

Team-Based Care – Collaborative Regulation

Hosted by

Federation of State Medical Boards (FSMB)

National Association of Boards of Pharmacy (NABP)

National Council of State Boards of Nursing (NCSBN)



THE 2015 TRI-REGULATOR SYMPOSIUM

Summary + Highlights



Federation of
STATE 
MEDICAL
BOARDS



NABP

NATIONAL ASSOCIATION OF
BOARDS OF PHARMACY



NCSBN

National Council of State Boards of Nursing

Introduction

On October 6-7, 2015, the Federation of State Medical Boards (FSMB), the National Association of Boards of Pharmacy (NABP), and the National Council of State Boards of Nursing (NCSBN) hosted the second Tri-Regulator Symposium held at the Ritz-Carlton, Pentagon City in Arlington, VA.

This meeting, which continued to advance the consensus building and dialogue on issues of state-based regulation and licensure, brought together leaders from three national regulatory organizations for one and a half days of presentations and open forums.

During the symposium, themed “Team-Based Care – Collaborative Regulation,” participants delved deeper into how best to collaborate and achieve greater cooperation among our regulatory scopes, ultimately improving patient access and outcomes. A summary of the meeting, including highlights of the discussions, is included in this publication.

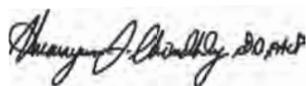
The symposium included a wide range of topics specifically geared toward all three regulatory associations and their members with the intent to provide knowledge to further enhance public protection. One such topic that was discussed in depth was the recent United States Supreme Court decision in the *North Carolina State Board of Dental Examiners v. Federal Trade Commission* case and the impact it may have on regulatory boards amid the interpretation of antitrust laws.

A misinterpretation is viewed as possibly having a chilling effect on regulatory boards whose member regulators include market participants. The critical question of the decision is defining active supervision in order to operate within state-action immunity. There is no doubt about the expertise physicians, pharmacists, and nurses bring to their respective boards and the need to allow them to regulate practice activities on behalf of the public without unduly burdensome oversight. In this regard, participants agreed that the Tri-Regulator Collaborative must continue to assist their member boards that the state-based system of licensure and regulation of health care professionals operates in the interest of the patient and avoids anti-competitive actions, which would place it outside of the scope of state immunity.

It imperative that the Collaborative demonstrates that this system exists solely for the purpose of protecting the public health and not for self-serving and/or preserving the professions. As the ever-changing face of health care practices and the regulatory landscape evolve, the Collaborative will continue to increase cooperation each other in an effort to advance health care and patient safety and outcomes.

We hope you find these highlights from the 2015 Tri-Regulator Symposium useful.

Sincerely,



Humayun J. Chaudhry, DO, MS, MACP
President and Chief Executive Officer
FSMB



Carmen Catizone, MS, RPh, DPh
Executive Director/Secretary
NABP



Kathy Apple, MS, RN, FAAN
Past Chief Executive Officer
NCSBN

Collaborating for the Public's Health, Safety, and Welfare

Symposium Explores Wide Range of Topics of Interest to Regulators

AS THE NATION'S HEALTH CARE SYSTEM continues to evolve through technological advances and regulatory changes, continued collaboration to determine how to best support the boards that license health care providers in the context of team-based care, new practice models and regulatory strategies, and stakeholder communications is vital to public protection.

Continued collaboration ... in the context of team-based care, new practice models and regulatory strategies, and stakeholder communications is vital to public protection.

The aforementioned is one of the key messages to emerge from the second Tri-Regulator Symposium, held October 6-7, 2015 in Arlington, VA. Hosted by the FSMB, NABP, and NCSBN, 140 leaders from the medical, pharmacy, and nursing professions participated in presentations and open forums on topics of high importance to the future of United States health care. (See full list of participants on last two pages.)

Topics addressed during the day-and-a-half Symposium ranged from successful team building to new practice models to communication ethics. A special panel session was held to discuss the *North Carolina Board of Dental Examiners v. Federal Trade Commission* case following a keynote address by the attorney who argued the case before the US Supreme Court. (See page 10.)

Keynote speakers included **Leonard J. Marcus, PhD**, director for the Harvard T.H. Chan School of Public Health Program for Health Care Negotiation and Conflict Resolution, and **Hashim M. Mooppan, JD**, partner at the Jones Day law firm. (See pages 4 and 10.)

Other featured speakers addressed collaboration issues affecting today's health care practitioners. **Teddie Potter, PhD, RN**, clinical associate professor, director of inclusivity and diversity, specialty coordinator, University of Minnesota, presented on successful team building and the challenges faces by teams. **Kristin Schleiter, JD, LLM**, senior legislative attorney with the American Medical Association (AMA), addressed new practice models and regulatory strategies. **John R. Stone, MD, PhD**, professor, Center for Health Policy and Ethics, Creighton University, addressed how to ensure fair and respectful stakeholder communication and why ethics matter.

During the symposium, participants interacted in three major plenary sessions.

Plenary Session One: The first session explored strategies to facilitate team-based care, including how successful collaboration among health care practitioners can exist and how to overcome the various challenges. Also addressed was how team-based care should be defined in the respective practice acts, as well as the need to enact regulations that allow broad interaction among providers to improve patient access and outcomes. Panelists from the three organizations also provided their individual experiences with team building. (See page 5.)

Plenary Session Two: The second session examined new team-based care practice models that are being encountered by health care practitioners as they care for the current and future needs of their patients. After discussing a case study, in which a lack of communication among health care providers resulted in the death of a patient, panelists focused on the need for their respective boards to communicate with each other and whether regulatory action may be the vehicle to prevent future patient harm. (See page 6.)



Plenary Session Three: The third and final plenary session was devoted to the important ethical principles that must be considered by health care practitioners during deliberations, collaboration, and other related communications, particularly when faced with the challenges of difference or diversity. Panelists presented various ethical challenges regularly encountered by each profession and, ultimately, how communicating and intervening with individuals who exhibit bad ethical behaviors is vital to protecting the public by putting the patient first. (See page 8.)

“Our responsibility is to move that leadership horizontally, vertically, diagonally, and in every direction that we can to foster communication and collaboration between our regulatory bodies, between other stakeholder groups and between federal agencies so that in the end, it is our patients that are best served.”

Finalizing the second Tri-Regulator Symposium, the chief executive officers of the three hosting associations provided their insights by discussing the state of the Collaborative and ongoing and future collaboration. Based on the comfort and trust among the groups,

they believe that collaborating on visionary and possibly controversial position statements, perhaps on electronic medical records, can be one of the next steps.

Humayun Chaudhry, DO, FSMB president and CEO stated, “We’ve heard more than one observation that the types of candid professional conversations we’ve had over the last two days were not necessarily ones we’ve could have had three years ago.” Chaudhry, in recounting a past protocol of “leading the code” and how that has evolved into everyone being encouraged to share their input, added that, “even within silos there were silos. This is a conversation that happily is being discussed,” and “we look forward to input from everybody.”

NCSBN past-CEO Kathy Apple, MS, RN, FAAN, noted that today’s generation can be referred to as “digital natives,” that connectivity comes naturally to them, and that they are also “team natives.” Her philosophy to tackling an issue is to first try the simplest approach as she pondered “what the role of the regulator should be,” and that we “would not want to rush off to regulate something that actually may be happening very competently and very naturally with the generations that are coming up.”

NABP Executive Director/Secretary Carmen Catizone, MS, RPh, DPh, stated that “our roles really are to be the meta-leaders of our boards and our organizations, and then across our organizations with our colleagues in medicine and nursing.” He further added that “our responsibility is to move that leadership horizontally, vertically, diagonally, and in every direction that we can to foster communication and collaboration between our regulatory bodies, between other stakeholder groups and between federal agencies so that in the end, it is our patients that are best served.”



Utilization of “Swarm” Philosophy

Leonard J. Marcus, PhD, *Director, Program for Health Care Negotiation and Conflict Resolution, Harvard T.H. Chan School of Public Health*

DR LEONARD MARCUS introduced symposium attendees to the concept of meta-leadership and swarm intelligence based off his “Why Do We Lead?” project. He began his presentation with that basic premise and asked participants, “Why do they lead?” He has researched how leaders react to catastrophic/tragic events, such as the Boston Marathon bombing, and has discovered that great leaders are highly motivated individuals who are intimately aware of why they lead.

Marcus described how organizational structures were developed to fit the industrial age and how we are in the midst of a transition. “The largest taxi company in the world has no cars; the largest hotel chain in the world has no rooms; and the largest retailer in the world has no stores.” Leaders must remain relevant during any time of change.

“Being a meta-leader is not about command and control, but rather creating influence well beyond your authority.”

Navigating through the complexity of health care change is the greatest challenge of the Collaborative leaders. A new kind of connectivity and cohesion for people and larger infrastructures must be developed in this new world that is much different than the traditional health care organizational chart. Marcus opined that the challenge for the future is “to figure out how to lead, and how to

change, and how to innovate in the future health system that we’re part of developing right now.”

He explained that the term “meta-leader” was analogous to a meta-researcher in that it is big, over-arching, wide, and encompassing of the perspective of a given situation. Meta-leaders have emotional intelligence, the ability to stay grounded, and the capability to understand complexity. They know what motivates them and why other people are motivated by them. Additionally, meta-leaders have the ability to understand and articulate the situation and what needs to be done, and then build connectivity of efforts by “leading down to your staff, leading up to your boss, and across within your organization, and beyond to other organizations as well.” Meta-leadership is all about making people successful.

The dilemma of disconnectivity, or silo-mentality, is that it creates conflict, but meta-leaders are able to communicate and encourage integration and connectivity of efforts and perspectives, particularly when dealing with situations that occur across silos. Marcus elucidated that “being a meta-leader is not about command and control, but rather creating influence well beyond your authority.” He encouraged attendees to walk around with a “mirror” so they could constantly gauge their emotional intelligence, explaining that if they looked calm others around them would remain calm.

Marcus then described how meta-leadership relates to “swarm intelligence” in that it involves a simple set of rules and social cues that help guide complex, self-organized productivity. He and other researchers discovered that there are five basic rules to swarm intelligence, which are 1) unity of mission; 2) generosity of spirit and action; 3) staying in lanes but helping others succeed; 4) “no ego – no blame;” and 5) having a foundation of relationships. The basic theme of meta-leadership and swarm intelligence is “how can I make you a success?” With that spirit of mutual success, you can achieve a lot more.



Successful Team Building and Challenges That Are Faced by Teams

Moderator: Shirley Brekken, MS, RN, President, NCSBN Board of Directors, and Executive Director, Minnesota Board of Nursing

Panelists: Susan Ksiazek, RPh, Executive Committee Member, NABP, and Member, New York State Board of Pharmacy; Ralph C. Loomis, MD, Treasurer, FSMB; and Katherine Thomas, MN, RN, FAAN, President-elect, NCSBN Board of Directors, and Executive Director, Texas Board of Nursing

Featured speaker: Teddie Potter, PhD, RN, Clinical Associate Professor, Director of Inclusivity and Diversity, Specialty Coordinator, University of Minnesota

Plenary Session One began with a presentation by the featured speaker, Dr Teddie Potter, who created the palliative care model. Potter offered that many health care practitioners believe that they are working collaboratively simply because they work together with other health workers, whereas the reality is that they may be simply working within a group where each individual has agreed to use his or her own skills to achieve a common goal.

The World Health Organization defines collaboration as occurring “when two or more individuals from different backgrounds with complementary skills interact to create a shared understanding that none had previously possessed or could have come to on their own.” Potter explained that “the magic that occurs between us, the synergy that happens when we work together and when we trust each other and respect each other . . . that something becomes possible because of this type of relationship.” She further explained that this type of culture needs to be fostered for the concept of team-based care to flourish.

Potter suggested that a dysfunctional culture has been shown to achieve suboptimal results. Key culture in the US revolves around the ranking or the creation of hierarchies, and “whereas excellence is wonderful, it can be a barrier to true team work.” She explained how every organization exists within a continuum of either a partnership (power with) or domination (power over) system and how that culture relates to collaboration. It has been shown that “safety, quality, and patient outcomes and satisfaction are negatively impacted in organizations with domination cultures, which are based on fear, shame, and blame; and that they improve in organizations rooted in partnership cultures that are based on respect and empowerment.”

Susan Ksiazek resonated Potter’s presentation, stating, “we, as health care providers need to recognize that the patient is the

most important member of the team,” as she recanted a case study of a patient with end-stage renal disease. She further added that the team members all need to have the same goals and clear roles, and that both of these need to be articulated to the patient. As professionals we need to trust and respect each other; however, that respect must be earned and not just something that practitioners should expect based on their degree or license.

Dr Ralph Loomis agreed with Ksiazek in that the patient must be put first. Health care providers have to blend multidisciplinary skills and involve efficient delegation of duties. Leadership, situation monitoring, mutual support, and communication are the core competencies that should be the focus of the team. Loomis also agreed with Ksiazek in that all members must have an equal voice in patient care.

Loomis provided the history of collaboration among health care providers by describing a policy regarding scope of practice passed by FSMB in 2005, which recommended that barriers to cooperation should be decreased. He further described the work group composed of members of the Collaborative who would be meeting the following week and were tasked “to identify the best state-based practices and recommend regulatory strategies for achieving greater cooperation and collaboration among health care professional boards in carrying out a shared responsibility to protect the public.”

Dr Katherine Thomas began by building on Loomis’ shared duty on patient safety, putting the patient first, and supporting a team-based approach. She then asked, “How do we do that as regulators?” Thomas mused that apparently something is not working, based on the 2014 report of the Commonwealth Fund, which ranked the US last out of 13 industrialized countries for health care outcomes. The third-party payers are looking at delivery models and best practices, and are looking into engaging with various stakeholders to help make improvements to those statistics. She offered that nurses have been working on health care teams for a very long time; however, there is a lot of work that still needs to be done.

Thomas described the health professions council she works on and some of the projects that have been completed, including a position statement by the Texas Board of Nursing and Texas State Board of Pharmacy on medication error prevention and a joint paper on the reclassification of hydrocodone combination products with the Texas medical, nursing, and pharmacy boards. She stated that “one of challenges is putting aside the interprofessional competition that exists . . . and focusing on the patient.” We need to deliberately communicate with each other and engage in work together.

New Practice Models and Regulatory Strategies

Moderator: J. Daniel Gifford, MD, FACP, Chair, FSMB

Panelists: Patricia A. King, MD, PhD, FACP, Board Member, FSMB, and Board Member, Vermont Board of Medical Practice; Joey Ridenour, MN, RN, FAAN, Executive Director, Arizona State Board of Nursing; and Jeanne D. Waggener, RPh, DPh, Treasurer NABP, and Member, Texas State Board of Pharmacy

Featured speaker: Kristin Schleiter, JD, LLM, Senior Legislative Attorney, American Medical Association

Team-based care is not a new phenomenon, but “some of the new payment models [and] some of the new practice structures certainly warrant a new approach, so to that end [the AMA is] appreciative of the work that you are all doing at the state level,” began Ms Kristin Schleiter. Improving the health of the nation is at the strategic focus and core of the AMA’s work to enable physicians and health care teams to partner with patients, and the AMA believes this goal overlaps very well with the goals of this symposium. She explained the AMA’s first targets were to improve diabetes and cardiovascular disease education and its work with the Center for Disease Control and Prevention, YMCA, and state agencies.

Schleiter explained that most relevant is AMA’s work to support practice sustainability and professional satisfaction for not only physicians but all members of the health care team. Its “Steps Forward Program” that launched a few months earlier is a collection of interactive educational modules designed to help physicians address common practice challenges and achieve better patient experience, improve population health, lower costs, and improve professional satisfaction. The modules cover topics such as pre-visit planning, team meetings, team documentation and team culture, and expanded rooming, and discharge protocols. “In short, these modules look at . . . all members of the team and how we

can use everybody to their fullest extent of the education, training, and individual experience.”

Additionally, the AMA has developed policies and best practices to guide physicians on how to be a member and potentially a leader of a health care team. One policy outlines elements that should be considered when planning a team-based model of care such as being patient-centered; promoting team work, clarity, and communication in each team members’ clinical roles and responsibilities; and how to efficiently manage the practice using current technology. “We think an ideal team supports open communication between the patient, the family, and team members.”

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Schleiter stated that, from a public policy perspective, AMA fully supports state-based licensing and regulation of the professions, but that there is a need for greater cooperation between the regulatory agencies, not only nationally, but at the state level as the regulatory environment evolves. She described some trends at the state level involving legislation that created joint regulatory boards or advisory committees including the medical and nursing boards to discuss issues such as collaborative practice, handling complex patients, communications, and prescribing controlled substances. She concluded by stating how important these efforts are in dealing with the current prescription drug abuse crisis, but recognized that more work



needs to be done, specifically for prescription monitoring programs to be integrated with physicians' and pharmacists' workflows.

Dr Patricia King began by commenting "that the team is not new," but what is new is putting the patient at the center. She described how her institution redesigned patient encounters by looking at all the members of the team. The team redefined their roles in order for members to work at the top of their ability, value all of the team members and build on that culture, and increase communication between team members. "This was all done with the focus on the patient."

King explained that the triple aim was to improve patient population health, patient care, and reduce costs. She described the various changes made to the patient scheduling system at her institution's primary care offices and the integration of other on-site community health care team members, including pharmacists, nutritionists, exercise specialists, and diabetes educators. She stressed the need to recognize that not all of the team members are regulated and that communication is key. While King emphasized that this example is from primary care, she is aware that teams are changing for subspecialties as well, and noted that the patient is the most important team member for all types of practice and should be the main driver.

Ms Joey Ridenour began by describing a regulatory team that evolved in Arizona when long-term care facilities approached the Arizona State Board of Nursing to pilot a program for certified nursing assistants (CNAs) to pass medications. The study was conducted and data was collected for three years in 10 long-term care facilities to determine whether CNAs could be educated to pass medication safely. The results demonstrated that these individuals

could achieve competency, so now CNAs now go through a clinical process and pass a test. The Arizona Board did, however, discover that many CNAs were having difficulty with calculations, so it encouraged the long-term care facilities to provide remedial math education prior to individuals beginning the program. She explained that this program resulted in a statutory change that codified how future pilot programs should be conducted.

Ms Jeanne Waggener added to the discussion, noting that while team-based care has been practiced in the hospital setting for some time, it is a relatively new term in the community pharmacy setting. She opined that team-based care in pharmacies is being governed now by the Centers for Medicare & Medicaid Services (CMS) and the Star Ratings, in addition to developing state regulations. She explained how critical these ratings are to pharmacies, which are based on their interactions with physicians and that may ultimately jeopardize the relationships they have with their patients.

"Patients want to come in and be able to interact with their pharmacists," stated Waggener. She explained how pharmacists are the most accessible member of the health care team, particularly by being available 24/7. She described how medication therapy management is also being driven by CMS and Star Ratings, specifically requests in the area of adherence issues. "This is slowly taking place, and in 2016 it is rolling out full steam." Waggener added that while her state does not have many regulations in place for team-based care, it must be addressed "because it here and it is now."

Following the panelists' remarks, Dr J. Daniel Gifford presented a case that resulted in the death of a patient because of a lack of communication regarding the patient's penicillin allergy among the health care team and the hospital utilizing separate electronic health record systems for inpatients and the emergency room. The panelists and audience then discussed how they and their state boards would handle an interprofessional case of this type.



Ensuring Fair & Respectful Stakeholder Communication: Ethics Matters

Moderator: Hal Wand, MBA, RPh, President-elect, NABP, and Past Executive Director, Arizona State Board of Pharmacy

Panelists: Philip P. Burgess, MBA, DPh, RPh, Executive Committee Member, NABP, and Member, Illinois State Board of Pharmacy; Arthur S. Hengerer, MD, Chair-elect, FSMB, and Board Member, New York State Office of Professional Medical Conduct; and Laura Rhodes, MSN, RN, Executive Director, West Virginia Board of Examiners for Registered Professional Nurses

Featured speaker: John R. Stone, MD, PhD, Professor, Center for Health Policy and Ethics, Creighton University

Dr John Stone began by stating, “This is about collaboration across difference. Collaboration involves team work, cooperation, and partnering.” He explained that for the best collaboration, health care professionals should all strive to be in solidarity with each other. In regard to crossing areas of difference and how that intersects with collaboration, Stone offered that it was analogous to community-based participatory research intersecting with clinical care and finding effective ways to partner between investigators and communities.

“Collaboration involves team work, cooperation, and partnering.”

He explained that community-based means collaborating together to develop mutual agendas, as opposed to community-placed, which means doing work in the community. Issues that arise with community-based participatory research revolve around the significant differences between knowledge, expertise, power, priorities, and that the main barrier in collaboration partnering is how to acknowledge distrust and show how it can be reversed. It is a worthwhile enterprise to discuss our core ethical principles collectively; the key is, if we can mutually discuss what a core principle means, then we might collectively gain some ground toward ethical and effective collaboration.

Stone continued by describing the core principles, or tenets, which include mutual respect, equitable deliberation, and openness. The tenet of mutual respect pertains to giving everyone equal moral worth, and the obligations of providing empowerment, recognition, understandable language, and ensuring that they have moral space (creating a metaphoric space where everybody can

speak comfortably). Equitable deliberation involves treating all with respect, providing fair opportunity and audience, focusing on issues and not persons, and agreeing on deliberative principles and values. The final tenet of openness includes being receptive to ideas, styles, and perspectives while suspending judgment.

In closing, Stone discussed the concepts of caring and trustworthiness. Caring includes showing concern, empathy, mutual support, and connectivity. Trustworthiness is established by being reliable, dependable, persistent, keeping promises, and having historical sensitivity. To validate the discussion that ethics is not just about being ethical, respectful, fair, and just. Stone indicated that ethics is a collective inquiry, a collective dialogue.” In our collaboration, health care professionals have to discuss what that means, particularly with having different backgrounds. “Ethics is worth talking about collectively. . . the first step is to have provisional names; the second step is to have group dialogue; the third step is then collectively agreeing on what they mean; and then of course, the fourth step is to apply them.”

Mr Philip Burgess first spoke on ethical issues and how they impact the practice of pharmacy and specifically himself as a regulator. A board of pharmacy member is constantly dealing with the challenges of conflict of interest, particularly when members have the unfortunate tendency of putting their own self-interest ahead of what the interest is of the patient. “One of the challenges that we deal with from an ethical issue is an order to get our members to look for the patient first.”

He stressed that another challenge is pharmacists’ lack of access to patients’ full medical records and how it can negatively impact patient care when pharmacists are unable to fill a prescription as a result of not having specific information such as a patient’s diagnosis. “Is that good ethics? Is that good patient care? Is that putting the patient first?” And if the prescription is for a controlled substance, it certainly adds to that type of dilemma, in addition to the challenge of the time pressures placed on pharmacists.



Lastly, Burgess opined that there are tremendous opportunities in regard to the ethics involved with the continuum of care between hospitals and community pharmacists, as well as the entire health care team working together. He described a sophisticated medication reconciliation system employed by a hospital, which seemingly worked only one way in that the hospital pharmacist validated a patient's medications from the community pharmacist, but upon discharge there was no outreach to inform the community pharmacist that the patient's medications had been changed. "There has to be a system where our professions; the hospitals, the physicians, the nurses, the pharmacists – whether they're in a hospital or community setting – that they work together, and work more closely."

Ethics and self-identity are topics for which each individual has a unique interpretation, began Dr Arthur Hengerer. He then shared a story from his surgical residency when he first became aware of team-based care and how he realized the importance of ethical, problem-solving steps in decision making. "There's a lot of things to take away from a meeting like this . . . We need to filter it back down into our institutions and begin to work on ways to make all of us listen and understand what it is we're all about, and how ultimately the patient responds in an effective way from what we do for them."

Hengerer went on to explain that the authority gradient is a hidden curriculum of how we make people aware of where they exist on the continuum and how we impact with one another to do things in a positive rather than a negative way. He described how he brought Flight Safety International to his institution to show surgeons, nurses, and various staff how two pilots, who may have never met each other, are able to fly planes safely by conducting the pre-flight briefing, following the checklist, and completing the debriefing afterward so that everything works smoothly. Hengerer emphasized that the intent of this exercise was to teach the importance of team work and the fact that the surgeon is not the most important person in the operating room.

He described a code of conduct that was implemented in his hospital, which all hospital employees were required to sign, that

addressed behavioral issues by a committee that treated doctors, nurses, and others on equal footing. Hengerer also described a committee that was formed to address disruptive behavior, which determined whether an individual needed anger management treatment. He explained how important it is to nip ethical and behavioral problems in the bud to ensure that they do not filter up to having to deal with them in team-based care. He concluded by detailing various FSMB work groups being convened that will address team-based care, marijuana and health care providers, medical student education, opioid issues, and physician wellness and how to deal with burning out.

The final speaker, Ms Laura Rhodes, shared her thoughts on what had been discussed at the symposium and the conclusions made related to our work, including the themes of shared duties to patient safety, respect for one another, "no ego – no blame," and group dynamics. She expressed that interprofessional battles can sometimes be a great challenge, particularly when they involve the boundaries between the professional organization and the regulatory body and how to meet the common goal of safe patient care together while having different approaches, and she also noted that "regular communication is certainly important in all areas."

In learning how to teach caring and see it evolve over time, Rhodes relayed a story about a West Virginia historical hotel's hiring practices and its rule that "it's easier to teach a nice person how to set the table than it is to teach a person who knows how to set the table to be nice." Having respect for others and continually reinforcing that concept is key. She explained how sometimes fear and the tenseness of certain situations can affect an individual's judgment and that he or she may need help in making a decision. She described models that were developed to help empower nurses to make decisions about their practice that revolve around standards of care and standards of practice, which include ethical considerations.

Rhodes imparted her list of "Rs" that she took away from the previous sessions. We need to review – is it a triangle, a circle, or a cone? We then need to reflect on that information to determine a better conclusion, and in doing that, there is a revision of our work, our thinking, and our practice. We can then have that "rejoice" moment when we watch the culture and attitudes change. Regeneration is really important for digesting and thinking issues through so they may be relayed to others and be reinforced. Lastly, Rhodes stressed the importance of empowering patients to be comfortable with asking questions. "And when everybody recognizes that the questions are permitted, it isn't taken as an ego issue or a blame issue, it's taken as an others issue and an accountability issue."



North Carolina State Board of Dental Examiners v. Federal Trade Commission

Hashim M. Mooppan, JD, Partner, Jones Day

Mr Hashim Mooppan, partner in the issues and appeals practice of the Jones Day law firm and former clerk of former Supreme Court Justice Antonin Scalia, was the attorney who argued before the US Supreme Court in *North Carolina State Board of Dental Examiners v Federal Trade Commission* (FTC), and provided symposium participants a detailed account of this very important case, which may lead to great change in how regulatory boards conduct their business of protecting the public health.

The basic background on the federal antitrust laws is that they are principally focused on the acts of private business people, ensuring that they do not raise prices or restrict competition in ways that harm consumers, explained Mooppan. The issues raised in the FTC case are whether individuals engaged in anti-competitive conduct that is pursuant to a state regulatory scheme are exempt from these laws if the state has clearly articulated a policy to displace competition, such as licensure requirements in state practice acts. Another issue involved in this case is that a state agency delegates its authority to a private party to engage in anti-competitive conduct, there must be clear articulation in addition to active supervision by state officials.

“The question that was presented in the dental board case [is] what do you do when you have what is essentially a hybrid entity – an agency that is a state entity created by the state that enforces state regulatory regime, but that’s run by part-time public officials who are also market participants in their personal capacities?” Should that entity be treated as a state entity that only requires clear articulation by the state to displace competition, or should it be treated as a private party, which requires the clear articulation standard plus active supervision?

“Now, I would have thought that this should have been an easy question,” opined Mooppan as he explained that states have been using entities that are structured exactly this way for decades. State medical and other regulatory boards have always had practicing physicians and other professionals on these boards for the obvious reason that they have expertise in the area. He voiced that he believes that the FTC has always been concerned about

the dual role board members play and the potential for conflicts of interest, and since the early 2000s has been looking for a test case to raise this specific question.

Mooppan went on to describe that the crux of the case was the cease and desist letters sent by the North Carolina State Board of Dental Examiners to non-licensed entities that were performing teeth whitening procedures in mall kiosks, alleging that they were engaging in the unauthorized practice of dentistry. The question was raised as to whether the Dental Board had the authority to send these letters; however, what is really important to recognize about the case, Mooppan claimed, is that nothing in the case turned on that fact. FTC was more concerned with not whether the board had state law authority, but the broader question of whether state boards, which are structured this way, have to be actively supervised.

FTC’s three main concerns regarding the case were that:

- the purpose of the active supervision requirement was to ensure that individuals who are enforcing state policy are furthering the state’s interests and not their own;
- the active supervision requirement should not only be applied to purely private parties, but should also be applied to part-time public officials who are also active market participants in their personal capacities, ie, the dentists sitting on the Dental Board and the potential for conflicts; and
- the entire state exemption should be narrowly construed because it is basically an implied exemption from the federal antitrust laws.

Mooppan then described the three counter-arguments to the FTC’s concerns. It should be assumed that Congress did not intend to regulate the states unless it is explicitly stated. The benefit risk balance of the states’ choice of whether to have the expertise of market participants serve as public officials on regulatory boards versus the risk for the potential conflicts of interest is “a core sovereign decision for the states to make, and it should be assumed that the federal government did not intend to override that decision absent very clear evidence to the contrary.”



The Dental Board's second argument was in regard to the purpose of active supervision and that conflicts of interest are for the states to deal with; state administrators and state courts will deal with state officials who violate the law. The active supervision requirement is meant to protect the federal government from states in the particular context where states authorize private people to violate the federal antitrust laws. Mooppan analogized this with state medical marijuana laws; just because a state passes a law to allow it, citizens are not exempt its citizens from the federal marijuana law.

“Going into the Supreme Court it was a little bit difficult to predict how the case was going to come out. I believe then and still believe now that we had by far the better of the arguments.”

Lastly, Mooppan explained that the Board's position regarding the active supervision requirement was that the states can basically make the conduct of private people the states' own conduct by authorizing individuals to do something, and by supervising it, states are making it their own. If this is the case, active supervision obviously does not apply to the states because by virtue of creating the agency and subjecting them to the normal scrutiny that all state agencies face, the state has made the conduct its own.

“Going into the Supreme Court it was a little bit difficult to predict how the case was going to come out. I believe then and still believe now that we had by far the better of the arguments.” Mooppan described how the conservative justices normally lean toward protecting the states' rights, but on the other hand are usually strong supporters of free markets. However, in this case these are conflicting issues. Conversely the liberal justices usually voice the opposite dynamic. While Mooppan believed the Dental Board received a very good hearing, as the argument went on, it appeared that some of the justices were less interested in state sovereignty and were more concerned about the practical implication of the rule.

By a 6-3 vote, the Court ruled in favor of the FTC and against the Dental Board. The Court ruled that the purpose of the active supervision requirement was to ensure that individuals are complying with

state policy and not furthering their own interest, and that for boards that have part-time public officials who are also active market participants, that interest is implicated. “When there are controlling number of decision makers who are active market participants in the profession being regulated; that such a board has to be subject to active supervision in order to get state action exemption.”

Given the ruling, Mooppan stated that there are basically three ways that boards can either regain their immunity or operate outside of antitrust concerning their immunity: they can change the composition of the board so that there is no longer a controlling number of decision makers who are active market participants in the profession being regulated; they can actively supervise such boards with a higher level of state review that does not contain part-time public officials; or, they can just not have state action immunity and comply with the antitrust laws. Each one of these options presents some legal and practical difficulties, and states will have to pick and choose among all three.

Mooppan further clarified the difficulties that each option will create. The first option of changing the composition of the board by reducing the market participants will require legislative changes because the composition of the board, in most states, is mandated by statute. Additionally, experts are put on boards for a reason – there is a real benefit of expertise and knowledge with having them on the boards. It will be difficult to obtain the level of expertise while keeping within the Court's guidance of not having a controlling number of decision makers.

The second option of having active supervision also presents several problems. Many states again will be required to make statutory changes, but even so, the fact of having supervision by those who lack expertise somewhat undermines the whole process. Additionally, the Court's opinion was vague regarding the active supervision requirements. What is required is that the state has to actually supervise, and review not just the policies, but the substance; furthermore, the substantive decisions that the board makes must be able to be modified. However, the Court also held that the inquiry must be flexible and that the state should not micromanage.

Mooppan explained that the third option for the states is to operate without immunity, as long as it can be structured to comply with antitrust laws. This is acceptable; however, it presents difficulties because while it is not inherently in violation of antitrust laws to regulate professions, the option in its very nature restricts competition. At a minimum, states will have to indemnify board members to decrease their liability for any potential monetary damages if any actions board members take are later deemed to violate antitrust laws.

About the Tri-Regulator Collaborative

A shared agenda of patient protection and health care quality

As organizations representing the health care professional licensing and regulatory boards of the United States, the Federation of State Medical Boards (FSMB), the National Association of Boards of Pharmacy (NABP), and the National Council of State Boards of Nursing (NCSBN) share a common mission of protecting the public and enhancing professionalism and the quality of health care.

Protecting the Public Health

Together, these three organizations regulate over 5 million health care professionals and play significant roles in impacting the national health policy. Each autonomous organization has its own constituent membership, but as they all share common values for protecting public health through state-based licensure, the FSMB, NABP, and NCSBN have much to collaborate on dialogue and consensus building.

Many benefits of collaborating more closely to better protect public health, safety, and welfare were realized when the FSMB, NABP, and NCSBN formally launched the Tri-Regulator Collaborative in 2011. A mutual feeling of familiarity among the organizations was certainly evident by the meaningful discussions held at this second symposium.

As well as convening the symposiums, the leaders of the Collaborative meet periodically to discuss issues of mutual concern, exchange ideas, and share resources in an effort to better protect patients and improve the quality of care.

Among its activities, the Collaborative has developed consensus statements on issues of importance to the regulatory community, including strong endorsement of state-based licensure for health professionals.

The Collaborative believes a system of state-based regulation, as mandated in the 10th Amendment of the US Constitution, offers the most effective regulatory framework for health care professionals and allows for close monitoring of licensees across the country, while providing for each state's diverse circumstances and needs.

In addition to advocating to improve the country's efforts to collect workforce data about health care professionals, the Collaborative strongly recommends enhancements to the electronic health records systems currently being utilized to

increase interoperability. In order to ensure the ability to meet the increasingly growing needs of the nation's aging population, it is vital to collect evidence-based, comprehensive data and analysis of the health care workforce. Equally important is for all health care providers to have access to a patient's medical record as there is much need for improvement in this realm. The second Tri-Regulator Symposium was intended to increase the sense of partnership and common purpose by providing a national forum to share dialogue on these and other issues critical to our health care future.

The Federation of State Medical Boards

The Federation of State Medical Boards is a national non-profit organization whose members are the seventy (70) state medical and osteopathic licensing and disciplinary boards of the U.S. and its Territories. FSMB is focused on improving the system of medical licensure in the United States and advancing the quality, safety and integrity of health care in general. The FSMB celebrated its 100th anniversary in 2012.

The National Association of Boards of Pharmacy (NABP)

The National Association of Boards of Pharmacy® (NABP®) was founded in 1904 and represents all of the pharmacy regulatory and licensing jurisdictions in the United States, Australia, Bahamas, nine Canadian provinces, and New Zealand. NABP is an independent, international, and impartial Association that assists its member boards and jurisdictions for the purpose of protecting the public health.

The National Council of State Boards of Nursing (NCSBN)

The National Council of State Boards of Nursing provides education, service and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection. Founded in 1978, NCSBN provides the opportunity for U.S. state and territorial boards of nursing to act and counsel together on matters of common interest and concern affecting public health, safety and welfare. NCSBN's members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories – American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are nine associate members.

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