboyes, senior research fellow with the Mercatus Center at George Mason University, wrote a commentary for *Inside Sources.com* about the benefits of and legal obstacles in the way of the spread of telehealth.

See the full article here: **http://tinyurl.com/y6fcwwvp.**

# CONTINUING PROFESSIONAL DEVELOPMENT

### ABMS Boards Embrace Longitudinal Assessment

In its June 13, 2019, *ABMS Insights*, ABMS asserts that "Longitudinal Assessment Balances Learning and Assessment." The article begins:

> Many American Board of Medical Specialties (ABMS) Member Boards are using **longitudinal assessment** to reframe the role of assessment in their continuing certification programs. Simply put, longitudinal assessment is designed not only to assess physician knowledge, but also to identify knowledge gaps and support learning and improvement. *"It draws on principles of adult learning and modern technology in order to promote learning and retention," stated David Swanson, PhD, ABMS' Vice President of Academic Programs and Services.*

See more here: **http://tinyurl.com/y4wlevb8.**

### ABMS Member Boards Announce "Collaborative Maintenance Pathway"

In March 2019, the American Board of Internal Medicine (ABIM) and the American College of Cardiology announced a new pathway for cardiologists who wish to maintain their board certification. According to the announcement,

> The new option, announced to coincide with the ACC's 68th Annual Scientific Session, March 16-18, in New Orleans, integrates lifelong learning and assessment with the goal of helping physicians stay current in knowledge and practice.
>
> "The new CMP leverages the respective expertise of the ACC and ABIM to create a literal 'pathway' that meets the ongoing learning needs of cardiologists, while also giving patients, the public and other stakeholders confidence that the care provided by their physicians is of the highest quality," said Timothy W. Attebery, DSc, MBA, FACHE, Chief Executive Officer of ACC. "We appreciate ABIM working with us on what we believe is a win-win solution for cardiologists and the patients they serve."
>
> **Program Overview**
>
> Based on feedback from cardiologists who expressed interest in a way to focus their study in specific areas over the course of several years, rather than a single test every 10 years, ABIM and ACC began work in 2017 to provide an alternate pathway for cardiologists seeking to maintain their ABIM certification.
>
> A Cardiovascular Disease CMP utilizing the ACC's Adult Clinical Cardiology Self-Assessment Program (ACCSAP) for both formative engagement in learning and the

> demonstration of currency with an annual performance assessment will be available in 2019. For certified cardiologists, this pathway centers on successful engagement with the ACCSAP educational materials in specific content areas each year as a prerequisite to qualify for a performance assessment later in the calendar year on those same topic areas. A new performance assessment will be available each year, with each covering approximately 20 percent of the field of cardiovascular disease. Ultimately, the breadth of general cardiology will be covered in a span of five years. The 2019 ACCSAP performance assessment will focus on arrhythmias. This means physicians planning to enter the CMP in 2019 can begin to focus their studying on the arrhythmia section of ACCSAP now, with the performance assessment on arrhythmias available in the fall.
>
> It is anticipated that CMPs in Clinical Cardiac Electrophysiology, Interventional Cardiology and Advanced Heart Failure, and Transplant Cardiology will become available in 2020. ACC is working in collaboration with the Heart Rhythm Society, the Society for Cardiovascular Angiography and Interventions, and the Heart Failure Society of America in conjunction with the ABIM on these efforts.
>
> With this new MOC pathway, ABIM will continue to set performance standards and issue certifications, and ABIM's current MOC program requirements will remain in place. ABIM's traditional 10-year MOC exam and the two-year Knowledge Check-In assessment will remain available to Diplomates if they choose not to participate in the CMP.
>
> Similarly, ACCSAP will remain a standalone Continuing Medical Education option as an educational resource in the field of Cardiology, regardless of a physician's participation in ABIM MOC.
>
> "Through meaningful engagement with the physician community and professional societies, ABIM is proud to continue the evolution of our MOC program in a myriad of ways to better meet the needs of physicians and the patients they serve," said Richard J. Baron, MD, President and CEO of ABIM. "This new offering increases choice, flexibility and relevance for board certified cardiologists while also keeping a performance standard that gives patients confidence that their physician possesses the current medical knowledge necessary to deliver high-quality care. We appreciate ACC's expertise and partnership throughout this journey to co-create an innovative new assessment…

For more, see: **http://tinyurl.com/y3cmm8bb.**

# QUALITY OF CARE

## VA Should Pay More Attention to Credentialing, says GAO

The Government Accountability Office (GAO) reported to Congress in February 2019 that a study of the Veterans Health Administration revealed that "Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care." The report says, in part:

> **What GAO Found**
>
> GAO found that Veterans Health Administration (VHA) facilities responded in various ways to adverse-action information from the National Practitioner Data Bank (NPDB) for

the 57 providers reviewed, and in some cases overlooked or were not aware of adverse action.

- In some cases, providers had administrative or other non-disqualifying adverse actions reported in the NPDB, but VHA facilities determined they could be hired. For example, VHA hired a physician who had surrendered his physical-therapy license for not completing physical-therapy continuing education. Although his license surrender resulted in an adverse action in NPDB, VHA determined that there were no concerns about the provider's ability to perform as a physician.
- VHA facilities disciplined or removed providers when they learned about adverse actions reported in NPDB. In addition, after GAO raised questions about certain providers' eligibility, based on GAO's examination of adverse- action information, VHA facilities removed five providers that it determined did not meet licensure requirements.
- In some instances, VHA facilities overlooked or were unaware of the disqualifying adverse-action information in NPDB. In these cases, VHA facilities inappropriately hired providers, but some providers were no longer working at VHA at the time of GAO's review. For example, VHA officials told GAO that in one case, they inadvertently overlooked a disqualifying adverse action and hired a nurse whose license had been revoked for patient neglect. This nurse resigned in May 2017.

VHA facilities did not consistently adhere to policies regarding providers with adverse actions. Among other issues, GAO found that some facility officials were not aware of VHA employment policies. Specifically, GAO found that officials in at least five facilities who were involved in verifying providers' credentials and hiring them were unaware of the policy regarding hiring a provider whose license has been revoked or surrendered for professional misconduct or incompetence, or for providing substandard care. As a result, these five VHA facilities hired or retained some providers who were ineligible. VHA provides mandatory onetime training for certain VHA staff, but not for staff responsible for credentialing. The absence of periodic mandatory training may result in facility officials who are involved in credentialing and hiring not understanding the policies and hiring potentially ineligible providers.

VHA officials described steps they have taken to better ensure that providers meet licensure requirements. For example, VHA completed a onetime review of all licensed providers beginning in December 2017, and removed 11 providers who did not meet the licensure requirements as a result of this review. VHA officials said these types of reviews are not routinely conducted, and noted the review was labor intensive. Without periodically reviewing those providers who have an adverse action reported in NPDB, VHA may be missing an opportunity to better ensure that facilities do not hire or retain providers who do not meet the licensure requirements.

See more here: **http://tinyurl.com/y2o7kbj6.**

# CONSUMER INFORMATION

## New York State Considers Probation Disclosure Law

Modeled after legislation passed in California, AO1142A would require a physician who is "currently the subject of ongoing proceedings, has been placed on probation, has been disciplined by the Board for Professional Medical Conduct, has been subject to the revocation, surrender, suspension or limitation of such license, or has received a verdict of guilty or entered into a settlement agreement in an action for medical malpractice to notify patients of such events. Such person must also notify each new patient in writing prior to any consultation or provision of services."

See the bill here: **http://tinyurl.com/y5k2yqv4,** and **http://tinyurl.com/y24am6b2.**

## Consumers Advised to Dig Deeper that Online Reviews of Practitioners

A television story aired in California in June 2019 gave watchers valuable information about how to research healthcare practitioners. The main message was not to rely on online reviews by other patients, which may contain erroneous or questionably relevant information.

See more here: **http://tinyurl.com/y28nsevf.**

# PATIENT ENGAGEMENT

## AHRQ Releases Patient Engagement App

In March 2019, the Agency for Healthcare Research and Quality (AHRQ) released an app to help patients prepare questions for their clinicians. AGRQ's announcement reads:

> **New AHRQ Question Builder App Helps Patients Maximize Time with Clinicians**
>
> AHRQ today released a new mobile app to help patients be more engaged in their own healthcare and to help make office visits more efficient. The Question Builder app, available at no charge on iTunes and Google Play, helps patients prepare and organize questions and other helpful information ahead of time and puts that information at their fingertips, as part of an e-mail or calendar appointment that allows for note-taking, during medical visits. The Question Builder app has a host of other features. For instance, it integrates with a phone's camera so that users can snap a photo of useful visual information such as an insurance card, a pill bottle, or even a skin rash….

Learn more here: **http://tinyurl.com/y2lt6ja2.**

# PATIENT SAFETY AND MEDICAL ERRORS

## Documentary Explores Consequences of Medical Errors

On February 6, 2019, The Agency for Healthcare Research and Quality (AHRQ) published a link to an article in the January 24, 2019, *Time Magazine:*

> This news article reports on the documentary *To Err Is Human*, which was produced and directed by the son of patient safety leader Dr. John M. Eisenberg. The film is structured around patient safety advocate Sue Sheridan's experience with diagnostic errors that resulted in harm for both her son and husband. It features a wide range of experts who

discuss the impact of error on all involved, the role of culture in facilitating both mistakes and progress, and why continued work in health care safety is needed.

For more, see: **http://tinyurl.com/y6489437.**

### FSMB CEO Criticizes Maryland Bill Cleansing Disciplinary Records

Federation of State Medical Boards Executive Director, Humayun Chaudhry released a strong statement in opposition to legislation in Maryland that would expunge physician disciplinary records every three years. The statement reads, in part:

> Maryland Senate Bill 372 proposes putting a three-year time limit on what patients in Maryland are allowed to know about the disciplinary history of their physician. Instituting a mandatory time limit to expunge a physician's disciplinary history is unprecedented. If passed, Maryland will become the first state in the nation to allow physicians to wipe their disciplinary records clean after a certain period of time, regardless of the severity of the offense or the danger to the public. This legislation will decrease transparency in the licensing process, potentially putting the health and safety of Marylanders at risk. It also would create a dangerous precedent that will have a national impact on patient safety.

See the full statement here: **http://tinyurl.com/yydfxd8n.** See also: **http://tinyurl.com/yxuubhzv.**

### Safe Medication Practices Group Defends Nurse Charged in Patient Death

The Institute for Safe Medication Practices defends nurse indicted after patient death from medication error. The ISMP explains its rationale in a February 14, 2019, article entitled, "Another Round of the Blame Game: A Paralyzing Criminal Indictment that Recklessly 'Overrides' Just Culture."

See the article here: **http://tinyurl.com/y5nhx6yd.** See also the American Nurses Association defense of the nurse: **http://tinyurl.com/yymb9pw5.**

## IN THE COURTS

### California Court Finds in Favor of Doctor Disciplined by Hospital

Anesthesiologist Kenneth Economy sued a hospital that removed his privileges for issues of competence. The court ruled in Economy's favor, finding that the hospital violated Economy's due process rights.

For more, see: **http://tinyurl.com/y4qtkhnz.**

## SCOPE OF PRACTICE

### Study Released About Effect of Collaborative Practice Agreements

The National Council of State Boards of Nursing's *Good Morning Members* reported on February 13, 2019, that the findings are available from a survey of the economic impact of collaborative practice agreements:

> Findings from The Economic Burden and Practice Restrictions Associated with Collaborative Practice Agreements: A National Survey of Advanced Practice Registered

Nurses were recently published in the *Journal of Nursing Regulation*. NCSBN researchers designed the study to identify current APRN practice trends in states that require collaborative practice agreements (CPAs), and to determine the economic burden and practice restrictions placed on APRNs by state laws. Researchers surveyed a random sample of 8,701 APRNs practicing across 29 states that mandate reduced scope of practice on at least one APRN role.

> The study determined that APRNs working in rural areas and APRN-managed private clinics were one and a half to six times more likely to be assessed CPA fees, often exceeding $6,000 and up to $50,000 annually. Similarly, APRNs subject to minimum distance requirements, fees to establish a CPA, and supervisor turnover reported a 30 percent to 59 percent uptick in restricted care of patients, which included a range of restrictions specific to prescribing authority, permitted procedures, patient profiles, and distant/setting requirements. Researchers concluded it is incumbent on state legislatures to address these disparities, remove the requirement for a CPA, and make their constituents' access to high-quality care a top priority.

See the survey report here: **http://tinyurl.com/yywwz4vj.**

***Editorial Note: Several states are considering legislation that would remove collaborative practice requirements and other restrictions on APRN practice. The American Association of Nurse Practitioners tracks state laws affecting advanced practice nursing here: http://tinyurl.com/yy58fmbr.***

## MedPAC Recommends Direct Billing by APRNs and PAs

On February 20, 2019, the National Council of State Boards of Nursing's *Good Morning Members* reported the following:

> The Medicare Payment Advisory Commission (MedPAC), an advisory body to Congress on Medicare payment issues, voted unanimously to recommend that, "The Congress should require APRNs and Physician Assistants (PAs) to bill the Medicare program directly, eliminating 'incident to' billing for services they provide." Under the current billing model, Medicare pays 85 percent of the fee schedule amount when APRNs bill the program directly, while APRN care services billed as "incident to" under a physician's identifier are paid at 100 percent. MedPAC notes that eliminating "incident to" billing would save the Medicare program money and improve data on who provides care to beneficiaries.
>
> In addition, MedPAC recommended that HHS refine Medicare's specialty designation for APRNs and PAs, which could be implemented by having APRNs and PAs report their specialty when they enroll as providers in the Medicare program.

It is noteworthy that this change would enable CMS to gather more accurate data about what professionals are delivering services to beneficiaries.

For more, see: **http://tinyurl.com/yxmf246o.**

## Acupuncture Board Concedes Physical Therapists' Right to Dry Needling

On March 12, 2019, *PT in Motion News* reported that the North Carolina Acupuncture Licensing Board (NCALP) settled a longstanding lawsuit and thereby authorized physical therapists in the state to practice dry needling. Similar contentious battles have occurred in numerous states.

For more, see: **http://tinyurl.com/y2gyav9k.**

## Certified Professional Midwives Score Legislative Victory in Kentucky

After years of effort, Kentucky's Certified Professional Midwives (CPM) have earned the right to be licensed healthcare professionals. Senate Bill 84, signed into law in April 2019, provides for licensing CPMs.

The legislation establishes an Advisory Council in the board of nursing composed of one ex officio member from the Board of Nursing, three certified professional midwives, two APRN-designated certified nurse-midwives, two obstetricians licensed in Kentucky, one practicing neonatal health care provider licensed in Kentucky and one member of the general public. It also allows CPMs to communicate openly with healthcare practitioners, obstetricians, and pediatricians and to openly identify themselves to caregivers.

For more, see: **http://tinyurl.com/y6sglgoa.**

## AHRQ Patient Safety Network Features Article on Teams

In March 2019, the AHRQ Patient Safety Network featured an article by L. N. Rosenbaum in the *New England Journal of Medicine* entitled, Teamwork—Part 1: Divided We Fall; Part 2: Cursed By Knowledge—Building a Culture of Psychological Safety; and Part 3: The Not-My-Problem Problem. The abstract reads:

> Breakdowns in communication and teamwork are common contributors to adverse events and can compromise safety. As medical care becomes more complex, more teams and subspecialists are involved in a patient's care, which may lead to fragmentation of care and a lack of clear ownership. This three-part series on teamwork highlights the challenges surrounding interprofessional communication and collaboration in today's health care environment, with an emphasis on the resultant adverse effects for patients. The first commentary describes a scenario in which many consultants were carefully considering a patient's case but were not communicating effectively with one another. The second commentary underscores how psychological safety can facilitate improved collaboration and error disclosure among teams. In the third part of the series, the author points out that although the practice of medicine is highly dependent on effective teamwork, medical culture continues to emphasize and even heroize the individual to its own detriment. The author suggests that further research is necessary to achieve optimal **teamwork** in medicine.

For more, see: **http://tinyurl.com/y58dgd7r.**

## Students Learn About Disclosure of Errors Involving Teams

The *Journal of the American Geriatrics Society* reported in April 2019 of an educational program related to a team disclosure of a medical error. According to the article's abstract,

> Medical errors can involve multiple team members. Few curricula are being developed to provide instruction on disclosing medical errors that include simulation training with interprofessional team disclosure. To explore more objective evidence for the value of an

educational activity on team disclosure of errors, faculty developed and assessed the effectiveness of a multimodal educational activity for learning team-based disclosure of a medical error.

This study employed a methodological triangulation research design. Participants (N = 458) included students enrolled in academic programs at three separate institutions. The activity allowed students to practice team communication while: (1) discussing a medical error within the team; (2) planning for the disclosure of the error; and (3) conducting the disclosure. Faculty assessed individual student's change in knowledge and, using a rubric, rated the performance of the student teams during a simulation with a standardized family member (SFM).

Students had a high level of preexisting knowledge and demonstrated the greatest knowledge gains in questions regarding the approach to disclosure ($P < .001$) and timing of an apology ($P < .001$). Both SFMs and individual students rated the team error disclosure behavior highly (rho = 0.54; $P < .001$). Most participants (more than 80%) felt the activity was worth their time and that they were more comfortable with disclosing a medical error as a result of having completed the activity.

This activity for interprofessional simulation of team-based disclosure of a medical error was effective for teaching students about and how to perform this type of important disclosure.

See the article here: **http://tinyurl.com/y2emldsl.**

# Letters

## From: Nurse Licensure Compact

Dear Supporters:

We are excited to update you on the progress of the Nurse Licensure Compact (NLC) in the 2019 session.

We are in the midst of the 2019 legislative session and many states are working vigorously towards moving the compact forward. Currently, there are nine states with NLC legislation: Alabama, Illinois, Indiana, Massachusetts, Michigan, Minnesota, New Jersey, Vermont, and Washington.

We are hopeful that several states will enact legislation this year and the NLC will continue to expand across the country.

To find out if your state is moving forward with joining the compact, visit our campaign site at **https://www.votervoice.net/BroadcastLinks/IGgFOCzgBpBpMbdrESZ7Tg** and scroll down to see an interactive map. To let your lawmakers know you support the NLC visit **https://www.votervoice.net/BroadcastLinks/hsb4xkDyifSyrAHsWamsiQ.**

Thank you for your continued support!

# IN-DEPTH FEATURE

## ACTIVATING NURSING TO ADDRESS UNMET NEEDS IN THE 21st CENTURY

***Editorial Note: This Quarter's In Depth Feature consists of excerpts from a report written by Patricia Pittman, PhD, FAAN Professor Health Policy and Management, George Washington Health Workforce Institute, Milken Institute School of Public Heath, George Washington University. Entitled, "Activating Nursing to Address Unmet Needs in the 21st Century," the report was commissioned by the Robert Wood Johnson Foundation to serve as background for the National Academy of Medicine committee on the Future of Nursing 2020-2030. See the entire report here: http://tinyurl.com/yxcrq4f5.***

***The Report's Executive Summary explains the historical roots and contemporary context on which future predictions are based.***

**Executive Summary**

The deteriorating epidemiological profile in the United States requires more than a traditional medical response. This report argues that the nursing profession could contribute significantly to addressing this crisis if it embraces its historic role at the intersection of medicine and society, and if educators, employers, and policymakers work with nurses to create jobs with roles that allow them to more effectively utilize their education and training. Several recent developments may provide a unique window of opportunity for this to occur, including the Robert Wood Johnson Foundation's reorientation of its mission and programming to focus on building a Culture of Health, the evolving alternative payment arrangements in health care, changes in the oversight of tax-exempt hospitals' community benefit spending, the ability of new health technologies to decentralize the delivery of care, and changes to the physician workforce.

The report is divided into four sections. Part I describes the historical forces that defined two models of nursing—one with a holistic focus on patients, families, and communities in the context of social justice, and the other focused largely on support roles with a defined set of clinical tasks in the hospitals. Part II describes the current epidemiological situation and provides background for major contextual developments that may help reposition nursing. Part III focuses on nursing today and provides examples of the types of nurse-led, or nurse-involved, models that have evidence of impact and are successfully spreading. Part IV concludes with an analysis of what it would take to activate nursing and scale up this holistic approach to addressing unmet needs of the 21st century.

Between 1910 and the 1930s, an important branch of nursing focused on patients in the context of their relationships and environment, and it developed a strong partnership with social workers. Yet by the 1920s, the expanding dominance of the medical profession, and following World War II, the growth of the hospital sector and the emergence of pre-paid health insurance companies, severely constrained this approach to nursing. Nurses were largely relegated to passive support roles in the context of professional hierarchies and silos that separated health professions according to their ability to bill for services. Home and community-based nursing care were marginalized, as physicians and hospitals emerged as the central players in the health care system.

Then, in the context of the women's movements in the 1960s and '70s, nursing experienced a partial renaissance, developing alternative patient-centered care models and moving nursing education into the university, where the profession formalized nursing science and theories. In the subsequent 50 years, however, many of these alternative nurse-led initiatives faced challenges of financial sustainability and remained largely outside the mainstream health care market. Nursing education also faced an incessant push by hospital employers to prepare graduates for clinical jobs in hospitals, a priority that trickled down into nurse licensure and education accreditation standards.

Today, the context is changing, and while both strands of nursing history co-exist, there are new opportunities for nurses to contribute to building a Culture of Health. With life expectancy stagnating and other industrialized nations far outperforming the United States on many health indicators, analysts point to the so-called diseases of despair and growing economic and social inequities as the primary drivers of poor population health outcomes. There is growing recognition that medical care alone is insufficient to address these health problems, and that a variety of new policies and initiatives are needed to incentivize the health care sector to consider the social determinants of health—including historic problems of racial, ethnic, gender and other forms of discrimination—as well as economic and geographic disparities in access to basic needs, such as affordable housing, transportation, quality education, healthy foods, and child care.

Several developments suggest that change may be afoot. Among the efforts that have emerged since passage of the landmark 2010 Affordable Care Act (ACA) is the Robert Wood Johnson Foundation's reorientation of all their philanthropic investments toward building a Culture of Health in America, which has fueled the design and testing of new cross-sector and community engagement models around the country. A second significant contextual development is the slow decline of fee-for-service payments in health care and the expansion of alternative value-based payment arrangements. Alternative payment methods are driving a transformation of the delivery system, and in some places expanding nurses' work into areas such as coordinating care, managing care transitions, conducting home visits, and developing community-based partnerships. Payments linked to patient reported outcomes are also placing a spotlight on nurses' work and providing opportunities for nurses to focus on patient and family preferences.

Three additional developments may speed the process of transformation. New oversight of tax-exempt hospitals requires the conduct of community health needs assessments and the implementation of subsequent community health benefit plans. The advancement of health technologies is facilitating the decentralization of health care and the engagement of patients in their own health care plans. And lastly, the physician workforce is experiencing changes that may alter the traditional relationship with nurses, including a decrease in self-employment among physicians, a reduction in their autonomy vis-à-vis managed care, and the growing participating of women, who now outnumber men among medical students.

All of the factors may help to explain why some large health systems and other healthcare employers are exploring old and new models of care that are nurse-led or involve expanded roles for nurses. Some of the most prominent models echo the successful partnership of nursing and social work of the early 20th century, and include care coordination for complex patients with a variety of wraparound services, interdisciplinary home care teams for the elderly and new mothers, programs to prevent the need for children to enter foster care, and stand-alone modern innovations outside the health sector, such as walking-to-school programs.

These conditions, and the wide ranging models of nursing care that exist, suggest that there is an opportunity to re-activate the massive U.S. nurse workforce to address the new epidemiological needs of the 21st century. For this to occur, progress is needed on a variety of fronts, including the following:

1. Identifying the core functions of nursing in the 21st century
2. Choosing to work at the intersection of disciplines
3. Aligning nursing education with core functions
4. Aligning jobs, professional development, payment and regulatory policies with core functions

Nursing roles and the settings in which nurses work are diverse and they will likely continue to diversify. As such, the profession will intersect and overlap with other professions and community-based personnel. Such intersections may not always be comfortable for nurses, but if they are embraced as opportunities for innovation, they could lead to the kind of creative social solutions that characterized Lillian Wald's vision of nursing in the early 20th century.

Regardless of the settings, or even sectors, in which a nursing job exists, nursing has the potential to help the nation focus on health and well-being as holistic values, and nurses can bring a specific set of knowledge and skills that are desperately needed in the 21st century United States.

***About aligning regulator policies to core nursing functions, the report says:***

Constraints on APRN scope of practice, as well as other "who is allowed to do what" rules that underpin credentialing, privileging and payment policies are also clearly a barrier to fully realizing the promise of these professionals. The American Association of Nurse Practitioners' online NP scope of practice map shows 31 states and territories that still do not allow full practice authority for this group of nurses, although many states are incrementally taking steps to improve regulations. Organizations also vary dramatically in the degree to which they allow APRNs full privileges (Pittman et al 2018), and payers, including Medicare, still prevent APRNs from serving in certain roles. As nurse organizations advocate for these changes, so too must they be advocating for the liberalization of other professions and lay health workers' scopes of practice, so that they can work together in teams that utilize all personnel to their full potential.

***Finally, the report concludes that:***

Faced with the surge in obesity, substance use disorders, mental health conditions and childhood asthma—among other conditions that are deeply rooted in social and economic conditions—, policymakers and health care organizations are beginning to see the limitations of the highly centralized and medicalized health services that characterized the last century. They are calling for greater integration of health and social services, and looking for ways to engage patients, families and communities in upstream solutions that improve population health, well-being and health equity. Payment policies and technologies are evolving as well, helping to drive and to facilitate these changes.

Given both its history and its sheer size, the nursing profession has the potential to help redirect the health care industry with the aim of addressing unmet needs of the 21st century. To do this, a set of core nursing functions— such as building trust and compassion with patients, facilities and communities, conducting comprehensive evaluations, coordinating partnerships and identifying

upstream collective solutions—must be identified and strengthened,. Many of these functions overlap with other disciplines, making it important for nursing, as a profession, to embrace the notion of working with other disciplines at intersections, where many roles will undoubtedly overlap. This may not always be comfortable, but if it is embraced as an opportunity for innovation, nurses will have the opportunity to engage in the kind of creative social solutions championed by Lilian Wald at the start of the last century.

Nursing education will also need to keep pace, with a stronger focus on population health and health equity, as well as programs to increase the diversity and inclusiveness of the nursing workforce. Likewise, health care and other employers will need to be convinced that new and incumbent nurses should be deployed in roles that allow them to realize their full potential. Nurses and others will need to lay out existing evidence and generate new studies that demonstrate the impact of using nurses in expanded functions on population health, well-being, health equity, as well as, of course, business revenues. Government and businesses will need to ensure that their incumbent nurse workforce has the opportunity to continue to learn and change through residencies and ongoing professional development and training. Payment and regulatory policies must be aligned to achieve these goals. Lastly, a robust research agenda associated with these transformational aims will help to inform and spur the process of change.

Regardless of the setting, or even sector, in which a nursing job exists, the nursing workforce has the potential to help the nation refocus on health as a holistic value. Nurses bring a specific set of knowledge and skills that, if encouraged to use them, could help address a new set of unmet needs that are emerging in the 21$^{st}$ century United States.