Transcript Details
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The Interstate Compact: Toward Medical Licensure Portability Nationwide

Mark Masselli:
This is Conversations on Health Care, I'm Mark Masselli.

Margaret Flinter:
And I'm Margaret Flinter.

Mark Masselli:
Well Margaret, more Americans will be seeing their medical provider virtually. Big insurers are paving the way for patients to be seen by their provider online for a variety of ailments that would ordinarily require a trip to their provider's office.

Margaret Flinter:
Well, the expansion of telemedicine's getting a big boost from the insurance industry. Etna currently allows for some three million e-visits with clinicians online, and that number is expected to grow to eight million in the coming year. And WellPoint, another big insurer, anticipates four million e-visits in the coming year.

Mark Masselli:
It makes good business sense for them, because it saves money. And for patients faced with higher and higher deductibles and copays it's more affordable for them, as well. A trip to the emergency room could cost thousands of dollars or more. A typical Teladoc consult is 50 dollars. Not to mention the convenience for the patient as well.

Margaret Flinter:
Well, there are some urging that we move into this realm with caution. Some providers are concerned about the high-tech approach undermining the high-touch approach, maybe some subtleties that are missed without a face-to-face consult, but I don't think that they have evidence to support that view.

Mark Masselli:
And then of course there are rules governing medical licensures that don't allow for practicing across state lines. We're still in the early stage of telemedicine regulations that will address all of these issues.

Margaret Flinter:
That's something that our guest today knows quite a bit about. Humayun Chaudhry is President and CEO of the Federation of State Medical Boards which oversees licensing and disciplining of physicians around the country, helping to set best practice guidelines.

Mark Masselli:
There are proposed new draft regulations, an interstate compact that would expedite licensure for physicians seeking to practice in multiple states that would help alleviate the growing shortage of physicians and allow for more expansive telemedicine enterprises. Should be an interesting conversation.

Margaret Flinter:
We'll also have our weekly visit with Lori Robertson, Managing Editor of FactCheck.org. No matter what the topic you can hear all of our shows by going to chcradio.com.

Mark Masselli:
And as always if you have comments e-mail us at info@chcradio.com or find us on Facebook or Twitter. We love hearing from you.

Margaret Flinter:
We'll get to our interview with Humayun Chaudhry in just a moment.

Mark Masselli:
But first here's our Producer Mary Ann O'Hare with this week's Headline News.

Mary Ann O'Hare:
I'm Mary Ann O'Hare with these Health Care Headlines. Two Federal Appeals Court panels issued conflicting rulings on whether the government could subsidize health insurance premiums for people in three dozen states that use the Federal Insurance Exchange. The decisions are the latest in a series of legal challenges to central components of President Obama's health care law.

The United States Court of Appeals for the Fourth District in Richmond upheld subsidies, saying that a rule issued by the Internal Revenue Service was a permissible exercise of the agency's discretion. The ruling came within hours of a two-to-one ruling by the US Court of Appeals for the District of Columbia Circuit which said the government could not subsidize insurance for people in states that use the Federal Exchange.

That decision could potentially cut off financial assistance for more than 4.5 million people who were found eligible for subsidized insurance on the Federal Exchange or Marketplace. Without subsidies many consumers would go without insurance and would be exempted from the individual mandate because insurance was unaffordable for them.

Meanwhile the numbers of those who gained coverage during the first open enrollment period shows an estimated 20 million Americans gained coverage. The Journal of the American Medical Association calculated some 7.8 million young adults had gained coverage under Obamacare by being allowed to stay on their parents' plan until the age of 26. Eight million gained coverage through the online Insurance Marketplaces, and over four million gained coverage through the expansion of Medicaid though only half of the states in the country chose to expand Medicaid coverage to include more folks living near the poverty line.

And handling all of that online insurance business continues to present challenges to centers, for Medicare and Medicaid has kicked off a search for a company that will serve as the technology vendor for healthcare.gov, the Federal Insurance Exchange. They're looking for a contractor capable of, quote, "working under aggressive time constraints," officials saying this does not mean they're dissatisfied with the current contractor Accenture, who replaced the original contractor that botched the rollout.

Cigarette smoking responsible for some half million American deaths per year, and yet smoking remains a persistent health scourge in this country as well as around the world. A Florida jury has dealt a decisive blow to one of the leading manufacturers of cigarettes, RJ Reynolds, a 23 billion dollar punitive damage ruling in the case of a woman who sued the company for her husband's untimely death due to smoking.

The case, Cynthia Robinson v. RJ Reynolds Tobacco Company, sued on the grounds the company knowingly sold a product to her husband, a long-time smoker, by marketing a product they knew was addictive, deadly, and filled with harsh chemicals that weren't listed on the package. The jury also awarded 16 million dollars in compensatory damages to the plaintiff, sending a statement to the tobacco industry that it cannot continue to lie to the American people and government about the addictiveness of their product. I'm Mary Ann O'Hare with these Health Care Headlines.

Mark Masselli:
We're speaking today with Dr. Humayun Chaudhry, President and Chief Executive Officer of the Federation of State Medical Boards, a national nonprofit organization that represents the 70 state medical boards of the United States and its Territories responsible for licensing and disciplining doctors. Dr. Chaudhry served as the Commissioner of Health Services for Suffolk County, New York.

An internist and osteopath, Dr. Chaudhry served as the Chairman of the Department of Medicine at the College of Osteopathic Medicine at the New York Institute of Technology, and he's the author of several books including Medical Licensing and Discipline in America. He earned his master's at Harvard School of Public Health, his MD at the New York Institute of Technology. Dr. Chaudhry, welcome to Conversations on Health Care.

Dr. Humayun Chaudhry:
Thank you very much. I'm delighted to be on your show.

Mark Masselli:
That's great. Your organization, the Federation of State Medical Boards, monitors regulations for licensing and discipline of physicians across the country. And while you're a national organization the licensing of physicians is still really governed at the state and territory level. Could you share with our listeners a little bit of history about the actual scope and reach of the Federation, and what type of oversight and policy directions are you responsible for in the medical field?

Dr. Humayun Chaudhry:
Sure. The practice of medicine in the United States has been regulated by the states since really the founding of our nation. The Federation of State Medical Boards, my organization, was founded more than a hundred years ago to respect states' rights while encouraging the sharing of information about doctors, encouraging the creation of a common language and taxonomy related to physician discipline, and best practices in the area of licensure and discipline of physicians.

So the FSMB does not have any authority over the state boards as such, but we do provide services for them as well as for physicians and put together policies on their behalf that better protect the public. Ultimately the mission of every state licensing board is to protect the public. Many of these policies that the Federation creates over time become state law in whole or in part, or not at all. Whether they do and to what extent is entirely up to the states.

Margaret Flinter:
Dr. Chaudhry, one area that's beginning to get a lot of attention is telemedicine, which we think is poised to just explode in the coming years, a combination of both available technology and real need for increasing capacity. But the efforts to expand telehealth and telemedicine have really been hampered by restrictions that are imposed by the way the state medical licensing protocols are written.

So your organization, the Federation of State Medical Boards, has been getting some attention lately for a proposal that would help expedite licensure across state lines. Maybe you could tell us about this draft legislation that you've created, the Interstate Medical Licensure Compact.

Dr. Humayun Chaudhry:
About two decades ago the states recognized a need to support what's known as licensure portability, in other words the ability of a physician to practice in more than one jurisdiction. So for instance back in 1996 the Federation created on behalf of the states a Federation Credentials Verification Service, FCVS, so that physicians wouldn't have to request a transcript from a medical school or verify their identity every time they applied for an additional license or moved to another state.

Last year the states wondered if they could do more or should do more for three primary reasons. One, the worsening physician shortage. Second, the Affordable Care Act and the greater need for access to care as a result of it. And really the third point that you mentioned, Margaret, the advancement of telemedicine. And so all those three compelling reasons came together.

This began January of 2013. The states got together under our auspices and explored what might be other options by which they could support these efforts, and so was born the notion of maybe an interstate medical licensure compact may be a way to address these issues in a way that makes sense for the state regulatory boards, for physicians, as well as the public.

Mark Masselli:
So frame up for us what are some of the requirements that states are thinking about, and what are their criteria governing providers seeking expedited licensures across state lines might face? How do you think this is going to roll out? Is there sort of a timeline for it?

Dr. Humayun Chaudhry:
Well, thankfully Mark we don't have to reinvent the wheel. It turns out that interstate compacts have been around in the United States since the founding of the nation. There are actually more than 200 interstate compacts. Many are national in scope, and some are regional. So the good news is that this isn't an entirely new concept. It is perhaps for the state licensing boards as it relates to doctors.

It looks like the states will be requiring that a physician who wishes to get multiple state licenses through this pathway should have an unrestricted license to practice in one of the participating states, and we call that a principal licensure state. So you have to identify as a physician if you want to go through this pathway one state where you've obtained licensure in the usual way. You should have an unblemished disciplinary record, completion of a residency training program, and not be the subject of any investigation by a licensing agency or law enforcement.

So if a physician does not meet every one of these eligibility requirements they are welcome to apply for state medical licensure or as many as they want under the current pathway, which doesn't generally require specialty certification, for example, or completion of a residency. But the states felt that there were some common elements to the requirements that would assure them of patient safety ultimately while enabling this sort of licensure portability to occur in a way that hasn't been seen before in the United States.

You asked about the timing of this. When we presented the idea to our House of Delegates last April in 2013 there was actually unanimous support to aggressively explore this idea. We haven't seen unanimous support like that in a long time coming from across the United States. So there is a lot of support for it and momentum.

We're currently in the process of finalizing some of the language, because it's critical that you get the language right if you want the states to endorse it. Because once you've come up with the language that's how you can facilitate the states to sign off on it. But you

want to make sure you've done your homework first. This is indeed the fastest-moving initiative in the history of our organization.

Margaret Flinter:
Let me maybe pose two questions. One, you're certainly not the only health care profession that's been looking at this issue of the interstate compacts, and we hear so much these days about inter-professional collaboration, and practice, and education. I'm curious as to whether you're collaborating with other professional organizations, nursing, dentistry, pharmacy, and trying to move forward kind of a common agenda which really would speak to a change, a significant change in health care in the United States across the board.

And then I guess on just a specific level, back to the safeguards issue, if there is a problem with a provider who requires professional discipline how does the fact that they're licensed under the compact make things different from what we would see today?

Dr. Humayun Chaudhry:
Yeah, great questions actually, Margaret. On the first one, we have over the years been having very good communications and meetings over the years with our friends at the National Council of State Boards of Nursing as well as the National Association of Boards of Pharmacy.

Those are our two counterparts in the area of nursing and pharmacy. In fact the last time we got together we remarked that collectively we regulate several million doctors, nurses, and pharmacists, and as team-based care moves forward there is a greater need for us to sort of not only stay close in touch but also to share some best practices.

There is a nursing compact, the nursing professional working under the auspices of the NCSBN. The Nursing Association for the Boards several years ago put together a compact, and they've had some success, 24 states have signed off on that. So when we began discussions about a interstate compact for physicians we talked to our friends at the nursing boards to find out what worked and what didn't work. Why were they unable for instance to get the entire nation, all the states, to sign off on it?

Margaret Flinter:
Right.

Dr. Humayun Chaudhry:
So for the physician side, on the state board side, that helped because the physicians said that if the state boards are going to sign off on this they need to know if a physician is practicing medicine in their jurisdiction. They felt hesitant about giving carte blanche approval for a physician to practice anywhere within the compact states without some notification.

And so one way to achieve that was through making sure that when a physician signals that they wish to practice in a particular jurisdiction that jurisdiction would formally issue a license just like they do today which allows them to follow through should something go wrong. And that was a critical step in getting much broader support than we might have otherwise.

In the current process when a board action is taken by a licensing board through the Federation's auspices we have a board action data bank, and as soon as that information becomes available to use electronically we share that instantaneously with all 70 of the state medical and osteopathic boards in the United States. And that's a great mechanism of assuring that there's data sharing and information sharing. With the compact there's actually greater flexibility because you can build in language to assure even greater protection of the public.

And so one of the items in the compact states that any state that is partner to this compact would agree ahead of time that if one of the physicians who has gotten a license through this compact is being investigated that that information that that physician is being investigated also be shared with the other states as a sort of a heads-up. Right now many state statutes only allow sharing of information across state lines when an action is taken, not before.

But you can build this into the compact because all the states have to endorse it, so that adds an additional layer of public protection so that if there's a need, and medicine can be wonderful, physicians by and large are outstanding individuals who provide a lot of services to the community at large, but every now and then things go wrong, and there should be mechanisms in place to protect the public. And so that is something that exists in this compact in a better way than perhaps exists otherwise.

Mark Masselli:
We're speaking today with Dr. Humayun Chaudhry, President and Chief Executive Officer of the Federation of State Medical Boards, a national nonprofit organization that represents the 70 state medical boards of the United States and its Territories responsible for licensing and disciplining physicians. Dr. Chaudhry, talk to me a little bit about the Affordable Care Act, and were there any elements of it that sort of stepped on the toes of states' medical licensing boards or issues that you're still trying to work out with HHS in terms of policies or things that you've brought up legislatively? Were there any tension points?

Dr. Humayun Chaudhry:
To be honest the one that most physicians talk about is the area of reimbursement, but that's an issue that the state boards don't usually get involved with because we're about public protection, we're not about the issue of cost per se. Having said that, we have a database of physicians who get disciplined as well as physicians who are licensed, and we are having some very good conversations with folks at CMS as well as HHS about making sure that they know that they have access to this sort of information today that may not always have been possible.

So that type of conversation is occurring, but really nothing directly in terms of anything coming out of the administration that negatively impacts what the states are trying to do, in fact, quite the contrary. Earlier this year the Federation received a very nice letter signed by 16 US Senators, bipartisan as a matter of fact, thanking the state boards for moving forward with this interstate compact idea. Talk about broad support.

Margaret Flinter:
Right.

Dr. Humayun Chaudhry:
You don't normally see a bipartisan letter of support for something.

Mark Masselli:
Frame it.

Margaret Flinter:
Frame it, exactly.

Dr. Humayun Chaudhry:
We framed it, as a matter of fact. But there's been broad support for what we're trying to do, which is move forward with supporting the access to care needs of the nation's population in a smart way, in a way that preserves state-based medical licensure which has been around since the beginning of the nation and ultimately protects the public.

Margaret Flinter:
Well Dr. Chaudhry, I know an enormous focus of the organization is the interstate compact now, but I wonder if you could share your thoughts on another area that you've been engaged in, that is really considering social media in the health care field.

I think your organization has taken a look at the proliferation of social media use among health care professionals and I'm curious, what are you seeing as some of the trends where social media and medicine intersect certainly positively, and also what kind of abuses are being reported or are you concerned about? And are you in the process of developing some social media guidelines that you're going to be recommending?

Dr. Humayun Chaudhry:
So as a matter of fact just as with telemedicine while technology is a wonderful thing, we all have smartphones it seems, we all have tablets or desktop computers and we can engage in instantaneous sharing of information and communications unlike ever before, and that's wonderful because there's a great potential there to support the health care needs, especially among underserved populations as well as those in rural areas.

That said, I'll go back to my original comment that the primary function of the state boards is to make sure that the public is protected. And so rather than just being reactive over the years the Federation has tried very hard to work with the states to be proactive and not only be good at enforcing when things go wrong but also giving some recommendations. So several years ago the Federation came up with a telemedicine policy that we recently updated as an example of how we're trying to keep up with all the advancements going on.

Social media is the other area that you've raised that was not actually on our radar as an area of concern per se, but we were approached by some researchers a few years ago who wanted to study the issue, and we said, "Sure. We're not sure if this is even a big issue among the state licensing boards." To make a long story short we did a survey of our licensing boards, and we were quite taken aback by the results, which were published in JAMA a few years ago, that 92 percent of the responding state medical boards said that they have had a problem with having to discipline physicians for inappropriate use of social media.

And the three areas that they most commonly identified through this survey, one was inappropriate patient communication where perhaps a physician was too forward with a patient or engaged in inappropriate communication that you would never expect to occur in person but somehow with technology it was facilitated, including asking a patient on a date, for instance.

Another was misrepresentation of credentials where a physician using social media claimed to have either a specialty certification or an

expertise in an area when they really didn't. And a third was really a violation of patient confidentiality, which has always been a concern with technology and the ubiquity of it and how there may not necessarily be safeguards. And there were others related to sometimes derogatory patient remarks or discriminatory language that may be used in social media even among physicians.

So this alarmed the state boards, and so two years ago the Federation partnered with the American College of Physicians and put together a joint policy statement that was published in the Annals of Internal Medicine in April of 2013 that goes into some of this background. It essentially says to physicians, "Feel free to use technology, but please pause before you send. Use social media thoughtfully and recognize that there are some inherent dangers in how you may use it inappropriately."

Mark Masselli:
You also had some of your own experience with social media. You were the Health Commissioner at Suffolk County in New York, ninth largest population base in the nation. And talk to us a little bit about your own personal experience there, I think it was with the H1N1 flu epidemic. And what where the lessons learned for the public as well? A little outside of this particular conversation, but you have a lot of hats that you wear.

Dr. Humayun Chaudhry:
Well, it was a good example, Mark, of how social media can be of value not only in one-to-one physician to patient care but also in population health and public health. So Suffolk County, for some of your listeners who may not know, is a fairly large jurisdiction, 900 square miles, with a population of about a million and a half. And we have all these towns within the jurisdiction as well, and town governments as well.

So as the H1N1 flu epidemic began to hit and we started seeing cases in the schools we had to shut down schools, we had to work very closely with state agencies devoted to public health as well as the CDC and some federal agencies as well. And while 2007 and -08 may not seem that long ago BlackBerry and Twitter were still relatively new, and smartphones were relatively new, but many of us used it in public health and found much to our pleasant surprise that many of the federal officials involved in managing that epidemic as well as the officials in New York State were also using it.

So it was a great way to not only get information instantaneously about any new cases for instance, or any follow-up investigation that needed to be done in any particular town or portion of the country, but also enabled me to stay in touch with the leadership of all the towns and villages across the county. And so that really impressed me with the value of technology in that particular area of public health.

Margaret Flinter:
We've been speaking with Dr. Humayun Chaudhry, President and Chief Executive Officer of the Federation of State Medical Boards, a national nonprofit organization that represents 70 state medical boards in the United States and its Territories, responsible for licensing and disciplining physicians. You can learn more about their work by going to fsmp.org or follow him on Twitter at #FedMed1. Dr. Chaudhry, thank you so much for joining us today on Conversations on Health Care.

Dr. Humayun Chaudhry:
My pleasure. Thank you.

Mark Masselli:
At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a nonpartisan nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson:
Well, in the run-up to the November midterm elections we're seeing Republicans claiming that their Republican Primary opponents support the Affordable Care Act. But the claim's used out-of-context quotes and exaggerations. In Georgia in a contentious House race Republicans Bob Johnson and Buddy Carter are both opposed to the Affordable Care Act, and have called for its repeal. But you wouldn't know that from their competing ads. Johnson's ad claims that Carter said Obamacare was, quote, "Not so bad." That's a cherry-picked quote.

Carter said that, quote, "Some of the things that have happened so far are not so bad." But he immediately added that, quote, "The worst part is yet to come." Johnson's campaign website further claims that Carter left the door open to Obamacare's Medicaid expansion in Georgia, and then highlights part of an op-ed Carter had written. But that too was out of context. Carter was explaining his views of others who favored the Medicaid expansion, saying he disagrees with them.

A Carter ad meanwhile says that Johnson has, quote, "Membership in and endorsement from groups that support Obamacare." The ad

doesn't say this, but it's referring to Johnson's membership in the American Medical Association, which has generally been supportive of the Affordable Care Act. Johnson is a surgeon. But Johnson like Carter has called for repeal of the law.

As the AMA President said in an interview on C-Span this summer, some members of the AMA support the health care law and some do not. The Carter campaign cites other medical groups that support Johnson, but those associations don't change the fact that Johnson has been opposed to the health care law. And that's my FactCheck for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter:
FactCheck.org is committed to factual accuracy from the country's major political players, and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked e-mail us at chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Food labeling could be going one step further than simple calorie counts in the future. Public health researchers at the University of North Carolina have some pep in their step for another approach to getting consumers' attention when pondering those food and beverage choices.

There's growing interest in a new approach to displaying calorie counts next to menu item. Instead, show the amount of exercise that would be required to burn off those calories consumed from drinking, say, a 20-ounce cola. They developed an icon symbolizing a person walking and how far that person would have to walk to erase the calories they're just about to consume. They conducted a randomized study to determine what if any effect the measure would have on consumer choices.

Dr. Anthony Viera:
And we showed them basically a full menu with all items. And so one group was randomized to no information except the food items. Another one was a menu of pretty much every item, exact same way, and it had the calories. And then a third option had calories plus minutes to walk with our little figure. And it had for example 91 minutes. And then finally a fourth menu that showed the same exact thing with the same exact figure with miles to walk. So it might say 5.1 miles.

Margaret Flinter:
Dr. Anthony Viera, Professor at the University of North Carolina Chapel Hill School of Public Health. He said the study showed quite clearly that when consumers saw the consuming of food or drink item would require them to walk five miles to burn those calories off as opposed to just seeing the calories it had a direct impact on the choice.

Dr. Anthony Viera:
So if you looked at total calories ordered when you were shown no label the average calories ordered were 1,020. When you were shown calories only, which is sort of the current policy, the average order was 927 calories. And when shown calories plus miles the average order was 826 calories. So as you can see there was a definite decrease in calories when you've shown calories plus miles.

Margaret Flinter:
The results of the initial study were so conclusive they are now scaling up their research to test it in restaurants. Restaurant food labeling showing a consumer how much exercise will be required to burn off the calories consumed, helping them comprehend the actual calorie value of the foods they choose and maybe thus positively impacting their intention to consume fewer calories more wisely, now, that's a bright idea.

This is Conversations on Health Care, I'm Margaret Flinter.

Mark Masselli:
And I'm Mark Masselli. Peace and Health.

Voiceover:
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