News & Views

Citizen Advocacy Center

Fourth Quarter, 2006 A Health Care Public Policy Forum Volume 18 Number 4

MARK YOUR CALENDARS

October 29-31, 2007 – Seattle, Washington

CITIZEN ADVOCACY CENTER 2007 ANNUAL MEETING

CAC's 2007 Annual Meeting will be co-sponsored by the Washington State Department of Health. It will be held October 29-31, 2007, at the Edgewater Hotel in Seattle, Washington. CAC meetings are open, and all interested parties are welcome. Look for an agenda and registration materials in the late spring.

REPORT FROM THE 2006 CAC ANNUAL MEETING: ACCOUNTABILITY THROUGH TRANSPARENCY

Editorial Note: The theme of CAC's 2006 Annual Meeting was "Accountability through Transparency." Co-hosted by the Virginia Department of Health Professions, the meeting took place in Williamsburg, Virginia. The Proceedings of a special pre-meeting training for public members are available from CAC headquarters.

John Rother, Policy and Strategy Director for AARP, was awarded the Ben Shimberg Public Service Award. His Shimberg Memorial Lecture will appear in the First Quarter 2007 issue of CAC News & Views.

The following summary of the main meeting plenary sessions is not a verbatim transcript, but is faithful to the speakers' presentations and the question and answer periods that followed.

INSIDE THIS ISSUE

KEYNOTE ADDRESS

Robert Holsworth, Ph.D., Dean, College of Humanities and Sciences, Virginia Commonwealth University

I usually talk about elections and campaigns, but speaking to this group gives me the opportunity to reflect more broadly on the kind of world we live in, the issues we face, and how they relate to the topics you will be discussing at your meeting. In particular, I'd like to talk about the demand for greater citizen empowerment and greater accountability as well as the revolution in communications.

The trend toward greater citizen empowerment transcends partisan and ideological debates that have become common in public life. In general, there is a broader embrace of the idea that the public – ordinary citizens – ought to have greater power and control over decisions that are important to their own lives. You hear this from both Democratic and Republican politicians, on talk shows, in letters-to-the-editor, and elsewhere.

The second theme is that officials, leaders, professionals, and others in the public realm ought to be accountable for their actions and activities. In Virginia, for example, every public school in the state sends to the people in their district a report card on how well the students are doing in that school. Overall, there is a greater demand for accountability at all levels of the public sector and in the practice of the professions.

The third theme is the explosion in the means of communication and the amount of information available to those who want it. The information age has dramatically changed the kind of information that is available, the ease of obtaining that information, and the rapidity with which it can be transmitted.

In my arena, politics, the communication explosion has led to an extraordinary paradox. On the one hand, those who are eager to have it can get more information about politics more quickly than ever before. But, oddly enough, because of that explosion of information, we have a whole set of people who know nothing about politics because they are no longer compelled to know by a common culture.

When I was growing up, you learned something about politics because there were only three TV networks and they all covered political conventions and other aspects of politics. Most people used to read newspapers, but that is now an age-related behavior. This means is that if you don't want to access information, you don't have to. You can choose to watch the golf channel or the home cooking channel, or some other. Today, seven percent of the public gets its information

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primarily from comedians. There is an unbelievable plethora of information for those who really want it and simultaneously less common culture about information and the context of information than we have ever had before.

So, we have empowerment, accountability, and a communications explosion. These trends seem to me to be by and large positive and by and large trends that are not going away. Still, these trends pose certain challenges.

First, with the tremendous explosion of information, we have a blurring of the standards that distinguish between what is good, reliable information and what is unreliable or false information. News vs. comedy -- what is the news and what is not the news?

There is a huge effort to get rumors reported as news. Bloggers put out rumors they hope will be picked up by the mainstream media. Even if they are not picked up in the mainstream media, those of us that watch politics will begin to think some of them are true. It may soon be that people in your states will start blogging about the people you regulate. The point is that we have democratized who can disseminate information that anyone can access and this creates the constant challenge of trying to understand which information is accurate and reliable and which isn't.

I think this has affected the mainstream media. We used to have the sense that the mainstream media was objective and could cordon off fact from opinion. But, more and more of the mainstream media are now being driven by what their opinion-position is, rather than the fact-position. Some of this has been brilliant in terms of marketing. ***Fox News***, for example, realized that there was a tremendous thirst in a portion of the public for a talk-radio-style television news show. They created the wonderful phrase: "We present, you decide," but they tilt the balance. My favorite show on ***Fox News*** is ***Hannity and Colmes*** where, as in professional wrestling, Colmes loses every night. In response, ***The New York Times*** tilted somewhat to the left, realizing that its market is college professors and liberal professionals. This blurring of information standards has implications for what kind of information ought to be available about the professions and disciplines you regulate.

We also have to realize that not everybody who is providing information is doing so with impartial motives. In many instances, people use information tools to support a particular objective. Regulators have to deal with this when you see accusations being made. Are they reasonable, not reasonable? What do we do with the information? A final important issue is the fact that a lot of information provided today is designed to set up or entrap an opponent or opposing point of view.

The information paradox raises additional issues for regulators. How do you balance the public's desire for empowerment and accountability, with fairness to the individuals who are regulated?

Next, what does the information age do to the broad incentive structure affecting particular practices and professions? For example, there is a common feeling today that no rational person would get into politics any more because of some of the features of modern communications. It used to be that someone entered the political arena after a career of accomplishment. Politics was considered to be a public service. This process excluded people; it did not, for example, surface many women or minorities. We now have an extraordinarily partisan system with a different set of incentives. People used to compromise. Politics was considered the art of the

possible – finding ways to align competing interests. While we used to have the deal-makers, now, we have the screamers. Overall, the level of scrutiny reaches back to high school. What is the incentive to get involved? Who is likely to stay involved? And, who is getting out?

As you think about regulating professions, you have to ask, "What are the incentives?" What kinds of people are encouraged to enter professions? What kinds of people are being discouraged? You want to encourage people who want to be accountable. You want to encourage people who are going to make good choices rather than bad choices. How do your rules establish a good rather than bad incentive structure?

Beyond that, what are the incentives for different kinds of practice? How do rules provide different kinds of incentives? Have we raised the costs of practicing medicine? Are the incentives to do more tests, whether or not they are needed?

One of the problems in the political arena is that we are losing too many good people. There are other reasons besides communications. It is so expensive to run a political campaign, politicians spend all their time raising money rather than doing things they want to do for the public. So, we have created a bad incentive structure for people wanting to get in. I believe we need to make sure we don't spread that problem to other fields of American life.

It is important to be sure the information you are providing is disseminated in the appropriate context. How do you deal with accusations? Should they be public? What do you do if you see a pattern of accusations and the perpetrator is able to use various technicalities to preclude complete conviction? How do you disclose this kind of information in a responsible way? You have to find some way of distinguishing between an unfounded accusation and what seems to be a pattern of behavior. What if something really terrible happens and the public learns that the board was already aware of a pattern of problems. The choices involve balancing the right of the individual while supplying information in an appropriate context. I don't have the answers, but I do know that these are the kinds of challenges you face.

Finally, the public good drives your decision-making. But, this is a complicated concept. On the one hand, the public needs to have information, while on the other hand, the public needs to have good people practicing the professions in an accountable way. At the same time, you want to avoid providing negative incentives that cause the professions to lose good people. We find that even in a state as large and prosperous as Virginia, there are areas of the state that have trouble getting OB/GYNs because the incentive structure is not there for them to practice.

We live in a remarkable society with unparalleled means of communication. Ordinary citizens want to be empowered, to have information that was unavailable before. People going to a health care professional want to know what the outcome is likely to be. People want accountability right down to the individual level. At the same time, we have to ensure that as we provide consumers with information, we do so in a way that's most responsible and provides incentives for the best people to enter these professions and uphold appropriate standards of accountability.

ACCOUNTABILITY THOUGH TRANSPARENCY IN DISCIPLINARY PROGRAMS

Part One: The Pros and Cons of Transparency in Disciplinary Programs

Panelists:

Margaret Edds, Editorial writer and former state government and politics reporter for the ***Virginian-Pilot*** newspaper.

Chip Woodrum, Former member Virginia House of Delegates and former Chair, Commission on Freedom of Information Act.

Arthur Levin, Director, Center for Medical Consumers and CAC Board of Directors.

Stephen Rosenthal, Esq., Member of the Health Care and Legislative and Administrative Practice Groups, Troutman Sanders law firm, and formerly Virginia Attorney General.

Margaret Edds: I commend you for making your communities safer by insisting that standards of care be adopted and enforced. You protect the public by encouraging professionals to perform with competence and integrity.

We have been asked to give our opinions about where the line should be drawn between transparency in what you are doing and the protection of professional privacy.

As a journalist, it is tempting for me to say that everything should be open and let the chips fall where they may. Virginia's Freedom of Information Act says that the bias in all such matters should tilt toward increased awareness by all persons of governmental activities, and should afford every opportunity for citizens to witness the operations of government. Any exception or exemption should be narrowly construed in order that no thing that should be public may be hidden from any person.

I believe this is a valid and important principle that speaks to a clear understanding that government is a creation of and owes allegiance to the citizens it serves. Certainly, you have an obligation to the professions you oversee and to which some of you belong. But, when you join health licensing and regulatory boards, your primary obligation is to the citizens and consumers of the services being offered and whose representatives you are on the boards. Citizen protection, not the security or convenience of professional peers, must be your primary concern.

At the same time, the privacy rights of individuals whose reputations and livelihoods could be harmed by scurrilous or false charges are a legitimate concern and deserve protection – up to a point. In Virginia, once probable cause of a violation is established by an investigation, then notice of a hearing, the hearing itself, and the order that comes afterwards (including findings of fact and conclusions of law) are all open to the public. I think that they ought to be. While I know that some would prefer that nothing be public until and unless disciplinary action occurs, that much secrecy can leave the public unprotected. It can take years – sometimes too many years – to move from complaint to action. And, once that relatively high threshold has been reached, protection of the public from a possibly incompetent or unethical professional

outweighs protection of the professional from public scrutiny.

I don't quarrel with complaints being kept private until there is some verification of legitimacy, but I do quarrel when investigative teams are stretched so thin, or regulations are made so cumbersome that legitimate complaints are lost for months or years in the bureaucracy. When that occurs, I think confidentiality amounts to a cover-up, potentially protecting incompetents and leaving unsuspecting citizens vulnerable to harm. For every ounce of secrecy that is tolerated in behalf of professionals licensed by the state, I think there ought to be a corresponding heightened obligation to act very expeditiously in handling complaints. Practitioners deserve protection from false charges, but they don't deserve to be shielded for years while an understaffed board investigates.

My direct familiarity with health regulatory boards and their challenges comes through a series of stories written by one of our reporters a few years ago about the Virginia Board of Medicine. Liz Szabo, who is now with ***USA Today***, chronicled several very disturbing instances in which physicians were allowed to continue practicing after serious complaints had been filed. Her freedom of information requests were rejected, so she had to sift through bankruptcy filings, lawsuits, property records, death certificates and patient medical records to expose flaws in a medical system that, as she wrote, was then "shrouded in secrecy and reluctant to root out its worst offenders."

In one of the stunning cases, Dr. Robert Brewer, nine years after he had paid a malpractice settlement of about $250,000 involving a botched surgery, five years after a hospital in Virginia Beach identified 38 patients to whom he had provided questionable care, and two years after he failed to tell a patient that he had mistakenly snipped out part of the man's large intestine, the Board of Medicine got around to yanking his license. Before that happened, a couple of patients had died under questionable circumstances.

A few years before Szabo's report, the legislative watchdog agency in Virginia had issued a report pointing out serious problems with delays at the Board of Medicine, not all of which were their fault. Some had to do with understaffing and cutbacks in state government. But, the General Assembly initially ignored that report, underscoring the influence of the medical profession in the legislature. Public outrage over Szabo's stories resulted in long overdue reforms. The standard for board action had now changed from gross negligence to simple negligence. A process was set up for hospitals to alert the board when they identified problem physicians through their internal disciplinary processes. The investigative staff at the Virginia Department of Health Professions was beefed up, and so on.

All those were excellent steps, but they did not really change the standards on transparency. With the exception of steady improvements in the Department's Web site and in an online data base involving physicians, the degree of openness remains essentially the same.

So, as long as the tension exists between the need of the citizenry for transparency and the privacy rights of practitioners, internal vigilance remains essential. It is the only way to make sure the public is safeguarded against abuse. That's why your role is so important. Here are steps I recommend:

- Health regulatory boards need internal watchdogs of their own. Government itself needs to have auditors, inspectors general, and oversight agencies that periodically monitor the work of oversight boards. They need to ask questions, such as: How much time is elapsing between the filing of complaints and the resolution? Are disciplinary actions concentrated primarily on ethics and substance abuse, or do they delve into patient care? Are appropriate punishments being administered and are they enforced for a sufficient period of time? Monitoring is not an infringement; it is a reasonable and necessary safeguard-- an essential one, in fact -- in an arena where so much secrecy exists. The press and the media also act as watchdogs. But, as newspapers become more and more concerned about declining readership and the bottom line, the resources necessary for the sort of reporting done by Liz Szabo are drying up.

- I think it is essential that as much data and basic information as possible about the internal workings of health regulatory boards be posted online. Those boards that are performing well have nothing to fear. Citizens deserve to know how government is working. Their eyes and ears can be a valuable resource in an age when government and media resources are tight.

- Third, health regulatory boards need to work on developing performance measures that can be used across the state to aid in evaluating licensing and disciplinary proceedings. Raw numbers have their limits in the age of quality, but they do tell you something. How long should certain types of cases be open? What are the ranges of disciplinary actions you can expect for a particular violation? How many citizens are visiting the Web site and are they satisfied with the information they find there?

- Finally, I urge all citizen board members to welcome as much transparency as can be tolerated. Disciplinary proceedings should be open, and earlier during the investigative process. As many internal measures as possible should be established to assure the public that the department is doing its job. In the long run, such openness will pay dividends because of greater citizen confidence in the professions that you help regulate.

Chip Woodrum: I agree with Margaret on the overwhelming need for transparency in the operation of government. The Declaration of Independence says government is by the consent of the governed. This is the authority and philosophical basis for government action. Consent implies knowledge of what is occurring and how it occurs.

During my years in the General Assembly, I found that most professions did not have regulation imposed upon them as much as they sought it. There are outstanding reasons it is in the public interest to regulate professions. Members of the profession seek regulation to protect standards, but there is a limitation of access aspect to regulation. Professions trade some of their independence for the public oversight and scrutiny they get through regulation. It follows that you cannot have effective regulation without effective public knowledge of what transpires.

Public members and professional members are selected to serve the Commonwealth.

This is participatory democracy at work. Your job is not only to set the standards and ensure that professional standards are observed, but also to protect the public. Professional members are there to be a guide to what the standards ought to be. They are also there to protect the *profession* – in the abstract – not to protect the *professional.*

Virginia's Department of Health Professions has a complex process for enforcing standards. It begins with intake and investigation. A report is submitted to the board. Before the board takes action, there is a procedure known as a "confidential consent" for minor infractions. One of the dangers lies in the determination of what constitutes a *minor* violation. That involves public members as a safeguard to the public to ensure that violations handled by a confidential consent agreement are in fact minor.

A board action results in a public notice, an informal fact finding hearing and, ultimately, a formal hearing before the board to seek discipline. The standard is clear and convincing evidence that a violation has taken place. A regulated professional is protected by this process from scurrilous, baseless charges. If the board finds no grounds to take action, they can enter a finding of exoneration in the licensee's record.

It is my basic philosophy that all records should be available to the public. The public has a right to know. There is a restrictive statute that says any disclosure other than that permitted by the statute constitutes a class one misdemeanor. Perhaps, that is overly restrictive, but it is there to protect the professional, not the profession, and not necessarily the public.

Stephen Rosenthal: Over the years, I have represented numerous providers before health regulatory boards. I come at this issue less from a policy perspective than from the perspective of the damage transparency can do to professionals who have been unfairly accused. I am not generally opposed to more transparency and I have represented providers for whom there could not be enough transparency. I am not opposed to transparency when it is in the public's interest, but I am completely opposed to transparency when it is not in the public's interest and when the consequences of openness damage a provider. In other words, I oppose transparency for transparency's sake, but I see it all too often.

Statutes mandate openness, often without consideration of the significant harm that can be done to professional licensees without any concomitant advantage to the public. Often, there is no balance between the public's true need for information and the damage to a professional's career that results from the release of that information.

Under our system is in Virginia, after a complaint is investigated, the investigation is sent to the relevant board. Board staff and/or board members decide whether there should be a hearing. If the decision is yes, the board sends out a notice of "informal conference." By Virginia law, once that notice is sent, it is a public record regardless of the outcome of the hearing.

Let me give you a couple of examples of what that means. I handled the case of a nurse whose public record online includes a notice saying she may have violated a section of the code during employment at such and such hospital. "Other nursing staff members have observed you exhibiting

behavior similar to that associated with alcohol impairment, including moodiness, intemperate outbursts, stammering, and walking into walls. Further, staff members have noted that you smelled of alcohol." The nursing board committee ruled in that case (and this is also on the Web site) that "there was insufficient evidence of a violation of the nurse practice act or nursing board regulations, therefore no action will be taken against your license."

What's wrong with this? Anybody who wants to look up this nurse, who did absolutely nothing wrong, will see that she may have a problem with alcohol, just because the allegation was made. These public documents have been an albatross around this nurse's neck since the allegations were made, even though the charges were false and she was exonerated. We eventually found out that the charges were made anonymously by a disgruntled employee who had been fired. For the rest of her professional life, she has to endure this disclosure on the nursing board Web site.

Another example involves a physician who received a notice in 2005 alleging several instances of code violations related to quality of care dating back to 1997. What action did the board take? "After thorough review and consideration of the statements and information presented, the committee concluded there was no clear and convincing evidence to substantiate the allegations set forth in the court's notice of informal conference. Therefore the committee voted to dismiss this matter with no action." This sub-specialist is saddled with this information on the Web site for the rest of his professional career.

I am not being critical of any particular agency, I am being critical of the system for being unfair in many instances. In the last example, the allegations were six to eight years old. The board's mission is to protect the public, so if this doctor was as dangerous as the allegations suggest, the public was at serious risk for as long as eight years. In this case, the board hired an expert who wrote in his judicial report that he did not have the documentation and files necessary to make a considered judgment on the allegations. He concluded that the investigator should contact the doctor's current employers to see if there had been any further incidents. Another four years went by while the investigator did nothing. The board nevertheless decided to have a hearing. As it turned out, the board's expert was much more favorable to the licensee than he was to the board, for the reasons I stated.

In these two examples, the system failed the professionals licensed under it. In the zeal for transparency, their documents were public, but not because the public has a need to know. This is transparency for the mere sake of transparency.

I do not necessarily disagree with CAC's philosophy that everything should be open to the public unless there is a strong reason it should not be. In these two examples, I contend there are *strong* reasons for confidentiality. I suggest it is critical that there be much greater attention to balancing public access and the need to know against professional damage that is done by unfettered transparency.

Arthur Levin: I wonder in all our discussions why I don't hear anything about informed consent. This is a well-accepted legal and ethical principle. When I think about transparency issues and people's right to know, I think about how someone exercises informed consent to have a procedure with a certain practitioner when they're not privy to information about the

practitioner's performance and behavior. A few states publish information about risk-adjusted mortality from cardiac surgery. Isn't that an essential piece of information a referring cardiologist and the patient would need to know to exercise informed consent to have cardiac surgery performed by surgeon X at hospital Y?

Margaret Edds mentioned another important issue, which is watch-dogging the performance of a board. In New York State, our boards are not very open. This has unintended consequences. My organization asked our state comptroller to audit the Office of Professional Medical Conduct, our medical discipline board. However, the confidentiality provisions of state law prohibited the comptroller from gaining access to the information needed to conduct a meaningful audit. The law says the board can disclose only final actions, and essentially nothing else.

The question of how much the public has a right to know is a dangerous and slippery slope in a democracy. I don't belittle the damage that can be done to a professional by a lot of transparency, and one has to be sensitive and willing to listen to that side of the argument. However, I don't know who has the wisdom and trust to be the one to say this should be public and that should not. In a democracy, we try to err on the side of openness and try to create a heavy burden for confidentiality. Someone is going to be hurt in either direction. If we keep things confidential, patients will be hurt. If we release information prematurely, licensees may get hurt. We have to decide as a society that we are willing to tolerate a certain amount or harm and we have to decide as a community on which side that harm should fall. I would argue that it is the responsibility of government to protect the public and allow the harm to fall on the other side.

Remember that the cases that come before licensing boards are retrospective already. You hear only about the bad things that have already happened. That is late in the game to be trying to decide whether a licensee is competent to continue to practice their profession. Slow systems hurt everybody. Much more expedient handling of complaints would alleviate a lot of the concerns and doubts the public may have about how well the system works to protect them.

I don't know how to protect either licensees or patients from harm 100 percent of the time. We have to do some soul searching and make some difficult decisions about what side we come down on. While the cases Stephen Rosenthal mentioned are striking, we have to know how many cases posted on the Web involve allegations that are dismissed and the licensee exonerated compared to how many cases are red flags or involve repeat offenders.

Question: Frequently cases come to a board involving an individual who has committed a technical or trivial violation. Many times these are in the area of record keeping or other areas that simply don't rise to the level of discipline. The boards, however, see these as opportunities to teach or counsel the respondent. My state uses non-disciplinary letters of concern, or assurances of compliance to communicate their concerns to licensees. We have found that in our litigious society, liability coverers have seized upon these as opportunities – regardless of the fact that they are non-disciplinary – to raise liability insurance rates for practitioners who receive letters of concern. Then, the boards are faced with a conundrum: if they choose to use the mechanism to prevent an individual from entering into a practice slide that may ultimately result in harm to the public, they are exposing the individual to risk of

expensive liability coverage and possibly malpractice. If they choose to do nothing, they potentially forfeit the ability to counsel and advise an individual whose practice may be heading in the wrong direction. Increasingly, our boards are choosing the latter route. Is the public's right to know so great that these communications should not occur?

Margaret Edds: We recently adopted a similar procedure in Virginia. The Virginia Pilot editorialized that it is legitimate for letters of concern-type interventions to remain confidential, with the caveat that internal oversight or a watchdog agency is making sure that these really are minor infractions and that they are not happening repeatedly.

Chip Woodrum: Isn't the insurance situation you describe the business of the practitioner and his or her insurance carrier, or the agency that regulates insurance practices in your state, rather than the concern of the licensing board?

Stephen Rosenthal: The problem we face in Virginia is that our statute protects confidentiality so thoroughly that it prohibits the physician from saying anything about the communication from the board.

Comment: I am interested in your comments about informed consent. As part of our agreement in a particularly egregious boundary violation, the physician agreed to disclose to his patients on their intake forms exactly what he had been disciplined for.

Arthur Levin: I applaud your board for that. I am troubled by the fact that boards often enter into agreements with licensees that restrict their practice, yet patients usually are not informed that the physician's practice is now limited. If we are honest about it, the state has very little ability to enforce such orders. Who's making sure, for example, that a chaperone requirement is lived up to? How do patients who enter that office know that there is supposed to a chaperone in the examining room?

ACCOUNTABILITY AND TRANSPARENCY THROUGH PUBLIC PARTICIPATION

Part One: How to Interest the Public in Board Activities

Jay DeBoer, Director of the Virginia Department of Professional and Occupational Regulation

The Virginia Department of Professional and Occupational Regulation interacts with individuals and citizen groups, but we rarely have members of the public attend board meetings. *Are the Department and its boards dealing with the right people?*

Most commonly, the citizens we see are from trade associations or unions, people who have a vested interest in the board's deliberations. Frequently, they have recommended people for appointment to the board and they regularly track regulations and disciplinary cases.

We also deal with citizen groups that have a cause or a reform agenda. Frequently, these are single issue folks, such as a group here in Virginia that wants to sell unpasteurized goat milk and goat cheese. There are also generic advocacy groups that promote the improvement of society, of government, of board deliberations. Frequently, they recommend citizen members for appointment to the boards. Finally, there are the "great unorganized," people who don't have a vested financial interest and are not associated with any group or entity.

Why do so few people come to board meetings? *Are boards delivering the right message?* What I consider to be the right message is this:

- Boards exist primarily for public protection.
- Boards provide due process when something has gone wrong.
- Boards promote maintenance of professional competence.

Do boards have effective outreach? We have a public information officer who maintains a working relationship with the press. The media like to cover the horror stories. We have to get the boring day to day information out, too – board reorganizations, hearings, new regulations, etc.

Once the public learns about a board, they may have unrealistic expectations. Considering that boards have strict statutory limitations on what relief they can offer, people are disappointed when they can't use the board as an alternative to the court system.

Julianne D'Angelo Fellmeth, Administrative Director, Center for Public Interest Law, University of San Diego School of Law

The Center for Public Interest Law (CPIL) teaches students about administrative and regulatory law. As part of their course work, our students are assigned to monitor the activities of two different regulatory agencies for an academic year. They attend board meetings, read enabling statutes and regulations, scour their agencies' Web sites, review dockets and meeting packets before meetings, and learn to track legislation and litigation that affects their agencies or licensees. Twice during the year, our students write articles about their projects which are published in the ***California Regulatory Law Reporter***, which covers 25 California occupational and professional licensing agencies. It is intended to shine light on the activities of these agencies which would otherwise operate almost invisibly.

We draft and sponsor legislation concerning boards and commissions. We oppose legislation drafted and sponsored by industry when we feel that the legislation would benefit the profession and not the public. We promote transparency and accountability and we have worked hard to try to improve enforcement programs. I recently completed a two-year term as the Medical Board of California Enforcement Program Monitor. This position was charged with analyzing and evaluating and making recommendations to strengthen and reform the medical board enforcement program and its diversion program for substance abusing physicians.

So, in a sense, my law students and I are the public that attends meetings and reports on the activities of California's boards and commissions. Besides the very important public members who sit on these boards, we often are the only people in the room who are not licensees of the agencies.

Before I address the questions posed to the panel, I want to tell you about something remarkable that has happened in California that is a tribute to Ben Shimberg and CAC and other consumer advocates who have gone before us. When I hear about licensing boards in other states, I am often told that the number of public members compared to licensee members is very small – token participation by citizen members.

Over the past 15-20 years in California, the composition of our licensing boards has changed dramatically. All of our non-healthcare boards now have a public member majority. Two of our 16 health care boards have a public member majority. For the rest of them, 42 percent of their members are public members. So, the balance is tipping. If you are from a state where your boards consist mostly of licensee members, take heart because California is often a bellwether state.

Why should boards strive to implement effective outreach programs? My answer is simple: Because if you don't, you won't be able to fulfill your mission of public protection and then, you might as well not exist.

For 20 years, I have watched boards attempt to fashion outreach programs. The first thing they do is identify all their constituencies that they want to reach and then identify various messages to direct toward each one. So, they look at outreach to consumers, to their licensees, and to entities that are mandated to report adverse actions against licensees to the boards. They also look at prospective expert reviewers and expert witnesses, prosecutors, lawyers, and the law enforcement community.

The next things boards do is worry that if the board is actually successful in becoming visible, it will be bombarded with complaints and questions -- a workload that it will be unable to handle. In other words, they worry that the public might actually expect them to do their job. If an outreach campaign by your board reveals abuses in the profession that you regulate that outstrip your resources, it is your duty to know that and to make that evident to the policy makers in your state.

Most boards are skilled at communicating with their licensees, but that is not the highest priority – public protection is the highest priority. Consumers are the highest priority and they want to know that you exist, what you do, who you do it to, how they can reach you, complain to you, and learn from you. That means you must engage in strong consumer outreach.

For example, a few years ago the California Board of Pharmacy contracted with an outside consulting firm to assess public opinion about the board, about its performance, and about pharmacists in general. Much to the board's chagrin, more than 75 percent of the people surveyed had never heard of the board of pharmacy. Of the 23 percent who had, most of them thought the board was there to represent the pharmacy profession, not the public.

In 2002, a California newspaper printed a series of articles on an OB/GYN who had a horrendous record of negligence and incompetence. The newspaper primarily blamed the medical board for failing to yank the doctor's license. But, the bigger picture revealed systemic failures on a number of levels – failure of the private peer review process in hospitals, failure of courts and insurance companies to make mandated reports to the medical board, and a number of loopholes in the law. One of the most shocking failures, to me, was the fact that the doctor's victims did not know who to tell about what happened to them. Of about a dozen victims of this doctor's incompetence, only one filed a complaint with the medical board. As the medical board investigator proceeded through her work, she came across victim after victim. So, outreach to consumers about your existence, your purpose, and your jurisdiction is very important.

There are other important constituencies. I mentioned mandated reporters – entities required to report about licensees. In California, for example, malpractice insurance companies have to report payouts. Court clerks and prosecutors are required to report criminal convictions. Coroners are required to report when an autopsy reveals that death resulted from gross negligence by a physician. Hospitals are required to report adverse peer review actions or internal hospital actions against physicians and other health care professionals. If these mandated reporters do their jobs, the board is not completely and solely dependent on consumers for information. What we found during our medical board enforcement monitor study is that many of these mandated reporters aren't doing their jobs -- in some cases because they don't know the reporting requirement exists. You need to find a way to communicate with these entities and solicit these reports. Others don't comply with reporting requirements because there is no penalty for non-compliance, a statutory deficiency which needs to be addressed by the legislature.

Another constituency is prospective expert reviewers and expert witnesses. In a quality of care case, the board is usually required to produce expert testimony that a licensee's conduct has fallen below the standard of care. These people are hard to find. Many doctors are unwilling to testify against other doctors; many are too busy; all of them can make more money practicing medicine than reviewing evidence. Still, these are constituents your board needs and to whom you should devote specific outreach. You should speak at their meetings and invite them to your meetings.

How can boards get the public to be more interested in their work? I think this is a chicken and egg question. I believe that if a board runs a quality regulatory program, if it educates the public about the importance of its program, people will be more interested in it. Some boards aren't interested in becoming more visible because they aren't sure how high quality their regulatory program is. As public members, you need to insist that your staffs provide you with adequate information and data so you can judge the quality of your licensing and enforcement programs and assist in identifying and addressing performance problems. Then get out and publicize your board.

Lots of boards do good outreach. They have toll-free numbers; public service announcements; press releases about disciplinary actions and major decisions; Web sites, the best of which have consumer education information, information about licensees (positive and negative), complaint forms, and reporting forms for mandated reporters. All these things enhance transparency and foster accountability.

In attempting to be visible, you need to learn much and think deeply about your audience. For example, how many of you publish your Web site and publications in a language other than English? More than 40 percent of Californians speak a language other than English and this trend is spreading across the country. If you have a toll-free complaint line, what capability do you have to respond in a language other than English? Do you send information to public libraries? Do you subject all of your consumer information brochures to readability tests?

Do boards interact with the right citizen organizations? Boards should interact with citizen organizations. They should seek attendance at their board meetings, testimony on rulemaking proceedings and input on important policy decisions. This is easier said than done. It is not enough to passively post a notice of a meeting on your Web site and expect people to come. You need to reach out and affirmatively identify local and statewide organizations that might have an interest in your subject matter and

try to establish personal relationships with representatives of those organizations so you can call on them and they can call on you.

Our medical board has a program they call "teams of two" where they pair a board member and staff member who appear at health fairs and other consumer events. They also appear before physician groups, hospital staffs, and specialty medical associations. Together, they educate folks about the board, its enforcement program, its diversion program, its need for expert witnesses, and other information. Nobody is going to respond to your outreach efforts unless they are convinced that your regulatory program is important to the members of their group and that their voice will be heard.

Should boards develop positive relationships with the press? I'm sure they should. I know they don't. My organization is a public interest organization. We have no money. We don't make campaign contributions. We have no clout in the legislature. Often times, the media is the only thing we have. Boards are in the same position. Boards need to learn how to use the media to reach out to consumers. There are several ways to do this. You should issue press releases to local newspapers, TV and radio in cities where board meetings are going to be held. When you take disciplinary action, you should issue press releases to local media in the region where the respondent practices. You can use the media as an educational tool for consumers, licensees, and policymakers.

Even negative stories are not always a bad thing. Sometimes boards are not performing well and sometimes, it is not your fault. Perhaps you don't have enough staff, resources, or authority. Nothing will get the attention of policymakers to those problems like a newspaper expose. At the very least, boards should have a protocol for responding to press inquiries. The very worst thing you want to read about in a newspaper article is: "Nobody at the board was available to comment…."

Madge Bush, Director of Advocacy, AARP Virginia

AARP Virginia has close to a million members. In talking about how to get the public interested, I'm going to repeat some of the things you have heard before. When we talk about the public, we are talking about: consumers, consumer advocate groups, citizen organizations, diversity groups, and key volunteer groups.

How do we engage with these publics? First, of all, AARP researches what the public is thinking. You, too, can do informal research or scientific research into the audiences you want to reach. AARP does lots of research about baby-boomers and we have found they are interested in retirement security, social security, health care, and long term care. As you do outreach, to try to engage people in the activities you are involved in. Think about the hot topics that they are likely to relate to.

Then look at which organizations you want to reach. I was recently consulting with an organization interested in outreach to consumers. We went to the Web and found 300 consumer organizations listed. In Virginia, there is the Virginia Citizen's Consumer Council and you probably have comparable organizations in your states. The Consumer Federation of America (CFA) has member groups across the country, as does the League of Women Voters. And, don't forget the Interfaith Councils.

We have to be careful to use the right language, and to speak to people on their own terms. Recent AARP research on talking to consumers about long term care found that people don't know what we mean when we speak about "long term care reform." We found that words like "choice" and "control" are the terms consumer associate with long term care decisions. So, when you look at your brochures and other communications, think about whether you are using language that will get consumers involved.

Once you get consumers engaged, you need to let them do something substantive. And, it is important to make the engagement fun. I challenge you to work with your boards to make consumer participation meaningful and enjoyable.

At AARP, we have job descriptions for every volunteer role and match people's resumes with the job descriptions. Our volunteers are trained in public speaking and delivering testimony, working with the media, and volunteering in the community. I suggest you look to AARP in your states for trained volunteers who can help you recruit board members and engage the public in your work.

LUNCHEON ADDRESS

Bernard Henderson, Senior Deputy Secretary of the Commonwealth of Virginia

Virginia calls itself a Commonwealth. To be a commonwealth means that virtually every function of Virginia government has a citizen board either making policy or providing advice. This structure is reflective of what we consider Virginia's common wealth – our people.

In 1776, George Mason wrote into Virginia's Constitution that "all power is vested in and consequently derived from the people, that magistrates are their trustees and servants, and they are at all times amenable to them." We encourage not only Virginians, but all folks, to structure their government accordingly.

But, in Virginia, nearly a century elapsed between the words of George Mason and the creation of the first professional regulatory boards. It took two centuries between those words and the time that we established citizen seats on those boards as a matter of state policy. I can assure you that establishing citizen seats on boards in Virginia was a legislative battle that was not quick, easy, painless, or genteel. Having citizen members was regarded at that time as an absolutely radical idea, fostered by a bunch of wild-eyed liberals.

One of the guiding principles that I like to use is a statement by Adam Smith:

> People of the same trade seldom meet together, even for merriment or diversion, but that the conversation ends in a conspiracy against the public or in some contrivance to raise prices. It is impossible indeed to prevent such meetings by any law, which either could be executed or be consistent with liberty and justice, but though the law cannot hinder people of the same trade from assembling together, it ought to do nothing to facilitate such assemblies, much less render them necessary.

Even though Virginia has had citizen members on boards for 20 years, our experience has shown that this is not maintenance-free. Merely establishing citizen seats is just not enough for proper citizen representation. We need to see that

those seats are filled by appointees who are qualified, prepared, conscientious, and diligent in the performance of their responsibilities. If the appointing authority – typically the governor – is not committed to having real citizen representation on boards, or if there is no ongoing accountability for members of boards, then it might even be better to have no citizen seats at all.

If citizen members are not willing or able to carry out their duties as board members, or if people are appointed to citizen seats who are in reality connected with the business, occupation, profession, or the trade regulated by that board, then that person's usefulness is nonexistent, and, even worse, their continued membership impedes the credibility of the board itself.

When I returned to state government five years ago, I found there was no accountability with regard to board members, citizen or professional. We found instances where appointees never even attended their meetings. But, those weren't the worst. One person appointed to a citizen seat had for several decades prior been the executive director of the professional organization whose members were regulated by the board. Another person holding a citizen seat and also serving as the chair of his board's continuing education committee owned the company that provided the courses that his board required licensees to take in order to continue to be licensed.

The important thing for assuring the success of citizen members – right after assuring that the law gives them the same rights and privileges as all other members – is to be sure that the right kind of individuals are being appointed. Recruitment is a key element to the success of effective citizen representation on boards. We simply cannot rely on there being a sufficient number of qualified persons seeking to be members of boards. In Virginia, we have more seats than applicants. We can't even rely on recommendations of people to serve as citizen board members. There are too many seats.

This becomes a greater challenge when you have a governor like Governor Kaine, (and Governor Warner before him), who insists on having at least two choice of viable candidates for every seat that he is called upon to appoint. So, while we have an aggressive outreach program to encourage Virginians to apply to serve on boards, we need all the help we can get from existing board members and from responsible organizations to provide the Office of the Secretary of the Commonwealth with names of qualified and interested candidates for board appointment. A big part of that effort is to dispel the misconception that only members of the Governor's political party or his supporters, contributors, or friends need apply.

Last summer, the Richmond Times-Dispatch set out to prove that the Governor was using his appointing powers for political purposes. They weren't quiet about their intentions because they were sure they were going to find chicanery. Well, the didn't, so they had to grudgingly publish an editorial acknowledging that the Governor had appointed few political allies, many non-political persons, and even an unexpectedly high number of persons who were on the other side of the political fence.

Another challenge is to be sure that boards have a real purpose for existing. Sometimes, a board accomplishes its task and outlives its usefulness. Sometimes a board loses focus. An excellent way of knowing whether any of those things are occurring is to listen to the citizen members because they have no vested interest in running a board merely to keep it running. During Governor Warner's administration that ended in January, our citizen members were essential in our successful efforts to

eliminate 57 boards and to consolidate or refocus many more. We do not have enough good people to appoint to waste them on unnecessary projects.

We also need to make sure board members are prepared to be as effective as possible as soon as they are members. Serving effectively means understanding the public member's role and having access to ongoing training as a board member. The most intelligent, diligent, committed, conscientious, and competent person still needs to learn how to be a good board member. Perhaps the first thing a board member needs to fully understand is that each and every board member – whether he or she occupies a citizen seat or a seat with specific professional background requirements – is responsible for the same thing. That is to protect the public safety, health and welfare, not to protect or represent the profession.

Each board member should understand from day one that as an individual, he or she has no power or authority to do anything except control his or her own voice and vote. A properly functioning board has only collective power. The newest board member has the same authority as the most senior member. There is no place on boards for bullies, bosses, or intimidators. No individual board member should be given authority to do anything unilaterally.

Also, there is no such thing as a probationary or junior board member. You have to hit the ground running. Each board member has an equal responsibility and that includes the obligation to speak up and ask questions from day one. There is no time to be seen and not heard as a board member.

Citizen members have a special obligation. Many times, two or more sides to a conflict or disagreement will make a deal and ask the board to endorse it. Somebody has to look at that agreement and say, "Wait and minute. What about the public?" It is not a matter between this profession and that. It is a matter of what is best for the public. This is entirely different from a private lawsuit where a judge will promote the idea of negotiating a settlement. Sometimes compromises overlook the reason boards exists: to protect the public.

Finally, board members need to be aware that they are public servants. You're probably not going to become a household name, but you have had a unique opportunity to serve the public – something that only a small percentage of citizens have an opportunity to do. Measure everything you do by asking yourself, "How is this going to look if it appears on the front page of the paper?" Remember these famous words: no reporter ever got a raise by writing about how good a government official is. Never think you are too obscure or too insignificant to be watched and written about.

I encourage you to enjoy to the fullest and be enormously proud of your service as board members. Always keep in mind that even though you might not become as famous as the governor, you have responsibility equal to that of any other high office because you also are a public servant. You are also participating in a democratic process that fulfills the prayer of Abraham Lincoln: that a government of the people, by the people, and for the people shall not perish from the earth.

Question: You spoke about the mission of each board member to protect the public. My concern is: protect at what price? Right now, two new professions are about to be regulated by the Department of Health Professions – medication aides and facility administrators. We are writing the regulations and butting up against the issue of access. I am morally torn because I believe strongly in the public protection

mission of the board and at the same time worry that if we set the bar too high, we will see facilities close and people who have been administering meds be unable to afford licensing fees and education costs. In this context, how do we balance the cost and benefits of regulation?

Bernard Henderson: Once you have established that there is a need for regulation – a judgment call that might be made by an agency such as Virginia's Board of Health Professions -- one approach might be to take things incrementally. In some situations, for example, it might be appropriate to start off with a simple registration program to find out who is in practice. Additional regulation could be added later, if called for.

Question: What recourse is there when a board member is not performing well?

Bernard Henderson: I think that will be determined by your state law. In Virginia, we ask board administrators to keep us informed about board member performance, attendance, and participation. If there is a problem, we will call the board member and express our concerns. Twice, we have asked board members to resign. The solution in your state depends on how much accountability you have in your structure and whether board members can be removed for cause by the governor.

Question: Do you have recommendations for effective outreach to attract candidates for boards?

Bernard Henderson: We haven't found any magic way of doing it. It is a challenge for us, but we welcome recommendations from organizations, such as AARP. We have an invitation and application on our Web site which folks can fill out on line. We speak to groups. Not only are we into the second governor who requires at least two viable candidates for every seat, but they also are firmly committed to boards reflecting the diversity of Virginia in terms of geography, gender, age, or ethnicity.

ACCOUNTABILITY AND TRANSPARENCY THROUGH PUBLIC PARTICIPATION

Part Two: Mechanisms for Involving the Public in Board Activities

Moderator: The earlier panel talked about public participation in general terms. This panel will focus in on some specific functional areas of board responsibility. Instead of having speeches, I will pose questions to the members of the panel and engage them in a discussion.

Panelists:

Carol Mitchell, Director, Dispute Resolution Section, Virginia Department of Professional and Occupational Regulation

Mark Speicher, CAC Board Member and former Executive Director of the Arizona Board of Medicine

Basil Merenda, Commissioner of the Pennsylvania Department of State, Bureau of Professional and Occupational Affairs

Elaine Yeatts, Senior Policy Analyst and Agency Regulatory Coordinator, Virginia Department of Health Professions

Question for Carol Mitchell: Please tell is how the dispute resolution program in your department operates and how it involves the public.

Carol Mitchell: In 2001, the Department decided to create an alternative dispute resolution program to give consumers an opportunity to resolve disputes that are not really part of the regulatory process. The program began primarily for contractor disputes and fair housing complaints. We used processes such as conciliation, mediation, negotiation and facilitation.

Complaints about such things as abandoning a project or stealing money would be candidates for mediation, where the only people at the table are the individuals involved in the dispute. Complaints alleging construction defects, fair housing claims, and the like would be sent to a conciliation process. Facilitation is an alternative dispute resolution process which we have used during regulatory negotiations.

Mark Speicher: The Arizona Medical Board did not have an alternative dispute mechanism while I was there. I believe they subsequently used one in very limited circumstances. The problem I see with alternative dispute resolution mechanisms is that your mission as a board is to protect the public, not to satisfy a complainant or a physician who has come under investigation. An outcome or resolution that might be satisfactory for the patient might not result in public protection. This is because physicians who agree to dispute resolution, in my experience, are motivated by the opportunity to keep an action that might be a disciplinary action out of the public realm. If they didn't think they were going to be subject to a disciplinary action, they are less motivated to engage in dispute resolution.

Basil Merenda: Pennsylvania does not have an alternative dispute resolution mechanism. I agree with Mark that protection of the public is the mission and that may sometimes come into conflict with alternative dispute resolution.

Carol Mitchell: Part of our agreement with the boards – the real estate board is an example -- is that the public interest be protected. So, there are may be training, monitoring, and reporting requirements in an agreement reached via alternative dispute resolution.

Elaine Yeatts: The Department of Health Professions does not have any alternative dispute resolution, but our intake people and board executives often try to provide alternatives to folks that they know clearly have complaints that don't fall within our jurisdiction. They will offer some other alternative agencies or organizations or professional societies that may provide assistance.

Question for Mark Speicher: A number of years ago CAC wrote a booklet recommending that complainants be given an opportunity to participate in negotiated settlements and in drafting consent agreements, or, at a minimum, be able to comment on the content of consent agreements before they are approved. Do you have experience with boards that do this sort of thing, and do you think this is a good idea?

Mark Speicher: Over the objection of our board and many other boards, a law was passed in Arizona specifically allowing complainants to speak at board meetings. Our board objected for two reasons. First, our quarterly board meetings were already four days long. The board didn't want to do anything that would further lengthen the meeting. Second, the board did not like

having conflict surface at their meetings because it slows down the process and is uncomfortable. In order to make the process as constructive as possible, we hired an ombudsman whose job it was to help the patient or complainant through the process and help them prepare comments to give to the board in person or in writing. Helping the public through that process made it better for the complainant and for the board because the comments were shorter and more to the point of the case. I think the board incorporated public comments, when appropriate, into consent orders. I'm not sure I ever saw a complainant change the board's mind about how to rule in the case.

Basil Merenda: There is currently legislation pending that would create a consumer advocate / ombudsman position in Pennsylvania. We try to perform this function already by making sure that prosecutors get input from complainants when they are working out a consent agreement. I'm all for the complainant having input into that process, however, I would not want to see the complainant have the final say because there may be a lot of emotion involved and there are legal issues and precedent that need to be addressed. We already have public input into consent agreements because our public members have the final say.

Carol Mitchell: The public is allowed five minutes to talk to the board at the beginning of each meeting. It is rare that a person's comments at a board meeting would change a consent order.

Elaine Yeatts: In the Department of Health Professions, the complainant is informed when a proceeding is scheduled and the complainant has an opportunity to attend and participate. However, they do not participate in the negotiation of a settlement. Most negotiations occur in executive session after which the board publicly announces its findings and conclusions of law. The licensee must be given due process so evidence presented at an ad hoc at the meeting could subsequently be challenged in court.

Question for Basil Merenda: Does your Bureau do anything to seek out consumer input into structuring legislative proposals? When legislation affecting the boards is pending before the legislature, does the Bureau attempt to stimulate any broadly based public awareness of that fact and encourage the public to voice its opinions? Do you see an important role specifically for public members to bring the public interest perspective to bear on legislative issues?

Basil Merenda: First and foremost, we get input from our public members on legislation that a board is considering. That's why they are there in the first place. Don't underestimate the role public members can play in addressing legislation.

We encourage our public and our professional members to meet with legislators. We ask them to keep us informed of the content of their conversations. My experience is that public interest groups seek out the boards as opposed to the boards reaching out to public interest groups. Examples are AARP and consumer protection groups. They are well organized and have networks in the state capital.

Elaine Yeatts: In Virginia, we are proactive in soliciting comment when a legislative proposal has arisen from one of our boards. The proposal is vetted through a public comment process. Our boards are considered part of the Governor's administration and, while every board member is free to express an opinion on a bill as an independent citizen of the Commonwealth, they are not free to express

personal opinions in their capacity as members of the board. Nor may they go out independently and seek legislation from a member of the General Assembly.

Basil Merenda: There are all kinds of permutations in that regard. You may have a particular board member who has a comment on a piece of legislation that is different from the board's, or different from the administration's. The individual has a legal right to testify as an individual.

Mark Speicher: In Arizona, we were not part of a regulatory department so we had less responsibility to ensure that the governor agreed with legislation we proposed. Remember that most executive directors think the public members represent the public on policy issues, while the professional members hold more sway in certain clinical cases.

Question for Elaine Yeatts: Please describe what ways the public is invited to participate in rulemaking by Virginia boards.

Elaine Yeatts: We use ad hoc groups -- focus groups, work groups – as a way of drawing interested parties into the process, particularly when we are dealing with an issue where we know there are a variety of opinions. While we do try to draw in consumer advocacy groups, the party we often find missing is what I call the true consumer. Ultimately it is the responsibility of the board's public member(s) to evaluate a compromise and assess whether it is in the best interests of the public.

The transparency of rulemaking in Virginia is enhanced by the Regulatory Town Hall – a Web site for all state agencies where every proposed action, meeting, and opportunity to comment is posted. People in the public have the opportunity to comment electronically. People can register on the Web site and be notified electronically of proposed actions in their areas of interest.

We also have a formalized process for petitioning for rulemaking. The board must provide notice that a petition has been received and respond within a statutorily prescribed time limit. It is generally members of the professions who petition, but occasionally a member of the public will do so.

Basil Merenda: In Pennsylvania, all stakeholders have input in formal proposed regulatory review. Our bureau maintains a list of interested stakeholders and contacts them when regulations are proposed. I encourage our boards to hold open subcommittee meetings when they are drafting a regulation to allow public input at that point in the process.

The best case study is the funeral board which is chaired by a public member. We would like to have all our boards chaired by public members, but the enabling statutes frequently specify that the chair must be a member of the profession. The chair of the funeral board decided to have open subcommittee hearings and receive testimony from the public on a regulation that had to do with pre-planning funerals. This is how the process should work.

Mark Speicher: While I was there, my board never had any members of the public participate in the regulatory process, except at the public board meetings. I think that is because the regulatory process is typically longer than the legislative process because Arizona has a 90-day legislative session. It is difficult to find members of the public who want to appear in either setting.

Question: Are there additional ways to get the public involved?

Mark Speicher: In retrospect, the medical board could have done a lot more to include complainants in the investigative process. That kind of leg work at the front end would have helped at the adjudicatory end of the process.

Elaine Yeatts: The Department of Health Professions has contracted with an outside source to create toll-free, multi-lingual telephone access to all the data the Department possesses. So, consumers will be able to search for public information about any practitioner they are contemplating seeing.

Carol Mitchell: Things are a little different at my agency where we regulate non-health care professions. We have a speakers' bureau and board officials give presentations about such things as how to select a contractor, fair housing laws, and the like.

Basil Merenda: We have a program called "Taking the Boards on the Road." We organize board meetings around a school or institution so that students can observe the licensure process and learn what will be expected of them when they are in practice. We also invite the public. We also have speakers' bureau.

Question from the Floor: What can you suggest to boards that have to face politically-charged medical issues? I refer to overzealous interest groups that advocate on reproductive choice and right to life issues and pressure boards to revoke the licenses of practitioners who involve themselves in medical practices that one group of citizens or another find objectionable. How do boards deal successfully with overzealous interest groups and paid lobbyists who try to influence board action in these areas?

Basil Merenda: Boards are there to follow the law. Your mission is to protect the health and safety of all consumers, to maintain the integrity of the regulated professions, and to do justice. You have to explain that to the people who come before you and ask you to do things you don't have the authority to do. Advocacy groups should direct their attention to the political process if they want to change the law.

Mark Speicher: In Arizona, we faced controversy over the participation of physicians in executions. I thought that my job as the Executive Director was to keep the board focused on following the process and to protect them from personal animosity and antagonism to the extent I could. So, when we could afford it, we hired outside counsel and out-of-state experts to participate in controversial cases. This took the focus off the board and decreased the number of staff resources I had to spend dealing with those folks.

Elaine Yeatts: Boards in Virginia understand they are part of the administration so they do not take a position politically charged legislative issues unless they clearly know the position of the governor.

Question from the floor: We have been talking about how to get the public more interested, but there is one segment of the public that has no problem organizing and expressing its opinions to board members – that is members of the regulated professions. Does any state regulate ex parte communications to board members by interested trade associations– either by prohibiting these communications or requiring that they be disclosed?

Elaine Yeatts: I can't say it has never happened in Virginia, but every board member undergoes conflict of interest training which makes clear that ex parte communication, particularly in disciplinary hearings and regulatory proceedings, is a conflict. If we thought that ex parte communication had occurred, we would encourage that board member to recuse him or herself from that vote.

Mark Speicher: Board member training is mandated in Arizona also, and ex parte communication is prohibited for all items on the agenda. I instructed my board members that since they didn't know what was going to be on the agenda, they shouldn't speak to anyone about any matter under the jurisdiction of the board, but should refer them to the executive director. On some occasions, we asked board members to affirmatively declare that they had not been party to ex parte communication.

Basil Merenda: Equally important is that the governor and legislature choose people of integrity to sit on the boards. For the most part, our members do recuse themselves if they have been approached about a disciplinary case. A regulation is a little different, because a board wants input from the profession so as not to create pie-in-the-sky rules.

ACCOUNTABILITY AND TRANSPARENCY THROUGH COLLABORATION WITH OTHER STAKEHOLDERS

Part One: The Virginia Model

Sandra Ryals, Director, Virginia Department of Health Professions

In Virginia, we focus on transparency and accountability through collaboration. There are four critical components of collaboration:

1) shared resources
2) shared information
3) shared power
4) shared recognition

The Virginia Board of Health Professions (BHP) lives and breathes that model.

Created by the legislature in 1997, BHP has representation from the boards of medicine, nursing, veterinary medicine, optometry, dentistry, pharmacy, counseling, physical therapy, social work, otolaryngology speech and language pathology, psychology, long term care administrators, and funeral directors and embalmers. The 18 members of the BHP are appointed by the Governor.

The Board's mission is about enhancing the delivery of safe, competent health and providing information about practitioners. It is also about objective policy analysis and recommendations related to professional and occupational regulation.

A variety of issues come before the BHP. Some involve scope of practice conflicts. Some involve deciding the appropriate degree of regulation needed: registration, certification, or licensure. Educating the public is also a role BHP plays. BHP reviews agency activities and develops standards.

Virginia does not have a routine sunrise / sunset process. It is done on an ad hoc basis when a group comes and asks to be considered for regulation. These requests are sent to BHP for review. BHP also conducts ongoing regulatory performance reviews.

BHP accomplishes its work through committees: Education, Regulatory Research, and Enforcement. Its work is

governed by Virginia's Freedom of Information Act, so meetings are open.

Requests for regulatory studies can come up different ways – from the boards, from the Director, from the General Assembly, the Governor, or the public. If a request is considered appropriate, a study is conducted using board members, consultants, and staff. The study may or may not result in a recommendation for legislation.

An example is the sanction reference study that will be explained in detail at a later session. Another example involved long term care issues where BHP review resulted in legislation in 2005 giving the board of nursing authority to promulgate regulations for dealing with the registration of medical aides. The long term care board is looking at regulation of facility regulators.

Other issues being studied include criminal background checks. This was initiated by the Department because the National Council of State Boards of Nursing licensure compact requires criminal background checks. The more we looked at it, the more deficiencies we found with criminal background checks. If they aren't done electronically, which is more costly, there are tremendous delays getting the information back. There are concerns about expense of background checks on certified nurse aides and other emerging professions. We are also looking at deficiencies in the data base. Because criminal background information is not public, in Virginia we need to show probable cause before we can check it.

BHP is about ensuring safe health care delivery by professionals. Its organizational structure allows for pragmatic analysis, strategizing, and resource allocation. BHP helps boards go about their business more consistently, without inadvertent impact on other boards.

ACCOUNTABILITY AND TRANSPARENCY THROUGH COLLABORATION WITH OTHER STAKEHOLDERS

Part Two: Collaboration with Credentialing Agencies, Quality Improvement Organizations and Facility Regulators

Sallie Cook, Medical Director, Virginia Health Quality Center and President, American Health Quality Association

One of the introductory sentences in the QIO's current core contract says "the goal of the scope of work is to assist providers in measuring and reporting quality, producing and using electronic clinical information, re-designing care processes, and transforming organizational culture so as to accelerate the rate of quality improvement and broaden its impact." We have between 55 to 60 staff doing this work. We have 90 acute care hospitals in the state, hundreds of home health agencies, 150-200 Medicare / Medicaid certified nursing homes, and more than 16,000 licensed physicians. It is only through partnership with many organizations that we can do our work.

To do large scale quality improvement projects, beginning at the local level, we engage those hospitals, nursing homes, and other facilities that are ready to join us in quality improvement. We use mass media and modern technology to get the word out more broadly in the state.

We work with professional associations, statewide and local medical societies, nursing associations, patient safety coalitions, hospital associations, health planning associations, and so forth, to magnify the impact of what we are doing and to create peer pressure as a way of sharing information on quality improvement techniques.

As an illustration, in Virginia, we had statutory barriers to allowing standing orders for flu vaccinations in hospitals. Through meetings over a two-year period with various boards within the Department of Health Professions we were able to come to consensus on a new piece of legislation that allows hospitals to have standing orders. The stakeholders feel confident about the legislation because they were in the loop.

When we find errors in judgment or substandard care in individual cases, we report those instances to the board of medicine (and other licensing boards) under a memorandum of understanding and the report becomes part of the board's investigative file. We report to the state survey agency when medical record reviews reveal substandard care in nursing homes. Those agencies can do things that we as a QIO are limited in doing. For instance, we don't go onsite to a nursing home to investigate, while the state survey agency can do this. So we work with them, understanding our limitations and their abilities. Most importantly, we never forget our primary reason for being and the beneficiary advocacy organizations with whom we work help us keep our focus on serving the beneficiary.

Several years ago, the Centers for Medicare and Medicaid Services (CMS) created the Web site, www.Medicare.gov, which is regularly updated with quality indicators related to hospitals, nursing homes and home health care in every state. We are told, mostly in relation to nursing home care, that this site has been very useful. The numbers of indicators and the topics covered on this Web site are expanded regularly.

CMS also sponsors a voluntary physician reporting program under which doctors report information on 16 quality indicators. This is the pilot phase of future reporting at the physician level. The indicators are consistent with things already reported at the hospital level. CMS envisions that this program will evolve into a pay-for-performance incentive to physicians to provide good quality care.

Some trends are pointing toward a more transparent system in the future. One important trend is that QIOs now disclose more information to complainants than they used to when care is found to be substandard. Currently, the American Health Quality Association (AHQA) has a legislative proposal that recommends that even more information be disclosed to complainants in individual cases and that there be an annual report of aggregate information about quality problems being found by QIOs across the country.

This is part of a QIO modernization package AHQA is supporting called the Medicare Accountability Program. The core components of the beneficiary complaint provisions are:

1) There should be more outreach and education to beneficiaries informing them of the existence of the QIO complaint program.
2) There should be a more standardized disclosure format so complainants will know what remedial and enforcement actions are being taken.
3) There should be more reporting of numbers, frequency, and types of complaints received.
4) The QIOs should continuously strive to improve the complaint process.

Another exciting trend involves the BQI or Better Quality Information pilots. This agenda has four cornerstones:

1) Connecting all components of the healthcare system,
2) Publishing quality measurement data,
3) Measuring and publishing price information, and
4) Creating appropriate incentives to induce better quality of care.

One goal of this initiative is to look at the continuum of care. Pilot projects are underway in California, Indiana, Massachusetts, Minnesota, Wisconsin, and Phoenix, Arizona. Additional pilots will begin in the next 18 months. More information is available at the Ambulatory Quality Alliance Web site.

My message is that information is becoming more transparent, and over the next decades we will see huge leaps in terms of the amount of information available. We need to be vigilant and involved because it will take a collaboration to make this happen. Hopefully, the QIO modernization legislation will take QIOs into the future with many opportunities for involvement in transparency and other quality improvement efforts.

Bonnie Niebuhr, Executive Director, American Board of Nursing Specialties

The American Board of Nursing Specialties (ABNS) has 28 member boards that certify registered nurses at the generalist and advanced practice levels. ABNS also accredits professional nursing certification programs. While I speak from a background of nursing certification and accreditation, I think what I will say applies to multiple disciplines.

Envision a triangle, which at one point is regulation, at one point is professional certification, and the third point is accreditation. Envision that the sides of this triangle are bi-directional arrows. I will be talking about collaboration around that triangle in both directions.

There are obstacles to collaboration around that triangle. The first is inadequate communication and education about processes, standards, and assessment criteria that occur at the licensing board level and at the certification and accreditation levels. Another major obstacle is distrust among the three entities, which neither fully understand nor fully trust the processes of the others. There is also insufficient transparency of processes and outcome reporting around the triangle. We need more data sharing. Lastly, there is a duplication of efforts.

First and foremost, there needs to be an understanding and agreement among all the groups involved in the triangle that *each* is committed to protection of the public and ensuring public safety. I think if you look at the missions of most professional certification organizations, you will find that it is public protection. Accreditors are devoted to public protection by ensuring that each certification program that comes to them for accreditation meets quality standards.

A way to be sure an organization is committed to public protection is to drill down by asking what I call the "Five Whys." Ask an organization why they are in business. They say it is to certify nurses. Ask why they want to certify nurses. They say it is because nurses need to demonstrate to employers that they have knowledge and experience in a particular specialty. Ask why that is important. Ultimately, if you drill down deeply enough, the answer will be public protection.

Second, there needs to be education. There is a lack of understanding around that triangle about what the others are doing and why they are qualified to do it. If we can identify instances where collaboration among these entities does not occur, it can be traced back to a lack of understanding about what each is doing.

Once the knowledge deficit is resolved, there needs to be trust that the other organizations have the expertise to achieve their missions. Trust is the cornerstone for collaboration, communication and transparency.

An example of successful collaboration involves the few states that use professional nursing certification as a supplement for a board's eligibility criteria for relicensure. These states recognize that accredited nursing certification programs do have value and that their certification satisfies eligibility requirements for relicensure at the RN level and at some advanced practice levels.

Another example of successful collaboration and communication is when a licensing board, an employer, or a member of the public wants to know if a practitioner is certified. Each group has mechanisms set up so that certification status can be easily and quickly verified.

Where can communication be improved? Most national certifying boards for nursing require that a nurse have an unencumbered or unrestricted RN license in order to sit for a certification. The communication problem occurs if a nurse's license were to become encumbered in the future. There is no system to ensure that certifiers will be notified by licensing boards if a particular license becomes encumbered. In the reverse, one would expect that licensing boards would want to be informed when a certification agency had to discipline an exam candidate or a certified professional because of cheating, ethical violations, or some other problem.

One possible step to correct this communication deficiency would be to assemble a database showing which RNs are certified. That way, if disciplinary action is taken against a certified nurse, there would be a way to communicate that to a certifying agency. Another potential strategy would be for licensing boards and certifying agencies to share information electronically when discipline occurs.

Within nursing, there is a huge issue related to the regulation of advanced practice registered nursing. When major issues such as this affect a discipline, they can be resolved only by collaboration at a national level among the key stakeholders. To improve communication about unresolved national issues, the parties must commit to come to the table to talk and trust the other stakeholders

Another component of the credentialing triangle is accreditation of educational programs and certifying programs. Accreditation assures that education and certification programs meet rigorous standards for quality. One has to trust that the accreditors' processes assure that their standards are being met. There are two organizations in nursing – ABNS and the National Commission for Certifying Agencies (NCCA) – that accredit certification programs involved in health care and public safety.

Most accrediting organizations related to nursing have a standard related to ensuring continued competence. As the physicians have done, within the nursing community, certification credentials must be periodically renewed – typically 3-5 years.

Strategies to enhance collaboration include setting up regular communication around the triangle, so all parties can air the issues they

are facing and identify who should be brought to the table to discuss them. Engendering trust is huge and hard. In the nursing community, as we look at the regulation of advanced practice, there has to be some trust in what the other two groups are contributing. The data sharing piece is also important. If licensing boards can collect data about what credentials their licensees hold, they will know what the population looks like.

Avoiding duplication of effort is directly tied to trust. For example does a board of nursing that is evaluating an education program trust that the accreditors for the education program have done their job properly? I know licensing boards have limited resources, just like certifying organizations, so rather than duplicating efforts or re-inventing the wheel, we have to trust that the other groups are able to do what they claim to do.

Let's not work in silos. There is nothing that we do in regulation, certification or accreditation that doesn't impact the others. Let's be sure we set up communication norms that recognize this.

Question: I would like to see the QIOs get back into beneficiary services, including beneficiary education. And, I would like to see certification agencies allocate funds to send all their public members to conferences like this one so they see the relationship between licensure and certification.

Sallie Cook: I couldn't agree more regarding your statements that QIOs don't have funding dedicated to beneficiary outreach. The Virginia QIO still does outreach without funding because we believe that if we are going to make a difference in terms of improving the quality of care, the only way this can be done is if all the partners are at the table and the most important partner is the recipients of care and their families. We do whatever we can, working with consumer advocacy organizations, to find opportunities to get the word out and to get feedback on how we can do our job better.

Bonnie Niebuhr: We learned that sometimes public members weren't allowed to vote. So, we revised our standard to say that public members on certifying boards accredited by ABNS must have a vote. It is also important that public members understand their role, the type of organization they serve on, and how it relates to others within the credentialing arena. This is a challenge. We will have a panel on the public member role and how to find them at our next ABNS meeting.

Question: What relationship does either of your organizations have to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)?

Bonnie Niebuhr: We have a collegial relationship. We are encouraging JCAHO to write into its standards that having certified nurses on staff is an indication of quality.

Sallie Cook: The quality indicators QIOs use to assist hospitals and other health care organizations with measuring quality of care are coordinated with JCAHO to avoid duplication of effort. So, QIO technical assistance helps facilities meet JCAHO accreditation standards.

ACCOUNTABILITY THROUGH TRANSPARENCY IN DISCIPLINARY PROGRAMS

Part Two: Results of a Survey of Boards of Medicine and Nursing Concerning Release of Disciplinary Information to the Public

David Swankin, President, Citizen Advocacy Center (CAC)

In the early 1990's, many boards asked CAC to find out when other licensing boards release information about disciplinary cases. Almost no boards release information about complaints before they have been investigated. The two places where boards most commonly release information are 1) after the board has investigated a complaint and finds probable cause, and 2) after the board takes action and there is a finding of fact resulting from adjudication or a settlement agreement resulting from negotiation. A third option would be to wait until all judicial appeals have been exhausted before releasing information to the public.

In 1992, we surveyed boards of medicine and nursing to determine when they released information to the public. Our survey revealed that at that time,

> The major difference in policy between the boards has to do with whether and how much, if any, information is released prior to the final resolution of a case. Once a case is settled, most policies call for the release of a substantial amount of information, but a number of states keep the process relatively confidential, if not entirely confidential, up to that point. This is true for both medical boards and boards of nursing. So, all states face a philosophical dilemma: where is the line between the public's right to know and the practitioner's right to protect his or her good name prior to final adjudication? It is clear that states continue to draw this line in different places.

Fourteen years later, we thought it was time to revisit the issue, particularly given the growing interest in transparency. The Center for Medical Consumers and the New York Public Interest Research Group collaborated with us in the 2006 survey. The conclusion of the 2006 report reads:

> We undertook this survey because we believe that any effort to hold state medical and nursing boards accountable for their performance can only succeed if their work routinely sees the light of day. The more transparent a board's work, the better the public it serves can judge how good a job the board is doing. Conversely, the more opaque the workings of a board, the more difficult it is for the public and others to determine how effectively it carries out its responsibilities under state law.
>
> To their credit, the trend among states is toward greater transparency for their medical boards. More information about an investigation and prosecution is made public earlier in the discipline process than was the case 14 years ago. In contrast, states have not been as robustly moving their boards of nursing towards greater openness. Instead, they appear to be either maintaining the status quo or moving towards an environment featuring less transparency rather than more.

As our survey shows, how boards deal with public disclosure is mainly determined by state legislatures and the statutes they enact.

We hope that our survey and this report will stimulate a public discussion among state legislatures, members of the public, members of state boards, and the licensed health care professions about the appropriate balance between the state's moral and legal responsibility to protect the public health and the legitimate economic interests of the licensed health professions. As we said in the beginning of this report, all three of our organizations believe that the priority for state boards must be the public safety and board performance must be open to public scrutiny at the earliest possible time.

Blair Horner, Legislative Director, New York Public Interest Research Group (NYPIRG)

We asked 12 questions in the 2006 survey. Forty-six medical boards and 37 nursing boards responded. We did not verify the responses. This is a self-reporting survey. There were slight differences between the 1992 and 2006 surveys, so we are looking at trends more than specific state-by-state comparative information.

With regard to medical boards, the first question asked whether "raw" complaints are released to the public. Very few states do this. Once formal charges are filed against a respondent, most states do release this information to the public, more states than did so in 1992. We found that the majority of nursing boards release information when formal charges are filed, but there was nevertheless a slight decrease as a percentage over the 1992 responses.

In terms of what information is disclosed, both medical and nursing boards in the vast majority of states report the name of the individual even when there is an appeals process going forward. In the vast majority of states, settlement negotiations are conducted behind closed doors, but most states conduct formal hearings in public.

Overall, the trend for medical boards is that there is greater openness in 2006 than in 1992. Slightly the opposite is true for boards of nursing.

Arthur Levin, Director, Center for Medical Consumers

As a New Yorker, I noticed that New York State is one of the least transparent states. The Department of Health started to release formal charge information a few years ago and was taken to court and told to stop. In New York, we get information only after a board has taken formal action. We get no information when the board has gone through the hearing process and decided not to take an action.

Dave Swankin: Contrast the administrative law system governing regulatory boards with the criminal law system where the police blotter is public information before an investigation has occurred and where indictments are public before a trial has been held. The notion that it is not fair or not right for regulatory boards to disclose information before the process has run its course is unique to administrative law. The question is not *whether* to disclose information but it is *where* to draw the line.

Question: In Florida, the voters passed an amendment to the state constitution calling for disclosure of peer review information. This is important voter input in favor of more disclosure rather than less. Later court cases have upheld this vote.

Blair Horner: One thing not yet covered in our discussion is *how* the information is communicated to people – other than searching on a Web site. How, for example, do the patients know when formal charges have been filed against their physician? Should they get a letter or a phone call? Should there be a sign in the physician's office? In New York, a provision that got knocked out of physician profile legislation called for posting profile information in offices and health care facilities.

Question: On the subject of raw complaints, I generally favor disclosure, but I am troubled by the possibility of malicious complaints, such as the one Stephen Rosenthal mentioned yesterday. I am concerned by the police blotter analogy because in that case, the charge is made by a trained police officer.

Art Levin: Mr. Rosenthal's example was not of a raw complaint, but of a case that had gone through the process. And, the fact that the individual was exonerated was included in the online profile. To decide this issue, we need to know how common malicious complaints are. We can't make policies for the rare situation.

David Swankin: Nine out of ten complaints never even get to the point of probable cause. So, there is a lot of protection for licensees in the investigation and probable cause process.

Comment: Washington State does release raw complaints. They are not posted on the Web site, but are disclosed to people who call to inquire. About 52% of the complaints are closed without an investigation. Few people ask for pre-investigation files. Our policy does give transparency to the public. And, since the boards and commissions have a reputation for being bodies that protect their own, the public is more protected by having access to pre-investigation information.

ACCOUNTABILITY THROUGH TRANSPARENCY IN DISCIPLINARY PROGRAMS

Part Three: Public Citizen's Medical Board Website Report Card

Peter Lurie, Deputy Director, Public Citizen's Health Research Group

The Health Research Group (HRG) has worked on three major areas related to doctor discipline. First, we created our own equivalent to the National Practitioner Data Bank (***Questionable Doctors***), since the federal government's data bank is not public. But, we don't do this project any longer because so much information is now available from the states. Annually, we rank state medical boards according to their disciplinary activity. Finally, we have surveyed medical board Web sites in 2000, 2002 and 2006.

In the current Web site survey (which is available in an interactive file at www.citizen.org), we looked at 65 medical and osteopathic board Web sites in 50 states and the District of Columbia. Fourteen states have separate medical and osteopathic boards.

We divided the information into these categories:

- Disciplinary Information
  - Board disciplinary actions
  - Hospital disciplinary information
  - Federal disciplinary information
  - Malpractice

- User-friendliness
  - Search engine
  - Medical practice act
  - FAQ
  - Ability to make a complaint online

Within each category, there are four questions, so there are 64 different variables. To decide how to weight these, we find experts to advise us – in this case, Mark Yessian and David Swankin. They advised that the disciplinary information category be given more weight than the user-friendliness category.

Our methodology consisted of reading through the Web sites to determine which of the 64 pieces of information was present. We sent our results to the boards for their review and correction, if necessary. All but six boards responded. The online report shows what information is available at each board's Web site and provides state-by-state recommendations for how they could improve their site.

We found several trends. In relation to state disciplinary information, ten states provided no disciplinary information in 2000; two provided no disciplinary information in 2002; and all of them provide some information in 2006. There are caveats:

North Dakota tells you only that doctors who have been disciplined have a public file. No details are given. So, the state counts as giving disciplinary information, but they really do not. The second state to get special mention is West Virginia (Osteo board) which really provides no more than a PDF of all the doctors in the state, but no information about discipline.

The median score (out of a possible 100) was 42.4 points. Even as many states did very poorly, there are some that did quite well, showing that states are able to do a good job when they try, or when their legislatures permit them to try.

Of the best states, the Web site for New Jersey scores the highest, receiving 83.7 out of 100 possible points. The 10 boards receiving the highest scores are:

- New Jersey (83.7 points)
- Virginia (79.2)
- Massachusetts (79.1)
- New York (70.9)
- Vermont (70.9, Medical only)
- Georgia (68.7)
- California(68.0, Medical only)
- Idaho (65.0)
- Florida (64.1, Osteo only)
- Florida (64.1, Medical only).

For the sites providing disciplinary information for each of these 10 boards, physician profiles are required by legislative mandate, but we do not know what other elements the laws in each state require the profiles to display.

Of the worst states, the North Dakota Web site scores the lowest, receiving 12.3 points, barely one-seventh as many as top-ranked New Jersey. The 10 lowest scoring Web sites are:

- North Dakota (12.3)
- New Mexico (12.5, Osteo only)
- West Virginia (13.0, Osteo only)
- Louisiana (14.9)
- South Dakota (16.6)
- Arkansas (16.9)
- Alaska (18.4)
- Indiana (20.1)
- Montana (20.3)
- Minnesota (20.5).

Of these 10 states, Indiana is the only one whose legislature requires that physician profiles be made available.

It is noteworthy that in the top ten boards, there are three that are Medical only, one that is Osteo only, and the rest are combined boards. In the bottom ten, two are Osteo only and none are Medical only. Thus, when there are separate boards, in general, the osteopathy board is worse than the Medical board.

Looking at overall scores, every state provides some doctor profile information. All but two boards provide some information about doctor discipline. Almost all provide other Web site elements. All but 13 boards provide some searching capacity. So, the differences among boards fall in the other four categories. At least half of the states received a score of zero in all four of these categories. At least one state received a score of 100 on four of the eight categories and another state came close to 100. This shows that states that make an effort can do an excellent job.

Looking at non-state disciplinary actions (hospital, federal, malpractice), 44 Web sites have no non-state disciplinary action information. Four states have all four categories of disciplinary information (Virginia, Idaho, Tennessee Medical and Tennessee Osteopathic). Of the categories, the most common is malpractice, next conviction, next hospital information, and lastly federal information. In terms of search engines, 13 boards do not have the capacity to search by name.

We looked at how many states use the Administrators in Medicine (AIM) DocFinder data base and found it dramatically underutilized. Of the 65 boards, 45 don't use the AIM database at all. Twenty boards use the database, but not in a very useful way. Ten indicate only that a public file exists; five expand on the AIM database in link to additional doctor discipline information. Five others house their data on the AIM database, but don't allow visitors to search. This shows that the AIM database is only as good as the number of states that provide it with data.

Comparing medical board rankings to the previous surveys, in 2000, only one state had all the disciplinary information elements in place and received an "A"; in 2002, seven states got an "A;" in 2006, 12 states earned an "A." This is an increase, but a disappointing one. User-friendliness has also improved, but not as much as one would hope. If you want to improve your board's Web site, the way to make a big difference is to improve the extent of disciplinary information.

Comment: I want to say something about why medical boards seem to have progressed further than other boards in the area of public disclosure. This is because

medical boards have been pounded by public interest organizations, such as Public Citizen, the Center for Public Interest Law (CPIL), and CAC, to be more transparent. In 1989, CPIL released a report blasting the California medical board's disciplinary program. In 1992, ***60 Minutes*** did a segment on the California medical board and its failure to publicize any information. In 1993, the California medical board finally made some modest changes in its public disclosure policy. In 1995, Massachusetts introduced physician profiles. In 2000, a Federation of State Medical Boards committee recommended guidelines for disciplinary and malpractice information disclosure by medical boards. At the same time, Public Citizen began its ranking of Web sites. The confluence of all of this pounding on medical boards got a response. It is not surprising that in 2006, CAC, NYPIRG, and the Center for Medical Consumers find an improvement in medical board public disclosure. It is not surprising that Public Citizen doesn't have to publish "Questionable Doctors" any more because state boards have taken over. There has not been the same pressure put on boards of nursing, pharmacy, and others. That's where public members come in to force these kinds of changes to bubble up through other boards. The history of pressure on medical boards should give you confidence that improvement is possible.

ACCOUNTABILITY THROUGH TRANSPARENCY IN DISCIPLINARY PROGRAMS

Part Four: Virginia's Sanction Reference Study

Elizabeth Carter, Executive Director, Board of Health Professions

Board members are called upon to serve in a quasi-judicial role in discipline proceedings. But, few board members receive training in case law and judicial procedures. One of our responsibilities at the Board of Health Professions (BHP) is to examine disciplinary processes and to ensure the fair and equitable treatment of the public and licensees.

We concluded that BHP could provide boards a tool – a Sanction Reference Study – which documents the history of cases handled by each board. The tool also provides information about the factors that were important to the particular board's decision making, factors such as recidivism and the severity of the infraction. Thus far, the boards of medicine, pharmacy, and nursing have begun to use this tool.

An example of what we learned from the board of medicine sanction reference study is that, holding all other factors constant, the board's ruling was affected by whether the respondent had an attorney present at the hearing. The sanction reference system allows boards to take such extra-legal factors out of the equation when they render a decision.

Neal Kauder, President, VisualResearch Inc.

The premise of the sanction reference project is that there should be consistency and neutrality in sanctioning. We didn't have any good information in 2000-2001 to determine whether sanctioning was neutral or consistent. Neutrality means similarly situated respondents are treated in the same way. Consistency means that these respondents get the same sanction over and over again, all other things being equal.

So we did a data analysis to establish sanction reference points. The guiding principle is that for the system to be successful, it has to be developed with board oversight. Board members should decide what the system should look like, what methods should be used, and what factors should be examined. The system should be value-neutral and grounded in sound data analysis. Most importantly, the use of the sanction reference points should be entirely voluntary; board members should be allowed to deviate from any sanction reference point to accommodate aggravating or mitigating circumstances.

Since it was value-neutral, the data analysis did not evaluate whether a board had been too harsh or too lenient toward any particular group of respondents. The research simply asked what has been done in the past and how can the board be sure people are treated the same, based on the factors that have been important in the past.

We started with the board of medicine because they wanted to do the study and they had a large enough number and variety of cases to permit a sound analysis. We interviewed everyone on the board and several past board members. On the basis of the interviews, we developed a blueprint for the study which established the sanctioning goals and the purpose of the reference points, proposed the analytical approach to measure case complexity, patient injury, and so on. We determined the key features of the sanction reference system should be data-based and voluntary.

The purposes were:

- to make sanctioning more predictable,
- to educate new board members,
- to add an empirical element to a very subjective process,
- to be a resource for staff and attorneys,
- to neutralize unwarranted inconsistencies,
- to validate board member recall, and
- to help predict future case loads.

The system had to accommodate a full range of aggravating and mitigating factors and operate within existing statutes and regulations. Recommendations from the key reference points could not be too narrow or specific because the board wanted to fashion sanctions to the circumstances of each particular case and to consider multiple sanctions, such as punishment, rehabilitation, and so on.

Most importantly, board members wanted an analysis that would show what factors could predict a sanctioning outcome. We have a descriptive model which tells us what factors have been used in the past to help board members make decisions. The model shows, for example how important factors such as prior record have been, compared to patient injury. This is the opposite of a normative model, which would prescribe what sanctioning will be in the future, regardless if history. We ended up with a descriptive model with some normative adjustments.

In addition to personal interviews, we profiled other states and found that no other states had done anything similar. We identified a sample, collected data, identified relevant factors and translated them into a worksheet system, implemented the reference points and solicited board feedback.

The study sample was 447 cases (violations) resulting in about 250 sanctioning events during the prior six years. We read every investigation file and coded and analyzed the data. We researched the public information Web site, microfiche, minutes

of hearings, and staff. The first analysis was descriptive: what sanctions were imposed, how many respondents had prior records, ongoing substance abuse problems, what injury levels occurred. Then we did a more scientific analysis in which we tested the influence of different factors. This analysis helps explain how similarly situated cases have been handled in the past, how much weight boards have assigned to various factors and what factors will predict a suspension.

As an example, we looked at what factors will predict any one of the possible sanction types: loss of license, reprimand, treatment monitoring, or no sanction. Historically, a patient death was very important in predicting whether a respondent would lose his or her license. Impairment was more important than a standard of care case. People who had an attorney present were less likely to lose a license, all other things being equal. One of the extra-legal factors that influenced decisions was gender – females were more likely to lose their licenses. Practitioners with a history of alcohol treatment were less likely to lose their licenses because they were likely to be ordered into treatment instead. The longer respondents were in practice, the more likely they were to lose their licenses. The longer it took to process the case, the less likely the sanction would be revocation.

The board looked at all the factors and decided that case type, patient injury, past substance abuse, and mental illness should continue to play a role. The board wanted some other factors to be added, such as the involvement of multiple patients and prior violations.

We placed historically relevant factors on worksheets, which are all available on the Virginia Board of Medicine Web site as a policy guidance document. Using the worksheets, we scored all the cases in the database and found about 70 percent accuracy across five worksheets. The board decided that the 30 percent that fall either above or below the sanction recommendations can be explained by mitigating factors.

The intent is to model the most typical cases, not every case. If a violation occurred, the appropriate worksheet is completed: impairment, patient care, inappropriate relationship, fraud, deception, or unlicensed activity. The factors on the worksheet are given scores. Filling in the grid forces the board to consider the same factors in every case and it helps beef up the integrity of the investigative files. A cover sheet accompanying the worksheets reports the grid result, the board's actual decision, and an explanation if the board's decision departs from the grid result. This makes it possible to continually adjust the point values or add new factors to adjust the reference points over time. Subsequent boards adapted the factors to their needs. Boards comply with the worksheets about 85 percent of the time. In the long term, we hope to evaluate the system and to evaluate what sanctions actually work. The experience has been that using the reference system reduces the caseload because respondents know what sort of sanction they are likely to receive and are more willing to negotiate a settlement prior to going to a hearing.

Question: Has anyone ever appealed on the grounds that a sanction fell outside the guidelines?

Elizabeth Carter: Not so far. But, as of now, we are using the system for informal conferences, so respondents can ask for a formal conference if they are dissatisfied.

Question: What would be the cost of tailoring this study to an individual state?

Elizabeth Carter: The medical board study cost about $200,000, but it is much less for subsequent boards – closer to $30,000. Other states can take the Virginia methodology and replicate it, creating worksheets based on their own board's history.

Comment: I'm on the Virginia Board of Medicine and I've found that the respondents understand and are more likely to accept sanctions that are based on an empirical system such as this one.

LUNCHEON ADDRESS: Effective Consumer Outreach on a Limited Budget

Logan Malone, Chief Executive Officer, Florida Medical Quality Assurance, Inc.

If you have read the Institute of Medicine (IOM) report, you know the federal government is promoting patient-centered, effective, safe, efficient, equitable, timely health care. We are all engaged in responding to the IOM's leadership in pursuing these goals.

QIOs have a three-year contract cycle, called a scope of work. The seventh scope of work which began two years ago called for QIOs to offer technical assistance to providers, provide education for beneficiaries, and protect beneficiaries and the Medicare Trust Fund.

For the seventh scope of work, the percentage of our contract dollars for outreach was only about 4.2 percent of the total contract. In the eighth scope of work there is no money for outreach and no longer any contract mission to do beneficiary outreach.

Under the seventh scope, all of the QIOs had a strategy for outreach and coordinated message delivery directly to beneficiaries and other stakeholders. The eighth scope is very task-oriented and we are discouraged from doing anything that is not a specifically funded task.

Under the seventh scope of work, we had campaigns, regional education about health care choices, and education about the Medicare drug benefit. Our message included Medicare rights, preventative health benefits, and other services. We used the media as much as we could. We conducted outreach to provider organizations as well as beneficiaries.

We targeted specific geographic areas and established partnerships with stakeholder agencies, including non-English-speaking agencies, in an effort to reduce disparities in health care delivery. We worked with hospitals, doctors' offices, nursing homes, home health agencies to deliver the message. We worked with Congressional offices. We created Spanish language public service announcements about the new drug benefit. We asked the Medicare carrier to include beneficiary education materials in their mailings. We provided text for other organizations to put in their newsletters.

Under the eighth scope of work, there is no contract language directing us to talk directly to beneficiaries. We have to go through nursing homes and home health agencies to distribute anything to the public. We have no outreach through the hospitals. A lot of effort is going into physician offices under the eighth scope having to do with outcomes measurement, but not beneficiary outreach.

We are solidly funded for beneficiary protection, but no funding for outreach. In effect, there is a mismatch: the program is there, but the public does not understand how to take advantage of it. One of the

problems is that bureaucracy implements programs without preparing the public to use them. There is a lot of complicated data coming online that will be helpful to beneficiaries if only they can understand it. We have a lot of money to do expedited appeals, but neither beneficiaries nor providers know how to access the process.

The QIO Manual says that QIOs are supposed to inform beneficiaries of their rights under the program and how to exercise them. But, this mandate is not included in our contract at this time. What will happen? Lots of changes can occur during the three-year contract period, but it is a ponderous process. So, changes we contemplate now may not get into the contract until the ninth scope – 2008-2011. Outreach is barebones, but there isn't much we can do except to look for a grassroots already-funded program we can take advantage of.

Question: You said you have good relations with the media. Do you have any advice for licensing boards which often complain that the media is only interested in "horror stories?"

Logan Malone: The media does occasionally ask about something bad that has happened in a hospital, but we have no authority to talk about this. To cultivate good relations, we try to work with media on a local level. When our teams go to visit a hospital, they also visit local media and talk about positive things that are going on and how beneficiaries can access the program. Local stations and local newspapers are interested in material so they respond favorably to our overtures. A positive message is important.

PROGRESS WITH SELF-EVALUATION OF BOARD PERFORMANCE

David Montgomery, Director of the Division of Administrative Services, Nebraska Health and Human Services Department of Regulation and Licensure

Last year, I told you about Nebraska's Periodic Regulatory Evaluation Process (PREP). Nebraska has a strong central agency that regulates multiple health and health related professions, some of which are regulated without boards. The boards have largely advisory powers. For example, the boards are not the final determinants of sanctions or discipline. Our boards are not the final determinants of rules and regulations and they do not issue licenses.

Nebraska is in the midst of a multi-year effort to re-write our entire uniform licensure law. One of the things we hoped to do in the legislation was increase the number of public members on our boards by one. That met with favor from the boards, but not the Governor's budget office, so the proposal was removed.

The mission of PREP is to periodically evaluate the continuing success and effectiveness of a particular profession's regulatory mechanism in protecting the public. The impetus for beginning the program was simple. We have a strong sunrise program that a profession has to pass in order to become regulated. The PREP program takes existing licensure boards one-by-one and reexamines their entire regulatory structure --- the laws, the regulation, the board, and so on.

It is a quality improvement process. It is not a sunset process, because there is no threat under the PREP to the continuing existence of the board, unless there is a finding that it does not need to continue to exist.

The review is both internal and external. The board is involved, as are the profession, the public, and other professions that employ or work closely with the profession under review. We have three public members on every PREP committee. We had trouble recruiting public members for those committees until this year when we started recruiting from people who sit or recently sat as public members of regulatory boards other than the one we are looking at. On our present review of respiratory care, we have a public member of the board of medicine and a former public member of the board of psychology, both of whom are well-versed in the regulatory system and able to contribute right away to the process.

Each review is focused around eight generic areas:

- Qualifications to obtain / maintain the credential,
- Regulatory balance among issues of quality, access to care, and cost containment,
- Relationship factors promoting public protection
- Licensure issues, denial, and discipline,
- Regulatory structure,
- Evaluation of alternative means to ensure public protection,
- Trends and future issues affecting regulation of the profession, and
- Other issues as determined by the committee.

Regulatory balance recognized that the mission of professional regulation always will be quality and the protection of the public, but the decisions that are made in the regulatory also arena impact cost containment and access to care. Relationship factors promoting public protection refers to boards working closely with other boards.

The process begins with the appointment of a committee which does a self-study with the board covering each of the eight focus areas. Recommendations are made.

So far, we have discovered what we call the "Eureka" factor in each of the three completed reviews. That is, we discovered an issue that no one expected PREP to be able to deal with.

As an example, the review of the funeral board uncovered questions about who is protecting the public in relation to abandoned cemeteries. As a result of the PREP review, the inspection process was upgraded, the pre-need planning system was improved in cooperation with the Department of Insurance, and the legislature became interested in the issue of cemeteries.

The review of the physical therapy board revealed a problem with the physical therapy and Medicaid billing practices of the second largest school district in the state. The problem affected the practice of physical therapy and the willingness of the state Department of Education to abide by physical therapy statutes, which we found were in conflict with one set of Medicaid regulations. The review produced a revamped practice act and also managed to get the parties to agree on how to bill for educator services for physical therapy in a way that conforms to Medicaid requirements and the physical therapy practice act.

The review of the respiratory care professions is dealing with overlapping scopes of practice, profusion issues, and questions about the appropriate entry level to practice. The issue that emerged out of nowhere was the inability or unwillingness of durable medical equipment providers to

abide by the respiratory care statutes or the reimbursement requirements.

As we proceed through the reviews of future professions, we expect to uncover a "Eureka" issue or two in each one of them. What in the process facilitates the emergence of these issues? We believe that the PREP process empowers the parties to bring these issues into the open and address them either legislatively or through the regulatory process.

The PREP process was viewed as a threat three years ago, but now boards are overcoming their anxiety, especially regarding scope of practice issues. The sunrise program is responsible for scope issues. The one disappointment is that we haven't been able to develop a set of indicators or goals for public protection out of each review so we can evaluate the implementation of goals in the next round. In the future, we would like to do more than one review per year. We want to evaluate whether the process did improve the regulatory structures of the professions we reviewed. We hope to improve the recruitment and retention of public members on all advisory committees and boards. The PREP process will be part of that so we are looking forward to having an expanded pool of public members from which to draw.

We believe the PREP program has succeeded in giving us a structured process for evaluating the continuing effectiveness of a regulatory system in protecting the public.

Lucy Gee, Director, Florida Department of Health Division of Medical Quality Assurance

Last year, I talked about some of the challenges the Division of Medical Quality Assurance faces and some of the ways we divided up the development of performance measures for the administrative function and the board function. Boards delegate some tasks to staff, such as evaluating credentials. Some of the things they wouldn't delegate to staff include imposing discipline, rulemaking, and legislative proposals.

It is alien for board members to think they have to operate under performance standards or measures. So long as the administrative side doesn't have performance measures, the boards won't be convinced to embrace the concept.

The Division has adopted the framework of the Governor's Sterling Award to achieve organizational excellence with the hope of winning the award. The Sterling framework looks at leadership skills, strategic planning, customer and market focus, measurement analysis, human resource focus, employee satisfaction, process management, and organizational business results.

We have had two important discoveries since last year. First, our mission and vision for the Division were too long and intangible for what we want to achieve. The new mission is "to protect the public through healthcare licensure, enforcement and information." Thus, the mission now embraces consumer information as a core function.

Second, we lacked internal infrastructure support to embark on something like the Governor's Sterling Award. So, we have combined a number of services into one strategic planning unit that does statements of work, process management, task inventories, and performance standards. Then they write the reports compiling the data necessary to self-evaluation.

They developed an eight-step plan:

- Identify the purpose or mission of the board,
- Decide what the best board would look like,
- Determine the public perception of the board,
- Identify the performance measures,
- Assess board member competence,
- Develop data collection tools,
- Collect customer satisfaction data, and
- Do benchmarking.

The Boards of Pharmacy, Massage Therapy, and Osteopathic Medicine have begun to develop performance measures and goals. We are planning to focus on change management – helping people accept change – to facilitate self-evaluation and performance measurement at other boards.

Maryann Alexander, Associate Executive Director of Regulatory Programs for the National Council of State Boards of Nursing

The mission of the National Council of State Boards of Nursing (NCSBN) is to promote excellence for our 55 member boards. For several years, NCSBN has been engaged in a performance improvement project for state boards of nursing. It is called the Commitment to Ongoing Regulatory Excellence (CORE) and seeks to establish a performance measurement system that will identify best practices and promote excellence. It is definitely a work in progress since we regularly review the data and look for ways to improve it.

Some of the questions NCSBN and its boards are able to ask through this project are:

- How does my board compare with others?
- What are the trends overall across all state boards of nursing?
- Are improvements noted?
- What are the changes?
- How satisfied are stakeholders with their board of nursing?
- What are boards doing to make themselves more efficient and their stakeholders more satisfied?

We identified areas of regulation for study and developed survey tools for boards and stakeholders. We have learned that it is best to ask fewer questions that are truly directed at what we want to find out. We identified the stakeholders we were interested in and began data collection. There are two steps in the benchmarking process: performance benchmarking and process benchmarking.

The areas of regulation we are looking at include discipline, licensure, education program approval, and practice. The stakeholder groups we are looking at include licensed nurses, health care employers, nurses who have been the subject of complaints, nursing associations, and nursing education programs.

In our newest instrument, all lines are linked to measurable outcomes, data collection is streamlined and there is increased board participation. We have added questions related to information technology, finance, and board members. We are able to compare data between states, and we have

tried to be as objective as possible, although a lot depends on perception.

Our surveys of the boards of nursing ask questions about their procedures: the length of time it takes to process an application, the length of time to complete an investigation, the interval between site visits to education programs, and similar questions related to board efficiency and quality. Our stakeholder surveys are related to perceptions of the board: how timely are they, how fair are they, how adequate are the regulations, how satisfied are the stakeholders with communication, with the education approval process, and so on.

Performance benchmarking looks at how well boards of nursing are doing. Are they tracking the right measures, are they making progress fast enough and are they using best practices? With this data, boards can compare their performance with other boards. The National Council is not comparing boards to one another; the boards are doing it themselves.

Performance benchmarking is basically choosing measures, collecting data, analyzing it, and producing a report. Process benchmarking is more complex and enables us to identify best practices. We will assemble interdisciplinary teams including investigators, attorneys, board members, executive officers, etc. who will determine the standards against which to compare processes. We will look closely at the boards that exceed the standard and determine what they are doing that makes them different from other boards.

The data we have so far is all performance benchmarking data. States can look at their state rating and compare it with the aggregate rating. Thus far, 42 states have participated in at least one aspect of the study. Sixteen states have participated completely. Thirty-two states have completed the board survey and 14 provided at least one group of stakeholders.

What trends can be noted between the 2002-2003 survey and the 2005? In terms of timeliness to process applications that are complete, all boards have improved. Each state can compare its results to the aggregate data and learn whether it has improved more or less than the average. For example, we asked nurses their perceptions of how well their education prepared them to practice. There is very little difference between the 2002 and 2005 results.

To determine best practices, we will look at the relationships between data points, for example, the timeliness of handling complaints and the number of FTEs and staff workload. We plan to analyze one process at a time.

For example, what is the best practice for the disciplinary process? The information so far tells us that the important factors include the authority of the staff, management of the investigative staff, and consistency in sanctions. So far in our analysis, the boards that do well in these variables tend to be the most cost-effective, have the highest ratings in perceived fairness and timeliness, and the highest perceived quality and effectiveness of the disciplinary process.

Coming soon…

We're nearing completion on a long overdue redesign of our www.cacenter.org website. Look forward to the following changes:

- The Citizen Advocacy Center site will have an improved look and feel.
- Registered users will be able to post comments to the site, and will be able to stay in touch with us by updating their contact information online.
- Subscribers to the CAC News & Views newsletter will be able to download their newsletters from the site, and to access previous issues of the newsletter.
- There will be an online option to register for annual meetings.
- Payments for the CAC News & Views newsletter and for annual meetings will be accepted online through a secure interface.

It's not too late for you to make suggestions for what you would like to see on our website. Unfortunately, we can't take your suggestions online (yet). However, we welcome your ideas via email at suggestions@cacenter.org.