Medical Commission Educational Conference

Putting the Patient in Patient Safety

October 1-2, 2014
Capital Event Center Tumwater, WA

A public service of the Washington State Medical Commission

Washington State Department of Health

Washington State Medical Commission
2014 Educational Conference
"Putting the Patient in Patient Safety"

WEDNESDAY – October 1, 2014 – Capital Event Center	
9:15 a.m.	**Welcome:** Richard Brantner, MD Chair, Washington State Medical Commission
9:30 a.m.	**Patient Safety Panel** Bonnie Bizzell, MBA Stephen Lovell Patient and Family Advisory Board Foundation for Health Care Quality, WPSC *"(Re)Focus on Safety: Incorporating the Patient's Perspective for Better Patient Safety"*
10:30 a.m.	William M. Sage, M.D., J.D. James R. Dougherty Chair for Faculty Excellence The University of Texas at Austin *"Communication and Resolution Program"*
11:30 a.m.	**Lunch Break (On your own)**
12:30 p.m.	**Presentation:** Augustus A. White, III, M.D., Ph.D. Culturally Competent Care Education Program Orthopaedic Surgeon-in-Chief Emeritus, Beth Israel Deaconess *"What Dr. Martin Luther King would like us to know about Health Care Disparities"* **Introduction:** Tom Green, M.D., Commissioner Pro Tem
1:30 p.m.	**Networking break**
2:00 p.m.	Byron D. Joyner, M.D., M.P.A. Residency Program Director, Department of Urology Seattle Children's Hospital *"Building A Better Professional: Iconoclasts & Idiosyncrasies (Dealing with Conflict)"*
3:00 p.m.	Blake T. Maresh, M.P.A., C.M.B.E. Past Board Member, Federation of State Medical Boards Executive Director, Board of Osteopathic Medicine and Surgery *"Deep Dive: The Interstate Physician Licensure Compact"*
4:15 p.m.	**Wrap up and discussion**

Washington State Medical Commission
2014 Educational Conference

THURSDAY – October 2, 2014 – Capital Event Center	
9:15 a.m.	**Welcome:** Richard Brantner, MD Chair, Washington State Medical Commission
9:30 a.m.	Caleb Banta-Green, Ph.D. Senior Research Scientist School of Public Health, University of Washington *"Long-term Opioid Management of Chronic Pain: Trends, Risk, and Naloxone"*
10:30 a.m.	Molly Voris, M.P.H. Director of Policy WA Health Benefit Exchange *"Status of the Washington Health Benefit Exchange"*
11:30 a.m.	**Lunch Break (On your own)**
12:30 p.m.	**Presentation:** John Wiesman, Dr.Ph., M.P.H. Secretary Washington State Department of Health *"Integration: Primary Care and Public Health"* **Introduction**: Richard Brantner, M.D., Chair, Medical Commission
1:30 p.m.	**Networking Break**
2:00 p.m.	Paul Buehrens, M.D. Medical Director Evergreen Health Partners *"The Clinically Integrated Network"*
3:00 p.m.	Randy Simmons Deputy Director Washington Liquor Control Board *"The Marijuana Market in Washington"*
3:45 p.m.	**Closing: MQAC strategic direction discussion and** conference debriefing
FRIDAY – October 3, 2014- PPE, Rooms 152 and 153	
8:00 a.m.-9:00 a.m.	Commission Business Meeting
9:00 a.m.-Complete	Case Reviews (closed session)

Washington State Department of Health

Bonnie Bizzell
Stephen Lovell
Foundation for Health Care Quality
Patient & Family Advisory Council
October 1, 2014

(RE)FOCUS on SAFETY

Incorporating the Patient's Perspective for Better Patient Safety

And Now!
Something Completely Different

70,000 -440,000

1/3

2.8 30

177

10^{-40}

60

1/2

3

Goal & Agenda

We want to…

explore components needed for patient involvement in patient safety

- **The Trifecta, I – Process: Patient-Centered Practice**
- **The Trifecta, II – Communication: Patient-Centered Service**
- **The Trifecta, Grand Finish – Trust: Patient-Centered Partnership**
- **Quick Detour: Patient- and Family- Centered Care**
- **So What? Applications and Implications**
- **Closing Remarks /Q&A**

The Trifecta, I
Process: Patient-Centered Practice

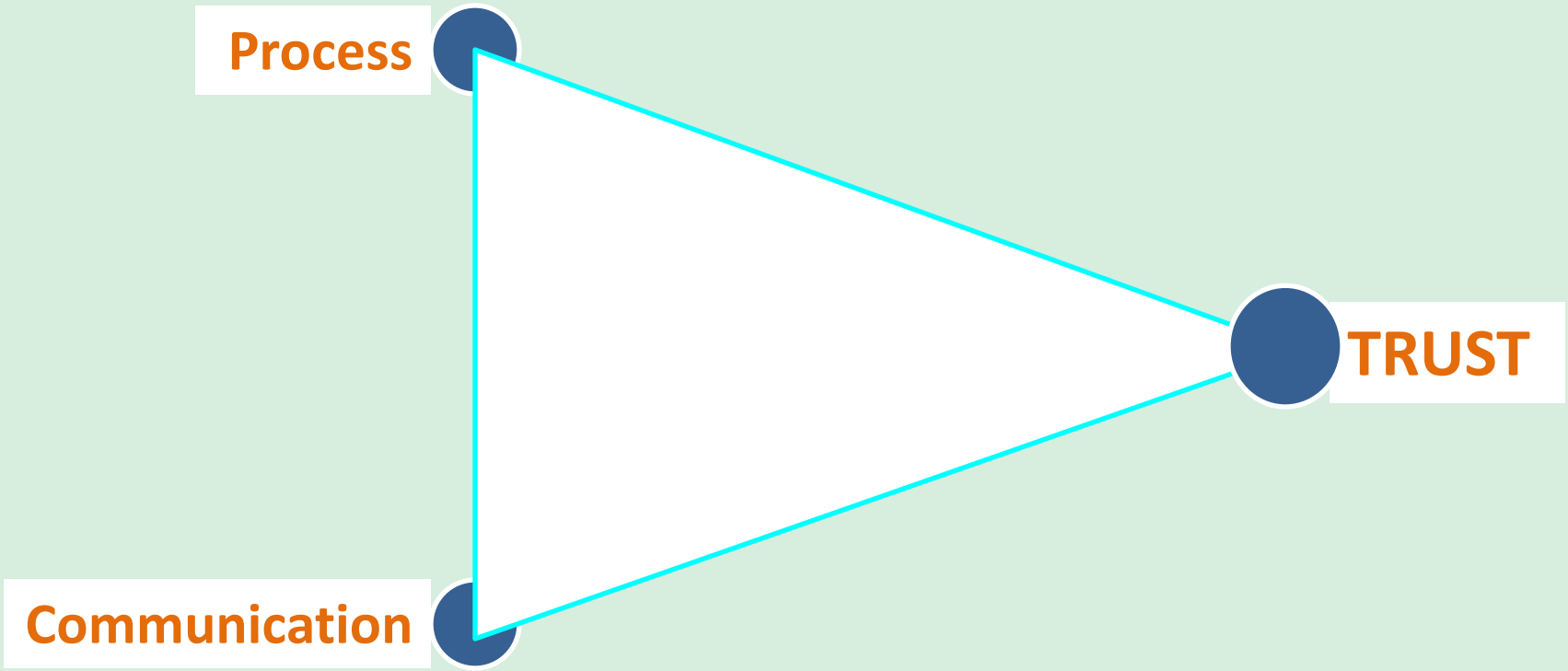
You never get a second chance to make a first impression.

- Decided to have neck surgery
- Chose a well-respected surgeon
- Office staff experience
- Surgery outcome
- But, what if it had not gone as expected?

The Trifecta, II
Communication: Patient-Centered Service

If speaking is silver, then listening is gold.

The Trifecta, Grand Finish
Trust: Patient-Centered Partnership



Quick Detour:
Patient- and Family-Centered Care

Driving forces for patient care

- **System-Centered**
  - The priorities of the system and those who work within it drive the delivery of health care.

- **Patient-Focused**
  - The patient is the focus or unit of care. Interventions are done to and for him/her, instead of with the patient. The patient is not seen within the context of family or community.

So What?
Applications & Implications

What Patients Want – Process: Patients Involved

- **Patients need to prepare for appointments**
- **Ways patients can participate:**
  - Medical lists
  - Medical history
  - List of questions
- **Providers can set expectations for patients**
- **The provider community is helping**
- **Ask for advice**
  - PFAC and other councils

So What?
Applications & Implications

What Patients Want – Communication: Patients Invited

Washington State Department of Health

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You and Your Family | Community and Environment | Licenses, Permits and Certificates | Data and Statistical Reports | Emergencies | For Public Health and Healthcare Providers

Home ▸ Licenses, Permits and Certificates ▸ Medical Commission

Print

- Birth, Death, Marriage and Divorce
- Facilities - New, Renew or Update
- File Complaint About Provider or Facility
- Medical Commission
  - Medical Licensing
  - Practitioner Regulation
  - Medical Resources
  - Commission Information
- Nursing Commission
- Professions - New, Renew or Update
- Provider Credential Search

Medical Commission

Join our ListServ

- Commission Newsletters
- Legal Actions
- Minutes and Agendas
- Rules

Update! Medical Commission Newsletter

Current Newsletter (PDF)

We Can Help You:

- File a Complaint
- About Us (PDF) and Contact Us
- Renew Your License or Verify Your License
- Change Your Contact Information
- View an MD or PA License
- Medical Marijuana Information
- Public Records

Current Topics

- Physician Assistant Rule Making
- Practitioner Regulation
- October Educational Conference
- 2013-2014 Flu Season Provider Resources
- Pain Management Resources
- Office-Based Surgery Rules
- More on our Current Topics Page

So What?
Applications & Implications

What Patients Want – Trust: Patients Included

- **Communication and Resolution Program (CRP)**
  - Managed by HealthPact (Foundation for Health Care Quality)
  - Based on just culture approach
  - Goals
    - *Ensure that patient/families harmed by healthcare have needs met
    - *Promote learning within and across providers/institutions to prevent reoccurrence
  - Creates transparent and accountable system
    - *(Re)Builds trust

So What?
Applications & Implications

- The best resolution is to have no issues (we all know this)
- However, there will always be unexpected outcomes
- How might a difficult situation turn out differently if there was trust in the relationship?
- The impact on the Commission could be significant

And Now!
Something Completely Different

70,000 - 440,000
deaths due to med. errors

1/3
hosp. patients harmed during stay

2.8
trillion spent on healthcare

30
% of amount wasted

177
billion treading medication problems

10 - 40
wrong site surgeries/week

60
% benefit from aspirin but no advice

1/2
adults with chronic disease

3
% invested in prevent

Few Closing Remarks

Q&A

What do you want to know about patients and families in the system?

We will be here through lunch to address additional questions OR contact us for a consultation

Bonnie Bizzell bizzellb@gmail.com

Steve Lovell selovell01@gmail.com

http://pfacqualityhealth.wix.com/pfac

References

Slides 2 & 12

American Public Health Association (a non-profit organization). (2014). Prevention and Public Health Fund. Retrieved from http://www.apha.org/advocacy/Health+Reform/PH+Fund/.

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Centers for Disease Control and Prevention. (2009, December 17). Chronic diseases the power to prevent, the call to control: At a glance 2009. Retrieved from http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm.

Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (n/d). NHE tables. Retrieved fromhttp://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

Classen, D. C., Resar, R., Griffin, F., Federico, F., Frankel, T., Kimmel, N., ... & James, B. C. (2011). 'Global trigger tool' shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs*, *30*(4), 581-589.

Cobb, T. K. (2012). Wrong site surgery—where are we and what is the next step?. *Hand*, *7*(2), 229-232.

James, J. T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of patient safety*, *9*(3), 122-128.

McGinnis, M. MD; MPP. (2014, August 8). Networking, learning, and evidence: Strengthening the foundation for progress. *The 6th International Conference on Patient- and Family-Centered Care: Partnerships for Quality and Safety.* Lecture conducted from Institute for Patient- and Family-Centered Care, Vancouver, BC, Canada.

Munro, D. (2014, February 2). Annual U.S. healthcare spending hits $3.8 trillion. *Forbes.* Retrieved from http://www.forbes.com/sites/danmunro/2014/02/02/annual-u-s-healthcare-spending-hits-3-8-trillion/.

Slides 7 & 8

Adapted from: Schwab, B. MD. (2014, March 31). Recognizing patient- and family-centered care. *Moving Forward with Patient- and Family-Centered Care: Partnerships for Quality and Safety.* Lecture conducted from Institute for Family- and Patient-Centered Care, Burlingame, CA.

Bonnie Bizzell
Stephen Lovell
Foundation for Health Care Quality
Patient & Family Advisory Council
October 1, 2014

Thank you!

(RE)FOCUS on SAFETY

Incorporating the Patient's Perspective for Better Patient Safety

Communication and Resolution Programs: Policy Goals and Legal Issues

William M. Sage, MD, JD
The University of Texas at Austin

THE UNIVERSITY OF TEXAS SCHOOL OF LAW

The Real Malpractice Problem

Little Connection Between the Malpractice System and the Health Care System!

How Medical Liability Affects Cost/Access/Quality of Care

- Two-sided mismatch between negligence and litigation
  - Not only unjustified lawsuits, but also
  - Uncompensated injuries
  - High rates of avoidable error
- Poor process
  - Restricted information
  - Limited non-monetary remedies
  - Extreme delay
  - Lack of quality feedback to providers
- Misdirected focus on individual physicians rather than “systems”
  - Fear of harm to reputation
  - Financial stress over insurability
  - Defensive assurance: costly over-testing and overtreatment
  - Defensive avoidance: refusing “risky” (sick or litigious) patients

Why Isn't Malpractice Policy Part of Health Policy?

- Doctors and Lawyers
  - Longstanding professional conflict
  - Unfinished battles for professional leaders
  - Paradox of public accountability in self-regulated profession ("holding experts accountable to non-experts")
- Government Structure
  - Judicial rather than legislative issue
  - Tenuous connection to state regulatory oversight
  - Minimal federal presence (Medicare and Medicaid not engaged)
- Politics
  - Specialized lobbying on both sides
  - Poster child for/against general business "tort reform"
- Periodicity and bias
  - "Crises" of mid-1970s, mid-1980s, early 2000s
  - Defined by availability/affordability of physicians' malpractice insurance

Malpractice Crises May End, But Improvement Shouldn't

"All bleeding stops."
- Surgical adage

- Crises are definitional
- Premiums may fall
- Lawsuits may drop

<u>BUT</u>

- Errors remain high
- Compensation is poor
- Process is miserable
- Change is possible

Guiding Principles for Malpractice Reform

- Think big: Do more than tinker with the legal system.
- Start small: Start with demonstration projects in the right places and with the right health care providers.
- Stay focused: Better health care is the goal, not more or fewer trial lawyers.

Communication and Resolution Programs

- Tell patients what happened
- Try to put things right
- Improve safety for the future
- Empower and support caregivers

What Do Patients Want?

- The truth
  - Did something happen?
- The facts
  - What was it?
- Emotional first aid
  - Empathy and compassion
  - Recognition and validation of emotions
  - Non-abandonment (a process, not an event)
- Accountability, including apology
- Future prevention
- Remediation

What Does the Ideal CRP Event Look Like?

- Early event reporting by provider
- Careful analysis by institution-was unanticipated outcome caused by medical error? If so, how can recurrences be prevented?
- Prompt, compassionate disclosure to patient
- Fast, fair resolution for patient
- Learning at individual and institutional level

Key Attributes of CRPs

1. Closer to the bedside
2. Farther from the courtroom
3. Based on teams and institutions

<u>Therefore</u>,

- Relevant to ongoing care
- Focused on system improvement
- More compassionate
- Less adversarial
- Less costly

Established CRPs

- University of Michigan (Early settlement)
  - Claims half as likely, lawsuits 1/3 as likely
  - Time to resolution cut nearly in half
  - Reduced liability costs
- University of Illinois-Chicago (Seven Pillars)
  - Increase in patient safety event reporting from 1,500 to 7,500 per year
  - 50% reduction in new claims
  - Median time to resolution now 12 months compared with 55 months before program

“The Need for Speed”

Delayed resolution means:

- Insufficient information for patients and families
- Lack of safety improvement; feedback after litigation is usually irrelevant
- High administrative cost
- Slow compensation
- Emotional pain/adversarial stress
- Actuarial unpredictability for liability insurers

Legal Issues Can Intrude

CRPs convey an ethical and practical commitment from providers to patients, but can be constrained by:

- Litigation concerns
- Regulatory and economic complications

<u>These can also be barriers to patient participation</u>!

Litigation Issues

- Damage caps
- Pre-suit notification laws
- Sovereign and charitable immunities
- Apology protection laws
- Legal representation of claimants

Regulatory/Economic Issues

- State and federal reporting requirements
- Professional disciplinary response
- Medicare/private insurer subrogation or non-payment

Example: Washington State CRP Certification Proposal

- Important exclusions: Gross provider negligence, provider impairment, boundary violations
- Certification process based at Foundation for Healthcare Quality
- MQAC retains all current authority.
- All mandatory reporting requirements remain in effect
  - Responsibility of institution, insurer
- Process is voluntary, open to all Washington physicians
- CRP Certification group will not perform independent investigations

CRP Certification Review

- Case reviewed by multi-disciplinary group including patient advocate, risk/claims specialists, physician leaders, individual with regulatory experience.
  - Reviewers can not be affiliated with institution where event occurred
- Review addresses whether key elements of CRP were met
- Institutions/insurers can resolve CRP deficiencies and resubmit

Hypothetical CRP Certification Request

- Provider uses bedside ultrasound, misses DVT
- Patient has PE, hospitalization, lost income
- Institution uses CRP: reporting by provider, communication with patient, prevention plans
  - Provider passes ultrasound course
  - New institutional policy developed
- Financial resolution of $30K proactively provided to patient. Mandatory reporting to MQAC.

Hypothetical (continued)

- Institution submits case for CRP Certification review.
- Review group determine all key elements of CRP present. Certification report provided back to institution/insurer.
- Institution/insurer send Certification Report to MQAC
- MQAC reviews report. Closes case as satisfactorily resolved without additional investigation.
- MQAC may conduct additional investigation before determining if closure is appropriate.

"I'm afraid you've had a paradigm shift."

CRP Paradigm Shift

	Traditional Response	Open Accountability
Incident reporting by clinicians	Delayed, often absent	Immediate
Communication with patient, family	Deny/defend	Transparent, ongoing
Event analysis	Physician, nurse are root cause	Focus on Just Culture, system, human factors
Quality improvement	Provider training	Drive value through system solutions, disseminated learning
Financial resolution	Only if family prevails on a malpractice claim	Proactively address patient/family needs
Care for the caregivers	None	Offered immediately
Patient, family involvement	Little to none	Extensive and ongoing

Washington State Medical Commission

Educational Conference 2014

With

Augustus A. White, III, MD, PhD

Harvard Medical School

Wednesday, October 1, 2014

12:30 pm

Washington State Department of Health

What Dr. Martin Luther King, Jr. Would Want Us To Know About Health Care Disparities

by
Augustus A. White, III, MD, PhD

"Of all the forms of inequality, injustice in health is the most shocking and inhumane."

-Dr. Martin Luther King, Jr.

Source:

King, ML Jr., National Convention of the Medical Committee for Human Rights, Chicago IL, March 25, 1966.

The Health Disparities List

- African Americans
- Appalachian poor
- Asian-Americans
- Elderly

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Smedley B, Stith A, Nelson A. Washington, DC: The National Academies Press; 2003.

The Health Disparities List

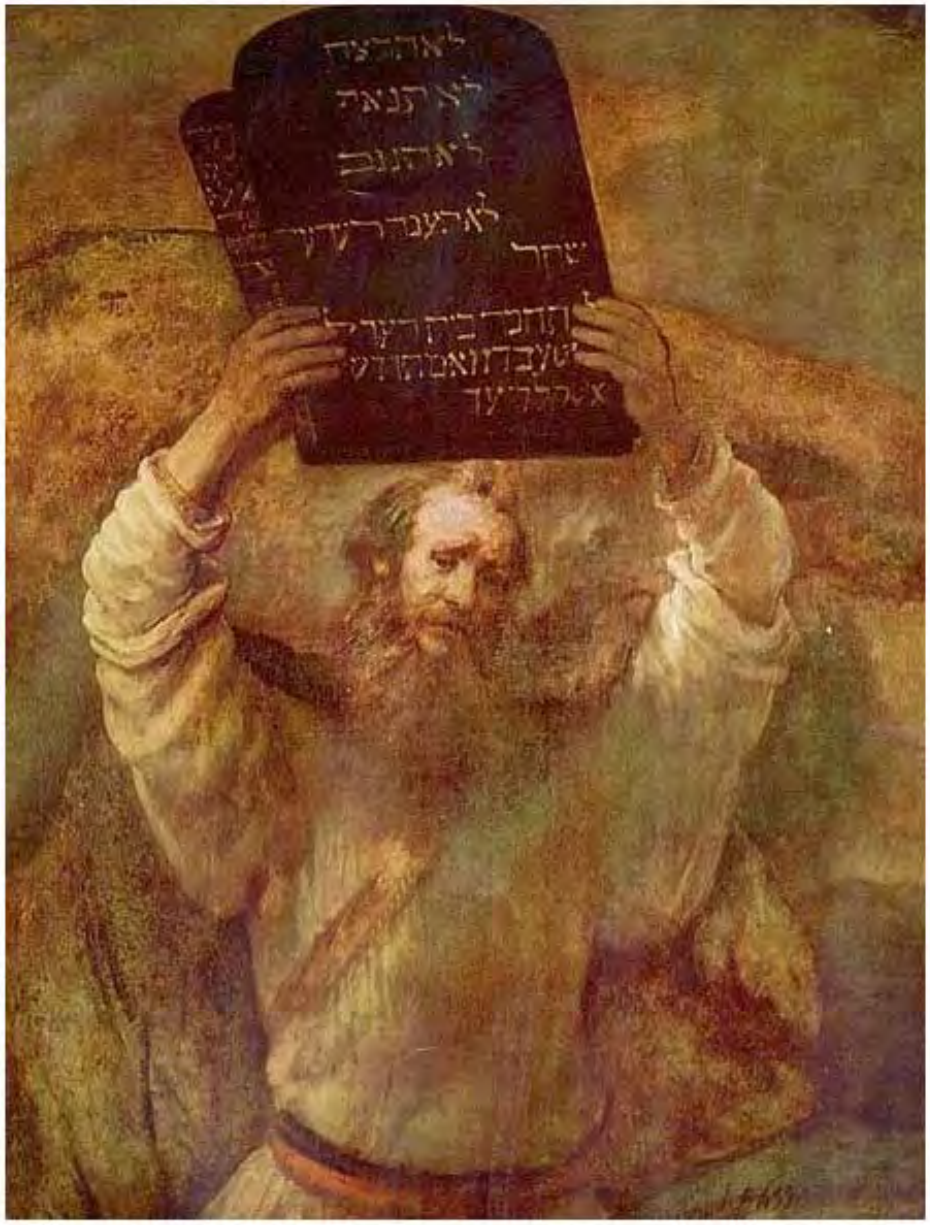
- Gays, Lesbians, Bisexuals, Transgendered (GLBT)
- Immigrants
- Latinos
- Native Americans

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Smedley B, Stith A, Nelson A. Washington, DC: The National Academies Press; 2003.

The Health Disparities List

- Over weight people
- People living with disabilities
- Some religious groups
- Women
- Prisoners

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Smedley B, Stith A, Nelson A. Washington, DC: The National Academies Press; 2003.



Artist: Rembrandt (1659) Source: Wikipedia

Challenging the "-isms"

- Ageism
- Sexism
- Racism
- Classism
- Ableism
- Xenophobia
- Ethnocentrism
- Heterosexism

African Americans

- Fewer kidney and liver transplants
- With diabetes, more amputations
- With prostate cancer, more castrations

Among All Women vs. Men

- Fewer joint replacements
- Less medication following heart attack
- Women heart attack patients, more EMT time to the hospital

For Hispanics

- Less pain medication for major fractures
- Less bypass surgery for heart disease
- Less basic recommended services, such as flu vaccines

Pittsburgh Post-Gazette, 1999

Lesbian

Pittsburgh Post-Gazette, 1999

Lesbian

Over weight

Pittsburgh Post-Gazette, 1999

Lesbian

Over weight

Pittsburgh Post-Gazette, 1999

Disabled

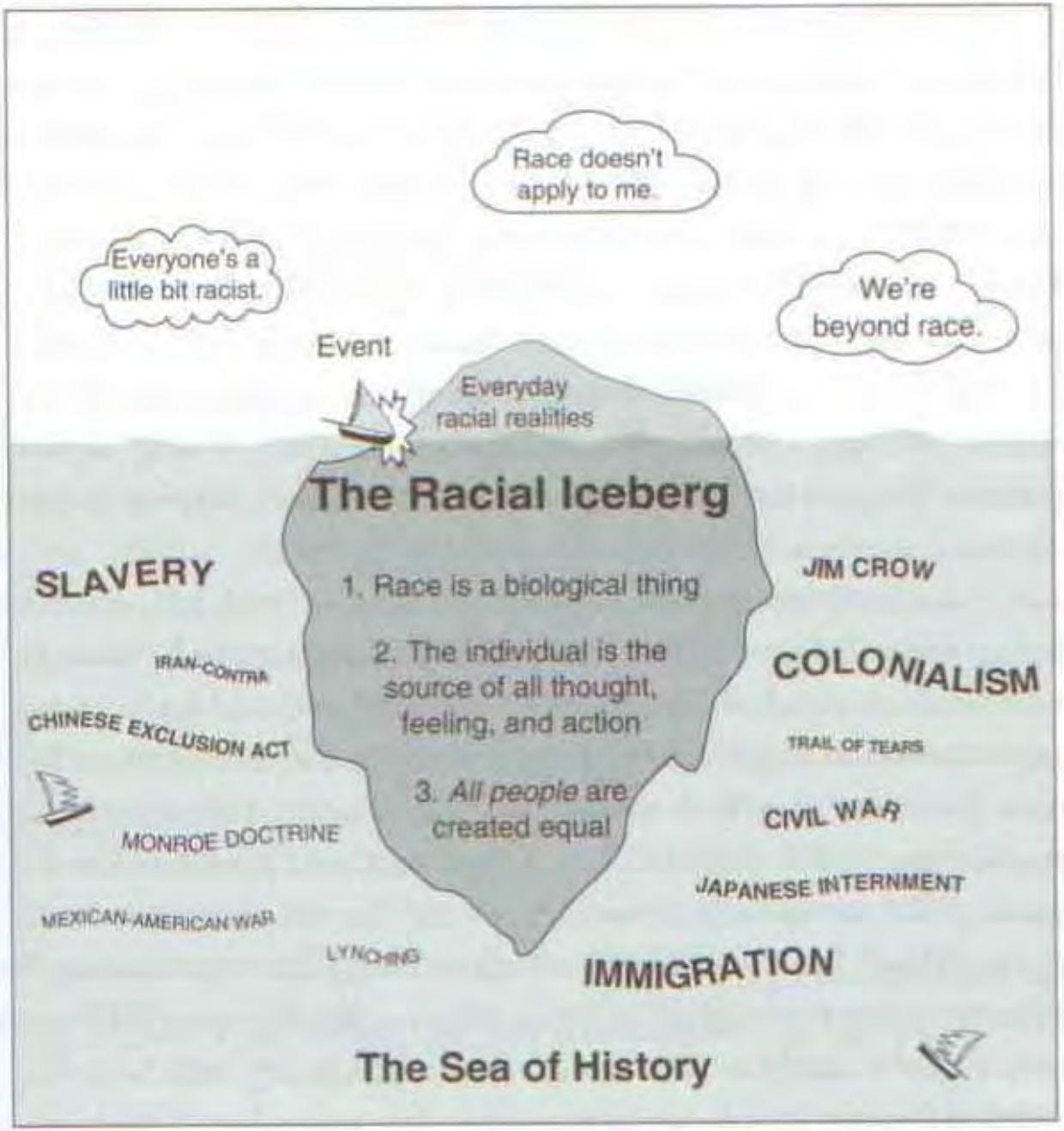
Lesbian

Over weight

Pittsburgh Post-Gazette, 1999

Disabled

Elderly


Race doesn't apply to me.
Everyone's a little bit racist.
We're beyond race.
Event
Everyday racial realities
The Racial Iceberg
1. Race is a biological thing
2. The individual is the source of all thought, feeling, and action
3. *All people* are created equal
SLAVERY
IRAN-CONTRA
CHINESE EXCLUSION ACT
MONROE DOCTRINE
MEXICAN-AMERICAN WAR
LYNCHING
JIM CROW
COLONIALISM
TRAIL OF TEARS
CIVIL WAR
JAPANESE INTERNMENT
IMMIGRATION
The Sea of History

Definition of Race

Race is a doing – a dynamic set of historically derived and institutionalized ideas and practices that…

Doing Race, Markus and Moya, 2010.

Definition of Race

…sorts people into ethnic groups according to perceived physical and behavioral human characteristics that are often imagined to be negative, innate, and shared.

Doing Race, Markus and Moya, 2010.

Definition of Race

…associates differential value, power, and privilege with these characteristics; establishes a hierarchy among the different groups; and confers opportunity accordingly.

Doing Race, Markus and Moya, 2010.

"Doing Race"

Employment

Housing

Schooling

Medicine

"Doing Race"

Justice

Sports

Media

- Stereotyping
- Unconscious Bias
- Conscious Bias

Mahzarin Banaji

Implicit Association Test
https://implicit.harvard.edu

Alex Green Study

"… physicians' unconscious biases may contribute to racial/ethnic disparities in use of medical procedures …"

- *Journal of General Internal Medicine* 22 (2007): 1231.

The Economic Burden of Health Inequalities in the United States

by
Thomas A. LaVeist, PhD
Darrell J. Gaskin, PhD
Patrick Richard, PhD

September 2009

Source: Joint Center for Political and Economic Studies

http://www.jointcenter.org

Disparate Care is more costly than Regular Care

2003 – 2006 Excess Costs of

30.6%

for

- African Americans
- Asians
- Hispanics

Doctor Stressors

- Error prevention
- Malpractice: 10% of careers fighting claims
- Sleep deprivation
- Surgeons: 40% burnout, 30% depression, 15% alcohol abuse

Doctor Stressors

Violence in health facilities are FOUR TIMES as common as in other private sector industries.

- JAMA, Dec 2010

Doctor Stressors

AMA states impending "storm of regulations" will hurt physicians

OH!

And by the way,

You're a Racist.

Getting to Equal: Strategies to Understand and Eliminate General and Orthopaedic Healthcare Disparities

by Daryll C. Dykes MD, PhD and
Augustus A. White, III MD, PhD

Clinical Orthopaedics and Related Research,
467: 2598-2605, 2009.

Over 100 solutions

- Improve Health Literacy!!!
- Educate Caregivers
- Increase Diversity of Caregivers
- Educate Patients

UC Davis Medical School

Affirmative vs. Routine

Graduation Rate

94% vs. 97%

- Davidson and Lewis, JAMA, Oct 1997

Affirmative vs. Routine

- Specialization rates
- Residency performance
- Honors received

} Equal

- Davidson and Lewis, JAMA, Oct 1997

Over 100 solutions

Expand Mandates like in New Jersey →

Must Have Culturally Competent Care Education to get or to renew license

Over 100 solutions

Verizon

Works to Eliminate Disparities in Health Care for its Workforce

Health Affairs (Millwood) 2005; 24: 21 – 423.

Over 100 solutions

Thoroughly Address
ACGME Cultural
Competency
Requirements of Residents

Over 100 solutions

Thoroughly Address LCME Directives 21 and 22 for Culturally Competent Care Education of Medical Students

Over 100 solutions

National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)

March 2001

Source: U.S. Department of Health and Human Services, OPHS Office of Minority Health

http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf

Over 100 solutions

"A-once-in-Human-History opportunity…"

Campaign to end health disparities by 2035.

- Professor Lawrence Summers, et.al.

Global Health 2035: a world converging within a generation.

The Lancet, 382 (9908), 1898-1955, 7 Dec 2013

Published online 3 Dec 2013

Over 100 solutions

A new report proposes doubling research and development spending, a heightened priority on family planning, and increased taxes on harmful substances such as tobacco, alcohol, and even sugar as part of an effort to eliminate health disparities between rich and poor nations.

- Professor Lawrence Summers

Global Health 2035: a world converging within a generation.

The Lancet, 382 (9908), 1898-1955, 7 Dec 2013

Published online 3 Dec 2013

Over 100 solutions

Needed by 2020

45,000 Primary Care
46,000 Specialists

MUST "harvest" more minorities!

SOURCE: 12/30/13 article on The Pew Charitable Trusts website states that The Association of American Medical Colleges (AAMC) provided these estimates.
http://www.pewstates.org/projects/stateline/headlines/are-there-enough-doctors-for-the-newly-insured-85899528912#

Over 100 solutions

Research shows that implicit biases are malleable

- Don't reinforce negative stereotypes
- Learn about people who contradict negative stereotypes

Howard J. Ross

Reinventing Diversity: Transforming Organizational Community to Strengthen People, Purpose and Performance.

Rowman & Littlefield Publishers, 2011.

Over 100 solutions

November 2010 Google Scholar Article hits

Keywords:

Minority Health	1,140,000
Cultural Competence	552,000

Source:
Like RC. Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions* 2011; 31(3):196-206.
http://www.ncbi.nlm.nih.gov/pubmed/21953661

Over 100 solutions

November 2010 Google Scholar Article hits

Keywords:

Health Care Disparities	438,000
Health Disparities	245,000

Source:
Like RC. Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions* 2011; 31(3):196-206.
http://www.ncbi.nlm.nih.gov/pubmed/21953661

Source:
https://plus.google.com/+nike/videos

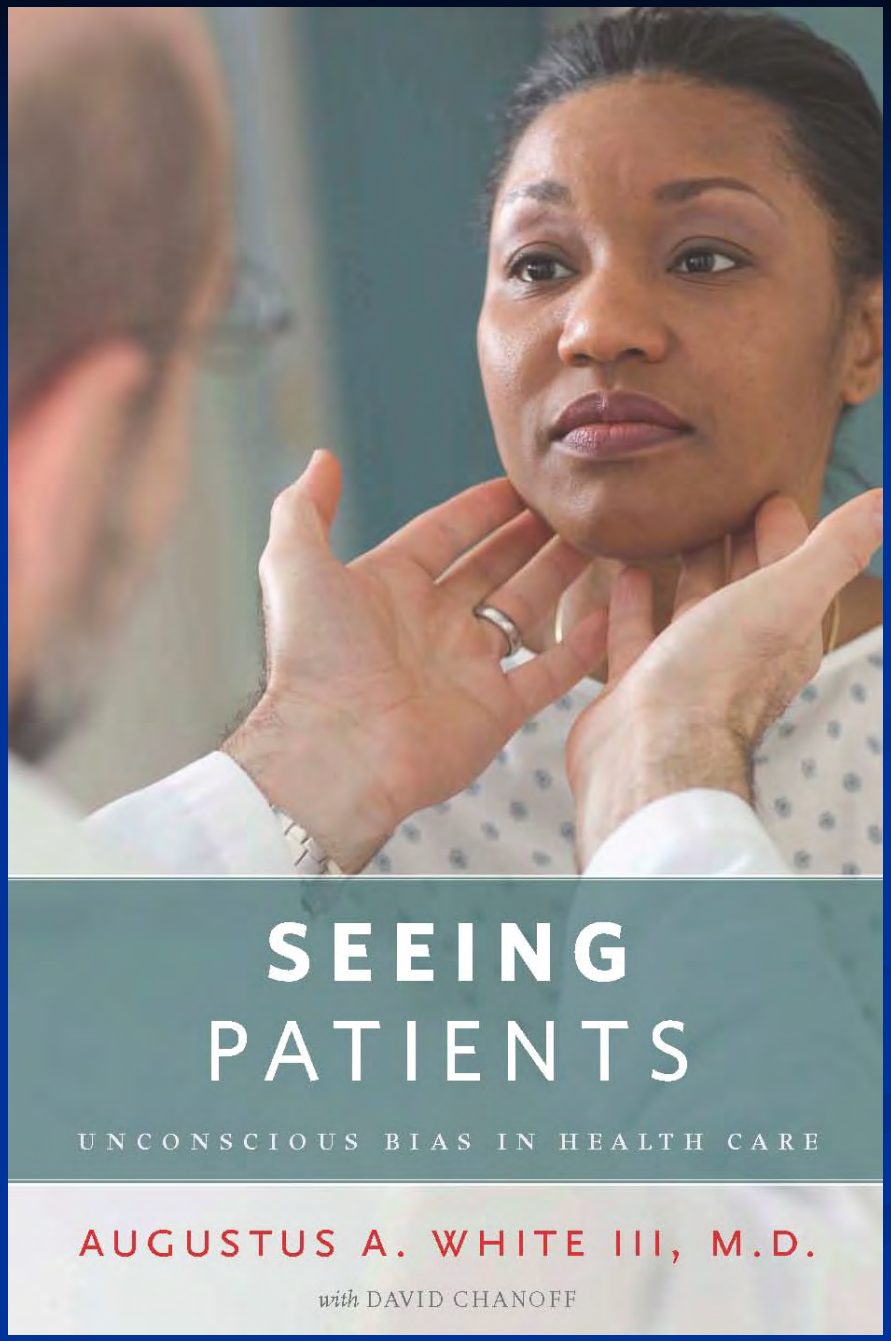
Culturally Competent Care Pedagogy: What Works?

by Daryll C. Dykes MD, PhD and
Augustus A. White, III MD, PhD
Clinical Orthopaedics and Related Research,
469: 1813-1816, 2011.

Distrustful

Suspicious

Anxious



Hostile

Frightened

Suggestions for Caregivers

- Believe Biases Exist
- Believe Disparities can be diminished
- Review and Select from CLAS

http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf

Suggestions for Caregivers

- Double F Criterion –

  Treat as Family or Friend

- Use "Teach Back" to help communications

- "Humanize" Our Patients

Suggestions for Patients

- "Humanize" Your Doctor
- Build Bridge and
  Meet Doctor "Half Way"
- Not working? Do a Frank Check.

Suggestions for Patients

- Study your Disease!!!

  MayoClinic.com Web MD

- Do a Teach Back with Your Doctor

- Take a Friend or Relative with You

Summary

- Formidable national problem
- Moral ethical problem
- We must improve!

Summary

- Unconscionable reality
- Shocking and inhumane
- The "11th" Commandment

Summary

Synergize
Solidify
Seize upon
Supplicate

} Our common humanity

Rev. Dr. Martin Luther King, Jr. (Inspiration)

I believe Dr. King would want us to continue to strive to be a more humane society and for doctors, nurses, and others to strive to be humanitarian role models.

SPHERE

OF

INFLUENCE

Be Well!

Respectfully submitted.

Acknowledgements

- Dr. Mark Bernhardt
- Beth Israel Deaconess Medical Center, Department of Orthopaedic Surgery
- Blue Cross Blue Shield of Massachusetts
- Rodger and Gloria F. Daniels Charitable Foundation (Richard J. Hindlian, Co-Trustee)
- J. Robert Gladden Orthopaedic Society
- Arthur and Barbara Higgins Charitable Foundation
- The Macy Foundation
- Massachusetts General Hospital, Department of Orthopaedic Surgery
- McKesson Foundation
- Macey Russell
- Zimmer Holdings Inc.

Building a Better Professional

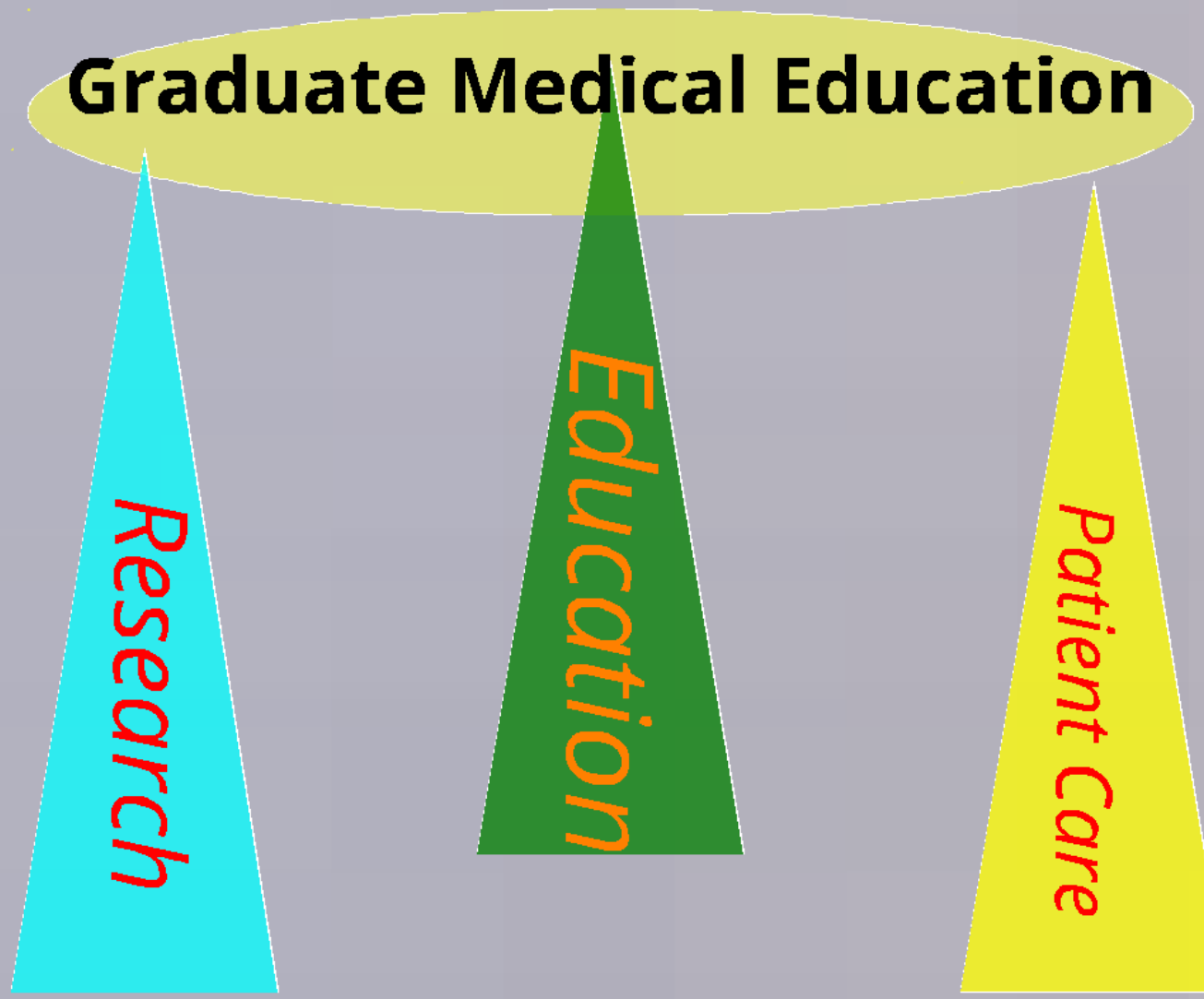
Iconoclasts & Idiosyncrasies
Dealing with Conflicts

Byron D. Joyner, MD, MPA
Vice Dean for GME and
Designated Institutional Official

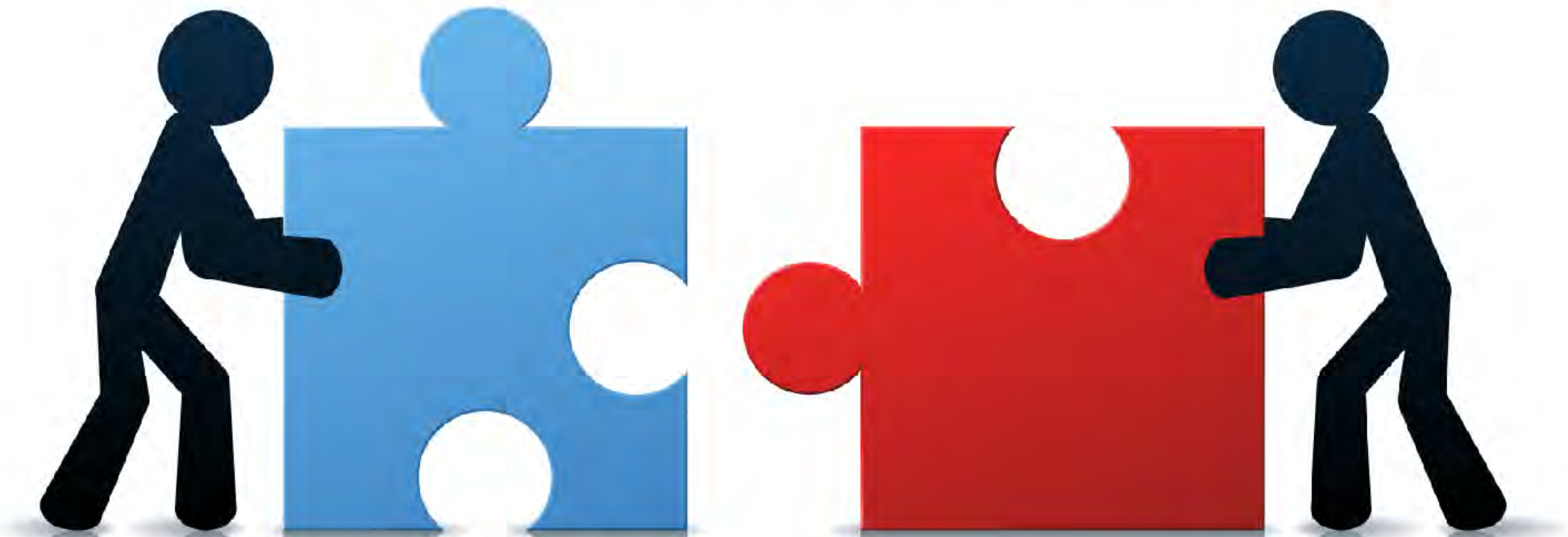
October 1, 2014

Standardization in GME

The GME Balance



Flexnerian Standards



"When a residency is set up with proper education standards, it is the most effective, economical and satisfactory method for obtaining this training."

Flexner Report, 1910

Professional

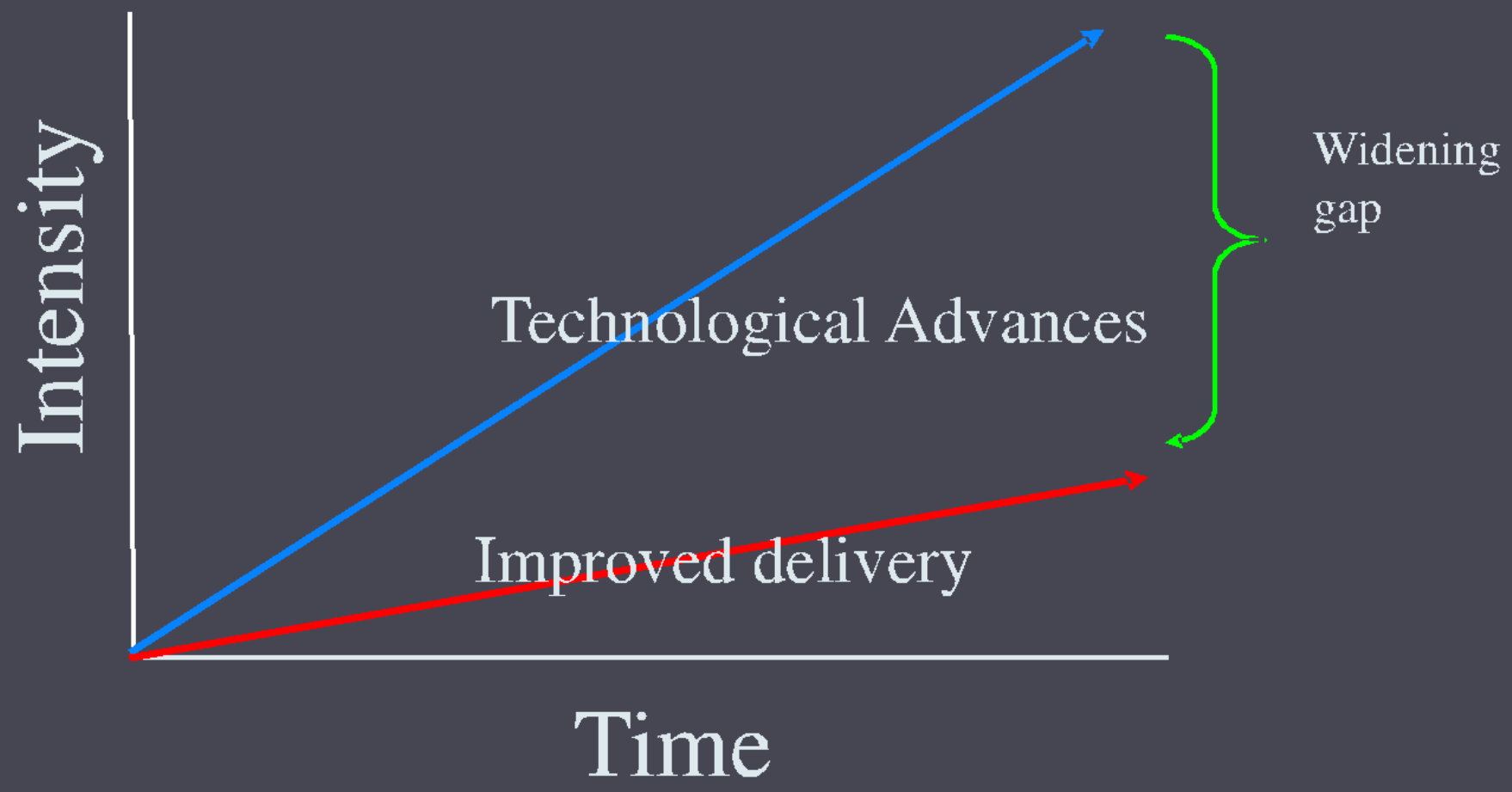
1. Esoteric knowledge and skills
2. Service and altruism
3. Financial reward is not a metric of success
4. Self-reflection ➔ Self-regulation

Supreme Court Justice Louis Brandeis, 1912

1. Esoteric knowledge and skills
2. Service and altruism
3. Financial reward is not a metric of success
4. Self-reflection ➜ Self-regulation

Supreme Court Justice Louis Brandeis, 1912

Crossing the Quality Chasm



Institute of Medicine, 2001

nt

ACGME Mission

To improve healthcare by assessing and advancing the quality of resident physicians' education through accreditation

The Clinical Learning Environment

ACGME Mission

To improve healthcare by assessing and advancing the quality of resident physicians' education through accreditation


Quality Improvement
Transitions in Care
Professionalism
Patient Safety
Duty Hours
Supervision

Professionalism

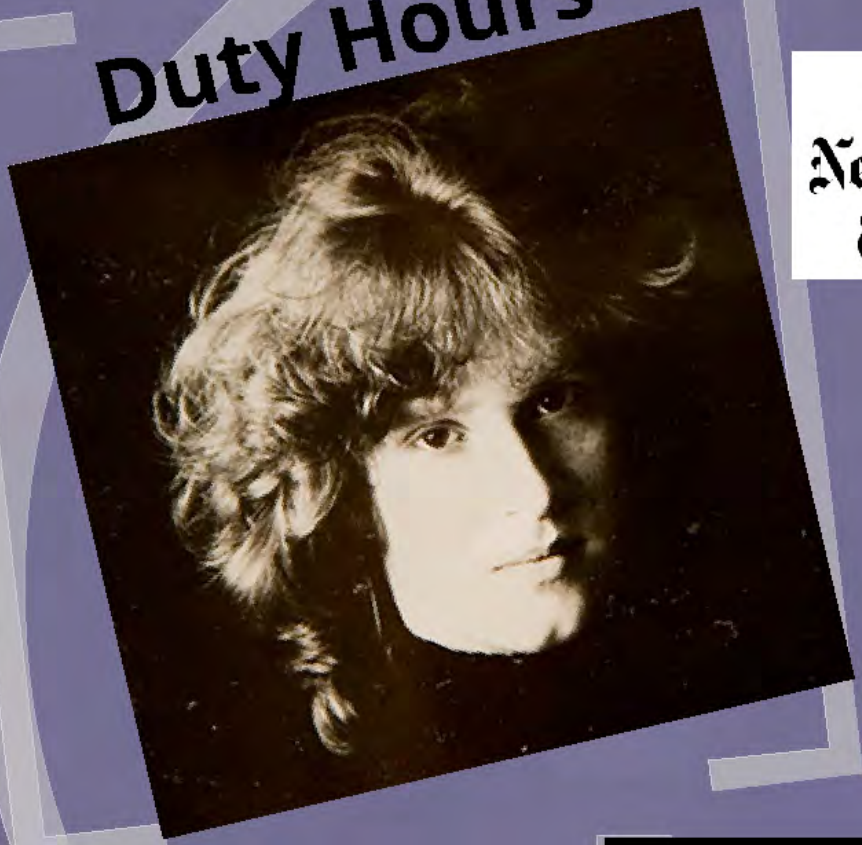
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

ACGME Outcomes Project, 2001

A Framework for Professionalism

Measuring Medical Professionalism, *Arnold and Stern, 2005*

Duty Hours



The New York Times

The NEW ENGLAND JOURNAL of MEDICINE

Fragmented Care

Decreased

Relationships
Training of all residents
"ownership"

Increased

Anxiety and stress
Culture of shiftwork
Culture of multitd

Fragmented Care

Decreased

Relationships
Training of all residents
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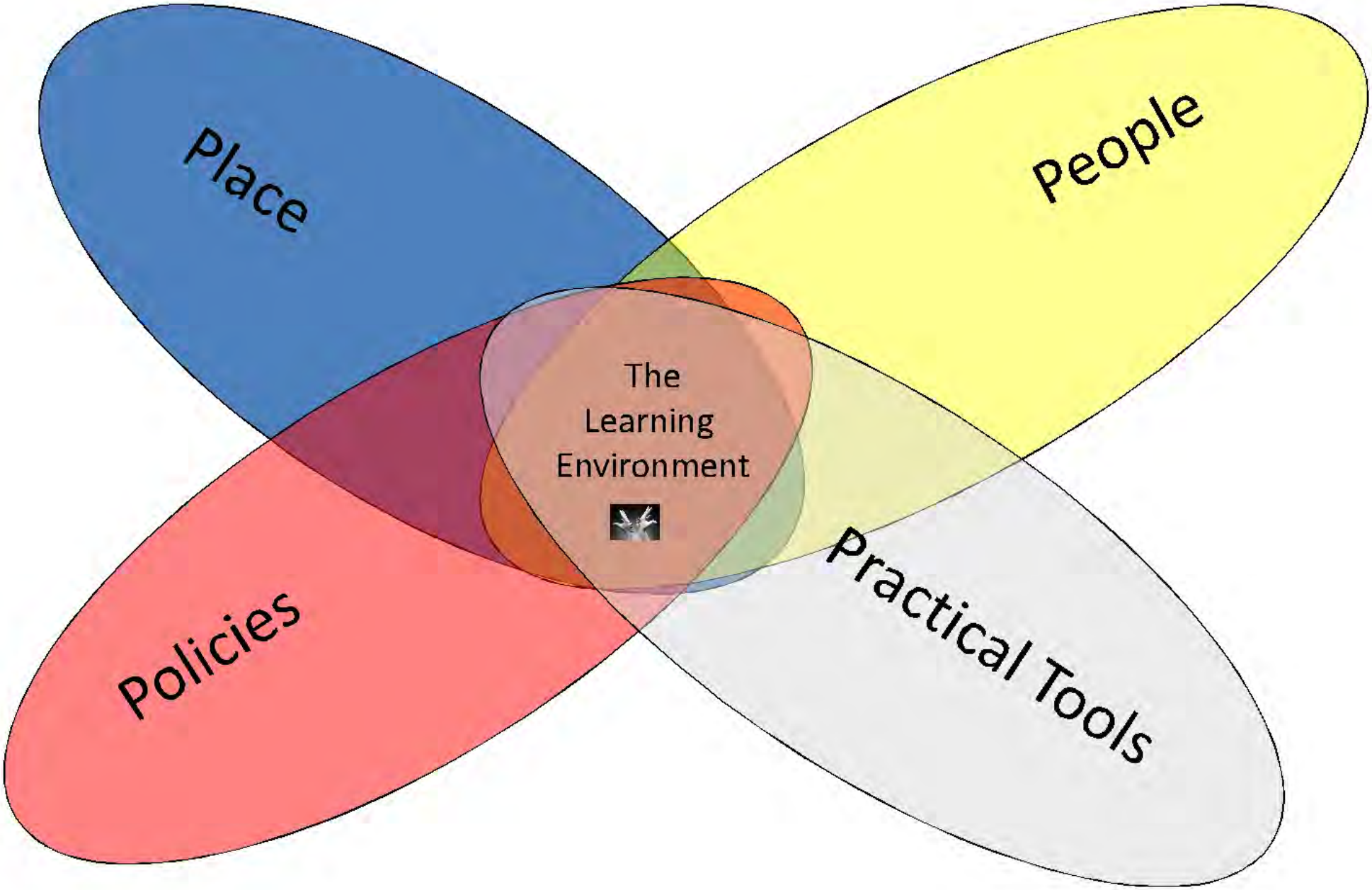
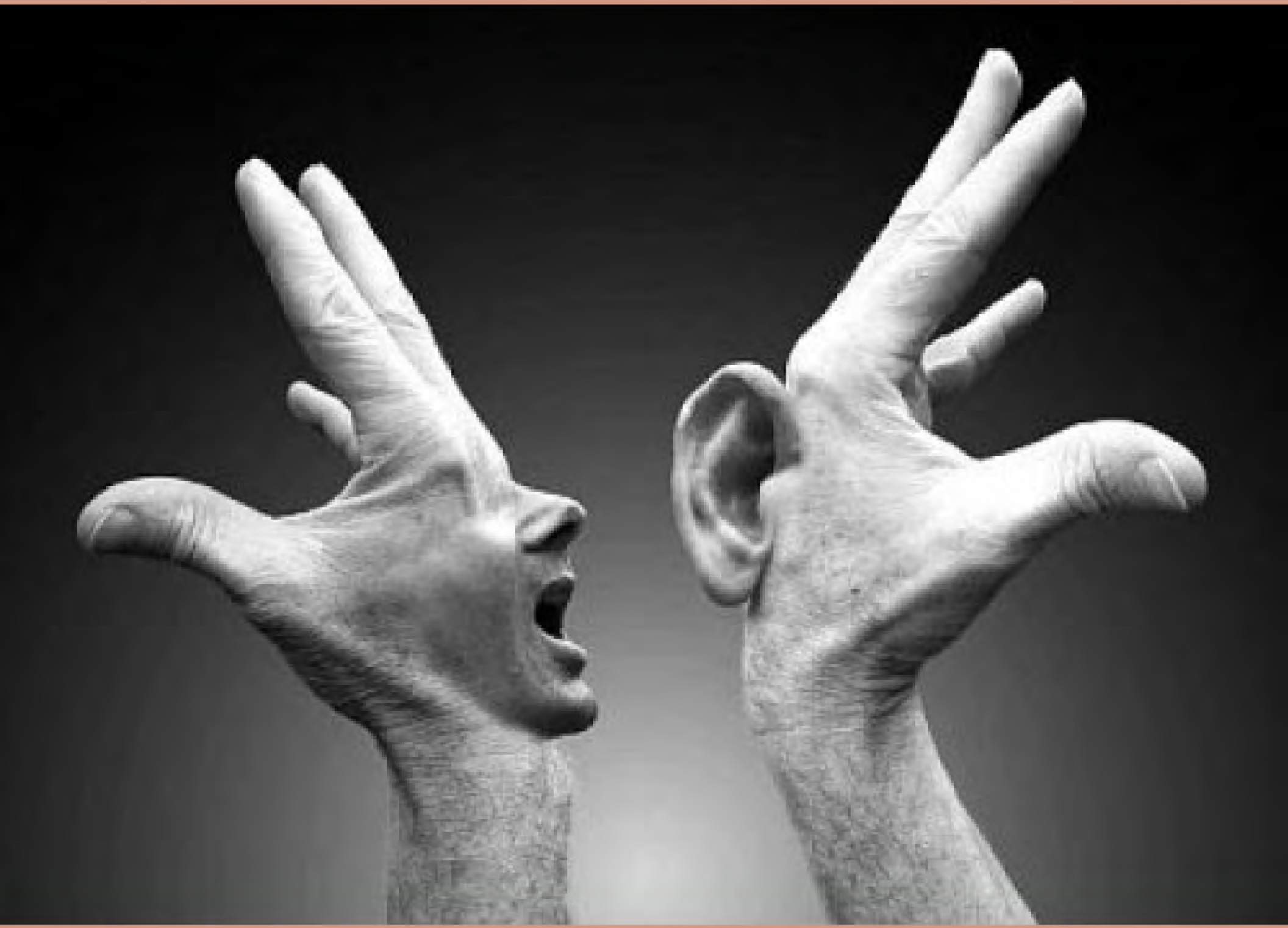
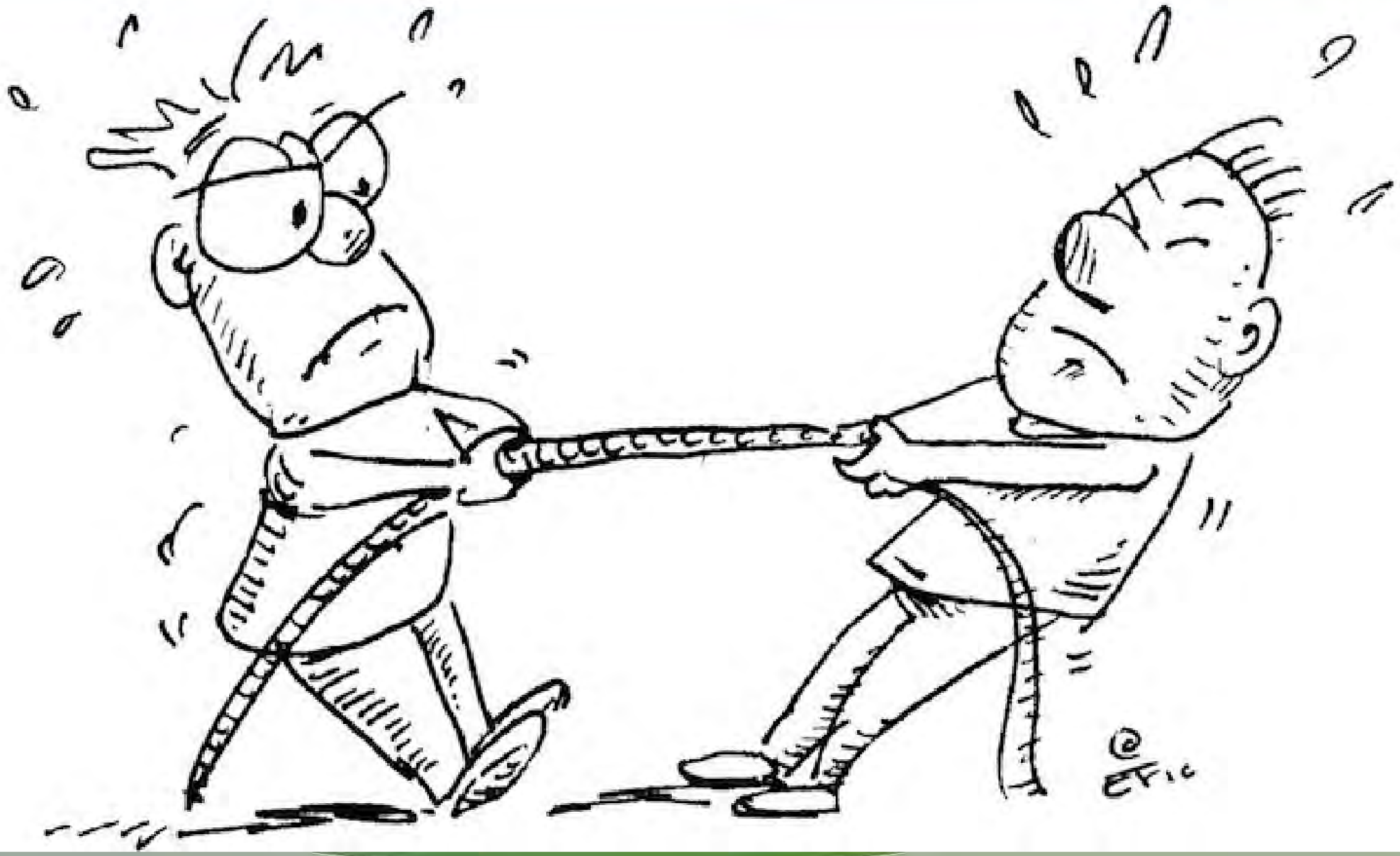
Increased

Anxiety and stress
Culture of shift work
Culture of conflict

Clinical Learning Environment





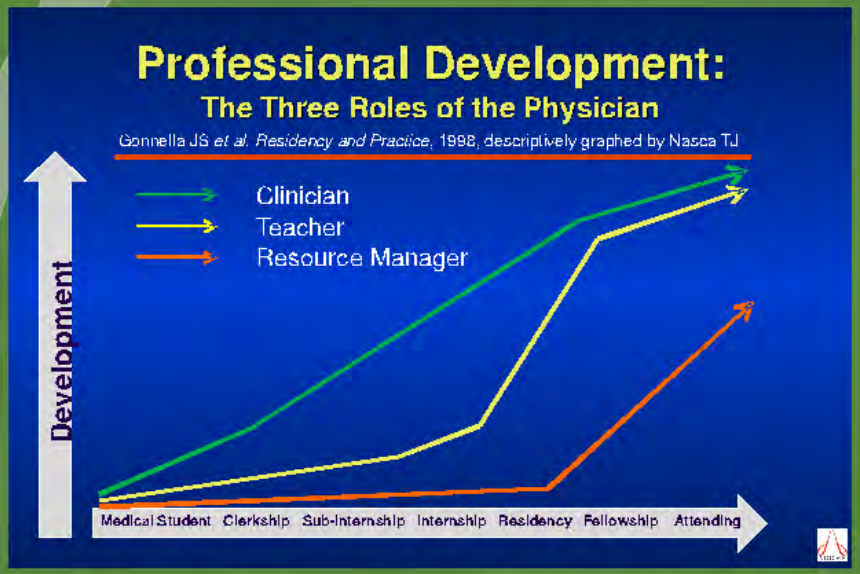



75%
of the 2025
workforce
more
MBAs
than no
degree
$2bn
US spending
power
30%
25-34s living
with family
36%
have a tattoo
flywheel

It is far harder to fathom the problem in its entirety than to criticize the specifics about the problem

~Kenneth Ludmerer

Adragogy



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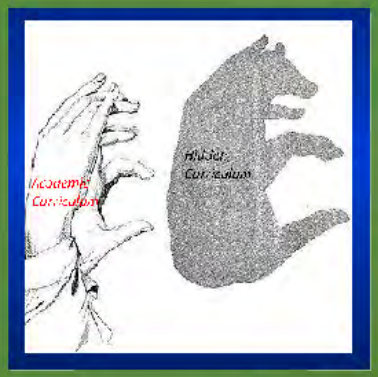
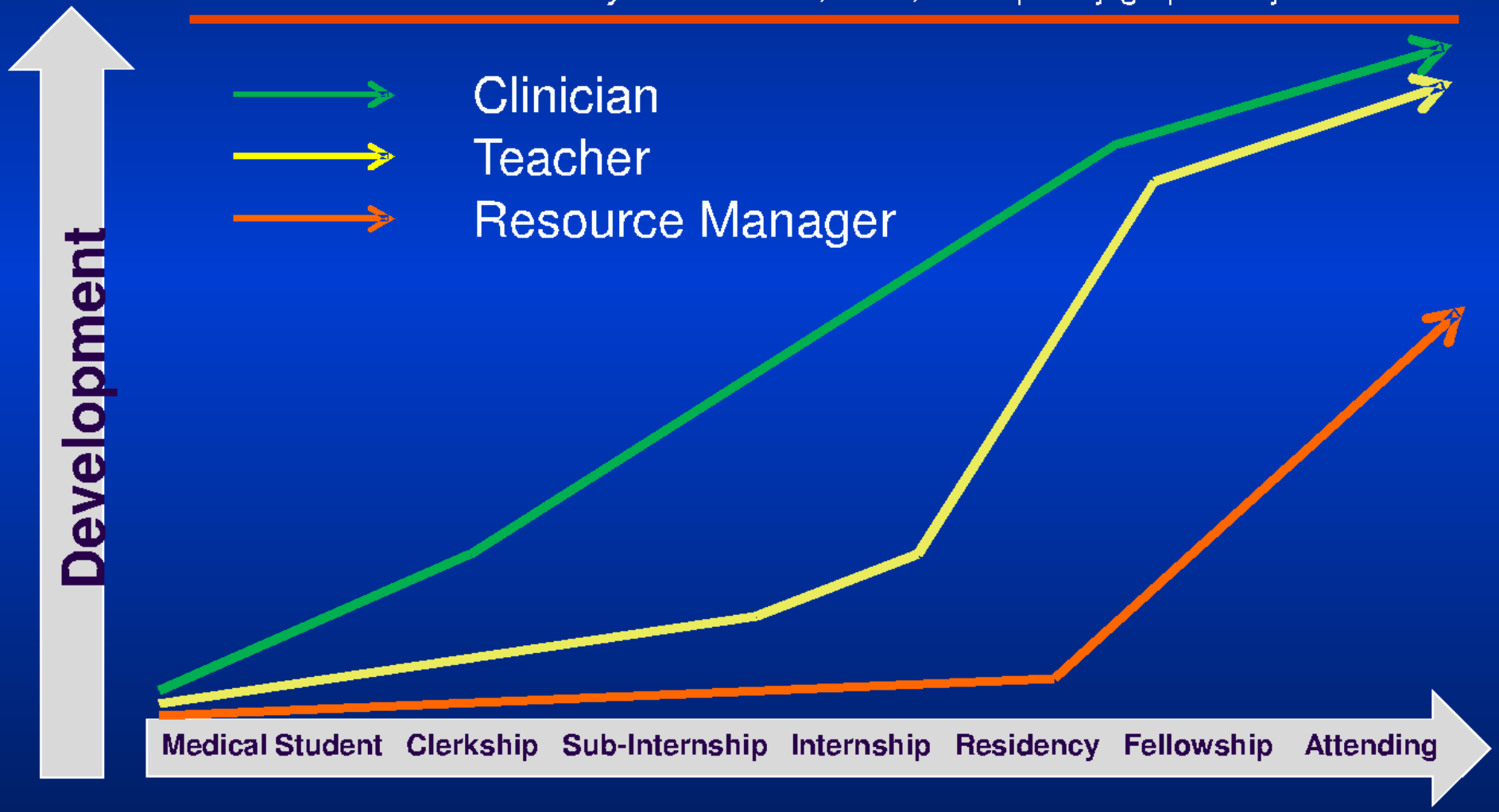


[redacted]

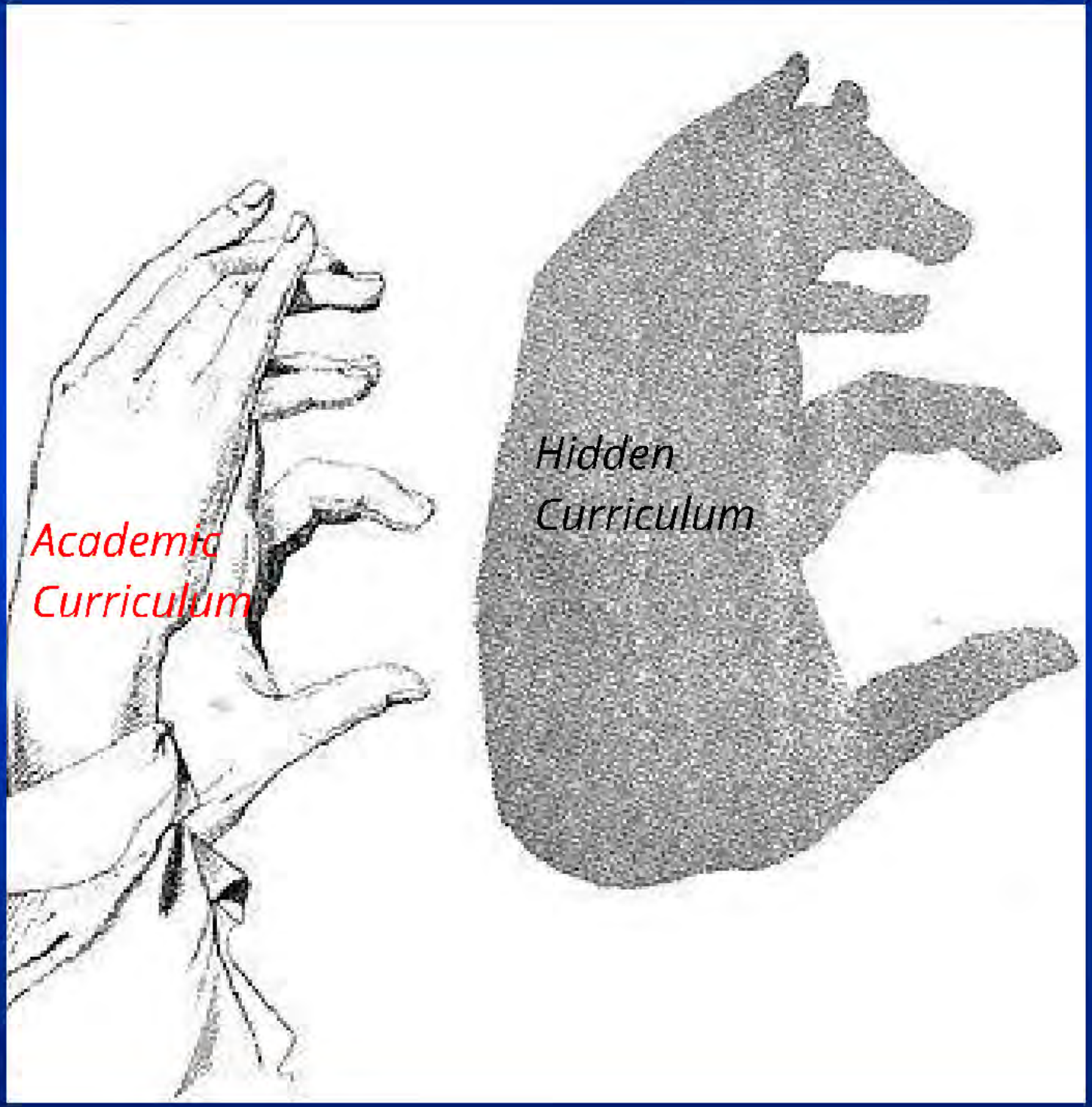
Professional Development:

The Three Roles of the Physician

Gonnella JS *et al. Residency and Practice*, 1998, descriptively graphed by Nasca TJ



Supervision


Academic
Curriculum
Hidden
Curriculum

CRISIS

危 机

Danger Opportunity

SUCCESS

Challenges:

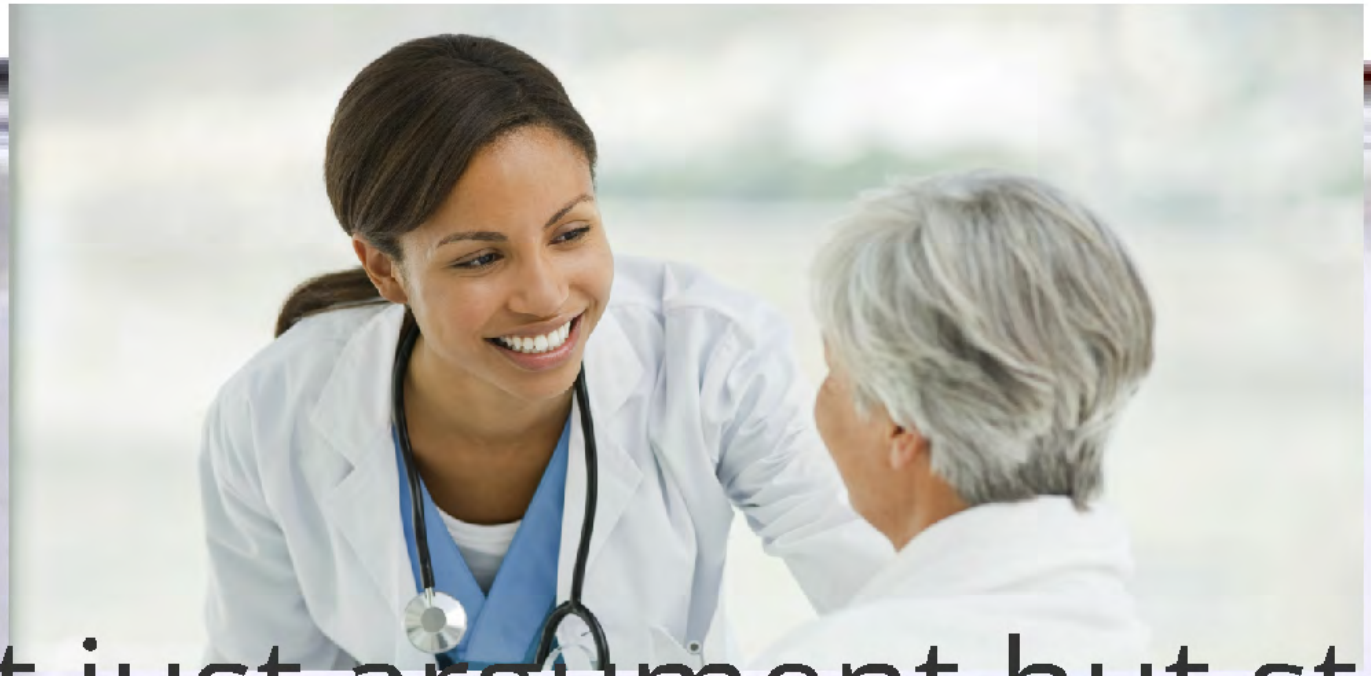
1) Look, Listen and Learn
2) Patient quality and safety
3) Learner centeredness
4) Einstellung Effect

Professionalism

Appealing to the 6 Senses

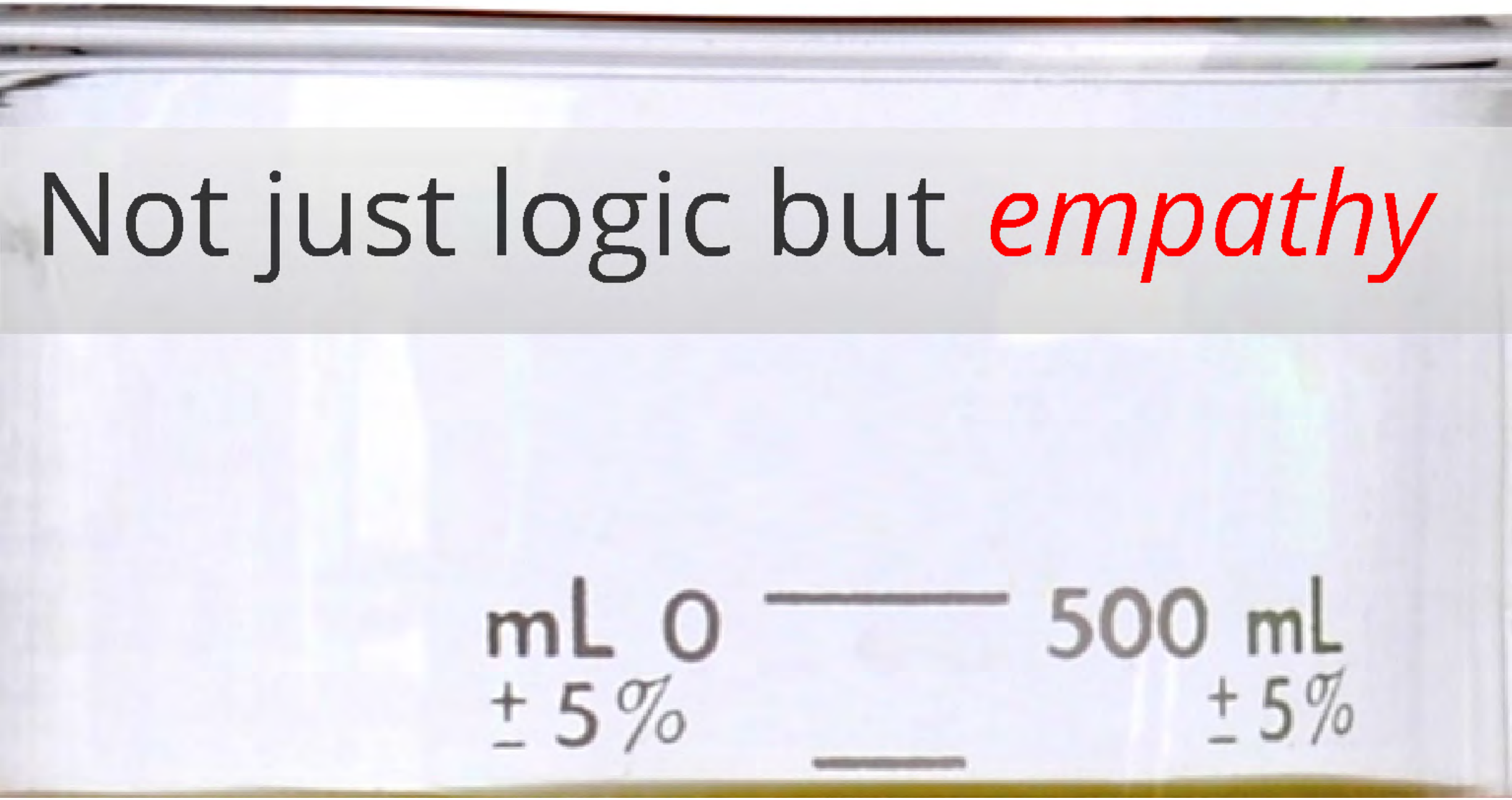
Daniel Pink, A Whole New Mind: Moving from the Information Age to the Conceptual Age

Not just function but design



Not just argument but story

Not just logic but *empathy*




Not just focus but symphony


Not just accumulation but meaning
DATA
INTO
MEAN
ING

Not just seriousness but fun

How We Learn


Experience
Processing with others
Learning by observing
Self-Reflection
Standardization/
Individualization

SO, WHAT IF SIR WILLIAM OSLER HAD TWEETED?

The practice of medicine is an art, not a trade, a calling not a business; a business in which your heart will be exercised equally with your head.

Intentionality

apoTHEOSIS

Trial & Error

antiTHESIS

Professionalism

Thank you


Appealing to the
6 Senses
Building a Better
Professional
Adragogy
SUCCESS

The Interstate Medical Licensure Compact

Medical Quality Assurance Commission Educational Conference

October 1, 2014

Disclosures

Organizational Affiliations

- Federation of State Medical Boards (FSMB)
- Administrators in Medicine (AIM)
- Washington Department of Health (DOH)
  - Board of Osteopathic Medicine and Surgery

Disclosure Statements

- The interstate compact does not reflect the views of, nor has it been endorsed by, the FSMB, AIM, or the Washington Department of Health.
- The interstate compact is not a formal work product of the FSMB, AIM, or the Washington Department of Health.
- The Board of Osteopathic Medicine and Surgery has formally endorsed the Compact and supports the Medical Commission's request legislation.
- The information and views expressed in this presentation are of the author only.

Goals for Today

- Recap the historical, legal, and policy contexts that gave rise to the consideration and development of an interstate compact.
- Consider the potential implications of national licensure.
- Provide an overview of interstate compacts.
- Highlight the features and processes of the proposed Interstate Medical Licensure Compact.
- Share selected stakeholder and media interest in the Compact.
- Address questions and foster discussion.

Historical Background

- "State"-based regulation of physicians actually dates to colonial times:
  - Virginia, 1639
  - Massachusetts, 1649
  - New York, 1665
- In US history, state regulation of physician licensing is largely uninterrupted, except for a brief period in the mid-1800s.
- However, the ACA, shifting demographics, technological advances, changes in physician specialty mix, consumer demands, and health care financing are changing expectations for how boards will regulate physicians.
- Large industry-based interest groups are lobbying for federal action on a national licensure system.
- Congress has passed or considered bills with the potential to erode state-based physician licensing.

Legal/Constitutional Background

- Tenth Amendment to the US Constitution is generally the starting point for defense of state-based regulation of physicians.
- Important US Supreme Court Case law supports it:
  - *Dent v. West Virginia (1889)*
  - *Hawker v. New York (1898)*
- However, federalist approaches changed in the 20th century, creating greater opportunities for federal intervention into areas of traditional state regulation.
  - The "layer cake" vs. the "marble cake"
  - Conditional spending power

Why NOT National Licensure?

- Important patient safety mission could be undermined:
  - Licensing funds are uncertain, but the same disciplinary mandate.
  - Public's practical ability to complain across state lines.
  - Could exacerbate the length and complexity of licensing, investigative and adjudicative activities
- Even "military" models, which Congress has looked to expand upon, dilute states' jurisdiction.
- Ignores long history of successful regulation within the state domain.
- Ignores federalist principles embodied in the 10th Amendment to the US Constitution.

<u>So is there a better option than federal intervention? I think so…</u>

Interstate Compacts – A Primer

- Like physician regulation, compacts also date to colonial times.
- Compacts are widely used, but not well understood, part of jurisprudence; the average state is a party to 25.
- They are explicitly authorized by the "Compact Clause" of the US Constitution *(Article 1, Section 10, Clause 3)*.
- Compacts contain elements of both contract and statutory law; as a result, they supersede state laws, rules, courts, but are neither federal nor state.
- States pass legislation and governors sign; the legislation must be identical to be effective. Consequently, once enacted, they are very hard to amend.
- As a result, effective compacts are generally drafted broadly and grant rulemaking authority to administrative organizations to allow for adjustments over time.
- Allow states to collectively solve shared problems without federal intervention.

Interstate Medical Licensure Compact

The interstate Medical Licensure Compact will:

- Set meaningful eligibility standards for physicians to participate.
- Create an Interstate Medical Licensure Commission to administer the Compact.
- Preserve revenues critical to state board operations.
- Clearly delineate the disciplinary protocols for medical and osteopathic boards in both "principal" and "compact" states.
- Require physicians to register their intent to practice in any and all states.
- Establish information systems for distribution of data between state boards.
- Be entirely voluntary, both for states and for physicians.
- Likely avert further federal encroachment on state authority for medical and osteopathic physician regulation.
- Promote multistate practice and telehealth in a manner responsive to patient safety.

Physician Eligibility Requirements

- Physicians must meet the following requirements to participate in the compact:
  - Successfully pass each component of USMLE or COMLEX-USA within three (3) attempts.
  - Successfully complete a graduate medical education program.
  - Specialty certification or a time-unlimited certificate from American Board of Medical Specialties or American Osteopathic Association Bureau of Osteopathic Specialists.
  - No discipline on any state medical license.
  - No discipline related to controlled substances.
  - Not under investigation by any agency.
- Not all physicians will be eligible.

Principal License

A principal license serves as the entry point for eligible physicians:

- Physician must obtain a full and unrestricted license from a member state.
- State of principal license cannot award a compact privilege without an underlying license.

What state can serve as state of principal license?

- State of physician's primary residence.
- State where 25 percent of medical practice occurs.
- Location of physician's employer.
- State designated for federal income taxes.

Interstate Commission

- Interstate governmental organizations are commonplace among "modern" interstate compacts.
- The compact does not create a "superboard".
  - Role is to oversee the administrative and policy elements of the compact.
  - No licensing or disciplinary role.
- Two representatives from each participating state (executive director or board member) participate in governance work of the Interstate Medical Licensure Commission.
- Does have rulemaking authority.

Financial Considerations

- User fees are envisioned as the method for funding the Interstate Medical Licensure Commission.
- Analogous to how most medical and osteopathic boards operate today.
- Section 13 allows the Commission to collect an annual assessment from member states. While not been intended to be used, it is necessary:
  - States hold ultimate fiduciary responsibility for this government organization.
  - Tax implications for the Commission.
  - Qualified immunity implications for members serving on the Commission.
- Boards will continue to set fees for licensure and renewal for physicians licensed in their states as they do now.

Investigative Functions

- Currently, states face challenges in effectively investigating complaints involving physicians beyond their borders.
- The compact would allow:
  - Boards to undertake joint investigations.
  - The timely sharing of investigative material.
  - Strengthened enforcement of administrative subpoenas across state lines for board investigations.
  - The information will be kept confidential, per Compact provisions.

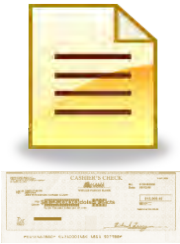
Registration and IT System

- An essential element of the Compact – member state boards have data on if a physician is, or is capable of, practicing in a given state.
- By requiring a full and unrestricted license to be issued, every state has a record of physicians who may practice there.
- More broadly, the Commission will serve as a clearinghouse for licensing data and disciplinary data:
  - States, in approving physicians to participate in the Compact, will notify the Commission, who will in turn notify other states.
  - States, including the principal state, will notify the Compact of licensure status, who will in turn notify other states.
  - The Commission will set out in rule disciplinary reporting requirements for boards, which will be accessible by member states.

Sample Workflow – Licensing with a Compact

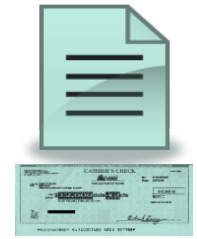
Dr. Doctor decides to apply to state of Emergency

Dr. Doctor first decides if he only wishes to practice in the state of Emergency, or if he wants to practice in multiple states.



If Dr. Doctor decides to seek only a standard state license (i.e., limited to practice in the state of Emergency), then he submits the normal application, documents and fee to the state board.

If Dr. Doctor decides wants to practice not only in his state of principal licensure but in other states within the Compact, he submits the normal application and documents for the principal state license, plus he submits a compact application with the principal state board. He submits only the check for the home state license to the state board.

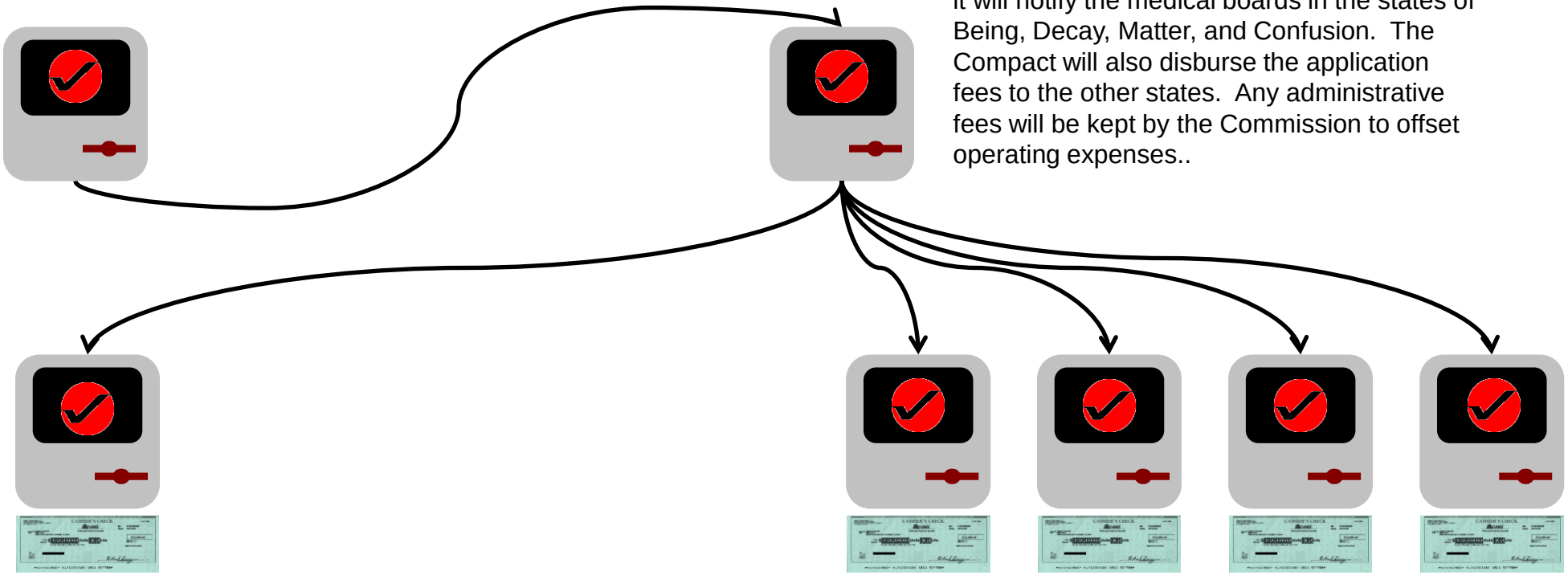


As part of his application, Dr. Doctor also submits to the Compact a registration form indicating he has applied to the state of Emergency, but also wants to practice in the states of Being, Decay, Matter, and Confusion and submits the appropriate fee(s).

Prepared by Blake T. Maresh, MPA, CMBE

Dr. Doctor's applications (both for principal state and the Compact authorization) are reviewed by the state of Emergency Medical Board. If he meets the qualifications for each, he may be an authorization for the compact. A compact authorization can only be held in conjunction with the principal state license. The principal state communicates that it has issued authorized Dr. Doctor for the Compact.

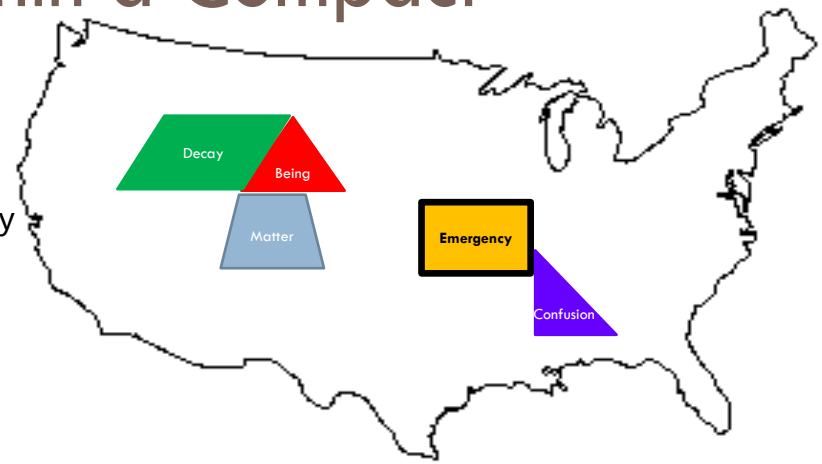
When the Compact is notified by the home state that the physician has been authorized, it will notify the medical boards in the states of Being, Decay, Matter, and Confusion. The Compact will also disburse the application fees to the other states. Any administrative fees will be kept by the Commission to offset operating expenses..



Prepared by Blake T. Maresh, MPA, CMBE

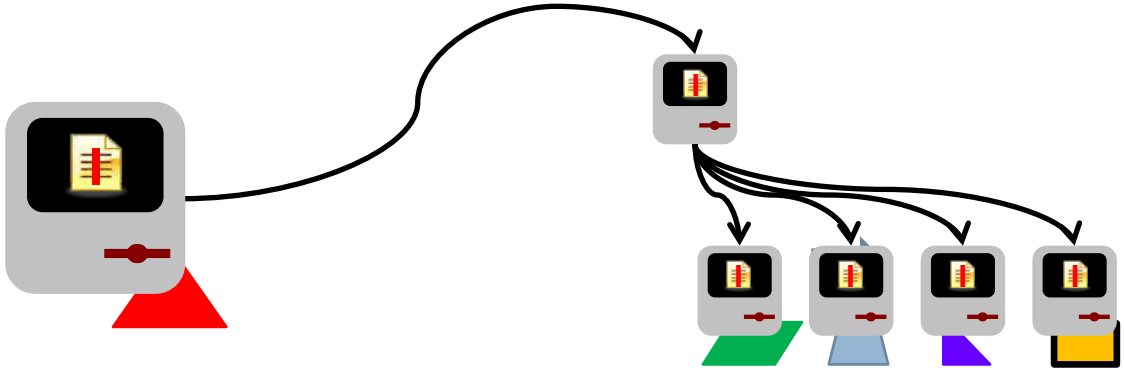
Sample Workflow – Discipline within a Compact

Dr. Doctor's home state is the State of Emergency. He applied for and received a compact privilege, and has licenses via the compact in the States of Being, Matter, Decay and Confusion.



Dr. Doctor commits a significant medical error while practicing in the State of Being, and the patient files a complaint with the State of Being Medical Board (BMB).

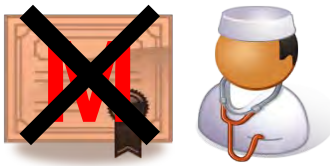
The BMB opens the complaint and refers it for investigation. The Board also notifies the Compact of the open investigation, which in turn provides notification to the other states where Dr. Doctor is licensed.



IMPORTANT NOTE: Regardless of any action(s) taken by any compact state against a licensee, he or she retains an underlying principal state license. While any state can act on a license issued via the compact, only the board in the state of principal licensure can act on the principal license.

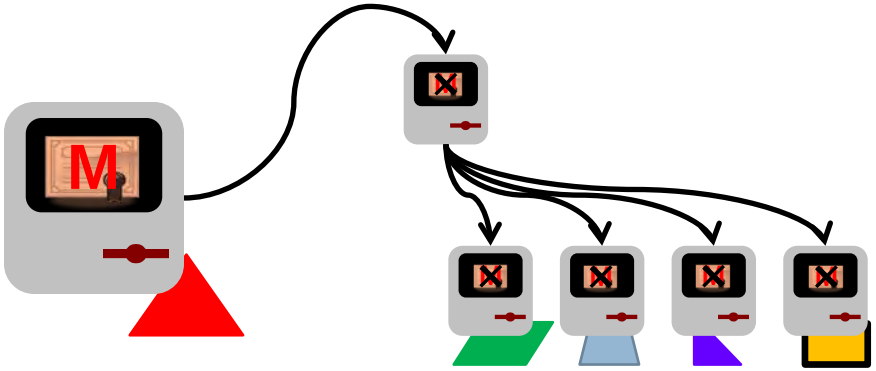
Prepared by Blake T. Maresh, MPA, CMBE

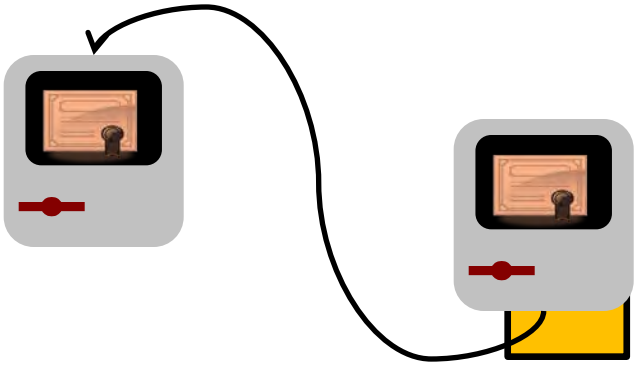
After investigation, the BMB decides to take action. Based upon the type of action taken, there are two possible outcomes for Dr. Doctor's multistate authorization.



If the BMB takes an action that prevents Dr. Doctor's ability to practice (i.e., revocation, suspension, or surrender in lieu of discipline), then the action taken by the BMB affects Dr. Doctor's ENTIRE multistate authorization. In this case, he may only still practice in his state of principal license unless action is taken on that license by the EMB.

When the action is final, the BMB reports it to the Compact, which in turn communicates to all the other states where Dr. Doctor is licensed, including the state of principal licensure. The other "compact" states then rescind their licenses as well without further action.



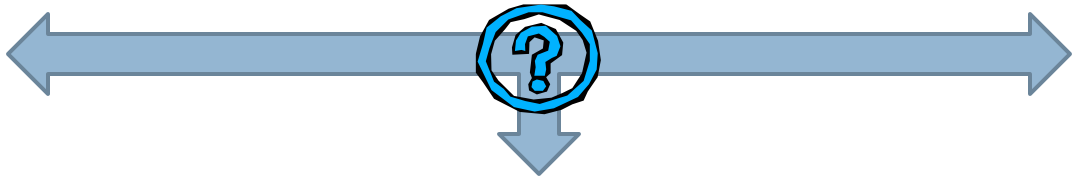


The EMB must then decide whether to act upon Dr. Doctor's principal state license based on the action of the BMB. If it does, this action is also reported to the Compact for documentation.

Prepared by Blake T. Maresh, MPA, CMBE

If the BMB takes a lesser action than revocation, suspension, or surrender in lieu of discipline, this information is also reported to the Compact to be reported to the other states where Dr. Doctor is licensed. For those “compact” states, they have three alternatives:

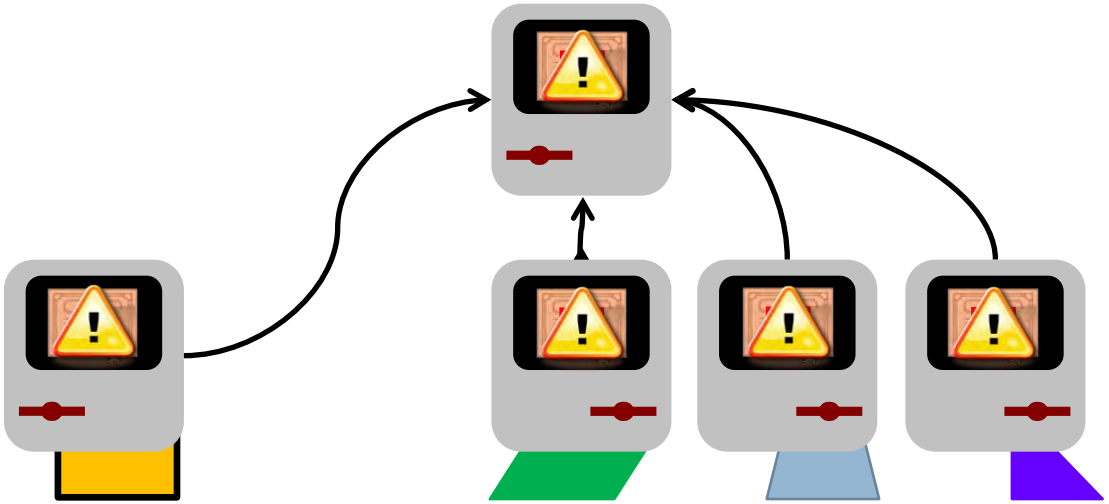
Concur: The other “compact” states can simply affirm the action of the BMB against Dr. Doctor.



Retry: Each state board reserves its authority to take action. For example, the state of Confusion Medical Board could separately investigate, charge and take action against Dr. Doctor if it felt the BMB’s sanctions did not adequately protect the public.

No action: If a state board feels no further action is necessary against Dr. Doctor, no action need be taken.

As before, the EMB must decide whether to act upon Dr. Doctor’s underlying principal state license. If it does, this action is also reported to the Compact for documentation.



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Impact of Disciplinary Actions

Action by State of Principal License—Effect on License(s) Granted Under Compact

Principal State Action	Major Action	Minor Action
Initial Action	Other licenses immediately placed on identical status without additional action by other member board(s).	Other member licensing board(s) may: 1) Deem factual findings to be *res judicata* and impose same or lesser sanctions; 2) Take separate action under its respective medical or osteopathic practice act; or 3) Take no action.
Reinstatement	Other license(s) remains encumbered pending action by the other member board(s).	

Impact of Disciplinary Actions

Action by Member State—Effect on Licenses in Other Member States

Member State Action	Major Action	Minor Action
Initial Action	Other licenses immediately suspended for 90 days automatically and without additional action necessary by other member board(s); however the other board(s) may lift or otherwise change the suspension prior to the completion of the 90 days	Other member licensing board(s) may: 1) Deem factual findings to be *res judicata* and impose same or lesser sanctions; 2) Take separate action under its respective medical or osteopathic practice act; or 3) Take no action.
Reinstatement	Other license(s) remains encumbered pending action by the other member board(s).	

State/Media/Stakeholder Interest

- TX, OK-MD, SD, and WA-MD & DO boards have formally expressed support, as has the MN Medical Association.
- CA, MN, NC, ND, NV, WI, WY boards have verbally expressed interest/support.
- Legislative interest in AR, AZ.
- American Medical Association is working on a support resolution for its House of Delegates.
- American Academy of Dermatology is close to issuing a letter of support.
- 16 US Senators issued a letter of support for the compact (*January 9, 2014*)

State/Media/Stakeholder Interest

- New York Times *(June 29, 2014)*
- MedPage Today *(July 2, 2014)*
- DotMed Daily News *(July 7, 2014)*
- vRad Press Release *(July 8, 2014)*
- JAMA Viewpoint *(July 28, 2014)*
- The Interstate Medical Licensure Compact: Making the Business Case *(Journal of Medical Regulation, August 2014)*

State/Media/Stakeholder Interest

- HealthLeaders Media *(August 7, 2014)*
- AMA Wire *(September 8, 2014)*
- HealthcareDIVE *(September 10, 2014)*
- Rapid City Journal *(September 14, 2004)*
- HealthLeaders Media *(September 17, 2014)*

What a Compact is NOT

A physician compact would <u>not</u>:

- Require state licensing boards to revise their practice acts.
- Create a pathway to national licensure – instead, it would likely forestall any further federal action.
- Clone the Nurse Licensure Compact, which is different in a number of respects.
- Alter the existing in-state functions or authority of medical and osteopathic boards.
- Increase fees for in-state licenses.

Next Steps

- The final draft of the Interstate Medical Licensure Compact has just been released.
- State boards, legislatures, and stakeholders will review during the fall.
- Legislative action on the Compact will begin in January.
- Seven states are needed to activate the Compact.
- Once activated, Commissioners will be convened to begin administrative work, including:
  - By-laws
  - Rules
  - Election of officers
  - Staffing
  - Location of offices
  - IT/Financial systems Development
  - Forms

Questions?

Blake Maresh, MPA, CMBE

Executive Director
Washington Board of Osteopathic Medicine and Surgery
Washington Department of Health
360/236-4760 (W)
360/888-5080 (C)
blake.maresh@doh.wa.gov

Opioid Overdose Prevention and Response

The roles of medical practitioners

Caleb J. Banta-Green PhD MPH MSW
Senior Research Scientist, Alcohol & Drug Abuse Institute
Affiliate Associate Professor, School of Public Health
University of Washington

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- Evidence-Based Practices
- Instruments Database

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Alcohol and Drug Abuse Institute
University of Washington
1107 NE 45th Street, Suite 120, Box 354805
Seattle, WA 98105-4631 USA

phone: (206) 543-0937 | fax: (206) 543-5473
e-mail: adai@u.washington.edu

The Alcohol and Drug Abuse Institute is a multidisciplinary research center at the University of Washington. Its mission is to support and facilitate research and research dissemination in the field of alcohol and drug abuse.

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A Resource for Washington State

Marijuana
Science-based information for the public


WA State Data & Resources

Opioid Overdose can be prevented and reversed!
stopoverdose.org

http://www.adai.uw.edu/

ADAI-UW Opiate Work

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE—*Seattle-King County Area*

Recent Drug Abuse Trends in the Seattle-King County Area

Caleb Banta-Green,[1] Susan Kingston,[2] Michael Hanrahan,[3] Geoff Miller,[4] T. Ron Jackson,[5] Ann Forbes,[6] Arnold F. Wrede[7] Steve Freng,[8] Richard Harruff,[9] Greg Hewett,[9] Kris Nyrop,[10] Mark McBride[11]

ADAI-IB 2003-03

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ADAI Alcohol & Drug Abuse Institute

INFO BRIEF

Prescription Opioid Use: Pain Management and Drug Abuse In King County and Washington State

October 2003

Caleb Banta-Green (Alcohol and Drug Abuse Institute, University of Washington), Joseph Merrill (Department of Medicine, University of Washington, and Harborview Medical Center), Ron Jackson (Evergreen Treatment Services), Michael Hanrahan (HIV/AIDS Program Public Health - Seattle & King County)

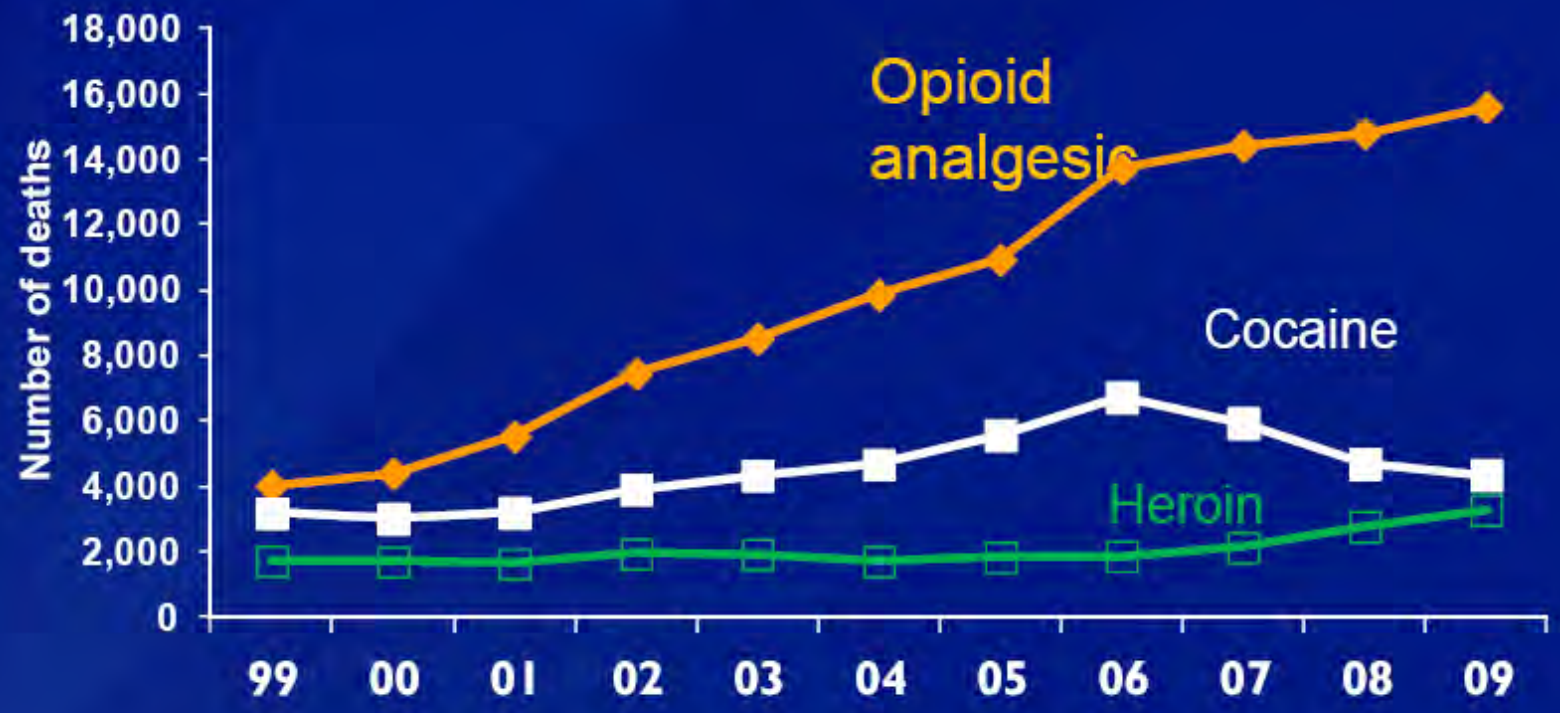
- HYS Rx opiate “to get high” question & analysis 2006
- DOH Opiate Workgroup since 2008
- Partnered with Public Health on syringe exchange survey analyses
- Group Health study of chronic pain patients and opiate use (NIH)
- Evaluated WA’s Overdose law, interviewing first responders
- PMP analyses (DOH)
- Study of overdose prevention with Rx and Heroin users in Harborview ER (NIH)
- O.D. training- Online & in person www.stopoverdose.org (AGO)

Outline

- Opiate drug trends in WA
- Prevention and Treatment of Opioid Abuse
- Overdose education and intervention
- Support for adding medical models

Opiate Overdoses in the U.S. Epidemiology, Prevention, Intervention and Policy

Drug overdose deaths of all intents by major drug type, U.S., 1999-2009



Heroin substantially under-reported in deaths

Source: National Vital Statistics System. The reported 2009 numbers are underestimates. Some overdose deaths were not included in the total for 2009 because of delayed reporting of the final cause of death.

Rx Opioids

- Prescribing appears to be leveling off for potent, long acting opioids in some states (ARCOS 2010)
- Mortality increasing nationally, declining in WA
- NSDUH indicate Rx non-medical “pain reliever” opioid use declined in 2011

Heroin

- 18 to 24-year-olds admitted to treatment for heroin increased from 42,637 in 2000 to 67,059 in 2009 TEDS cited in [A]
- Epidemiologists in 15/21 US cities report increases in heroin, notably among young adults and outside of urban areas (NIDA CEWG June 2012)
- NSDUH data indicate the number of persons who were past year heroin users in 2011 (620,000) was higher than the number in 2007 (373,000).

A. Banta-Green, CJ 2012 Adolescent Abuse of Pharmaceutical Opioids Raises Questions About Prescribing and Prevention. Arch Pediatr Adolesc Med. 2012 May 7. [Epub ahead of print]

Rx to Heroin

- A relationship between misuse of prescription-type opiates and subsequent heroin use is indicated by NSDUH data* and published research** particularly adolescents and young adults
- King County 39% reported being "hooked on rx-type opiates" before they began using heroin (2009)

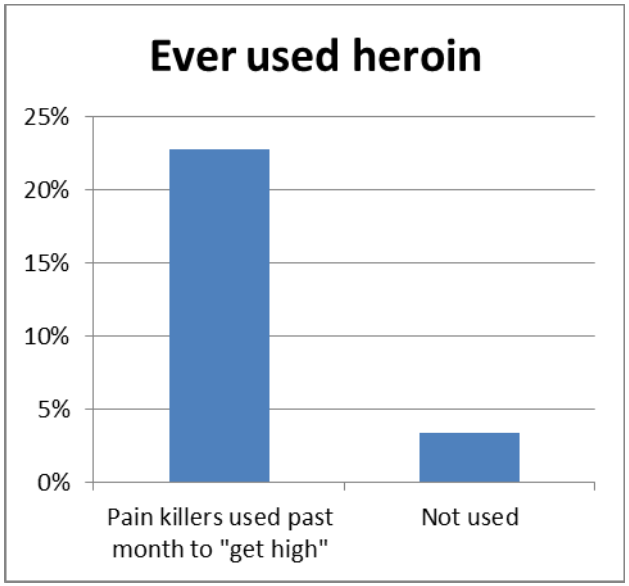
*C. Jones 2013 article

** Peavy et al, 2012 and Lankenau et al, 2012

WA State, 12th Graders, 2012 Healthy Youth Survey

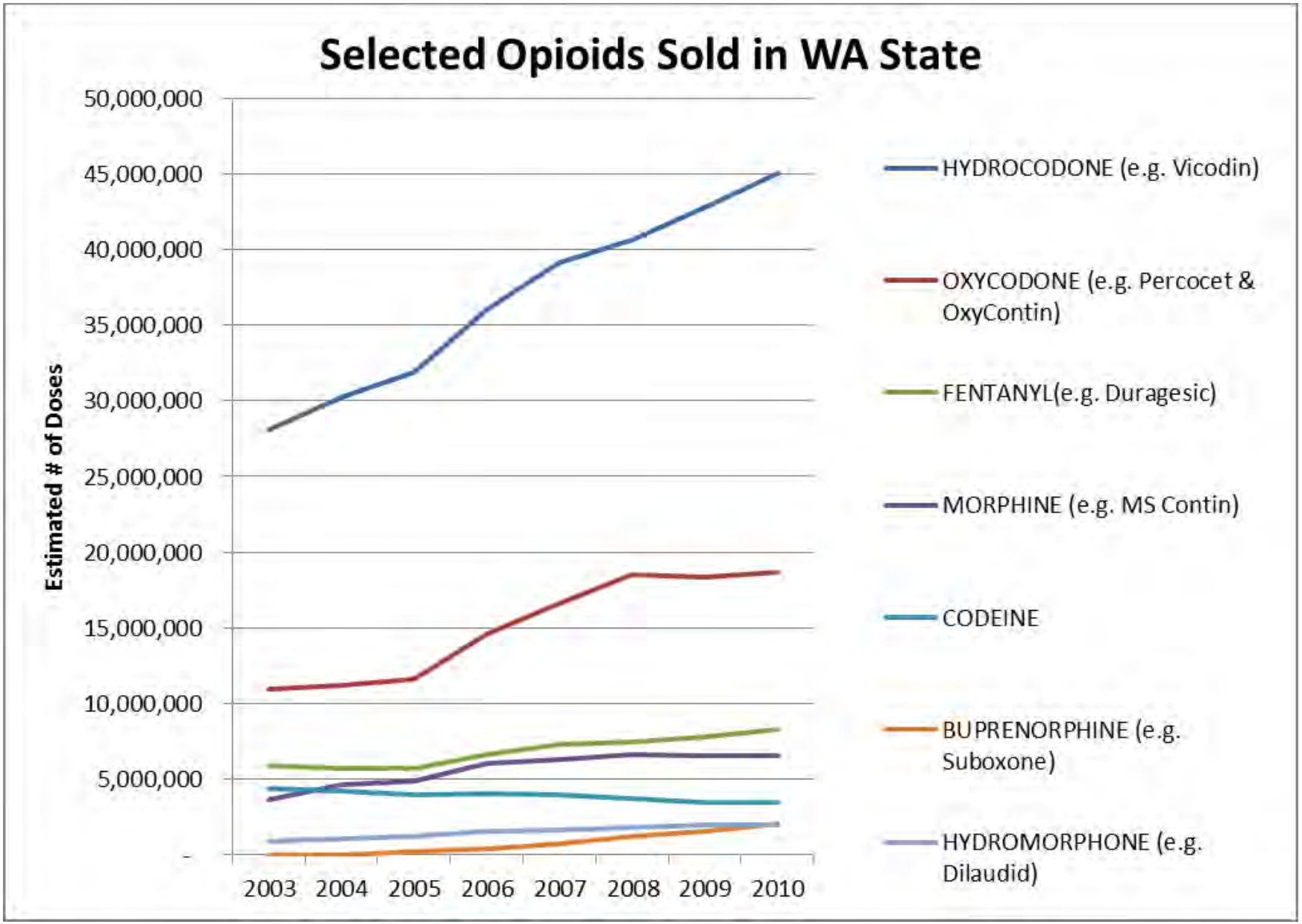
	Use Estimate	95% C.I.
Alcohol, past month	36.1%	± 2.3%
Marijuana, past month	26.7%	± 1.5%
Rx opiates, past month	7.5%	± 1.0%
Heroin, ever used	5.1%	± 1.3%

Association ?

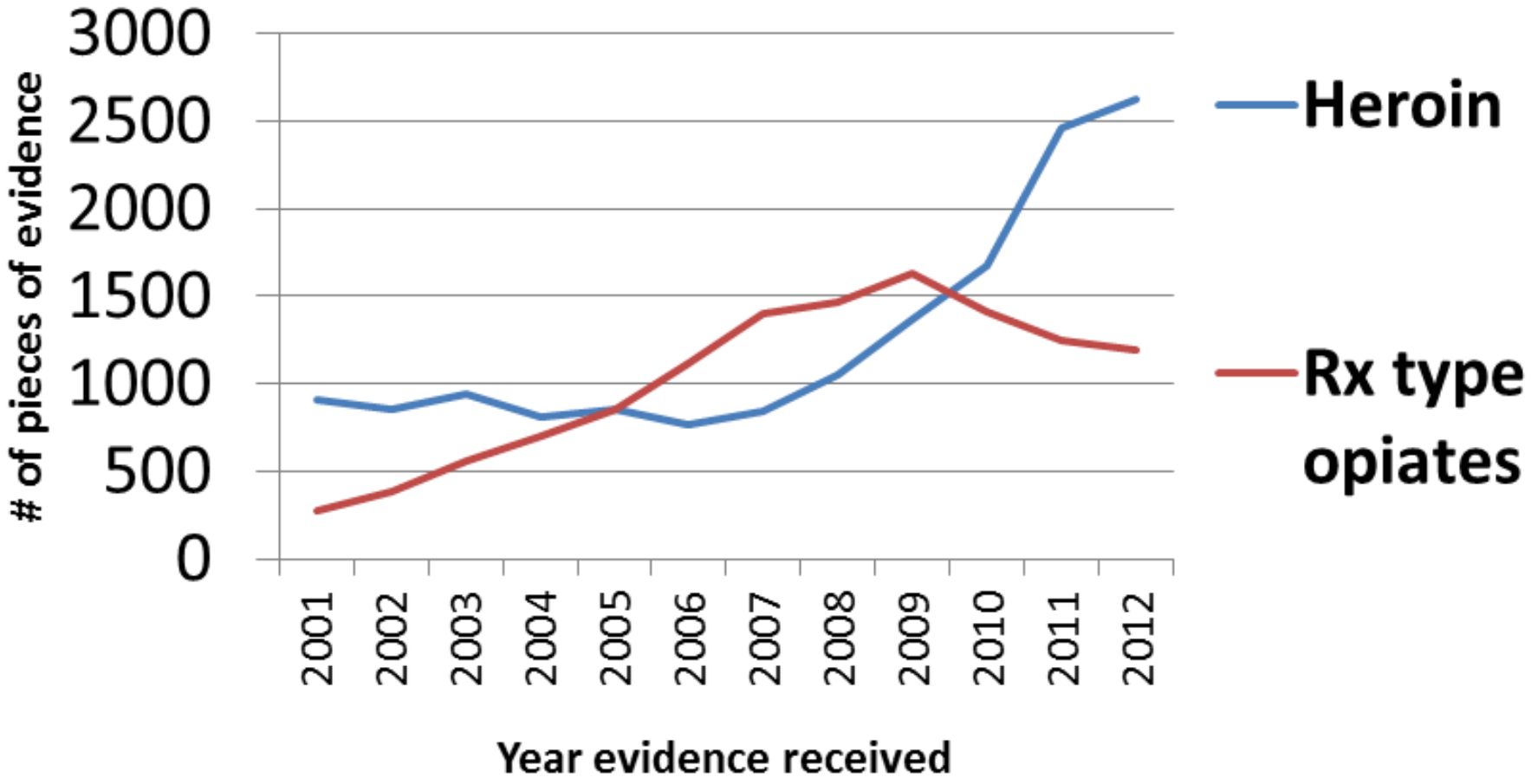


		Lifetime Heroin Use		
		No	Yes	Total
Current Use of Rx Opiates "to get high"	no days	96.6% ± 0.9% 2,703	3.4% ± 0.9% 94	100.0% 2,797
	any days	77.2% ± 5.8% 193	22.8% ± 5.8% 57	100.0% 250

23% of recent users of Rx opiates to "get high" report ever using heroin, compared to 3% for those not recent using pain killers to get high

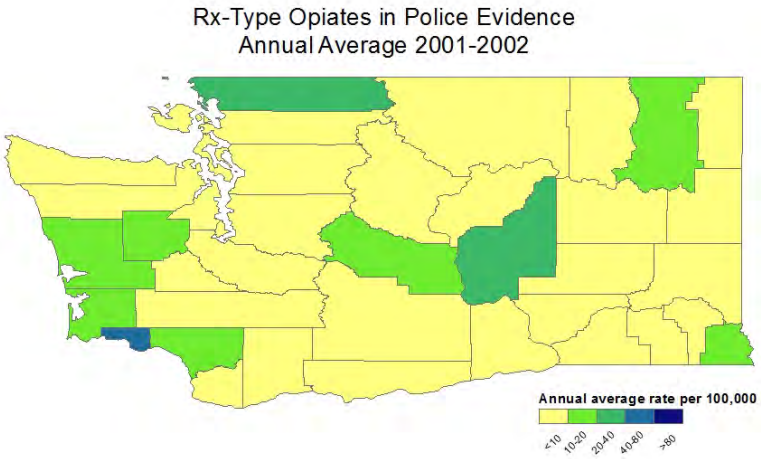

Selected Opioids Sold in WA State
Estimated # of Doses
50,000,000
45,000,000
40,000,000
35,000,000
30,000,000
25,000,000
20,000,000
15,000,000
10,000,000
5,000,000
-
2003
2004
2005
2006
2007
2008
2009
2010
HYDROCODONE (e.g. Vicodin)
OXYCODONE (e.g. Percocet & OxyContin)
FENTANYL(e.g. Duragesic)
MORPHINE (e.g. MS Contin)
CODEINE
BUPRENORPHINE (e.g. Suboxone)
HYDROMORPHONE (e.g. Dilaudid)

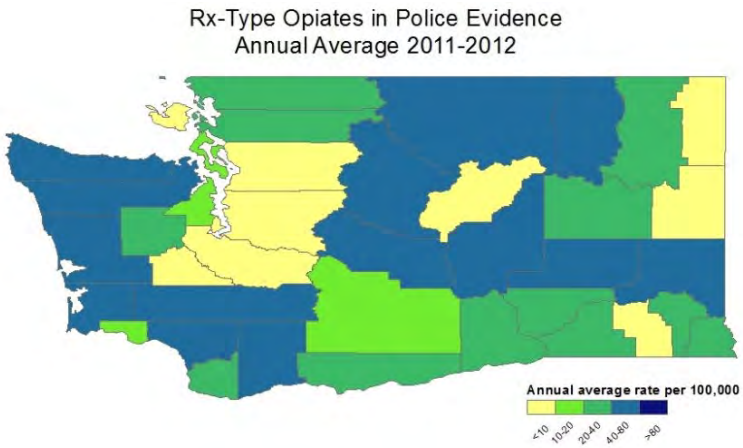
WA State
Local police evidence testing

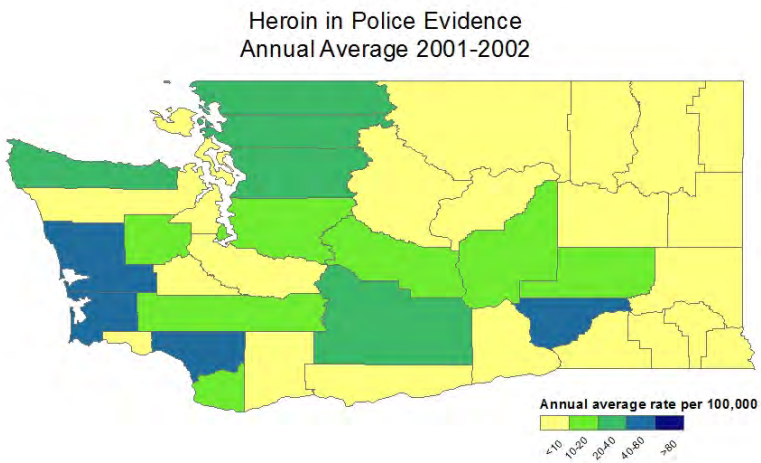


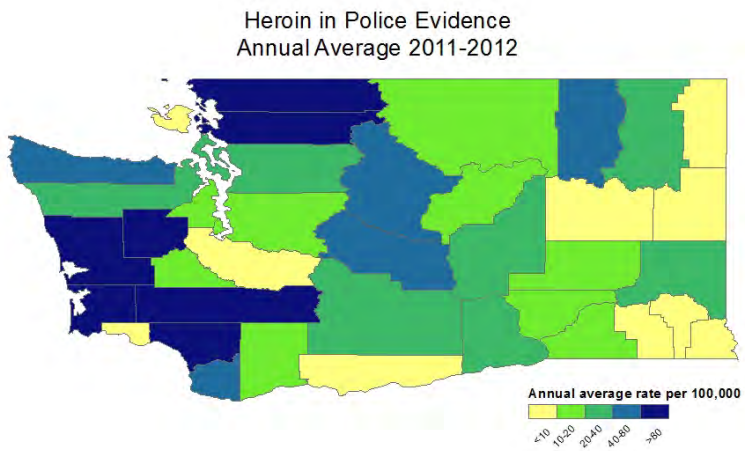
Data source: Washington State Patrol, Crime Lab, NFLIS data set
Data analysis and mapping: Caleb Banta-Green, University of Washington

Trends in Police Evidence for Heroin and Rx-type opiates









Data source: Washington State Patrol, Crime Lab, NFLIS data set
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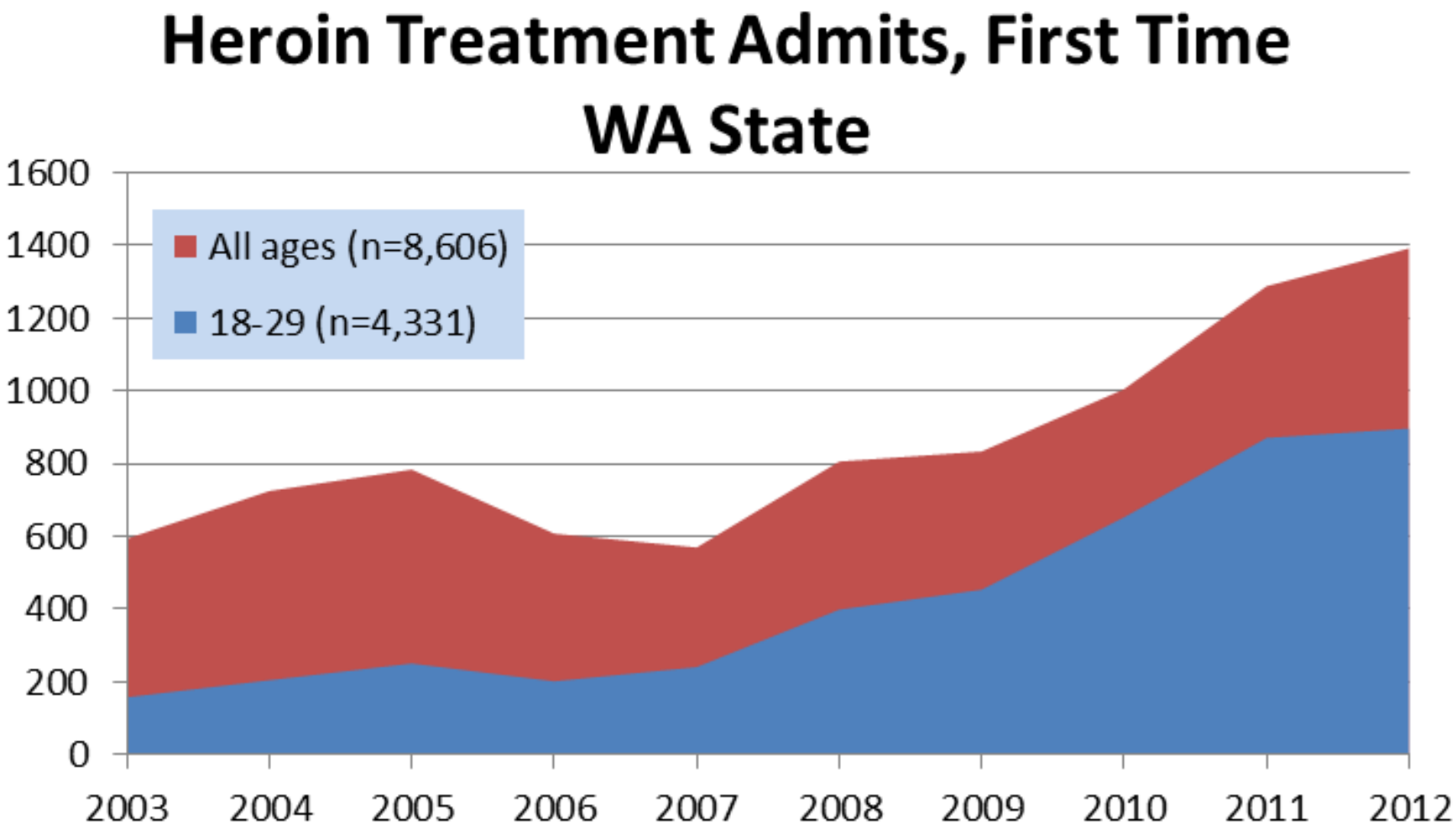
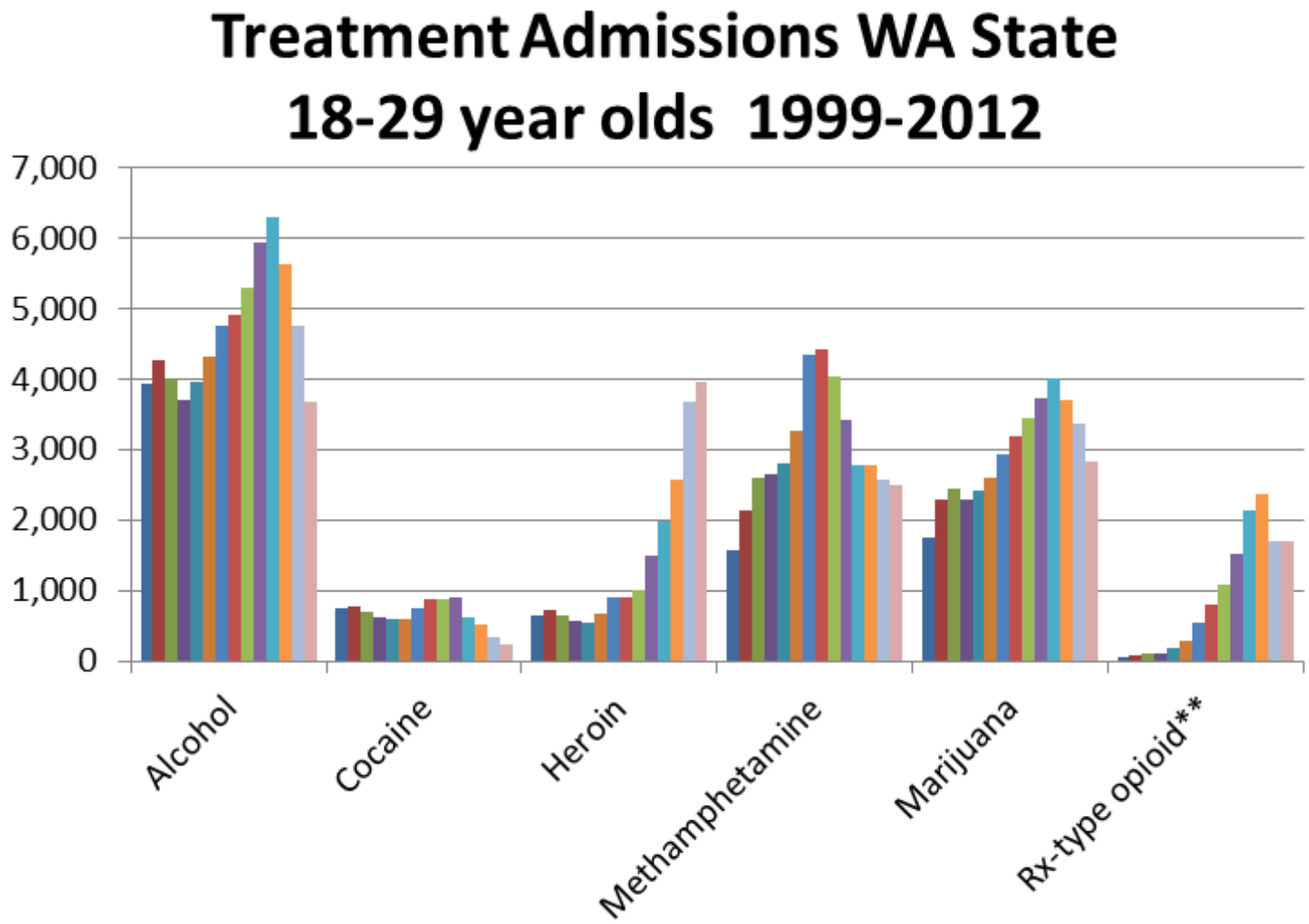


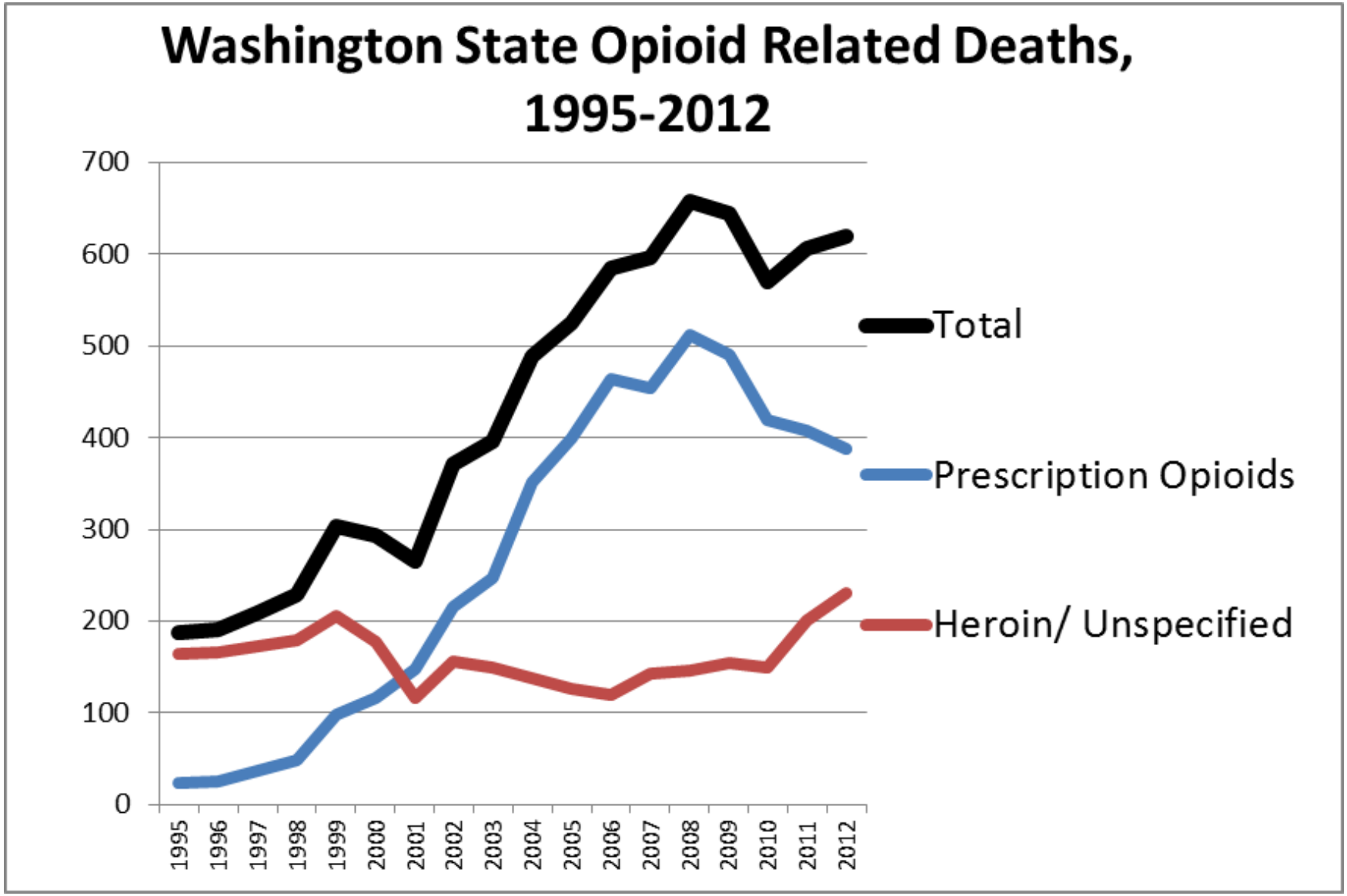
Two-thirds are injectors, remainder are smokers (who will likely transition to IDU)



As every other substance declined,

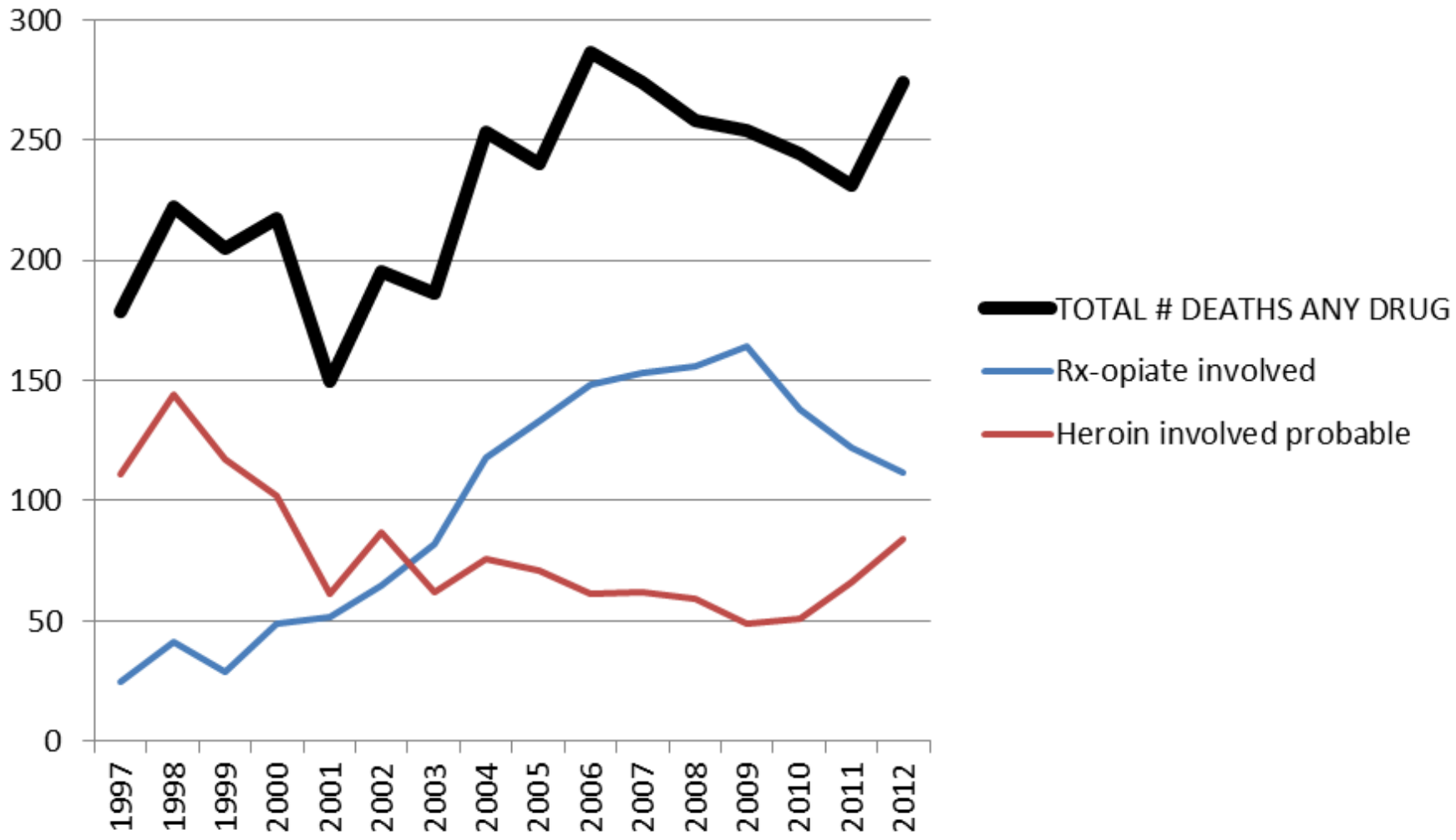
- 512% Statewide among 18-29 year olds
- Heroin is the #1 drug in this age group
- Just public treatment, undercount overall

2,189 caseload for buprenorphine/Suboxone for 18-29 years olds (March 2012 per DOH PMP)



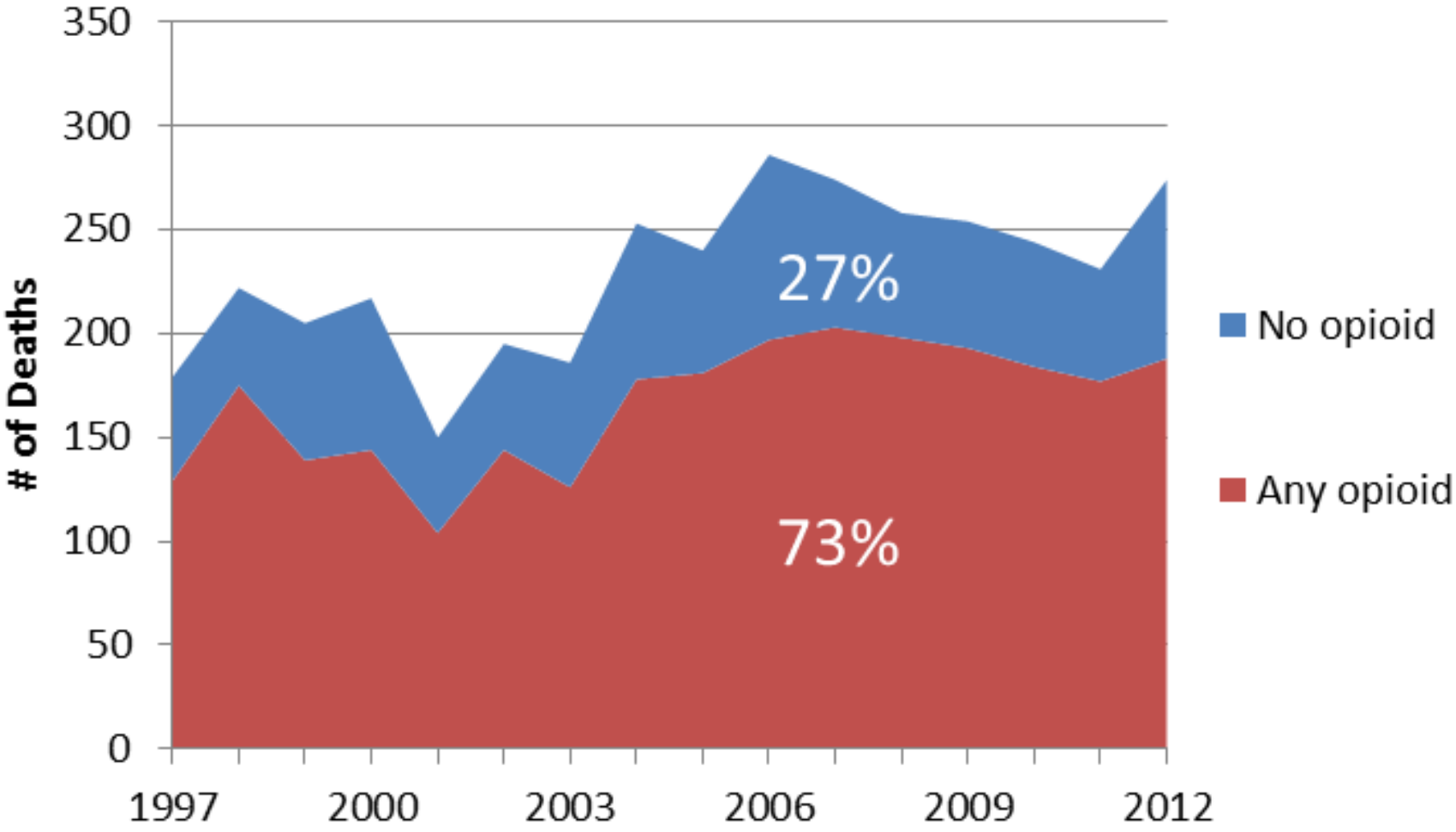
Center for Health Statistics, Washington State Department of Health, December 12, 2013.

Drug Caused Deaths King County, WA



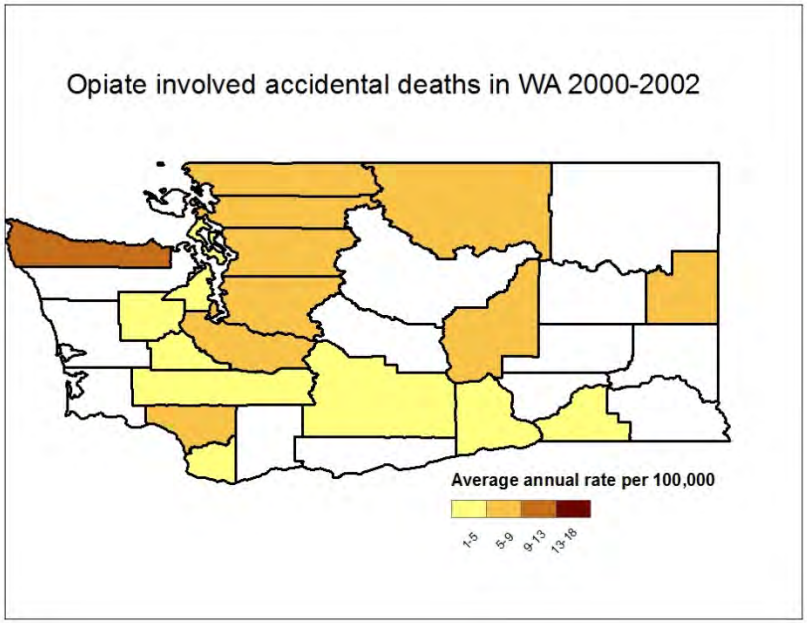
Source: PHSKC Medical Examiner's Office
Data analysis Alcohol & Drug Abuse Institute, UW

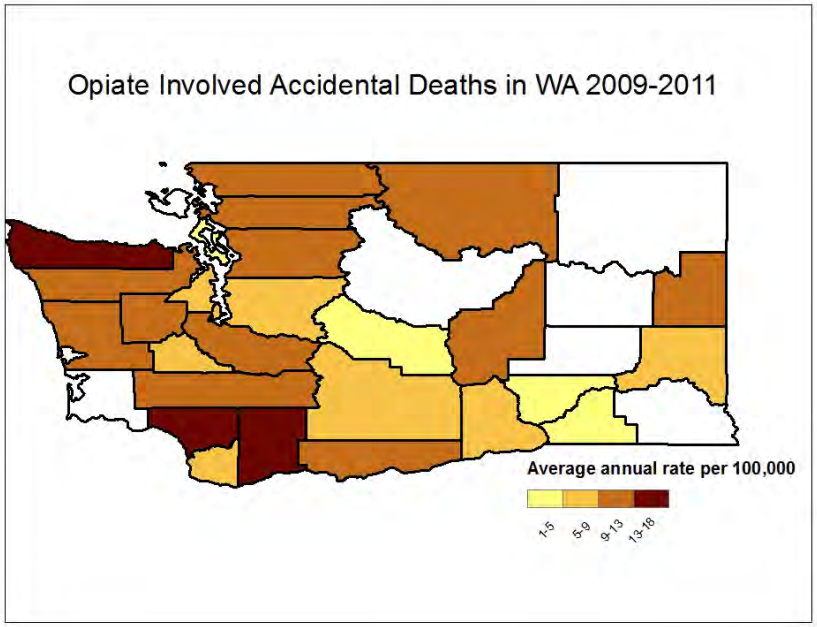
Drug Caused Deaths King County, WA



- All of these deaths were preventable
- Many of these overdoses could have been reversed before they became fatal

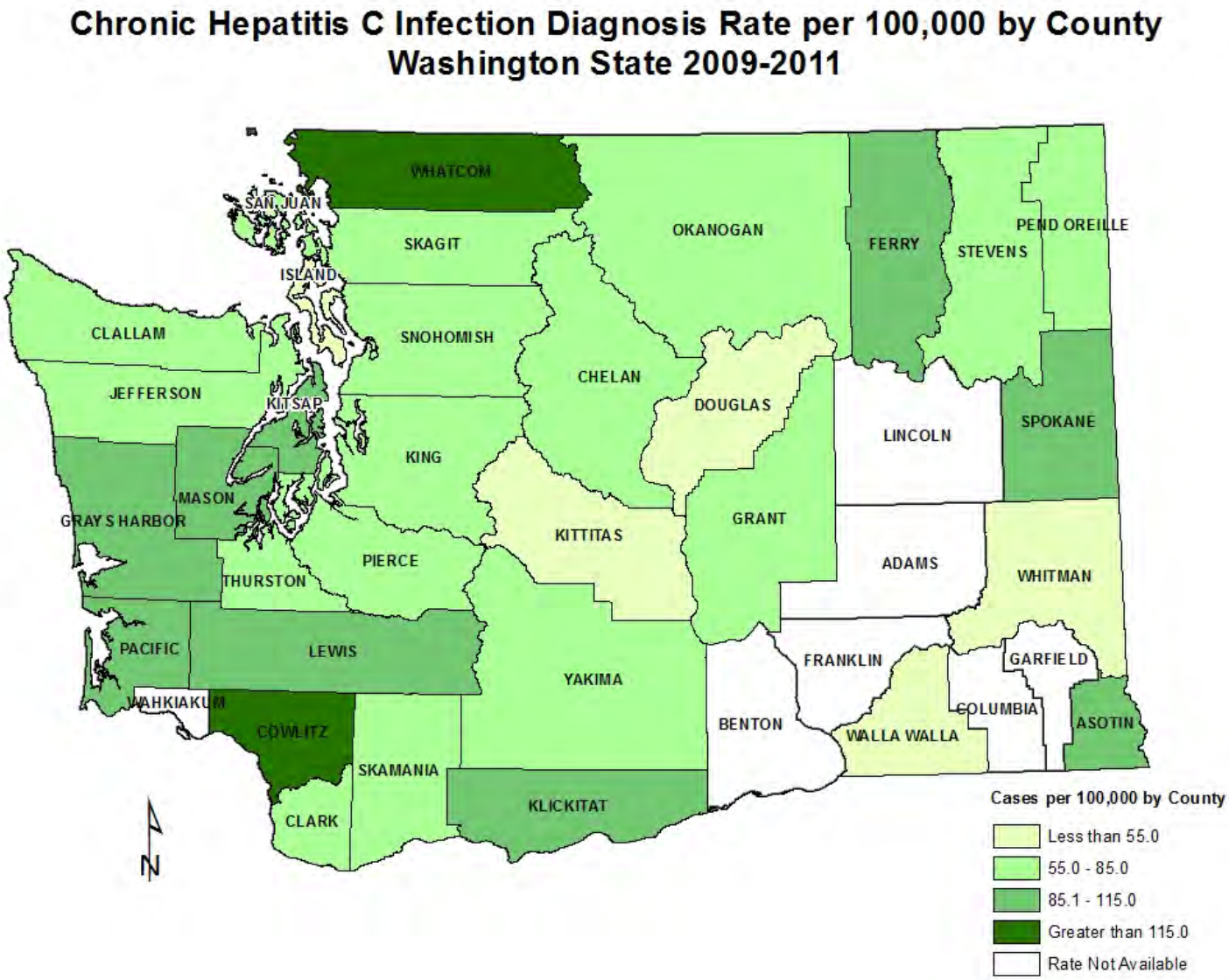
Opiate involved death trend





- The average annual number of deaths from 2000-2002 was 310
- The average annual number of deaths from 2009-2011 was 607
- The majority of deaths involved prescription-type opiates

Note that rates for counties with counts less than 5 over the 3 year period are suppressed



Data are substantially out of date due to diagnosis and reporting delays

Data source: WA Dept. of Health

Conclusions

- Nationally young adult heroin treatment admits are up 57%
- Treatment data indicate a dramatic increase in heroin use among young adults 18-29 across Washington State.
  - **These data are a substantial, but unknown, understatement of heroin treatment utilization** (and need) given the exclusion of private/self pay treatment including buprenorphine maintenance treatment
- **These findings raise questions about the ability of local communities to meet the treatment needs of new heroin users**, let alone the public health needs including *overdose* and *infectious disease* risks.

Preventing
Inappropriate initiation of Rx opioids

- The past two years approximately one-third of people had at least one prescription for a controlled substance (e.g. Vicodin, Valium, Ambien)
- More than half of adults take a prescription medicine of any kind.
- Taking prescription medicines is now typical and normal, **talking about medication usage with family members purposefully and thoughtfully is not *yet* normal.**

Access issues

- Most teens get Rx opiates from
- Own Rx (33%)
- A friend (28%)
- Family gave (10%)
- Took from a home (9%)

- Don’t accept unneeded Rx’s
- Dispose of unneeded medicines
- Lock up medications that are needed

Addressing motivation issues

- Parents should reflect on their **own use** of alcohol/medication/drugs
- Consider what messages they are sending
- Determine if they are the messages they **want** to be sending
- Consider their youths' situation- e.g. trauma
- Be explicit about reasons for their use and expectations for youth
- This may be hard and involve the adult seeking help

What are the treatments for opiate addiction?

- A variety of effective treatments are available including both behavioral/counseling and medications.
- Both help to restore a degree of normalcy to brain function and behavior, resulting in increased employment rates and lower risk of HIV and other diseases and criminal behavior.
- Although behavioral and medications can be extremely useful when utilized alone integrating both types of treatments is generally the most effective approach.

SOURCE: NIH NIDA

Medication Assisted Treatment

Buprenorphine/Suboxone
Methadone

Saves lives

Is cost effective

Availability- geographic & financial varies greatly

"…mortality rates were 75 percent higher among those receiving drug-free treatment, and more than twice as high among those receiving no treatment, compared to those receiving buprenorphine…" or methadone

Health Aff August 2011 vol. 30 no. 8 1425-1433

J Subst Abuse Treat. 2013 Mar;44(3):355-60. doi: 10.1016/j.jsat.2012.07.006. Epub 2012 Aug 30.

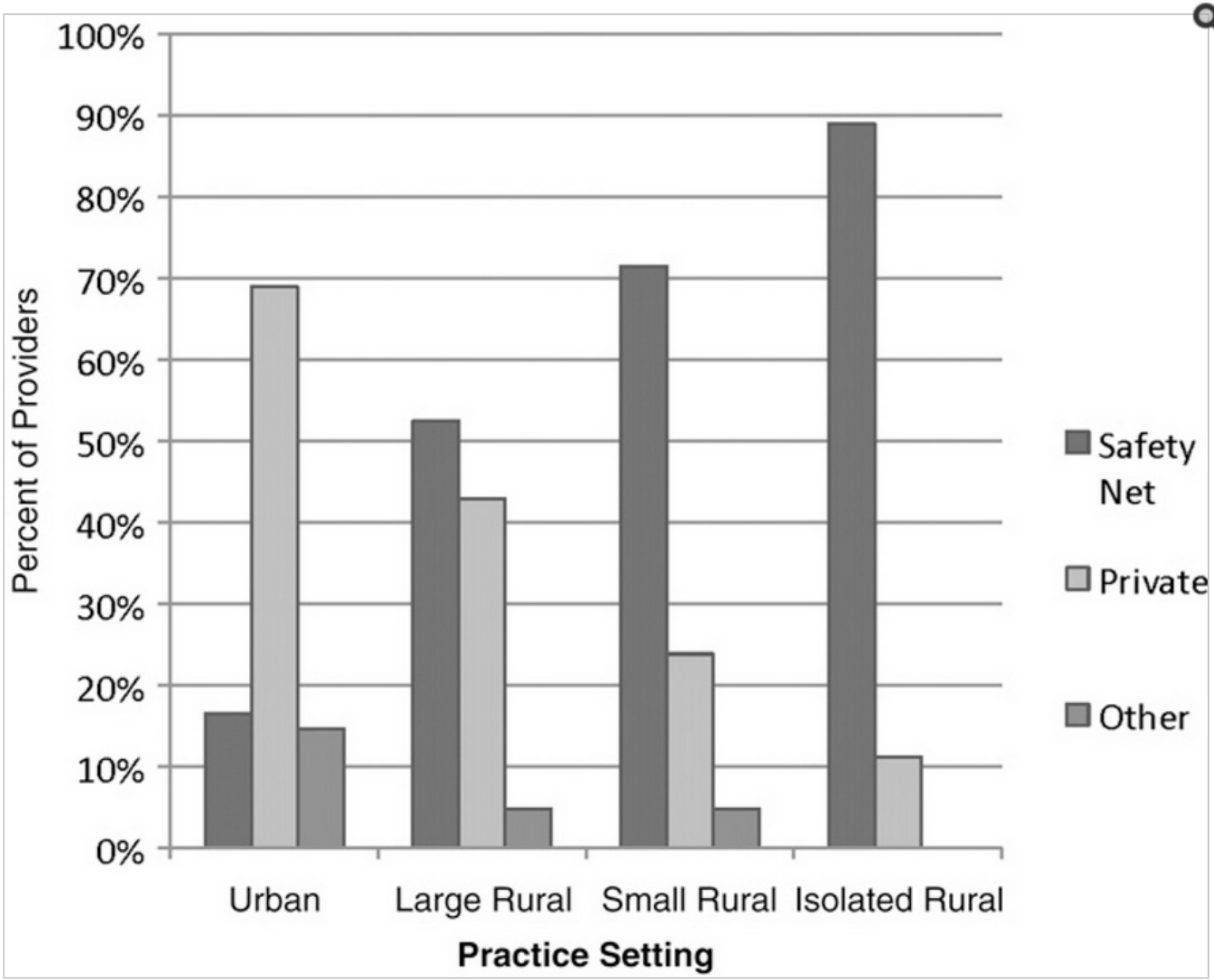
Who prescribes buprenorphine for rural patients? The impact of specialty, location and practice type in Washington State.

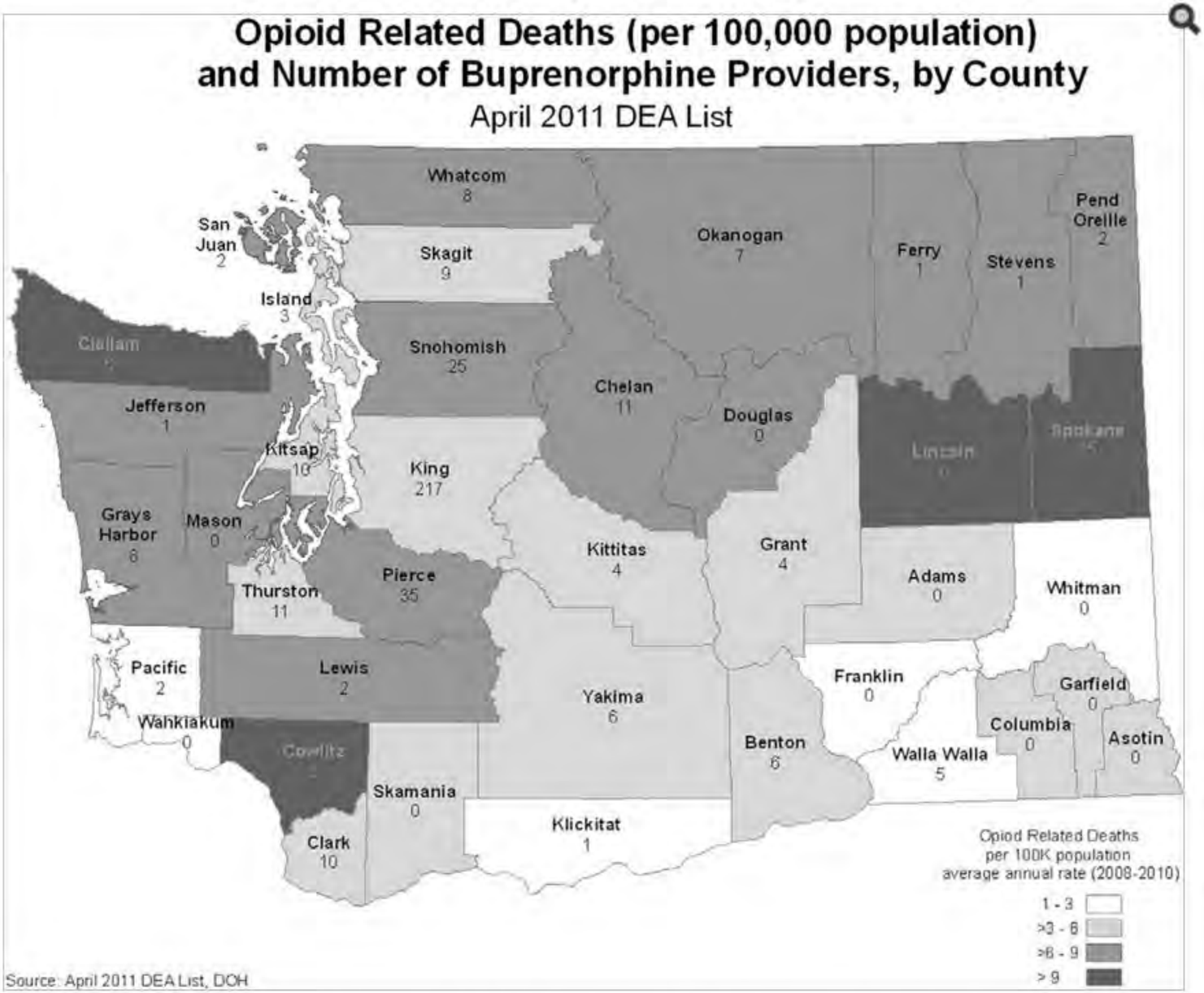
Kvamme E[1], Catlin M, Banta-Green C, Roll J, Rosenblatt R.

Author information

Abstract

We determined the specialty, geographic location, practice type and treatment capacity of waivered clinicians in Washington State. We utilized the April 2011 Drug Enforcement Agency roster of all waivered buprenorphine prescribers and cross-referenced the data with information from the American Medical Association and online resources. Waivered physicians, as compared to Washington State physicians overall, are more likely to be primary care providers, be older, less likely to be younger than 35 years, and more likely to be female. Isolated rural areas have the lowest provider to population ratios. Ten counties lack either a buprenorphine provider or a methadone clinic. In rural areas, waivered physicians work predominately in federally-subsidized safety-net settings, which underscores the need for continued governmental support of primary care and mental health in these settings.


100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percent of Providers
Urban
Large Rural
Small Rural
Isolated Rural
Practice Setting
Safety Net
Private
Other



Washington State counties with ORT options as of April 2011. In Washington State, 28% of the population lives in a county without MMT and 7% of the population lives in a county without MMT or BMT.

Evidence and Support for Overdose Education &

- National support-
  - Medical, Pharmacy, Public Health associations
  - Drug Czar/ONDCP; DOJ; DHHS/SAMHSA; CDC
- Research indicates
  - Saves lives
  - Cost effective
  - Limited implementation of laws to date

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AMERICAN MEDICAL ASSOCIATION

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ies at Annual Meeting

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AMA Adopts New Policies at Annual Meeting

For immediate release:
June 19, 2012

Promoting Prevention of Fatal Opioid Overdose
Opioid addiction and prescription drug abuse places a great burden on patients and society, and the number of fatal poisonings involving opioid analgesics more than tripled between 1999 and 2006. Naloxone is a drug that can be used to reverse the effects of opioid overdose. The AMA today adopted policy to support further implementation of community-based programs that offer naloxone and other opioid overdose prevention services. The policy also encourages education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities.

"Fatalities caused by opioid overdose can devastate families and communities, and we must do more to prevent these deaths," said Dr. Harris. "Educating both physicians and patients about the availability of naloxone and supporting the accessibility of this

SAMHSA
Substance Abuse and Mental Health Services Administration

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Opioid Overdose Prevention Toolkit

Average Rating: 5 out of 21 ratings.

Rate!

Comments

Price: **FREE** (shipping charges may apply)

Equips communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. Addresses issues for first responders, treatment providers, and those recovering from opioid overdose.

Tweet 46

Pub id: SMA13-4742
Publication Date: 8/2013
Popularity: 443
Format: Kit
Audience: Community Coalitions, Family & Advocates, Law Enforcement, Prevention Professionals, Professional Care Providers, People in Recovery as Audience

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Kit - ELECTRONIC ONLY

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- Facts for Community Members (PDF, 625 KB)
- Essentials for First Responders (PDF, 465 KB)
- Safety Advice for Patients (PDF, 312 KB)
- Information for Prescribers (PDF, 478 KB)
- Resources for Overdose Survivors and Family Members (PDF, 323 KB)

http://tinyurl.com/od-toolkit-2013

Background- Opiate overdoses

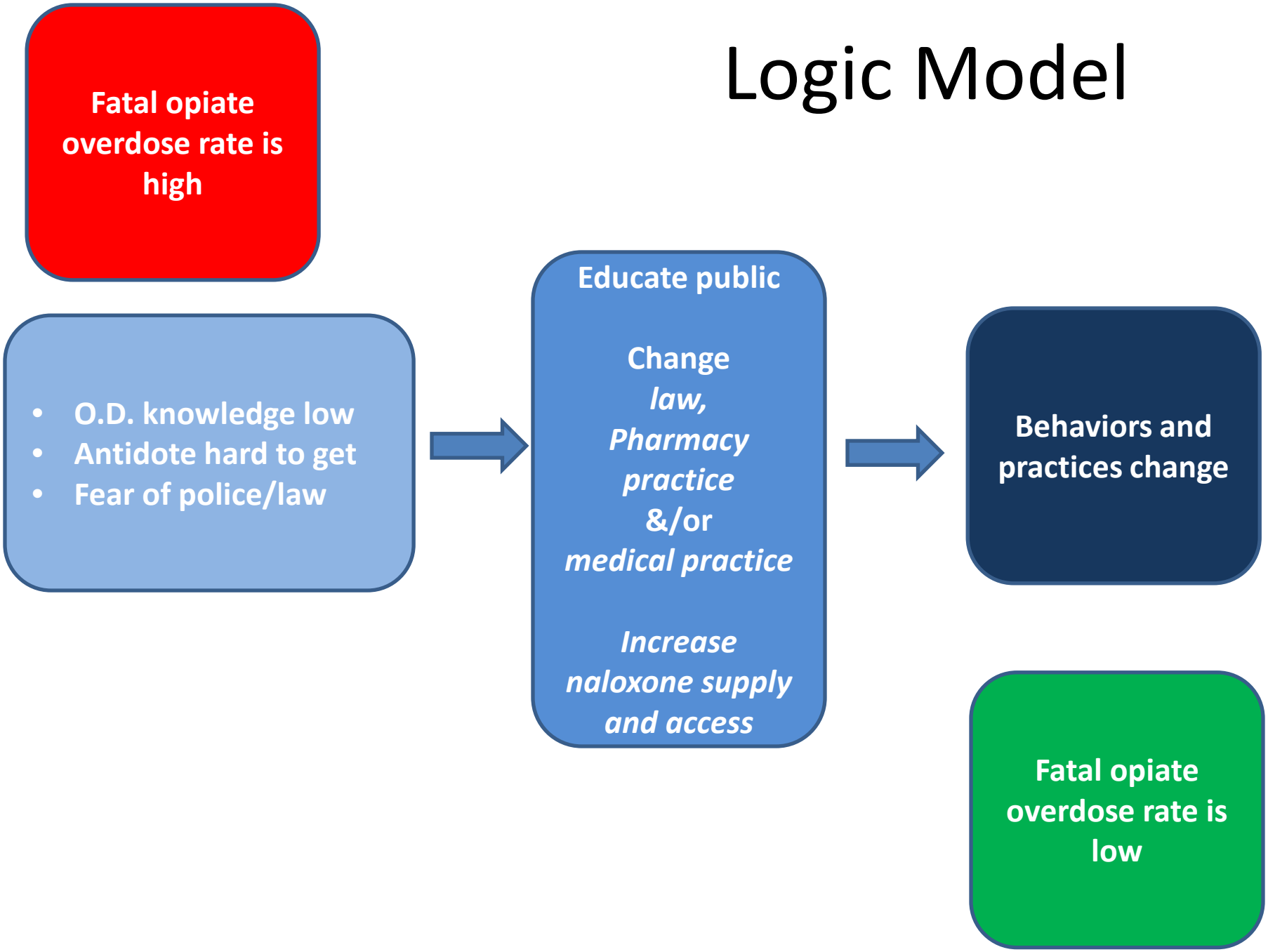
- Overdoses can be prevented
  - Most opiate (heroin and/or Rx) overdoses can be intervened upon before death ensues
- Low overdose knowledge
  - Risk factors; Signs of overdose; How to intervene
  - Audiences include users and family/friends as well as general population
- Bystander fear of police response may inhibit calling 911
  - Perceptions are powerful
- An antidote for opiate overdoses is available
  - Supply and access points are limited

All overdoses can be prevented and many opiate reversed before they become fatal

- Overdose education and an opiate antidote are available (naloxone/Narcan)
- RCW 69.50.315
  - Legal immunity from drug possession charges for person who has overdose and person who seeks medical aid
  - Allows prescribing opiate antidote to person at risk for having and witnessing overdose
- Online training, printable materials, and an antidote locator are online at:

www.stopoverdose.org

Logic Model


Fatal opiate overdose rate is high
O.D. knowledge low
Antidote hard to get
Fear of police/law
Educate public
Change
law,
Pharmacy
practice
&/or
medical practice
Increase
naloxone supply
and access
Behaviors and practices change
Fatal opiate overdose rate is low

O.D. Knowledge
How to increase

- General awareness needed that opiate overdoses can be *prevented* and if they occur they can be *reversed* with naloxone
  - National problem, need broad awareness
  - Supply and demand need to be built
- Regular user of opiates could receive overdose education and take-home naloxone
- Family/friends of regular opiate users should also receive overdose education including how to use take-home naloxone (and get THN if not already in household)
- SAMHSA OD Toolkit

SAMHSA

Antidote/Naloxone
Increasing access

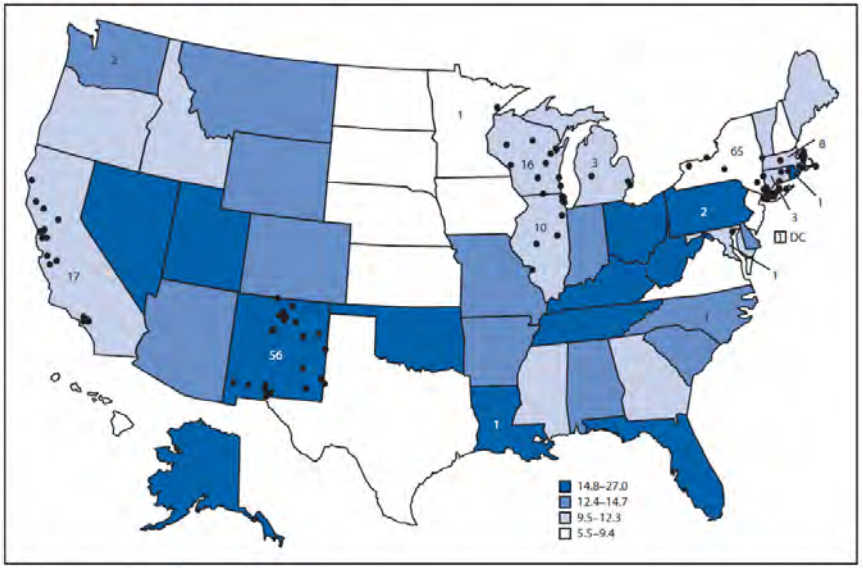
- Medical providers could prescribe to potential overdose
  - and to potential witnesses
  - Settings- Primary care, Emergency Dept, Pharmacy, drug treatment, jail
- Insurance (public and private) could cover Rx costs
- Pharmacists could directly prescribe and dispense
  - lowers $ and increases access tremendously in terms of time burden and geography
  - Collaborative practice agreement
- Overdose education and prescribing time could be reimbursed
  - SBIRT codes should allow reimbursement for education
  - Pharmacists' time educating could be reimbursed

Antidote/Naloxone
Increasing access

Maintain, support and expand community, syringe exchange, social service agency based education and delivery models

Non-licensed persons e.g. PH educators, could *dispense* depending on local rules and with prescriber oversight

FIGURE 2. Number (N = 188) and location* of local drug overdose prevention programs providing naloxone in 2010 and age-adjusted rates† of drug overdose deaths§ in 2008 — United States



* Not shown in states with fewer than three local programs.
† Per 100,000 population.
§ Source: National Vital Statistics System. Available at http://www.cdc.gov/nchs/nvss.htm. Includes intentional, unintentional, and undetermined.

Naloxone for Overdose Prevention

Rx

Naloxone HCl 0.4 mg/mL (Narcan)
1 x 10 mL as one fliptop vial (NDC 0409-1219-01) OR
2 x 1mL single dose vials (NDC 0409-1215-01)

Refills: _____

Intramuscular (IM) syringe, 23 G, 3cc, 1 inch

Qty: _____ Refills: _____

Sig: For suspected opioid overdose,
inject 1mL IM in shoulder or thigh.
Repeat after 3 minutes if no or minimal response.

Are they breathing?

Signs of an overdose:

- Slow or shallow breathing
- Gasping for air when sleeping or weird snoring
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won't wake up or respond (rub knuckles on sternum)

Call 911 for help

All you have to say:
"Someone is unresponsive and not breathing."
Give clear address and location.

Airway

Make sure nothing is inside the person's mouth.

Rescue breathing

Oxygen saves lives. Breathe for them.
One hand on chin, tilt head back, pinch nose closed.
Make a seal over mouth & breathe in
1 breath every 5 seconds
Chest should rise, not stomach

Evaluate

Are they any better? Can you get naloxone and prepare it quickly enough that they won't go for too long without your breathing assistance?

Prepare naloxone

- Remove cap from naloxone and uncover needle
- Insert needle through rubber plug, with bottle upside down
- Pull back on plunger and take up 1 cc into the syringe
- Don't worry about air bubbles (they aren't dangerous in muscle injections)

Muscular injection

inject 1cc of naloxone into a big muscle (shoulder or thigh)

Evaluate + support

- Continue rescue breathing
- Give another shot of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opiate right away
- Encourage survivors to seek treatment if they feel they have a problem

How to Avoid Overdose

- Only take medicine prescribed to you
- Don't take more than instructed
- Call a doctor if your pain gets worse
- Never mix pain meds with alcohol
- Avoid sleeping pills when taking pain meds
- Dispose of unused medications
- Store your medicine in a secure place
- Learn how to use naloxone
- Teach your family + friends how to respond to an overdose

For More Info
PrescribeToPrevent.com

Poison Center
1-800-222-1222
(free & anonymous)

v01.20121

Naloxone access

- **Q. Who can be prescribed naloxone?**
- A. A prescriber can prescribe take-home naloxone to anyone who is at risk for opioid overdose.
  - WA state explicitly allows for the prescription of take-home naloxone to persons at risk for witnessing an overdose.
- **Q. Where can naloxone be obtained?**
- A. Naloxone availability varies by city/town. Generally very limited.
  - To locate overdose education & prevention and naloxone programs http://hopeandrecovery.org/locations/
  - Current efforts to get in community based pharmacies

Q. What has research shown to be the impacts of distributing Naloxone to potential overdose bystanders?

- Naloxone administration has not resulted in dangerous health outcomes;[b]
- Drug users are willing to administer naloxone to each other;[c]
- Naloxone availability does not increase drug use;[d]
- Evaluation data suggests that many who receive overdose education and take-home naloxone decrease their own risk for overdose by reducing drug use and/or entering drug treatment;[e,f]

Cont.

- More than 10,000 opioid overdoses have been reversed with naloxone given by bystanders in the U.S.
  - Naloxone distribution programs generally provide overdose prevention and recognition training combined with the dispensing of take-home Naloxone (THN).
  - More than 100 programs that distribute naloxone to opioid users are operating in at least 15 states. [g]
- As of 2012, two studies in the United States have recently received funding to conduct studies of overdose education and take-home naloxone distribution to populations at high risk for overdose.[h]

BMJ

BMJ 2013;346:f174 doi: 10.1136/bmj.f174 (Published 31 January 2013)

RESEARCH

Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis

Alexander Y Walley *assistant professor of medicine, medical director of Massachusetts opioid overdose prevention pilot*[1 3], Ziming Xuan *research assistant professor*[2], H Holly Hackman *epidemiologist*[3], Emily Quinn *statistical manager*[4], Maya Doe-Simkins *public health researcher*[1], Amy Sorensen-Alawad *program manager*[1], Sarah Ruiz *assistant director of planning and development*[3], Al Ozonoff *director, design and analysis core*[5 6]

[1]Clinical Addiction Research Education Unit, Section of General Internal Medicine, Boston University School of Medicine, Boston, MA, USA; [2]Department of Community Health Sciences, Boston University School of Public Health, USA; [3]Massachusetts Department of Public Health, USA; [4]Data Coordinating Center, Boston University School of Public Health, USA ; [5]Design and Analysis Core, Clinical Research Center, Children's Hospital Boston, USA ; [6]Department of Biostatistics, Boston University School of Public Health, USA

Reduction in population death rate when 150/100,000 population were trained

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FAMILY
PRACTICE

Kevin P. Hill, MD, MHS; Lindsay S. Rice, BA; Hilary S. Connery, MD, PhD; Roger D. Weiss, MD

Division of Alcohol and Drug Abuse, McLean Hospital, Belmont, Mass (Drs. Hill, Connery, and Weiss, and Ms. Rice); Harvard Medical School, Boston (Drs. Hill, Connery, and Weiss)

khill@mclean.harvard.edu

The authors reported no potential conflict of interest relevant to this article.

Diagnosing and treating opioid dependence

The surge in opioid abuse highlights the importance of questioning patients about their use of prescription analgesics—and knowing when and how to intervene.

PRACTICE RECOMMENDATIONS

› *Ask all patients about the inappropriate use of substances, including prescription opioids.* (A)

› *Recommend pharmacotherapy for patients entering treatment for opioid dependence.* (A)

› *Warn patients who are opioid dependent about the risk of accidental fatal overdose, particularly with relapse.* (A)

CASE► Sam M, age 48, is in your office for the first time in more than 2 years. He has gained a considerable amount of weight and appears a bit sluggish, and you wonder whether he's depressed. While taking a history, Sam reminds you that he was laid off 16 months ago and had been caring for his wife, who sustained a debilitating back injury. When you saw her recently, she told you she's back to work and pain-free. So you're taken aback when Sam asks you to refill his wife's oxycodone prescription for lingering pain that often keeps her up at night.

If Sam were your patient, would you suspect opioid dependence?

Dependence on opioid analgesics and the adverse consequences associated with it have steadily increased during the past decade. Consider the

Annals of Internal Medicine | ORIGINAL RESEARCH

Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal

Phillip O. Coffin, MD, and Sean D. Sullivan, PhD

Background: Opioid overdose is a leading cause of accidental death in the United States.

Objective: To estimate the cost-effectiveness of distributing naloxone, an opioid antagonist, to heroin users for use at witnessed overdoses.

Design: Integrated Markov and decision analytic model using deterministic and probabilistic analyses and incorporating recurrent overdoses and a secondary analysis assuming heroin users are a net cost to society.

Data Sources: Published literature calibrated to epidemiologic data.

Target Population: Hypothetical 21-year-old novice U.S. heroin user and more experienced users with scenario analyses.

Time Horizon: Lifetime.

Perspective: Societal.

Intervention: Naloxone distribution for lay administration.

Outcome Measures: Overdose deaths prevented and incremental cost-effectiveness ratio (ICER).

Results of Base-Case Analysis: In the probabilistic analysis, 6% of overdose deaths were prevented with naloxone distribution; 1 death was prevented for every 227 naloxone kits distributed (95% CI, 71 to 716). Naloxone distribution increased costs by $53 (CI, $3 to $156) and quality-adjusted life-years by 0.119 (CI, 0.017 to 0.378) for an ICER of $438 (CI, $48 to $1706).

Results of Sensitivity Analysis: Naloxone distribution was cost-effective in all deterministic and probabilistic sensitivity and scenario analyses, and it was cost-saving if it resulted in fewer overdoses or emergency medical service activations. In a "worst-case scenario" where overdose was rarely witnessed and naloxone was rarely used, minimally effective, and expensive, the ICER was $14 000. If national drug-related expenditures were applied to heroin users, the ICER was $2429.

Limitation: Limited sources of controlled data resulted in wide CIs.

Conclusion: Naloxone distribution to heroin users is likely to reduce overdose deaths and is cost-effective, even under markedly conservative assumptions.

Primary Funding Source: National Institute of Allergy and Infectious Diseases.

Ann Intern Med. 2013;158:1-9. www.annals.org
For author affiliations, see end of text.

Evidence base

- We know naloxone <u>works physiologically</u>
  - Used by EMS and in OR's and ED' for decades
- Community based OD education and take-home naloxone <u>shown to impact death rates at population level</u>
- Evaluations of existing programs not had $ for rigorous research…

Fear of police/law
How to minimize

- Good Samaritan laws at State level can change practice OR perception
- Prosecutorial/Police policy at municipal level can be changed or made explicit [blessing by others may catalyze]
- Police could be trained and allowed to administer naloxone e.g. Quincy Mass
- *I , believe we have spread the word that no one should fear calling the police for assistance and that the option of life is just a 911 call away. We have also re-inforced with the community that the monster is not in the cruiser but indeed the officer represents a chance at life.* *Lt. Glynn*

- PH/LE communication and coordination
- to discuss overdose as public safety issue to change practice and in turn perceptions

- Training police and public essential
  - Transparency will help build trust

WATCH Seattle Police training video about Washington's 911 Good Samaritan law and Narcan.

Naloxone- medical access

Firefox

StopOverdose.org - For Pharmacists and...

www.stopoverdose.org/pharmacy.htm

Most Visited | Getting Started | Suggested Sites | Web Slice Gallery | Bookmarks

StopOverdose.org

Opioid overdoses can be prevented and reversed!

- Home / Opioid OD Education
- Where to Get Naloxone / FAQ
- Sources for Help
- Law Enforcement
- Evaluation of WA Law
- Pharmacy/Prescribers
- Other Drugs and Overdose
- News

For Pharmacists and Prescribers

Who can prescribe naloxone (Narcan®)?

Physicians, nurse practitioners and physician assistants in Washington State who have prescriptive authority may prescribe take-home-naloxone to anyone at risk for having or witnessing an opioid overdose (prescription opioids or heroin) according to WA law RCW 69.50.315.

Pharmacists can dispense naloxone directly to the public if the pharmacist has a protocol in place signed by a legal prescriber. This protocol is part of a collaborative drug therapy agreement (CDTA) also known as a collaborative practice agreement.

How do I prescribe naloxone?

For sample prescriptions, see http://www.prescribetoprevent.org/prescribe-naloxone-now/.

If naloxone is not available in your area, your pharmacy may first need to order the medication.

How can my pharmacy start to dispense naloxone directly to persons at risk of an overdose?

Decide which naloxone to carry intranasal, intramuscular, or both.

Order intramuscular naloxone HCL, either:

- 1 X 10 ml as one fliptop vial (NDC0409-1219-01
- 2 X 1 ml single dose vial (NDC 0409-1215-01

Order intranasal naloxone HCL, both parts:

- 2 X 2 mL as pre-filled Needleless Luer Jet Prefilled Syringe (NDC# 0548-3369-00)
- 2 X intranasal mucosal Atomizing Device (MAD 300)

Verify which insurance companies in your area will cover naloxone. For example Medicaid in Washington State pays for naloxone for a person at risk of an overdose (but, not a potential bystander who is not at risk, e.g. a family member who does not use opioids).

Decide if your pharmacy wishes to fill orders from other prescribers or would like to dispense directly to the public with a collaborative drug therapy agreement.

Design patient education materials for each route of administration. Sample patient education materials are available from many sources. One source for printed educational materials is: http://www.prescribetoprevent.org.

Prepare an overdose rescue kit with the naloxone, nasal applicator or intra-muscular syringe, overdose education materials, perhaps a rescue breathing mask, and a list of local social and health services providers. Set a price.

Prepare a teaching kit so patients can demonstrate that they understand the instruction by practicing drawing up the medication and selecting an injection site, or practicing squirting with the nasal applicator. Hands-on practice is important.

Let your local prescribers know that you are carrying naloxone. [If you would like to be included in the naloxone locator on this website, email: info@stopoverdose.org]

Overdose education, such as that available on this website, is very important in addition to instruction on how to use naloxone. Most people are unaware that opioid overdoses are due to respiratory depression (breathing slows down) and therefore that rescue breathing (and calling 911) is very important to maintain oxygen supply to prevent brain damage or death. Many may also be unaware of WA State's Good Samaritan overdose law that provides immunity from drug possession prosecutions during overdose situations.

Train the pharmacy team so all members know that take-home-naloxone is available, which pharmacists are authorized on the CTDA, the education to provide, and where to find answers to frequently asked questions.

How can I enter into a collaborative drug therapy agreement (CDTA) so that I, as a pharmacist, can dispense naloxone without the patient having to see a medical provider for a prescription?

If your pharmacy wants pharmacists to to prescribe naloxone you will need to create a collaborative drug therapy agreement (CDTA), identify a provider to sign off on the agreement, and then submit it for review by a pharmacist consultant at the WA Board of Pharmacy. A sample CDTA may be downloaded here.

Contact information for the WA State Board of pharmacy is available here: http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewRenewor Update /Pharmacy/BoardInformation.aspx

Is prescribing take-home naloxone controversial?

No. The WA State Board of Pharmacy released a letter of support for take-home naloxone CDTA's (March 2012).

The American Medical Association and the American Public Health Association both have policies supporting availability of take-home naloxone:

- http://www.ama-assn.org/ama/pub/news/news/2012-06-19-ama-adopts-new-policies.page
- http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1443

Professional research articles suggest prescribing take-home naloxone to those at risk for having an opioid overdose. For example: Diagnosing and treating opioid dependence (Hill KP, Rice LS, Connery HS, Weiss RD. *Journal of Family Practice* 2012;61(10):588-597).

To conclude, medical providers can…

- Educate patients about hazards of opioids, treatment of problem use, OD prevention
- Become buprenorphine prescribers
- Prescribe naloxone
- Collaborate with pharmacists and community organizations on OD education and naloxone distribution
- Help educate the community about addiction, stigma, medical condition with medical responses available
- ***No other addiction has such a well proven medication assisted treatment or available antidote***

Stopoverdose.org

You are posting, commenting, and liking as Stopoverdose.org — Change to Caleb Ban

Stopoverdose.org | Timeline | Recent

September 6

Public health relevance of WA's overdose law and implementation thus far http://fridayletter.aspph.org/article_view.cfm?FLE_Index=261&FL_Index=6

ASPPH Friday Letter #6 - 06 September 2013
fridayletter.aspph.org

Opioid overdose – from heroin or pharmaceuticals – is an epidemic in the U.S., but fear of police is a common barrier to calling 911. In 2010, Washington became the second state to pass a Good Samaritan law providing immunity from drug possession charges for victims or

Like · Comment · Share

Ramese Mac likes this.

Write a comment...

81 people saw this post

Boost Post

Stopoverdose.org shared a link.
September 4

Remember: WA's Good Samaritan law applies to all drugs & www.stopoverdose.org has information about stimulant/hallucinogen overdoses

Electric Zoo Festival Cut Short by Two Deaths

Twitter @nomoreoverdose

Stop Overdose .org

stopoverdose.org
@nomoreoverdose
Overdoses can be prevented. Educational information on laws, policy, public health, health care and treatment.
WA State · stopoverdose.org

TWEETS	FOLLOWING	FOLLOWERS
51	29	31

Edit profile

Tweets

stopoverdose.org @nomoreoverdose · 5h
Overview & encouragement for many access points for naloxone/Narcan JAMA News jama.jamanetwork.com/article.aspx?a...
Expand

Retweeted by stopoverdose.org
U.S. Drug Policy @ONDCP · Apr 3
Joining @HHSGov Sec. Sebelius and @US_FDA Commissioner Hamburg to announce a new, lifesaving #naloxone autoinjector. pic.twitter.com/J50QYLvzAx

Washington Health Benefit Exchange

Exchange Update

Washington Medical Quality Assurance Commission
October 2, 2014

Molly Voris, Policy Director

Presentation Topics

- Enrollment Information
- Lessons Learned from Year One
- Looking Forward to Year Two

Key Enrollment Numbers

Since Oct. 1, 2013, nearly 1.3 million people enrolled in health coverage through Washington Healthplanfinder.

- ✓ QHP enrollments: 147,888
- ✓ New MAGI Medicaid: 352,386
- ✓ Medicaid previously eligible but not enrolled: 199,631
- ✓ Medicaid renewals: 583,765
- ✓ New MAGI Medicaid enrollment exceeded target for January 2018.

Enrollment Highlights

- **Washington Healthplanfinder attracted a wide variety of consumers**
  - ✓ "Young Invincibles" (ages 18-34) accounted for 25% of enrollments, 29% in March; grows to more than 35% when including Medicaid

- **People relied on consumer assistance**
  - ✓ 43% of new enrollments assisted by in-person assisters or agents/brokers

- **The Exchange has leveraged federal dollars to benefit residents and the state**
  - ✓ More than $300 million in federal tax credits have gone to residents to reduce their premium costs
  - ✓ Residents have also received over $30 million in federal cost-share reductions to reduce the cost of hospital and provider visits

- **The Exchange is already having a big impact**
  - ✓ Uninsured population reduced by more than 370,000
  - ✓ Harborview Medical Center recently reported that uninsured patient dropped from 12% last year to 2% this spring

What Worked Well

- ✓ Early start, structural set up, bipartisan support from elected officials, Board
- ✓ Managing scope, governance in a transparent manner
- ✓ Key stakeholder engagement
- ✓ Strong marketing and outreach, engaged community partners
- ✓ Collaboration and coordination among key state agencies

Key Learnings

- ✓ Seismic shift to the health care landscape in WA
- ✓ New process generated new customer needs
- ✓ Remain nimble and execute changes as necessary
- ✓ Understanding and projecting volume (call center, renewals, etc.)
- ✓ Testing the system: limited time, real world environment

Payment and Invoicing Issues

- Problems with transferring enrollment information to carriers which has prevented people from getting coverage
- Problems with people receiving incorrect invoices
- Resolution is top priority
  - Impacts to consumers, carriers, agents/brokers, providers, and consumer assisters
- Making Progress
  - Increased engagement with insurance carriers to identify top priority issues
  - Continuing to address known technical issues and fix individual accounts
  - Continued outreach to affected consumers and assisters
  - Recently terminated over 4,000 individuals

Operational Requirements

REQUIRED

Call Center
Plan Certification
Printing for required notices
SHOP
Consumer Rating System
State Audit
Data Reporting to Federal Government
Reconciliation of enrollment information with carriers (834 files, ongoing, etc.)
Streamlined application (QHP and Medicaid) & eligibility determination
Navigator Program
Pediatric dental
Translation/Interpreter Services
Consumer Survey
Appeals

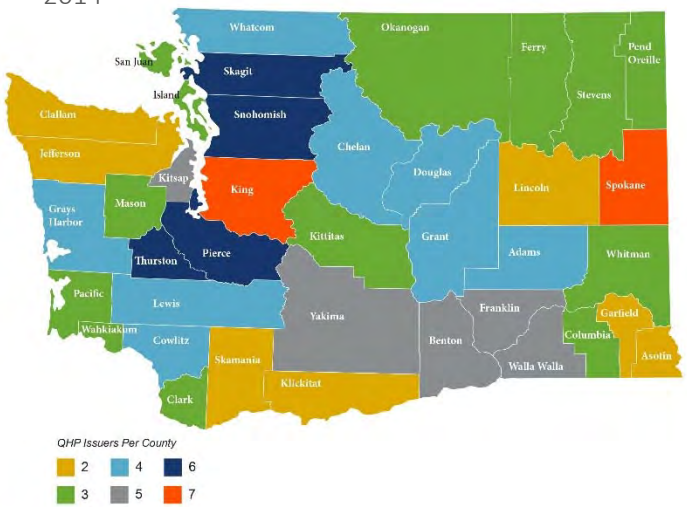
NOT REQUIRED

Outreach and Marketing
Specialized broker support
Post-eligibility referrals to WaConn (classic Medicaid, etc.)
Consumer decision/shopping tools (plan display features, etc.)
Provider directory
Adult dental
Premium aggregation and invoicing

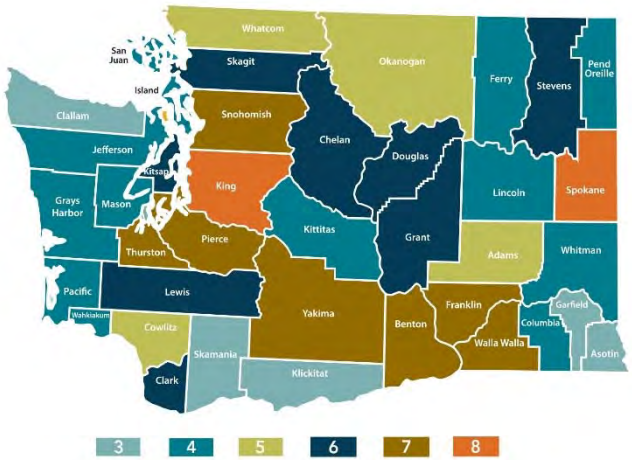
Breakdown of 2015 Exchange Plan Offerings

Individual QHP Market – Issuers per County

2014



2015



Individual Market

2014: 8 issuers, 46 plans

2015: at least 10 issuers, 90 plans (8 multi-state plans)

New: More choice

Healthplanfinder Business/SHOP

2014: 1 Issuer, 5 plans

2015: 2 Issuers, 23 plans

New: Statewide market

Individual Pediatric Dental Market

2014: 5 Issuers, 5 Plans

2015: at least 5 issuers, 6 plans

New: High-level plans (85% AV)

Breakdown of 2015 Participating Issuers

Individual Market:	Healthplanfinder Business/SHOP:	Individual Pediatric Dental Market:
BridgeSpan Health Company	Kaiser Permanente	Delta Dental of Washington
Columbia United Providers*	Moda Health Plan*	Dental Health Services
Community Health Plan of Washington		Kaiser Permanente
Coordinated Care Corporation		LifeWise of Washington
Group Health Cooperative		Premera Blue Cross
LifeWise of Washington		
Moda Health Plan*		
Molina		
Premera Blue Cross		

**New issuers in 2015*
All 2014 issuers are continuing in 2015

QHP Renewal Timeline

- Issuers send letter on non-renewed QHPs by October 1
- Exchange sends QHP renewal letter in late October
  - Informs consumer about renewal plan for 2015
  - Tax credit amount (based upon second lowest cost silver plan) for 2015
  - Enrollee's premium contribution for renewal plan in 2015
- Open Enrollment begins November 15

Provider-Related Issues

- Grace period issues related to system problems
- Narrower networks in QHPs
- Doctor availability and longer wait times

Resources

www.wahealthplanfinder.org

www.wahbexchange.org

1-855-WAFINDER (1-855-923-4633)

TTY/TTD for Deaf : 1-855-627-9604

info@wahbexchange.org

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Washington State Department of Health

Integration: Primary Care and Public Health

October 2, 2014

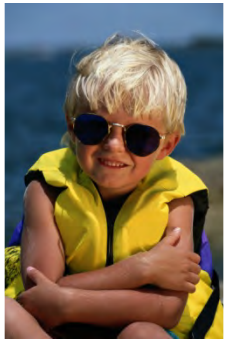
Washington Medical Quality Assurance Conference

John Wiesman, DrPH, MPH
Secretary, Washington Department of Health

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER COMMUNITY








Outline

- Context setting
- Health Transformation: Integration of primary care and public health
- Washington's Health Innovation Plan

Washington State Department of Health

Strategy

- Department of Health Strategy:

Through collaborations and partnerships, we will leverage the knowledge, relationship and resources necessary to influence the conditions that promote good health and safety for everyone.

Washington State Department of Health

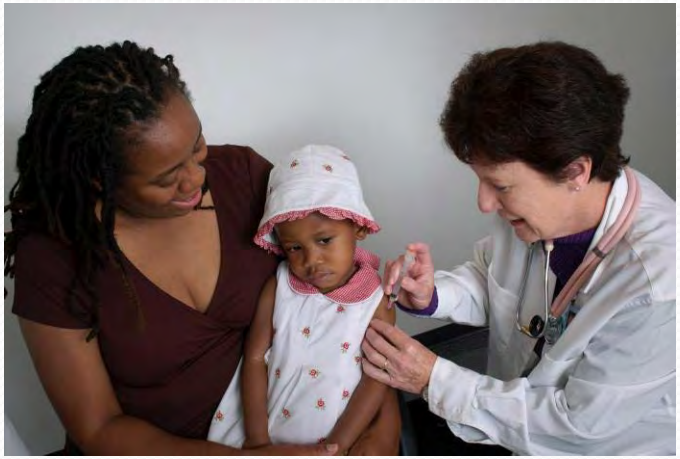
Traditional Public Health

- Works on a population-basis
- Prevents disease and injury
- Promotes good health
- Protects food, water, air
- Prepares for/Responds to health emergencies

Washington State Department of Health

Traditional Primary Care

- Works on a individual-basis
- Responds to health needs and provides care on a broad range of health needs
- Prevents illness with vaccines
- Acts as a point of entry for accessing specific health services



Washington State Department of Health

Population-based Approach

- Distinguishing attribute between public health and primary care
- Community-level interventions
- Complementary strategies: individual and community
- Incorporates:
  - Behavioral science
  - Biological science
  - Environmental science
  - Social science

Significant Challenges

- Health disparities
- Rising costs
- Increasing obesity
- Silo-ing behavioral health

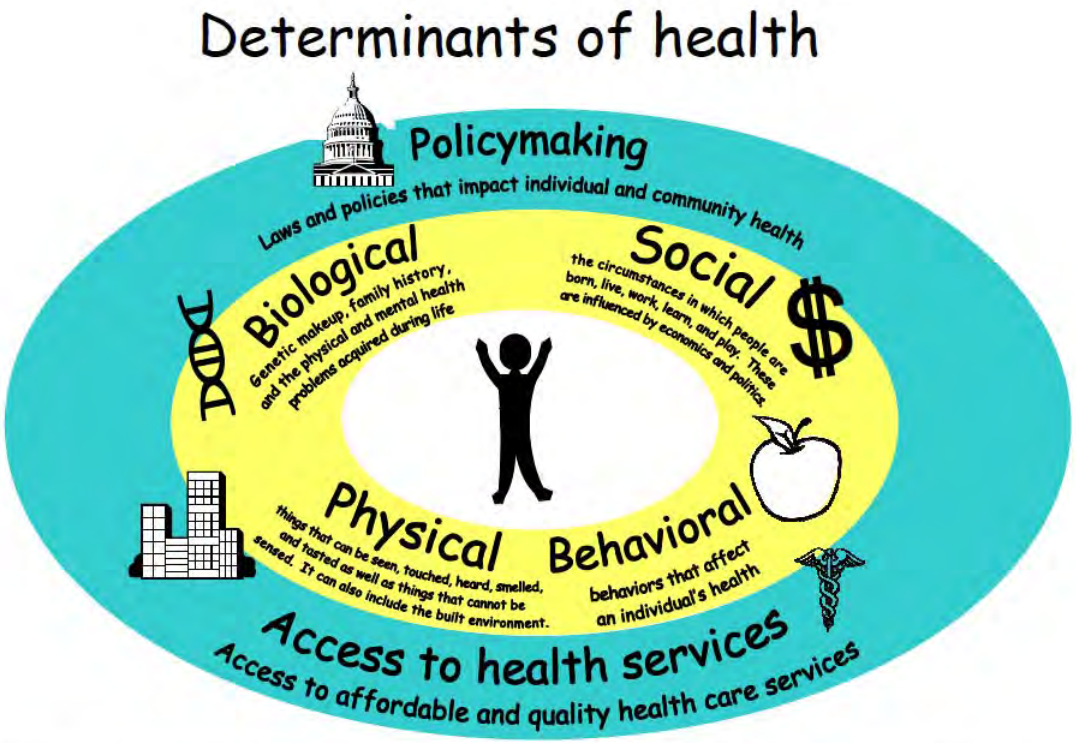
Washington State Department of Health

Requirements

- Build partnerships – Population-based health transformation
- Create place-based policy systems
- Integrate physical and mental health

Washington State Department of Health

Health Transformation



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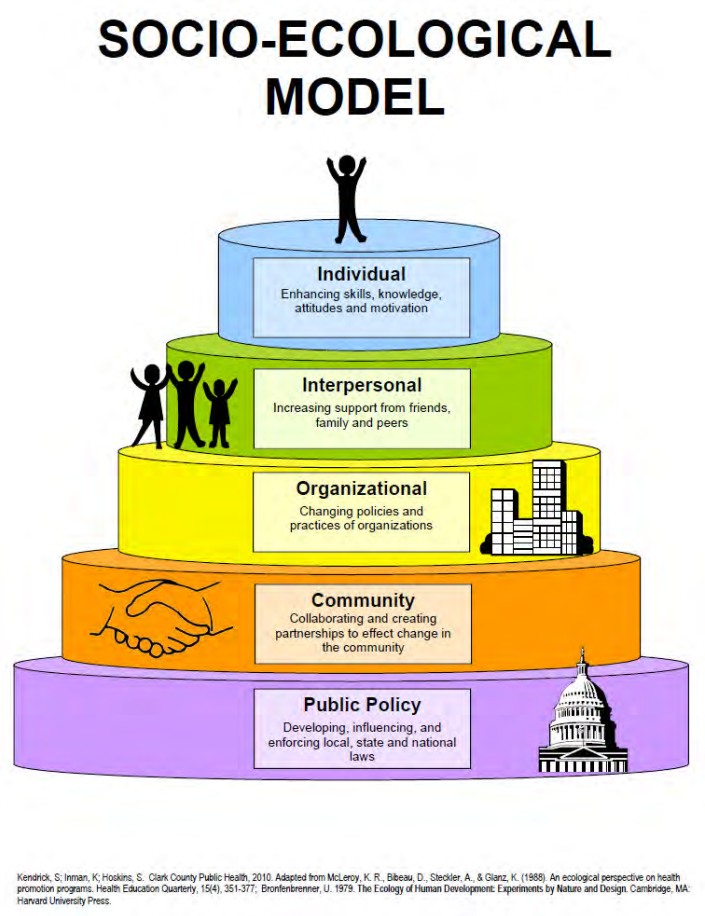
Washington State Department of Health

Socioecological Model



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State Health Care Innovation Plan

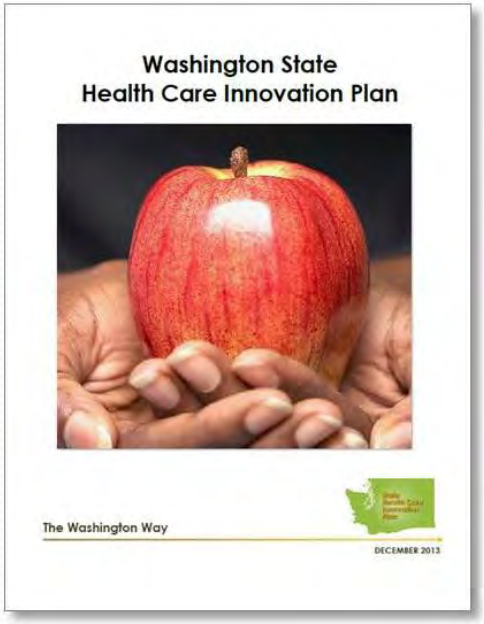
Goal - **a Healthier Washington**

- **Pay for value and outcomes** starting with the State as "first mover"
- **Empower communities** to improve health and better link with health delivery
- **Integrate physical and behavioral health** to address the needs of the whole person

Critical - **Legislation Enacted**

- **E2SHB 2572** – Purchasing reform, greater transparency, empowered communities
- **E2SSB 6312** – Integrated whole-person care

Potential - **Federal Financing (Round 2)**



Questions

- What questions or comments do you have?

Washington State Department of Health

EvergreenHealth Partners

Aligning Incentives

Clinical Integration and Patient Safety

EvergreenHealth Partners

A Glimpse at Our Market Situation

EvergreenHealth

EvergreenHealth Partners

Partners

EvergreenHealth

EvergreenHealth Partners

Partners

EvergreenHealth Partners

EvergreenHealth

Kirkland, WA

900 providers

80 specialties

400,000 primary service area

800,000 total service area

LOCATIONS

EvergreenHealth Partners

EvergreenHealth Medical Center and EvergreenHealth Home Care and Hospice

24-hour Emergency Care in Kirkland and Redmond

Urgent Care - Redmond and Woodinville

Primary Care - Canyon Park, Duvall, Kenmore, Redmond, Monroe, Sammamish & Woodinville

Specialty Care—12 in Kirkland and 6 satellites in Redmond

RECOGNIZED FOR QUALITY

EvergreenHealth Partners

Distinguished Hospital For Clinical Excellence

~ Healthgrades

~ 5 of the past 6 years

Best Regional Hospitals

~ US News & World Report

~ #2 Best Hospital - in the Seattle area

~ #3 Best Hospital – in Washington state

~ Recognition in 9 specialty areas

PURPOSE, MISSION & VALUES

EvergreenHealth Partners

Purpose ~ shared commitment

Working together to enrich the health and well-being of every life we touch.

Mission ~ why we exist

EvergreenHealth will advance the health of the community it serves through our dedication to high quality, safe, compassionate, and cost-effective health care.

Vision ~ what we will become

EvergreenHealth will create an inclusive community health system that is the most trusted source for health care solutions.

EvergreenHealth Partners

The Circumstances the Health Care Industry Faces

Why EvergreenHealth Partners?

EvergreenHealth Partners

Host of Pressures Pushing Physicians, Hospitals Together

- Driving Factors for Alignment

Hospitals | **Physicians**

Aging Population
- Shift to public payers
- Deteriorating case mix

Shifting Workforce Demographics
- Premium on work-life balance
- Interest in team-based care

Changing Market Demands
- Competing on value
- At risk for outcomes

Worsening Financials
- New reimbursement cuts
- Rising practice costs

Future Threats
- Expected reduction in volumes
- Proposed Medicare cuts
- Market share loss

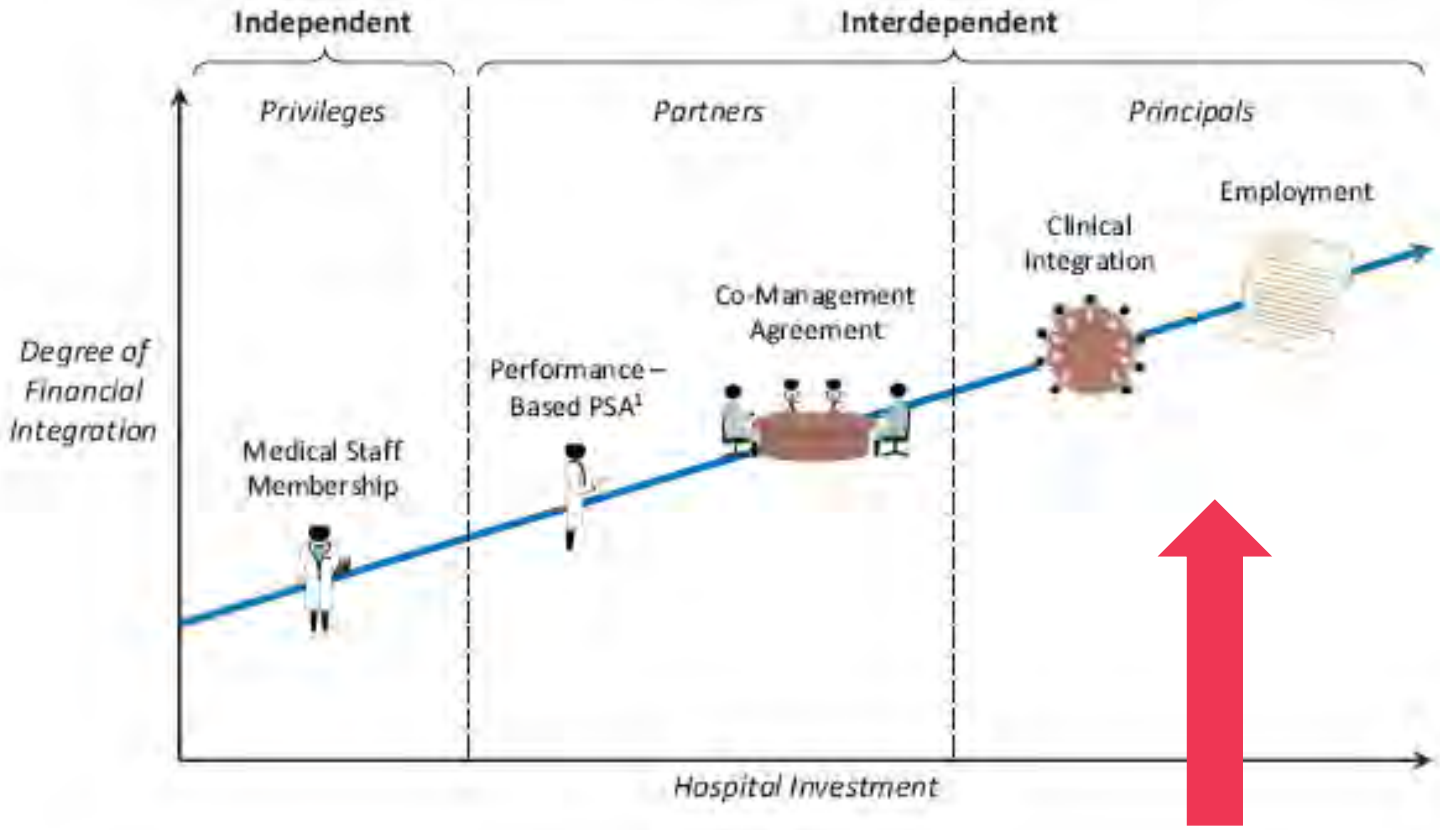
Reform Uncertainty
- Unable to cover investment in care management resources
- Fear of referral stream loss

Source: Health Care Advisory Board interviews and analysis.

TRANSITIONING FROM INDEPENDENT TO INTERDEPENDENT

EvergreenHealth Partners

Hospitals, Physicians Strengthening Formal Relationships

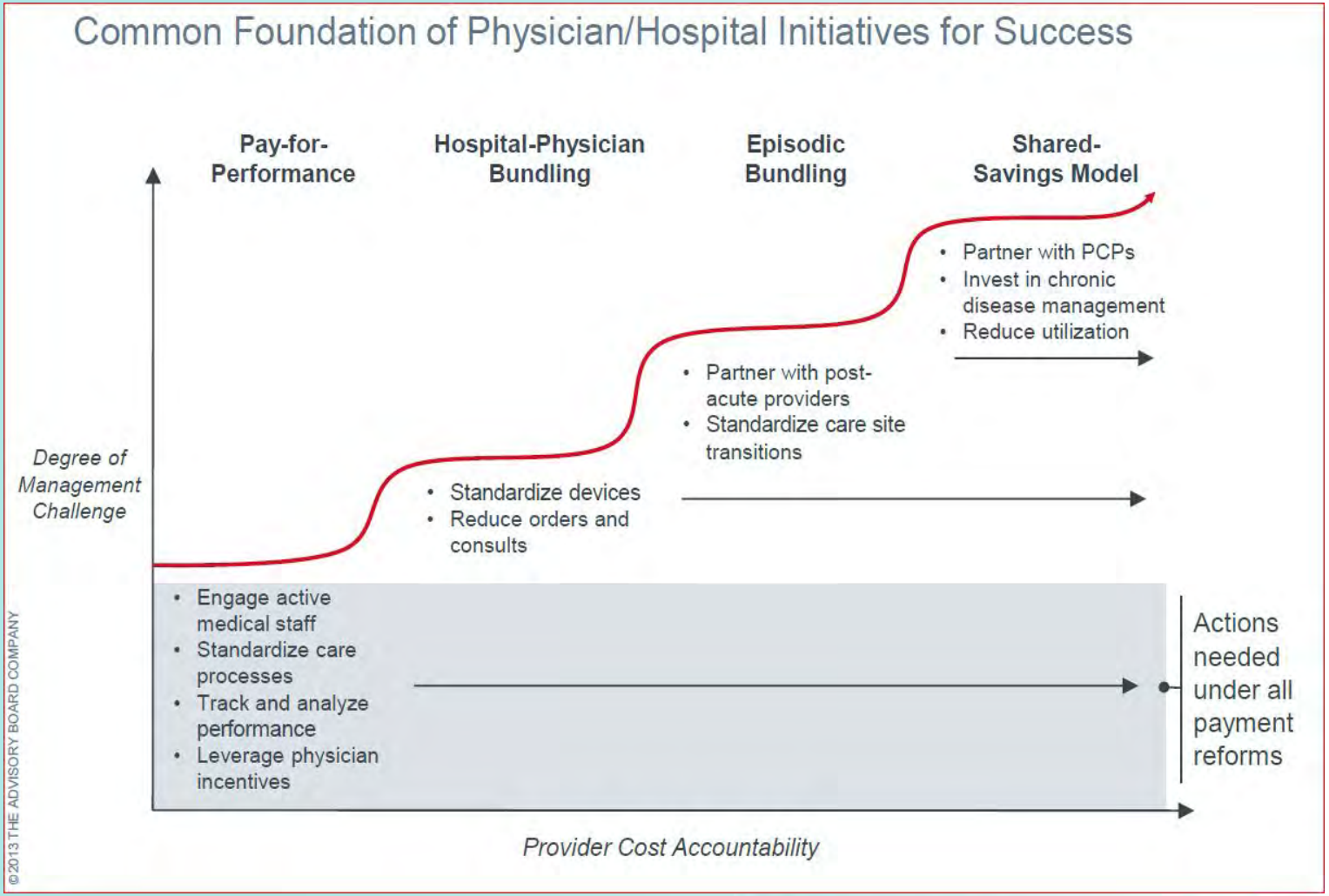


1 Professional services agreement.

Partners

SUCCESS REQUIREMENTS LINKED TO PAYMENT ENDGAME

EvergreenHealth Partners



IN NEED OF A HOSPITAL/PHYSICIAN INTEGRATION PLATFORM

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Current Contracting Models Insufficient

Employed Physicians

Limited Scale

- Represent fraction of medical staff; restrained by hospital resources, physician interest
- Often lack strategy-aligned compensation model, performance improvement infrastructure

Independent Physicians

Limited Levers

- Antitrust, regulatory barriers restrain financial incentives
- Limited data sharing, performance improvement infrastructure
- Collection of stakeholders too diffuse for organized performance achievements

Performance-Focused Integration Platform

Key Characteristics

- Selective, scalable membership
- Commitment to evidence-based, standardized care
- Care coordination infrastructure
- Performance management system
- Legal, meaningful performance-based incentives
- Capable of joint contracting with commercial payers

EvergreenHealth Partners

Our Response: Clinical Integration

CLINICAL INTEGRATION IS…

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- Physician-led strategy to improve quality, control costs and bring value to patients across the continuum of care
- Means for physicians to contract collectively with fee-for-service health plans
  - Without violating antitrust laws
- Undertaken in conjunction with a sponsoring hospital such as EvergreenHealth

A FOUNDATIONAL STRATEGY

EvergreenHealth Partners

Clinical Integration is…

- A network of physicians, working (most often) in collaboration with a hospital
- A program of initiatives, developed and managed by physicians, to improve the quality and efficiency of patient care and supported by a performance management infrastructure
- A legal basis for collective negotiation by independent physicians for improved reimbursement on the basis of improved clinical outcomes and efficiency

Clinical Integration is not…

- Physician employment by another name
- A return to capitation
- EMR implementation
- IPA / PHO Messenger Model
- Gimmick to bypass anti-trust law
- Program led by the hospital

Legal Compliance at Core of Success

"Clinical Integration is an active and ongoing program to evaluate and modify practice patterns by a network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality." ***- FTC Definition***

- *Recognizes joint contracting may be acceptable on the basis of value creation for patients and payers*
- *Establishes a "Clinical Integration" concept as a defense against price-fixing challenges*
- *Allows for layering CI-related contracts on top of existing models of economic alignment*
- *Provides general concepts but limited detail on desired CI program structure*

A MEANS TO ALIGN PHYSICIANS

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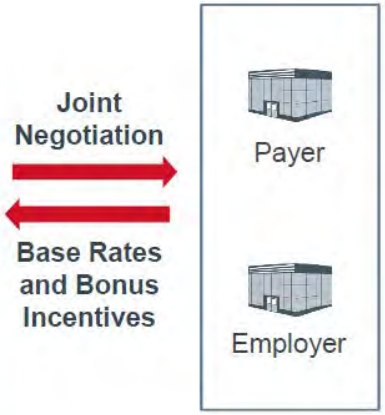
Clinically Integrated Organization

Core Components

Comprehensive Improvement Initiatives
Identified (and evolving) metrics and targets designed to meaningfully impact the clinical practice of all physicians in the network to improve value across the full continuum of care

Performance Improvement Architecture
Data-based mechanisms and processes to monitor and manage utilization of health care services, designed to control costs and ensure quality of care

Selective Physician Partnerships
Network of physicians opting to collaborate with the hospital(s) in delivering evidence-based care and improving quality, efficiency, and coordination of care



Benefits to Independent Physicians

- Access to coordination infrastructure
- Access to technology
- Data visibility across full continuum of care
- Leadership opportunities
- Enhanced community impact
- Potential for better reimbursement

REQUIRES MULTI-PRONGED EFFORT

EvergreenHealth Partners

Typical CI Program Components

Selective Physician Partners

- Right specialty mix to advance care delivery
- Clear participation requirements

Physician Oversight

- Broad engagement in governance, management
- Platforms for shared hospital-physician decision making

Meaningful Performance Metrics

- Program-wide and specialty-specific measures
- High-yield targets and objectives

Payer Engagement

- Early involvement in initiative selection
- Joint contracts that recognize CI value

Support for Clinical Redesign

- Scalable care coordination infrastructure
- Principled referral management policies

Optimized IT Infrastructure

- Platforms for seamless data exchange
- Disease registry and other clinical tools

Performance Monitoring

- Systems to track physician performance
- Process to remedy underperformance

Performance Incentive Pool

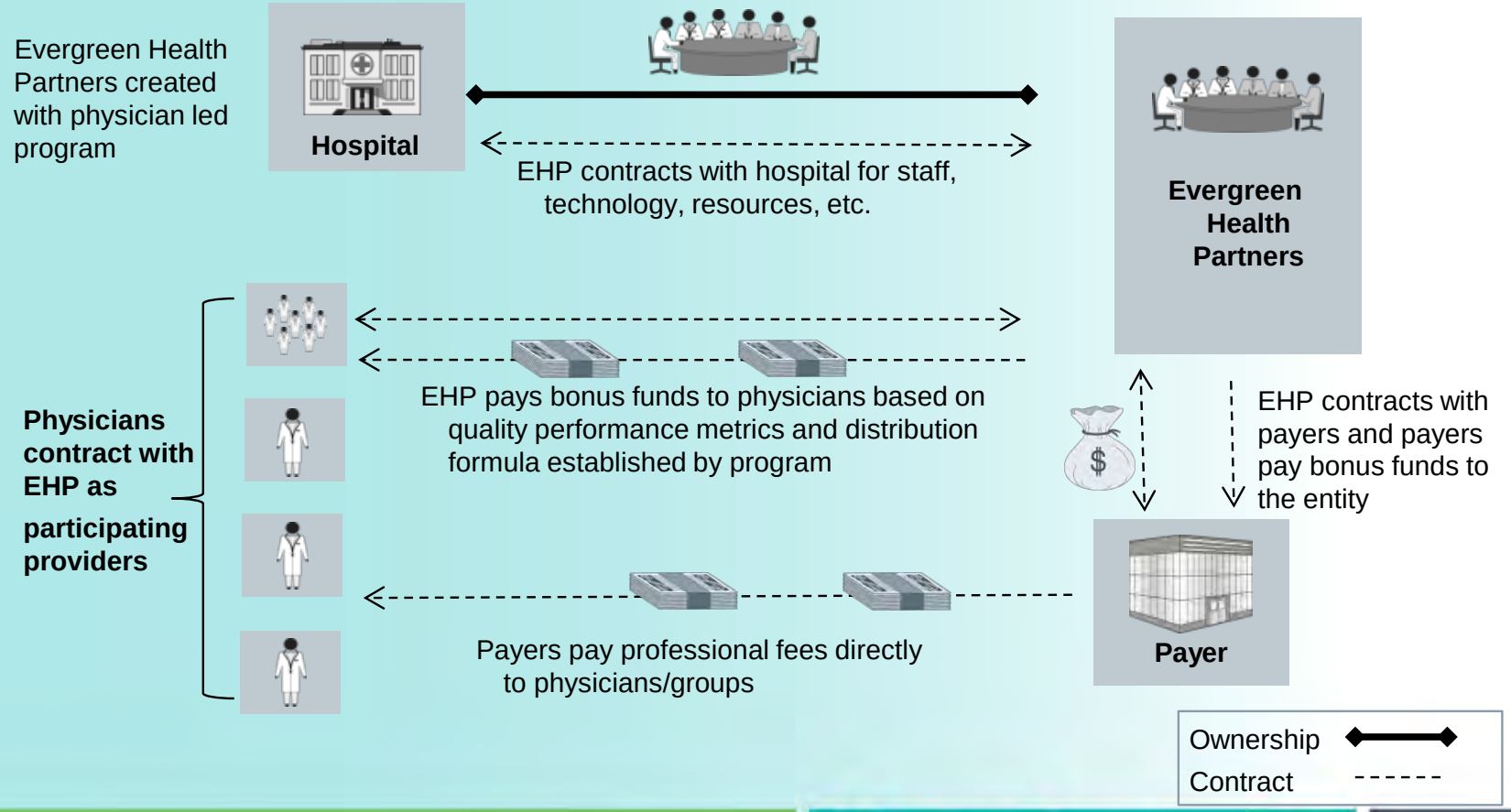
- Bonus structure tied to program goals, physician performance

Source: Health Care Advisory Board interviews and analysis.

BUILDING EHP

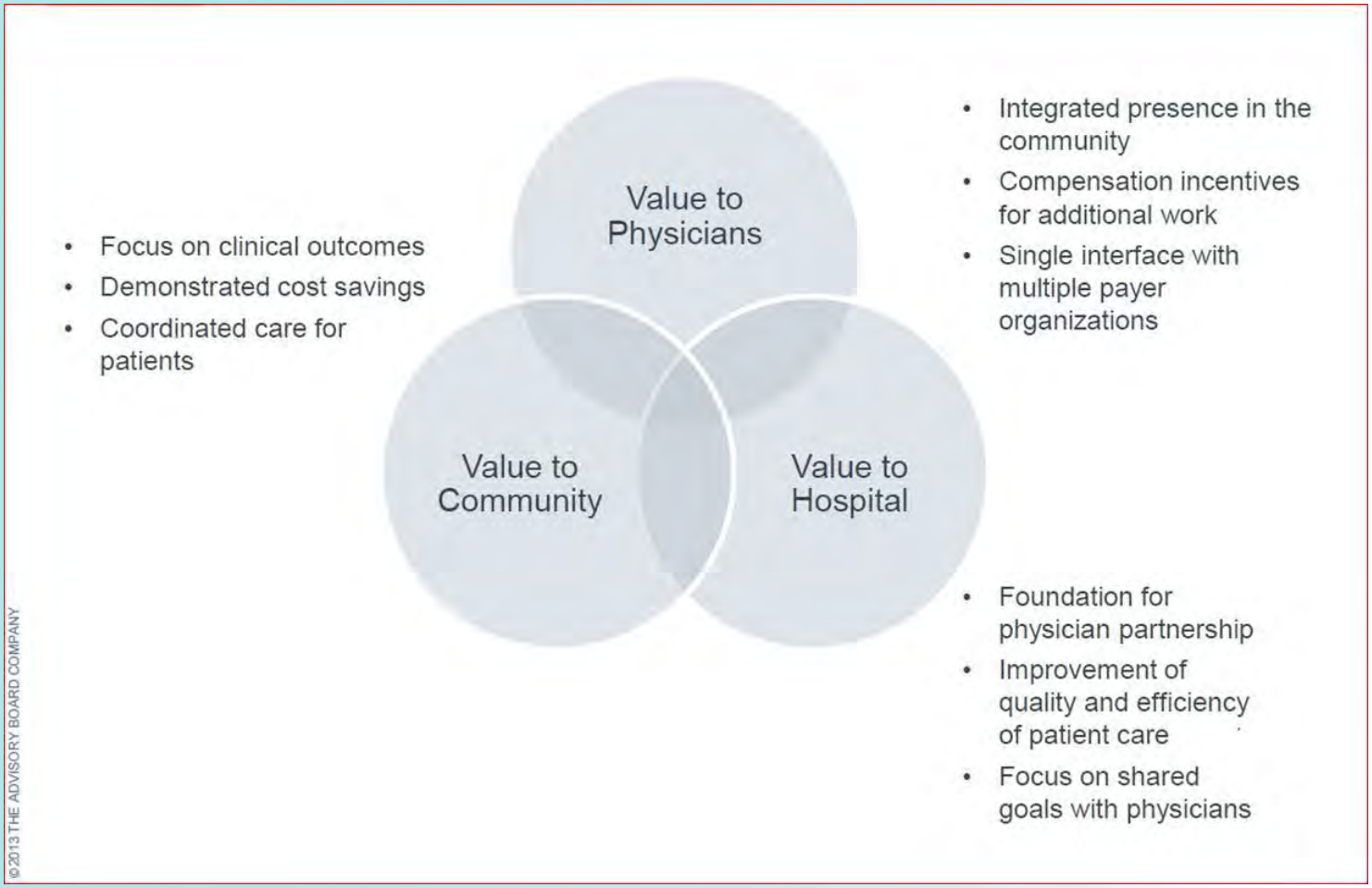
EvergreenHealth Partners

Organizational Structure and Funds Flow Supporting Clinical Integration



CI BENEFITS PHYSICIANS, HOSPITAL & COMMUNITY

EvergreenHealth Partners



EvergreenHealth Partners

VISION

Redefining Healthcare

EvergreenHealth Partners

MISSION

EvergreenHealth Partners provides our community with high quality, safe health care through an integrated network of health care providers delivery the best service and value.

MEMBERSHIP

EvergreenHealth Partners

515 Participants

97 Practices

45 Specialties

Oct. 1, 2014

GOVERNANCE

EvergreenHealth Partners

Board of Managers

Committees

- Quality
- Payer Relations & Finance
- Education & Remediation

QUALITY PROCESS & MONITORING

EvergreenHealth Partners

- Public reporting of indicators: chosen by Board from over 600 available
- At least 5 metrics per specialty
- Claims data from every practice fed across all payers to business intelligence tool: internal benchmarking

QUALITY PROCESS & MONITORING

EvergreenHealth Partners

- Commitment to internal transparency: "airing our laundry." Specialty specific transparent review.
- Flexibility: metrics can be changed by the Board as able and needed

CONTRACTS

EvergreenHealth Partners

~ First Choice / EvergreenHealth

~ First Choice / High-Value Network

~ Cigna

~ Regence Accountable Health Network

~ Many to follow….

HOW DOES CI IMPROVE PATIENT SAFETY?

EvergreenHealth Partners

- Incentive alignment toward relevant goals and metrics
- Reducing waste = reducing error = patient safety
- Standard work = reliability = improved patient experience

HOW DOES CI IMPROVE PATIENT SAFETY?

EvergreenHealth Partners

- Improved value = competitive advantage; others have to follow, or we earn the loyalty of their patients
- Metrics from more robust data than any payer
- The ability to spread improvement out from the mother ship and in from the grassroots

BASIC QUALITY PLANNING FRAMEWORK

EvergreenHealth Partners

ANNUAL QUALITY & SAFETY PLAN

EvergreenHealth Partners

2014 CLINICAL OUTCOMES & ABSOLUTE SAFETY PLAN

2014 INITIATIVES

TRANSFORM CARE BY EXCELLING AT THE COORDINATION AND TRANSITIONS OF CARE

1. Follow Up Visits Within 7 Days of Discharge — Nancee Hofmeister*, Greg Allen

Opportunity: Currently no system in place to schedule patient for follow up visits within 7 days of discharge

Desired Outcome: Design a process to schedule patients recommended by the Inpatient Hospitalists for a follow up visit within 7 days of discharge

Timeline: Continuation of 2013 Handoffs/Transitions Initiative, begin Q2, complete Q3

Measurement: X % of recommended patients discharged from Hospitalist's Service have appointments scheduled with primary provider within 7 days; X% of patients were seen in 7 days by primary provider

2. Intensive Chronic Disease Management of High/Moderate Risk Patients Across the Continuum — Monique Ruyle*, Stacy Olinger

Opportunity: First Choice and other Total Cost of Care contracts provide us with data so that we are able to identify particular high utilizers or those at risk for high utilization of services, which we can use to focus our care coordination activities more effectively.

Desired Outcome: Help patients to access the right type of service, at the right time in the right location. Decrease in cost for our self-insured and shared savings patients.

Timeline: Continuation of 2013 Diabetes and Behavioral Health Initiatives; begin work Q1, plan in place by Q3.

Measurement: Decrease total cost of care while improving health maintenance indicators; reduce ED visits and hospitalizations; increase access to primary care.

3. Create a Perioperative Surgical Home — Neil Johnson*, Sean Kincaid

Opportunity: Deliver high quality medical care to the surgical patient in a cost-effective and coordinated manner through the perioperative period that decreases the potential for complications such as readmissions, surgical site infections and perioperative cardiac events.

Desired Outcome: Develop an algorithm for the preoperative process that embraces the complexity of the numerous variables such as the urgency of the procedure and the service line; implement smoking cessation resource for preoperative patients; implement a better process for glucose management in the perioperative period; develop multimodal pain management plan for hip fracture patients.

Timeline: Q1 develop plans, Q3 complete implementation of plans; Q4 evaluate results

Measurement: Fewer day or surgery cancellations, better glycemic management, decreased opioid use in hip fx patients

4. Create a Preventative Health and Health Maintenance Infrastructure — Greg Allen*, Milton Curtis

Opportunity: Develop the infrastructure for EvergreenHealth Primary Care for a Standard Patient Preventative Assessment to be reviewed during all visits based on best practice guidelines and individual patient needs.

Desired Outcome: Higher perceived quality for EvergreenHealth primary care providers as reflected in patient satisfaction scores, perform better than Puget Sound Health Alliance (PSHA) competitors in the marketplace; generate additional office visits and related services and referrals as a result of increased loyalty.

Timeline: Started in Q4 2013; infrastructure complete by Q3 2014

Measurement: Improved Puget Sound Health Alliance clinical scores for all EvergreenHealth primary care practices that have access to the Evergreen Cerner IT platform; raise performance scores to PSHA average score by 2015, and all clinics to above average by 2017. Improved Patient Satisfaction scores and market preference.

*Executive Sponsor

ADVANCE NURSING PRACTICES THROUGH MAGNET PRINCIPLES

5. Increase Use of Evidence-Base Practice in Nursing — Nancee Hofmeister*

Opportunity: Improve the overall quality outcomes related to nursing care

Desired Outcome: Improve patient outcomes and patient satisfaction specific to nursing sensitive indicators

Timeline: Continuation from 2013 of Magnet Journey Initiative

Measurement: All measures at or below mean: Falls, Falls with Injury, Falls with Moderate to Severe Injury; Pressure Ulcers; Central line associated blood stream infections; Catheter associated urinary tract infections, HCAHPS pain score (above mean)

ELEVATE A CULTURE OF TRANSPARENCY AND ACHIEVING ABSOLUTE SAFETY

6. Develop a Community of Safety — Kay Taylor*, Kathy Schoenrock

Opportunity: Broaden focus from patient safety to absolute safety – develop a Community of Safety; build pride, ownership and inspiration with all stakeholders (employees, physicians, volunteers) and understanding and motivation for their personal and collective part to play. Just Culture is how we do our work. Event reporting is an individual accountability.

Desired Outcome: Every stakeholder (employees, physicians, volunteers) understands their role in the Community of Safety. We are best practice in safety results compared to the past and in the market.

Timeline: Continuation of the Optimize the Patient Safety Reporting System Initiative begun in 2013

Measurement: Stakeholders "own" safety, understand their role and responsibility, and are inspired by the organization's commitment to and results in being absolutely safe. Improve key measures on 2014 Culture Survey; increase reporting of events and near misses.

EFFECTIVELY LEVERAGE OUR IT SYSTEMS TO REDUCE HUMAN ERROR AND IMPROVE QUALITY

7. Achieve Safe Practices Through Improvements in Documentation — Nancee Hofmeister*, Tony Yen

Opportunity: When Cerner was implemented we allowed and encouraged many custom builds, today this is discouraged as customization has a significant impact on the functionality of the EMR to work as a system. We need to realign our documentation to increase the flow of information across the system (inpatient, outpatient and ambulatory).

Desired Outcome: Safer care practices for our patients demonstrated by improved communication among the teams and a better handover of the patient to the next step in the continuum of care with a focus on family/social history, housewide discharge process/Krames education, Care Compass, Plan of Care and IView functionality.

Timeline: Ongoing, with a goal to have changes implemented by end of Q 2.

Measurement: Improved communication among the care team through individualized plans of care and improved compliance with documentation requirements to support care standards.

8. Early Detection and Warning of the Deteriorating Patient — Jeff Tomlin*, Nancee Hofmeister

Opportunity: Early detection modules are available through Cerner and other vendors; through evaluation of these options we can develop systems that will provide early detection and warning to clinicians to enable timely intervention in the deteriorating patient.

Desired Outcome: Patient outcomes will be enhanced through timely intervention

Timeline: Continuation of 2013 Initiative to develop a Clinical Decision Support Structure

Measurement: Deploy Early Detection Tool(s) in 2014; satisfy one or more of the 5 Meaningful Use Criteria

Depts1/QM/Clinical Outcomes & Absolute Safety Plan/2014/2013November 22, 2013

*Executive Sponsor

EvergreenHealth

Operating System (v. 1.0)

VISION

To create an inclusive community health system that is the most trusted source for health care solutions.

Strategic Pillars

Clinical Outcomes & Absolute Safety	Customer Engagement	People & Process	Growth & Access	Financial Stewardship

Patient & Family Centered

STANDARD WORK

PEOPLE
- Coaching & Development
- Magnet Principles
- Art of Caring

PROCESS
- Lean
- Safety Management System
- Change Management System

STRUCTURE
- Leadership Dyads
- Service Lines
- Leadership Councils
- Strategic Partnerships

LEADERSHIP PRINCIPLES

VALUES

Compassion · Respect · Excellence · Collaboration · Accountability

Mission

To advance the health of communities we serve though our dedication to high quality, safe, compassionate, and cost-effective health care.

Purpose

Working together to enrich the health and well-being of every life we touch.

Partners

The Four SMS Components

Safety Policy

Establishes senior management's commitment to continually improve safety; defines the methods, processes, and organizational structure needed to meet safety goals

Safety Assurance

Evaluates the continued effectiveness of implemented risk control strategies; supports the identification of new hazards

Safety Risk Management

Determines the need for, and adequacy of, new or revised risk controls based on the assessment of acceptable risk

Safety Promotion

Includes training, communication, and other actions to create a positive safety culture within all levels of the workforce

EvergreenHealth Partners

NURSE CARE COORDINATOR

GOAL:

Provide high quality, cost effective care to high risk patient populations.

"Right service, right patient, right time, right place"

NURSE CARE COORDINATOR

EvergreenHealth Partners

Identify the high-risk patients

- Uncontrolled diabetes, hypertension, depression, asthma, re-hospitalized within 30 days

Identify "rising risk" patients: chronically ill

Identify patients in the "care gap"

- No BMI in past year, or is over 50 without a colonoscopy, diabetic who hasn't been seen in 9 months

NURSE CARE COORDINATOR

EvergreenHealth Partners

METHODS

- Develop systems and processes to address these patient populations with minimal bureaucracy
- Collaborate with providers and their team, patients and families, and for payers
- Care Coordinator will serve as the “eyes and ears” for coordination of care and services

NURSE CARE COORDINATOR

EvergreenHealth Partners

BENEFITS

- Improve quality/safety/reduce error in handoffs
- Improved patient outcomes
- Clinical initiatives and care gaps addressed
- Improve coordination of care for payers
- Meet payer quality initiatives and financial incentive goals
- Serve as “eyes and ears” across the care spectrum

MARKETING MATERIALS

EvergreenHealth Partners

FOR PATIENTS FOR MEDICAL STAFF ABOUT US

EVERGREENHEALTH PARTNERS

Home › EvergreenHealth Partners

Categories
- Overview
- For Patients
- For Physicians
- For Brokers & Employers

EvergreenHealth Partners

Welcome to EvergreenHealth Partners (EHP). We are a clinically integrated network of EvergreenHealth-affiliated physicians that is working together with EvergreenHealth Medical Center to transform health care delivery and provide you and your family with the best quality care and service, at the best value.

We are the first clinically integrated network in the Puget Sound region.

What's the Value of a Clinically Integrated Network?

The nation's health care systems are gradually moving from traditional fee-for-service reimbursement models to new performance- and value-based payment models. Clinical integration networks bring value to patients, employers, payers and providers by removing communication barriers, improving efficiency and enabling health care providers to join together to enhance the health of the community.

How does EHP work?

EvergreenHealth Partners brings together independent physicians, specialists and hospital-employed doctors to streamline care, increase cost efficiencies and improve access to resources. With these tools, EHP providers are able to have a deeper, more patient-focused conversation and to align around quality and cost in a way not achievable in traditional health care models. This ensures that each patient receives expert care delivered by a group of physicians with access to

Who Benef
EHP?

FOR PATIENTS

Learn about the benefits of EHP care, and find an EHP member physician.

FOR PHYSICIANS

Learn how our clinical initiatives are sustaining

Proud Member of

EvergreenHealth Partners

Redefining Healthcare

EvergreenHealth Partners

NEWSLETTER

Issue 2 - September 2014

Welcome to the EHP Newsletter.

Each quarter, we'll bring you the latest EvergreenHealth Partners news in an easy-to-read email digest.

Message from the Medical Director

The word is out about EvergreenHealth Partners, the first Clinical Integration Network in Washington - and there's been a lot of interest about this groundbreaking clinical partnership for our area.

Read more >

Participant Update

EvergreenHealth Partners

EvergreenHealth Partners: Combining Quality and Value

You want—and deserve—the highest quality healthcare and service at the best value. That's exactly what you get when you choose an EvergreenHealth Partners (EHP) provider for your care.

EHP providers are members of the medical staff at EvergreenHealth or other Eastside providers, and are backed by the full resources of EvergreenHealth Medical Center.

Higher Quality Care and Service

When you receive care from an EHP provider, you can rest assured knowing that your care is being guided by proven, evidence-based standards and that your provider is meeting a high level of quality set and reviewed by them in partnership with his or her colleagues.

Coordinated Specialty Care

The EHP network includes more than 500 providers from more than 40 specialties. So when you need specialty care, your family physician can confidently refer you to EHP colleagues knowing that they share the same commitment to high quality care and service. Our coordinated plan for your care takes you from your family physician's office through specialty care and hospitalization.

Increased Value for Your Healthcare Dollars

We all want better value, but without reducing the quality of our care. That's why EHP providers are working together with EvergreenHealth to reduce the cost of providing the high quality care and service you deserve through streamlined processes, better communication and group purchasing.

Find an EvergreenHealth Partners Provider

EvergreenHealth Partners providers are ready to help you live your healthiest best.

Find your partner at www.evergreenhealthpartners.org.

Partners

EvergreenHealth Partners

Questions?

EvergreenHealth Partners

Paul Buehrens, MD

Medical Director

EvergreenHealth Partners

buehrenspe@comcast.net

www.evergreenhealthpartners.org

Partners

I 502 Recreational Marijuana

"The Marijuana Market in Washington"

Medical Commission Education Conference

Presented by Randy Simmons, Deputy Director

Washington State Liquor Control Board

October 2, 2014

Today's Presentation

- Overview of I502
- Lessons Learned
- Consumer and Public Education
- Legal Issues
- Legislative Activity
- Tax Collections

Overview of I502

Marijuana Legalization

Washington's Legalization at Glance

- Established by Initiative 502 on Nov. 6, 2012
- I-502 drafted by ACLU Drug Policy Director Alison Holcomb
- WSLCB charged with:
  - Drafting rules governing the new system
  - Licensing applicants
  - Enforcing the law at licensed locations
- 30-day window application period drew 7,000+ applications
  - No limit on producers and processors
  - Retail stores limited to 334 statewide
  - Retail lottery held in April to identify 334 "winners" out of 2,100 applicants

Timeline

December 2012	I-502 effective date
October 2013	Rules effective
March 2014	First producer licenses
April 2014	Retail lottery
July 7, 2014	First retail licenses issued
July 8, 2014	First retail stores open

Goals of Developing Washington's System

- Public safety is top priority
- Protecting children is focus
- Open and transparent system of rule-making and implementation
- Tightly regulated controlled marketplace
- Collect revenue for state of Washington

Lessons Learned

Lesson 1

There are many challenges of implementing a state law that is illegal federally.

- Schedule 1 controlled substance
- Banking
- Public agencies reluctant to cooperate
- Creating a controlled market, not open market
- Walking the line between federal expectations and state law requirements – DOJ memo

Lesson 2

Be realistic about the time it takes to set up a comprehensive system of growing, processing, and retailing recreational marijuana.

- Public forums and hearings
- Right system is more important that being fast
- Brookings Institute
  - "If Colorado is the sizzle. Washington is the steak."

BROOKINGS

The Legalization of Marijuana

Report | August 25, 2014

Washington's Marijuana Legalization Grows Knowledge, Not Just Pot

Lesson 3

The impact on agency and state resources is heavy. This is not normal business.

- Original OFM Fiscal Impact Statement
  - Estimated 100 producers
- WSLCB Application Window Nov. 2013
  - 7,000+ marijuana applications w/in 30 days
  - 2,600 producers and 2,500 processors
  - By comparison….
    - 5,534 grocery stores that sell alcohol licensed
    - 4,929 total spirits/beer/wine restaurants licensed
- Media
  - Top 5 statewide AP story
  - 3,000+ media contacts per year

Lesson 4

It helps to know your license applicant base.

- Many marijuana license applicants are not used to operating any regulation.
- Basic technology, such as computer access or proficiency, can be challenging.
- Vocal

Lesson 5

Limit each applicant to a single license per license category to get the system started

- Creating a restricted marketplace to avert diversion
- WSLCB rules allowed up to 3 licenses per category
- WSLCB had to later limit applicants to single license and refund fee or hold application.

Consumer and Public Education

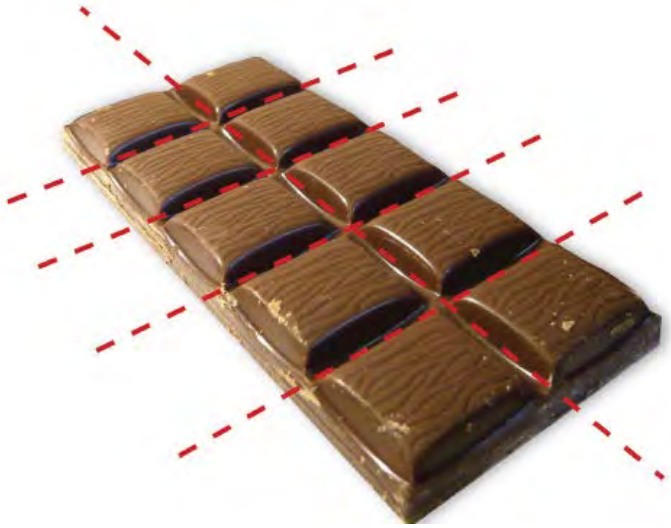
Packaging / Labeling Requirements

Child resistant packaging, and packaging must not appeal to kids

- 4 mil plastic minimum
- Sealed packaging
- No easy-open devices
- Poison Prevention Act compliant

Packaging / Labeling Requirements

Defined serving and dosage limits



- Serving = 10 mgs THC
- Maximum of 10 servings per unit
- Maximum 100mgs THC per unit
- Servings must be physically indicated
- All products must be tested

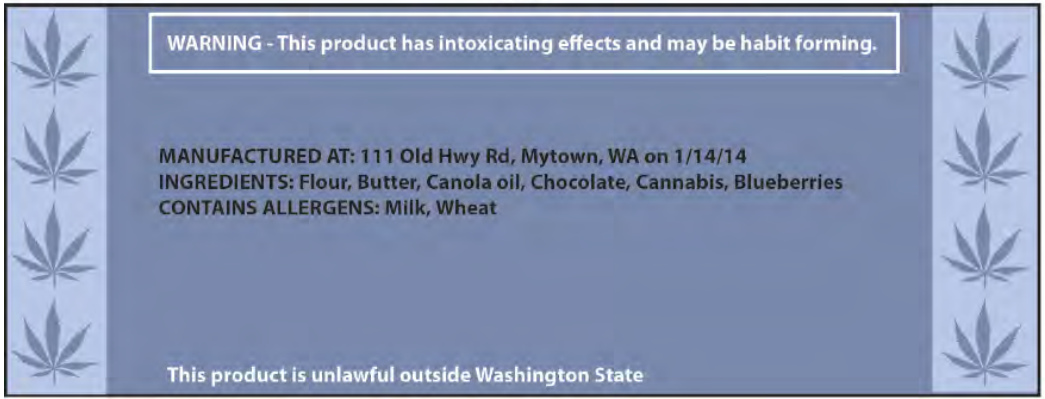
Packaging / Labeling Requirements

Defined labeling requirements

Sample Label

FRONT

BACK



- Business/trade name, UBI
- Lot number
- Batch number
- Manufacture date
- Best by date
- Recommended serving size
- Servings per unit
- Total milligrams of active THC
- Net weight
- All ingredients (incl. allergens)
- Warnings and cautions
- Identifier, “Product contains marijuana”
- All marijuana-infused products must be approved by the WSLCB

Unregulated THC-Infused Products

Mimic popular brands, use colors, cartoons, and candies that may appeal to children, and have inconsistent potency/dosage

Emergency Rule Changes

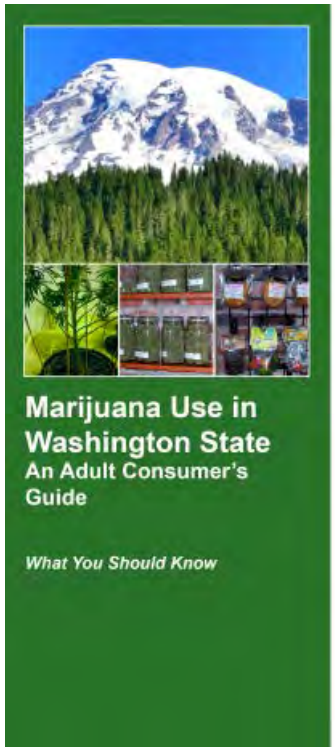
- Approval for all marijuana-infused products, labeling and packaging prior to offering items for sale
- Products in solid form must be scored to indicate servings
- Products must be homogenized to ensure uniform disbursement of cannabinoids
- Marijuana-infused products must state on label, “This product contains marijuana.”

Emergency Rule Changes

Some of the types of foods that cannot be infused with marijuana:

- Any food that requires refrigeration, freezing, or a hot holding unit may not be infused with marijuana
- Any food that has to be acidified to make it shelf stable
- Food items made shelf stable by canning or retorting
- Fruit or vegetable juices
- Fruit or vegetable butters
- Pumpkin pies, custard pies, or any pies that contain egg
- Dairy products of any kind, such as butter, cheese, ice cream, milk
- Dried or cured meats

WA State Liquor Control Board



Consumer Education

- Consumer safety
  - Potency
  - Edibles
  - Driving/DUI
- Basic law facts
- Resource referral
- 40,000 copies, also available on-line

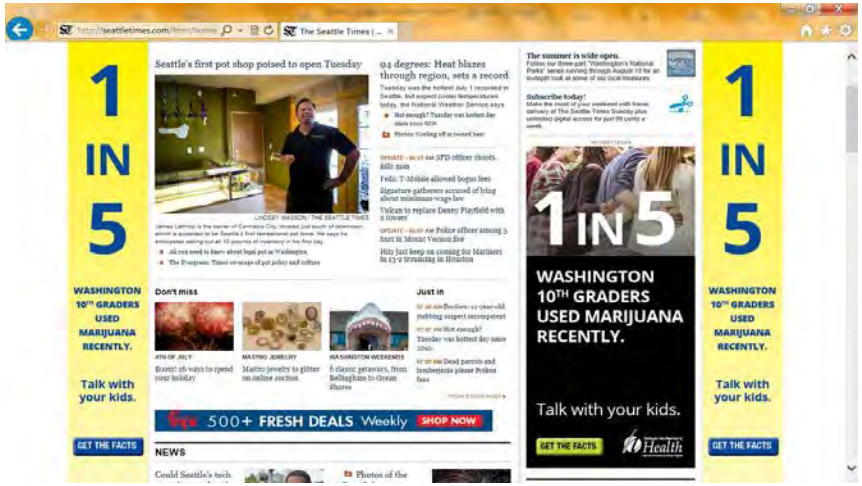
Parent Education

- Health risks and laws
- Nine languages
- 55,000 copies printed to date

WA State Dept. of Health

Public Awareness: Paid Media

- Radio
  - Statewide reach
  - English, Spanish, cities and rural
  - More than 3 million reached
- Digital
  - Two ads
  - Network sites (parenting/health/local news)
  - Social media (Facebook)
  - Paid search (Google, Bing)



More than 20 million impressions, more than 19,000 click-throughs

WA State Dept. of Social and Health Services Div. of Behavioral Health and Recovery

- Toolkits for preventing underage use distributed to community coalitions, schools, and available on-line. Includes:
  - Parent guide
  - Parent information card (WSLCB)
  - "Marijuana and Teens" CD
- Updated StartTalkingNow.org website with resources for parents and community groups

WA Traffic Safety Commission

- "Drive High, Get a DUI campaign
- TV ads from Colorado airing now
- Target Zero emphasis patrols

University of Washington Alcohol and Drug Abuse Institute

Designated by I-502 to provide: "Web-based public education materials with medically and scientifically accurate information about health and safety risks posed by marijuana use."

www.LearnAboutMarijuanaWA.org

- Factsheets
- Information for Parents and Teens
- Policy and Law
- Research
- Adult Consumers

Legal Issues

Legalized Possession

- Limited possession 21 & over
  - 1 oz “useable” marijuana +
  - 1 lb marijuana-infused product in solid form +
  - 72 oz marijuana-infused product in liquid form +
  - 7 g marijuana concentrate
- Consuming in view of general public prohibited
- DUI *per se* limit: 5 ng active THC / mL blood

Commercial Licensing

- Liquor Control Board licenses and regulates
  - Producers
  - Processors
  - Retail stores (sell only marijuana, paraphernalia)
- Licenses limited to 3-month state residents
  - Applies to all "members" of business entities
  - Criminal background checks for members and financiers
- Taxes
  - 25% excise tax on sales at each level
  - Earmarked for public health research and education

Federal Response

Department of Justice Memorandum to United States Attorneys (Aug. 2013)

- Applies to all states.
- 8 priorities "will continue to guide the Department's enforcement of the CSA against marijuana-related conduct."
- "If state enforcement efforts are not sufficiently robust to protect against the harms, **the federal government may seek to challenge the regulatory structure itself** in addition to continuing to bring individual enforcement actions, including criminal prosecutions, focused on those harms."

Supply and Demand

- 30-day application window
  - Over 7,000 applications received
- Producer/processor licenses
  - Number of licenses not limited
  - Square footage limited
  - 109 producer/processors as of mid July
- Retail licenses
  - 334 stores allocated to cities/counties
  - Lottery held to rank applicants for processing
  - First 24 retail store licenses issued July 7

Minors

- 1000’ buffer from schools
  - No marijuana business locations
  - No advertising by licensees “in any form or through any medium whatsoever” within 1000’
- No products/advertising “especially appealing to children”
  - *Preapproval* for all edible products
  - Child-resistant packaging

Public Health

- Quality assurance testing
  - WSLCB accredited 3rd party testing labs
- Food safety
  - WSLCB rules for hazardous foods that may not be infused
- Edibles
  - Limited to 10 mg THC serving & 10 servings/product
  - Scoring and labeling to indicate servings

Local Jurisdictions

- Some cities/counties banned I-502 businesses
- Local authority
  - I-502 does not preempt local jurisdictions from banning marijuana businesses, per formal AG Opinion
  - I-502 does not give WSLCB authority to deny licenses based on local law
  - Lawsuits have been filed by licensees against cities with bans

Banking Challenges

- Deposits to banking system = money laundering
- Cash business = crime target
- USDOJ/FinCEN banking guidance (Feb. 2014)
  - Authorizes filing special SARs
  - Requires bank due diligence - customer complying WSLCB rules
  - Banks waiting for guidance from federal regulators

Medical Marijuana

- Unregulated
- Only sales tax (but illegal to sell)
- Possess 24X as much w/authorization
- No age limit
- Challenge for legislature

Legislative Activity

Marijuana: 2014 Legislative Session

What did the Legislature do in 2014?

- Senate Bill 6505 removed tax preferences otherwise applicable to the marijuana industry (PASSED)
- Engrossed Substitute House Bill 2304 added marijuana concentrates to list of products certain recreational marijuana licensees could manufacture and sell (PASSED)
- Engrossed 3rd Substitute Senate Bill 5887 would have brought medical marijuana under the licensing and taxation structure applicable to I-502 recreational marijuana (DID NOT PASS)

What to expect for 2015 legislative session:

Federal issues will continue--

- Federal government will crack down if health and safety concerns especially for youth not addressed by state bringing medical marijuana under state regulatory umbrella
- Some movement to minimize impacts of federal income tax consequences on I-502 licensees by moving incidence of marijuana tax on retailers to buyers
- Lots of concern previously voiced about federal banking restrictions on illegal drug money forcing businesses to do business and pay taxes in cash.

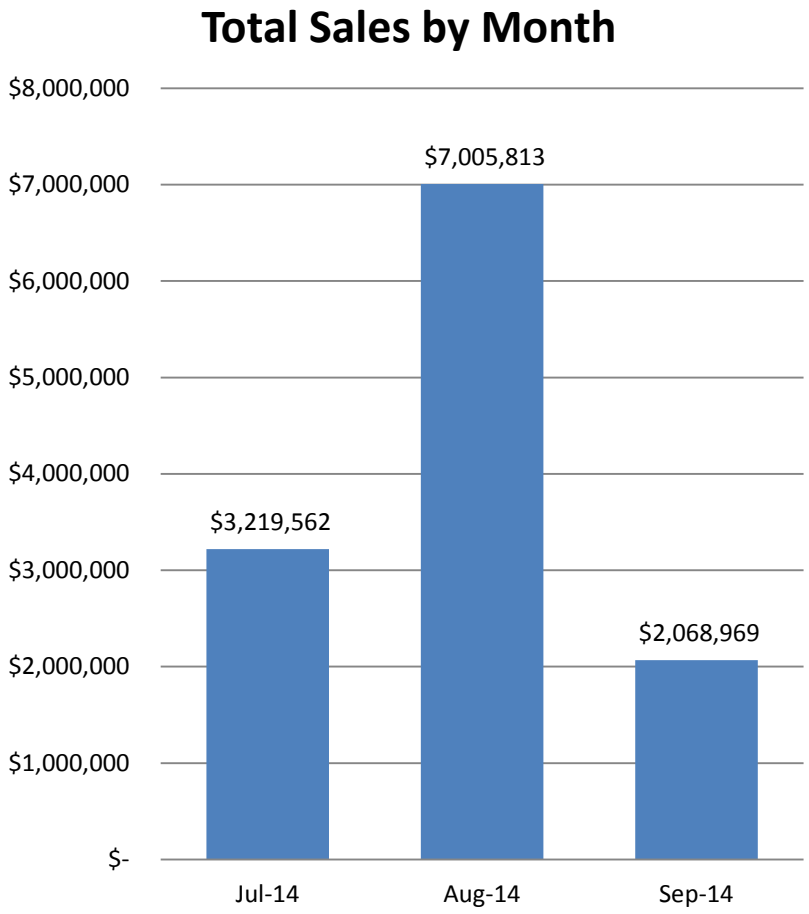
What to expect for 2015 legislative session --

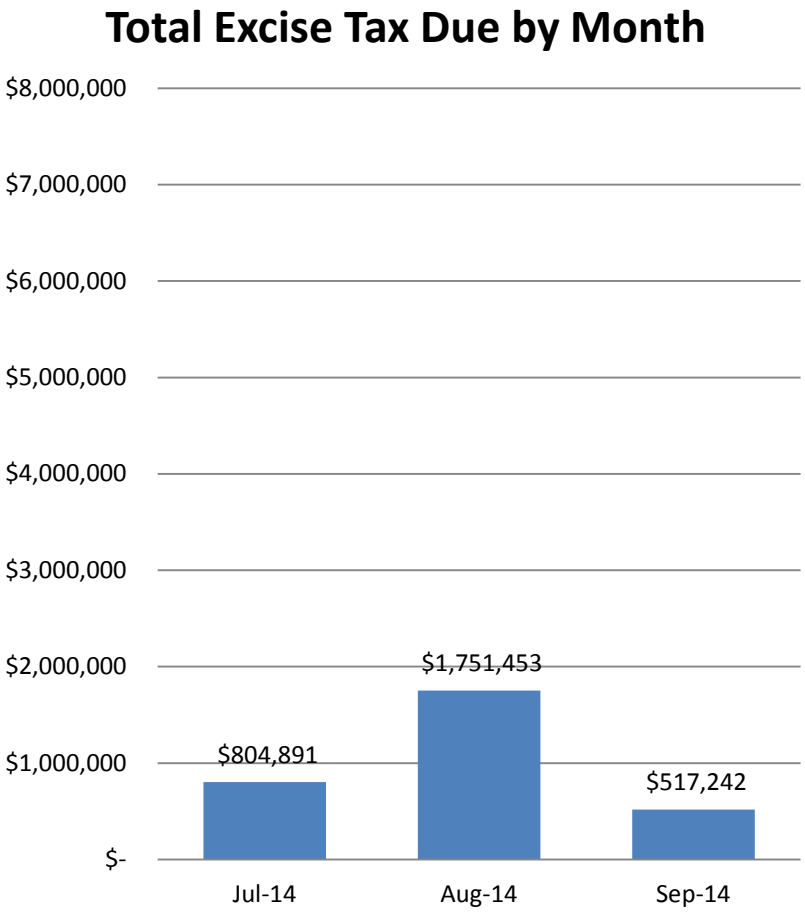
At state level on medical side:

- Expect more proposals to regulate and tax medical marijuana like I-502 marijuana
- Likely to add equivalent of prescription drug sales tax exemption for medical marijuana
- Look for requirements for health care providers writing medical marijuana authorizations to be tightened up, and state registration of medical mj patients in some form
- Medical marijuana advocates will continue to make their case, but I-502 licensees will also be more visible, vocal
- Local government will again press for funding for enforcement

Tax Collection

Total MJ Sales and Excise Tax Due by Month





Data current 9-9-2014

Data source

Questions?

Thank you

Caleb J. Banta-Green, PhD, MPH, MSW

Senior Research Scientist, Alcohol and Drug Abuse Institute
Affiliate Associate Professor, School of Public Health, University of Washington

Education:

- BA, Biology, University of California, Santa Cruz
- MSW, Social Work, University of Washington
- MPH, Public Health, University of Washington
- PhD, Public Health, University of Washington

Research Interests:

- Epidemiological measures of drug use in rural and urban settings
- Development of novel drug epidemiology surveillance tools
- Drug-caused morbidity and mortality e.g. drugged driving, drug overdoses
- Youth abuse of prescription drugs
- Health services research -- prescription opiate use patterns among chronic pain patients, Prescription Drug Monitoring Program analyses
- Drug treatment outcomes -- impact of access to treatment and drug use characteristics
- Public health law research
- Opiate overdose prevention and intervention -- individual and community level

Selected Activities:

- Senior Science Advisor, Office of National Drug Control Policy, Executive Office of the President, July-December 2012.
- Numerous interviews for news organizations on selected topics of expertise:
    - Drug trends in Seattle/King County: Seattle Times, 7/15/2007; Seattle Times, 6/8/2011.
    - Prescription-type opiates: **Newspaper:** Take action to prevent fatal overdoses from heroin, prescription opiates, Seattle Times, 4/18/2012; **TV and Radio:** "Prescription for Abuse" KCTS documentary, 1/2012, with supplementary material.; "Overdose Antidote Could Save Lives", KOUW, 5/14/2012; "The Complexity of Treating Chronic Pain", KUOW,

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- Technical Editor, Assessing Drug Abuse Within and Across Communities, Community Epidemiology Surveillance Networks on Drug Abuse (2nd Edition), NIDA, 2006. (pub. no. 06-3614)
- Reviewer, American Journal of Public Health (2010-present); Addiction (2010-present); Drug and Alcohol Dependence (2008-present); Clinical Journal of Pain, (2008-present); Environmental Science & Technology (2007); Contemporary Clinical Trials (2009)

Bonnie Bizzell, MBA, MEd

Family Advisor, Patient and Family Advisory Council
Foundation for Health Care Quality

In three short consecutive years, each of Bonnie Bizzell's close family members experienced a traumatic medical event. Her brother, at age 34 and diagnosed with Crohn's, had part of his intestine removed. Her father suffered a heart-attack which resulted in an emergency quadruple bypass surgery. And, in 2006, her mother's biopsied brain tumor was identified as non-Hodgkin lymphoma. Experiences in the different hospitals varied greatly for the family: sometimes there was disregard for their needs; sometimes there was incredible attention and responsiveness. Often the two ends of the spectrum occurred within hours of each other in the same hospital. But, when care and caring happened simultaneously, the results were powerful.

Inspired by her personal encounters and family's history, Bonnie joined the University of Washington Medical Center's Inpatient Patient and Family Centered Care (IPFCC) Advisory Council in 2007 as a family advisor. During her tenure, the IPFCC council's accomplishments include ensuring documents are patient and family friendly, participating in charge nurse education, transforming the meal delivery system to include on-demand menu options, and creating a staff training video about the voice of the patient (that she's featured in!). In September 2013, Bonnie was honored to attend the day-long HealthPact Forum; in November, she joined its Patient and Family Advisory Council (PFAC). Energized by the trends in healthcare, Bonnie is excited by PFAC's transition into the Foundation for Health Care Quality and the opportunities it brings to widen the audience for patient and family centered care.

Professionally, Bonnie brings to over ten years of operations management experience to the group with expertise in process evaluation, continuous improvement, organizational development, team building, communications, and strategic and event planning. She holds a MBA in Change Management as well as a Master of Education. For fun, she likes to throw glamorous dinner parties, listen to old radio detective shows, and watch cartoons with her husband.

Paul Buehrens, MD

Medical Director, Evergreen Health Partners

Dr. Paul Buehrens has practiced full-time for 33 years in family medicine at the Lakeshore Clinic in Kirkland, WA. Of those years, 29 of them have been spent as the clinic's Medical Director. Previously serving as chairman of the Puget Sound Family Physicians, Dr. Buehrens spearheaded the use of innovative technology for the group.

Dedicated to improving healthcare, Dr. Buehrens has served as the president and chairman of the Northwest Medical Group Alliance since 2011. He is a member of both the Washington Health Alliance and Medical Staff Council of Evergreen Healthcare and advises hospital administration on community healthcare needs. He has been recognized as a "Top Doc" in Family Medicine by Seattle Magazine and has been awarded recognition by the National Committee for Quality Assurance/American Diabetes Association Diabetes Physician Recognition Program.

Having been especially involved on the regional level, Dr. Buehrens' expertise is in the intersection of healthcare practice and policy. He is truly an advocate for excellent family care. In this effort, he held positions as vice president of the Northwest Medical Group Alliance for 15 years, another 15 years as medical director of LakeVue Gardens Convalescent Center, five years as medical director of the Cascade Vista Convalescent Center, four years as assistant secretary-treasurer of Washington Academy of Family Physicians and has been an executive committee member of the King County Academy of Family Physicians.

Dr. Buehrens received his BA in Biochemistry from Harvard University and his medical degree from Case Western Reserve University in Cleveland, Ohio. He completed his internship and residency at the Medical University of South Carolina. He is Board Certified in Family Practice. In addition to being an avid outdoorsman, Dr. Buehrens enjoys spending his free time listening to many types of music, reading, fishing, traveling, and working out at his athletic club.

Byron D. Joyner, MD, MPA

Professor and Program Director, Department of Urology, Associate Dean for GME
University of Washington School of Medicine

Education Philosophy

Dr. Joyner's passion is learning of and designing better ways to improve graduate medical education (GME). He is responsible for the core curriculum and competency-based training of the urology residents at the University of Washington. He is also serves as the Associate Dean for Graduate Medical Education and is in charge of the educational learning environment for over 1280 residents and fellows in 96 different training programs at the same institution.

His training in the **UW Teaching Scholar's program** has allowed him to create new approaches to teaching trainees about interpersonal and communication skills and professionalism. In fact, his efforts have been rewarded with the 2005 **Julian S. Ansell Teaching award**. Besides the more than 70 scientific articles he has published, he has written some of the seminal articles for urology in the field of graduate medical education and continues to champion better ways to improve doctors and doctoring. He was honored with the coveted **Parker J. Palmer Courage to Teach Award** in 2011. He participated in and assisted in the publication of the **2011 Josiah Macy Jr. Foundation** Atlanta Conference "Ensuring an Effective Physician Workforce for the United States." In January 2014, he was named one of the top 10 Medical Educators in the US by *Black Health Magazine*.

Education & Training

Dr. Joyner graduated from Princeton University and received his medical degree from Harvard Medical School in Boston, Massachusetts. He completed his residency at the Massachusetts General Hospital and then performed a research fellowship at the Boston Children's Hospital. He had an additional 2 years of pediatric and reconstructive urology training at the Hospital for Sick Children in Toronto, Canada. He has been on faculty at the Seattle Children's Hospital since 2001 following a 4-year commitment in the US Army where he was chief of pediatric urology at Madigan Army Medical Center. In 2009, he received a Master in Public Administration, which he felt organized many of his principles of executive leadership in medical education.

Present Responsibilities

As the Associate Dean for GME at the University of Washington, he continues to be a change agent in founding and being the executive sponsor for a two specialty groups to assist trainees in learning about themselves and the world in which they live, the UW House staff Quality & Safety Council (HQSC) and the UW Network for Underrepresented Residents & Fellows (NURF). Dr. Joyner is the director for GME Learning Gateway, Life After Residency, GME Research Day and GME Grand Rounds. He has been the co-chair of the American Urological Educational Meeting for Program Directors & Chairs for the last 3 years. He is involved with involved in many national urology educational meetings and has recently been admitted to the Urology Residency Review Committee at the ACGME.

Research Interests

Besides his interest in resident and fellow education, Dr. Joyner has interests in clinical research related to voiding dysfunction and urinary tract infections in children. He is a Fellow of the American Academy of Pediatrics and the American College of Surgeons. He is an active member of many urological societies including the American Urological Association, the American Academy of Pediatrics, the Society of University Urologists, and the American College of Surgeons.

Honors

2014: Named one of top 10 Medical Educators in the US by *Black Health Magazine*
2013: Alpha Omega Alpha Honor Medical Society, University of Washington
2011: Golden Humanism Award, Arnold P. Gold Foundation
2011: Accreditation Council for Graduate Medical Education (ACGME) Parker Palmer Courage to Teach Award
2010: Madison Who's Who, Seattle's Best Doctors (Pediatric Urology)
2009: Excellence in Service Award
2008: Seattle's Best Doctors (Pediatric Urology)
2008: America's Top Surgeons (Pediatric Urology)
2005: Dr. Julian Ansell Resident Teaching Award from Department of Urology
2004: Teaching Scholar's Program, University of Washington

Stephen E. Lovell

Patient Advisor
Patient and Family Advisory Council
Foundation for Health Care Quality

Mr. Lovell has over 30 years of corporate experience in a variety of industries including aviation, transportation, environmental consulting, and oil and gas. He recently retired from Alaska Airlines and has been working with and advising several organizations including the Seattle Cancer Alliance, Foundation for Health Care Quality, National Park Service, and Washington State Historical Society. He has a Bachelor of Science degree from the University of Texas at Austin and a Master's Degree from Texas A&M University.

Mr. Lovell was diagnosed with a myelodysplastic syndrome and underwent a successful stem cell transplant in 2010. Upon completing treatment, he has worked tirelessly to ensure the patient perspective is represented in our health care system. Mr. Lovell works cooperatively with providers and clinical staff to evaluate and identify issues and assist in arriving at solutions that ultimately serve providers, clinical staff, and patients on an equal basis.
Mr. Lovell is currently Co-Chair of the Patient and Family Advisory Council, Seattle Cancer Care Alliance; Advisor on the Patient and Family Advisory Council, Foundation for Health Care Quality; and the Patient Representative on the Action Planning Subcommittee, Washington Patient Safety Coalition.

Blake T. Maresh, MPA, CMBE

Executive Director, Board of Osteopathic Medicine and Surgery
Washington State Department of Health

Blake has served as Executive Director with the Washington State Department of Health since November 2004. During his tenure, he has had responsibility for the Osteopathic, Podiatric, Naturopathic, Physical Therapy, Nursing Home Administrator, Massage, and Denturist Boards, the Dental and Medical Commissions, as well as many Secretary Professions. He currently oversees the administration of 13 health professions programs representing over 50,000 credential holders.

Blake served on the Board of Directors of the Federation of State Medical Boards (FSMB) from 2012-2014. In that role, he served on a number of committees and workgroups, including the Planning, Awards, and Audit Committees, and the CAI/Board Metrics Workgroup. He was also the Board liaison for the FSMB Uniform Application program, and he served on the FSMB Advisory Council of Board Executives from 2007-2014. Since 2012, he has been a leader in the exploration and development of an interstate compact for physician licensure. He served as a co-chair of a June 2013 FSMB compact workgroup meeting with participants from across the country, and was a member of the team that drafted the Interstate Medical Licensure Compact.

Between 2006 and 2014, Blake participated on the Board of Directors of Administrators in Medicine (AIM), an organization of medical and osteopathic board executives from across the US. He was elected Vice President of AIM in 2008, and he served as President of the organization from 2009 to 2012.

He has been a Certified Medical Board Executive since April 2009. In 2014 he was honored with AIM's Doug Cerf Executive Director's Award. This award may be given annually to an individual "in recognition of outstanding contributions on a national or state basis to improve the quality of standards for medical practice in the United States and territories."

Blake received his BA at the University of Puget Sound as a Coolidge Otis Chapman Honors Scholar. After receiving his Masters in Public Administration from the University of Washington-Evans School of Public Affairs as a Brewster C. Denny Fellow, Blake started his state service as a Governor's Executive Fellow in 1993. He worked in several progressive analytic and management roles with the State of Washington for 11 years before joining DOH.

William M. Sage, MD, JD

James R. Dougherty Chair for Faculty Excellence
University of Texas Law School

Education

- JD Stanford
- MD Stanford
- AB Harvard

A.B., Harvard, 1982; M.D., J.D., Stanford, 1988. Docteur h.c., Université Paris Descartes, 2011. Note editor, *Stanford Law Review*. Areas of teaching are health law, regulatory theory, antitrust, and professional responsibility. Visiting professor of law Yale 2013, Harvard 2007, Duke 2001. Vice provost for health affairs, UT Austin 2006-13. Taught at Columbia Law School 1995-2006. Associate, O'Melveny & Myers, Los Angeles, 1990-95. President's Task Force on Health Care Reform, 1993. Resident in anesthesiology and critical care medicine, The Johns Hopkins Hospital, 1989-90. Intern, Mercy Hospital and Medical Center, San Diego, 1988-89.

Member, Institute of Medicine; Member, The Academy of Medicine, Engineering, and Science of Texas; Fellow, Hastings Center on bioethics. Board member, ChangeLab Solutions. Vice chair, Children's Optimal Health. Serves on the editorial board of *Health Affairs*. Serves on the Code Red Task Force on the uninsured in Texas. Principal investigator, The Pew Charitable Trusts Project on Medical Liability in Pennsylvania, 2002-05. Served on the Institute of Medicine's Committee on Rapid Advances in Health Care, 2002. Received Robert Wood Johnson Foundation Investigator Award in Health Policy Research, 1998.

Co-editor, *Medical Malpractice and the U.S. Health Care System* (Cambridge University Press, 2006), *Uncertain Times: Kenneth Arrow and the Changing Economics of Health Care* (Duke University Press, 2003). Articles include: "Regulating through Information: Disclosure Laws and American Health Care," *Columbia Law Review* (1999); "Antitrust, Health Care Quality, and the Courts," *Columbia Law Review* (with Hammer, 2002); "Medical Liability and Patient Safety," *Health Affairs* (2003); "The Impact of Malpractice Reforms on the Supply of Physician Services," *JAMA* (with Kessler and Becker, 2005); "Some Principles Require Principals: Why Banning 'Conflicts of Interest' Won't Solve Incentive Problems in Biomedical Research," *Texas Law Review* (2007); "Legislating Delivery System Reform: A 30,000 ft. view of the 800 lb. gorilla," *Health Affairs* (2007);

"Combating Antimicrobial Resistance: Regulatory Strategies and Institutional Capacity," *Tulane Law Review* (with Hyman, 2010); and "Getting the Product Right: How Competition Policy Can Improve Health Care Markets," *Health Affairs* (2014).

Randy Simmons

Deputy Director
Washington State Liquor Control Board

Randy Simmons has been with the Washington State Liquor Control Board since March of 2002 when he was appointed as the Director of the Finance Division. In 2005, the Finance and IT divisions were combined into the Administrative Services Division under his leadership. In 2006 Randy received the Governor's Award for Leadership in Management for implementation of risk management practices that reduced over $400,000 a biennium in cost to the agency. In July of 2013, Randy was named Deputy Director of the agency.

Mr. Simmons was appointed in March 2002, after serving for 18 months in a management position at General Administration. Prior to this he spent 23 years in a private company in Olympia, beginning his career as a pension actuary and then holding positions in both finance and marketing.

Randy's educational background includes a Bachelor's of Science Degree in Accounting from St. Martin's College and post-graduate work in Entrepreneurial Studies at Babson College and in Management Science at The American College. He holds the following professional designations, CLU, FLMI, and LLIF.

Randy's off work activities are dominated by his grandchildren and spending time with Linda, his wife of 39 years. He also enjoys golf, local football teams, reading and an obsession with playing piano.

Molly Voris, MPH

Director of Policy
Washington State Health Benefit Exchange

Molly Voris is the Director of Policy for the Washington Health Benefit Exchange. Molly leads the planning and policy development process for the HBE, which includes developing policy options and recommendations for the Exchange Board, running various Board and stakeholder committees, and decision-making within the operational build of the Exchange. In this capacity, Molly works closely with the Governor's office, state legislators, federal partners, and key organizations throughout the state to move toward a collaborative and robust exchange.

Prior to the Exchange, Molly was a program director at the National Governors Association Center for Best Practices where she oversaw the health reform implementation portfolio. She was responsible for developing meetings, publications and other activities for governors' health reform leads. She also created state-to-state learning opportunities in Medicaid, private insurance and delivery system reform. Prior to NGA, Molly focused on Medicare policy issues at the Kaiser Family Foundation.

Molly has a Master's degree in public health from the George Washington University School of Public Health and Health Services. She holds Bachelor of Arts degree in political science and Spanish from the College of Charleston in South Carolina.

Augustus A. White, III, M.D., Ph.D.

Ellen and Melvin Gordon Distinguished Professor of Medical Education, Culturally Competent Care Education Program, Professor of Orthopaedic Surgery, Harvard Medical School (HMS)

Dr. Augustus A. White is a scientist who has distinguished himself on several fronts, most notably orthopaedics. He was the Orthopedic Surgeon-in-Chief at Beth Israel Hospital in Boston for thirteen years. Today he is the Ellen and Melvin Gordon Distinguished Professor of Medical Education, Professor of Orthopedic Surgery at Harvard Medical School and former Professor of the Harvard/MIT Division of Health Sciences and Technology. He was born and raised in Memphis, Tennessee. After growing up in the Jim Crow-era South, Dr. White went on to become the first African American graduate of Stanford University's medical school, the first African-American resident and surgery professor at Yale and later the first black department head at Harvard's teaching hospitals. Seeing Patients draws on both original research and Dr. White's own experiences to examine how care is affected by the unconscious prejudice of providers.

After serving in the U.S. Army Medical Corps from 1966-1968, Dr. White studied at the Karolinska Institute in Sweden, obtaining his PhD in orthopedic biomechanics in 1970. There, he met his wife Anita, with whom he has three adult daughters.

Dr. White returned to Yale in 1970, where he joined the faculty as an assistant professor of orthopedic surgery, and was subsequently made director of the Engineering Laboratory for Musculoskeletal Disease—a currently operating laboratory, which he had a leadership role in founding. During his years at Yale, Dr. White was instrumental in efforts to accept and train women and minorities in orthopedic surgery. While actively promoting diversity at Yale and Harvard, Dr. White also supported diversity efforts at his alma mater, Brown University. He also advocated for diversity while serving as a board member of Zimmer Holdings, Inc.

White has served as a mentor to Harvard medical students as a former master of the Oliver Wendell Holmes Society, an organization committed to the promotion and support of the academic and professional development of Harvard's medical students through a system of academic advising and enrichment programs. In addition to his mentoring work, White

dedicates much of his life to diversity-related issues. He is a founding member and founding president of the J. Robert Gladden Orthopedic Society, a multicultural organization dedicated to advancing excellent musculoskeletal care for all patients, with particular attention to underserved groups. White also served as the inaugural chairman of the American Academy of Orthopaedic Society (AAOS) Diversity Committee.

Dr. White's accomplishments began in 1966 during the Vietnam War. As a captain in the U.S. Army Medical Corps, he cared for patients in a Vietnamese leper colony, volunteered for a medical rescue mission on a non-secured mountainside, and provided a year of hard, dedicated orthopedic care for the troops. For all of these activities, Dr. White was awarded the Bronze Star. Since then, Dr. White has received various awards honoring his character, his distinguished career and his commitment to diversity in medicine. These include the 2006 AAOS Diversity Award. The honor recognizes AAOS fellows who have significantly contributed to the advancement of diversity in orthopaedics through the recruiting, mentoring and leadership of minority and women orthopedists, and the treatment of diverse patient populations. Dr. White is an internationally known, widely published authority on biomechanics of the spine, fracture healing, and surgical and non-surgical care of the spine. He has authored or coauthored more than 250 scientific and clinical publications including chapters, books, and articles. He published in January 2011, with David Chanoff, a book titled "Seeing Patients: Unconscious Bias in Health Care", a memoir on his life and a lifelong project that began when he served in the Army as a surgeon during the Vietnam War.

Those who know Dr. White say he remains unassuming; a leader who consistently shares credit or passes it on to someone else.

John Wiesman, Dr.PH, M.P.H.

Secretary, Washington State Department of Health

John Wiesman, Dr.PH, MPH was appointed secretary of health by Governor Jay Inslee and joined the Department of Health in April 2013. He's an accomplished transformational leader with more than 22 years of local public health experience.

John has been passionate about public health since reading a 1983 Time magazine article about disease detectives tracking Legionnaires' Disease, toxic shock syndrome, and HIV. It was the impetus for him to enter the profession.

He has worked in four local public health departments in Washington and Connecticut. He started his public health career in Connecticut in 1986 and was in its first group trained to provide HIV counseling and testing. During his career John has:

- Transformed health departments from providing individual clinical services to implementing policies, systems and environmental changes that make healthy choices easier and less expensive.
- Partnered with a community clinic to provide integrated primary care and behavioral health.
- Transformed Clark County Public Health into a first responder organization.

Currently, John serves as an adjunct assistant professor at the University of North Carolina-Chapel Hill, Gillings School of Global Public Health, Health Policy and Management. He also serves as a clinical professor at the University of Washington, School of Public Health, Department of Health Services.

He earned his doctor of public health (Dr.PH) in public health executive leadership in 2012 from the University of North Carolina-Chapel Hill. He received his master of public health (MPH) in chronic disease epidemiology from Yale University in 1987 and his bachelor of arts (BA) in biology from Lawrence University in Wisconsin in 1983.

John was born and raised in Wisconsin. He and his husband have lived in Washington State since 1989.

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SEEING PATIENTS

UNCONSCIOUS BIAS IN HEALTH CARE

AUGUSTUS A. WHITE III, M.D.

with DAVID CHANOFF

Perspectives on Health Care Disparities and Human Survival

My talk today may not be the most upbeat, exciting, humorous, or entertaining talk you'll ever hear. But it does have the virtue of describing some sobering realities about a profound and pervasive, but mostly silent problem, we in the health care community face.

I'm not going to indulge in blame, guilt, and certainly not despair. We know that where there are problems, there are opportunities. The opportunity this problem gives is that if we can move towards solving it, our success will go far beyond the health care field. Solving this problem will not only make us a healthier nation, it will make us a stronger and richer nation as well.

The problem I'm talking about is disparities in health care—that is, inequalities in the way we as doctors treat our patients. I'm talking about all of us, including the vast majority of us who are absolutely committed to providing the best care we can to all our patients, regardless of race, gender, age, sexual orientation, or any other characteristic that creates differences between ourselves and those we treat.

The inequality in treatment I will be describing and documenting for you is not simply a national health care problem. It is, in a real sense, a major human problem. Disparities in treatment are a paradigm for many of our local, regional, and global human problems. Finding solutions to inequalities in our health care will likewise help us achieve solutions to some of the great global problems. This is because cultural literacy and skillful accurate cross cultural communication along with the shedding of what I call *the isms* help so greatly to focus us on the celebration of our common humanity, which moves us forward as a global society.

To the extent that we solve these problems in the health care arena and learn to focus on and celebrate our common humanity, we will be engaged in a kind of humanitarian evolutionary process. The process of solving the health care challenge will develop skills and abilities that will help us avoid war and will facilitate our ability to recover from the wars that we cannot avoid. Moreover, the development of cultural literacy, cross cultural communications, self-awareness, and the elimination of –isms will help to facilitate our recovery from such devastating global realities as pandemics, tsunamis, tornadoes, hurricanes, fires, earthquakes, and avalanches.

To put it a different way, in order to eliminate health care disparities, we must hone our cross cultural communication skills and self-awareness as we eliminate our practice of "–isms." These same skills are broadly applicable to our global problems including war. One of the themes of Dr. King's inspiring life was his strong advocacy for social justice to supercede the practice of "–isms."

Respectfully,

Augustus A. White, III, MD, PhD
Harvard Medical School
Boston, MA

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Prepared for October 1, 2014 session
Washington State Medical Commission
Educational Conference 2014

Lecture entitled:
What Dr. Martin Luther King, Jr. Would Want Us To Know About Health Care Disparities
by Augustus A. White, III, MD, PhD

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Shared by Augustus A White, III, MD, PhD
augustus_white@hms.harvard.edu
9/16/14

Harvard

cloth • $29.00
ISBN 9780674049055
352 pages • 19 halftones

Seeing Patients

Unconscious Bias in Health Care

Augustus A. White III, M.D.

With David Chanoff

"As vital to medicine as mapping the rhythm of the heart and the firing of the nerves is an understanding of the diversity of the human family. Gus White takes us on a marvelous personal journey that illuminates what it means to care for people of all races, religions, and cultures. The story of this man becomes the aspiration of all those who seek to minister not only to the body but also to the soul."

—Jerome Groopman, M.D., author of *How Doctors Think*

If you're going to have a heart attack, an organ transplant, or a joint replacement, here's the key to getting the very best medical care: be a white, straight, middle-class male. This book by a pioneering black surgeon takes on one of the few critically important topics that haven't figured in the heated debate over health care reform—the largely hidden yet massive injustice of bias in medical treatment.

Growing up in Jim Crow–era Tennessee and training and teaching in overwhelmingly white medical institutions, Gus White witnessed firsthand how prejudice works in the world of medicine. And while race relations have changed dramatically, old ways of thinking die hard. In *Seeing Patients* White draws upon his experience in startlingly different worlds to make sense of the unconscious bias that riddles medical treatment, and to explore what it means for health care in a diverse twenty-first-century America.

White and co-author David Chanoff use extensive research and interviews with leading physicians to show how subconscious stereotyping influences doctor-patient interactions, diagnosis, and treatment. Their book brings together insights from the worlds of social psychology, neuroscience, and clinical practice to define the issues clearly and, most importantly, to outline a concrete approach to fixing this fundamental inequity in the delivery of health care.

Augustus A. White III, M.D., is Professor of Medical Education and Orthopedic Surgery at Harvard Medical School and the first African American department chief at Harvard's teaching hospitals. **David Chanoff** is a writer living in Marlborough, MA.

"I enjoyed the book immensely. I liked the fact it has so many interesting vignettes about your life's journey, including your experiences in Vietnam, your medical career, and your astonishing ride to chair of orthopedic surgery at BIH. With all your achievements, you have not lost sight of your roots. You have made recruitment of minorities into orthopedic surgery a priority and have been a leader in promoting cultural literacy in all physicians. This is an excellent book and quite readable. Exciting and insightful, Dr. White has hit a home run. Everyone should read this book!"

- Alvin F. Poussaint, MD, Professor of Psychiatry
Harvard Medical School, Boston MA

"A fantastic book. Read it!" - Bill Cosby

-- Coauthors of ***Come on People: On the Path from Victims to Victors***" by Bill Cosby and Alvin F. Poussaint, MD.

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"Gus White has written a compelling and timely book. Describing a life as a preeminent orthopaedic surgeon and medical scholar, he gracefully interweaves the personal evolution and insights of a trail blazing racial pioneer with a fact-based analysis of America's unfinished business in addressing unequal treatment in medical care. With Healthcare reform now at the top of the nation's agenda, this is a must read for medical professionals and the general public. Further, this book should be brought to the attention of all individuals whose policies and decisions affect the delivery of equitable Healthcare."

- Price M. Cobbs, author of ***My American Life: From Rage to Entitlement*** and coauthor of ***Black Rage***.

####

"We couldn't put down Gus White's story of how he fought his way through a racially segregated medical world to become one of the nation's finest orthopedic surgeons. It is a part of the civil rights revolution that we rarely confront, and his courage and tenacity have paved the way for hundreds of other African-American and Latino doctors to follow in his footsteps. What is even more remarkable is how he fought these battles and managed to emerge with the extraordinary sensitivity and compassion that have made him a great doctor. *Seeing Patients*, though, is far more than an inspirational autobiography. Gus White is a central player in today's effort to rid the American health delivery system of the built in disparities that deprive women and minorities of equal care. In this book White exposes what these often shocking disparities are, how they come about, and, most important, he explains what we need to do about them. For everyone concerned about health care, lay people and health professionals alike, *Seeing Patients* is a must read."

- The Honorable Michael Dukakis and Mrs. Kitty Dukakis

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"This compelling story should be read by all. It will increase our appreciation for the advances in medicine and in our society made over the past century. And, it should inspire us to do more to ultimately rid ourselves and our society of the vestiges of prejudice which remain, including our unconscious biases. White and Chanoff's optimism is inspiring. One hopes that future developments will show that their optimism is justified."

- Louis W. Sullivan, MD, President Emeritus, Morehouse School of Medicine
U.S. Secretary of Health and Human Services, 1989 – 1993

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"Doctor White's powerful and insightful work gives us great insight of our inherent biases, and challenges us to offer uniformly high quality care for all our patients."

- John R. Tongue, MD, 2011 President Elect
American Academy of Orthopaedic Surgeons

Order information via Amazon.com : ***Seeing Patients: Unconscious Bias in Health Care***
By Augustus A. White, III, MD, PhD with David Chanoff, PhD

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"**SEEING PATIENTS** is a thought- provoking, passionate and timely treatise on what Dr. White terms *unconscious* bias in healthcare. Part memoir, part history, and part instructive guide for physicians and patients, this powerful book opens with evidential narratives that chronicle the *historical* origins of racial bias in medicine and science - dating back to the thinking of scientists such as Plato, Aristotle and Galen! Dr. White recounts the innumerable prejudices and injustices he had to confront as an African American growing up in the segregated South, and later in his quest to become a physician in the 1960's. He explains how these same ingrained biases impeded his journey and stifled those of so many others. More sobering is his admonition that these unconscious biases (age, gender, race, etc.) are the sine qua non of today's healthcare disparities resulting in unnecessary pain, suffering and even death. As a lay person, I was moved by Dr. White's sensitive approach to such a highly provocative subject; the statistics are devastating and heartrending. He lays out his case to make "humanitarian and egalitarian medicine" the norm and asks physicians - as well patients - to open their eyes and examine the unconscious biases we all harbor, and use that self-awareness for change. This should be required reading for anyone with a conscience…"

- Linda Kenney Miller, CMM, author of ***Beacon on the Hill***

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"Seeing Patients is a powerful and extraordinarily important book, well written and easy to read. The author's sincere effort to use his own experience to be helpful to all of us is apparent, and very useful in enabling us to take a close look at the sensitive issue of bias in health care; and how it hurts the less privileged most, but all of us. His warm description of his family and community, challenges and supports, helps us understand the roots of his own character and determination. His insider view of good people negatively affected by forces they are often not even aware of, and the historical and experiential sources of those forces help us understand the complexity of bias, not only in medicine, but as a factor in the human condition. And while acknowledging the magnitude and complexity of the problem, he didn't declare problem solving as hopeless, but did something, encouraged medical schools and practicing physicians to do something, suggesting that a collective effort among all of us against what is wrong is the way to make it right."

- James P. Comer, M.D., Maurice Falk Professor of Child Psychiatry
Yale Child Study Center
Associate Dean, Yale School of Medicine, New Haven, CT

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"If you care or aspire to care for or about patients, you need to read this book. It is a tremendous contribution to the goal of eliminating disparities in health."

- David Satcher, M.D., Ph.D., Director, The Satcher Health Leadership Institute and
Center of Excellence on Health Disparities
Poussaint-Satcher-Cosby Chair in Mental Health, Morehouse School of Medicine, Atlanta, GA
16th Surgeon General of the United States

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"As vital to medicine as mapping the rhythm of the heart and the firing of the nerves is an understanding of the diversity of the human family. Gus White takes us on a marvelous personal journey that illuminates what it means to care for people of all races, religions and cultures. The story of this man becomes the aspiration of all those who seek to minister not only to the body but also to the soul."

- Jerome Groopman, MD, author of ***How Doctors Think***

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"Dr. Gus White has written a tour de force. In his journey from Memphis, Tennessee to Boston, Massachusetts, Dr. White's new book, "Seeing Patients: Unconscious Bias in Health Care", tells a compelling story about race, health and conquering inequality in the health field. From growing up in a segregated South, to receiving his medical training at Stanford, to his time in Vietnam, and to the election of President Obama, Dr. White's perceptive lense in seeing and analyzing unconscious bias in the health care arena is unparalleled. Each chapter offers powerful anecdotes, and superb analysis of the growing prevalence of health care disparities, and Dr. White's book offers powerful prescriptions to address our national crisis. You will not be able to put this book down."

- Charles J. Ogletree, Jr., Jesse Climenko Professor of Law at Harvard Law School
Author of ***The Presumption of Guilt: The Arrest of Henry Louis Gates, Jr., and race, class, and crime in America*** (2010 Palgrave Macmillan)

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"Seeing Patients: Unconscious Bias in Health Care, is a splendid and lucidly written story of the life of Augustus A. White, III, MD, PhD with numerous accomplishments, and many, many seminal contributions to the world of patient care, education, research, health care policy, community health, and social justice. A real *tour de force*, inspirational, and evocative *must read* for medical students, residents, faculty, practicing physicians, policy makers, advocates, leaders, the general public, and everyone concerned with fostering greater health equity and improving the health and well being of our increasingly diverse society. I plan to strongly recommend it our faculty and medical students here at RWJMS and to as many people as I can."

- Robert C. Like, MD, MS, Professor and Director,
Center for Healthy Families and Cultural Diversity. Robert Wood Johnson Medical School

J. Racial and Ethnic Health Disparities (2014) 1:61–66
DOI 10.1007/s40615-014-0011-9

PERSPECTIVE ARTICLE

Some Advice for Minorities and Women on the Receiving End of Health-care Disparities

Augustus A. White III

Received: 9 October 2013 / Revised: 9 January 2014 / Accepted: 13 January 2014 / Published online: 12 February 2014

Abstract The pervasive, distressing realities of health-care disparities were well documented in the milestone publication by the Institute of Medicine in 2003. This work reviewed numerous articles published in peer-reviewed journals showing disparities in health care for a number of groups in our society, including African Americans, Native Americans, Asian Americans, Latinos, and women. These disparities are caused by conscious and subconscious bias, stereotyping, racism, and sexism in our society. Although not enough, there are numerous programs and activities designed to eliminate health-care disparities. Health literacy is one element that is helpful in improving anyone's health care. For those who are at risk to experience health-care disparities, a patient education program is thought to be helpful, although presenting without evidence basis. If patients at risk for health-care disparities can be educated to have the knowledge, skills, and attitudes to negotiate a system wrought with disparities, this would be helpful in diminishing the existence of these disparities. Fifteen specific recommendations are offered which together are expected to provide considerable help in diminishing health-care disparities in the at-risk patient population. A brief explanation of the reason and rationale for the recommendations is offered as needed. A presentation of the patient's rights and responsibilities is provided to help patients cope in this current medical environment. These rights and responsibilities are well-regarded examples of current best practices.

Keywords Advice to patients · Health care disparities · Conscious bias · Subconscious bias · Stereotyping · Racism · Health literacy · Patient education · Patient rights · Patient responsibilities · Ambient racism · Distrust · Teach back · Humanize · Interpreter

A. A. White III (✉)
Culturally Competent Care Education Program, Harvard Medical School, Landmark East 2N07, 401 Park Drive, Boston, MA 02215, USA
e-mail: augustus_white@hms.harvard.edu

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
Martin Luther King, Jr.

Introduction and Background

Dr. King, of course, was a very wise man. But given his legendary struggle for equality and fundamental human rights, it may seem a little odd that he would place inequality in health care at the very top of the list of injustices—"the most shocking and inhumane," as he put it.

But think for a moment. When in the normal course of our lives, are we at our most vulnerable? When are we most frightened? When are we in most pain? The answer is—when we are suffering from illness or injury. And it is exactly then that we must go for help to someone we may know only slightly or who may be a complete stranger to us. That person may come from a different culture; he or she might speak differently. If we are not native English speakers, we may have difficulty understanding what that person is telling us even at the most basic level. In the best of circumstances, he or she will be using a language we are likely not be very familiar with—the language of medicine. We are faced with all these when we are in distress physically and, very likely, emotionally as well. It is in these difficult circumstances that injustice and inequality strikes most egregiously.

Injustices in health care are commonly described as disparities. These disparities are pervasive, and, sometimes, a harsh reality for many of us. Peer review journals confirm a substantial inequality in health care for minorities and women in America today. The infant mortality rate for Blacks is more than twice that for whites [1]. African Americans receive fewer cardiac catheterizations [2], fewer angioplasties, fewer bypass surgeries [3], fewer kidney transplants [4], and fewer lung cancer surgeries [5]. African Americans [6] and Hispanic Americans [7] with

fresh long bone fractures receive significantly less pain medication as compared with whites. In addition, pharmacies in predominantly nonwhite neighborhoods of New York City do not stock sufficient medications to treat patients with severe pain adequately [8]. African Americans received fewer total joint replacements [9] and fewer procedures for open reduction and internal fixation of femoral fractures [10]. African Americans receive more hysterectomies [10, 11], more amputations [12], and more bilateral orchiectomies [13]. The average American life expectancy in 2001 was 77.2 for African Americans, and whereas for whites, it was 77 years [14]. The death rate for nine of the top ten causes of death in America is at least 1.5 times greater for Blacks than for whites [1, 15].

One might ask, "Why is this?" How can these realities be so striking, pervasive, extensive, and persistent?

There are a number of factors behind such shocking facts. We know from research in psychology and other disciplines that unconscious bias is an ever present and powerful reality impacting many of our day-to-day decisions, large and small. Physicians are not exempt from this reality. Moreover, we know that the likelihood of unconscious or subconscious factors affecting decision making is much greater for individuals under stress [16], which typically include doctors. The list of "doctor stressors" is a long one: rushed schedules, sky-high debt burdens from medical school, the need to keep up with an avalanche of research and clinical studies, ever mounting medical insurance costs, and that is the short list. As a result, physicians are especially prone to the impact of the subconscious, which includes biases that run beneath the surface and awareness of our mental lives. And yes, some caregivers still carry conscious prejudices as they practice, though that may be reduced from what it used to be.

There is another context in which health-care disparities occur. This has to do with a tendency for stereotyping on the part of caregivers. People have a propensity to stereotype; it is a universal human trait, and often damaging or dangerous for those who are stereotyped. "Driving while Black" is a danger. "Being a patient while Black" can be one, too.

A third mechanism that can contribute to health-care disparities in the patient-doctor interaction is the harsh and still ubiquitous ambient racism [17]. Institutions, businesses, schools and other social environments incorporate in their practices histories of racial prejudices that remain, even given efforts to eliminate them. Clinics and hospitals are far from immune to these residual and difficult to extract biases [18].

Subconscious and conscious bias, stereotyping, and ambient racism affect health care [19]. They are, simply, realities that minorities must take into account. These are discussed in detail in *Seeing Patients: Unconscious Bias in Health Care* [17]. Patients who are aware of this can proceed realistically in their interactions with the health-care system. The purpose of this awareness is not to create or magnify distrust, but to help develop practices that will result in the best possible outcomes when we need medical treatment or health maintenance.

It is also good to remember that distrust on anyone's part is a problem, patients' as well as doctors'. One factor in the medical care equation is that patients, most especially in cross-cultural patient-doctor interactions and most especially when the patient is African American, do have a tendency for distrust. Doctors are aware of this. It is recognized in the medical literature; it comes up in doctors' conversations with each other. The renowned African-American psychiatrist Dr. Price Cobbs famously said in his book, *Black Rage* [20], "If you're Black in America, and you're not paranoid… you must be crazy." But bringing any hint of paranoia with you into the examining room will not help produce good results. Remember, doctors are as patients are. They will react to the way you treat them just as you react to the way they treat you.

Hopefully this background will alert, focus, motivate, and help the reader to develop knowledge, attitudes, and skills that will result in a good outcome when the patient encounters caregivers in the current US health-care system. The intended outcome is for the patient to be alert, savvy, sophisticated, and wise, but not with a chip on the shoulder. A chip is not going to help get the kind of care that the patient deserves.

The Advice

Consider the following preamble. As with any human interaction, one is encouraged to be polite, respectful, but also direct. Know your rights. In the patient-doctor encounter, remind yourself of the obvious: it is your health, perhaps your life, that is on the line, no one else's. What you want is the very best care that you can get without any confrontation or hostility. We want you to be empowered because you do have rights as a patient, and you should be aware of them. We want to help you to be aware of them.

You have a right as a patient to receive equitable care, to receive good care. You should not have to demand good equitable care, but you should get it by merely being present, pleasant, and cooperative. There are a number provisions in the US Constitution, federal civil rights statutes, state statutes, and professional association and accrediting standards that prohibit a hospital or doctor from discriminating against a patient based on race. To support this, you may cite the 14th Amendment (guaranteeing equal protection of law), title VI of the *Civil Rights Act of 1964*, the reconstruction Civil Rights Acts, 42 U.S.C. Sections 1981.982 and 1983—among others.[1]

- Read the general guidelines on "Getting the Most Out of Your Doctor's Visit" [21].

[1] Based on a consultation in Dec. 19, 2013 with Frank M. McClellan, Professor of Law Emeritus, Co-Director Temple University Center for Health Law, Policy and Practice, James E. Beasley School of Law, Temple University, Philadelphia, PA

- Cooperate and respond to demographic questionnaires collected by the health facility. Institutions collect this data, so that it will be possible to review the care received by various demographic groups: racial, ethnic, gender, and LGBT and others. This is important because it can uncover inequitable care when it occurs and hopefully lead to successful remedies.
- Be sure to complete Patient Satisfaction forms. Such feedback is enormously important. Some institutions will give serious considerations to your response and will seek to improve when the patient interactions in which they can do better are pointed out. If they do not have your feedback, they will not have the incentive nor the information with which to address inequitable unsatisfactory care.
- Networking is useful in two ways. First, it allows patients to learn the good and the bad about how they may be treated in a given facility. We, at-risk people, can oftentimes accurately sense conscious and unconscious bias on the part of caregivers. Networking activities can provide useful positive and negative feedback which can inform and incentivize the various treatment institutions. Moreover, social media communications greatly facilitates these important communications, activities, and mechanisms.
- Know your patients' rights. Some health facilities publish a list of patients' rights. Ask for a copy. If they are not published in the facility, you can find them online. See www.nationalhealthcouncil.org/.
- Become health literate. Here is one of the most important measures you can take: Study your symptoms and your disease(s) on WebMD or the Mayo Clinic.com website or some other reliable source of medical information and learn about your disease. This will help you to interact with your physician, ask questions more effectively, and get better care.
- Ask questions. Ideally, write down your questions before you go into the physician's office. If helpful, read them when you have the opportunity during the visit. If you do not have a chance to write them down, ask them anyway. When in doubt, in any patient-doctor interaction, if you are anxious or worried or confused, ask questions. Repeat: ask questions.
- Do a "teach back." This more structured way of asking questions can clarify your health status, the plan for addressing issues, and help establish your role as an active participant in your care. At some point before the visit is over, say "Doctor, may I just take a moment to see if I understand what my illness is, what we're doing about my illness, and the reasons for what we're doing?" Then review the visit. "Doctor, please let me see if I understand my problem and what we're going to be doing to solve it." Then, tell the doctor. The doctor will then tell you if you got it right and correct you as and if needed. You will then explain things again to the doctor who will once again correct you if needed. This process (teach back) continues until it is clear that you understand the doctor's instructions and/or prescriptions. Some doctors have had training and are instructed to initiate this teach back activity. But remember, if the doctor does not initiate the teach back, *you* should initiate it.
- If you sense a need, do what we call a "reality check." True, we want to be cautious about our distrust, but if you sense, for whatever reason, that you are not receiving adequate care, that in fact, you are receiving disparate care, I repeat, *for whatever reason*—whether it is because you encountered lack of attention, discourtesy, prejudice, disrespect—we recommend the following. Relax, focus, look at the physician, and say, "Doctor, I came here because of your reputation/the reputation of this facility as a place where I would receive good care. Doctor, I have to be frank and tell you that I feel that I'm not receiving good care. I'm not sure why. I'm not sure if you have not treated African-American patients before, (or elderly patients before, or seriously overweight patients before), but I feel somehow we're not moving forward together and I'm not receiving the care I need and deserve."

  This can be done forthrightly and respectfully and is 100 % within your rights. If the doctor responds with an apology or some other positive response such as, "That was not my intent, I do want to provide good care for you," that is a good outcome. You, the patient, may then say, "Doctor, let's move forward and see how we can work together effectively." If you, the patient, have a special specific complaint, then express that again or add that to what you have already said. If the doctor responds in an unconcerned, detached, offensive, or aggressive manner, then I think you should fill out your Doctor Satisfaction form and look for another doctor. If the doctor makes an attempt to adjust and expresses a desire to move forward and provide the care that you expected, then it makes good sense to continue with that doctor as long as you feel you are making progress. Again, this is entirely within your rights. Remember that it is *your* health that is on the line. You must advocate for yourself.
- Try to humanize your doctor/your caregiver. This is something we recommend physicians do as well when treating their patients, as an attempt to enrich the patient-doctor relationship and develop a more collaborative, cooperative partnership, which will result in more effective care. Two human beings, the caregiver and the patient, constitute this relationship. Any personal exchange can work toward establishing a human connection—which is always helpful in furthering the professional connection. Ask about family, children, grandchildren, or ask about the weather. If the doctor asks how you are, ask in turn how he or she is. Be interested. By all means seek to humanize your doctor.

Doing that will help him or her to focus on you as a fellow human person.

- Perhaps you can research your caregiver ahead of time, either online or through word of mouth. You may find you have things in common: maybe you are from the same city or region, perhaps you went to the same school, or to a similar church, maybe you played the same sports, or have a particular overlapping interest in art or music—anything that you can relate to, however briefly, that engages experience in common.
- If you are comfortable sharing your health information, by all means, take a friend and/or a relative with you and ask the doctor if he or she is comfortable having your friend be present because it is important for you. That person is another set of ears. If what is going on is complicated, he or she might take notes or may simply remind you of things that you would like to include in your discussion with the doctor. It is a good check, and it lets the doctor know that at least one other person cares about you. This "buddy visit" tends to add confidence and security in any circumstances.
- If you have a negative, unsatisfactory, unpleasant, inadequate patient-doctor interaction, make sure to report the incident to someone in a supervisory capacity at the hospital or clinic, preferably in person or by telephone or by mail as a last choice. Report to the highest-ranking person you can contact. Simply explain your disappointment, report that you are upset, and explain the reason for it. This will not erase your experience, but it will give you a sense of satisfaction in that you are doing something about the problem, and in many instances, it will be helpful to your fellow patients as your complaint is addressed with by the institution and the caregiver involved. If not satisfied, seek a facility with a better reputation for equitable care.
- If surgery is in the picture and you are inclined toward surgery and your caregiver is pushing against it, get a second opinion. If you are inclined not to have a surgical procedure and your caregiver is pushing for you to have it, get a second opinion. Actually, if a major surgery is in the picture, get a second opinion regardless of your inclination to proceed or not.
- If in any doubt or difficulty with English proficiency, ask about having an interpreter [21].

A Parting Observation

You cannot control health policy for the nation nor for your local health facility. You cannot control health insurance. You cannot control the doctors, the nurses, or the staff in your health facility, but you can control yourself. The most important benefit of all to your health is *your health literacy.* And that is under your own control. *Know as much as you can about your problem, your symptoms, and how you can most effectively interact with your health care provider!*

Hopefully some, if not all, of the suggestions made here will be helpful. Keep your chin up, keep your head up, keep your pride up, know your rights, and be assertive and persistent in search of collaborative mutually respectful arrangements with your caregivers.

The following is the standard list of patient rights and responsibilities from the Beth Israel/Deaconess Medical Center, a Harvard Medical School teaching hospital [22].

Your Rights as a Patient [22]

Our statement of patients' rights, incorporating state and federal law, describes the medical center's commitment to protecting your rights.

1. You have the right to receive medical care that meets the highest standards of BIDMC, regardless of your race, religion, national origin, any disability or handicap, gender, sexual orientation, gender identity or expression, age, military service, or the source of payment for your care.
2. You have the right to receive visitors of your choosing that you (or your support person, where appropriate) designate, including a spouse, domestic partner (including same-sex domestic partner), or another family member or a friend.
3. You have the right to prompt, life-saving treatment in an emergency without discrimination based on economic status or source of payment, and to treatment that is not delayed by discussion regarding the source of payment, except in an emergency.
4. You have the right to be treated respectfully by others and to be addressed by your proper name without undue familiarity.
5. You have the right to privacy within the capacity of the medical center.
6. You have the right to seek and receive all the information necessary for you to understand your medical situation. You have the right to know who will perform an operation or a test and to receive a full explanation of the details in advance, in order for you to exercise your right to give informed consent or elect to refuse.
7. You have a right to know the identity and the role of individuals involved in your care.
8. You have a right to a full explanation of any research study in which you may be asked to participate.

9. You have the right to leave the medical center even if your doctors advise against it, unless you have certain infectious diseases that may influence the health of others, or if you are incapable of maintaining your own safety or the safety of others, as defined by law.
10. You have the right to access your medical record.
11. You have the right to inquire and receive information about the possibility of financial assistance.
12. You are entitled to know about any financial or business relationships the medical center has with other institutions, to the extent the relationship relates to your care or treatment.
13. You have the right not to be exposed to the smoking of others.
14. You have the right to take part in decisions relating to your health care.
15. You have the right to appropriate assessment and management of pain.
16. You have the right as a patient who may have limited English proficiency to have access, free of charge, to meaningful communication via a qualified interpreter either in person or by phone, as deemed appropriate.
17. You have the right to receive information about how you can get assistance with concerns, problems, or complaints about the quality of care or service you receive and to initiate a formal grievance process with the medical center or with state regulatory agencies. Should you have concerns, problems, or complaints about the quality of care or service that you are receiving, you are encouraged to speak to the providers directly involved in your care.

Your Responsibilities as a Patient [22]

1. Provide accurate and complete information regarding your identity, medical history, hospitalizations, medications, and dietary supplements (herbal and other nutritional supplements).
2. Follow treatment plans recommended by physicians and other health-care providers working under the attending physician's direction.
3. Participate and collaborate in your treatment and in planning for posthospital care.
4. Be part of the pain management team.
5. Be considerate and respectful of other patients and medical center personnel.
6. Follow medical center rules and regulations, including those that prohibit offensive, threatening, and/or abusive language or behavior, and the use of tobacco, alcohol, or illicit drugs or substances.
7. Provide the medical center with a copy of any advance directive or health-care proxy designation you have prepared.
8. Provide accurate and complete financial information and work with the medical center to ensure that financial obligations related to your care are met.

Acknowledgments Some portions of this article first appeared in the Boule Journal. See White, AA, III, "Preventing Health-Care Disparities: Advice for Minorities and Women", *Boule Journal* 77 (3): 23–25, 2013. Thanks to Nancy Ferrari for her editorial contributions and to Yolanda Bauer for her general administrative assistance. The author wishes to also acknowledge the following support: Dr. Mark Bernhardt, Beth Israel Deaconess Medical Center, Department of Orthopaedic Surgery, Blue Cross Blue Shield of Massachusetts, Culturally Competent Education Program, Harvard Medical School, Rodger L. and Gloria F. Daniels Charitable Foundation (Richard J. Hindlian, Co-Trustee), J. Robert Gladden Orthopaedic Society, Arthur and Barbara Higgins Charitable Foundation, Dr. Melvin Law, The Macy Foundation, Massachusetts General Hospital, Department of Orthopaedic Surgery, McKesson Foundation, Reverend Willie and Mrs. Anne Naulls, Macey Russell, and Zimmer Holdings Inc.

Conflict of Interest Dr. White declares that he has no conflict of interest.

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Best hospitals ranked for 2014

By Sara Cheshire , Special to CNN
updated 7:19 AM EDT, Tue July 15, 2014

CNN.com

The Mayo Clinic in Rochester, Minnesota, was ranked as the best overall hospital by U.S. News & World Report.

(CNN) -- Looking for the best hospitals in the United States? U.S. News & World Report has released its annual rankings for 2014 -- with the Mayo Clinic topping the site's honor roll list for the first time.

The yearly analysis specifically looks at the best medical centers for patients with life-threatening or rare conditions. Factors such as patient survival rates, adequate nursing staff, reputation with specialist physicians and patient safety, which has more emphasis this year, are taken into account.

"U.S. News strives to provide patients and their families with the most comprehensive data available on hospitals," said Avery Comarow, U.S. News health rankings editor. "With an estimated 400,000 deaths occurring in hospitals each year from medical errors, measuring safety performance is critical to understanding how well a hospital cares for its patients."


Cancer center: We know how to save lives

Why you should try to avoid going to the hospital in July

In addition to an overall ranking, the report also breaks down the best hospitals into 16 specialties, including the best hospitals for cancer and heart surgery.

All the rankings can be viewed on usnews.com. Highlights include:

Best overall hospitals

1. Mayo Clinic, Rochester, Minnesota
2. Massachusetts General Hospital, Boston
3. Johns Hopkins Hospital, Baltimore
4. Cleveland Clinic
5. UCLA Medical Center, Los Angeles

Best cancer hospitals

1. Memorial Sloan Kettering Cancer Center, New York
2. University of Texas MD Anderson Cancer Center, Houston
3. Mayo Clinic, Rochester, Minnesota
4. Dana-Farber/Brigham and Women's Cancer Center, Boston
5. Johns Hopkins Hospital, Baltimore

Best cardiology and heart surgery hospitals

1. Cleveland Clinic
2. Mayo Clinic, Rochester, Minnesota
3. New York-Presbyterian University Hospital of Columbia and Cornell, New York
4. Duke University Hospital, Durham, North Carolina
5. Brigham and Women's Hospital, Boston

For less life-threatening conditions, U.S. News and World Report recommends that patients use the best regional hospitals list.

Inequality persists in health care

By Louis W. Sullivan and Augustus A. White, III
updated 11:12 AM EDT, Wed July 16, 2014

CNN.com

Louis Sullivan and Augustus White think equal treatment for all should be a factor in what makes a hospital excellent.

Editor's note: *Louis Sullivan is the president emeritus of Morehouse School of Medicine and Chairman and CEO of The Sullivan Alliance. He served as U.S. Secretary of Health and Human Services from 1989-1993. Augustus A. White is the Ellen and Melvin Gordon Distinguished Professor of medical education and a professor of orthopedic surgery at Harvard Medical School. The opinions expressed in this commentary are solely those of the authors.*

(CNN) -- Growing up in the Jim Crow-era South, we saw firsthand the great disparities in health care suffered by African-Americans. The lack of access to basic services, the dearth of black physicians and the often overtly racist attitudes of white health care providers contributed to higher rates of infant mortality, chronic illnesses and shorter life expectancy.

The Rev. Martin Luther King, Jr., said that "of all forms of inequality, injustice in health care is the most shocking and inhumane." But hasn't the prejudice that prevailed in those far off times been eliminated in today's more equitable society? Or do health disparities persist in less obvious but no less worrying ways -- and not just for African-Americans?

Studies emphatically conclude that such disparities do persist.

U.S. News and World Report released its latest issue announcing the best hospitals in the nation on Tuesday. People put a lot of stock in these rankings, and equality of treatment should be considered as a factor in what makes a hospital excellent.

"Unequal Treatment," published by the Institute of Medicine in 2002, spelled out exactly how Latinos, African-Americans, Native-Americans, Asian-Americans, and Pacific Islanders receive care that's inferior to that enjoyed by mainstream Americans. The IOM report triggered other studies that demonstrated the (often unconscious) prejudice that prevails in treating women, the elderly, the LGBT community, the obese --13 groups in all -- a large percentage of the health care consuming public.

Here are a few shocking examples: Women with symptoms of heart disease often are not transported by emergency medical services to health facilities as rapidly as men. Women and blacks with heart attack symptoms are not given cardiac catheterizations and other appropriate clinical tests at the same rate as white men. Latinos and African-Americans do not receive the same pain medication for long bone fractures as do their fellow citizens.

Attacking health disparities head-on can make a big difference. A program in Alaska designed to train dental health care therapists -- the rough equivalent of physician's assistants -- celebrated its 10th

anniversary this month. The Native Tribal Council initiated the program, Dentex, because the state had few dentists and most wouldn't accept Medicaid. Many native children lost all of their teeth by age 18, affecting their health, social lives, school attendance, and employment possibilities.

The dental health aide therapists have improved oral health in Alaska dramatically. Now, despite the fierce opposition of the American Dental Association, Maine and Minnesota have approved the training and deployment of similar mid-level dental providers, and other states are considering it.

It is widely accepted that African-Americans and Hispanics are underserved. Shortening the waiting times at Grady Hospital in Atlanta, Georgia -- which primarily serves African-American, Hispanic and other minority populations -- allowed greater access to mental health services because the population is admitted more quickly and provided with care.

See why these executives gave up bonuses

Hospitals would be encouraged to join the fight if equality were included as a metric in the U.S. News and World Report rankings. These rankings are popular and closely watched. They bestow bragging rights on hospitals, but most important, provide guidance for people deeply interested in where they might go to receive the best care in the specialties that concern them most.

U.S. News and World Report has a tremendous opportunity to facilitate significant changes in health care delivery by rating hospitals for their care of the underserved. Its annual hospital rankings tell consumers nothing on this vital subject.

Where do hospitals rank in their understanding of the problem of unequal care? What measures do they take to counteract the effects of prejudice in the treatment they provide?

We encourage the publication to maximize this opportunity before next year's "Best Hospitals" issue. That would enable women and minorities to advocate for health care equality more successfully. It would help U.S. health professionals understand health disparities and more effectively treat underserved and minority populations.

Most important, it would help all patients and their families, not just those who need not worry about disparities in care, to know better where to go for the care they need.

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VOLUME 100
NUMBER 2
2014

The Interstate Medical Licensure Compact

Making the Business Case

ALSO IN THIS ISSUE

Medical Board Complaints against Physicians Due to Communication: Analysis of North Carolina Medical Board Data, 2002–2012

State Regulatory News

Federation of STATE MEDICAL BOARDS

The Interstate Medical Licensure Compact: Making the Business Case

Blake T. Maresh, MPA

ABSTRACT: The United States Constitution established and the Supreme Court has affirmed the proper role of states in regulating medicine throughout American history. However, the opportunities and mounting pressures of modern medical practice have called into question the viability of state-based regulation to address the increasing practice of physicians across state lines. This article will argue that the crossroads at which state medical boards find themselves provides an opportunity for an interstate compact as the best solution for adapting to the forces of current and future trends.

A brief examination of the history of state-based licensing, and the dynamics that led up to the formation of the Federation of State Medical Boards will provide a basis for consideration of interstate compacts as a constructive response to critiques of the present regulatory structure. With a common understanding of the utility and widespread use of the interstate compact, we will turn our attention to how it emerged as a viable option, key specifics of an interstate compact for medical licensure, and the extent to which the model that has been crafted by the FSMB can complement the existing authority of state medical boards.

> "One believes things because one has been conditioned to believe them."
> — Aldous Huxley, *Brave New World*

> "The choice for mankind lies between freedom and happiness and for the great bulk of mankind, happiness is better."
> — George Orwell, *1984*

An interstate compact offers the prospect of taking a giant leap forward in expedited licensure, a means to facilitate multistate practice within a state-based licensing framework, and a response to those who would bypass state-based regulation entirely through federal legislation. An interstate compact would also represent a departure from how medical boards have operated, in many cases, for over a century.

Depending upon one's point of view, an interstate compact might conjure up different visions of the future. For some, the interstate compact offers a tested Constitutional precept that could creatively forestall federal intervention that might otherwise supplant the long-standing authority of state medical boards. The power of interstate compacts might also provide state boards with valuable new tools with which to do their work. For others, the possibility of other state boards licensing physicians who practice in their states, coupled with the establishment of new governmental organizations, leaves them uneasy at best. Dissenters also raise questions about how boards will obtain the necessary financing to do their work. This paper will show how the interstate compact is the best solution for adapting to the forces of current and future trends. With a common understanding of the utility and widespread use of the interstate compact, we will turn our attention to how it emerged as a viable option, key specifics of an interstate compact for medical licensure, and the extent to which the model that has been crafted by the FSMB can complement the existing authority of state medical boards.

Origins of State-Based Physician Licensing

Readers of this article, and of this journal, are likely to be familiar with important recent works on the history of medical regulation, such as *Medical Licensure and Discipline in America*, authored by David Johnson and Humayun Chaudhry (2012) and Ruth Horowitz's *In the Public Interest: Medical Licensing and the Disciplinary Process* (2013). Though it is not necessary to repeat the efforts of these and other authors, it is instructive for this

AN INTERSTATE COMPACT OFFERS THE PROSPECT OF TAKING A GIANT LEAP FORWARD IN EXPEDITED LICENSURE, A MEANS TO FACILITATE MULTISTATE PRACTICE WITHIN A STATE-BASED LICENSING FRAMEWORK.

discussion to underscore several key themes through highlighting specific historical episodes and milestones of the long history of state-based medical regulation.

Efforts to regulate the practice of physicians predate the founding of the United States, with the earliest legislation dating to 1639 in the Virginia Colony, the Massachusetts Bay Colony in 1649 and in New York in 1665.[1] Precursory state requirements to have a license issued through a medical society comprised of physician peers (such as New York in 1760[2], New Jersey in 1772[3], Pennsylvania in 1794[4], and Maryland in 1798[5]) and to have an examination (New Jersey in 1772 and New York in 1797, for example) were commonplace.[6] However, between 1826 and 1852 nearly every state (except New Jersey) repealed laws requiring licensure of physicians, due primarily to consumer confusion and skepticism about the efficacy of the many types of physicians practicing in the day. Nevertheless, as a result of multiple effects, not the least of which were public sanitation and scientific advances, states gradually established (or reestablished) licensing boards and independent examinations of their own by 1910.[7,8,9]

EFFORTS TO REGULATE THE PRACTICE OF PHYSICIANS PREDATE THE FOUNDING OF THE UNITED STATES, WITH THE EARLIEST LEGISLATION DATING TO 1639 IN THE VIRGINIA COLONY.

In other words, even prior to the nation's founding, the basic infrastructure of how we regulate physicians at the state level emerged, and it has since evolved into a model (well over a century ago) that is easily recognizable as similar to what universally exists in the U.S. today. How state medical boards have responded to changes in their operating environment, including the expectations placed on them by the public and key stakeholders can be easily illustrated:

- While the founding of the National Board of Medical Examiners (NBME) in 1915 might have hastened movement toward a more unified examination process for medical students, states only gradually gave up the use of their own licensing examinations. However, it became apparent that educators were embracing new and better methods of testing, as a means to truly measure fitness for practice and not just factual recall.[10,11] Over time, state examinations gave way to national examinations — the NBME, the Federation Licensing Examination (FLEX), the National Board of Osteopathic Medical Examiners (NBOME)[12] Examination, and ultimately, the U.S. Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) — that promoted greater consistency in content and standards, in contrast to the variability of state examinations.[13]
- Although medical boards' initial focus was on the licensing of physicians, as time went on, public skepticism grew about how licensing (sometimes licensing for life) was protecting the public. Relatively few complaints resulted in professional discipline, and most often, these were in the realm of substance abuse or sexual or other misconduct, not substandard practice. In response, Dr. Walter Bierring called for boards to broaden their perspective in the January 1960 *Federation Bulletin:*

  > "If a state cannot, or does not, for just cause, revoke a license or discipline a physician…a fatal weakness exists. If no machinery exists for investigations and hearings…discipline does not really exist. If there is nothing beyond what the state or county society can do, a license to practice becomes a potential license for abuse."[14]

  Today, the range and volume of state medical board discipline has expanded greatly, with substandard practice comprising a significant percentage of the disciplinary work of boards.
- In stark contrast to the stated mission of state medical boards to protect the public, for many years these boards were populated only by licensees. However in 1961, that changed for the first time with the appointment of one "public member" to the Medical Board of California.[15] This began a movement that has resulted in virtually all state medical boards having public member representation today; moreover, these members are not merely tolerated, but appreciated for bringing an important alternative perspective. As Horowitz notes "[t]he idea that the public should have its own representatives on a board is generally accepted today, but it was once controversial."[16]
- In recent years, state medical boards have responded positively to license portability efforts

led by the FSMB. Sixty-seven of 69 state medical boards that engage in licensing activities now accept or require the FSMB's Federation Credentials Verification Service, which provides a centralized process for boards to obtain primary source verified physician records for credentialing.[17] Twenty-two states use the FSMB's Uniform Application, which standardizes and simplifies the licensure application process for physicians.[18]

- In response to growing sentiment that better communication between states was needed to prevent physicians from using increased mobility to evade detection, medical boards began to rely on databases such as the National Practitioner Data Bank (NPDB) and the FSMB's Physician Data Center as a part of their licensing activities. The NPDB, for example, was created in 1986 with the express purpose of "encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior, and to restrict the ability of incompetent physicians…to move from State to State without disclosure or discovery of previous…adverse action history."[19] Today, reporting to these databases, and checking them during the licensure process, is a commonplace activity for state boards.

It is true that the earliest licensing efforts in this country may have been aimed more at securing reimbursement for physicians than the virtue of patient safety, and that the repeal of many laws during the mid-nineteenth century reflected inter-professional squabbles, along with a dose of public suspicion. Nevertheless, with respect to the re-establishment of medical licensing, Horowitz notes "[t]he fact that legislatures first granted licensure to occupations concerned with health and cleanliness confirms a vital link between the successes of licensure and the public health movement."[20] Further, she states that "[w]ith the onset of the Progressive era, it was common for physicians to mention patients as main beneficiaries of the licensure policies advanced by medical societies."[21] These statements are powerful in that they not only capture the essence of why state medical boards were created and exist to this day, but that responsible physicians themselves recognize the value of state medical boards as a means of ensuring the safety of their patients and the general public. State boards have not wavered from that overarching mission, yet their responsibilities and activities continued to evolve through the twentieth century.

License Reciprocity and the Formation of the Federation of State Medical Boards

It is well known by many in the field of medical regulation that the Federation of State Medical Boards resulted from the 1912 merger of the National Confederation of State Medical Examining and Licensing Boards (National Confederation) and the American Confederation of Reciprocating Examining and Licensing Boards (American Confederation). What may be less broadly understood is that the issues of license reciprocity and barriers to physician mobility across state lines were pivotal to the fracture of the National Confederation and the creation of the American Confederation a decade earlier.[22,23,24] At the heart of the American Confederation's mission was to create a national examining board to help eliminate obstacles to interstate practice. Shryock also describes the "continued efforts of the Reciprocity Confederation" during this period "to encourage inter-board agreements."[25] However, due to the practical constraints of limited financial resources for both organizations, combined with a public perception that two contending organizations did not serve the public interest, leaders from the organizations began merger discussions in 1910 and, on February 28, 1912, the National Confederation and the American Confederation adopted a constitution and by-laws creating the Federation of State Medical Boards.[26,27]

AT THE HEART OF THE AMERICAN CONFEDERATION'S MISSION WAS TO CREATE A NATIONAL EXAMINING BOARD TO HELP ELIMINATE OBSTACLES TO INTERSTATE PRACTICE.

A more nuanced understanding of the schism between the two organizations illustrates that the difficult questions of how to license and regulate physicians at the state level, yet allow movement of medical practice across state lines, have eluded leaders in this field for over 100 years and continue to resonate in today's debates. Interestingly, Johnson and Chaudhry speak to the public's expectations of the role of that newly-formed FSMB:

> Looking back, these aspirations for a broadly influential Federation while flattering and well intentioned, expected perhaps too much from the fledgling organization. In some ways and at a fundamental level, writers such as those

> from *Harper's* and the *Times* misunderstood the true nature and authority of the Federation. They seemed to conflate an annual gathering of representatives from individual state gencies with a truly national body akin to a federal agency.[28]

More than a century ago, there was an acknowledgement of the important issues of license reciprocity and physician mobility across state lines, even in an era before telehealth[29]. In that day, the concern was to prevent unscrupulous physicians from fleeing across state borders. But the passage above also highlights an acknowledgement of the need and desire for interstate coordination, in a way that the Federation was not empowered to provide.

Concurrently, the use of interstate compacts in the early 20th century was beginning to evolve, but they did not yet possess the mechanisms to accommodate ongoing and complex regulation, such as that of interstate medical practice. As we shall observe below, important changes in interstate compact design and use place us today at a unique confluence point in history, one where the need is there and the tool has developed to ideally suit the need.

The Legal and Constitutional Context of State-Based Physician Regulation

As we examine the history of state-based physician regulation as it relates to contemporary challenges, we would be remiss not to also briefly consider the constitutional and legal contexts in which state medical boards exist. The Tenth Amendment to the U.S. Constitution, which embodies the principle of federalism, is generally the starting point for such conversation. The Tenth Amendment, which echoes language from Article II of the Articles of Confederation,

THE TENTH AMENDMENT REMAINS A CORNERSTONE UPON WHICH THE STATE REGULATION ARGUMENT, SUCH AS THAT FOR PHYSICIAN PRACTICE, IS BUILT.

reserves those powers not explicitly granted to the U.S. government to the states.[30] Derbyshire states the impacts of the Tenth Amendment plainly: "the practice of medicine for many years has been regulated by the states; this policy will not change since the federal government cannot assume this function without an amendment to the Constitution."[31]

Two U.S. Supreme Court rulings were critical in reinforcing the doctrines laid out in the Tenth Amendment.[32] In the first, *Dent v. West Virginia*, Frank Dent, an eclectic physician challenged the

MORE THAN A CENTURY AGO, THERE WAS AN ACKNOWLEDGEMENT OF THE IMPORTANT ISSUES OF LICENSE RECIPROCITY AND PHYSICIAN MOBILITY ACROSS STATE LINES, EVEN IN AN ERA BEFORE TELEHEALTH.

authority of West Virginia due to failing to meet state licensing standards. In 1889, stating the unanimous opinion of the court, Justice Field said in part: "Few professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which health and life depend…Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications. Due consideration, therefore, for the protection of society may well induce the State to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified."[33]

A decade later, in 1898, in *Hawker v. New York*, Dr. Benjamin Hawker had been previously convicted of a felony and served jail time, after which he sought to resume his medical practice. However, the State of New York had, in the interim, passed laws prohibiting felons from practicing medicine, and Dr. Hawker was again convicted under these laws, which form the basis for many "good moral character" provisions in current licensing laws. Writing for the majority, Justice Brewer stated "…it is insisted that within the acknowledged reach of the police power, a State may prescribe the qualifications of one engaged in any business so directly affecting the lives and health of the people as the practice of medicine…we are of opinion that this argument is the more applicable and must control the answer to the question."[34,35]

The Tenth Amendment remains a cornerstone upon which the state regulation argument, such as that for physician practice, is built; nevertheless, the debate rages today as to whether Congressional action in recent decades has, in practical terms, eroded its strength. Its federalist canons are

often described through three touchstone concepts: enacting limitations on the power of the federal government in order to protect against tyranny, placing the locus of governance as close as practicable to the people, and fostering innovation in governance at the state level.[36,37] However, how Congress and the Supreme Court have interpreted the core tenets of federalism over our nation's history have shifted significantly.

For most of our national existence, federalism has been structured as a "layer cake" with distinct and separate roles for federal and state governments, also known as dual federalism. These distinctions were preserved by the courts, through common law rulings, but with a series of Supreme Court decisions in 1937 and 1938, an era of greater federal preemption began with the New Deal and lasted for nearly six decades. During this time, the Supreme Court simultaneously shrank its own role in preserving federalism via common law to mere interpretation and allowed that of Congress to expand.[38,39,40] This is most explicitly illustrated in the 1985 *Garcia* ruling where, writing for the majority, Justice Blackmun questioned whether the Court could even define what activities are so within the sphere of state regulation as to be exempted from federal regulation.[41,42] This loosening of Congressional restraint manifested itself as cooperative federalism, where the federal government sets a broad policy direction yet allows states flexibility and creativity in how to implement and administer program requirements, and it resulted in the expansion of federal regulation in a number of new areas. It also gave rise to a more coercive federalism, where the federal government sought to impose policies via regulatory mandates, funding restrictions and/or federal preemption.

FOR MOST OF OUR NATIONAL EXISTENCE, FEDERALISM HAS BEEN STRUCTURED AS A 'LAYER CAKE' WITH DISTINCT AND SEPARATE ROLES FOR FEDERAL AND STATE GOVERNMENTS ALSO KNOWN AS DUAL FEDERALISM.

While President Reagan heralded a new relationship between a more limited federal government (i.e., his pronouncement that "government is the problem") and the states in the early 1980's, cooperative federalism abruptly ended, at least from the perspective of the Supreme Court, with *New York v. United States* in 1992.[43,44] The ruling solidified New Federalism, and the Supreme Court's rulings reversed a decades-old pattern of accommodating federal preemption. Although the essence of cooperative federalism remains today in tools such as bloc and categorical grants to states, a tension continues to exist between Congress's more intergovernmental approach of cooperative federalism and the Supreme Court's more restrictive new federalism approach.

The historical vicissitudes of federalist theory in the United States and the concomitant risks of federal preemption bear on the question of state regulation of physicians in at least two respects. First, the extent to which the regulation of medicine ceases to be a "layer cake" and becomes a "marble cake" is vitally important. Chemerinsky, in his assessment of the risks of federal overreach, cites Jonathan Tribe's remarks: "no one expects Congress to obliterate the states at least in one fell swoop. If there is any danger, it has to be in the tyranny of small decisions."[45] Is it idle speculation to suggest that, when a sufficiently large health care regulatory portfolio has been created at the federal level (i.e., when the cake has become sufficiently "marbled"), this creates a clearer path to full federal preemption, and does it simultaneously make it harder for states to retain their sovereignty in those areas?

Second, the potential implications are unclear of a national licensure scheme where sharing revenue with the state medical boards occurs, as it may present an opportunity to attach policy conditions to state regulation of physicians. A well cited example of this is the withholding of federal highway funds to states for not raising the legal state drinking age to 21[46]. Moreover, the message in *New York v. United States* was not that federal funding could not be tied to the storage and disposal of low-level radioactive wastes, but that state regulatory authority may not be commandeered by the federal government.[47,48] It is conceivable then that, as part of partial preemption of physician licensing, the federal government could seek to leverage its control over state medical boards via a modified form of conditional spending power.[49]

According to Learner, if a critical mass of states forges a policy consensus on a policy issue, "courts should apply the Supremacy Clause with more restraint."[50] His assertion is more narrowly in the context of federal preemption of environmental regulation, yet it is well worth contemplating whether the message is the same — that is, a show of solidarity in resolving the policy question of

interstate physician licensure at the state level, using a Constitutionally-authorized tool like an interstate compact, should carry weight with Congress and, if necessary, the courts. The "chaotic, conflicting, and rather rudimentary"

STATE MEDICAL BOARDS' FIAT DERIVES BOTH FROM THE U.S. CONSTITUTION AND FROM THEIR LONGEVITY OF OPERATION.

Tenth Amendment jurisprudence[51], and the accompanying uncertainty of whether federal mandates will come to states cloaked in full preemption, partial preemption, collective federalism, and/or constraints on federal licensing revenue, beg the question of whether states are better off to simply embrace the pure federalist spirit to operate as policy laboratories and proactively fill in the policy gap themselves.

State medical boards' fiat derives both from the U.S. Constitution and from their longevity of operation. State medical boards and their predecessors have functioned in America as regulators of physician practice since the mid-17th century. This structure has been firmly underwritten by the 10th Amendment to the U.S. Constitution and has been reinforced by the U.S. Supreme Court. These provide a solid foundation to argue that maintaining the regulatory structure for physicians through state boards is reasonable. Yet those associated with state medical regulation would be unwise to stop here, as the complex and changeable landscape of federalism suggests. Additional compelling arguments, beyond mere historical or Constitutional entitlement, are warranted.

Emerging — and Emergent — Forces on State Medical Boards

The first sentence of the 2013 Congressional Research Service (CRS) report, "Physician Supply and the Affordable Care Act," plainly states the relationship between physician supply and patient care: "[a]n adequate physician supply is important for the effective and efficient delivery of health care services and, therefore, for population health and the cost and quality of health care."[52] Consider that the Affordable Care Act projects that 32 million newly-insured Americans will enter the health care marketplace by 2019.[53] The nation also continues to grow older and more populous. By 2050, U.S. Census numbers indicate the U.S. population will grow by over 85 million to 400 million, and the over-65 population, which statistically tends to use more health care services, will nearly double from 43.1 million to 83.7 million, or more than 20 percent of the overall population.[54] Yet another factor that will affect the public's future utilization of health care is the growing prevalence of chronic disease, responsible for seven out of ten deaths in the U.S. in 2010, and of "lifestyle" conditions, such as obesity, which afflicts more than one-third of adults.[55]

At the same time, a shortage of physicians and other health care professionals is anticipated, which is likely to be exacerbated in certain clinical specialties and in certain geographic areas, especially rural and underserved communities. The Association of American Medical Colleges has estimated for some time that the nation will face a shortage of more than 90,000 MDs by 2020 and more than 130,000 by 2025.[56] Moreover, the maldistribution of physicians in the United States has been well documented, both through research and through federal reimbursement policy.[57,58,59]

The interrelated issues of physician training and reimbursement also guide where and in what specialties physicians practice. The CRS report states that "some specialties, such as general surgery, geriatrics, the pediatric subspecialties, and psychiatry, have…widely acknowledged shortages."[60] In addition, a 2009 study by the Robert Graham Center noted that "[c]urrent U.S. graduate interest falls short of maintaining the current proportion of primary care in the physician workforce…This loss in production of primary care physicians may join the problem of maldistribution and further erode access to primary care services."[61] The relationship of medical school debt to selection of medical specialty is complex and not clearly determined, but there is evidence to demonstrate that post-educational salary does strongly correlate to choice of specialty.[62] Further, it has been chronicled by the Council on Graduate Medical Education that "[n]othing affects the location decision of a physician more than specialty. Unfortunately for rural areas, the more highly specialized the physician, the less likely it is the physician will settle in a rural area,"[63] a conclusion echoed by Rosenblatt and Hart.[64] For some physicians, the costs, professional challenges and/or lifestyle limitations of service in rural or underserved areas may be decisive in their choice of practice location and specialty.[65] These elements in turn bear directly on the ease or difficulty of the population accessing medical care.[66]

Taken together, the above factors paint a picture of more Americans, more insured Americans, and more elderly Americans taxing our health care system in the years to come. In tandem, despite more physicians entering the workforce every day, evidence suggests there may not be enough, in the right specialties, or in the needed geographic locations, to meet all patients' needs. As the final gatekeeper to physician practice in the U.S., state medical boards are an essential ingredient in innovatively connecting physicians with patients.

A second force reshaping medicine, and the expectations around how it is delivered, is the exponential expansion of technology in health care. As in most every other aspect of modern life, the ubiquity of technology has fundamentally reshaped the practice of medicine. Plumbing the foundations of human existence through gene and stem cell therapies, implanting wireless devices that monitor and regulate vitals, operating artificial limbs with thought-controlled pressure sensors, performing simulated and robotic surgery, and accessing electronic health records and health information exchanges are but a few examples of how technology has altered how physicians care for patients. Consider that, as of 2012, more than 13,000 health-related apps were available for download at Apple's Appstore.[67] In addition, Healthcare IT News reported earlier this year that "[m]ore than half of people with chronic conditions say the ability to get their electronic medical records online outweighs the potential privacy risks."[68]

But perhaps no other aspect of technology has broader transformational potential to provide high quality and more accessible care to patients than telemedicine. Telemedicine is often seen as a remedy to geographic and access barriers by allowing patients the freedom to directly seek out specialists who may practice remotely, facilitating virtual staffing of rural health care facilities, and allowing physicians in centers of excellence to treat and consult on patient care without the time and expense of arranging face-to-face patient visits. Using telemedicine to care for pediatric patients in the ER[69], placing technology on board ambulances to facilitate treatment en route to hospitals[70], delivering eye care in rural and underserved areas of India[71], using Google Glass to display information and digitally record surgical procedures[72], and remotely treating hepatitis C virus infection in underserved communities[73] are but a few examples of how the advent of technology in patient care across state lines seems destined to rapidly accelerate into the future.

However, a common misconception persists among proponents of the broader use of telemedicine, as a means to facilitate the multistate practice of medicine, that state medical boards oppose the use of technology. Although this is untrue, many are concerned that the unchecked spread of telemedicine may endanger patients. The practice of telemedicine, in whatever the form, is still the practice of medicine, and the same care and protection must be afforded patients whether they are being seen by their community primary care doctor or a highly-focused specialist from across the country. This is the charge state legislatures have given to state medical boards — to ensure that the public in their jurisdictions have access to competent medical care, not unfettered access, lacking the proper accountability.

AS THE FINAL GATEKEEPER TO PHYSICIAN PRACTICE IN THE U.S., STATE MEDICAL BOARDS ARE AN ESSENTIAL INGREDIENT IN INNOVATIVELY CONNECTING PHYSICIANS WITH PATIENTS.

Unfortunately, some critics of state-based medical regulation have sought to portray medical boards as the source of the problem. In some cases, these critics are major corporations that appear to have vested interests in promoting the proliferation of technology in the health care system.[74] The American Telemedicine Association (ATA), a leading organization in the advocacy of telemedicine, represents a large number of corporate communications and telehealth interests,[75] and the ATA has repeatedly called for Congressional action to preempt state regulatory authority for medicine. In 2011, the ATA launched a website, fixlicensure.org, to elicit public support for this policy position, stating that "requiring health providers to obtain multiple state licenses and adhere to diverse and sometimes conflicting state medical practice rules, is a barrier to progress, quality, competition and economy. This partitioned approach also presents a concern for patient safety as state-by-state licensing and enforcement inhibits tracking down and disciplining bad doctors located in other states."[76]

The Chief Executive Officer of the ATA, Jonathan Linkous, has further expounded on the alleged failings of state licensure on a number of occasions, stating that "we estimate it costs about $300 million a year to do extra licenses…that's growing

because physicians are increasingly holding multiple medical licenses. It's an access problem."[77] He has been quoted as saying "the patchwork of state-by-state licensing creates a mire of costly red tape and has become an untenable barrier for both providers and patients."[78] Mr. Linkous has further opined "It is wrong to deny a patient health care because of state boundaries and overly cumbersome state licensing rules."[79]

As recently as March 10, 2014, Mr. Linkous provided testimony to the Federal Trade Commission on telemedicine and competition.[80] In it, he indicated that the ATA did not necessarily oppose state-based regulation, but warned that any proposed alternative must be "accomplished without delay and with a specific timeline included for implementation." Mr. Linkous's testimony referenced an interstate compact model but detailed ATA's concern that, after 15 years in existence, the Nurse Licensure Compact only operates in 24 states, implying that only a true national solution is acceptable to his organization. Ultimately, Mr. Linkous reprised the tenor of his earlier statements, saying that state-based licensure requirements are "costly and serve as a barrier to fair competition. Licensure costs professionals and the taxpayer hundreds of millions of dollars each year. Separate licensing is without justification for clinical services that do not require face-to-face interactions such as the interpretation of images or peer-to-peer consultations."[81]

It remains unclear whether the motivation for organizations such as the ATA to preempt the states in favor of a federal solution for physician licensure is purely financial, or a true belief that the access to be gained through federal action outweighs any collateral damage to patient safety, or a combination of the two. At the very least, such statements demonstrate a fundamental misunderstanding of the vital role of state medical boards by implying that the current system does not work.

STATE MEDICAL BOARDS HAVE BEEN VOCAL SUPPORTERS OF RESPONSIBLY USING TELEMEDICINE TECHNOLOGIES TO EXPAND ACCESS, ESPECIALLY IN RURAL AND UNDERSERVED AREAS.

Still, these voices have been heard by lawmakers. A litany of bills considered or passed by Congress in recent years reflects a trend toward the gradual erosion of states' responsibilities:[82]

- **HR 1832 — the STEP Act.** Introduced on May 11, 2011 by Rep. Glenn Thompson (R-PA), this bill expanded the current Department of Defense state licensure exemption for credentialed health care professionals, regardless of where they or patients are located. This expansion includes civilian employees of the Department of Defense, personal services contractors, and other health care professionals credentialed and privileged at a Federal health care institution. The bill became law on December 31, 2011.
- **HR 1540 — 2012 National Defense Authorization Act.** Introduced on April 14, 2011 by Rep. Howard P. "Buck" McKeon (R-CA), the bill authorized Department of Defense civilian employees and other health care professionals credentialed and privileged at a federal health care institution or location designated by the Secretary of Defense to practice at any location, regardless of where the health care professional or patient are located, so long as the practice is within the scope of authorized federal duties. The bill became law on December 31, 2011.
- **HR 6179 — The Telehealth Promotion Act of 2012.** Introduced on December 30, 2012 by Rep. Mike Thompson (D-CA), the bill would redefine telehealth services as originating from the site of the treating provider and not the patient. This stance on the location of physician practice has traditionally been viewed as inconsistent with how medicine is defined and as contrary to patient safety.
- **HR 6107 — The VETS Act.** Introduced on July 12, 2012 by Rep. Charles Rangel (D-NY) the bill would allow any licensed health care professional employed in the VA system, either employed or contracted, regardless of state of licensure, to practice in any facility nationally through the use of telemedicine.
- **HR 3077 — The TELE-MED Act of 2013.** Introduced on September 2013 by Rep. Devin Nunes (R-CA), the bill would allow for a Medicare provider, licensed in one state, to treat any Medicare beneficiary in any other state via telemedicine without requiring licensure where the patient is located. The bill currently has 58 bipartisan co-sponsors. The ATA has voiced strong support for this bill.[83]

- **The Increasing Credentialing and Licensing Access to Streamline Telehealth (ICLAST) Act.** Not introduced, this bill authored by Sen. Tom Udall (D-NM) in 2011 would initially create a voluntary national license, issued in tandem with a state license, which would allow physicians to practice across state lines. This system would transition to a mandatory system for physicians accepting Medicare or Medicaid payment, and would eventually be expanded to all types of health care providers. The bill would reserve investigation of complaints and discipline to the states, but the bill does not stipulate how these activities would be paid for.[84]

There is little to dispute about the many potential benefits of the use of technology in the delivery of health care. Weighing the implications of how our population's demographics and geography drive utilization of health care, or how the economics of medical education and reimbursement shape not merely how doctors practice but in what specialties they choose to practice, also does not dispute the myriad possibilities of technology in serving the health care needs of the public. Finally, it is critical to reemphasize that mere identification of the troubling aspects of legislative proposals or stakeholder critiques should not and does not constitute a *de facto* indictment of either telemedicine or interstate practice.

State medical boards have been vocal supporters of responsibly using telemedicine technologies to expand access, especially in rural and underserved areas. However, state medical boards must also recognize that the statements of influential critics, proposed—and enacted—federal bills, and changes in technology, demographics and financing, all represent fundamental challenges to how they have operated for decades. By natural extension, should the boards choose not to adapt to changing conditions and expectations, these elements can pose risks to the ability of state medical boards to continue their enduring public protection mission. As Ameringer counsels, "If state medical boards fail to put aside their differences and create a uniform approach to regulating the practice of medicine across state lines, the federal government would have cause to intervene."[85] How then might state medical boards operationalize Ameringer's advice?

Interstate Compacts: A Primer

The purpose of this article is twofold. Thus far its focus has been to set out how state medical boards have historically safeguarded the public through the licensure and discipline of physicians, and to describe how this role is consistent with federal legal and constitutional principles. In response to a rapidly changing landscape within health care prompted by technology, multistate medical practice and evolving consumer expectations, the remainder of this inquiry will center on the concept of an interstate compact for physician licensure, how it has been developed and why it is the ideal mechanism to meet these challenges.

To evaluate the compact mechanism, it is necessary to gain a working understanding of how compacts exist. Broun, Buenger, McCabe, and Masters, in *The Evolving Use and the Changing Role of Interstate Compacts: A Practitioner's Guide*, provide what may be the quintessential "elevator" speech for the utility of interstate compacts:

> [C]ompacts can effectively preempt federal interference into matters that are traditionally within the purview of the states but that have regional or national implications. Unlike federal actions that impose unilateral, rigid mandates, administrative compacts afford states the opportunity to develop dynamic, self-regulatory systems over which the member states can maintain control through a coordinated legislative and administrative process. The very nature of an interstate compact makes it an ideal tool to meet the need of cooperative state action…[86]

Multiple factors contribute to the merit of interstate compacts as a means of collective state governance. First, despite the relative obscurity of interstate compact law in the field of jurisprudence, its bedrock lies squarely in the U.S. Constitution, and the forerunners of interstate compacts even precede the nation's founding. The Constitutional authority of compacts uniquely suits them to resolving statutory and regulatory differences between states, and they have been successfully applied across the gamut of regulation. Furthermore, inter-

THE CONSTITUTIONAL AUTHORITY OF COMPACTS UNIQUELY SUITS THEM TO RESOLVING STATUTORY AND REGULATORY DIFFERENCES BETWEEN STATES, AND THEY HAVE BEEN SUCCESSFULLY APPLIED ACROSS THE GAMUT OF REGULATION.

state compacts have adapted over time to address progressively more challenging public policy issues. Finally, in contrast to anxiety over a perceived erosion of state sovereignty, the long history of compacts demonstrates that the benefits for states far outweigh any loss of authority.

Ironically, interstate compacts are widely used in American government and yet are not well understood by the general public.[87] At the same time, interstate compacts are one of the oldest forms of cooperative government. As with the history of medical regulation in the United States, the history and use of compacts dates to colonial times, where they were used for boundary settlement negotiations where land charters were vague or incorrect. When appointed parties forged an agreement, it was then submitted to the Crown for approval.[88] Indeed, in the 1838 United States Supreme Court case *Rhode Island v. Massachusetts*, Justice Baldwin, writing for the Court, hearkens back to "the Crown of England to the Plymouth Company in 1621; to Massachusetts in 1629; to Rhode Island in 1663; the new charter to Massachusetts in 1691; together with sundry intermediate proceedings of the council of Plymouth."[89] This framework remains the basis for interstate compacts today.

Compacts are a hybrid of contract law and statutory law that states are specifically authorized to use under the "Compact Clause" of the U.S. Constitution (Article 1, Section 10, Clause 3):

> "**No State shall, without the Consent of Congress,** lay any Duty of Tonnage, keep Troops, or Ships of War in time of Peace, **enter into any Agreement or Compact with another State,** or with a foreign Power, or engage in War, unless actually invaded, or in such imminent Danger as will not admit of delay." (emphasis added)[90]

Compacts are unique in American governance in that they rely on the premise of states' rights, yet they exist between state and federal authority. Because states enter into a contractual relationship with other states via the passage of state legislation, once entered, the terms of a compact cannot be changed unless agreed to by all the member states of the compact.[91] As a result, the authority of compacts supersedes that of state laws, rules, courts, and even state constitutional provisions, unless specifically exempted.[92]

The question is often asked of whether the Compact Clause requires Congress to affirmatively consent to every compact, or whether the lack of explicit consent is an obstacle to establishing a compact. Although it might imply this, according to the Council of State Governments, "[t]o clear up the ambiguity of the Compact Clause, the U.S. Supreme Court in *Virginia v. Tennessee* held that Congress must approve only two types of compacts: those compacts that alter the balance of political power between the state and federal government; or those compacts that intrude on a power reserved to Congress."[93] Others have similarly noted that

COMPACTS ARE A HYBRID OF CONTRACT LAW AND STATUTORY LAW THAT STATES ARE SPECIFICALLY AUTHORIZED TO USE UNDER THE 'COMPACT CLAUSE' OF THE U.S. CONSTITUTION (ARTICLE 1, SECTION 10, CLAUSE 3).

Congressional consent may be implicit or explicit, depending on whether the compact would have a bearing on the balance of federal/state powers as laid out in the Constitution.[94,95,96] Congress's consent to an interstate compact can be either prospective or after a compact has already been established. Congress also has the authority to deny or withhold its consent to any interstate compact that it believes would violate either the federally-enumerated powers test or the federal-state balance of power test. However, a threat of withdrawal or denial is, practically speaking, extremely remote.[97] Indeed, especially in regard to the regulation of physicians, this article has laid out multiple reasoned arguments for it to remain within the domain of the states.

A final note regarding the issue of Congressional Consent relates to what becomes of compacts, and the interstate organizations created by them, when formal consent is given. The answer, in operational terms, is absolutely nothing. Only in one respect does having formal consent "transform" the compact into federal law. As Justice Brennan wrote for the majority in the 1981 Supreme Court case *Cuyler v. Adams*, "[b]ecause congressional consent transforms an interstate compact within this Clause into a law of the United States, we have held that the construction of an interstate agreement sanctioned by Congress under the Compact Clause presents a federal question."[98] Thus, unlike any other type of federal legislation, compacts with consent are

"federalized" only in that they fall exclusively within the jurisdiction of federal courts and enjoy protection against attacks on Constitutional grounds.[99]

An indication of the true significance of interstate compacts is that disputes arising from compacts are one of the few areas where the United States Supreme Court may exercise original jurisdiction.[100,101] As a result, there is an important body of U.S. Supreme Court case law related to interstate compacts, including some of the most important cases the High Court has heard. One such case, relating to the enforceability of interstate compacts, is *West Virginia ex. Rel. Dyer v. Sims* in 1951. The case involved a dispute in West Virginia as to whether or not a payment of $12,250 to support the Ohio River Valley Water Sanitation Compact represented an illegal (per West Virginia's Constitution) delegation of the state's police power to other states and the federal government. Edgar B. Sims, the state's auditor, refused to issue the warrant to pay for the compact's expenses.[102]

Writing the majority opinion, Justice Felix Frankfurter found the compact to be a "conventional grant of legislative power" and that the language of the compact, in which states agree to appropriate funds for its administrative expenses, did not represent a conflict with the West Virginia Constitution.[103,104] Justice Reed, in a concurring opinion specifically noted that "under the Compact Clause…the federal questions are the execution, validity, and meaning of federally approved state compacts. The interpretation of the meaning of the compact controls over a state's application of its own law through the Supremacy Clause, and not by any implied federal power to construe state law."[105,106]

IT MUST BE ACKNOWLEDGED THAT, FOR SOME, THE NOTION OF 'GIVING' AWAY THE AUTHORITY OF STATE BOARDS TO THEIR ASSOCIATES IN OTHER STATES, OR TO AN INTERSTATE COMMISSION, IS DISQUIETING.

An especially important feature of interstate compacts, for the purposes of this discussion, is the evolution of compacts in the 20th century to include governmental organizations for ongoing regulation. This occurred as a result of interstate compacts not having the necessary tools to respond to changing conditions and complexities, as well as not being able to effectively enforce the provisions of compacts with member states. The New York/New jersey Port Authority, created by a bi-state compact in 1921, was significant in that it was the first interstate government agency created in the western hemisphere and was the first interstate agency created by interstate compact.[107] In more recent times, ongoing regulatory agencies have become fixtures in interstate compacts. In some cases, existing compacts have even been renegotiated to incorporate interstate commissions, such as with the Interstate Compact for Adult Offender Supervision, the Interstate Compact on Juveniles, and the Interstate Compact for the Placement of Children.[108]

It must be acknowledged that, for some, the notion of "giving" away the authority of state boards to their associates in other states, or to an interstate commission, is disquieting. That state-specific laws or rules may be overridden by an interstate compact mechanism gives rise to visions of "big brother" for skeptics. There is an undeniable relinquishing of some individual board autonomy to participate in a compact. Further, because the compact is intended to create uniform standards and processes across all states that enact it, it cannot by definition accommodate all the individual regulatory nuances of any given member state. However, it is also undeniable that, at present, state boards have no true jurisdiction over physicians who are licensed elsewhere, even when it is their states' patients who are harmed by them. State laws do not give boards the ability to reach beyond those governed by their licensing statutes to investigate or take action on physicians providing unsafe or improper care from afar. The compact mechanism, however, gives states the authority to collectively act in a way that individual states, relying solely on their individual authority, cannot. Broun, Buenger, McCabe, and Masters further evaluate the trade-offs of individual versus collective state authority:

> As for concerns related to the loss of individual state sovereignty, there is no question that the parties to interstate compacts necessarily give up the right to unilaterally control the joint agencies they create. But when measured against the nature of congressional intervention and the loss of authority that can result from federal preemption of a particular field, the state legislative and regulatory control that states jointly retain under interstate compacts is usually preferred by states. Viewed through this lens, the decision to empower an interstate

> agency is more likely to be seen as a welcome protection of 'collective state sovereignty' than it is to be resisted as an unacceptable sacrifice of individual state authority.[109]

Interstate compacts have been widely applied in the history of American government, with more than 200 active compacts, including 22 truly national ones. The average U.S. state is a party to 25 interstate compacts.[110] They have evolved in their form and application throughout American history and are effectively employed for purposes as varied as boundary disputes, resource management, taxes, insurance, criminal justice, health care, education, emergency management, transit, and economic development. Indeed, as Supreme Court Justice Felix Frankfurter noted, "that a legislature may delegate to an administrative body the power to make rules and decide particular cases is one of the axioms of modern government."[111] More than sufficient evidence exists to reasonably infer that compacts can be just as effective for the regulation of physician practice across state lines.

INTERSTATE COMPACTS HAVE BEEN WIDELY APPLIED IN THE HISTORY OF AMERICAN GOVERNMENT, WITH MORE THAN 200 ACTIVE COMPACTS, INCLUDING 22 TRULY NATIONAL ONES. THE AVERAGE U.S. STATE IS A PARTY TO 25 INTERSTATE COMPACTS.

The Interstate Medical Licensure Compact—Origins, Development, and Key Themes

The antecedents to development, or even consideration, of an interstate compact for physician licensure began some years ago. The FSMB has been engaged in activities for a considerable period to promote expedited licensure and to facilitate practice in multiple states. It is also clear from the above discussion that both Congressional activity and stakeholder interest in telehealth and multistate practice were well underway by 2012.

For the purposes of this discussion, however, we will focus on the most immediate events, beginning with a 2012 resolution to the FSMB House of Delegates from the Maine Board of Licensure in Medicine. Resolution 12-4, dubbed the Platinum Standard Model, directed the Federation to "convene and charge Member Boards with defining and developing a set criteria of qualifications for a Platinum Standard Certification, and a system to allow State Medical Boards to make rapid licensing available to the highest caliber of licensed physicians by September 1, 2012."[112] The intent of the resolution was that states, in collective examination of their licensing standards, could establish a "highest common denominator" of requirements and, if a physician were to qualify for the Platinum Standard and be licensed by one state, other coordinating states could then license him or her based on that distinction, without further evaluation.

Resolution 12-4 was initially defeated in the House of Delegates, in part based upon apprehension that such a designation would connote a two-tiered system of physicians. However, further floor action revived the resolution in a different form, referring the question of a Platinum Standard to the Board of Directors for study and a report back to the House of Delegates in 2013, which passed the House.[113] The FSMB Board of Directors subsequently referred the matter for consideration to the FSMB Advisory Council of Board Executives, a standing group of state medical board executive directors.

The Advisory Council engaged in extensive debate on the Platinum Standard Model at its August 2012 meeting, yet it came to the same subdued conclusion as had the FSMB House of Delegates. Nevertheless, the Council remained in clear consensus that, as Resolution 12-4 stated, "a national trend [was] rapidly emerging, whereby state and federal policymakers [were] questioning the validity of the current state-based licensure system."[114] This recognition prompted the Council in that meeting toward exploration of a number of other alternatives. This included an initial conceptual discussion of a multistate license, possibly offered through an interstate compact.

In order to further delve into these alternatives, the FSMB, in coordination with Administrators in Medicine, hosted a meeting in January 2013 for the purpose of examining existing state licensure processes and exploring innovative licensure approaches that could facilitate multistate practice. The meeting, which included representatives of 48 of the 69 licensing boards in the United States and its territories, was intended to move forward a more concrete discussion of one or several models that boards could pursue to better accommodate the practice of medicine across state lines, including via telemedicine.

Crady DeGolian, Director of the National Center for Interstate Compacts with the Council of State Governments, was one of the featured speakers at this meeting and provided the audience with an overview of interstate compacts. It was the first time that a detailed examination of interstate compacts explicitly entered the conversation, and although the participants did not leave the meeting having coalesced around any single methodology, the notion of an interstate compact for physician interstate practice emerged from the meeting with substantial support.

Not long afterward, the State of Wyoming Board of Medicine submitted to the FSMB, for consideration by the House of Delegates at the 2013 Annual Business Meeting, Resolution 13-5, which read in part:

> Therefore, be it hereby resolved, that the FSMB convene representatives from state medical boards and special experts as needed to aggressively explore the development of an Interstate Compact to facilitate license portability hereinafter known as the Medical License Portability Interstate Compact project, and be it further resolved that the Medical Licensure Portability Interstate Compact project be initiated no later than July 2013.[115,116]

The passage of Resolution 13-5 by the FSMB House of Delegates at the 2013 Annual Business Meeting is extraordinary in at least two respects. First, despite no shortage of membership discomfort about a loss of state authority, about whether a compact was a suitable scheme for regulating physicians, and about a general lack of familiarity with compacts as a governing tool, the Resolution passed the House unanimously, and with virtually no discussion on the House floor. Second, given that discussions about how to facilitate physician mobility and practice across state lines has divided the regulatory community since the foundation of the FSMB, that the membership should unite in singular fashion behind such a proposal, even merely to study its feasibility, is remarkable.

GENERALLY, PARTICIPATION IN AN INTERSTATE COMPACT CREATES ANOTHER PATHWAY FOR LICENSURE, BUT DOES NOT OTHERWISE CHANGE A STATE'S EXISTING MEDICAL PRACTICE ACT.

To comply with the Resolution's timelines to begin work by July 2013, the FSMB convened two developmental meetings in June and September 2013. During the two two-day sessions, representatives from a cross-section of medical and osteopathic boards conferred and sometimes actively debated the principles and goals of what a compact might accomplish and what the organization of a compact system might resemble. The groups extensively probed the details of how a compact might be financed, how licenses might be issued, what qualifications might be necessary to participate, and what role an interstate commission would play. The representatives gave great thought to how discipline would be handled, both with respect to licenses issued by the physician's primary state of practice and those issued by other states in the compact, and they weighed how to enhance data sharing amongst the compact states. Finally, the groups carefully considered the need and methods to communicate with state medical boards, stakeholders and partners within the House of Medicine, and the broader public about how this complementary process would balance patient protection with changes in medical practice. The deliberations of the June and September meetings resulted in eight foundational principles upon which a compact would be structured:[117]

- Participation in an interstate compact for medical licensure will be strictly voluntary for both physicians and state boards of medicine.
- Generally, participation in an interstate compact creates another pathway for licensure, but does not otherwise change a state's existing Medical Practice Act.
- The practice of medicine occurs where the patient is located at the time of the physician-patient encounter and, therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.
- An interstate compact for medical licensure will establish a mechanism whereby any physician practicing in the state will be known by, and under the jurisdiction of, the state medical board where the practice of medicine occurs.
- Regulatory authority will remain with the participating state medical boards, and will not be delegated to any entity that administers the compact.
- A physician practicing under an interstate compact is bound to comply with the statutes, rules and regulations of each compact state wherein he/she chooses to practice.

- State boards participating in an interstate compact are required to share complaint/investigative information with each other.
- The license to practice medicine may be revoked by any or all of the compact states.

Following the groundwork and consensus-building in the June and September meetings, which created a clear set of parameters around which to construct a compact, a small drafting team met with FSMB staff in November of 2013 to craft and refine the provisions of a draft document. In drafting the compact, the drafting team identified several essential themes to address:

PARTICIPATION IN THE COMPACT SHOULD NOT ADVERSELY AFFECT STATE MEDICAL BOARDS EITHER BECAUSE OF REDUCTION IN LICENSING REVENUE OR AN INCREASE IN FEES.

- Participation in the compact should not adversely affect state medical boards either because of reduction in licensing revenue or an increase in fees. The compact is designed to act as a clearinghouse, ensuring that licensing fees are collected and distributed to the appropriate states. Moreover, those fees would be set, as all fees currently are, by the states, and not by an interstate commission. All licensees would have to pay the fees set in those states in order to obtain and maintain a license via the compact, just as with licenses currently obtained via traditional methods.
- Participation in the compact should not afford a physician an opportunity, under the guise of multistate practice, to elude discipline, nor should it impinge on states' ability to take action against their licensees. At the same time, participation in a compact should facilitate more effective disciplinary action than the present system of states reporting to one another, and it should foster protection of the public across all states. Under the compact, an interstate commission would not have disciplinary authority, but would, as with fees, serve as a clearinghouse for disciplinary information to states. The compact would also provide states the flexibility of whether to pursue action against a licensee or not when another state already has, except in the most serious of cases.
- State boards participating in a compact should be aware of the physicians who are, or are capable of, practicing within their borders. It is recognized as critical to boards' patient safety missions that they must not only have jurisdiction over physicians practicing in their states, but they must have clear knowledge of their physician population in their states. Under the compact, all states, when selected by a physician who is deemed eligible by their principal state, would issue a full license to that physician, creating a clear regulatory linkage. Moreover, states will report to one another, again, using an interstate commission as a hub, any changes in physicians' licensing or disciplinary statuses.
- The interstate compact contains mechanisms, such as rulemaking authority, to allow member state boards to clarify important areas of policy. Because the compact itself is essentially a multistate contract enacted as legislation, by necessity its provisions must remain broad. When substantive changes to a compact are necessary, member states must go through the excruciating process of amending the statutory language in every member state, with the amended provisions not taking effect until every state has enacted the change. Consequently, rulemaking authority is essential for addressing many operational details of the compact. A prime example of this is the issue of requiring federal background checks via fingerprint as part of the licensure process. Likely to be a subject of rulemaking by an interstate Commission, to explicitly require in the compact that such checks be performed by fingerprinting could preempt new future methodologies that might be even more effective.
- States participating in a compact will have regulatory responsibility for an Interstate Commission, not the other way around. Participation in the compact requires state legislatures' and governors' authorizations, but this does not equate to a ceding of authority to a "superboard." As noted above, state boards will collectively comprise an Interstate Commission and oversee its operation. This governance of the compact by a Commission is needed due to the complexity of medical practice and the ongoing interstate coordination needed to maintain the compact's currency, but it is administrative in nature and does not extend to direct licensure or discipline of any physician.
- States should not have to pay to participate in the compact. Undue concern has been raised about

whether an interstate compact could require states to pay dues or fees as cost of that participation. There is no intention to charge states a fee to join or remain in the compact; those developing it specifically envision that an interstate commission would be financially self-supporting through physician fees, as is the case with most state medical boards currently. That said, there are important reasons that the draft compact contains language specifically authorizing direct state financial support. The compact, and an interstate commission, would exist as instruments of the states that join it. It is their authority they are expressly giving to the compact, and with that goes the ultimate fiduciary responsibility for that governmental entity. Without the member states underwriting its authority, an interstate commission might not be considered a government organization for tax purposes. Moreover, those who would serve on the interstate commission might not enjoy the same qualified immunity that they now enjoy as members of their state boards. It does not mean, however that your colleagues that crafted the proposed interstate compact, visualized in any way that boards or states would have to "pay to play."

- The full utility of an interstate compact should be used to develop additional tools to assist boards in their licensing and regulatory responsibilities. Because of the uniqueness of the authority of compacts, they allow states to innovatively address problems they share. One such area for state medical boards is in the area of out-of-state investigations. The proposed compact contains language intended to empower the sharing of investigative information between states and still maintaining the proper confidentiality. Joint investigations between state boards, the sharing of investigative information, and the enforcement of subpoenas across state lines are all examples of what could be accomplished with an interstate compact for physicians.

The Interstate Compact: The Better Alternative for State Medical Boards

Despite evidence of the long history of state board regulation of medicine, and the mandate from their state legislatures to do so, state boards cannot rely merely on those facts as a defense of the status quo. As a strategy, they are certainly necessary elements, but are not by themselves sufficient. However, an interstate compact is the optimal policy response for boards, for a variety of reasons:

1. Compacts, as noted above, are as old as the Constitution itself, and have been used throughout American history. Over 200 interstate compacts currently exist, including 22 that are truly national in membership. While the concept of compacts may be novel within the medical community, they are well-tested and operate with great effectiveness across the spectrum of government.
2. Former Wyoming Governor Jim Geringer spoke at the January 2013 FSMB meeting about his preference for interstate compacts as a means for states to collectively solve their policy problems. In January 2014, sixteen U.S. senators (including one MD) wrote to the FSMB and expressed their appreciation for the work of the state boards in exploring development of an interstate compact, saying "[a]s you continue the development process, we would like to express our support for an interstate compact to provide a solution to expedite the process whereby physicians can be licensed in multiple states and practice telemedicine in a safe and accountable manner."[118]

THE PROPOSED COMPACT CONTAINS LANGUAGE INTENDED TO EMPOWER THE SHARING OF INVESTIGATIVE INFORMATION BETWEEN STATES AND STILL MAINTAINING THE PROPER CONFIDENTIALITY.

Elected officials at both the federal and state levels, including Democrats and Republicans, liberals and conservatives, understand the role of interstate compacts and broadly support their use in lieu of federal intervention. And, as noted above, development of an interstate compact by states forestalls the uncertainties that may come with federal mandates.

3. Some have asserted that we can achieve many of the same goals without such drastic steps, that states can respond to these forces in more organic and less formal ways. I counter-assert that if this were so, states would have already taken the initiative. Today's state regulation of physicians reflects an evolutionary process, for which boards deserve credit; that said, absent an imperative to weigh the merits of an interstate compact, it is fair to ask whether boards would still be doing so. For those seeking a substantive change in how state boards operate, the creation of an interstate compact represents a good faith

effort to be responsive to their needs yet safeguard the public.

4. Given that state medical boards are contemplating an interstate compact, the opportunity exists via the compact mechanism to make important process improvements that would be challenging for states to enact individually. Allowing for boards to jointly investigate licensees and to share data between boards during the investigative process are two key examples. In addition, an interstate compact would streamline the licensure process for qualifying physicians by eliminating the need to reproduce documents multiple times for different jurisdictions once they have been primary-source verified by another state. Interstate compacts serve ideally to allow states to focus more broadly in problem resolution without resorting to federalization.

AN INTERSTATE COMPACT WOULD STREAMLINE THE LICENSURE PROCESS FOR QUALIFYING PHYSICIANS BY ELIMINATING THE NEED TO REPRODUCE DOCUMENTS MULTIPLE TIMES FOR DIFFERENT JURISDICTIONS ONCE THEY HAVE BEEN PRIMARY-SOURCE VERIFIED BY ANOTHER STATE.

5. There is an important distinction between the harmonization of state standards and the ceding of state authority to a uniform national standard. An interstate compact would foster more consistent standards across the country in how state boards carry out their licensure and discipline activities, but it would not usurp that state authority to an interstate compact, a federal bureaucracy, or any other entity. In fact, because compact terms cannot be altered except by unanimous consent of the member states, compacts offer a remarkable degree of constancy. Only through the rulemaking process of an interstate commission can changes be implemented. Because the interstate commission concept is, as yet, an abstraction, it is an easy target for skeptics. However, once implemented, the commission will be comprised of members of state boards, not strangers. There is no reason to assume that fellow board members and executives from other states, serving on such a commission, would exercise any less care and caution in administering the compact than would the skeptics themselves.

6. Consider the premise that, due to the combined effects of federal action and the explosion in the interstate practice of medicine (either in person or by telemedicine), health care is becoming a type of interstate commerce; consequently, it merits asking whether it could eventually subject it to the Commerce Clause. If so, the provision of health care could become subject to either "field preemption" where federal regulation is already sufficiently pervasive to crowd out state regulation, or "conflict preemption," where state and federal regulation are inconsistent or state law essentially impedes the intent of Congress.[119]

7. Some national licensing schemes that have been discussed could enable some or all licensing at the federal level, yet leave the matter of physician discipline to the state boards.[120] Given that the essential task of public protection through enforcement is paid for through licensing and renewal fees, this could become an unfunded mandate, seriously impairing the ability of state boards to take appropriate and timely action when needed.[121] If, as noted above, some partial preemption of licensure was coupled with a method of allocating funds back to the states, there is no assurance that the funds will not come with policy strings attached. Finally, investigating and imposing discipline, at the state level, on a national license could prove jurisdictionally challenging, as would the question of coordination of federal licensing with state disciplinary actions.[122,123]

8. A federal system would necessarily require a significant new bureaucracy, and it is unclear whether or how such an organization could take advantage of the significant existing expertise and board infrastructure within the states. While the federal government does have some limited experience overseeing physicians in its systems, they are still licensed by and accountable to state boards. The federal government's experience is also limited to closed systems such as the Department of Defense and the Veterans Administration, where physicians are employees or contractors of the government and see only defined populations. According to Gilman, "there is no federal agency with the authority, experience, and expertise to perform the various licensing functions undertaken by the states and it would not be trivial to create one."[124]

The Future of Physician Regulation — To Compact or Not?

Social critic Neil Postman, in the foreword of his book, *Amusing Ourselves to Death: Public Discourse in the Age of Show Business*, contrasted the fictitious futures of Aldous Huxley and George Orwell:

> Orwell feared those who would deprive us of information. Huxley feared those who would give us so much that we would be reduced to passivity and egotism. Orwell feared that the truth would be concealed from us. Huxley feared the truth would be drowned in a sea of irrelevance. Orwell feared we would become a captive culture. Huxley feared we would become a trivial culture, preoccupied with some equivalent of the feelies, the orgy porgy, and the centrifugal bumblepuppy. As Huxley remarked in *Brave New World Revisited,* the civil libertarians and rationalists who are ever on the alert to oppose tyranny "failed to take into account man's almost infinite appetite for distractions." In *1984*, Huxley added, people are controlled by inflicting pain. In *Brave New World,* they are controlled by inflicting pleasure. In short, Orwell feared that what we hate will ruin us. Huxley feared that what we love will ruin us.[125]

It is clear that neither Huxley and Orwell, nor Postman in his critique of the two authors, envisaged the future as an enchanted utopia. Certainly care must be taken not to spin too fine of an allegorical thread between the future worlds of these authors and what an Interstate Medical Licensure Compact might portend for the state-based medical regulatory system. Still, we also should have no illusions that bringing an interstate compact to life will be uncomplicated or a consequence-free panacea. Such a sea change will require continued critical thinking to refine the compact's language; extensive communication and change management efforts with the public and our licensees, partners, and stakeholders; and the passage of new laws in Legislatures across the country. It will require the establishment of an interstate commission, including physical offices, staff, bylaws, rules, and complex information and financial systems.

Mostly, it will require many, many additional hours of dialogue, consultation and even debate among those of us in the medical regulatory community. Recall that it was the very issue of states honoring "candidates presenting themselves based upon their license having been obtained through examination in another state"[126] that split the American Confederation from the National Confederation for over a decade at the beginning of the 20th century. Still, just as the leaders of that day resolved their differences for the greater good, creating the FSMB to serve a vital collaborating role for all the state medical boards, those of us within this profession today must exercise the same intrepidness and sagacity to confront the new and more complicated obstacles of the present and the future, and to push onward.

All that said, the hard work will be worth it. The U.S. Constitution and important Supreme Court case law have affirmed the proper role of states in regulating medicine, a practice that has progressed over nearly four centuries. The question of physicians practicing across state borders has vexed those charged with regulating it since even before the founding of the Federation of State Medical Boards in 1912, although both the opportunities and mounting pressures of modern medical practice have elevated this question's significance to an existential level for boards. Yet these same boards possess the capacity and the expertise to answer the question, springing from decades, even centuries, of responsibility for physician licensure. Finally, the interstate compact, widely used in the collective solution of state problems, has also grown and evolved since the colonial era, and it stands as both a feasible and powerful tool for state medical boards to retain the best aspects of what they do as they continue to adapt to a changing world.

One might say, a brave new world. ■

About the Author

Blake T. Maresh, MPA, is the Executive Director of the Washington Board of Osteopathic Medicine and Surgery.

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118. Letter to FSMB President/CEO Humayun Chaudhry, DO and Board of Directors Chair Jon Thomas, MD from US Senators Thune, Enzi, Carper, Alexander, Barrasso, Blunt, Coburn, Isakson, Johnson, Cochran, Boozman, Inhofe, Rockefeller, Warner, Klobuchar, and Franken; January 9, 2014.

119. Learner, H. Restraining Federal Preemption When There is an 'Emerging Consensus' of State Environmental Laws and Policies; p. 659.

120. Ameringer; State-Based Licensure of Telemedicine: The need for Uniformity but Not a National Scheme; p. 76.

121. Hoffman and Rowthorn; Legal Impediments to the Diffusion of Telemedicine; p. 20 and p. 21.

122. Ameringer; "State-Based Licensure of Telemedicine: The need for Uniformity but Not a National Scheme"; p. 79-80.

123. Hoffman and Rowthorn; Legal Impediments to the Diffusion of Telemedicine; p. 21.

124. Gilman, D; Physician Licensure and Telemedicine: Some Competitive Issues Raised by the Prospect of Practising Globally While Regulating Locally; *Journal of Health Care Law and Policy*; Vol.14:87; 2011; pp. 115-116.

125. Postman, N.; *Amusing Ourselves to Death: Public Discourse in the Age of Show Business*; Penguin Books; 1986; pp. vii-viii.

126. Johnson and Chaudhry; *Medical Licensure and Discipline in America*; p. 48.

INTERSTATE MEDICAL LICENSURE COMPACT

The ideas and conclusions set forth in this document, including the proposed statutory language and any comments or notes, have not been formally endorsed by the Federation of State Medical Boards or its Board of Directors. This document has been prepared as part of a study of the feasibility of an interstate compact, and it does not necessarily reflect the views of the Federation of State Medical Boards, the Board of Directors of the Federation of State Medical Boards, or any state medical board or its members.

INTERSTATE MEDICAL LICENSURE COMPACT

SECTION 1. PURPOSE

In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. The Compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the Compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the Compact.

SECTION 2. DEFINITIONS

In this compact:

(a) “Bylaws” means those bylaws established by the Interstate Commission pursuant to Section 11 for its governance, or for directing and controlling its actions and conduct.

(b) “Commissioner” means the voting representative appointed by each member board pursuant to Section 11.

(c) "Conviction" means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the

offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

(d) "Expedited License" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the Compact.

(e) “Interstate Commission" means the interstate commission created pursuant to Section 11.

(f) "License" means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.

(g) "Medical Practice Act" means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

(h) “Member Board" means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government.

(i) "Member State" means a state that has enacted the Compact.

(j) "Practice of Medicine" means the clinical prevention, diagnosis, or treatment of human disease, injury, or condition requiring a physician to obtain and maintain a license in compliance with the Medical Practice Act of a member state.

(k) "Physician" means any person who:

(1) Is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;

(2) Passed each component of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)

within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(3) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(4) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;

(5) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(6) Has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(7) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license;

(8) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and

(10) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

(l) "Offense" means a felony, gross misdemeanor, or crime of moral turpitude.

(m) “Rule” means a written statement by the Interstate Commission promulgated pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or

prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Interstate Commission, and has the force and effect of statutory law in a member state, and includes the amendment, repeal, or suspension of an existing rule.

(n) “State” means any state, commonwealth, district, or territory of the United States.

(o) "State of Principal License" means a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the Compact.

SECTION 3. ELIGIBILITY

(a) A physician must meet the eligibility requirements as defined in Section 2(k) to receive an expedited license under the terms and provisions of the Compact.

(b) A physician who does not meet the requirements of Section 2(k) may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the Compact, relating to the issuance of a license to practice medicine in that state.

SECTION 4. DESIGNATION OF STATE OF PRINCIPAL LICENSE

(a) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the Compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

(1) the state of primary residence for the physician, or

(2) the state where at least 25% of the practice of medicine occurs, or

(3) the location of the physician's employer, or

(4) if no state qualifies under subsection (1), subsection (2), or subsection (3), the

state designated as state of residence for purpose of federal income tax.

(b) A physician may redesignate a member state as state of principal license at any time, as long as the state meets the requirements in subsection (a).

(c) The Interstate Commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5. APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

(a) A physician seeking licensure through the Compact shall file an application for an expedited license with the member board of the state selected by the physician as the state of principal license.

(b) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission.

(i) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the Interstate Commission through rule, shall not be subject to additional primary source verification where already primary source verified by the state of principal license.

(ii) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have suitability determination in accordance with U.S. C.F.R. §731.202.

(iii) Appeal on the determination of eligibility shall be made to the member state

where the application was filed and shall be subject to the law of that state.

(c) Upon verification in subsection (b), physicians eligible for an expedited license shall complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (a), including the payment of any applicable fees.

(d) After receiving verification of eligibility under subsection (b) and any fees under subsection (c), a member board shall issue an expedited license to the physician. This license shall authorize the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state.

(e) An expedited license shall be valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full and unrestricted license within the member state.

(f) An expedited license obtained though the Compact shall be terminated if a physician fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without redesignation of a new state of principal licensure.

(g) The Interstate Commission is authorized to develop rules regarding the application process, including payment of any applicable fees, and the issuance of an expedited license.

SECTION 6. FEES FOR EXPEDITED LICENSURE

(a) A member state issuing an expedited license authorizing the practice of medicine in that state may impose a fee for a license issued or renewed through the Compact.

(b) The Interstate Commission is authorized to develop rules regarding fees for expedited

licenses.

SECTION 7. RENEWAL AND CONTINUED PARTICIPATION

(a) A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the physician:

(1) Maintains a full and unrestricted license in a state of principal license;

(2) Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(3) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license; and

(4) Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration.

(b) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(c) The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(d) Upon receipt of any renewal fees collected in subsection (c), a member board shall renew the physician's license.

(e) Physician information collected by the Interstate Commission during the renewal process will be distributed to all member boards.

(f) The Interstate Commission is authorized to develop rules to address renewal of

licenses obtained through the Compact.

SECTION 8. COORDINATED INFORMATION SYSTEM

(a) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under Section 5.

(b) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaints against a licensed physician who has applied or received an expedited license through the Compact.

(c) Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(d) Member boards may report any non-public complaint, disciplinary, or investigatory information not required by subsection (c) to the Interstate Commission.

(e) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(f) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(g) The Interstate Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9. JOINT INVESTIGATIONS

(a) Licensure and disciplinary records of physicians are deemed investigative.

(b) In addition to the authority granted to a member board by its respective Medical Practice Act or other applicable state law, a member board may participate with other member

boards in joint investigations of physicians licensed by the member boards.

(c) A subpoena issued by a member state shall be enforceable in other member states.

(d) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

(e) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 10. DISCIPLINARY ACTIONS

(a) Any disciplinary action taken by any member board against a physician licensed through the Compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that state.

(b) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a licensed issued to the physician by any other member board shall remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the Medical Practice Act of that state.

(c) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law

and fact decided, and:

(i) impose the same or lesser sanction(s) against the physician so long as such sanctions are consistent with the Medical Practice Act of that state;

(ii) or pursue separate disciplinary action against the physician under its respective Medical Practice Act, regardless of the action taken in other member states.

(d) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, then any license(s) issued to the physician by any other member board(s) shall be suspended, automatically and immediately without further action necessary by the other member board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period in a manner consistent with the Medical Practice Act of that state.

SECTION 11. INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(a) The member states hereby create the "Interstate Medical Licensure Compact Commission".

(b) The purpose of the Interstate Commission is the administration of the Interstate Medical Licensure Compact, which is a discretionary state function.

(c) The Interstate Commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers, and duties set forth in the Compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the

respective legislatures of the member states in accordance with the terms of the Compact.

(d) The Interstate Commission shall consist of two voting representatives appointed by each member state who shall serve as Commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall appoint one representative from each member board. A Commissioner shall be a(n):

(1) Allopathic or osteopathic physician appointed to a member board;

(2) Executive director, executive secretary, or similar executive of a member board; or

(3) Member of the public appointed to a member board.

(e) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting shall be a business meeting to address such matters as may properly come before the Commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(f) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or electronic communication.

(g) Each Commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of Commissioners shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A Commissioner shall not delegate a vote to another Commissioner. In the absence of its Commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who shall meet the requirements of subsection (d).

(h) The Interstate Commission shall provide public notice of all meetings and all

meetings shall be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the Commissioners present that an open meeting would be likely to:

(1) Relate solely to the internal personnel practices and procedures of the Interstate Commission;

(2) Discuss matters specifically exempted from disclosure by federal statute;

(3) Discuss trade secrets, commercial, or financial information that is privileged or confidential;

(4) Involve accusing a person of a crime, or formally censuring a person;

(5) Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(6) Discuss investigative records compiled for law enforcement purposes; or

(7) Specifically relate to the participation in a civil action or other legal proceeding.

(i) The Interstate Commission shall keep minutes which shall fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including record of any roll call votes.

(j) The Interstate Commission shall make its information and official records, to the extent not otherwise designated in the Compact or by its rules, available to the public for inspection.

(k) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission, with the exception of

rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the Compact including enforcement and compliance with the provisions of the Compact, its bylaws and rules, and other such duties as necessary.

(l) The Interstate Commission may establish other committees for governance and administration of the Compact.

SECTION 12. POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The Interstate Commission shall have the duty and power to:

(a) Oversee and maintain the administration of the Compact;

(b) Promulgate rules which shall be binding to the extent and in the manner provided for in the Compact;

(c) Issue, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the Compact, its bylaws, rules, and actions;

(d) Enforce compliance with Compact provisions, the rules promulgated by the Interstate Commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process;

(e) Establish and appoint committees including, but not limited to, an executive committee as required by Section 11, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties;

(f) Pay, or provide for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission;

(g) Establish and maintain one or more offices;

(h) Borrow, accept, hire, or contract for services of personnel;

(i) Purchase and maintain insurance and bonds;

(j) Employ an executive director who shall have such powers to employ, select or appoint employees, agents, or consultants, and to determine their qualifications, define their duties, and fix their compensation;

(k) Establish personnel policies and programs relating to conflicts of interest, rates of compensation, and qualifications of personnel;

(l) Accept donations and grants of money, equipment, supplies, materials and services, and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest policies established by the Interstate Commission;

(m) Lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve or use, any property, real, personal, or mixed;

(n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(o) Establish a budget and make expenditures;

(p) Adopt a seal and bylaws governing the management and operation of the Interstate Commission;

(q) Report annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the preceding year. Such reports shall also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission;

(r) Coordinate education, training, and public awareness regarding the Compact, its implementation, and its operation;

(s) Maintain records in accordance with the bylaws;

(t) Seek and obtain trademarks, copyrights, and patents; and

(u) Perform such functions as may be necessary or appropriate to achieve the purposes of the Compact.

SECTION 13. FINANCE POWERS

(a) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the Interstate Commission, which shall promulgate a rule binding upon all member states.

(b) The Interstate Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same.

(c) The Interstate Commission shall not pledge the credit of any of the member states, except by, and with the authority of, the member state.

(d) The Interstate Commission shall be subject to a yearly financial audit conducted by a certified or licensed public accountant and the report of the audit shall be included in the annual report of the Interstate Commission.

SECTION 14. ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall, by a majority of Commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes

of the Compact within twelve (12) months of the first Interstate Commission meeting.

(b) The Interstate Commission shall elect or appoint annually from among its Commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(c) Officers selected in subsection (b) shall serve without remuneration from the Interstate Commission.

(d) The officers and employees of the Interstate Commission shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties, or responsibilities; provided that such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(1) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person’s state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The Interstate Commission is considered to be an instrumentality of the states for the purposes of any such action. Nothing in this subsection shall be construed to protect such person from suit or liability for damage, loss, injury, or liability

caused by the intentional or willful and wanton misconduct of such person.

(2) The Interstate Commission shall defend the executive director, its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, shall defend such Interstate Commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate Commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(3) To the extent not covered by the state involved, member state, or the Interstate Commission, the representatives or employees of the Interstate Commission shall be held harmless in the amount of a settlement or judgment, including attorney's fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

SECTION 15. RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event

the Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the Compact, or the powers granted hereunder, then such an action by the Interstate Commission shall be invalid and have no force or effect.

(b) Rules deemed appropriate for the operations of the Interstate Commission shall be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, and subsequent amendments thereto.

(c) Not later than thirty (30) days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Interstate Commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16. OVERSIGHT OF INTERSTATE COMPACT

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the Compact and shall take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of the Compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine.

(b) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the Compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(c) The Interstate Commission shall be entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the Compact, or promulgated rules.

SECTION 17. ENFORCEMENT OF INTERSTATE COMPACT

(a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the Compact.

(b) The Interstate Commission may, by majority vote of the Commissioners, initiate legal action in the United States District Court for the District of Columbia, or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the Compact, and its promulgated rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

(c) The remedies herein shall not be the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or the regulation of a profession.

SECTION 18. DEFAULT PROCEDURES

(a) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the Compact, or the rules and bylaws of the Interstate Commission promulgated under the Compact.

(b) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the Compact, or the bylaws or promulgated rules, the Interstate Commission shall:

(1) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state must cure its default; and

(2) Provide remedial training and specific technical assistance regarding the default.

(c) If the defaulting state fails to cure the default, the defaulting state shall be terminated from the Compact upon an affirmative vote of a majority of the Commissioners and all rights, privileges, and benefits conferred by the Compact shall terminate on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

(d) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate shall be given by the Interstate Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

(e) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

(f) The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination including obligations, the

performance of which extends beyond the effective date of termination.

(g) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the Compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(h) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

SECTION 19. DISPUTE RESOLUTION

(a) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes which are subject to the Compact and which may arise among member states or member boards.

(b) The Interstate Commission shall promulgate rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 20. MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

(a) Any state is eligible to become a member state of the Compact.

(b) The Compact shall become effective and binding upon legislative enactment of the Compact into law by no less than seven (7) states. Thereafter, it shall become effective and binding on a state upon enactment of the Compact into law by that state.

(c) The governors of non-member states, or their designees, shall be invited to participate in the activities of the Interstate Commission on a non-voting basis prior to adoption of the

Compact by all states.

(d) The Interstate Commission may propose amendments to the Compact for enactment by the member states. No amendment shall become effective and binding upon the Interstate Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 21. WITHDRAWAL

(a) Once effective, the Compact shall continue in force and remain binding upon each and every member state; provided that a member state may withdraw from the Compact by specifically repealing the statute which enacted the Compact into law.

(b) Withdrawal from the Compact shall be by the enactment of a statute repealing the same, but shall not take effect until one (1) year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(c) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the Compact in the withdrawing state.

(d) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw within sixty (60) days of its receipt of notice provided under subsection (c).

(e) The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(f) Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the Compact or upon such later date as determined by the Interstate Commission.

(g) The Interstate Commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 22. DISSOLUTION

(a) The Compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the Compact to one (1) member state.

(b) Upon the dissolution of the Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission shall be concluded and surplus funds shall be distributed in accordance with the bylaws.

SECTION 23. SEVERABILITY AND CONSTRUCTION

(a) The provisions of the Compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(b) The provisions of the Compact shall be liberally construed to effectuate its purposes.

(c) Nothing in the Compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

SECTION 24. BINDING EFFECT OF COMPACT AND OTHER LAWS

(a) Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the Compact.

(b) All laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

(c) All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

(d) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(e) In the event any provision of the Compact exceeds the constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.