Mark Masselli: This is Conversations on Healthcare 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 they would ordinarily require a trip to their provider's office.

Margaret Flinter: With the expansion of telemedicine's getting a big boost from the insurance industry. Aetna 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 well point. Another big insurer anticipates four million E-visits in the coming year.

Mark Masselli: It saves money and for patients faced with higher and higher deductibles and co-pays 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 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 concerned about the high tech approach undermining the high touch approach but I don't think they have much evidence to support that view.

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

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

Mark Masselli: There are proposed new draft regulations in inter-state compact that would help alleviate the growing shortage of physicians and allow for more expensive 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 email 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 Humayan Chaudhry in just a moment.

Mark Masselli: But first here is our producer Marianne O'Hare with this week's headline news.

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Marianne O'Hare: I'm Marianne O'Hare with this Healthcare Headlines. Two federal appeals court penal 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 United States court of appeals for the fourth district enrichment upheld subsidize saying that a rule issued by the internal revenue service was a permissible exercise of the agencies 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 are found eligible for subsidized insurance on the federal exchange or market place.

Meanwhile the numbers of those who gain 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 gain coverage under Obama Care by being allowed to stay on their parents plan until the age of 26, eight million gain coverage through the online insurance market places and over four million gain coverage with the expansion of Medicaid. And handling all of that online insurance business continues to present challenges the centers for Medicare and Medicaid has kicked off a search for a company that will serve as their technology vendor for healthcare.gov the federal insurance exchange. They're looking for a contractor capable of "working under aggressive time constrains" official saying this does not mean they're dissatisfied with the current contractor Accenture who replaced the original contractor that bought the rollout.

A Florida jury is (inaudible 3:58) to decisive blow to one of the leading manufacturer of cigarettes R. J. 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 versus R. J. Reynolds Tobacco Company sued on the grounds of company knowingly sold the product to her husband a long time smoker by marketing a product they knew was addictive, deadly and fill 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 Marianne O'Hare with these Healthcare Headlines.

(Music)

Mark Masselli: We're speaking today with Dr. Humayan Chaudhry a 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 their Commissioner of Health Services for Suffolk County, New York an internist in osteopath Dr. Chaudhry served as the Chairmen of the Department of Medicine at a college of osteopathic medicine at the New York Institute of Technology and he's author of several books including medical licensing and disciplining America. He earned his masters at Harvard School of Public Health his MD at the New York Institute of Technology. Dr. Chaudhry welcome to Conversations on Healthcare.

Dr. Humayan 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 licensing a physician 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 why type of oversight and policy directions are you responsible for the medical field?

Dr. Humayan Chaudhry: Sure the practice in medicine in the United States has been regulated by the state since really the founding of our nation. The Federation of State Medical Boards my organization was founded more than a 100 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 licenser 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 of the federation creates overtime become state law, 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 poise to just explode in the coming years, combination of both available technology and real need for increasing capacity. So your organization the Federation of State Medical Boards has been getting some attention lately for a proposal that would help expedite licenser across state lines. Maybe you could tell us about this draft legislation that you've created the interstate medical licenser compact.

Dr. Humayan Chaudhry: About two decades ago the states recognize a need to support what's known as licenser portability in other words the ability of the physician practice in more than one jurisdiction. So for instance back in 1996 the federation

created on behalf of the state 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 move to another state. Last year the states wonder 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 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 offices and explored what might be other options by which they can support these efforts. And so was born the notion of maybe an interstate medical licenser compact maybe way to address these issues in a way that make 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 the criteria governing providers seeking expedited licensers across state lines might face.

Dr. Humayan Chaudhry: 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. 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 the doctors. It looks like the states will be requiring that a physician who wishes to get multiple state licenses through this pathway should have unrestricted license to practice in one of the participating states and we call that a Principle Licenser State so you have to identify as a physician if you want to go through this pathway one state where you have obtain licenser 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. But the states felt that there were some common elements to the requirements that would assure them of patient safety ultimately while enabling the sort of licenser portability to occur in a way that hasn't been seen before in the United States. 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 report like that in long time coming from across the United States. So there is a lot of support for it and momentum. We're currently in a process of finalizing some of the language this is indeed the fastest moving initiative in the history of our organization.

Margaret Flinter: You're certainly not the only healthcare profession that's been looking at this issue of the interstate compacts and we hear so much these days about inter-professional collaboration 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 across the board. And then I guess on just the 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 will see today?

Dr. Humayan Chaudhry: We have been having very good communications and meetings over the years with our friends as that 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 remark that collectively we regulate several million doctors, nurses and pharmacist so there is a nursing compact the nursing professional working under the offices of the NCSBN the nursing association for the boards. Several years ago put together a compact and they've had some success 24 state have signed off on that. So when we began discussions about a interstate compact for physicians we talk to our friends at the nursing boards to find out what work and what didn't work. So for the physician side on the state board side that help because the physician 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.

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 offices we have a board action data bank and as soon as that information becomes available to us electronically we share that instantaneously with all 70 of the state medical in 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 is states that any state that is partner to this compact would agree that if one of the physicians who's got the license through this compact is being investigated that information of that physician's being investigated also be shared with the other states. Right now many states statutes only allow sharing of information across state line when an action is taken not before. So that adds an additional layer of public protection every now and then things go wrong and there should be mechanisms in place to protect the public. And so that is something that exist in this compact in a better way than perhaps exist otherwise.

Mark Masselli: We're speaking today with Dr. Humayan Chaudhry President and Chief Executive Officer of the Federation of State Medical Boards responsible for licensing and discipline 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. Humayan Chaudhry: To be honest 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 discipline 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 receive a very nice letter sign by 16 US senators bipartisan as a matter of fact thanking the state boards for moving forward with this interstate compact idea. 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 base medical licenser which has been around since the beginning of the nation and ultimately protects the public.

Margaret Flinter: Mm-hmm, well Dr. Chaudhry I wonder if you could share your thoughts on other area that you've been engaged in that is really considering social media in the healthcare field. I think your organization has taking a look at the proliferation of social media use among healthcare professionals. And I'm curious what are your seeing as some of the trends where social media and medicine intersect.

Dr. Humayan Chaudhry: So as a matter of fact while technology is a wonderful thing we can engage in instantaneous sharing of information and communications unlike ever before. There's a great potential there to support the healthcare needs especially among underserved populations. And so over the years the federation has tried very hard to work with the states to be proactive. So several years ago the federation came up with a telemedicine policy that we recently updated as an example how we're trying to keep up with all the advancements going on. Social media is the other area that was not actually on our radar as an area of concern per se but we were approach by some researchers a few years ago who wanted to study the issue and we said sure we're not sure 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 that 92% of the responding state medical boards said that they have had a problem with having to discipline physicians for inappropriate use of social media.

One was inappropriate patient communication where perhaps the physician was too forward with the patient or engaged in inappropriate communication that you would never expect to occur in person but somehow with technology it was facilitated including asking the patient on a date for instance. Another was misrepresentation of credentials where a physician using social media claim to have either especially 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 so two years ago the federation partnered with the American College of Physicians and put together a joint policy statement that goes into some of this background but 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 are the health commissioner Suffolk County in New York talk to us a little bit about your own personal experience there I think it was with the H1N1 flu epidemic and what were the lessons learned for the public as well?

Dr. Humayan Chaudhry: Well it was a good example Mark of how social media can be a value not only in one to one physician to patient care but also in population of health and public health. So Suffolk County for some of your listeners who may not know is a fairly large jurisdiction with a population of about a million and a half. And so as the H1N1 flu epidemic began to hit we have to shut down schools, we have to work very closely with state agencies devoted to public health as well as the CDC and some federal agencies as well. And blackberry and Twitter were still relatively new and smart phones are relatively new but many of us used it in public health and found that many of the federal officials involve 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. But also enabled me to stay in touch with the leadership of all towns and villages across the county. That really impressed me with the value of technology in that particular area of public health.

Margaret Flinter: We've been speaking with Dr. Humayan Chaudhry, President and Chief Executive Officer of the Federation of State Medical Boards. You can learn more about their work by going to FSMB.org or follow him on Twitter at (inaudible 19:42). Dr. Chaudhry thank you so much for joining us today on Conversations on Healthcare.

Dr. Humayan Chaudhry: My pleasure thank you.

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Mark Masselli: At Conversations on Healthcare we want our audience to be truly in the know when it comes to the facts about healthcare 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 claims use out of context quotes and exaggerations. In Georgia in a contentious house raise republican 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 Obama Care was "not so bad" that's a cherry picks quote. Carter said that "some of the things that have happened so far are not so bad" but he immediately added that "the worst part is yet to come". Johnson's campaign websites further claims that Carter left the door open to Obama Care's Medicaid expansion in Georgia and it highlights part of an up ad Cater had written. But that too was out of context, Cater was explaining the views of others who favored the Medicaid expansion a Carter ad meanwhile says that Johnson has "membership in and endorsement firm groups that support Obama Care" 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. Some members of the AMA support the healthcare law and some do not. The Carter campaign besides other medical groups that support Johnson but those association don't change the fact that Johnson has been opposed to the healthcare law. And that's my fact check for this week I am 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 would like checked, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

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Margaret Flinter: Each week conversations highlights a bright idea about how to make wellness a part of our communities and to 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 menu items instead show the amounts of exercise that would be required to burn off those calories consume

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 are just about to consume.

Dr. Anthony Viera: And we showed them the full menu with all items and so one group was randomize to no information except the food items. Another one was a menu of pretty much every item and it had the calories and then a third option had calories plus minutes to walk with our little figure and it had, you know for example 91 minutes. And then finally a fourth menu that show 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 consumer saw the consuming of food or drink item would require them to walk five miles to burn those calories off as oppose 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 are shown no label the average calories ordered with 1020 when you are shown calories only which is, you know, sort of the policy the current policy the average order was 927 calories. And when shown calories plus miles the average was 826 calories so as you could see there was a definite decrease in calories when you're 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 chose and maybe that's positively impacting their intention to consume fewer calories more wisely, now that's bright idea.

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Margaret Flinter: This is Conversations on Healthcare, I'm Margaret Flinter.

Mark Masselli: And I'm Mark Masselli, peace and health.

Conversations on Healthcare, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.