News & Views

Citizen Advocacy Center

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Announcements

Save the Dates:
We will convene a multi-disciplinary Continuing Competence Workshop May 12 and 13, 2008, in Washington, DC. Please visit our website at www.cacenter.org for more information and for registration forms.

Our 2008 meeting will be held on Monday, Tuesday, and Wednesday, October 27, 28, and 29, 2008, at the Renaissance Hotel in Asheville, North Carolina. It will be co-sponsored by The Health Licensing Boards of North Carolina.

REPORT FROM THE 2007 CAC ANNUAL MEETING

Editorial Note: CAC's 2007 annual meeting in Seattle, Washington was co-hosted by the Washington State Department of Health. The following report from the plenary sessions is not a verbatim transcript, but is faithful to the speakers' presentations and the question and answer periods that followed.

The meeting was entitled, Creative Regulation: Keeping Boards Relevant. The program announcement said that:

> ***Three pillars underpin the programs of health professional licensing boards: Licensing, Discipline, and Rule-making. In order to remain relevant, regulation must be creative, forward-looking and open to***

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> *change in all three areas: so this year's annual meeting addresses each one. For licensing, we will examine recent developments related to continuing competency requirements as a condition of licensure renewal. For discipline, we will look at how boards have improved their disciplinary processes, often in response to a media expose or auditor general critique. For rulemaking, we will look in depth at creative approaches licensing boards have taken to implement scope of practice expansions and at the innovative use of IT to implement educational requirements for licensure.*

Thirty-two states and twenty-three different types of licensing boards were represented at the meeting, along with representatives from Quality Improvement Organizations, specialty certification boards, the Federal government, and other interested organizations.

KEYNOTE ADDRESS: Are Licensing Boards Still Relevant Players in the Safety and Quality Arenas?

Mark Yessian, former Director, Regional Operations, Office of Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services, and CAC Board member

I ask you to imagine that it is tomorrow afternoon and you say to yourself, "It's been another great conference. How do they do it year after year? The sessions were terrific. We had great conversations. My head is on

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overdrive." During a break, you walk outside to get some air and find an inviting bench at the edge of Elliott Bay.

While there, you have a chance encounter with a fellow named Paul. He's a thoughtful-looking guy, so you don't mind when he joins you on the bench and asks what brings you to Seattle. You tell him you are attending a conference and he asks, "What kind of conference?

You say it's a conference about health care licensure boards. Paul asks what these boards do. You respond they are there to protect the public; they make sure everyone who has a license meets the necessary minimum qualifications. He asks how often one has to get a license, and you explain that it varies by state and type of board, but usually every couple of years.

Paul is digesting this and comes up with this question: "Can these boards assure me that any licensed health care practitioner I see is competent?" You decide to be straight with Paul, so you say, "Not necessarily. We can assume that they meet the necessary minimum qualifications. In addition, in some states, some boards also have a continuing education requirement licensees have to meet." Paul responds, "That's all?"

You say many licensees work for hospitals or other facilities that have their own internal review processes to review the quality of care being provided and the capabilities of individual practitioners. Paul asks if boards have anything to do with such institutions. "Well," you say, "Some may, but not usually."

"So, then," asks Paul, "are you really protecting the public from someone who is incompetent?" "Paul," you respond, "you didn't give me a chance to tell you that we spend most of our resources responding to complaints. If there is sufficient evidence of wrongdoing, we can take action; even revoke a license if the situation is that bad."

Paul observes that he sees all kinds of health care professionals and has never heard or seen anything about boards to complain to.

Imagine further that as you head back to the conference, you think about your conversation with Paul and acknowledge that boards are reactive. They don't have the mandate or the resources to be proactive in the sense of monitoring compliance with practice acts. Boards focus mainly on complaints and referrals but, it is true, boards can't be sure most people even know about them. Those who do know probably don't know the difference between a licensing board and a professional society.

So, you ask yourself whether the reactive role is sufficient in today's health care environment. It is an important role, but with all the transformations taking place since the boards were first established, do we need to make changes in order to be more effective in today's health care environment?

This is the question I would like to address in my remarks. Let's begin by looking at three key features of today's health care environment that have particular relevance to this question.

The first is heavy reliance on *systems of care*. All of the practitioners you license are part of a system of care that involves other care care-givers, insurers, government agencies, and health care facilities with which the licensees are affiliated or employed. More than ever, health care is a

team sport, yet, licensure boards focus on individuals and pay little attention to systems of care.

A second feature of the current health care environment is *the significant role of health care facilities and facility overseers*. Most health care, especially for very sick people takes place in healthcare facilities – hospitals, clinics, dialysis facilities, nursing homes, and so on. Within each of these facilities, there are varying degrees of internal oversight and peer review. Yet, as you acknowledged to Paul, boards tend to have little to do with this world. There are health departments, accrediting bodies, and others that do external review of care being provided in the facilities, yet, here again, boards tend to be out of the loop.

The third and biggest issue is that the overall health care system is facing *major strains that constrain access, raise costs, and produce uneven quality*. This situation makes the role of quality assurance bodies such as licensing boards all the more important, yet in carrying out their traditional functions, boards can do little more than play around the edges. In fact, some would say the predominant restrictive scope of practice laws contribute to the problem by precluding many categories of professionals from using the full range of skills for which they have been trained.

Scope of practice is getting more and more attention, and there is no one who has been for focused and more critical than Dr. Ed O'Neil, Director of the Center for Health Professions at the University of California, San Francisco and formerly head of the Pew Health Professions Commission. Ed O'Neil wrote recently:

> The practice acts that define professional practice are vestiges of a bygone era. As they emerged at the end of the nineteenth century, they were established to protect the public and the interests of the profession. Today, they still protect the guild interest of the professions, but their capacity to assess what is needed by the public and how that might best be provided has long since disappeared.

This is strong stuff and it might annoy some of you, but he is not a lone voice in the wilderness. This is a view that is getting more and more prominent.

Let's go back to the nagging question. *Is this reactive role sufficient in the current health care environment?* I think not.

I think boards can and should play a more proactive role, and I will use the rest of my time throwing out a half dozen ideas on what that role might be. I offer these ideas more as a thought exercise than a practical agenda for everything that might be done. Someone asked yesterday what we get out of these conferences. What can we take home with us? My response is *ideas*. Ideas can be very practical. They can lead one to ask questions and push in directions that make a difference. I will now talk about ideas about how boards can play a more proactive role.

First, *make sure licensees are subject to credible continuing competency assessments.* To me, this is the number one issue – the biggest issue – and we will devote the rest of the morning to it. If boards can't do more to convince Paul and others like him that they have credible

mechanisms for assessing current competence, I think they will remain in the quality assurance backwaters. This is a complex issue. There is no one easy answer. Ideas need to flow; we can explore different kinds of approaches. Boards will have to develop continuing competency standards. When it comes to assessing compliance in accordance with these standards, boards could do it themselves, and/or they could contract it out to other entities, such as hospitals or specialty certification bodies.

During the summer, I was in London and stopped by the General Medical Council, which is like the medical board for the entire United Kingdom. This was shortly after the terrorist bombings with which foreign-trained doctors were associated. One of the public protection ideas that was gaining traction was to limit the practice of certain categories of doctors, such as newly trained or newly licensed doctors, doctors who had been out of practice for a while, and maybe certain doctors coming in from other countries where the training might not as good as in the U.K. The practice of these doctors would be limited to what they call "approved practice settings." By this they mean a setting where the medical board has determined there is adequate continued competency assessment going on, adequate internal review. While this idea is yet to be implemented, it represents the sort of linking of the regulation of individuals to the regulation of facilities that I think is crucial if boards are to play a key role in coming years.

*Connect more closely with the patient safety movement***.** The patient safety movement, let's be clear, is all about medical errors – especially serious errors that lead to patient injury and even death. This is a different universe than boards typically operate in. It focuses on system-oriented, blame-free approaches to errors. Its raw material is adverse event reports. When something goes wrong, an adverse event report is filed, a root cause analysis is done, and corrective measures employed to prevent the error from occurring again. How can boards connect with this different universe?

One way of connecting more closely with this movement is to have a whole separate function within the medical board (with a firewall between the disciplinary function and this new function) that focuses on receiving adverse event reports from facilities. Then, when you get these reports, to work with the facilities to see how effectively they have responded to them, to see that they have put in place mechanisms to prevent them from happening again, and then to develop a data base to be used to provide alerts to other facilities so the same things don't happen in their settings. Some of you may think this is a fantasy. It may be, but the Massachusetts Medical Board has been doing this for a number of years, and with some degree of success.

Establish mechanisms for identifying, assisting, and monitoring marginally competent licensees. I think we would all acknowledge that every profession has licensees whose practice skills are questionable and who represent a danger to the public. The challenge is to intervene before bad things happen. This idea, as most of you know, is important to the CAC which has had a PreP 4 Patient Safety demonstration underway for several years. PreP stands for the Practitioner Rehabilitation and Enhancement Partnership which offers boards and health care facilities the opportunity to work together, outside the disciplinary process, to identify, remediate and monitor licensees who have practice deficiencies that are not yet at a level warranting reporting for disciplinary action.

This is a difficult line to find, but it is doable. For licensees who enter a program of this nature, there would be supports put in place – training and other supports – that provide assistance and monitoring, while allowing the licensee to practice at the same time. Polly Johnson talked yesterday about the impressive efforts underway at the Board of Nursing in North Carolina.

Search for system interventions that can be linked with board orders. When an investigation generates enough credible evidence to warrant some kind of board order, there is a portfolio of possible actions, from revocation to reprimand. Beyond action involving a licensee, is there something about the fact pattern that suggests an opportunity for intervening in the system of care? You could argue that any complaint related to care provided in a facility is by definition a system issue. Why were the facility's processes unable to prevent the problem?

Some of you may be thinking that you don't have jurisdiction over the facility. My response is: "Think about 'soft power.'" This is a concept advanced in the foreign policy arena by an academic named Joseph Nye who is often critical of the U.S. government's militaristic approach to international problems. He says there is such a thing as *soft* power, which can take the form of moral authority, diplomacy, use of the bully pulpit. I believe state boards have soft power that is largely unused. People will listen to you because you have control over the license.

Where might boards exercise their soft power? Examples that come to mind include a hospital's drug review procedures, a clinic's training or hiring practices, a provider group's patient referral practices. Boards miss a lot when they just discipline the individual even while they have information that bears on system issues.

*Identify and share systems information culled from complaints***.** Most complaints you receive are dropped, sometimes for jurisdictional reasons. Ask yourselves these questions: Of this universe of complaints that don't lead to board action, how many, if properly examined, could signal some kind of system safety problem? Are there ways in which your investigators could be trained to flag such cases and for your boards to refer them back for further review to the facility, or even to the facility overseer?

Examine scope of practice laws to determine if they allow licensees to perform the full range of skills for which they have been trained. There is a lot of skilled talent out there that is bottled up because of scope of practice restrictions. It is past time to give attention to this issue. The states have become a primary locus of action related to health care reform. From what I understand, the state that has been most out-front so far is Pennsylvania, where Governor Rendell's health care reform proposals have a scope of practice plank aimed at relieving shortages of health care providers, improving access to services on nights and weekends, and not least of all, increasing the diversity of the health care workforce. This particular proposal would involve such elements at permitting advanced practice nurse practitioners, physician assistants, pharmacists, dental hygienists, and others to perform all the procedures they were trained to do. It would allow nurse midwives to practice and to prescribe medications under certain conditions, and allow dental hygienists to practice independently in schools, clinics, and other such settings.

To sum up, I wouldn't be surprised if some of you are asking, "Where is this guy

coming from?" Barbara Safriet yesterday spoke about the realities of our health care system and how the things I am talking about would create all kinds of difficulties and unintended consequences.

You might also ask, "Where is the support for all of this?" I doubt that most professional associations would buy into this kind of agenda. Even the citizen groups you claim to represent aren't banging down our doors for this kind of change.

I sympathize with such doubts. But, I also believe it is important not to belittle what each of us can do to change things. It is really important from time to time for any organization to examine how well it is accomplishing its basic mission and to think imaginatively about new approaches. Boards can't turn things around all by themselves, but they can exert leadership. They can raise questions, acknowledge the limitations on what they can do, and assess the consequences of this. They can recognize the importance of taking more proactive approaches, no matter how impractical they may seem at first.

You as public members are particularly well-suited to take the lead because you have the broader perspective. This gives you credibility when you raise these kinds of possibilities and point out the potential that exists.

Let me say one other thing about practicality and change. My sense is that significant change happens more frequently as a result of external jolts rather than internal deliberations, as important as they may be. You know what I mean by external jolts – the horror case on the front page is certainly one. My favorite example occurred in New England years ago. One doctor felt it was only right that everyone should have a pacemaker, whether they needed one or not. The outrage when this was discovered led to a total shakeup at the Rhode Island medical board and the appointment of 50% public members.

When such jolts happen in your sphere, there will be a lot of people asking where you were and why you didn't do more to protect the public. I say, be ready. Be ready with a package of ideas so that at that critical moment, you can suggest proactive ideas for how your board can better protect the public. Even in the midst of current realities, search for ways to heighten awareness of how boards can and must play a more proactive role in carrying out their patient protection mission.

LICENSING SESSIONS

CAC's Roadmap to Continuing Competence Assurance

Becky LeBuhn, Board Chair, CAC

For some time, CAC has been pressing licensing boards and other organizations, such as certifying bodies, to be more aggressive about promoting continuing competency assessment and enacting requirements that health care practitioners demonstrate their competence as a condition of relicensure or recertification. Mark Yessian spoke of external jolts that promote change. We have seen several jolts or driving forces during the years we have been advocating for more meaningful continuing competency requirements. One of these was the 1999 Institute of Medicine Report, ***To Err is Human***, in which it was estimated that there are as many as 98,000 deaths a year attributable to preventable errors in hospitals. In all health care settings, there

may be as many as 195,000 preventable errors.

Moreover, studies show that the public *expects* to receive safe care; they assume that licensure means a governmental assurance that health care practitioners are currently competent. As we will hear later in connection with the public's expectations, the Virginia chapter of AARP did a survey of Virginians aged 50 and older. Two findings are relevant here. Sixty-eight percent of respondents believe that being license *means* the provider has undergone periodic evaluation and assessment. In response to another question, 98 percent of respondents indicated the feel it is *important* for professionals to periodically demonstrate their current competence.

The licensure system was established in a simpler time, when it was probably okay to rely on a diploma from school and a licensure exam to verify competence and to look to professional societies to do continuing education. However, the current environment of rapid technological change requires different approaches to verifying current competence.

The evidence is that it takes as long as seven years for current medical technology to be incorporated into mainstream practice. We also know that the older a practitioner gets, the more prone he or she is to errors, not simply because of age, but because they are farther away from academic training and the current state-of-the art. Insisting on demonstrations of current competence could change both these findings.

Are we at a tipping point? Probably not, but we see some evidence that there is far more attention being paid to continuing competency requirements and some action taken. In the errors report I referred to earlier the IOM recommended that health care licensing bodies should:

1) Implement periodic reexamination and relicensure of doctors, nurses and other key providers, based on both competence and knowledge of safety practices, and

2) Work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

Among others, the Pew Health Professions Commission made similar recommendations.

A few states and a few licensing boards have taken steps to implement continuing competency requirements and we will hear more about that at a later panel. Significantly, all 24 member boards of the American Board of Medical Specialties have committed to implementing lifelong learning requirements and a multi-faceted Maintenance of Certification (MOC) process. Many of these boards are close to having this fully implemented. The process will require demonstrations of competence through a variety of methods including, tests, peer review, patient and co-worker evaluation, and other methods. Some major health plans are going to factor conformance with MOC into their recognition and reward programs for practitioners. At least on presidential candidate is recommending that Medicare take maintenance of competence into consideration as part of its reimbursement structure.

Associations of regulatory boards in fields such as medicine, nursing, pharmacy, physical therapy, optometry, psychology, and others are actively exploring how to address continuing competence in their respective professions. And, even a few professional associations are joining the movement. The American Nurses' Association, for example, has issued a draft policy statement on continuing competence for public comment. In it they say:

> ANA believes the public has a right to expect nurses to demonstrate competence throughout their careers. Assurance of competence is the shared responsibility of the profession, regulatory bodies, employers, individual nurses, and other key stakeholders. Competence is definable, measurable, can be evaluated, and context determines what competencies are necessary.

David Swankin, President and CEO, CAC

In CAC's paper entitled, ***Implementing Continuing Competency Requirements for Health Care Practitioners***, which was published by AARP's Public Policy Institute, we made the following seven recommendations. This morning, we will talk briefly about each of them:

1) Eliminate continuing education requirements.

2) Mandate that as a condition of relicensure, licensees participate in continuing professional development programs approved by their respective boards.

3) Mandate that the continuing professional development programs include a) assessment, b) development, execution and documentation of a learning plan based on the assessment, c) periodic demonstration of continuing competence.

4) Provide licensure boards with the flexibility to try different approaches to foster continued competence.

5) Ensure that boards' assessment of continuing competence addresses the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure.

6) Require that boards evaluate their approaches and gather evidence on the effectiveness of various methods used.

7) Authorize licensure boards to grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care institutions, when the private programs meet board-established standards.

The first recommendation is to eliminate continuing education requirements. We wrote it that way to get everyone's attention. Obviously, we are not going to eliminate continuing education programs; this is one of the main ways people keep current on new developments.

The point is that continuing education is a means and not a surrogate for maintaining continuing competence. The legislatures established requirements for entry into practice and set up disciplinary programs for the boards to deal with the small percentage of practitioners charged with violating the practice act. When it came to re-licensure, some state legislatures enacted continuing education requirements. About a decade ago, the Colorado nursing board repealed all continuing education requirements, saying the literature could not establish its relationship to competence.

Continuing education is important. If a strong current competence model is adopted by the states, it is likely to result in more rather than fewer continuing education courses. However, the way we currently do continuing education is terribly flawed, as many of you would acknowledge. Practitioners take any courses they want at any time, whatever is convenient, or packaged with an attractive trip. The real flaw in our current approach to continuing education is that course selection is not based on an assessment of the individual's strengths, weaknesses and learning needs.

Secondly, continuing education requirements are almost always based on seat-time. You have to show you were there. You don't often have to show that you learned anything. Nor, do you have to demonstrate that what you learned in the course was incorporated into your practice. Suppose your record-keeping is poor. The reason may be that you don't know how to keep good records. Or, it may be that you know how, but are too lazy to keep good records. No amount of seat time in a continuing education course is going to fix things if the problem is behavior rather than knowledge.

What we really are saying is not to eliminate continuing education, but to improve the way we do continuing education and to look at it as a means to an end. The end is to demonstrate that you are currently competent. The means is likely to include appropriate continuing education courses and learn the content.

LeBuhn

Our second recommendation is that state laws should make demonstrations of current competence a condition of relicensure. This is "the mandate." Another Institute of Medicine Report in 2003 called, **Health Professions Education: A Bridge to Quality**, reiterated the basic point:

> All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care as defined by the five competencies (identified in the report) through direct measures of technical competence, patient assessment, evaluation of patient outcomes, and other evidence-based assessment methods.

A similar recommendation was addressed to certification bodies. At CAC, we agree that a legislative mandate directing licensing boards to develop and implement continuing competency requirements is absolutely necessary for this to move forward. There are several reasons why we think this.

We and others have been talking about meaningful continuing competence for years, and very little has happened. Even though there has been experimentation and the creation of some really good programs,

primarily by non-governmental entities such as specialty certification bodies, only a small percentage of the practitioners in those professions actually take advantage of the opportunity to participate in continuing competency assessment and demonstration programs.

Another reason a mandate is necessary is that the licensing boards are the entity legally responsible for protecting the public. They are the only authority that has jurisdiction over everybody practicing in any given profession. We believe that boards should be working with other institutions that are also committed to meaningful continuing competence, but that the ultimate authority has to rest with the licensing board as the preeminent legal entity responsible for protecting public safety.

Swankin

We recommend a five-step model that draws heavily on the work of many others. The first step is routine periodic assessment. Assessment is key, because this is where one determines what it is they need to know to improve their practice and maintain their current competence.

The second flows from the first. You develop a personal plan based on the assessment. The third is implementation of the plan; the fourth is documentation that you have implemented the plan. The fifth is periodic demonstration that steps one through four have ensured that you are currently competent. I consider the first four steps to be quality *improvement* and the fifth to be quality *assurance*.

If we adopted only steps one through four, I'd be the first to say we've made a huge improvement over what we do now. But, unless we include the quality assurance step, we haven't done it all.

The fifth step is the toughest one. Requirements for initial licensure assess whether applicants *know* the basics. Continuing competence needs to assess also what practitioners *do* in their current practice setting. It is more complicated that taking another test.

LeBuhn

The fourth recommendation would give licensing boards flexibility to try different approaches to fostering continuing competence. We recognize that we don't know everything there is to know about effectively to demonstrate competence, so experimentation is needed and appropriate.

Each profession is likely to approach this differently. To illustrate this, we often contrast medicine with other professions, such as pharmacy. In medicine, the overwhelming majority of physicians are certified by one or another of the American Board of Medical Specialties certification bodies. A licensing board that chooses to recognize that certification has a very different job than a board of pharmacy because only a small fraction of pharmacists are certified by any specialty body. So, a pharmacy board would be responsible for creating and implementing a continuing competence requirement.

We don't yet know which are the most efficient and effective methodologies to use to demonstrate current competence. There are many from which to choose, and a number of organizations are now experimenting and gathering data.

For example, the ANA document I mentioned earlier states that, "Competence

can be evaluated by using objective and subjective data in a combination of the following tools, as appropriate to the specific situation and desired outcome of the competence evaluation." They refer to assessing knowledge and actual performance. They suggest tools such as direct observation, patient records, portfolios, demonstrations, skills labs, performance evaluation, peer review, credentialing and privileging, simulation exercises, computer-simulated and virtual reality testing, targeted continuing education with outcomes measurement, employer skills and practice evaluation.

The American Psychological Association is working on a competency benchmark document which suggests various assessment methods applicable to various levels of practice. For example, for students entering a practicum, one would evaluate academic products; for evaluating students entering an internship, direct observation by supervisors and peers would be appropriate; for individuals entering practice, supervisor, peer, client and self-evaluation is appropriate; to assess psychologists ready for advanced practice, use of standardized patients, supervisor review, peer review and review of professional activities are appropriate.

Canada's National Association of Pharmacy Regulation has designed a model program which will test four instruments: 1) a written or computer-based knowledge assessment, 2) peer and patient assessments, 3) simulated patients and situations administered via objective, structured clinical examination, and 4) analysis of prescription data bases.

The American Board of Medical Specialties and the Accreditation Council for Medical Education have a tool box of assessment methods they use for evaluating residents. These include 360 degree evaluation of actual practice, chart-stimulated recall, oral examination, checklist evaluation, global evaluation of live or recorded performance, objective structural clinical examination, and so on.

Licensing boards, certification bodies, and hospital privileging authorities are using some of these methods and are beginning to learn which ones are most effective and least burdensome. We'd like to encourage additional experimentation.

CAC plans to conduct a workshop in the spring in Washington, DC where we plan to look in depth at every one of the main methods and explore their strengths and weaknesses and their applicability to various professions. For example, 360 evaluations are suitable where there are peers and patients to participate, but what about professions such as pathology which are practiced in a setting less susceptible to that sort of evaluation. We hope to have all the stakeholders participate in this workshop because we recognize it is important to have broadly-based buy-in in order to make progress in this area. We think we are at the point where it is the methods and the evidence-base that are the obstacle to progress rather than disagreements over the desirability of continuing competency requirements.

Swankin

The next recommendation is to ensure that boards' assessment of continuing competence addresses the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of

relicensure. The key here is the concept of current practice setting.

The goal is to demonstrate competence in what one does now, not simply mastery of academic learning. The American Board of Internal Medicine, for example, is not interested in measuring whether its diplomates know a little bit of everything, as they did when they first earned their licenses. It is interested in competent performance in the current practice setting.

LeBuhn

The sixth recommendation is to require that boards evaluate their approaches and gather evidence on the effectiveness of various methods used. This really is self-evident and self-explanatory and we have already discussed the importance of evaluation in connection with other recommendations. Experimentation and evaluation are critical to developing an evidence base as a foundation for legislation and rulemaking in this area.

Swankin

The final recommendation is to authorize licensure boards to grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care institutions, when the private programs meet board-established standards.

The notion of deemed status is this: If competency assessment and demonstration is already being done well by somebody else – a hospital, a certifying body – there is no need for licensing boards to enact duplicative requirements. Before according deemed: status, boards would have to satisfy themselves that the third-party's program meets board-established standards.

A document soon to be released by the Federation of State Medical Boards is likely to recommend that medical boards recognize conformance with the specialty certification boards' Maintenance of Certification programs as evidence of current competence.

The concept of deemed status will make continuing competency requirements more acceptable and more efficient. It will take away the stigma that this is a punitive undertaking. The key for the boards will be to set the standards through rulemaking for what they consider to be an acceptable demonstration of competence to a third party.

How Others Are Addressing Continuing Competence

Ilene Henshaw, Associate Director, State Legislation, AARP

In many states, Governors and legislators are proposing significant health care reforms in response to the public's demand for positive change. What does this have to do with continuing competence?

AARP believes that to be successful, health care reform must address access, cost and quality. If a proposed reform deals only with access, costs will increase. If lowering costs is our only concern, access may be limited and quality may suffer. If quality is the only focus, we will have done nothing about the number of people without insurance.

With respect to AARP's efforts to improve the quality of health care, we are pushing in state legislatures throughout the country for greater transparency -- public accountability through published performance assessments of practitioners and facilities. We are urging

more widespread adoption of health information technology. We are working for payment reforms, such as better alignment between payment and performance. We are advocating for delivery reform, such as chronic care coordination and demonstrations of continuing competence.

There are two major reasons AARP Virginia decided to take on the issue of continuing competence. The very first reason is that we were pushed into this by a wonderful AARP volunteer, Dr. Richard Morrison, who first brought the issue to our attention. Dick had had a very successful health policy career before joining AARP Virginia's Executive Council in 2004. He was absolutely tenacious in his efforts to get us to take on this issue. He organized the first AARP Virginia Task Force on improving the safety and quality of health care in the Commonwealth. He was one of the authors of the Public Policy Institute's report that we just heard about. Until he passed away earlier this year, he made it his mission to put this issue high on AARP's agenda. We listened and were convinced.

The second reason AARP Virginia took the issue on was the survey you have already heard about. AARP doesn't take on any public policy issue without doing research. We want to hear from our members and from the public about what is important to them. We listened to the public and they told us loud and clear at this is an issue that resonates with them. They want something done about it.

We polled eight hundred Virginians aged 50 and older to gauge their awareness, understanding, and support for systems that would periodically evaluate health care professionals. Highlights of the survey are available at www.aarp.org/states/va/.

This is what we found. A whopping ninety-five percent of respondents told us that health care professionals should be required to demonstrate that they have up-to-date knowledge and skills as a condition of retaining their licenses to practice in Virginia. Nine in ten Virginians thought it was extremely or very important for health care professionals to be periodically reevaluated to show that they continue to have those skills.

The real turning point for us was uncovering important misconceptions on the part of the public. Misconception number one is that more than fifty-eight percent of our survey respondents thought this was already happening. They incorrectly believed that health care professionals were already required to demonstrate that they have up-to-date knowledge and skills.

Misconception number two: Respondents were asked what they thought being licensed meant in Virginia. More than half (fifty-two percent) incorrectly believed that being licensed meant that a health care professional had undergone periodic evaluation and assessment when this is actually not the case.

In a nutshell, a majority of the public believed that Virginia's current licensure requirements afforded the public far greater protection than was actually true. The public's expectations, which AARP believed to be totally realistic and appropriate, are very much out of sync with the current licensing system in Virginia.

We took the survey a couple of steps further. We asked the respondents about their support for specific evaluation tools that could be used to assess the continuing competence of health care professionals. These tools, such as reevaluation every five

years, rating by patients or peers, requiring high success rates for the conditions they treat most often, were all given a very big thumbs up by the survey respondents (ninety percent or more).

A couple other key findings include the fact that respondents are concerned about medical errors. While eighty-seven percent of respondents were generally satisfied with the quality of their own health care, thirty-three percent said either their own selves or a family member had experienced a medical error. Not surprisingly, the survey respondents favored a wide range of practices designed to reduce medical errors, such as having sufficient nursing staff, certain quality control systems, and suspending the licenses of professionals with a pattern of committing medical errors.

Our survey also told us loud and clear that Virginians wanted more information about health care quality. While most reported that their own doctor was licensed, most did not know if the doctor was board certified. Fewer than half remembered seeing any information over the past year that compared performance. Yet, over eight in ten said such information would be extremely useful.

When we do these surveys at AARP, we often have the opportunity to listen to some of the respondents. There was an amazing amount of confusion in response to these questions. People asked, “Are you telling me this isn’t already being done?” There was total incredulity.

After sufficient prodding from Dick, our concern about the widespread misconceptions on the part of the public about the level of protection, and the strong public support for action, we embarked on our continuing competence journey in Virginia. Losing Dr. Morrison was a blow to our efforts, but another volunteer, Dr. Ed Susank, stepped up to the plate to lead our efforts. Ed has had a long and distinguished career as a health care consultant and he is a sought-after expert on a wide range of employee benefit and health care issues.

We created a task force to study the issue and lay out a strategy. The task force is made up of volunteers with experience and involvement in health care. We have physicians, nurses, hospital administrators, folks with experience with regulatory boards and consumer advocates. The task force also includes staff from our office in Virginia and our national office, and consultants from CAC.

The next important step was to start ongoing dialogue with stakeholders, including health care providers and regulators. Very early in the process, we met with the Virginia Board of Health Professions, with the co-chairs of the Patient Safety and Transparency Workgroup of Governor Kaine’s Healthcare Commission. We met with the Virginia Medical Society, numerous state associations representing hospitals, dentists, pharmacists, nurses, and long term care facilities.

What are we learning from these meetings? We learned that most of the professions are aware of the issue, and some have taken steps to address continuing competence. We also learned how to better communicate with these groups in a non-threatening way. We began to talk about how our goal would help ensure that systems are in place to verify competence, rather than imposing burdens on individuals to demonstrate their continued competence.

As a result of this process, we decided to work for the introduction of legislation that would authorize a study by the Joint Commission on Health Care, a legislative

commission made up of members of both houses of the Virginia General Assembly. This study would determine how the various health professional licensing boards can best implement demonstrations of current competence. We don't anticipate that all the professions will measure competencies in the same ways. Part of the reason for recommending a study is to give each board an opportunity to tailor its requirements to the unique characteristics of the professions they regulate. In fact, we hope that there will be pilots set up to pilot and compare the reliability of the various measures.

Not only are there thirteen different licensing boards in Virginia, from audiology to veterinary medicine, there is a wide range of entities and professions that are regulated. Some practitioners are hospital-based and are already being reassessed in a credentialing process. Some are already required to demonstrate continuing competence. We don't want to reinvent or replace any of these processes. We merely want to make sure that some effective measurement of current competence is applied to all health care practitioners.

We recognize that there are many methods of demonstrating continuing competence. Some professions might use a peer review process; some might opt for chart review; others might use professional portfolios. If a group wants to use continuing education, we won't object so long as the practitioner is taking a class that focuses on an identified need in his or her practice and that someone verifies that the practitioner has successfully addressed that deficiency. We don't want to perpetuate a continuing education system that merely verifies attendance.

We are going to move forward, advocating for legislation to require a study by an appropriate body (still to be determined) which will include recommendations for action. We will draft legislation, find sponsors, organize a broad-based coalition, train our advocacy volunteers, develop a communications plan, ensure the issue gets full debate in the 2008 legislative session. We fully expect it to be a multi-year campaign.

In the short-term, our goal is to gain commitment and support from the public and key policy makers that this public policy change is needed in Virginia. We believe we have a window of opportunity and we need to act now with the momentum from our survey and the results of our stakeholder meetings.

This may be the most challenging issue AARP Virginia has undertaken. But, we believe that winning this will make a real difference in AARP's members' lives. The issues has the added benefit of strengthening the clout and influence of AARP in the Commonwealth of Virginia, helping us to attract high-impact volunteers, coalition partners and allies, and adding new members to the already one million AARP Virginia members.

This is a highly complex issue that is difficult to message and communicate. We are working on developing communication tools to support the campaign. We are also going to have to deal with the strong opposition of influential provider groups, some of the Board of Health Professions staff, and certain faculty that train health care professionals. We are making slow but steady progress. Virginia prides itself with incremental approach to policy change. We are trying to make a state that is not often known as cutting-edge into a national leader in this area by rejecting the obsolete model that it and many other states use to license health care professionals.

As we move forward, we hope to replicate our continuing competence efforts in other targeted states. To make it easier for other state offices to take on this issue, and with CAC's help, we hope to prepare a tool box, including substantive background on issues, frequently asked questions, alternative legislative approaches, model ads, testimony, and the like to help other states get started.

We are encouraged that there seems to be a groundswell for change and that this issue is gathering momentum. We are pleased to be playing our part in making a real difference in the quality of health care for Virginians and all Americans.

Bonnie King, Director, State of Washington, Health Professions Quality Assurance

I will take you on a journey across some pretty rocky terrain. To provide a context, let me talk a little bit about our regulatory framework in Washington State. The Department of Health and independent boards and commissions set standards, credential and discipline for sixty-two professions. There are fifteen governor-appointed boards and commissions that regulate thirty-three of the sixty-two professions. The Department of health regulates the other twenty-nine professions. Together, we regulate about 320,000 health care professionals and process 8,000 complaints a year with a staff of about 250.

Regarding the history of continuing competence in Washington State, many years ago laws were passed that either required or permitted continuing education. However, in the mid-1980ies, the legislature and the department concluded that continuing education was not an effective program for assuring practitioner competence. In 1991, the legislature passed a new law authorizing regulatory entities to require licensee participation in continuing competency pilot projects. Although the legislation read well, it encountered implementation difficulties.

As an example, in 2000, the Board of Psychology invited volunteers to participate in a pilot project involving extensive self-assessment, planning a program of learning objectives, and carrying out that program over a three-year period. It was to be an alternative to existing continuing education requirements for relicensure. However, the Washington State Psychology Association had other ideas, and in an alert to the membership encouraged them to decline participation in the project for the following reasons:

- They said it would be a high risk to participants because the paperwork for self-evaluation is a public record subject to disclosure in the event of a civil lawsuit against participating psychologists. In Washington State, we are required to disclose just about everything, except complainant names or medical records. Documents that come into the department are subject to public disclosure.

- They said it was based on bad science because the correlation studies were done with nurses and other health care providers who work under direct supervision, so generalization to psychologists in private practice was not warranted. Also, the decisions would be made by the board based on the self-assessments done by only twenty self-selected psychologists. In fact, the psychology board was looking

for volunteers just to try out the self-assessment approach.

- They said it was bad public policy because there was not a rulemaking process since participation was voluntary. Therefore, there was no opportunity for the association to provide meaningful input. The lesson learned there is to get your association on board early.

- They said it would be bad psychology in Washington because "it is important for psychologists to maintain our position in the marketplace. Mandatory CE is a requirement we share with psychiatrists and mental health professionals. This pilot begins the slippery slope toward removing mandatory CE, and thus toward lessening the distinction between PhD providers and other groups."

- They also encouraged the board to delay implementation of the pilot so immunity could be obtained in a more thorough and collaborative investigation situation.

In 2001, there was a proposal in the department to amend the pilot continuing competency project law. The proposed amendment would have exempted continuing competency tools, specifically self-assessments and peer assessments, from public disclosure and discovery. Practitioners would have been able to participate without fear of liability or disciplinary action.

We talked with stakeholders to determine their positions on this concept. The psychology association supported exemption, but not continuing competency proposals. The medical association was skeptical. The dental association was neutral on the bill, but opposed to continuing competency proposals. The chiropractic association and dental hygienists were supportive. The newspaper lobby, which is important in sunshine states, was neutral until further consideration. The concept for the bill went nowhere.

At that time, about half of the professions still had mandatory continuing education in rules, even though our previous governor issued an executive order in 1997 mandating that every rule in the state be reviewed to determine whether, among other things, the rule provides the results it was originally designed to achieve in a reasonable manner, and whether there are regulatory alternatives that could more effectively and efficiently achieve the same objectives. Also, the department had already concluded in a 1999 study that CE should be voluntary, not mandatory, and that we should pursue continuing competence.

One word of caution when looking at continuing competence models is to decide what you will do with the information when you learn that a licensee doesn't measure up. Because we have mandatory CE, we have to do random audits to see whether licensees are complying. When we find that someone has not done the required CE, that information is sent back to the disciplining authorities who have to decide whether the matter rises to the level of discipline. If they chose to do nothing, what message does that send with regard to the audit? If they chose to do something, a case is opened, investigated, added to the mix of cases along with sexual misconduct, fraud, and standard of care, and probably assigned a low priority and added to the backlog. So, it is important to anticipate what will happen with

information that a licenses does not measure up to expectations.

There were some continued, valiant attempts in Washington State. In 2002 and 2003, the Chiropractic Quality Assurance Commission conducted a paper survey about self-assessment with 159 questions, many open-ended. Eight hundred chiropractors responded. The commission determined that the effort was too resource-intensive and abandoned the project.

In 2003, the orthotists and prosthetists passed rules regarding categories of continuing competence activities. In 2004, the physical therapy board adopted rules requiring evidence of continuing competence every two years in the form of education and employment related to PT. In these two instances, and in virtually every other case, according to the AARP report, the rules consist of requirements for continuing education and documentation of the completion of CE, not necessarily complying with the spirit of continuing competence. We don't have any evidence in Washington that the approaches taken by the two boards improved practitioner performance or lessened disciplinary activity.

Have we given up? The Nursing Care Quality Assurance Commission has not given up. In January 2006, they began work using a portfolio approach to self-assessment. They backed away from that because of the possible liability consequences of sharing documents with the department. But, just this month, the Commission requested authorization to begin a pilot project and rulemaking in keeping with the 1991 legislation. They will be using the North Carolina model as a starting point.

Over the past two years we have surveyed boards and commissions to see how we can continue to improve services and support for their regulatory activities. One thing we have learned is that the boards and commissions want more collaborative activities. Continuing competence is one of the areas which would provide that opportunity.

While we have traversed rocky terrain in the past, we are hoping that building on past successes and working in partnership with all of the stakeholders, we can smooth the way in the future.

Melanie Brim, Director, Michigan Bureau of Health Professions

Michigan has twenty-three regulatory boards that license and register approximately 400,000 individuals in thirty-five different professions. We have been exploring continued competence and are at what I call the baby steps stage.

We have had a statute since 1986 that says boards "may promulgate rules to establish a system of assessing continued competence of licensees as a condition of periodic license renewal."

The good thing about the statute is that it used the phrase "continued competence." The bad part is the word "may."

Of our twenty-three boards, only nine have a continuing education (CE) requirement. The remaining boards require sending in a form and paying a fee for licensure renewal. Some of these boards wanted continuing education, but the lack of evidence to show the efficacy of CE caused our prior governor to issue a moratorium on additional CE requirements.

In 2004, things began to change in Michigan, in part because I attended the CAC summit on continuing competence. My licensing director and I returned home from that summit very inspired and ready to change the shape of Michigan related to competence.

Our opportunity surfaced when the respiratory therapists were successful in becoming licensed, after several years of trying. They started with a CE requirement, about which our new governor was ambivalent. She indicated she would consider alternatives to CE, recognizing the challenges to the effectiveness of CE as a way to change or modify or enhance behavior.

After negotiations, the governor's office agreed to a pilot study to review alternatives to CE. The respiratory therapists' legislation was passed without CE, but with an administrative agreement to look at alternatives for continued competence. The respiratory therapists formed an ad hoc committee to look at alternative approaches and make recommendations. After a year, they produced a nice analysis.

In the meantime, participation in the project was extended to other professions, including psychologists. The social workers had succeeded in gaining licensure status and wanted CE in their legislation, but the governor included them in the pilot instead. At that point, it was only equitable to include other professions that had been requesting CE requirements, including veterinary medicine, physical therapy, and professional counseling. So, the pilot study quickly encompassed five different boards.

Respiratory therapy's ad hoc group's proposal was submitted to the governor who gave her approval in July 2007 (despite objections from a splinter group of psychologists) to a plan allowing for voluntary participation by boards. If they wanted some sort of competency evaluation, it would have to follow the approved structure.

The proposal approved by the governor recognized that

- Continuous professional development is an essential part of any professional's career.
- Boards need a mechanism to ensure that knowledge, skills, and abilities at least remain current and, at best, are continuously improved.
- Competence is diverse and difficult to measure objectively.
- There is a rapid turnover of knowledge in all health professions.
- Self reflection and objective testing are an important part of professional development.
- It is important to focus on the needs of the individual practitioner.
- Experiential or event-based learning may provide some of the best evidence of meaningful continuing professional development.
- There needs to be a planned approach to the maintenance of existing skills and knowledge and the acquisition of new skills and knowledge.
- A portfolio is the preferred model for planning and documenting

participation in professional development.

- A Web-based system is the most efficient and effective way to maintain a professional development portfolio.

- It is desirable to minimize the administrative burden of compliance.

- There should be a variety of acceptable activities to assure that everyone's learning style and preferences can be accommodated.

When we began talking to people about this project, we referred to it as "ongoing continuing competence," or "competency assessment." We were asked how we were going to be able to assure every practitioner's competence, given that so many professions are not at a level of sophistication nationally where there are certification exams and other assessment tools in place.

We began to move away from calling his ongoing continued competency assessment and started calling it "continuous professional development" because the one thing we knew we could do was to require licensees to engage in a program of continuous professional development designed to maintain or improve skill sets. We see this as a building block to a more complex system, but felt initially, this is as far as we can go with the resources we have and the varying levels of sophistication among the professions involved.

In the proposal to the governor, we identified three major categories of continuous professional development (CPD) activities: continuing education, hands-on learning, and competency assessment.

Examples of CPD activities in the continuing education arena include courses, teaching, publishing and other diverse ways. Examples of hands-on learning include demonstration, simulation, observation, and events-based learning to enhance critical thinking skills, address job-related problems, and help build a bibliography. Competency assessment includes certification, certification exams, self-assessment tools, participation in national exam development administration, and in employer credentialing programs. So long as institutional credentialing meets certain characteristics, a board could decide that it will accept that as evidence of competency assessment.

We will tell the boards they should encourage diversity in learning, that they ought to make sure a certain number hours must be live and interactive, and that continuing education hours have to have some type of evaluative component.

The four components of the program are a learning assessment, a learning plan, a learning activities log and a learning evaluation. The assessment consists of identifying learning goals, scope of practice, areas to improve or expand, the results of any quantitative and qualitative assessments, including self-reflection.

Sample assessment questions include: What are my strengths and weaknesses? What practice trends or changes in the profession affect what I need to know?

The learning plan takes the results of the assessments and targets learning preferences and activities to be accomplished, including event-based activities. The log documents what has been done and shows successful completion of the learning plan.

What is important at the end of the licensure cycle is an evaluation of what has been accomplished and what, if anything, is unaddressed and needs to be incorporated into the next learning cycle. Examples of evaluation questions are: Describe the outcome of your learning plan in terms of what you now know. Explain how it changed your practice.

With the portfolio process, we hope at some point to get to where they are processed via the internet which gives us an opportunity for virtual audit of everyone who is participating.

Here's where we are. This was approved in July and has been adopted by the boards of psychology and physical therapy. Veterinary medicine is debating because they really wanted CE and CE only. But, if they don't do it this way, they may not do anything at all because there is no more "just CE" in Michigan. In November and December respiratory care and counseling will adopt the program, and the board of pharmacy which has had CE for a long time has asked to join because nationally, they are moving in this direction.

The bureau will develop a standard framework for administrative rules. Everyone will use the same structure, but will be able to tailor it to fit the individual profession. We will develop general requirements for portfolios and the templates they will use. We will develop a roll-out plan and Web-based training materials.

The boards will decide what kinds of activities they will count -- what counts as CE, what counts as assessment, what counts as hands-on learning, how many hours are required and how they will be quantified. They will be responsible for changes to their rules, for providing feedback on portfolios, and for helping to educate licensees about the new requirements.

Once this is up and going, we will use the current random audit process to verify participation. Individuals will be required to submit certain documents. Because of our obligation as a regulatory agency to do something about it when a deficiency is found, we decided to ask licensees to provide an affidavit attesting that they completed the learning assessment instead of submitting the assessment itself. They could produce the assessment if we asked for it, but routinely, the data does not end up in the hands of the regulatory agency. They would be required to submit the learning plan, the learning log and the learning evaluation. And, our staff would evaluate compliance with the rules on behalf of the board.

In terms of budget, we have no additional staff for the design and implementation phases. We expect to hire one or two FTEs over time once boards enter renewal cycles where this is a requirement. We are very excited about the program and hope to move forward in about sixty days.

What are the Goals of Continuing Competence Programs?

LeBuhn

Rather than delivering speeches, the panelists will respond to questions about their continuing competence programs and efforts. I will start with Denise Fandel who serves with me on the National Commission for Certifying Agencies (NCCA) which accredits certification bodies. Denise's organization, which certifies athletic

trainers, is accredited by NCCA. A couple of years ago NCCA revised its standards. In relation to recertification of certificants, the revised standards ask each accredited organization to specify whether the purpose of its recertification process is to enhance or to measure certificants' competence. Depending on the response to that question, the organization is supposed to provide some evidence or explanation as to how their recertification program accomplishes its stated goal.

Denise, how did the Board of Certification respond to the revised standards? What have you done to change your approach in order to conform to the revised standards?

Denise Fandel, Executive Director, Board of Certification, Inc.

Looking at the requirements in the revised standards, we recognized that we couldn't say we were *enhancing* and we couldn't say we were *measuring* because we have a traditional seat-time continuing education requirement. So, seeing the NCCA standards as they were being revised, and having participated in CAC events, and attended CLEAR (Council on Licensure, Enforcement and Regulation) conferences, our board acted back in 2002, before our accreditation came up for renewal under the new standards. We began a study to determine whether our continuing education program actually maintains entry-level competence, and, if so, how.

We've been looking at this since 2002 and in January 2008, we will begin a longitudinal study to measure where we are going. Entry-level competence has always been defined by our examination, but we want to know what happens afterwards. We are in the last stages of designing the study to actually measure a cohort of certified athletic trainers over the course of their continuing education cycle to look at the choices they made, based on what characteristics, and in which subject areas. We hope to end up with a tool that will allow us to go back and see whether they actually made good choices and are maintaining their entry-level competence. We have a brave board of directors that hopes to develop a measurement tool to show whether we can keep going the way we are, or whether we need to change our program in order to maintain entry-level competence.

LeBuhn

Are you saying that if you discover at the end of this study that they aren't making good choices, you will do something to ensure they do make good choices?

Fandel

Yes, that will provide actual quantitative data for the board to make changes to the CE program, very much like what you have heard here. We hope to be able to answer such questions as, "Do we need to require a certain number of CE units in each category?" Right now we leave it up to the credential holder based on individual needs. Part of this study is working with personalized self-assessments and learning plans. We are working with our preferred provider network, trying to entice them to come in as partners and start providing different types of activities to change the culture of what we think about as continuing education and focus on continued competence. We have some buy-in at the low levels of the committees of our national organization to do some things with their continuing education programming as a part of the process.

LeBuhn

Dargan, I understand that the theme of your recent annual meeting was continuing competence. Please tell us a little bit about what you discussed, what your program is now and where you think it is going. Do you measure, do you enhance, do you do both?

E. Dargan Ervin, Jr., President, Federation of State Boards of Physical Therapy

We probably do a combination of all. The Federation of State Boards of Physical Therapy stuck in its toe in1996 when we looked at the potential for developing continuing competence programs. We have since developed a definition of competence and continuing competency standards. This year, the board wants to develop a comprehensive program. We project a cost of two to three million dollars to develop and offer a menu of tools to jurisdictions which would then decide which they want to use. We are sensitive to letting jurisdictions decide how they want to measure the competence of their licensees. Some may want to use the tools for discipline, as well. Our delegate assembly supported the program and we have a commitment to develop it over the next two years.

Our current tools include a jurisprudence exam that jurisdictions use for initial licensure, or periodically for renewal as they see fit, and a competency assessment portfolio system that was piloted here in Washington State. Early in development is a practice review exam that will include a general section and content-specific sections. We envision secure delivery and jurisdictions may choose to use it as a measurement tool and to consider those who pass it to be deemed competent. As with our initial licensure exam, we are able to prepare feedback reports to inform test takers in which content areas they are weak or strong. Our vision is to give licensees partial credit for taking the exam because it involves doing a self-assessment and using the score report to determine what they need to work on to demonstrate their competence.

LeBuhn

Polly, you have a program at the board of nursing in North Carolina which offers several options for establishing current competence. We have applauded you for taking this initiative, but we have also said that even though North Carolina nurses are offered many options for complying, they can if they choose comply by just logging continuing education hours. Please talk a little bit about the reasons for this, the environment in which the program was developed, and the reaction to it within the profession. Also, tell us how the program might change in the future.

Polly Johnson, Executive Director, North Carolina Board of Nursing

Until legislation was passed in 2005, all nurses needed to do in North Carolina to maintain their license was to pay the fee and stay out of trouble. We started to talk about continuing competence in the 1990ies in response to work being done at the National Council of State Boards of Nursing. In 2000, we created a broadly representative task force that over four years developed the model we follow now.

We decided early on that this was going to be a step-by-step process because we don’t yet have the research base to tell us exactly how to objectively assess, particularly in a profession that is very broad and varied.

We started by developing a reflective practice model, borrowing largely from Canadian provinces. Ontario and Alberta guided us in developing learning tools and processes to help licensees reflect on their practice and recognize where they need work.

I don't think we can distinguish between *maintaining* and *enhancing* competence. The world is changing too quickly. Even if one stays in one practice setting for a long time, if all he or she does is maintain competence, the individual is really falling behind. Of course, when one moves to a new area of practice, one's level of competence declines, so it is necessary to enhance competence in the new areas.

We put together learning tools and sought enabling legislation in 2005 authorizing us to adopt rules requiring evidence of continuing competence at the time of licensure renewal and reinstatement. The bill sailed through with no opposition because we had many people working on it and we had been doing a lot of education with the nursing community.

In 2006, we began informing licensees of the new requirements for providing evidence of continuing competence at licensure renewal. They have two years to develop their learning objectives and learning plans. Their options for what they can submit range from national certification, academic course work, papers, and other evidence we have been talking about this morning, as well as continuing education. An important nuance is that it must be focused continuing education. Licensure renewals in 2008 will have to attest to completion of their learning objectives and compliance with continuing competence requirements. Then we will begin random audits.

We see this as only step one. I would never say this is the best plan. As I have listened to Washington State and Michigan talk about their experiences, I am convinced there should not be a static plan. This needs to continually evolve over time. Where we want to end up is a form of objective assessment.

I think the research base is accumulating. The National Council of State Boards of Nursing has had a task force looking at continuing competence for a number of years and is at the point of conducting feasibility study of how licensees can be evaluated. Once that tool is available, we hope boards will take it on and adopt what it is possible to adopt in their respective states.

I certainly believe that for the future, we need to move toward objective assessment. In North Carolina, we are looking at objective assessment during transition to practice for newly licensed nurses. That information will inform us as we move along from socializing licensees to expect to maintain and enhance their competence. This is step one. To get to step two, we need more evidence, and that is our challenge for the future.

LeBuhn

As I understand it, Ray, the Washington State Board of Psychology presently relies primarily on continuing education. Are you satisfied with this, or where would you like to see it go?

Raymond Harry, **Chair and Public Member, State of Washington Board of Psychology**

The Washington State Board of Psychology's rules say that continuing

education must be completed as a condition of license renewal. In many cases that I am aware of, continuing education courses are chosen solely to meet the requirement, regardless of whether the courses meet an individual's learning needs. One aspect of the rule that I think is good requires a certain number of hours of continuing education in ethics.

In order to help psychologists licensed in the state of Washington, the educational committee of the board presents workshops three to four times a year on the case reviews for those psychologists who have been sanctioned or who have had charges filed and results published. The objective is to help psychologists understand how they can keep out of trouble. This is all well and good, but there is nothing in our present requirement for continuing competency improvement.

The proposal I would like to throw forward is simple. It is to require psychologists to develop a professional improvement plan to be submitted by the psychologist at the time that they renew their license. It is envisioned that the individual would specify his or her area of practice or specialty and what type of professional improvement they want to accomplish during the next three year licensure cycle.

How would the board make sure the individual stuck with his or her improvement plan? The practice of psychology is not invasive. The work psychologists do is highly confidential, so the only type of evaluation I envision happening in this profession is peer review. There would need to be some time put aside by each professional to observe and review another psychologist's practice in the delivery setting.

Getting there is a challenge, but we will never get there unless we start the process. Continuing education by itself is not good. But, continuing education based on a plan of self-improvement would be meaningful.

The content of professional improvement plans would be instructive to educational institutions and CE providers. The types of course work, or the experiences that that psychologists wish to accomplish during their three year cycle could be summarized and given to the educational institutions so they could develop the type of course work that is really needed, instead of standardized workshops put on solely for the purpose of satisfying the CE hours requirement.

LeBuhn

Kathy, we have heard from Polly and others that nursing in Canada has been a pioneer in this area. Is the same thing true for occupational therapy? Can you comment on what you are doing in British Columbia?

Kathy Corbett, Registrar-CEO, College of Occupational Therapists of British Columbia

We have challenges similar to those we have been talking about this morning. However, one of the advantages we have in Canada is that in eight of ten provinces, there is legislative authority for regulators to develop continuing competence processes.

In British Columbia, legislation tells us we must develop a continuing competence program to promote high practice standards amongst registrants. We are looking at a three-point program.

The first part, which has just been launched, is competency maintenance and ongoing development. This is consistent with the

principles that have been talked about here around the creation of a professional development plan based on self-reflection. The self- assessment tool is based on a nationwide essential competencies document. The individual reflects on those areas of competence he or she believes need to be enhanced or improved. We encourage people who change their area of practice or enter a new role or level of performance to go through the self-reflection process. Then the professional creates a professional development plan with learning goals, strategies and an action plan, an evaluation plan. The next cycle is evaluating and documenting the impact on practice.

There were comments earlier about liability and exposure of those who are honest on a self-assessment. In Canada, there is legislative protection in the health professions so self-assessment information cannot be accessed or subpoenaed during civil litigation. This information is also exempted from our freedom of information and privacy protection laws, which are almost overarching in all provinces.

The legislation provides a duty to report, so employers and other individuals who see competency problems or other types of issues in their own or another regulated profession are required to report to the registrar of that particular college. We haven't tested this with the public, but it is clear there is an expectation that practitioners should not turn a blind eye.

The second component of our program will be competency review and evaluation. We are visualizing that this is the competency assessment piece, whether peer review or some other form of assessment. The first part might be called the "tell me" part and this is the "show me" part. I'm still waiting for the "prove it" part.

The assessment part is consistent with other provinces. We are learning a lot from Quebec, for example, where they have a long history of competency assessment and inspections. We are also learning from Ontario where the legislation called for a quality assurance program.

The legislation was recently amended to require quality assurance programs. Our federation of health regulators certain sees continuing competence as an element of quality assurance. Our tools and processes for registering individuals at the entry level is as much a quality assurance issue as is continuing competence.

Our registrants are very aware that this will be a three-part process. We had huge positive uptake within the profession after the self-assessment phase was introduced. Employers asked if they can use the self-assessment as a performance review tool. Even though the goal of self-assessment is different from performance review, practitioners are welcome to share their self-assessment with employers if they choose to do so.

LeBuhn

I'd like to follow up on what you have said about the confidentiality dimension. In the earlier panel, Bonnie King pointed out that this has been a problem in Washington State because of sunshine laws. Have the others on the panel thought through how they will address the confidentiality issue and do you anticipate that it will be an obstacle to enacting meaningful continuing competence programs in your field? For Denise, what would happen if someone failed to meet your requirements, would this put their certification in jeopardy?

Johnson

In this first round, we don't require nurses to submit their learning plans, but to tell us how they met their learning objectives. It is unclear what would happen if the Board of Nursing were to collect this information.

Ervin

The Federation is too early in the process to have an answer. I am on a physical therapy licensing board where we currently have just a continuing education requirement. We are moving toward continuing competence and have had one case where a person refused to provide requested documents. This resulted in a suspension, which is a public order.

Fandel

Right now, demonstrating competence is not a requirement for recertification – and certification is voluntary to begin with. That said, most of the states that regulate athletic trainers require our exam and require that licensees retain their certification. We are striving to get as much compliance as possible with the personal learning portfolios and the self-assessments and see what happens. We, too, are very early in the process.

Harry

What has to happen to make this work in Washington State is to keep self-assessments and learning plans confidential, unless a sanction or some other violation is alleged and proven. Otherwise, there won't be an open and honest discussion between the individual licensee and the licensing agency.

LeBuhn

Do the panelists think the five-step model for continuing competency assurance that CAC is advocating is a useful construct? In particular, please talk about what Kathy called the "prove it" step.

Corbett

I think the five-step model is pretty strong. We are probably to level four in our planning. Our fifth step will be the second part of our program, which is the competency review piece. If we audit practitioner's development plans, there could be ways to tie in competency assessment, whether it is simulated chart review or some other technique, to show how learning affects practice.

Johnson

I certainly believe it is a strong plan, but it is a huge leap from step four to step five. I believe we need demonstration projects before we can get to the point of feeling we know enough to make the leap. This is particularly true in nursing where we have numerous practitioners who practice in multiple ways.

Fandel

We are utilizing the model because we know that regulators are talking about it. As a voluntary board, we want to build a culture of self-assessment with our credential holders because that is the direction our board believes needs to be pursued.

LeBuhn

Do any of the panelists' organizations have a specific clinical skills assessment dimension to their program?

Corbett

That will be our second component.

Johnson

I think one of the tools that is becoming more sophisticated and will be helpful to get to level five is simulation. It is a promising technique for assessing how people think through and respond to clinical situations.

Question from the Floor

You said that self-assessment in British Columbia is based on a set of national competencies. Do occupational therapists specialize?

Corbett

We don't have recognized specialties from the perspective of advanced training and certification. However, occupational therapists – probably like nursing and physical therapy – choose an area in which to practice. In developing the tools for continuing competency – the "tell me" part – we are assuming occupational therapists are competent and want to remain competent around a special area of practice.

In Canada, we have umbrella health legislation that defines broad scopes of practice and specific "reserved acts" that are considered potentially harmful. Occupational therapists in some specialty areas may be certified to perform certain reserved acts. We will have to determine how to recognize such competencies.

Question from the Floor

Recognizing that there may be a need for some degree confidentiality in order to get these programs off the ground, how can you reassure the public that the self-assessment and the professional development process are assuring current competence?

Corbett

In British Columbia, the duty to report if someone is terminated for competency reasons provides some public accountability. The legislation requires that notwithstanding confidentiality, if in the course of the assessment of another person's performance, you find capacity issues or professional competence issues, you are required to report that. It doesn't mean all the information is public, but an inquiry will occur. Assessors may not turn a blind eye to problems they see.

Johnson

When individual licensees come to us with questions about competence, we have a broad range of options from remediation through formal discipline. Part of our evaluation review of those individuals is to ask about the contents and implementation of their learning plan. In the PreP program, that might be a defined learning plan.

Question from the Floor

Polly, you talked about the goal of objective assessment. Is that by the individual him or herself, or by the profession?

Johnson

From a regulatory standpoint, we need some form of objective assessment that goes beyond the reflective practice model. To be objective, it would have to go beyond self-assessment and include a third-party oversight piece. This could be a uniform test, for example, or clinical assessments in a practice area. My forecast is that there

will be several objective assessment tools, depending on the individual situation.

Question from the Floor

Is there a basic level of nursing (or some other professional practice) that all practitioners must meet?

Johnson

Licensees all have to demonstrate a minimum competency level by passing the initial licensure exam. The real challenge is developing a model that is meaningful in terms of continued competence. The National Council of State Boards of Nursing has gone through a process to identify competency areas such as communication, collaboration, delegation, management, patient safety, knowledge and skill. The acceptable level has to be at or above what we consider minimum competence to be.

DISCIPLINE SESSIONS

The Value of External Review as a Catalyst for Reform

Laurie Jinkins, Assistant Secretary, Health Systems Quality Assurance, Washington State Department of Health

The Office of Health Professions Quality Assurance in Washington State regulates more than 320,000 practitioners. There are sixteen independent boards and commissions appointed by the governor. Other professions are regulated by the Department of Health. We receive complaints about approximately five percent of the practitioners in the state and we spend about eight-five percent of our thirty million dollar annual budget on discipline. That's about twenty-five million dollars spent on about five percent of practitioners. You all know that discipline is a very expensive endeavor.

Our panel will talk about two kinds of external review that the office has undergone in the last eighteen months. One is external review by the media and the second is external review by the state auditor.

Tim Church, Director of Communications, Washington State Department of Health

I am going to talk about what it was like to experience an audit by the media. It started out as what I would call a normal news story. We received calls from the ***Seattle Post-Intelligencer*** asking for information about how we discipline and dental providers. It is not unusual for us to get calls about health care providers in disciplinary situations. We issue about 175-200 news releases a year, about a quarter of which deal with health care providers in disciplinary situations. We are required to inform the public when we discipline a health care provider – within twenty-four hours in the case of a summary suspension.

But, this story started to grow. One morning in October 2005, the paper ran a story entitled, "Toothless: Washington Lacks Dental Oversight." Around that time the ***Seattle Times*** began to call with questions about the department's disciplinary program. In a period of a year and a half, we received forty-nine public disclosure requests and provided the paper with almost 7,500 pages of information.

What was interesting and challenging for us was that we discovered that the newspaper was better able to analyze our data than we were. We are incredibly busy keeping up

with complaints and we don't have extra people. The ***Seattle Times*** had four or five reporters doing nothing but this story for about a year.

The reporters sliced and diced the data in ways we could not. They defined offenses – such as sexual offenses – differently than we do. When they reported it, they used their definition, not ours. It was traumatic, but what made this series of articles different than the first one was that the ***Post Intelligencer*** chose to gather information without telling us what they were working on until the story came out. The ***Seattle Times*** gathered information, told us what they concluded from the information, and asked us what we planned to do about it.

We made a key decision during this time. For some time we had been working to improve how we discipline providers. We listened to what the reporters told us and took action to correct some of the problems they identified without waiting for the story to come out.

It made a huge difference in the end that we listened and accepted the criticism and took action. Toward the end of the series, the reporter wrote an article commending us for the work we had done – the changes we had made before and during the series, and the changes we planned to make after the series was printed.

The strategic lesson is that when you know the headlines are going to talk unfavorably about you, decide ahead of time where you want to be when it is over. Are you going to listen to the headlines and take action, or are you going to wait for the headlines and see what happens?

In the midst of this situation, I ran across a quote: "When written in Chinese, the word crisis is composed of two characters. One represents danger. The other represents opportunity." Certainly, it felt like a crisis to us. It was also clearly an opportunity to look at what we were doing and how we were doing it and to use the data that the reporters had analyzed for us and ask what we could do to make things better.

Linda Long, Deputy Auditor, Office of the State Auditor, Washington State

Our office is responsible for auditing all state agencies and local government – about 2,400 public entities. We are committed to doing audits in a constructive way, so we work hard with the client to make sure our recommendations are actionable. External review is not a silver bullet, but it is a useful tool you can use to make sure you are being responsive, transparent and accountable to the public.

After the newspaper accounts were published, the governor asked the auditor to come in under the new authority in Initiative 900 and do a performance audit according to government auditing standards. Because the department has many initiatives underway, it would have been opportune to wait until 2009 to do this audit. The department was introducing new information technology and was undergoing a major reorganization of the quality assurance group to add consistency and strength to disciplinary actions, and improve Web sites. But, given the "License to Harm" newspaper series, the political climate dictated that we do the audit earlier.

From an auditor's perspective, one of the interesting aspects of Initiative 900 is that it requires that the legislative body hold hearings within thirty days of an audit. Another part of the initiative requires legislators and executives who prepare

budgets to consider the content of the audit report.

The audit identified opportunities for improvement and also acknowledged things that are going on well within the agency. The newspaper covered the report fairly and positively. We consider it a success if the report and its executive summary stand on their own and don't need to be explained to the public and the media.

There are thirteen findings and sixty-seven recommendations, twelve of which are directed to the legislature. Several key findings have to do with performance management and the government management accountability program (g-map). The focus is on actual results rather than just policies and procedures.

Recommendations related to performance management address the operating agreements between the Department of Health and the boards and commissions, the quality and ownership of performance measures, and performance management by managers and supervisors within the department.

We double-checked the accuracy of our sampling results with the department. One of the things the department asked us to look at is whether the department is the adequacy of its staffing. Throughout the report, we make recommendations about staffing and resources.

To maximize the benefit of external review, it is important that the agency fully participate. The tone set by leadership is critical, and we couldn't have asked for a better tone than at the top of the Department of Health.

It is advisable to suggest areas that you would like to have looked at because you can help shape the audit and the report. Select the right liaison or point person within the agency who can interface with the auditor's office and arrange the interviews and document retrieval that they need. Respond promptly and make sure you are getting the right information to the auditor so time isn't wasted. Establish regular intervals for updates and a method for dealing with issues. Respond effectively to draft findings and recommendations. We incorporated many suggestions from the Department of Health for how they wanted the findings and recommendations portrayed.

Jinkins

From the programmatic side, the media reports actually helped us look in the mirror and we weren't all that happy with our reflection. It doesn't mean that everything they said was correct, but when we shed our defensiveness and looked at ourselves, we quickly realized that the reporters had identified ways in which we could better protect the public. For example, the ***Seattle Times*** pieces focused mostly on sexual misconduct by health care providers. Now all sixty-two boards and commissions have sexual misconduct rules that very clearly prohibit sexual contact with patients. In the last year, we have taken twice as many disciplinary actions related to sexual misconduct as we had taken the four prior years combined, largely because of the clarity with which we now define sexual misconduct.

The performance audit made a number of recommendations about staffing, consistency in discipline, criminal

background checks, more investigatory tools, and other helpful things. Also, the newspapers and the audit supported what we were already trying to do in the way of taking a more systems approach to department performance.

The auditor's office was asked by the governor to look at best practices in other states. They spent a great deal of time and quite a bit of their funding on this search, but they were unable to find best practices nationally because there is very little data to prove that practices work. The only two best practices that the auditor could find data to support were both in Washington State.

Five post-audit legislative hearings and media coverage of the audit were helpful to us in getting more information out to the public. There is a painful side to external review because cooperating with reporters and auditors is very resource-intensive. The auditors had five full-time staff with us for seven months. A hundred and fifty of our staff talked to auditors; all the boards and commissions were surveyed. So, you want to make sure you are getting something constructive in return for the investment in resources.

The media headlines were hard at first, but it is a bad idea to be combative with the press, even if you think what they have said is not correct. It was different with the auditors, because we decided from the start to treat them as outside consultants. They helped us by looking at things we wanted them to help us with, and by drawing our attention to things we hadn't realized needed attention.

It is important to orient the auditors from the start about the work that you do. For us, this helped create a trusting relationship and helped them understand what we do so, in the end, we thought they looked at most of the right things. Defensiveness is never going to win points with either the media or the auditors.

Question from the Floor

What were the two best practices you did have data to support?

Jinkins

One of them was a process for triaging complaints to identify right off those that might result in a summary suspension. The second one was emergency case management of high-priority cases, where we bring the investigator, the programmatic staff, the attorney, a board or commission member, and our assistant Attorney General together from the very beginning to develop a plan for that case.

Question from the Floor

Could you give us an idea how much an outside audit costs? Is there a list of auditing resources?

Long

This audit, including the overhead costs in the auditor's office, cost $1.4 million. This audit was lengthy and comprehensive and it involved retaining specialized expertise. We have a data base of about 500 vendors who follow the government standards.

Comment from the Floor

One way you might get an audit paid for is to irritate some legislators enough so that they demand that an audit be done. This was the best thing that could have happened to our board because the audit confirmed how much we needed additional

investigators that we hadn't been able to get approved in our budget.

Rose McCool, Director, Division of Registrations, Colorado Department of Regulatory Agencies

I have three objectives with my talk. I will tell you about the Division of Registrations. I will share my experience with an external review. Most importantly, I hope to leave you with the feeling that audits or external reviews are *good.*

The Divisions of Registration has six centralized offices that do licensing, investigations, complaint handling, and expedited settlements. We have nine program directors who handle all the activities for the boards. We have 170 full-time employees. We regulate forty-two professions. We have about 300,000 licensees in health and non-health professions.

Colorado's state auditor's office is in the legislative branch. In 2003, the state auditor's office asked to do a full-blown performance audit of my division and all of its processes. As in Washington State, we were in the middle of a reorganization, including the introduction of a new computer system. They postponed the audit for eighteen months because they weren't interested in auditing old processes.

The audit began in December, 2004. I felt a responsibility to set the tone and expectations. I told my management team: Audits are good; do not be afraid, because their job is to find things; be honest, up-front and direct. I asked staff to provide all the documentation the auditors requested directly to the auditors, but to copy my office so we had one centralized place where all the information was held.

I asked the staff to bring any concerns to my attention and to provide the auditors with any resources they needed. I wanted the auditors to be comfortable and well-supplied and able to do their job efficiently. I wanted them to see the audit as an opportunity to help us in those areas were we were not able to receive the support that we needed to further some of our own goals.
We had four full-time auditors in-house for seven months. We were given about two weeks to review their report and provide written and verbal comments. Then, we met face-to-face with the auditors. This was our opportunity to present our case about some of the audit recommendations that we didn't agree with, to affect change in some of the recommendations. They allowed us to wordsmith the document – not the substance, but the tone, so it didn't feel so negative to us, or so critical. That enabled us to feel good about the final document.

Our audit produced eighteen recommendations and thirty-seven sub-recommendations. I believe we have successfully implemented all of those recommendations. I want to highlight one recommendation I believe was particularly helpful to my division. I let the auditors know that I thought contract management was an area in which we were not performing as well as we could. I asked them to look at our processes and offer recommendations. As a result of the auditor's recommendations, my division has improved tremendously in all aspects of our contract management. Additionally, the audit recommendations led to the support I was looking for at the department level in that my boss directed the IT director to develop or purchase a contract management

tool. Not only my division, but the entire department benefits from that contract management data base.

The auditors will return to see what we have done with their recommendations. In anticipation, I built an electronic spreadsheet to document our response to the recommendations.

The audit of my division was extremely beneficial. It has led to improvements and efficiencies and the recommendations have made us a stronger and better organization. I encourage you to embrace audits and view them as an opportunity for improvement, rather than as an exercise to be avoided, because in the long run, it is the consumers in your state who will benefit from the changes resulting from an in-depth review of your processes and performance.

Julie D'Angelo Fellmeth,

Administrative Director, The Center for Public Interest Law at the University of San Diego School of Law, and CAC Board Member

The Center for Public Interest Law (CPIL) monitors occupational licensing agencies and teaches law students about the laws governing the functioning of those agencies. California uses a variety of methods to externally and independently assess the performance of occupational licensing agencies. Occasionally, the executive branch will order an audit of one of its own agencies, but more frequently, the legislature uses its own Bureau of State Audits to do a performance or financial audit.

On about a dozen occasions in recent decades, the legislature has created an external monitor position charged with examining a particular agencies regulatory program, usually its enforcement program, and issuing reports at various intervals. The statute vests the monitor with significant investigative authority, and requires the agency to cooperate with the monitor.

My organization has served as the monitor at three California agencies – the State Bar, the Contractor's Board, and the Medical Board. I served a two-year term as the medical board enforcement monitor two years ago. That position was created as a result of one of those external jolts Mark Yessian referred to yesterday – a very critical news series called "Doctors Without Discipline."

As the monitor, I was required to look at both the enforcement program and the board's diversion program for substance-abusing physicians, which had not been externally audited in eighteen years. As monitor, I published two reports which are posted a www.cpil.org.

In our first report, we described each step in the processes used by each program – enforcement and diversion. We documented delays at each step, errors, gaps, inconsistencies, and failure to comply with statutes and regulations. We made a total of sixty-five recommendations for change in our two reports, about half of which could be accomplished by the board on its own and half required legislative change. Most of those changes were enacted during 2005.

Why is external evaluation important? First, regulation is an important governmental function that no other governmental mechanism addresses. The regulation and licensure of health professionals is necessary to prevent irreparable harm to patients. No other mechanism is designed to do that. We all know from the Harvard medical study back in 1990, that the civil court system is

rarely used to address medical negligence, compared to the frequency with which it occurs. Even when it is used, it is expensive, time-consuming, inefficient, and ineffective in preventing future harm to future patients. It is important to ascertain periodically whether your regulatory program accomplishing its mandate.

Second, self-examination is inadequate. It is simply not possible for those of you who are inside the box to do your jobs, evaluate how well you are doing your jobs and look outside your box at alternative ways of doing your jobs. You are volunteers. You don't have the time or the access to all the information you need in order to evaluate the performance of your boards. Board staff are too close to the action to be objective and independent. Staff never wants to be the bearer of bad news to board members. It is often necessary to bring in a fresh set of eyes, a new skill set, a different perspective.

In my medical board enforcement monitor project, my team was able to question processes and procedures that had become unquestioned and unquestionable. External review can shine light on practices that are outmoded, silly, illegal, too costly, or just plain inefficient. These practices are perpetuated not because anyone is evil, but because they aren't questioned.

For example, in our initial report, we focused heavily on complaint processing and investigation. We quantified the delay inherent in each step. One of the most egregious delays took place at the point at which the board was attempting to collect medical records from a physician. The state law imposes a fifteen-day deadline, but doctors were ignoring the deadline. We found the medical board spent an average of 140 days collecting medical records requested under the fifteen-day deadline. Everyone was tolerating these delays. Nobody knew how bad the situation was until we came in and quantified the problem.

In our initial report, we called on the medical board and the AG's office to institute and enforce a crackdown on medical records procurement and they did it with great results. Within one year, the medical board reduced its medical records procurement time by thirty-four percent, with no new staff, no new resources, and no new authority.

Third, external review assists in ensuring accountability. Many boards operate relatively invisibly. Many are controlled by the profession they regulate. They are funded by the profession which expects something in return. Many have a poor track record of taking disciplinary action against their own. To put it mildly, they do not often inspire the confidence of the public. Subjecting agencies to meaningful external review ensures accountability to the public – or, at the very least to the executive and legislative branches whose officials we elect.

Finally, external review, while sometimes painful, often yields critical evidence that is necessary to gain needed resources, enhance authority, or acquire new tools that enable regulators to do their job better. The legislature is not necessarily going to believe you, but will believe an outside, independent consultant or auditor who has looked at your processes and produces data and other evidence supporting your need for more resources.

An example of the importance and power of external review came up yesterday during our breakout session. Part of my job as an external enforcement monitor was to look at the medical board's diversion program for

substance-abusing doctors. We found serious problems with the program. It claimed to have monitoring mechanisms, including random drug testing, required group meeting attendance, and work-site monitors for physicians who were permitted to practice. All of these mechanisms were failing. Everyone was gaming the system in ways that were very dangerous for patients.

The program was so chronically understaffed, the staff didn't detect these problems, let alone do anything about them. The board members had no idea how the program worked, or was supposed to work, so they could not ask intelligent question of staff members.

The program touted a seventy-five percent success rate, but failed to mention that it does not do any post-graduate tracking. It has no idea whether the physicians who went through the program are practicing safely or have relapsed.

In response to our report, the legislature imposed a July 1, 2008 sunset date on the diversion program and sent in state auditors in early 2007 to evaluate the program. The board had tried. It beefed up the program's budget; it directed the program to make changes. Still, the Bureau of State Audit reported in June, 2007 (www.bsa.ca.gov) that the program was still failing – the fifth failing audit in twenty-seven years. The random direct tests were frequently given on days the participants could anticipate. There were no standards for work-site monitors. There were no rules or enforceable standards at all. In the vast majority of cases the auditors looked at, the program failed to adhere to its own policy of immediately removing from work physicians who tested positive. The medical board completely failed to adequately oversee the program

After receiving two failing audits in a two-and-a-half year period, the medical board voted unanimously to abolish the entire program, start over again. They agreed to reevaluate whether there is a role of the medical board in an individual physician's recovery from addiction, or whether the role for a board charged with protecting public safety is to suspend licenses and put the onus back on physicians to come back when they can demonstrate they are capable of safe practice.

No board should ever fear external review. You should welcome it, as Rose said. If your programs are well-run, the audit will prove it. If they are not, the audit will provide a roadmap to improvement and better public protection. Isn't that why we are all here? Wouldn't you rather find out about your problems yourself than have them on the front page of the newspaper?

Question from the Floor

My board has been discussing how to speed up the process of getting information to investigate a case. Please talk more about the crackdown in California.

Fellmeth

The board revised its procedure manual. It started personally serving requests for data rather than mailing them. The Attorney General's office revised its policies and procedures to warn physicians after the first fifteen days, that if the documents are not produced in an additional fifteen days, they will be subpoenaed at the physician's expense. The AG notified all physician organizations and the defense Bar of its intention to enforce the timeline. The legislature gave the board the power to fine doctors who don't comply.

Danger Ahead: Will Raising the Legal Standard of Proof in Discipline Cases Hamper Effective Public Protection?

Patricia Latsch, Deputy Director, State of Washington, Health Professions Quality Assurance

Regulatory boards are charged with protecting the public from unsafe or unprofessional practitioners. Health care practitioners have a corresponding right to due process before their credential can be restricted or removed. Practitioners also have a liberty interest, which means they have an interest in protecting their professional reputation. Boards have to balance these practitioner rights with the public's right to safe, professional care.

Those sitting on disciplinary panels are fact-finders looking for the true story of any case. Standards of proof help instruct fact-finders about the degree of confidence they should look for to back up the correctness of their conclusion. How sure are you that you are reaching the correct factual determination?

The standards talk about allocating the risk of a mistake and depriving a professional of his or her license, versus the right of the public to safety. Standards also talk about the relative importance attached to decisions.

There are three basic standards of proof. *Preponderance of the evidence* means the information provided is more likely to be true than not; the information is more persuasive; that the witness for whatever reason was more credible.

The *Clear, cogent and convincing* standard rises to another level of confidence in decision making. It means substantial evidence. Some people refer to it as the eighty percent rule. It means that the elements of the case are shown with evidence that indicates the information is highly probable.

Evidence beyond a reasonable doubt is used in criminal cases. It means that the elements of the case are backed up by evidence that leaves little room for doubt. This standard is sometimes equated with a near moral certainty – there is no question in one's mind that there is any other version of the story that might be accurate or true.

In 2001, the Washington State Supreme Court established a new standard of proof for cases involving physicians whose licenses were going to be revoked. The court determined that doctors should not have their medical licenses revoked unless unprofessional conduct is established with clear, cogent and convincing evidence.

An appeals court case involving engineering licenses reached the conclusion that the clear, cogent and convincing standard should apply to all licenses. In another case, an appeals court distinguished between professions, ruling that real estate appraiser cases didn't require the higher standard.

The department had to decide what to do with the court decision that said that in revocation cases involving *medical* physicians, the higher standard of proof should apply. The decision was based on the level of education and the property interest, so the department asked, what is the difference between an allopathic physician and an osteopathic physician, or podiatric physician? Another option was to apply the

decision to all types of physicians across the board, but not other professions.

The department chose a third option, which was to use the clear, cogent and convincing standard in all cases and also to evaluate the evidence according to the preponderance of the evidence standard. The rationale was that if we use both standards, if a superior court reviews the decision and rules that the wrong standard was applied, we would have already taken both standards into account and could avoid sending the case back to the board or commission or judge for further action looking at the records using a different standard of proof.

Then, the *Ongom* case came along. Alice Ongom was a registered nursing assistant, whose education level and training and experience levels are not nearly what they are for physicians. Miss Ongom worked in an Alzheimer's care facility where one employee reported she threw a dish at a patient, slapped the patient's hands and kicked the patient. Miss Ongom denied the incident and charged that the patient had been picking on her every since she started work at the facility. A third witness who didn't testify, but whose statement was admitted into the record, arguably supported Miss Ongom's story in the sense that the statement mentioned conflicts between this patient and Miss Ongom.

The department charged Miss Ongom with abuse of a patient based on the conduct. The health law judge concluded that the department had met the preponderance standard regarding an abuse case. The conflicting statements of Miss Ongom and her co-worker were enough to convince the judge that the incident occurred and Miss Ongom abused the patient. He imposed a twenty-four month suspension on Miss Ongom's license.

The judge also evaluated the evidence under the clear, cogent and convincing standard and reached a different conclusion. He said the department had not met the higher standard of proof because of the written statement that tended to support Miss Ongom's version of the story. This represented the first time we had divergent outcomes saying that we had met the preponderance standard, but not the clear and convincing standard.

In deciding this case, the Supreme Court of the State of Washington said that procedural safeguards are not a substitute for the standard of proof. So, the fact that a licensee has the right to be represented by counsel, to call witnesses, and to have judicial review was not a replacement for the failure of the department to satisfy the higher standard of proof.

The court evaluated the case under what are called the *Matthew v. Eldridge* standards, which basically involve balancing three factors: the private interest affected by the governmental action, the risk of an erroneous decision, and the government interest (the fiscal and administrative costs associated with discipline).

What did *Ongom* do to us? It said that for health professions, no matter what type of license is involved, we have to meet the clear, cogent and convincing standard. You heard earlier about department initiatives about assigning case priorities and using a team approach in certain high priority cases. That helps us deal with the clear, cogent and convincing standard because it helps us identify the types of evidence we are going to need for more serious cases.

Our investigators and staff attorneys have been trained about evidence standards. Under a clear, cogent and convincing

standard, close decisions are difficult. When there is a "he said, she said" situation, the disciplining authority must gather more evidence to support its version of the facts. As a result, our investigators are not gathering physical evidence, if they can, to support witness statements. We have to be sure to have supporting evidence when there is an issue with credibility. For example, the victims of sexual abuse are often drug-seekers who have issues of credibility, so we need to do a better job of documenting other evidence to support our case.

The message is that decision makers have to weigh the importance of the individual's interest in his or her professional license and emphasize public protection by methods such as prioritization of cases and sanction guidelines. Emphasize credibility determinations. Be careful about how you write the order. If you describe the evidence adequately and you make sufficient findings of fact, you will be able to meet the higher standard. In Washington State, the balance has shifted slightly to the due process side because we have to meet the higher standard.

Why should you care about a decision in Washington State? First, the Washington Supreme Court based its decision on the Fourteenth Amendment to the U.S. Constitution. Thus, this decision could be applied to all states. The clear, cogent and convincing standard applies in about eight states now, and defense attorneys are likely to be raising it elsewhere. Second, the U.S. Supreme Court declined to review the decision. The reality in Washington is that we were already sort of using the higher standard. When disciplining authorities made decisions to charge, the AG was always careful about making sure we had the most current information possible from the investigation.

The court decision has caused us to do better investigations because we have to be more thorough and obtain a more complete picture of the circumstances alleged by a complainant before we go forward with charges. When it comes to the adjudication phase, discipline panels are listening very carefully to the evidence.

Innovative Uses of Information Technology to Help Licensees Avoid Unprofessional Practice

Kevin Earle, Executive Director, Arizona Board of Dental Examiners (formerly Executive Director, New Jersey Board of Chiropractic Examiners

Members of the New Jersey Board of Chiropractic Examiners who were active in the Federation of Chiropractic Licensing Boards learned that several boards were interested in doing orientation programs for new licensees using a process whereby licensees come to an orientation conducted by members of the boards to acquaint licensees with their responsibilities as professionals. The model for this was established by the Massachusetts Board of Registration in Chiropractic which holds orientation programs two or three times a year in which all licensees were required to participate.

In New Jersey, we had a tradition of giving new chiropractic licensees a pen and pencil jurisprudence examination. We were finding that chiropractors who were working for insurance and managed care companies located in New Jersey were flying to the state to take this required one hour jurisprudence examination.

While we had a statutory requirement for the jurisprudence examination, we didn't have a

statutory requirement for orientation, which we wanted to require our licensees to undergo. So, we looked for a way of combining the examination with orientation.

Some of the problems associated with live orientation have to do with the costs of renting a facility, staff travel, inconvenience, and delays in issuing licenses. There are also challenges associated with maintaining consistency from one presentation to the next.

Our previous jurisprudence examination was offered once a month, meaning people had to travel to Newark to take the examination. There were three versions of the examination, with little updating of questions. It was a pen and paper examination that board staff had to physically grade.

We revisited our jurisprudence examination in light of what we really wanted to accomplish, which was to have licensees understand the laws and regulations, understand where to find statutes and regulations, understand the basis for the regulations, and put them in context. We know that professional schools spend very little time on jurisprudence and operating a practice in a regulated environment. So, we started at the beginning by explaining the difference between a law and a regulation.

The orientation program was put online, with members of the board delivering presentations on camera about various jurisprudence topics. After each presentation, licensees respond to questions online and then go on to the next section. Thus, the orientation and jurisprudence exam are combined.

We considered several options for delivering the orientation and exam. We could have required licensees to come to the office and use board computers to take the exam, but decided that would be too inconvenient. We thought about burning the program onto a CD and mailing it to applicants, but thought that was also impractical. We considered offering the program on a secure Web site, but that would have been difficult to do internally and we rejected the idea of using the state's Web site.

So, we decided to retain a vendor experienced with online continuing education in the health care field. They had the capability to develop the software and do the Web hosting and ongoing maintenance. It took about eighteen months to put the entire production together.

A board committee and staff wrote the scripts for each lecture topic. The vendor had access to a film studio and the capability to edit the presentations and to integrate PowerPoint slides into the production at the appropriate locations.

The total lecture time in the program is almost three hours. The applicants can sign in and out of a secure Web site and complete the lectures at their convenience. As each lecture portion closes, the program goes into an item pool that is about ten items deep for each randomly selected question. The format is True/False and multiple choice questions.

There is a timer on the exam portions which must be competed within an hour. Applicants cannot return to the lecture portion to search for the answers to the questions. Not all the answers to the questions were contained in the lectures, anyway, so applicants have to have read the statutes and rules.

The vendor supplies us with reports that show the performance of each question and staff can go in and modify the question if it is not performing well, or if it is phrased in a way that produces wrong answers. We can add questions at any time.

There are eight lecture topics related to legislation, regulations, and board authorities. The topics are: Introduction, Scope of Practice, Record-keeping, Fraud and Abuse, Sexual Misconduct, Advertising, Diagnostic and Electro-diagnostic testing, and Administrative Responsibilities.

The lectures are not all-inclusive. Applicants need to read the booklet to answer the questions. Our objective was to try to put these regulations in plain language and explain the historical background and basis for regulations and professional ethics. We talk about consequence-based ethics. Sometimes practitioners don't understand that if they don't keep good records, and they transfer the patient and his or her records to another licensee, the incomprehensiveness or inaccuracy of the records can affect patient safety.

At the end of the program, candidates have an opportunity to review all of their answers. All tests are electronically graded and test-takers are instantly informed whether or not they have passed the examination.

When they hit complete and get the passing score, there appears what we call the "honor code." There is a reference in statute about interference with an examination process, so we remind licensees that if they had anyone help them complete the examination and we found out about it, they could be subject to sanctions. However, we look at the process as an exercise in having them learn to use the statute and regulation book. Therefore, we don't worry too much about exam security. When the applicants get their pass notice and sign the honor code, these are returned to the office by mail.

We have received tremendous positive feedback from the candidates. A candidate survey is included with the program so we can get feedback from licensees. Some raised technical issues which the vendor was able to rectify.

The production and software cost was $25-30,000. The annual maintenance fee is $3,750, which includes Website hosting and any upgrades. There will be additional charges for any major changes. The candidates pay the vendor $50 over and above their application fee. There are about 135-140 new candidates annually who take this program.

We don't give CE credits for taking the exam, but we sometimes issue remedial orders that include re-taking the jurisprudence exam.

ADDRESS

Mary Selecky, Secretary, Washington State Department of Health

When I spoke at the CAC Annual meeting here in 2000, I was just beginning to learn about the work you do to protect the public as citizen advocate members of boards and commissions. I appreciate the fact that you are willing to serve. Not everyone is willing to spend the time you do to help us do our jobs working for patient safety.

Much has changed in the seven years since you first met here in Seattle. The public is more aware of our work – in part because of newspaper stories about the department and our performance audit. We want to be sure that as a result of our work, consumers have

the information to select providers and that they receive safe, quality health care.

It is challenging work. When I talk about the performance audit, I refer to it as "rough and rewarding." It was difficult, but it was rewarding because the external eyes helped us see some things differently and notice things we had overlooked.

There are administrative recommendations in the report that we don't consider our top priority, and I have been honest with the governor about that. But, there is some really important stuff that improves patient safety that has to be our highest priority.

The nation has discovered public health in these last seven years. When I signed on as Secretary of Health under Governor Gary Locke, my first priority was not emergency preparedness or patient safety. He asked me to make public health relevant in the citizens' daily lives. What does it mean when your health is protected? How do people know we are protecting their health?

When you think of the kinds of threats we have been addressing since 9/11, the people in the country have awakened to public health issues. We now have a full-scale exercise going on in eastern Washington, involving ten counties. This three-day exercise will test our response capability. Emergency operations centers in Spokane and surrounding counties are up and running. An emergency operations center at the Department of Health is under consideration. Epidemiologists at our public health lab are overwhelmed by the number of salmonella cases that aren't typed yet. I will have to make a decision in the next few hours what we need to do next in this exercise. My senior staff is meeting now to assess the situation and determine whether we should alert the governor or access the strategic national stockpile. Seven years ago, this kind of thing wasn't on anyone's radar screen. Do we need more health care professionals to help us do the work? Have we exceeded our capacity in some counties? Can the hospital ERs even hold the number of patients?

The work that you are doing in your citizen advocacy role on our boards and commissions plays into this. In every state, policy makers are asked if there is some way we can authorize health care professionals to ramp up and do things in a different way if we were to have a flu pandemic. What kinds of standards would we have in an alternate care site? Suppose retired practitioners were to come back to work; what could they do? Are there other people we could train to do ventilator assists and other needed procedures?

The public is much more informed about what to expect from the health care system. They are aggressive about pursuing information and want to be sure we are ready to go into action.

Another thing we are paying attention to is the aging of the baby-boomer population. They want to live active life styles, but they also have chronic diseases and other health issues. To illustrate, consider Valley Hospital in Spokane Valley. It is a community hospital, but has to have a certain amount of specialty care. It is only eleven miles away from two major hospitals in downtown Spokane. I asked them what their biggest issues are. They said recruitment of family practice doctors. Their biggest populations are people having babies and the Medicare beneficiaries. Family practitioners are scarce, and increasingly they won't take Medicare.

What is your role in all of this in your states? Are you working on this with your professional organizations? I asked them what specialty is the hardest to recruit. They said nuclear radiologists and nuclear technicians – practitioners trained to use the very equipment every hospital wants to have.

About sixty years ago, a ground breaking study in Massachusetts provided the first data about causes of coronary heart disease. Today, we are reaching deeper and deeper into subspecialty practice. The popular media is full of health advice. These things impact how those that you license and regulate practice every day. Everyone wants a perfect outcome.

I'm sure you know about the 100,000 Lives Campaign that has evolved into the Five Million Lives Campaign. I have a message on my computer quoting Don Berwick who is responsible for these campaigns. It says, "Some is not a number, soon is not a time." While those campaigns focus on saving lives by making hospitals safer, they have received so much publicity, how could it not impact all the professionals you work with every day?

The media is paying more attention in every state. In Washington State, there was an increase in media attention in the fall of 2005, starting with an investigative report in the ***Seattle Post Intelligencer*** entitled, "Toothless: Washington Lacks Dental Oversight." It took the dental board to task for not disciplining "wayward dentists." In 2006, the ***Seattle Times*** came out with its series called "License to Harm." The articles covered a number of professions, documented what it called "inconsistent, lax discipline."

The legislators responded. Legislation to strengthen patient safety became the rule of the day. Our current governor asked me to make patient safety my highest priority. She has supported our budget requests for our integrated licensing and regulatory system. We got additional investigators and legal counsel.

Increased public awareness brings with it a demand for accountability. I'm fortunate to be working for a governor who is committed to improving both health and government performance and who holds me accountable. Cabinet members routinely appear in front of the governor and her senior staff to show her the data and tell her who is being held accountable for it.

A year ago, the governor asked us to tell her what is going on with all the health professions. She said she didn't like our backlog. When I told her we would get back to her, she wanted to know who was going to be responsible for looking at the backlog and reporting back.

This year, when we presented information to the governor about the performance audit, she observed that we still have a backlog. I replied that at least now, we know what is in the backlog and what isn't. There are no priority-one cases in the backlog. She saw that we are paying more attention to priority-one and that our summary suspensions have gone up without increases in staffing. She asked us to bring forward a package telling her what staff improvements we need.

So, the data and accountability worked in our favor. The kinds of things she held us accountable for include establishing uniform sanction guidelines across the professions and having sexual misconduct rules in place for every profession.

Last night, the governor held a town hall meeting in Spokane Valley attended by 600 people. In response to a question about health care, the governor said the first priority in this state is patient safety. Everyone deserves to have quality health care from facilities and providers – evidence-based medicine, access, and healthy lifestyles.

When the newspaper articles came out, we knew we needed an external look. The governor suggested we might want the state auditor to take a look. At this year's presentation to the governor, I actually thanked her for the performance audit.

We took the information in the audit and created a road map, singling out what was most important, making sure the information was shared, and making sure we stayed true to the priority of patient safety. Citizen members, professional members, and board or commission staff all have an opportunity to make a difference. The public is paying more attention to the decisions we make.

Let me focus on your work. Citizen advocacy makes a difference in all our actions at every level of government. I went to work in local government in 1975. That's about as close to things as you can get – whether the issue is a septic tank, a person's child who didn't receive proper care, or a complaint about the tax structure. Connecting with people helps government employees do their jobs better. Those of you who are citizen advocates on boards and commissions come in with different eyes and community values and let us know when something doesn't make sense, when more needs to be done, or we need to look at an issue differently.

You really do have a special place on boards and commissions. We need you to make sure we look at things differently – that you bring your values. A couple years ago, a former chief of staff of our governor wrote about the characteristics of excellent public members:

> They come prepared and participate. They ask questions when something isn't clear. They ask for training in areas that need a broader understanding. They remember who they represent and can separate their public from their private roles. They don't forget that while you are on that board or commission, you represent government, but when you come to that board or commission you are bringing community. They understand there are there to develop policy rather than manage the agency's activities. They understand ethics and act ethically. They care about and make decisions based on the interests of the public.

So, when you come to meetings like this one, you help each other look at very serious issues. You learn from each other. When you go back to your states from meetings like this, you take some new ideas. Hopefully, your colleagues will be open to listening to these new ideas.

Question from the Floor

Please tell us more about how you made Washington a smoke-free state.

Selecky

Our attorney general, now governor, was one of the lead AGs in the battle with tobacco companies in the late 1990ies. In

October, 1998, I was named Acting Secretary of Health. The anti-smoking advocates felt the department of health was not doing what it should about the issue. The master settlement occurred in December, 1998. Almost all of the Washington money went into health care, including smoking prevention. The legislature instructed the department to come up with a tobacco control and prevention plan before we could spend any dollars on other health care activities. So, we set out on a comprehensive approach, preventing kids from starting, helping adults to quit, concentrating on pregnant women. We did retail education, worked in communities, involved schools, evaluated continuously. Our media campaign is dwarfed by the tobacco industry's advertising, but we let teens help with our ads and we have reduced by fifty percent the rate of new smokers in schools.

Question from the Floor

Please comment on diversity within your boards and commissions. Do they reflect the communities that they serve?

Selecky

We can always do better. Our previous governor challenged us to look long, hard, and deep. It is difficult to recruit people, as you know. We have more work to do.

RULE-MAKING SESSION

Implementing Scope of Practice Expansions via Rulemaking

Catherine Dower, Associate Director, Health Law and Policy at the UCSF Center for the Health Professions

This topic of scope of practice is likely to become even more important in coming years, for several reasons. States are responsible for determining scope of practice acts, so they do vary state by state. We are now working on a project in California with the California Health Care Foundation comparing the nurse practitioner practice acts state by state. The variation is startling.

There are countless examples of professionals who are educated to higher levels of competence than they are permitted to practice under state scope of practice laws and rules. Examples include physical therapists, nurse practitioners, nurse midwives, lay midwives, naturopaths, naturopathic physicians, acupuncturists. The rules vary quite a bit, but they do not permit these individuals to practice to the full extent of their competence.

This afternoon, we will not be talking about the role legislatures play in enacting scope of practice acts. We will talk about the role that boards play implementing those acts through rulemaking. Many boards don't realize they have a major role, but they should be prepared to roll up their sleeves when it comes time to implementing laws.

There is a high risk of abuse in having professional boards involved in this area because of the vested interests of the professions in their scopes of practice. Some of the boards around the country do a better job than others in putting the public interest first in terms of the quality, access, and cost of care. Some boards have used their actual and their soft power to fight proposed scope of practice expansions.

Other boards have helped facilitate legitimate expansions based on evidence.

There are new forces in the health care world that are putting renewed pressure on the scope of practice issue. These include the fact that we are seeing looming shortages in the allied health professions that may make shortages of physicians and nurses look easy in retrospect. Also, we see increasing problem with maldistribution, even in the professions where we have sufficient numbers. Physicians, for example, are choosing to practice in urban and suburban areas, and they are focusing on sub-specialties and declining to take some patients, such as Medicaid beneficiaries.

We also have several proposals for health care reform which will increase coverage. Any of those plans, if they pass, are likely to increase the number of insured people. Many of these will be people who have not been covered, including people of color and patients who are not proficient in English, population segments where there are already shortages of professionals.

There is still opposition from the medical establishment to complementary and alternative professions, such as acupuncture and naturopathy. Some are suggesting that we combine community health workers with emergency medical technicians in community clinic settings. There may be other combinations of professions we could encourage at the clinical level.

Finally, we have the emergence of retail clinics. These business interests are putting pressure on the supply of nurse practitioners and other providers.

All these drivers highlight the need to revisit practice acts and practice models. We will not have enough practitioners in the future. The professions simply will not grow as fast as they have in past decades.

For boards, there is a risk of abuse, but also an opportunity to do the right thing. There is a unique role for public members because you don’t have a vested business interest in scope of practice disagreements. You bring a more objective and less biased perspective to the process. Our speakers come from different states and different professions and will talk about varied examples of scope of practice rulemaking.

While you listen to the speakers, think about what your board is doing in relation to scope of practice. What has it been doing? What is it prepared to do? Could it be done any better? Will you be able to avoid potential abuse of the process? Are you ready for opportunities as they arise? Are you ready to implement scope of practice expansions appropriately?

Blake Maresh, Executive Director, Section 5, State of Washington, Health Professions Quality Assurance

I am going to touch on three things this afternoon. First, the reasons I think we are seeing an increase in scope of practice issues. Second, the prescriptive laser rule recently promulgated by the Medical Quality Assurance Commission. Third, a few ideas about what we can do to avert scope of practice conflicts.

Traditional supply and demand theory says that the point where the supply and demand curves intersect determines the price and quantity for goods and services. What happens if demand increases, perhaps as a result of a new health care technology or a change in demographics? The demand curve shifts upwards, meaning more services are offered, but at a higher price. Once the

price goes up, some people will drop out of the market so that even though the quantity has increased, the price goes back down; perhaps even lower than where it started. So, there is a lot of quantity at a very low price. Even in health care, supply is always going to respond to changes in demand.

Changes in technology affect scope of practice. Three examples come to mind. Atrial defibrillation monitors provide information about the patient's cardiac behavior. Portable electron beam radiation devices provide radiation treatment for cancer patients more flexibly than in the past, and without personnel having to wear the same protective gear. Another example is a robotic device that provides assistance to people who have partially paralyzed limbs or are recovering from traumatic injuries. The difference between this and previous devices is that it runs off of the individuals biological signals. It is non-invasive and does not require electrical stimulation.

How do these new technologies affect scope of practice? They bring the therapies these technologies have been invented to provide within the reach of many more practitioners – even laypersons.

The changing face of health care alters the way patients interact with health care practitioners. New therapies include laser eye surgery, plastic and cosmetic surgery, non-surgical cosmetic procedures, and obesity surgery. Direct to consumer advertising of prescription drugs changes the interaction between patients and their practitioners. Patients know more than ever before about health care.

So, contemporary health care is more driven by economics; there are increased and more varied public expectations about health care; there is greater clinical and technical knowledge; there is enhanced technology, and there is a broader spectrum of personnel. All of those things taken collectively provide a perfect Petri dish for scope of practice issues.

There are certain factors that influence scope of practice: statutes, rules, policies, and professional standards. At the same time, there are exogenous forces that put pressure on scopes of practice at the areas of overlap between different types of providers.

The context for the Medical Quality Assurance Commission's laser rules is the FDA's rule that to be permitted to purchase a prescriptive laser, a practitioner must have prescriptive authority. In our state, the Medical Practice Act clearly states that the practice of medicine is defined as severing or penetrating the tissues of human beings and the Commission has in the past taken action against unlicensed individuals who were using prescriptive lasers. A case came before the Commission in 2004 involving a young woman who had laser treatment in a mall by an unlicensed person. The unlicensed person treated what she thought was a spot of hair with the laser. The spot was actually a malignant melanoma. The laser increased its growth rate and obscured the true diagnosis.

There are separate laser rules for physicians and physician assistants. The rules apply only to prescriptive devices with laser radio frequency and plasma devices. The rules require the practitioner to be appropriately trained in the device and also have a relationship with the patient (history, diagnosis, treatment plan, and informed consent). If use of the laser is delegated, the person must be a licensed professional within the state of Washington, and must be performing within their scope of practice. The delegating doctor must be present

during the initial treatment and be able to arrange for a pre-determined backup in the event of temporary absences in the event of later treatment.

The rulemaking process was long and involved. There were nine formal drafts and twenty public meetings, including workshops and deliberations by the Commission's policy committee, which has both clinical and public members. The Commission knew there would be concern about the rules, so they delayed their implementation, but they were taken to court, nonetheless.

Of the opponents of the rule, two groups were particularly interesting. One was the estheticians, who are regulated by the Department of Licensing. At the time, they had broad, vague language in their rules about the use of electrical and mechanical means of hair removal. They were doing laser treatments. The other group is laser technicians, who are not licensed in the state, but they do have professional certification through a training program in Colorado. They were also doing laser treatments. The point here is that the issues I mentioned earlier were active here: a relatively new technology, a growing demand, a lucrative service, a variety of players. But, I believe there was a strong basis for the Commission taking the approach it did because of the Medical Practice Act. In terms of scope of practice, from these groups perspective, they felt they were being cut out of a lucrative procedure they felt qualified to do.

What can we do to avoid contentious scope of practice battles? First, be collaborative up front with other professional boards and regulators. Second, be precise and clarify your professional scope. Third, look forward and try to anticipate what the upcoming issues are likely to be. Resources for this include peer reviewed articles and research and national professional associations. Be thinking about technological factors; demographic factors, such as the aging to the physician population; economic factors, such as the possibility of a national health plan at a time when there is a shortage of practitioners. Fourth, reach out and educate members of the profession in terms of appropriate delegation and limits on scope of practice. Also educate the public about what professionals should and should not do and what to do if someone exceeds his or her scope of practice. Work with educational institutions to be sure that scope of practice is understood.

Jay Campbell, Executive Director, North Carolina Board of Pharmacy

Scope of practice battles in the health care field are nothing new. Although the professions say the battles are over public safety, but they are really over economic self-interest. In pharmacy, the fights tend to be between pharmacists and pharmacy technicians.

I will talk about a positive experience at the Board of Pharmacy in North Carolina in terms of expanding its scope of practice in a way that I think serves the public health and safety. Then I will offer some suggestions for minimizing scope of practice conflicts.

In 2001, the boards of medicine and pharmacy in North Carolina passed a series of rules governing a credential called clinical pharmacist practitioner. This is a credential whereby pharmacists can monitor, alter, and initiate drug therapies under a collaborative practice agreement between the pharmacist and a supervising physician. The physician diagnoses, prescribes and sets

the parameters for drug therapy and the pharmacist monitors, updates, adjusts drug therapy.

Currently, a pharmacy degree is a minimum six-year doctoral degree focused principally on clinical aspects of drug therapy management. Most pharmacy students already have some sort of undergraduate degree, so they are graduating with a minimum of eight years of education. As a result, they have a high level of expertise which too often is heavily underutilized. Sometimes the reason is barriers to practice expansion, sometimes pharmacists decline the added responsibility because they don't want to be sued.

The clinical pharmacy practitioner credential allows pharmacists to apply their expertise in a way they typically cannot in a routine community retail setting. There is a high degree of patient interaction, reducing the chance of drug therapy errors, mismanagement, duplication, and other problems.

The North Carolina Pharmacy Practice Act states that pharmacists may administer drugs and adjust therapies "consistent with rules promulgated and agreed to" by the boards of pharmacy, nursing and medicine. Thus, the clinical pharmacy practitioner (CPP) credential was a collaborative effort largely between the pharmacy and medical boards to hammer out rules addressing the nature of the credential, the scope, appropriate limitations, disciplinary options, and so on.

There was at the time this rule went through a member of the medical board who was a strong supporter of allowing non-physicians to provide the care they are trained to provide. Sadly, that person is no longer on the medical board and I fear that the window of good feeling and cooperation may be closed, in keeping with nationwide trends in the medical profession.

The CPP credential is overseen by an entity called the Clinical Pharmacist Practitioner Joint Subcommittee, composed of four Board of Pharmacy members and four Medical Board members. Either board can discipline at CPP credential. Only the pharmacy board, however, can discipline a pharmacy license. The joint subcommittee has negotiated protocols for triaging complaints to either the pharmacy or medical board for investigation. But, there have not been any complaints against CPPs in the six years the credential has existed.

There was enthusiasm about the credential in the beginning, but by 2005, squabbling began, mostly driven by staff at the medical board creating unwritten and difficult-to-explain administrative procedural hurdles to getting a CPP credential approved. I think the reason this occurred is that the joint subcommittee stopped meeting regularly, so minor misunderstandings were compounded because people weren't talking. The subcommittee has become active again and is meeting at least three times a year. Getting people face-to-face to talk about administrative issues has gone a long way toward resolving procedural squabbles because committee members tell their respective board staff to stop getting in the way of the process.

One of the reasons this has worked is because there has been communication and interaction between the boards. Boards tend to function in isolation and focus on their own issues, with very little interest in looking at how their regulatory schemes fit in the larger framework. Boards need to be encouraged, and forced when necessary, to interact on a regular basis, through meetings or informal gatherings. If you have board

members getting together and seeing each other as human beings instead of obstinate bureaucrats and turf-protectors, it goes a long way. Most board members act in good faith and believe they are serving the public. They need to see for themselves that other boards operate the same way.

Often, board staff are a barrier to positive interaction between the boards. Staff members can provide plausible deniability for board members who are afraid to take a public stance on issues. Finally, members themselves may not be aware of what their staff is doing in the course of negotiations. The critical decisions have to be made by members, with clear and explicit directions to staff about how to get it done.

When something needs to be changed for the benefit of public health, don't be afraid to court respectful publicity. Where a staff member or committee member appears intransigent and you really believe it is being driven by reasons other than public health and safety, insist on being placed on a board's public agenda. Take up the issue in full view of the public. Don't be afraid to encourage media coverage of the public health issue. Sunshine is the best disinfectant.

A concern I have going forward is that I don't think the board of pharmacy could get the CPP rule passed today. Recently, the board of pharmacy tried to get a very minor expansion of the ability of pharmacists to administer vaccines – specifically the vaccine for shingles which is recommended for everyone over sixty. If a medical board is willing to deny access to vaccines, I don't think there is much hope in other areas.

My view is that this intransigence is rooted in two things. One is that the American Medical Association is intransigent on scope of practice issues in general. The marching orders from the AMA to state medical boards are to create a line which no other professions can cross. The motive is economic. In many states, medical board members tend to do the bidding of the medical societies, regardless of whether this is consistent with public health goals. What economic drivers are out there that might work in favor lowering arbitrary scope of practice barriers? The biggest one is that the federal government is the largest single payer for health care in the United States. This creates irresistible pressure to reduce costs. This is a pressure to make care available from a variety of practitioners. This increases the supply and the price goes down.

Here is a specific example. The FDA is considering creating a third class of drugs called a "behind the counter" class of drugs. These are drugs that previously were available by prescription only, but would now be available without a prescription – but could only be dispensed by a pharmacist who had made a determination as to the appropriateness of that drug therapy. The driver for this is the statin drugs. The federal government spends $4 billion on statins now, if these were moved to over-the-counter, it could save the federal government a couple of billion dollars. This would be a positive development for pharmacists.

Ida Darragh, Director of Testing, North American Registry of Midwives

I'm here in two capacities, as the director of testing for the certified professional midwife's credential issued by the North American Registry of Midwives and as a member of the midwives' advisory board in the Arkansas Department of Health off and on for the last twenty-five years, during

which time there have been several revisions of our rules and regulations.

The North American Registry of Midwives is the leading certification agency for direct-entry midwives in the United States. We issue the credential "certified professional midwife," which is accredited by the National Commission on Certifying Agencies (NCCA).

Our job on licensing boards is to set education, training and experience requirements, to prepare a contract for licensure examinations, to define what constitutes acceptable practice, to investigate complaints, monitor compliance with regulations, to investigate, hold hearings and impose sanctions. One of the great things about licensure for many of the professions is that it sets standards for that profession and requires accountability on the part of professionals to the state for their practice. But, as you have been hearing from many of the speakers, one of the down sides of licensure is that it tends to set limits on who can practice a profession, and in doing so restricts competition.

In doing that, it also restricts the supply of practitioners when the eligibility requirements are set higher than they need to be for competent practitioners, when the licensure examination is not really relevant to the profession, or is more difficult than necessary to measure minimum competence, or if the licensure fees are too high. These variables can restrict the supply of practitioners and lead to higher costs, thereby protecting the profession without necessarily protecting the public.

The biggest problem occurred in the health care field by the end of the 1950ies, all states had medical practice acts intended to license and regulate physicians. But, most of these laws had language so broad that the unintended effect was to prohibit anyone but physicians from performing almost any task related to health care. As a result, all the other professions also had to pass their own practice acts including exemptions to the medical practice act in order to practice legally.

Here are four examples of medical practice acts that illustrate some of the language used in old laws that are still in force. One law says the practice of medicine includes relieving just about any condition a patient might have. Another says medical practice is "the arts and sciences dealing with the prevention, diagnosis, treatment, cure or alleviation of human physical or mental ailments, conditions, diseases, pain or infirmity." You will notice that "conditions" is always in the medical practice acts and that is what makes these scopes so very broad. In Washington State, a person is practicing medicine if they "diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, or condition (physical or mental, real or imaginary) by any means."
In Arkansas, it is any type of profession requiring education or skill that relates to the prevention of illnesses.

With these broad definitions, many people with training specific to promoting health or advising on any conditions are forced to seek licensure in order to avoid being charged with practicing medicine without a license, which can be a misdemeanor or, in ten states, a felony.

The interesting thing that has come up in relation to scope of practice is that the American Medical Association pulled together several physician specialty organizations and formed a Scope of Practice Partnership which specified its

purpose as "opposing legislation allowing non-physician groups to engage in the practice of medicine without physician supervision." It should be of serious concern to anyone who is on any board in an allied health profession that organized medicine is concentrating its resources to oppose scope of practice expansions by allied health professionals.
The AMA has urged state medical associations to file lawsuits to ask the courts to force state regulatory boards and allied health professionals, such as chiropractors, optometrists, and podiatrists, to stop expanding their scopes of practice through regulatory changes.

In response to this, another organization was formed, the coalition for patients' rights. It is composed of 24 allied health professional organizations who prepared a response to the AMA Scope of Practice Partnership. The signatories state, "It is inappropriate for physician organizations to advise consumers, legislators, regulators, or policy makers regarding the scope of practice of licensed health care professionals whose practice is authorized in statutes other than medical practice acts. The erroneous assumption that physician organizations should determine what is best for other licensed health care professionals is an out-dated line of thinking that does not serve today's patients."

My special area of concern is regulation and scope of practice issues that affect midwives. In the rest of the world, midwives are not first trained as nurses, but are admitted directly into midwifery training programs. In the U.S., we have two kinds of midwives: nurse midwives, who are first trained as nurses, and direct-entry midwives, who are trained directly through midwifery education programs without first becoming nurses.

Nurse midwives are licensed in all the states. Almost all states require physician supervision for nurse midwives. They are almost all licensed through nursing boards, and most are not allowed to attend home births.

Direct entry midwives, however, are licensed in only twenty-two states. Direct entry midwives attend births at homes and birth centers. They are independent practitioners who do not have required physician supervision because you cannot get physician supervision for out-of-hospital births. In states that do not license direct entry midwives, practicing their profession may be a misdemeanor or felony. Most states without a current licensure program are seeking licensure through their state legislatures, using the certified professional midwife credential as the basis for entry into practice.

So, in the states that do have licensure for direct-entry midwives, they are usually licensed under the department of health or department of professional regulation, but a few license them under the board of medicine. These boards are responsible for drawing up rules and regulations that govern practice. On these boards are direct entry midwives, and almost always physicians and nurse midwives and public members.

The unnecessary restriction of entry to practice is one of the hazards of regulation. In my profession, we are seeing another hazard, which is the fact that most midwife regulatory boards are populated by a majority of other health care providers, such as physicians and nurse midwives who not only may be in direct competition with the professionals they are seeking to regulate, but who also may hold diametrically oppositional philosophies about normal birth. In fact, they may never have seen a

normal birth, which we define as a birth without obstetrical intervention.

In some cases, the members of these regulatory boards may actually see their role as preventing the licensee from practicing. Thus, there are very restrictive regulations that limit which clients a midwife can see, define exactly what she can and cannot do, and also define when she must refer the client to another health care provider, such as a physician. While these restrictions have a role in regulation, when they are overly restrictive, they often serve to prevent a midwife from seeing the clients who seek her services, or from practicing according to the scope of practice for which she has been trained.

One way we advise the boards to remedy this problem is to specify in their laws that the regulations will be consistent with a particular definition of how the midwife was trained, such as the national standards of practice for certified professional midwives, or the job analysis of the North American Registry of Midwives, or the core competencies of Midwife Alliance of North America, or some document that actually is related to the practice of midwifery. And, that those who are actually practicing the profession should make up at least a majority of the regulatory board.

In summary, we would encourage all public members of regulatory boards to ensure that their regulations, regardless of who you are regulating, should reflect the profession's scope of practice and should also reflect the practice according to the training that the licensee has received, and that restrictions should not be determined by those who stand to benefit economically from the implementation of those restrictions.

Paula Meyer, Executive Director, Section 6, State of Washington, Health Professions Quality Assurance

I am going to talk about the evolution of the practice of advance registered nurse practitioners (ARNPs) in the State of Washington. There have been three legislative changes to the ARNP scope of practice in the last decade. The challenge in everything we do is to balance the protection of the public with providing access to care.

The definition of an ARNP in Washington State is one of the most independent in the U.S. It includes the performance of acts of a registered nurse and the performance of an expanded role in providing health care services as recognized by the medical and nursing profession, the scope of which is defined by rules by the Nursing Commission.

The first generation of nurse practitioner rules was put into law in the early 1990ies. They permitted nurse practitioners to diagnose and treat but there was a limitation on prescriptive authority to Schedule V and Legend drugs. Schedules refer to how addictive a drug is, not how dangerous it is. Schedule I is the most addictive. Schedules II through V have varying degrees of addictiveness. Legend drugs, while dangerous, don't really have addictive characteristics.

The Nursing Commission took about two years, with public hearings around the state, to complete implementing rules. The medical commission recognized the scope of practice as defined.

A few years later, the legislature expanded the prescriptive authority to include

schedule II through IV drugs with a collaborative agreement. The legislature also said this required joint rulemaking adopted by consensus of the Medical Quality Assurance Commission, the Nursing Care Quality Assurance Commission, and the Board of Osteopathic Physicians and Surgeons.

We established what was called a "discernment" process, whereby each of the three boards and commission selected three members to participate in the process. This group met to work through the rules, however long it took. We went through the rules line by line. If anyone disagreed, he or she had to say why and to suggest an alternative. After three and one-half hours, there was consensus on every rule.

The draft language was sent to the three commissions which, under the legislation, had to adopt these rules. We held a joint meeting of all the commission members. They had to either adopt the rules or completely deny them. We were successful.

Two years later, the legislature made ARNPs completely independent, including prescriptive authority over Schedule II – V drugs. No longer is the joint practice agreement required. No longer is there any sort of relationship with prescriptive authority. It helped that at this time, there were eight nurses in the legislature. What also helped was that nurse practitioners had been collecting data as the practice of nurse practitioners evolved. The evolution, the disciplinary actions, and the practice of prescriptive authority were all documented. We were also helped by the public members who were there throughout the process.