

# Discipline Outcomes: What Good Comes from What Boards Do?

A speech by Rebecca LeBuhn, CAC Chair, given at the National Council of State Boards of Nursing's annual Investigator-Attorney Workshop in Memphis, Tennessee, in May, 2006.

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Let me begin by thanking Vickie Sheets and the National Council of State Boards of Nursing for inviting me to speak this morning, and for choosing to begin this workshop with comments from a consumer or patient point of view.

CAC and the National Council have enjoyed an excellent working relationship for nearly two decades. Our organizations have a lot in common: a commitment to public protection, to quality health care, to safe practitioners, to accountable, transparent regulation – in short, to good government.

CAC is dedicated to the proposition that the regulatory process is best when it includes informed, accountable public participation. Having public members on licensing boards is an essential – but it is only one way to keep the public involved and informed, and thereby help see that boards stay on their toes and do the best possible job. I'll have some things to say later about public-board interaction, and about involving the public in the disciplinary realm where you concentrate your attention.

At CAC, we've been great admirers of the National Council for original and progressive thinking in a number of spheres, including numerous initiatives aimed at trying to learn from experience and get a handle on measuring the impact and outcomes of nursing board activity.

Kathy Apple was the keynote speaker at CAC's annual meeting last year, where she talked about the National Council's Regulatory Performance Measurement Project – a real pioneering effort, from what I have seen. She told us about some of the findings related to best practices in the disciplinary realm. The main message is, as you know, that those boards that do best in performing their disciplinary function are the ones that hire their own investigators and attorneys and provide them with training and mentoring. These boards *delegate authority and responsibility* to staff members – *like you*. They expect staff to seek board input, but they authorize staff members to resolve certain types of cases without full board or legal counsel

review; they trust staff to know how to write good consent agreements; they count on staff to communicate well with stakeholders; they want staff to work with them to apply disciplinary sanctions consistently, fairly, and appropriately.

The message is that you are important – staff performance is a critical – if not the critical – ingredient in effective regulation. So, speaking as someone who benefits when boards regulate effectively, I'm glad to see all of you here to take advantage of this workshop offered by NCSBN.

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I've been asked to talk about “**What Good Comes from What You Do?**” My answer to that is very simple – *When you do your jobs well*, you protect the public from inferior quality health care. You identify substandard performers and either remove them from practice or require that they upgrade their knowledge, skills and performance – hopefully you do this before they have caused patient harm, but absolutely if patient harm has already occurred.

Perhaps there are additional questions to pose in order to examine the good works done by nursing boards and, in particular, board investigators and attorneys.

Why not ask:

- **How Do Your Boards *Know* Whether They Are Doing as Much Good as They Can?**
- **How Does the Public Know What Good Comes from What Boards Do?**
- **How Might Boards Do Even *More* Good?**

At CAC, we try to keep tabs on what is going on in variety of types of licensing boards, and we come across a lot of good ideas we wish all boards would adopt to make their work more effective, and their performance more accountable. I'll be referring to some of these good ideas in relation to the questions I just posed.

**First, How Do Boards *Know* Whether They Are Doing Good?**

\* One way to know is to collect the right data. What happens to the people you discipline? Do they improve their practice? Do they leave the profession? Do they re-offend. This is another area where the National Council is a leader in following up on disciplined practitioners through initiatives such as the TERCAP study of practice breakdown.

\* Another way to know how much good you are doing is to look at the nature of your case load. A favorite speaker at your meetings and ours is Barbara Safriet who famously tells audiences that a regulatory board's work is difficult and frustrating because most of its time is spent on sex, lies and drugs. How much of your board's case load involves sex, lies, and drugs and how much of it

involves the important questions of practitioner competence and quality of care? You are on the front lines. You know what allegations are being investigated and prosecuted. You help collect the evidence on which to base a recommendation to your board's policy-makers that the highest priority be given to investigating and taking action in cases involving patient safety and quality of care. I'll say more later about setting investigative and disciplinary priorities.

\* When an investigation doesn't yield enough evidence to prosecute a licensee for a violation of the practice act, what happens to the information that has been uncovered? Is it discarded, or is it kept in the nurse's file in case there are subsequent offenses – or near offenses – in the future that may demonstrate a troublesome pattern of practice. I worry a lot when I hear boards say that the large proportion of complaints that they dismiss without any action become lost in the shadows – protected from public scrutiny because no case was ever brought – and lost from institutional memory because they are not properly documented in the licensee's file. Perhaps boards of nursing are more careful with this data so it can be referenced when practitioners are the subject of a second, third, or multiple complaints. But, even if it never leads to formal cases, dismissed complaint data could yield important information about patient awareness, patient and employer expectations, deficiencies in the preparation of new nurses, and other aspects of practice that boards should want to know about.

\* Data collection and record-keeping can help boards be fair and consistent in their disciplinary actions – something that should interest both attorneys and investigators. The Virginia Board of Health Professions - which is an umbrella agency in that state - has developed an empirically-based structured sanctioning system for its boards. "Sanctioning reference points," as the system is called, are presently used by the boards of medicine and dentistry in that state and will eventually be used by other health care boards. Boards in a few other states have developed sanction guidelines, but I believe Virginia is the only one that has undertaken in-depth, board-specific historical analyses of sanctions as a basis for its reference points.

As explained by its creators, Elizabeth Carter, Executive Director of the Virginia Board of Health Professions and Neal Kauder, President of VisualResearch, Inc., the purposes of establishing sanctioning reference points are to:

- make sanctioning decisions more predictable
- provide an education tool for new board members
- add an empirical element to a process or system that is inherently subjective
- provide a resource for the board and others involved in disciplinary proceedings
- "neutralize" sanctioning inconsistencies
- validate board member or staff recall of past cases
- constrain the influence of undesirable factors, such as board member conflicts, overall board makeup, race or ethnic origin, etc., and
- help predict future caseloads and need for probation services and terms.

Virginia's sanctioning reference points are determined by an analysis of past cases. According to

the Board of Health Professions,

The fundamental question when developing a sanctioning reference system is deciding whether the supporting analysis should be grounded in historical data (*a descriptive approach*), or whether it should be developed normatively (*a prescriptive approach*). A normative approach reflects what policymakers feel sanction recommendations *should be*, as opposed to what they *have been*. Sanctioning reference points can also be developed using historical data analysis with normative adjustments to follow. This approach – which was chosen by both the Virginia Board of Medicine and Board of Dentistry – combines information from past practice with policy adjustments in order to achieve some desired outcome.

The historical analysis is used to create sanction worksheets that take into consideration the nature of the offense and relevant respondent attributes. The board of medicine decided to remove certain non-legal variables from the worksheets to minimize the impact of non-germane factors, such as years of practice, the presence of an attorney, respondent gender, and case processing time. These factors account for some of the historical variability of sanctions, but should not continue to do so, in the board's view.

That each board has its own “sanctioning culture” is a truism confirmed by the sanctioning patterns of Virginia's four largest professional boards: medicine, nursing, pharmacy and dentistry. Historically, the Virginia Board of Nursing has used suspension far more often than other sanctions, followed by reprimand or censure and probation. Revocation has been next in frequency, followed by surrender, mandatory suspension, and “other.” If there is someone here from Virginia, perhaps they can tell us whether and when the Virginia Board of Nursing will begin to use sanctioning reference points based on a historical analysis of its prior decisions.

### **Moving to another question, How Does the *Public* Know What Good Comes from What You Do?**

\* You may not think of public outreach as part of your job assignment, but at CAC we place great store in boards having a customer-friendly process. At its most rudimentary level, customer-friendly includes making the public aware of the existence of the board; what it does; how to register a complaint; and what kinds of behavior violates the practice act. Consumer initiated as opposed to co-worker initiated complaints may be atypical for boards of nursing, but I would expect them to become more commonplace as advanced practice nursing expands in volume and scope and as consumers become more attuned to taking into account performance data and outcome measures for hospitals, long term care facilities, and other health care institutions. Consumer complaints are likely to increase also with enhanced public awareness about boards and the kinds of situations they are created to handle.

Nursing organizations – and some boards – feel strongly that nurses should wear badges or in some other way make patients aware of their job titles so patients would know what to expect

from one kind of nurse versus another. Personally, I think the consumer education job needs to begin at a much more elementary level. People need to have at least a rudimentary understanding of licensing, scope of practice, and other concepts before job titles will have any useful meaning to the average consumer.

\* Customer-friendly also means keeping complainants informed – in a timely manner – of the progress – if not the specific details – of the investigation into their complaint, and keeping them informed of the board’s decisions related to the complaint. At CAC, we think customer-friendly should also mean referring complaints that fall outside the board’s jurisdiction to another authority that may be able to handle the matter. If it really is true that the majority of complaints consumers lodge with licensing boards result in no action, that makes for a lot of frustrated and disappointed constituents unless some effort is made to help them find a resolution. I am aware of a couple of medical boards that have experimented with having an ombudsman position on staff to work in this way with complainants. In the absence of a staff ombudsman, I would think these responsibilities could mesh nicely with the jobs investigators and attorneys perform.

\* What about public disclosure of information about disciplinary actions? Barbara Safriet told CAC’s annual meeting last November she thinks boards should more actively exercise their public information function – that is, “gathering, summarizing and disseminating information to the people who will be affected by it – the public, complainants, the profession.”

CAC is in the process of analyzing the returns of a survey of boards of nursing and medicine to learn when during the course of a disciplinary case information is made public – at the time of the complaint, at the time the board finds probable cause to prosecute, or only after the board has made a final decision. This is an update of a similar survey we conducted in 1993. What we are finding is that the information disclosure policies of boards of nursing have not changed dramatically since 1993, but far more boards of medicine are now releasing information earlier in the disciplinary process than they did thirteen years ago. We believe this is a positive trend – that more deference should be given to the consumer’s right to know in this situation than to a practitioner’s right to confidentiality. If you can influence your board’s policy, we urge you to recommend earlier and more comprehensive disclosure.

A disturbing step in the wrong direction was taken in Iowa early this year when a judge ordered the Iowa Board of Medical Examiners to stop disclosing the details of allegations against physicians. Under the court’s order, the board may disclose the title of the action being taken against a respondent, such as “unethical” or “unprofessional conduct,” but can’t reveal the specifics until the case is resolved – however many months that may take. The medical board has appealed to the Iowa Supreme Court and plans also to seek legislation undoing this judge’s ruling.

\* Where is disciplinary information made available? The most common place is a board newsletter. Some boards (the Ohio BON and the TX BOM come to mind) disseminate information on an email list-serve.

Of the health care professions, medical boards were the first to begin posting disciplinary information on their Web pages – sometimes in the form of reports or minutes from board meetings, and increasingly in each licensee’s individual profile. Also, the Administrators in Medicine – the association of medical board executive directors – sponsors a national data base called “Doc Finder” which includes disciplinary and malpractice data from boards.

In a random check of ten nursing board Web sites, I found only two that provide detailed information about disciplinary actions. One of these reports the name and license number of the respondent nurse, the action taken by the board, and a brief, plain English explanation of the basis for the action – that is, the nurse’s offense. On the second Web site, you can click on the name of a nurse against whom an action has been taken and you are sent to the board order or consent agreement with all the findings of fact and other specifics.

Of the other eight Web sites I checked, three list the names and license numbers of disciplined nurses and state the action taken, e.g., suspension, probation, fine, revocation, etc., but give no information about the offense that led to the action. The other five Web sites do not appear to have any disciplinary information available, although some do allow visitors to verify licensure status if you know the name and / or license number of the nurse in question. (One of the nursing boards I checked has no Web site of its own. A link to the board on the state health department’s Web site leads to a board meeting agenda from February 2004!)

So, you see, some board Web sites are more informative and user-friendly than others. I happen to think that a list of disciplinary actions, with specifics about offenses as well as the actions the board chose to take, is important information not only for consumers, but also for employers, health plans and others who need to know when and why a nurse has been disciplined. I was also struck that fewer than half of the Web sites I looked at had information about how to complain, a complaint form, and some explanation of the complaint process.

Good Web-based information has become so important that Sid Wolfe’s Health Research Group now “grades” medical board Web sites. CAC has been asked on occasion to review board Web sites for content and consumer-friendliness and will be happy to offer that service to any interested board of nursing.

It is not only patients and employers but also licensees who benefit from being able to access information about discipline cases. CAC has reported several times in our newsletter, *Citizen Advocacy News & Views* about boards of pharmacy (and others) that use their newsletters or Web sites to inform licensees of patterns of errors or causes for board discipline precisely to alert licensees of common problems to be avoided – primarily to protect patient safety but also to keep from running afoul of the practice act..

A recent article in the Missouri State Board of Nursing’s newsletter noted that including the findings of fact in newsletter reports of disciplinary actions “is an excellent teaching tool for student nurses as well as nurses who are currently licensed. The information contained in the

Newsletter may give rise to nurses taking immediate corrective action in a behavior ... and thereby protecting patients....”.

\* Is your board making the most of having a public member? A conscientious public member can be a two-way information conduit for the board. He or she can help spread awareness about the board and can inform the board about public concerns and expectations. I have direct experience with this. A number of years ago, I was appointed the public member of the District of Columbia Board of Funeral Directors and Embalmers. I was interested in the appointment because I was affiliated with a national association of consumer cooperatives that negotiate contracts with agreeable funeral homes to provide simple, inexpensive, dignified funerals consistent with the specified wishes of coop members. So, I knew something about the funeral industry, I had a strong pro-consumer bias, and a connection with a consumer constituency group. As the public member of the board, I volunteered to make presentations to community groups about the role of the board and consumer rights and protections connected to the purchase of a funeral. I testified at DC City council hearings when the funeral licensure regulation was up for revision. I pressed the board to take a more consumer friendly posture in lots of its activities, including investigating and adjudicating complaints. The board’s investigators and attorneys considered me to be their ally.

How else might boards exploit, in the best sense, their public member(s)? I believe there should always be a public member on the panel that decides whether there is probable cause to proceed with an investigation or prosecution. Some states mandate this in the practice act. In other states, it can be accomplished through board policy. The reason for having public members on probable cause panels is to make sure their perspective is represented in this important decision. The significance of this is illustrated by the scandal recently uncovered by the Seattle Times involving sexual abuse cases treated with shocking indifference by several types of health professional licensing boards in Washington State. I cannot imagine that a public member worth his or her salt would tolerate such a cavalier attitude toward sex abuse cases.

Another area that needs a healthy dose of input from public members is setting priorities for complaint processing because, here too, public members may have a different view of which cases are most significant from a public protection point of view. I’ll bet thoughtful public members would insist that quality of care cases that threaten to expose patients to imminent harm go to the top of the pile. We did some research several years ago into board priority setting and were surprised and disturbed to find that at that time most boards didn’t have a formal prioritization policy or process, and among those that did, competence and quality of care cases were not always assigned the highest priority.

### **Now, on to How Might You Do *Even More Good*?**

\* Let’s start with enforcement of board actions. How do your boards ensure that the responsible parties comply with board-imposed revocations, suspensions or probationary agreements? I’m alarmed when I read reports about nurses, doctors and other professionals who continue to

practice even after their licenses have been suspended or revoked. Or, about health plans and PPOs that continue to list practitioners whose licenses are no longer valid. Or, practitioners who don't abide by board-imposed restrictions on their licenses. Boards invest precious resources prosecuting cases. These resources are essentially wasted if practitioners, their hospitals or their health plans don't enforce whatever restrictions have been imposed.

I think it is worth examining and perhaps copying a couple examples from medicine where boards have given priority attention to enforcement. After some bruising publicity connected with a surgeon who became known as "Dr. Death," the Oregon Board of Medical Examiners created a staff position called "compliance officer" to ensure the public that the board's disciplinary orders are being enforced. This individual meets regularly with licensees who are under restriction – and with their staff and peers – to check compliance with board orders. The compliance officer helps licensees in the peer assistance program with lab work and required psychiatric reports. He does random chart reviews to see if charts are up to date, or, in cases of sexual boundary violations, to be sure that the presence of a chaperone is noted in patient charts. I think boards in all professions should consider hiring at least one compliance officer.

In California, the legislature created the position of Enforcement Program Monitor for the medical board and filled it with Julie D'Angelo Fellmeth, an attorney with the Center for Public Interest Law (CPIL) at the University of San Diego School of Law who has for years helped run a program where law students monitor and write law review articles about all manner of licensing boards in the state. Julie was the perfect choice to fulfill the Enforcement Monitor's mandate, which was to evaluate "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system." Julie and LA District Attorney's Office consumer affairs attorney, Thomas Papageorge, monitored the medical board for two years and presented a final report to the legislature in November 2005 recommending a number of improvements in administration, staffing, budget, and board structure, some of which the board can implement on its own, and some requiring new legislation. I know from authoritative sources that the Medical Board of California has been grateful for the Enforcement Monitor program and appreciates and respects the Monitor's recommendations . (The Enforcement Monitor report can be found on the CPIL Web site: [www.cpil.org](http://www.cpil.org).)

It may be unrealistic to think than many boards of nursing will create a similar enforcement program monitor, but would it be too much to expect boards to regularly self-evaluate – with help from tools developed by the National Council – or to *request* – rather than resist – an independent evaluation by a state auditing agency?

Before leaving this subject and on a personal note, I'm proud to tell you that CAC honored Julie Fellmeth with the second annual Ben Shimberg Public Service Award last November at our annual meeting. Since then, to our great pleasure, Julie has joined the CAC board of directors.

\* One of the recommendations in the California Enforcement Monitor's Report is right on target

for this workshop because it addresses the operational relationship between investigators and attorneys. Not surprisingly, the Enforcement Monitor found that medical board field investigations are “plagued by delays and excessive case cycle times,” in part due to the length of time it takes to get complete medical records, receive responses from respondents and experts, and schedule subject interviews, and so on.

Here’s the part that is relevant to you. The report proposes that a significant reduction in case cycle times could be accomplished if the board were to switch from a “hand-off prosecution” process to a “vertical prosecution” model. As described in the report, the currently used “hand-off” system involves:

(1) an investigator with limited legal guidance and support investigating a case, preparing the file, and “handing off” or transmitting the case to (2) an attorney in the Health Quality Enforcement Section of the Attorney General’s Office who has had no role in the shaping or preparation of the case and must function with little or no investigative support in the pre-hearing and hearing process. This “hand-off” system is woefully inadequate for complex white collar crime-type cases of the sort usually handled by MBC – where the subject is highly technical, the facts and legal issues are complicated, and the process requires a lengthy commitment of time and enthusiasm to achieve a sound result.

In contrast, the vertical prosecution model used by several federal agencies and state and local agencies in California, involves investigators and prosecutors working together as a team from the time a case is sent for investigation. Working as a team from the start, the investigator and prosecutor can gather the evidence in the investigative stage needed to effectively present a case in the prosecutorial stage:

The essential elements of any such model are early coordination of the efforts of attorneys, investigators, and other staff; continuity of teamwork throughout the life of a case; mutual respect for the importance of the professional contributions of both attorneys and investigators; and early designation of trial counsel....

Applied to MBC, the benefits of vertical prosecution would be numerous and substantial: (1) improved efficiency and effectiveness arising from better communication and coordination of efforts; (2) reduced case cycle times; (3) improved commitment to cases; (4) improved morale, recruitment, and retention of experienced prosecutors and investigators; (5) improved training for investigators and prosecutors; and (6) the potential for improved perception of the fairness of the process.

Your situation at boards of nursing may not be exactly analogous. The nature of your cases is different; the respondents are less likely to have high powered legal representation, and so on. Nevertheless, it strikes me that the vertical prosecution model has unquestionable merit.

\* How is your work affected by your board’s philosophy? Is your board proactive as well as

reactive? Do you value remediation as well as punishment? Later in the program, you will hear from Julie George, AnneMarie Sonntag, and Lisa Emrich about how their three states remediate outside of discipline. In other words, their boards are able to take meaningful corrective action even when the practice act has not been violated. Julie George will talk about the Practitioner Remediation and Enhancement Partnership program in North Carolina. PreP 4 Patient Safety, as we call it, was a brainchild of CAC's and I can't say enough good things about how well the North Carolina nursing board has put the program into operation in that state.

One motivation for developing the PreP program was to put some perspective into the system safety movement that gained currency in the aftermath of the Institute of Medicine's Errors Report. At CAC, we felt that you could over-emphasize *system* safety and forget that individual practitioner competence and performance are very often a contributor to errors. But the primary motivation behind PreP was to get at the problem of non-compliance with mandatory reporting statutes – both state and federal. We perceived a cultural aversion on the part of hospitals and other institutions to reporting adverse actions to licensing boards. We reasoned that creating a more trusting relationship between health care institutions and licensing boards would make the institutions more likely to cooperate with boards in identifying problem practitioners before there has been any patient harm, and then in reporting to regulators adverse actions they impose in cases where patient harm has occurred.

\* Does your statute have mandatory reporting requirements? Do you enforce them? When investigating a quality of care case, for example, do you consider which hospital authorities, nursing supervisors or co-workers did or didn't report the incident to the board? Do you take any action – even a warning – against institutions and / or nurses who failed to report when they should have? There's a session on the Cullin case later in the meeting where I expect there will be some serious second guessing about failure to report.

Looking at reporting from another angle, has your board gone to the legislature to request whistle-blower protection for nurses who report quality of care issues involving other professionals? A "Health Care Worker's Protection Act" was introduced earlier this year in the Colorado legislature for just this purpose. The legislation was inspired by the situation of a nurse who had made numerous complaints during her career about medication errors, substandard practices, and inappropriate behavior on the part of co-workers and was ultimately fired for lodging one of these quality of care complaints in 2000. The nurse sued the hospital for wrongful termination. The hospital argued that there was no applicable public policy – neither a requirement that professionals report quality of care problems, nor a protection from retaliation for those who do. The Health Care Worker's Protection Act is intended to fill in those gaps in public policy. (The other side of this coin is protection against retaliation for nurses who decline to accept work assignments that are beyond their scope of expertise.)

\* Turning to another subject, it is generally accepted that in many states a majority of licensing cases are resolved through negotiated agreements or consent orders rather than full-blown hearings. As Barbara Safriet points out, consent agreements are efficient and effective – but only

if there are clear procedures for identifying and segregating out those kinds of offenses best dealt with by consent order. CAC wrote a publication some years ago recommending the use of alternative dispute resolution to take care of lesser offenses and reduce case backlogs. We were emphatic that alternative dispute resolution should not be employed in serious quality of care cases involving practitioner competence or malfeasance. ADR is appropriate only for lesser violations.

I think the same general rule should apply to consent agreements, although I recognize that there are some situations in which it is possible to negotiate a stronger penalty than the law would allow if the case were adjudicated. For example, a board might be able to persuade a respondent to negotiate a permanent surrender of his or her license when, if the case were won at a hearing, the respondent could reapply after a period of time, or go to another jurisdiction to practice. So, the important question becomes who gets to decide when a negotiated settlement is appropriate? Board counsel should definitely be involved. And public members also should be involved in this decision, and in negotiating the contents of a settlement. If the board leaves the decision to staff discretion, the board should definitely establish criteria and procedures for how the staff should reach a determination and for when the full board needs to be consulted.

Crafting a consent order is important. Kevin Heupel who staffs several licensing boards in Colorado told CAC's annual meeting last November that creativity is important in writing consent orders, in part because a negotiated settlement allows the board to go beyond the sanctions permitted in the statute. Clarity, he said, is as important as creativity so that the staff person responsible for monitoring the order understands what is expected. He offered examples of creative consent orders, including one in which a board decided to forego revocation and opted instead for a five-year suspension with remediation because then the burden was on the licensee to show that he or she is fit to return to practice. He pointed out that agreeing on an admission of fault can be tricky. The respondent may resist, but boards generally want an admission to at least some of the alleged offenses, both to resolve the case and to establish a formal record in the event the licensee moves to another jurisdiction.

\* Does your board have a process that allows consumer complainants and / or other members of the public to participate in the settlement or consent order process? In 1993, CAC published a white paper arguing that the public should have a right to comment on proposed consent orders. This publication was not well received by board attorneys, but perhaps the climate has changed by now. Personally, I think that at a minimum, complainants should be given an opportunity to review and approve the terms of settlement agreements, even if they are not at the table during negotiations.

Are your board's consent agreements made public? I would argue they should be. Remember the Web site that gives the public access to the text of board orders? Many of those final board decisions were consent agreements. Until a board is empowered to release the terms of individual consent agreements, I see no reason not to release aggregate data showing the percentage of cases resolved this way, the kinds of offenses involved, and the kinds of remedies imposed.

\* Let me close by saying a few words about caseload and backlogs – two measures of board performance that are most likely to register with the public, whether or not they are the most revealing indicators of the “good that comes from what you do.” My recommendation is that boards not be afraid to compare their per-investigator case loads or backlogs with those of other states – particularly other states that enjoy more resources. The comparison can be useful to build a rationale for increased appropriations or higher licensure fees to support more staff. Or, to seek additional authorities – proactive authorities, for example – from the legislature.

Also, I encourage you to work with your board members to find ways you might collaborate with other organizations to root out problems, investigate cases, and monitor compliance. I’m thinking of organizations such as sister boards in your states, the Medicare Quality Improvement Organizations, long term care survey agencies, specialty certification bodies, and others who oversee quality of care and investigate and intervene when patient safety is at stake.

Thank you again for the invitation to speak, and I wish you a very productive workshop.

