News & Views

Citizen Advocacy Center

Third Quarter, 2008 | A Health Care Public Policy Forum | Volume 20 Number 3

Announcement

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SCOPE OF PRACTICE

New Approaches to Scope of Practice Decisions

The following article is excerpted from the Federation of State Boards of Physical Therapy's Online Spring 2008* Federation Forum *(www.fsbpt.org/download/Forum). It was written by J. Kent Culley, Esq. of the Pittsburgh firm of Tucker Arensburg, PC, who is the federation's counsel for legislative and regulatory affairs.

This article will explore recent ways that some states have coped with the question of how best to define scope of practice as a departure from the traditional approach. I would define the traditional approach as one in which the professional associations initiate legislative action dealing with scope of practice and practice act issues and licensure boards are "sideline" players in the legislative process.

~ TABLE OF CONTENTS ~

SCOPE OF PRACTICE 1
New Approaches to Scope of Practice Decisions 1
Pennsylvania Home Care Patients Have Greater Access to PT 5
Walk-In Clinics Expand in Type and Location 5
Practice Opportunities for Dental Therapists and Hygienists 5
"Doctor Nurses" Extend Advanced Practice Nursing 6
Midwives Win Some, Lose Some 6
Ohio Pharmacists Seek to Expand Role in Patient Care 7
CURRENT COMPETENCE 8
CPEP Announces Collaboration with NBME and FSMB 8
Physical Therapy Boards Launch Practice Review Tool 8
Medical Boards Revisit Continuing Education 9
Physicians in UK to Undergo Annual Assessments 9
Occupational Therapists Address Continuing Competence 10
CONSUMER INFORMATION 10
NCQA Website Reveals NY Health Plans' Physician Quality Measurements 10
North Carolina Medical Board Waters Down Malpractice Disclosure 10
QUALITY OF CARE 11
Researchers Look at New Ways to Measure the Quality of Care 11

Continued on page 2…

…(C)onsider first the definition of scope of practice from one well-known outside source, the Pew Health Professions Commission (1995),

Definition of the rules, the regulations and the boundaries within which a fully qualified practitioner, with substantial and appropriate training, knowledge and experience may practice in a field of medicine…, or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability.

This definition focuses on qualifications, education and training of a practitioner who is subject to accountability for their actions and who provides healthcare services within a framework of rules and regulations in their field. The continuing education facet of the definition, while not universal, has been adopted by a majority of the jurisdictions.

…These elements operate first and foremost for the public's protection by assuring or promoting the competency of the practitioner to provide their services as safely and effectively as possible. "Professional accountability" in the above definition establishes a means to deal with those practitioners who violate or fall below the standard for which they are trained and licensed…

A current trend regarding scope of practice focuses on expanded consumer access to qualified professionals using the full extent of their scope of practice based upon training, education and experience… Recently, for example, Pennsylvania embarked upon such a legislative initiative to expand public access to healthcare professionals and health occupations utilizing their training, education and knowledge to the fullest extent possible…

…continued from page 1

AMA Delegates Oppose "Secret Shoppers" 14
Communication / Collaboration Improve Quality of Care 14
Few Americans Considered to Be "Health Literate" 14
Students at Culturally Diverse Schools Exhibit Greater Cultural Competence 15
Few Patients Receive Information from Pharmacists 15
LICENSURE **17**
Virginia Eliminates Jurisprudence Exam for Nursing Home Administrators 17
DISCIPLINE **17**
Investigative Reporter Questions Discipline by Washington Dental Board 17
IN THE LEGISLATURES **18**
Licensing Boards Resist Legislature's Fund Grab 18
IN THE COURTS **18**
Licensing Board Accused of Being Too Close to Trade Association 18
PAIN MANAGEMENT AND END OF LIFE CARE **19**
Course on Pain Care Available Online 19
Senate Passes Comprehensive Pain Management Policy 20
Chronic Pain Meds Unlikely to Cause Addiction 21
Jury Finds Negligence in Failure to Treat Pain 22
ADMINISTRATION **23**
Washington State Boards Increase Fees 23
IN-DEPTH: *Final Report of the Practitioner Remediation and Enhancement Project* 23
NEW CAC BOARD MEMBERS **31**
CAC MEMBERSHIP **33**

NOTICE

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Scope of practice development and change is shaped from time to time by such things as technological advances, research, consumer demands, regulatory intervention and advanced education leading to new skills or techniques. Conventionally, however, the scope of practice development is also sometimes influenced and affected by so-called “turf battles,” or intra-professional conflict regarding the ownership of a scope of practice… As a paper presentation, *Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations* notes, “No one profession actually owns a skill or activity in and of itself.”

…Previously, turf wars frequently raged in states on the right or exclusive use of certain modalities or physical agents for treating patients. Fortunately, either the courts or insurance payors have sorted out many of these issues in recent years. More importantly, however, is the recognition of the physical therapy profession that its scope of practice far transcends the “cookbook” approach of the use of modalities as their “practice.” Increasingly, the focus of practice definition has been on more relevant and significant aspects of their practice as reflected both in the Federation’s *Model Practice Act for Physical Therapy* and also numerous jurisdictions’ updating of statutory definitions of the practice of “physical therapy.”

Nevertheless, state legislatures are still left to struggle with competing interests among healthcare providers and professionals in trying to balance all the interests and understand scope of practice in attempting to regulate for public protection. It is just this dilemma that caused several states to focus on other means to approach the turf and scope issues traditionally left to the professions or state boards and to develop rational and effective legislation among the healthcare players themselves. *(Emphasis added)*

According to the National Council of State Boards of Nursing, the Oregon legislature, in its frustration over what it believed detracted from its decision-making solutions and believing that it was becoming just a venue for occupational arguments and conflicts,

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CAC ***News & Views*** is published quarterly by the

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Washington, DC 20036
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inaugurated legislation to address these concerns. The Oregon legislature proposal, based on a similar type of proposal in the Louisiana legislature, would have set up a Scope of Practice Review Committee through the Medical Board of Examiners to review proposed changes to all regulated health professions' scopes of practice. At the time in question, scope of practice changes were being sought by a number of health professionals. While it turned out that the particular bill died in session before final passage, nevertheless, the concept is still out there and has been more formalized in other states. Similar concepts existed in Iowa, but that oversight mechanism expired, apparently for lack of use.

Editorial Note: In CAC's view, history indicates a medical board does not always take an objective, evidence-based approach to requests for scope of practice expansions by other professions, especially since the AMA' Scope of Practice Partnership (SOPP) is actively opposing scope of practice changes in the states.

In contrast, in 2001, the Minnesota legislature established a Council of Health Licensing Board ("Council") which requires professions or occupations seeking new licensure or changes in the scope of practice to go before the Council for review and scrutiny. The main purpose of the program according to the Council's *Manual of Procedure* is "to provide the Legislature with impartial information on proposals relating to the regulation of the health occupations." Health occupations seeking new or expanded regulation of their occupation must file a report with the Council and the legislature standing committees where the bill was introduced or referred. This report must address at least 11 different categories, such as the purpose of the fill, the need for the bill, specialized training required, harm to the public by not regulating the practice and the expected impact of the proposed regulation on manpower and costs.

The Council is essentially made up of all healthcare or health delivery occupations in Minnesota… (T)he Council appoints an appropriate subcommittee to review the proposed legislation and submits this to the full Council. Once the Council agrees on the report, it is submitted to guide and inform the legislature in its deliberations on the bill. The Council's reporting process normally takes some six to nine months from the referral to the Council.

…States having no such model as Minnesota, Louisiana, or the proposed Oregon law may be guided by these types of state-sponsored initiatives to develop new or expanded practice laws when considering practice act revisions. Legislatures need guidance, too, in trying to sort out the competing interests and the scopes of practice of numerous health occupations that so often overlap.

…While it may be argued strongly that the profession is in the best position to determine its scope of practice, as we can see from the above examples, such is not always today's reality. Short of having an outside source like the legislatively-mandated Council's impact on the scope of practice issue, it will behoove the states while considering practice legislation, to plan carefully anticipate full involvement in the process and focus on providing the legislature with solid education and rationale for the changes. In educating the legislatures, perhaps the paper mentioned above, *Changes in Healthcare Professions' Scope of Practice: Legal Considerations*,

summarizes most succinctly the following critical factors:

- Historical basis for the profession, especially the evolution of the profession advocating a scope of practice change;
- Relationship of education and training of practitioners to scope of practice;
- Evidence related to how the new or revised scope of practice benefits the public; and
- The capacity of the regulatory agency involved to effectively manage modifications to scope of practice changes.

Pennsylvania Home Care Patients Have Greater Access to PT

Governor Ed Rendell signed legislation in July, 2008 that allows physical therapist assistants greater autonomy. The legislation permits physical therapists assistants to provide services without direct supervision by a physical therapist. Instead, a licensed physical therapist will be required to make supervisory visits at least every seven visits or every 14 days.

Pennsylvania's home care and hospice officials supported this legislation because of a shortage of licensed physical therapists and a growing demand for their services among the baby-boom generation.

Walk-In Clinics Expand in Type and Location

Walk-in clinics in retail settings are growing in popularity in the U.S. Now, clinics and pharmacies are opening up in airports to serve the health care needs of travelers. Airports in Atlanta, Newark, Philadelphia, and New York (JFK) have, or soon will have, pharmacies operated by Harmony Pharmacy. Aeroclinic, Solantic, and AirportMD are among the companies operating or opening airport-based clinics.

Meanwhile, the medical profession continues to push back against clinics staffed primarily by advanced practice nurses. Dr. Richard Moody of Chattanooga Family Practice Associates has opened his own on-site quick clinic staffed by physician assistants, according to the ***Chattanooga Times/Free Press*** (June 2, 2008). MedStar PromptCare clinics staffed by physicians will open this summer in drugstores in the Baltimore/Washington, DC area.

Practice Opportunities for Dental Therapists and Hygienists

Following the trend of using advanced practice nurses to operate walk-clinics, the State of Alaska permits "dental therapists" to operate dental clinics serving Alaska natives. The state dental society, with support from the American Dental Association, opposes permitting clinics to be operated by practitioners other than dentists. According to an article by Alex Berenson in ***The New York Times*** (April 28, 2008), Alaska is the only state with this particular category of licensure and the fewer than a dozen licensees are limited to treating Alaska natives.

The therapists have two years of extensive training and are allowed to perform routine tooth extractions and fill cavities. More complex procedures must be referred to a dentist. The program has had promising results and is gradually expanding, according to Berenson.

In Maryland, legislation expected to become effective next fall permits dental hygienists to provide preventive care, such as cleanings, sealants, and fluoride treatments

in public health settings, such as clinics, schools, and Head Start programs without prior authorization or direct supervision of a dentist. The board of dentistry fought against a similar expansion of dental hygienists' scope in South Carolina. The FTC intervened and sided with the hygienists who may now perform preventive care in schools without a dentist first examining each student.

"Doctor Nurses" Extend Advanced Practice Nursing

The growing shortage of physicians has spawned a new category of doctorate nurses – or "Doctor Nurses." More than ninety nursing schools offer comparable programs and that number is expected to nearly triple in coming years. The University of Minnesota School of Nursing Website describes the doctor or nursing program this way:

> This practice doctorate will prepare nurses for leadership as advanced practice nurses, clinical experts, health care executives, policy experts and informaticians. The DNP is offered via two programs.
>
> **DNP**: for students who are registered nurses and who hold, at minimum, a baccalaureate degree. It is designed to prepare for advanced practice roles in clinical, administrative and public health arenas. It will provide approximately 91 credits, depending on the student's specialty and degree at time of entry.

The American Medical Association's Scope of Practice Partnership (SOPP) is forming a work group to resist scope of practice expansions for doctor nurses. Delegates to the AMA's June, 2008 annual meeting passed a resolution asking the AMA to advocate for a policy requiring all practitioners in a clinical setting to identify their degrees and qualifications. Further, the delegates asked the AMA to develop model legislation that would make it a felony for non-physicians to represent themselves as physicians.

Editorial Note: An article by Myrle Croasdale in* American Medical News *(www.amednews.com) (April 21, 2008) catalogues advanced-practice nurse scope of practice initiatives in 24 states:

- ***Independent practice or establishing an independent licensing board: AL, CA,CO,MD,MA,NY, NC, SC, TN, UT, VT***
- ***Prescribing authority, including independent prescribing of controlled substances: CA, FL, IL, MA, MI, MO, OH, NY, WV***
- ***Direct reimbursement from commercial insurers, Medicaid or Medicare: CA, KY, MA, NY, ND, UT***
- ***Other scope areas, such as authority to certify death, supervise fluoroscopic x-ray systems, provide pain management, and make mental health and substance abuse commitments: AL, FL, IA, KS, LA, NE, OK***

Midwives Win Some, Lose Some

In 2007, Pennsylvania nurse midwives won legislative authority to practice and to prescribe medications and devices often used in childbirth. However, the implementing rules proposed by the board of medicine say that nurse midwives may practice in collaboration with a doctor licensed by the medical board. This would exclude entering into collaborative

agreements with doctors of osteopathic medicine who are licensed by a different board.

Lobbying by physicians in Maine successfully derailed a proposal to license lay midwives in that state. Still, certified lay (or professional) midwives did win the right to purchase, possess, and administer a limited number of prescription drugs often used in home births.

In Idaho, the Idaho Midwifery Voluntary Licensing Act (House Bill 488) was the subject of two days of impassioned hearings before the House Health and Welfare Committee. The medical society opposed the legislation, in part because it was voluntary. Nevertheless, an amended version of the bill was passed out of committee 9-3 with the voluntary nature of the bill intact. After several readings on the House floor, the bill appeared close to passage but was referred to the Attorney General for an opinion about some ambiguous language. This was enough to get the bill pulled from the House calendar for 2008, but proponents promise to re-introduce it in 2009.

In Utah, the state Senate easily passed legislation granting licenses to sixteen midwives who entered practice via apprenticeship rather than education. The bill, SB93, was expected to meet a less welcome reception in the House.

Ohio Pharmacists Seek to Expand Role in Patient Care

On May 8, 2008, Ohio's University of Findlay School of Pharmacy convened a Health Care Summit on Pharmacist Provided Patient Care. One goal of the summit was to persuade insurers to pay pharmacists for direct patient care.

Ohio pharmacists look to the successful program in Asheville, NC involving pharmacist care for patients with diabetes, asthma, high blood pressure and high cholesterol levels and other chronic conditions. Asheville pharmacists are compensated through the city's self-insurance program. Many city and county governments in Ohio, as well as several large employers, also self-insure and could adopt a similar model.

Pharmacists believe they can play an important role in direct patient care, not the least because they can keep tabs on the multiple medications many patients are prescribed by their various health care practitioners and prevent adverse interactions.

In addition to Ohio, pharmacists in Milwaukee, Tampa, Colorado Springs, and perhaps elsewhere have negotiated contracts with employers to be compensated for coordinating care for patients with chronic conditions, such as diabetes.

Editorial Note: In some circumstances, compensation for pharmacists for direct patient care may be a double-edged sword. According to an article in the* Bluefield Daily Telegraph *(February 26, 2008). A bill in the West Virginia legislature that would require free clinics to use pharmacists to dispense mediations was controversial because many feared it would hamper the free clinic's ability to give free medications to needy patients. Clinic operators doubted it would be possible to find pharmacists willing to volunteer to serve at the clinics, so they would have to hire them.

CURRENT COMPETENCE

CPEP Announces Collaboration with NBME and FSMB

Editorial Note: CPEP issued the following press release on September 17, 2008 announcing plans to collaborate with the National Board of Medical Examiners and the Federation of State Medical Boards in assessment of licensed physicians:

> CPEP, a nationally recognized leader in physician assessment and education services, is pleased to announce it will be adding standardized examinations of the Post Licensure Assessment System (PLAS) to its Assessment Program starting September 2008. The PLAS is a joint program of the National Board of Medical Examiners (NBME) and Federation of State Medical Boards (FSMB) providing assessment services to state licensing authorities and others for their use in evaluating licensed or previously licensed physicians. CPEP will be including PLAS examinations as a testing option for its competence Assessment and Clinical Practice Re-Entry Programs.
>
> Founded in 1990, CPEP was created with a single, clear purpose: to provide in-depth information and educational solutions needed to objectively address physician performance concerns. Dennis K. Wentz, M.D., CPEP Board President, states, "We are pleased to have joined forces with the PLAS program to provide an even more complete range of evaluation tools for our physician clients. The mission of CPEP is to improve the quality of patient care by providing clinical competence assessment and education programs; these tools will enhance our ability to serve both the physicians and society. CPEP has been at the forefront of physician evaluation programs; this partnership will be valuable as we move forward to the next phase of our nationally recognized services.
>
> CPEP also offers a *Patient Care Documentation Seminar*, and *ProBE, Professional/Problem-Based Ethics Program*. With 18 years of experience and the completion of over 900 competence Assessments, CPEP is excited to have these additional tools for physician evaluation available, and to be collaborating with the PLAS Program.
>
> For more information, visit http://www.cpepdoc.org.

Physical Therapy Boards Launch Practice Review Tool

The Federation of State Boards of Physical Therapy (FSBPT) announced the activation of a new Practice Review Tool (PRT) on July 17, 2008. According to a Federation Newsflash:

> The Practice Review Tool is a new initiative created by FSBPT to allow PTs to compare their knowledge, skills and abilities to current entry-level practice. It is also an opportunity to review PT fundamentals.
>
> The PRT uses scenarios and multiple choice questions that emphasize clinical application of content knowledge. Realistic case scenarios that describe clinical situations are presented and the PT answers a series of related

questions. Scenarios include the age, gender, and presenting problem/current condition of a patient and may also include past medical history, physical therapy examination results, physical therapy interventions and other information.

More information is available at www.fsbpt.org.

Medical Boards Revisit Continuing Education

The Federation of State Medical Boards' ***Journal of Medical Licensure and Discipline*** (Vol 94, No 2, 2008) contains an article that examines "the tentative nature of linkages between medical licensing requirements and evidence for the effectiveness of continuing medical education (CME) participation, the abilities of physicians to self-assess, and policymaking in CME." The article is entitled, ***Continuing Medical Education, Professional Development, and Requirements for Medical Licensure: A White Paper of the Conjoint Committee on Continuing Medical Education.*** The Conjoint Committee consists of 16 organizations, including accreditors, professional associations and specialty societies, continuing medical education providers, and regulators. The article's abstract reads as follows:

> To provide the best care to patients, a physician must commit to lifelong learning, but continuing education and evaluation systems in the United States typically require little more than records of attendance for professional association memberships, hospital staff privileges, or re-registration of a medical license. While 61 of 68 medical and osteopathic licensing boards mandate that physicians participate in a certain number of hours of continuing medical education (CME), 17 of them require physicians to participate in legislatively mandated topics that may have little to do with the types of patients seen by the applicant physician. Required CME should evolve from counting hours of CME participation to recognizing physician achievement in knowledge, competence and performance. State medical boards should require valid and reliable assessment of physicians' learning needs and collaborate with physician and CME communities to assure that legislatively mandated CME achieves maximal benefit for physicians and patients. To ensure the discovery and use of best practices for continuing professional development and for maintenance of competence, research in CME and physician assessment should be raised as a national priority.

Physicians in UK to Undergo Annual Assessments

The Chief Medical Officer of the United Kingdom, Sir Liam Donaldson, has proposed annual assessments of doctors' prescribing habits, diagnostic skills, and personal issues which may affect their work. Senior doctors will assess other doctors practicing in their areas and patients will be asked for their feedback. In addition, doctors, and hospital consultants will be required to renew their licenses every five years.

The UK's General Medical Council has been examining options for periodic

assessment for nearly a decade. The effort was spurred on by the case of Harold Shipman, a general practitioner who killed at least 215 patients.

Occupational Therapists Address Continuing Competence

The focus of the National Board for Certification in Occupational Therapy's (NBCOT) 14th Annual Conference on Occupational Therapy State Regulation in October 24-25, 2008 is "The State of Continuing Competency." The agenda includes presentations on effective rule writing, top regulatory cases impacting continuing competence, a benchmark survey or renewal requirements for certification and licensure, a multi-faceted approach to continuing competence and competency assessment, and challenges to the occupational therapy scope of practice.

CONSUMER INFORMATION

NCQA Website Reveals NY Health Plans' Physician Quality Measurements

The National Committee for Quality Assurance (NCQA) announced on July 31, 2008 a new Web site (www.nyrxreport.scqa.org) which provides detail on the extent to which health plans in New York measure and report on physician performance in accordance with an agreement reached between the health plans and New York Attorney General Andrew Cuomo. NCQA is the official Ratings Examiner under the agreement.

The Web site reports include verification of the accuracy of measurement methods, the involvement of physicians in the program's development, and the right of physicians to request changes or corrections to data.

According to NCQA President Margaret O'Kane, "Few decisions a patient makes hold greater sway over their health than their choice of physician. Rating physicians with trusted, transparent measures of quality gives patients a meaningful foundation for making these choices. Out Web site takes physician rankings out of the black box and sheds light upon what goes into physician measurement efforts."

North Carolina Medical Board Waters Down Malpractice Disclosure

In April, 2008 the North Carolina Medical Board introduced a proposal to post malpractice settlement data on its Web site. The Board planned to post limited information about malpractice settlements during the prior seven years. Under the proposal, the posting was to have included the physician's name, the date the settlement occurred, but not the dollar amount of the settlement. The proposal gave physicians the option to post an explanation of the reasons for the settlement.

The North Carolina Medical Society opposed the proposal from the start, arguing that the medical board should post malpractice settlement information only after reviewing the case and determining that substandard care was in fact involved. The North Carolina Academy of Family Physicians suggested that if the board supports full disclosure, it should reveal the suing attorneys' fees and how often the plaintiff files malpractice suits.

After a public comment period, the medical board backed off its original proposal and agreed in July, 2008 to disclose only settlements of more that $25,000. Rather than going seven years back, the board will disclose settlements that have occurred since October 2007 when the legislature authorized the disclosure. The Web site will

also disclose whether the case led to discipline by the board.

Editorial Note: The North Carolina Medical Board commissioned a 1,000 person state-wide survey to assess public support for the malpractice settlement disclosures. Eighty-one percent of respondents supported the disclosure of malpractice information. Eighty-four percent of respondents supported disclosing settlements during the prior seven years. Fifty-eight percent supported making all malpractice case information available on the Web rather than filtering out payments below a certain level or cases that were not found by the board to involve substandard care.

QUALITY OF CARE

Researchers Look at New Ways to Measure the Quality of Care

A study reported online by the journal ***Health Affairs*** looks at current approaches to pay-for-performance (P4P) and offers an alternative approach designed to engage physicians as partners in identifying and addressing areas of overuse and misuse. The study's authors detail how this approach was used among the roughly 900 primary care physicians and 2,500 specialists at the Rochester Individual Practice Association (RIPA) in New York State to determine better-quality care in treating hypertension and using fiberoptic laryngoscopy to evaluate problems with swallowing. As reported by ***Health Affairs:***

> The trouble with current P4P methodology stems from primarily employing a measure known variously as an "efficiency index" (EI), an efficiency factor, or an observed-expected ratio, the study says. This measure, which compares the costs incurred by a particular physician with the average per physician costs in the relevant specialty, is used in most current physician P4P schemes.
>
> "The EI reflects a judgmental approach that attempts to motivate physicians through blame and fear, making physicians adversaries rather than partners in change. What's more, the EI focuses on global cost control rather than identifying and then encouraging a reduction in overused procedures and – equally importantly – an increase in underused procedures on a condition-by-condition basis," said coauthor Howard Beckman, medical director at RIPA…
>
> Based on that experience, RIPA developed an alternative approach to measuring physician performance. RIPA's approach was based on analyzing which interventions were the main cost drivers for specific conditions, and determining whether physicians who used these interventions more intensively than others were obtaining better outcomes or simply costing more…
>
> In the case of throat disorders, the main cost driver was the performance of fiberoptic laryngoscopies. Physicians in the highest spending quartile performed 3.4 times more procedures than their counterparts in the lowest spending quartile. Greater use of the procedure was not associated with better outcomes or a decrease in costs elsewhere. In fact, physicians who performed more laryngoscopies had relatively higher costs for office visits and pharmaceuticals as

well, compared with those performing fewer of them. RIPA designed a project to try to shift the practice pattern among its otorhinolaryngologists. To ensure that quality of care was maintained, the project was conducted under the leadership of the otorhinolaryngology community…

The researchers also examined hypertension care as a proof of their concept, although RIPA did not conduct the same sort of intervention with physicians regarding hypertension care as it did regarding throat disorders. Cost differences among physicians treating hypertension were predominantly due to differences in pharmacy costs…

In treating hypertension, higher-spending physicians were more likely to prescribe brand-name drugs, while lower-spending physicians prescribed more generics. Physicians in the highest spending quintile were more than six times more likely than their counterparts in the lowest spending quintile to prescribe drugs known as angiotensin receptor blockers (ARBs), which are only available in brand-name formulations, even though angiotensin-converting enzyme (ACE) inhibitors work just as well for most patients and are available as inexpensive generics.

The ***Health Affairs*** Web exclusive can be found at: http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w250

In other quality-related research, the Commonwealth Foundation www.cmwf.org funded a study entitled, ***The Feasibility and Value of New Measures Showing Patterns of Quality for Patients with Three Chronic Conditions.*** As described on the fund's Website,

In "The Feasibility and Value of New Measures Showing Patterns of Quality for Patients with Three Chronic Conditions" (*Journal of Ambulatory Care Management,* Jan.–Mar. 2008), researchers led by Stephen M. Davidson, Ph.D., of the Boston University School of Management, set out to demonstrate the feasibility of a novel way of measuring quality—using a "level of care" approach for measuring patterns of service to ascertain quality, rather than individual measures of performance.

To date, nearly all quality research has focused on whether or not one or more specific services were provided to patients with a particular condition. But focusing on individual measures of quality performance may limit efforts to improve care, the authors say. Taking a more comprehensive approach, the study adopted an "all-or-none" approach to assessing patient care. Under this approach, a patient's care is of good quality only if he or she has received all the services recommended in standard treatment guidelines for a given condition.

Five Levels of Care

The researchers analyzed four years of claims data to reflect patterns of services used in a single, large metropolitan market, focusing on more than 80,000 patients with asthma, diabetes, and heart failure. Their approach was based on two

assumptions: 1) optimal patterns of care exist for most patients with a chronic condition; and 2) patients may receive only some recommended services, therefore gradations of quality exist.

Five quality categories were created for each condition, "level I care" through "level V care," with the higher levels representing better-quality care. For example, level I diabetes care was indicated by patients having no outpatient visits, no HbA1c test, and no continuity of hypoglycemic medications. Patients in level II care received only one of an outpatient visit, HbA1c test, or medication continuity, but nothing else. This continues on to level V care, where patients have used all desired services and have not had an emergency department visit or a hospitalization due to inadequate management of the condition.

Quality Care Remains Elusive for Many Chronically Ill Patients

Using this level-of-care approach, the team found that between 1994 and 1997, 59 percent to 62 percent of heart failure patients and 66 percent to 75 percent of diabetes patients received care in the lowest two categories. Asthma patients did not fare as badly: nearly 40 percent were in the lowest two categories, but more than half were in the top two categories. Fewer than 16 percent of patients with heart failure and diabetes were in the top two levels of their respective categories.

Patterns tended to persist from year to year. Patients in the lowest level one year were likely to be in the same category for all four years. For instance, 51 percent of patients with diabetes who were in the level I category in 1994 were in the same category in 1995, 46 percent in 1996, and 43 percent in 1997. This finding "indicates that health care providers in the study market had not succeeded in moving large amounts of the patients they saw to higher levels," say the researchers.

Conclusions

The authors believe their measures effectively differentiate the care received by groups of patients with the three chronic conditions studied. "The levels of care approach to quality measurement can help caregivers and policymakers find methods for avoiding unnecessary utilization and expenditures while raising – not lowering – the probability that utilization patterns will conform to condition-specific recommended care," they conclude.

The study data, which represent the combined experience of all private insurers and Medicare in a single market, show that many patients did not receive appropriate services for the management of their chronic conditions. While noting their data are more than 10 years old, the researchers say that more recent national ambulatory care studies as well as reports from the National Committee for Quality Assurance make it clear that the problem persists.

The study conducted by S. M. Davidson, M. Shwartz, and R. S. Stafford can be found in the *Journal of Ambulatory Care Management,* January–March 2008 31(1):37–51.

AMA Delegates Oppose "Secret Shoppers"

The AMA's House of Delegates voted on June 15, 2008 to oppose the use of "secret shoppers" in the medical setting, thereby rejecting the recommendation of its Council on Ethical and Judicial Affairs which hoped the body would endorse the practice. Secret shoppers are being used increasingly by hospital and other health care organizations to evaluate such things as provider communication, and other consumer satisfaction aspects of care.

Opponents of secret shoppers say the practice is unethical because secret shoppers pretending to be ill in emergency room settings, for example, can interfere with treatment of real patients with legitimate complaints. Proponents of the use of secret shoppers point out that they can alert health care practitioners and organizations of aspects of service they may be unaware of. The information supplied by secret shoppers, they contend, can lead to improvements in health care management and delivery.

Communication / Collaboration Improve Quality of Care

Research sponsored by the Agency for Healthcare Research and Quality found that good communication and collaboration among surgical team members is linked to better patient outcomes 30 days after surgery. Organizational climate variables, such as perception of organizational commitment to patient safety, working conditions, and job satisfaction were not linked to patient outcomes.

The researchers surveyed staff perceptions of teamwork, job satisfaction, management, safety climate, working conditions, and stress effects on clinical teams. They also surveyed staff about their perceptions of communication and collaboration with attending and resident doctors.

The survey report, "*Risk-adjusted morbidity in teaching hospitals correlates with reported levels of communications and collaboration on surgical teams but not with scale measures of teamwork climate, safety climate, or working condition,"** ***by Daniel L. Davenport, PhD., William Henderson, PhD., Cecilia Mosca, M.P.H., and others in the December 2007 **Journal of the American College of Surgeons,** ***205, pp. 778-784. (http://www.facs.org/jacs/index.html)***

Another survey reinforces the relationship between good doctor-patient communication and the quality of care. A study in the May issue of the journal **Mayo Clinic Proceedings** ***based on a survey of 172 patients discharged between February and April 2006 who were sent home with at least one new medication. Researchers called them within the first three weeks of discharge and asked them if they knew the name, purpose, dosing amount and schedule, and potential side effects. Eighty-six percent knew they had been given a new medication, but only 64% could state its name or purpose. Only 11 percent recalled being told about potential side effects.***

The study can be found at: ***http://www.mayoclinicproceedings.com/Abstract.asp?AID=4678&UID=&Abst=Abstract***.

Few Americans Considered to Be "Health Literate"

The Agency for Healthcare Research and Quality's 2007 ***National Healthcare Disparities Report*** found that only 12% of American adults have the skills to manage their own health care proficiently.

In more detail, the survey found that 53% or respondents possessed "intermediate" skills, including the ability to read instructions on a prescription label and determine the right time to take the medication. Twenty-two percent had "basic" skills, such as the ability to read a pamphlet and understand two reasons why a disease test might be appropriate even though no symptoms are present.

Fourteen percent had below basic skills. This means the can understand simple instructions, such as what it is permissible to eat and drink before a medical test. Many of the people in this category are not fluent, or even comfortable, with English.

Editorial Note: This data should be a wakeup call telling doctors and nurses that they need to do more to be sure their patients understand conversations and instructions during office visits and in acute care settings. Communication is an important responsibility of health care practitioners. Licensing boards should examine what they can do to create incentives for better practitioner-patient communication.

Students at Culturally Diverse Schools Exhibit Greater Cultural Competence

The Commonwealth Fund's September 22, 2008 Washington Health Policy Week in Review reported on a study showing that students who attend ethnically diverse medical schools are better prepared to work with diverse groups of patients. Commonwealth Fund staff writers, Phil Mattingly and Lydia Gensheimer summarized the results of a new study published in the ***Journal of the American Medical Association:***

> Led by Dr. Somnath Saha of the Portland VA Medical Center, a group of researchers defined diversity in the study based on the degree to which medical schools promote interaction between races and the total proportion of minority students at each school.
>
> The researchers found that students who attended classes at the most racially diverse schools felt they were the most comfortable dealing with a diverse patient population after graduation. Researchers also found that the rate of students who felt comfortable increased when their school made a concerted effort to promote interracial interaction.
>
> "We were trying to see—does diversity matter in the way that people speculate it does?" said Saha, who conducted the study. "And we found that it did. The diversity hypothesis did hold true."
>
> Researchers found that 61 percent of students attending schools classified by the study as diverse felt they were prepared to handle diverse patient populations. Just under 54 percent of students from schools lacking diversity felt the same way.
>
> Saha said students at more diverse schools also were more likely to view access to health care as a fundamental right.
>
> "There was a question about whether all people are entitled to health care, and what we saw was that fewer than half of students nationwide strongly agreed with that statement," Saha said. "Students at more diverse schools, though, were more likely to believe that access to care was a fundamental right."

Saha said that in conducting the study, he and his colleagues were attempting to determine whether attention paid to race and ethnicity in admitting students to medical schools is justified.

"Race-conscious policies and programs have been used to achieve racial diversity, and particularly to increase the numbers of black, Latino, and Native American individuals who are underrepresented in the physician workforce," researchers write in the introduction of the study. "In recent years, however, these policies have come under increasing scrutiny as being unnecessary and discriminatory."

The study is prime evidence of the need for diversity in medical schools throughout the country, researchers argued.

"I think the study offers empirical evidence to support education policy perspectives that we've educated for a very long time about the importance of diversity," said Charles Terrell, chief diversity officer at the Association of American Medical Colleges, which administered the questionnaire used in the study. "I think it also continually supports the Supreme Court's advocacy for diversity."

The study was conducted from the compiled surveys of more than 20,000 graduating medical students from 118 medical schools over 2003 and 2004. Minority students were placed in two categories: those that are underrepresented in the field such as blacks, Native Indians, Mexican Americans, and Puerto Ricans, and those minorities that are well-represented, primarily Asians and Southeast Asians.

The study also excluded data from historically black and Puerto Rican medical schools due to the skewed diversity that occurs when minority groups comprise the majority of students. For more information, visit www.commonwealthfund.org/healthpolicyweek.

Few Patients Receive Information from Pharmacists

Consumer Reports Magazine surveyed 40,000 of its readers about their experiences purchasing pharmaceuticals, specifically whether they ask pharmacists about such things as dosage and interactions. Respondents asked for advice about prescription drugs at only 38% of walk-in visits during a year and about over-the-counter drugs during only 29 percent of visits. This is a decline in patient inquiries from the previous such survey in 2002.

Editorial Comment: CAC News & Views wishes the survey results revealed how frequently pharmacists offered to counsel patients about their prescriptions and the methods used to make such offers. In any case, these statistics may prompt boards of pharmacy to invigorate their enforcement of counseling requirements in the hope that more patients will welcome this professional guidance about how to use their prescriptions.

For details of the survey, see www.consumerreports.org/health/prescription-drugs/drugstore.

LICENSURE

Virginia Eliminates Jurisprudence Exam for Nursing Home Administrators

Virginia's Board of Long-Term Care Administrators has enacted a "Fast-Track" regulation for nursing home administrators, effective July, 2008. The regulation eliminated the state jurisprudence examination, for licensure by examination. Instead, applicants for licensure will be asked to attest that they have read and understood the laws and regulations governing nursing homes in Virginia. Applicants for licensure are still required to pass the credentialing examination approved by the Board, which is the examination for Assisted Living/Residential Care offered by the National Association of Long Term Care Administrator Boards.

The fast-track regulation also increased the number of Internet or self-study courses that may be obtained for continuing education. This increase went from 5 hours to up to 10 of the required 20 hours of continuing education that may be obtained through Internet or self-study courses. "The additional flexibility in obtaining CE hours online or by Internet," according to the board, "may enable some administrators to spend those additional hours in their facilities where their job is to serve a vulnerable population."

Explaining its rationale for this fast-track process, the board wrote:

> The board has determined that a fast-track process is appropriate because there is no controversy with this action. It will eliminate a costly examination that the board does not believe is essential to ensure minimal competency and will expand the opportunities available to current licensees for compliance with continuing education requirements. Elimination of the state examination is consistent with recently adopted regulations for licensure of assisted living administrators under the same board.

Additionally, for a limited time, the regulations for Assisted Living Facility Administrators were revised to reduce the experience requirements of full-time assisted living facility administrators and assistant administrators in an assisted living facility from two years of experience to **one of four years experience immediately preceding application for licensure.** This licensure option is only available until January 2, 2009 and will then expire.

DISCIPLINE

Investigative Reporter Questions Discipline by Washington Dental Board

Carol Smith, a reporter for the ***Seattle Post-Intelligencer*** wrote an article on July 15, 2008 under the headline: "Enough Scrutiny in Dental Deaths? Handling of 3 Cases Raises Questions about State's Review Process – Board Found No Wrongdoing, Meaning Public Isn't Told About Cases." The article looks in-depth at three cases involving patient deaths in which the dental board took no disciplinary action. The board investigated two of the cases but closed them without a full hearing by the board. The third case was not even investigated after a panel of the board was satisfied by the dentist's account of what happened.

Smith points out this significant consequence of the board's failure to act: "Because no action was taken by the dental

board in any of the cases, none of the deaths shows up on the state Web site where consumers can check their dentists' histories."

Other states -- Smith cites California and Texas -- conduct full investigations of all death cases while Washington's dental board can dismiss cases involving patient deaths on the strength of the dentist's explanation. The case covered in the article which was not investigated at all involved a dentist, Mark C. Paxon, who was at one time a member of the dental board. In this case, the patient went into cardiac arrest while being put under general anesthesia. He suffered brain damage and died within the week. Paxon had been sanctioned by the board in 2005 for using unlicensed assistants to administer anesthesia.

In a second case involving death associated with anesthesia, the dentist under investigation currently sits on the dental board. He also holds a physician's license. The medical board investigated the case and decided to file unprofessional conduct charges against him. In the third case, death resulted from an aggressive bacterial infection three days after the dental surgery.

The process followed by the dental board is to refer dentists' self-reports of a patient death to a screening panel, usually comprised of three dentists and one public member. The identity of the dentist under scrutiny is withheld from the panel. If the panel refers the case for investigation, a single dental board member reviews the investigation and makes a recommendation to the panel.

Editorial Note: CAC News & Views believes that California, Texas and other states that require a full investigation and hearing in all cases of death during a dental procedure have got it right and that Washington's dental board should undertake a rulemaking or seek legislation, if necessary, to require that all deaths be thoroughly investigated.

IN THE LEGISLATURES

Licensing Boards Resist Legislature's Fund Grab

Tennessee's boards of nursing and medicine cried foul in when the state legislature suggested in May 2008 that it would open up their financial reserves to make up a budgetary short fall which threatened state education, conservation and medical programs. The boards warned that they wouldn't be able to fulfill their mandates if the legislature dipped into their funds. Moreover, the boards' reserves are not taxpayer's money and the legislature should not treat them as such.

The Tennessee Nurses Association (TNA) sided with the nursing board whose $4.5 million revenue is 98% licensure fees. The nursing board should not be penalized, according to TNA's executive director, for responsibly managing its funds.

IN THE COURTS

Licensing Board Accused of Being Too Close to Trade Association

A group of Pennsylvania funeral directors and cemetery operators have sued the State Board of Funeral Directors accusing it of having an "incestuous relationship" with the Pennsylvania Funeral Directors Association. The suit seeks to invalidate laws and regulations the plaintiffs allege to be "unduly restrictive, overly broad, anti-competitive, discriminatory, and constitutionally infirm."

Among the specific grievances raised by the plaintiffs, who include members of the

Pennsylvania Cemetery, Cremation and Funeral Association, is a longstanding dispute over regulation of pre-need services planned and paid for by consumers before they die. The also claim that funeral home inspections, as currently conducted, violate unreasonable search and seizure protections.

They allege several arbitrary or anti-competitive rules, such as a prohibition against gay or lesbian funeral directors bequeathing their business to their partner, restrictions on serving food in funeral homes, and a requirement that funeral homes must be named after the licensed proprietor.

PAIN MANAGEMENT AND END OF LIFE CARE

Course on Pain Care Available Online

The Pain & Policy Studies Group has announced a new on-line course entitled, ***Increasing Patient Access to Pain Medicines around the World: Improving National Policies that Govern Drug Distribution.*** As explained in the announcement, the course is about the relationship between government policies that affect the medical availability of opioid analgesics and patients who experience moderate to severe pain. The authors of the course contend that it is critically important for health care professionals, government drug regulators, and advocates involved in palliative care and pain relief to understand the government policies that control opioid analgesics and how they can block or ensure patient access to opioid analgesics.

The course was designed to provide a synthesis of the critical background material and current methods that have been developed to improve national policies governing medical availability of essential pain medicines for cancer and HIV/AIDS patients. It is intended for an international audience of health care professionals, local and national policy makers, palliative care advocates, government drug regulatory personnel, national health policy advisors, and health policy scholars with an interest in pain management or palliative care.

The course is accessible at no cost and is self-paced so that it can be taken at any time that is convenient for the learner. It has 7 lessons each with required readings. Upon successful completion of the course the learner will receive a certificate.

- Lesson 1: Understanding the Relationship between Pain and Drug Control Policy
- Lesson 2: The Role of International and National Law and Organizations
- Lesson 3: Barriers to Opioid Availability and Access
- Lesson 4: WHO Guidelines to Evaluate National Opioids Control Policy
- Lesson 5: WHO Guidelines to Evaluate National Administrative Systems for Estimating Opioid Requirements and Reporting Consumption Statistics
- Lesson 6: WHO Guidelines on Procurement and Distribution Systems for Opioid Analgesics
- Lesson 7: How to Make Change in Your Country

The development of this course was supported by the National Hospice and Palliative Care Organization and the Foundation for Hospices in Sub-Saharan Africa. For more information, and to access

the course, please visit: http://www.painpolicy.wisc.edu/on-line_course/welcome.htm.

Senate Passes Comprehensive Pain Management Policy

As reported in the June 3, 2008 ***Congressional Record*** p. S4978, the U.S. Senate passed a comprehensive pain care policy for the Department of Veteran's Affairs. The bill provides for the following:

TITLE II – PAIN CARE

SEC. 201. COMPREHENSIVE POLICY ON PAIN MANAGEMENT

a) *Comprehensive Policy Required* – Not later than October 1, 2008, the Secretary of Veterans Affairs shall develop and implement a comprehensive policy on the management of pain experienced by veterans enrolled for health care services provided by the Department of Veterans Affairs.

b) *Scope of Policy* – The policy required by subsection (a) shall cover each of the following:

   (1) The Department-wide management of acute and chronic pain experienced by veterans.

   (2) The standard of care for pain management to be used throughout the Department.

   (3) The consistent application of pain assessments to be used throughout the Department.

   (4) The assurance of prompt and appropriate pain care treatment and management by the Department, system-wide, when medically necessary.

   (5) Department programs of research related to acute and chronic pain suffered by veterans, including pain attributable to central and peripheral nervous system damage characteristic of injuries incurred in modern warfare.

   (6) Department programs of pain care education and training for health care personnel of the Department.

   (7) Department programs of patient education for veterans suffering from acute or chronic pain and their families.

c) *Updates* – The Secretary shall revise the policy required by subsection (a) on a periodic basis in accordance with experience and evolving best practice guidelines.

d) *Consultation* – The Secretary shall develop the policy required by subsection (a), and revise such policy under subsection (c), in consultation with veterans service organizations and other organizations with expertise in the assessment, diagnosis, treatment, and management of pain.

e) *Annual Report* –

(1) **IN GENERAL –** Not later than 180 days after the date of the completion and initial implementation of the policy required by subsection (a) and on October 1 of every fiscal year thereafter through fiscal year 2018, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the implementation of the policy required by subsection (a).

(2) **CONTENTS** – The report required by paragraph (1) shall include the following:

A. A description of the policy developed and implemented under subsection (a) and any revisions to such policy under subsection (c).

B. A description of the performance measures used to determine the effectiveness of such policy in improving pain care for veterans system-wide.

C. An assessment of the adequacy of Department pain management services based on a survey of patients managed in Department clinics.

D. An assessment of the research projects of the Department relevant to the treatment of the types of acute and chronic pain suffered by veterans.

E. An assessment of the training provided to Department health care personnel with respect to the diagnosis, treatment, and management of acute and chronic pain.

F. An assessment of the patient pain care education programs of the Department.

f) *Veterans Service Organization Defined* – In this section, the term "veterans service organization" means any organization recognized by the Secretary for the representation of veterans.

Chronic Pain Meds Unlikely to Cause Addiction

***The following article is reprinted from the June* Pain Monitor*, an online report from the American Pain Foundation* www.painfoundation.com.**

By MedHeadlines – May 9, 2008

The general population and many in the medical community alike harbor the popular opinion that using strong pain medications, including opioids, for long-term, chronic pain puts the patient at high risk of developing an addiction to the pain medications. A report presented recently at the annual meeting of the American Pain Society (APS) reveals evidence to the contrary.

Srinivasa Raja, MD, a professor of anesthesiology at Johns Hopkins University Medical School, reports that less than 3% of all patients suffering from chronic pain and who have no history of abusing drugs of any kind may eventually show signs of dependence or abuse when taking these medications pain relief. He urged the medical community to keep this very small percentage of risk in mind when establishing policies for prescribing such medications to patients who are far more likely to benefit from them than be endangered by them.

Raja also points to media attention surrounding an increase in the abuse of such medications but says these drugs are easily obtained from unregulated internet pharmacies and through theft and forgery of prescriptions, not just from within the legitimate medical establishment. While the established medical community is not the sole source of supply for these medications, Raja urges diligent communication between physician and patient, with patient screening procedures to identify addictive or potentially abusive behaviors becoming a routine part of the prescription and follow-up phases of treatment.

Raja further calls for uniformity in state and federal drug regulations and praises the teen drug awareness campaigns underway across the country as a means of preventing abuse of this type of drug. Raja says collaboration from the healthcare community, law enforcement agencies, and the pharmaceutical industry is needed to ensure people who need them will be allowed continued access to these medications, especially in the many cases where the benefits far exceed the risk of dependency.

Alternative treatments such as cognitive behavior and physical therapies should be used to supplement pain medications whenever possible, according to Raja. He says using this multi-faceted approach to pain management is much more effective than relying only on pain medications as the sole means of relief in most cases.

In his address to the APS, Raja cited past beliefs about pain that have been disproved by scientific evidence, such as that babies didn't feel pain and therefore didn't need anesthesia, and that cancer patients should eschew the most potent and effective pain medications due to the supposed risk of addiction. These outdated beliefs have been proven wrong, and he feels the fear of addiction should be abandoned as well in favor of effective treatment for pain management without the stigma of potential addiction influencing treatment options.

Jury Finds Negligence in Failure to Treat Pain

A Nebraska jury ruled in March 2008 that the nursing staff at Hospice House were negligent in their failure to provide adequate pain medication to a patient with terminal cancer. In the last week of her life, a nurse attending Frances Tolliver declined to apply a new morphine skin patch, as prescribed to control pain.

According to Compassion & Choices, an organization that advocates for expanding and protecting the rights of the terminally ill, the nurse told Tolliver's daughters that she

didn't want to "waste" a patch on a terminal patient. However, Tolliver lived longer than the nurse anticipated, and suffered uncontrolled pain until her death.

Hospice House markets itself as a hospice facility that provides non-curative comfort to dying patients. Its staff, however, was not adequately trained for the purpose, nor was the facility licensed to provide hospice care.

ADMINISTRATION

Washington State Boards Increase Fees

Effective September 1, 2008, licensure fees for many Washington State health care practitioners have been increased by as much as two or three times. Comments by stakeholders raised concerns about the amount of the fee increases. In an explanatory statement issued July 25, 2008, the Department of Health wrote:

> The rules increase fees for the listed professions by no more than the amount approved by the legislature in ESHB2687 (Chapter 329 Laws 2008). Fees were temporarily reduced for many professions in July 2005. In 2007, some of these fees were returned to the prior level. These rules raise the fees to a level that will cover the current costs to regulate the professions. For some professions the rules also add a fee up to $25 for online access to University of Washington Library resources.
>
> The cost to regulate health care providers is about $27 million each year. Increases in regulatory activities based on new laws, court cases, and in disciplinary actions has made it necessary for the department to request an increase in fees. For example, from the 2001-2003 to the 2005-2007 biennium, authorized investigations increased 44% and disciplinary actions increased 50%. During this same biennium, revenue increased approximately 7% while expenditures increased about 61%.
>
> Without an increase in fees, or alternative funding, the programs will not be able to maintain current levels of service. Credentialing, background checks, investigations, and disciplinary activities will decrease to the level that could place patients at risk and create barriers to receiving health care.

IN-DEPTH: Final Report of the Practitioner Remediation and Enhancement Project

Editorial Note: CAC recently completed the final year of funding from the Health Resources and Services Administration (HRSA), Department of Health and Human Services for its Practitioner Remediation and Enhancement Project (PreP 4 Patient Safety). This quarter's In-Depth Feature consists of excerpts from CAC's Final Report to HRSA.

Additional information about PreP 4 Patient Safety, including resources for starting a program in your state, can be found at www.cacenter.org and www.4patientsafety.net.

I. Introduction

A. What is PreP 4 Patient Safety?

The Practitioner Remediation and Enhancement Partnership (also referred to as PreP 4 Patient Safety, or PreP), is a pilot project conceived and administered by the

Citizen Advocacy Center (CAC) in cooperation with the Administrators in Medicine (AIM) and the National Council of State Boards of Nursing (NCSBN). It is funded through a contract with the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

PreP 4 Patient Safety is a framework within which state medical, nursing, and eventually other health professional licensing boards work with hospitals and other healthcare organizations to identify, remediate, and monitor healthcare practitioners with knowledge and skill deficiencies that cause concern but do not rise to the level of precipitating disciplinary action. Working together in PreP 4 Patient Safety's non-punitive environment, healthcare organizations and licensing boards can identify and correct individual practitioners' clinical deficiencies, and may also discover systemic issues that jeopardize patient safety.

PreP 4 Patient Safety earned the endorsement of Dr. Lucian Leape, one of the better-known members of the Institute of Medicine (IOM) Committee that produced the "Errors" report, and one of the leaders of the "system safety movement." In correspondence with CAC, Dr. Leape wrote:

> …I strongly support what you are setting out to do. I think it is a great idea, clearly needed, for the reasons you outline, and it has immense potential to significantly improve both the boards' and the hospitals' processes. Clearly, we need much more collaboration to move ahead in safety, and where more importantly than here? I don't see safety failures overall as a dichotomy: either as systems problems or as performance problems. Performance problems are systems problems, too. We have totally inadequate systems for identifying potentially unsafe practitioners before (emphasis crucial) they cause harm.

B. What Did We Hope to Learn from the PreP 4 Patient Safety program?

In establishing PreP 4 Patient Safety, we wanted to learn several things:

(1) Can a program designed to enhance the skills of healthcare practitioners also lead to the identification and correction of institutional system safety weaknesses?

(2) Can a licensing board be both a disciplinary body when discipline is called for, and also a proactive force for quality improvement in situations where discipline is not the appropriate answer to a quality problem?

(3) Will healthcare practitioners accept confidential, non-punitive interventions developed by hospitals and licensing boards, with the practitioners' participation, to enhance their skills and knowledge and improve the quality of their patient care?

(4) What types of remedial interventions are most effective and affordable? What steps will lead to a proliferation of high quality, cost-effective remediation resources?

C. Who Benefits from the Program?

The PreP 4 Patient Safety program encourages the early identification of deficient practitioners through collaboration between hospitals and licensing boards. Identification is followed by assessment of both individual provider and system issues.

Assessment permits the players to design appropriate remedial action to prepare the practitioners to return to safe practice, and to rectify systems safety issues that are revealed during the PreP 4 Patient Safety process.

The PreP 4 Patient Safety program asks the public, healthcare organizations, practitioners, and licensing boards to become pieces of the patient safety mosaic. Each stakeholder group stands to benefit from improved practitioner performance, improved patient safety, and improved relationships between licensing boards and healthcare organizations.

(1) Benefits to the Public

The public stands to benefit from PreP 4 Patient Safety in several ways. While consumers are asked to accept that the assessment and improvement of a PreP 4 Patient Safety-eligible practitioner's performance will not become public information, patients will benefit from the resulting betterment in the safety and quality of care.

The competence of individual practitioners can be expected to improve, as can the quality of healthcare provided to individual patients. Marginal providers are more likely to be identified before harm occurs, and medical errors can be expected to decrease in frequency. The decline in medical errors may be hastened as individuals who are "systems" experts take a seat at the PreP 4 Patient Safety table, as recommended by the PreP 4 Patient Safety advisory committee.

The PreP 4 Patient Safety program offers provider institutions another pathway for identifying and correcting systems safety problems in their institutions. In addition, peer review will become more accountable as licensing boards participate in hospital quality improvement and safety initiatives. It is important to remember that PreP 4 Patient Safety is not a substitute for an effective discipline program; rather, it is an additional tool for licensing boards that allow boards to enter areas in which they previously were not involved.

(2) Benefits to Healthcare Organizations

Why would hospitals and other healthcare organizations allow state licensing boards to participate in "employment" or "peer review" decisions currently viewed as private? The answer is that healthcare organizations stand to gain substantial benefits from PreP 4 Patient Safety. These include having access to a "turnkey" patient safety program with a proven support network that will enable the facility to meet new Joint Commission (JCAHO) and emerging state licensing requirements for patient safety and quality improvement activities.

The PreP 4 Patient Safety program can help facilities reduce turnover and retain practitioners, an especially important consideration given current shortages in many health professions. In PreP 4 Patient Safety, assessment of incidents involving individual practitioners becomes a means for identifying both practitioner deficiencies and also systems issues that might otherwise go unnoticed. Especially with the addition of a "systems" person at the table, PreP 4 Patient Safety enables better identification of individual versus system problems, and fosters an appreciation of the interrelationships between the two. In this way, the program uses resources wisely, and is, therefore, an efficient risk management and quality improvement tool. PreP 4 Patient Safety promotes a culture conducive to disclosing safety problems with facilities. Finally, PreP 4 Patient Safety enriches the relationship between facilities and licensing boards by fostering cooperation and trust in pursuit of patient safety, much as licensing board programs for chemically dependent healthcare practitioners have done.

(3) Benefits to Practitioners

One might expect some practitioners to view PreP 4 Patient Safety as "another way to get in trouble with the licensing board." However, experience has shown that practitioners are likely to appreciate the ways in which PreP 4 Patient Safety protects their interests. PreP 4 Patient Safety is voluntary, collaborative, and non-threatening. Practitioners participate in the design of their remediation plans, which may well impart significant, career enhancing skill development.

The practitioner's perspective on the problem and the solution is an essential ingredient. It gives the program "professionalism" in the sense that the professional has input into his or her own competence assessment and competence improvement plan. PreP 4 Patient Safety is a framework within which the licensing board, the healthcare organization, and the practitioner work together in a non-disciplinary, non-public setting. In fact, practitioners may come to view PreP 4 Patient Safety as a welcome contribution to meaningful continuing competence assessment and assurance. The PreP 4 Patient Safety process exists in a framework within which environmental factors – system safety issues – can be taken into account and addressed, along with the knowledge and skill enhancement of individual practitioners.

(4) Benefits to Licensing Board

Licensing boards have much to gain from the PreP 4 Patient Safety program. This program is a "win-win" for both of the boards' constituencies – the public and the profession. This is because PreP 4 Patient Safety gives the boards a proactive role in the systems safety arena without interfering at all with the boards' powers and responsibilities when discipline is called for. Boards cannot undertake PreP 4 Patient Safety without rededicating themselves to ensuring the effectiveness of their disciplinary programs, because PreP 4 Patient Safety is not a substitute for discipline when the practice act has been violated. PreP 4 Patient Safety programs have explicit guidelines for distinguishing between those practitioners who are eligible for PreP 4 Patient Safety and those who belong in the disciplinary track.

PreP 4 Patient Safety should result in the boards receiving improved information from healthcare organizations; not only information about PreP 4 Patient Safety-eligible situations, but also information about transgressions that call for formal investigation which could lead to disciplinary action. Boards often comment that healthcare organizations are their most valuable sources of information about quality of care concerns, and by improving communication and trust, PreP 4 Patient Safety will result in healthcare organizations being more willing to alert the boards in a timely manner about instances of substandard practice where discipline, rather than non-public remediation, is the appropriate course of action.

PreP 4 Patient Safety offers licensing boards a non-disciplinary, non-punitive means to prevent errors before they happen, to monitor practitioners' progress toward fulfilling remediation goals, and to help ensure the continuing competence of the workforce. Until now, this quality maintenance role has been thought to belong to healthcare organizations. Boards need to become involved because, unlike healthcare organizations, licensing boards retain jurisdiction over practitioners whether or not they complete a remediation or skills enhancement plan, and whether or not they resign from one facility and seek employment elsewhere. The public depends on licensing boards to have compete, useful,

timely information about practitioner performance. PreP 4 Patient Safety's formula for two-way information exchange and trusting collaboration between boards and facilities will help boards fulfill that public duty.

D. The Relationship between Mandatory Reporting and PreP 4 Patient Safety

PreP 4 Patient Safety aims to institutionalize information sharing between hospitals and licensing boards when one or the other of these entities identifies a practitioner whose performance is below an acceptable standard of quality, and recommends remedial actions, such as targeted education or mentoring. Most states already have statutes that require hospitals to report to licensing boards when they take an adverse action that results in termination or significant restrictions on practice privileges. Federal data banks administered by the Health Resources Services Administration have similar reporting requirements.

PreP 4 Patient Safety will not affect these mandatory reporting requirements. Rather, it is designed to trigger communication among hospitals, licensing boards, and those practitioners who (1) have some clinical skills or knowledge deficiencies, (2) have not to this point caused patient harm or committed acts that would subject them to a licensing action, and (3) who could benefit from an appropriate educational intervention.

PreP 4 Patient Safety strives to change the current climate in two important ways. It fosters trust between hospitals and regulators, and it helps clarify the distinction between the PreP 4 Patient Safety early intervention and remediation cases and the more serious cases that trigger state and/or federal mandatory reports. These two changes can be expected to result in more hospital cooperation with mandatory reporting requirements and in more early interventions. By preventing errors and patient harm, the increase in early interventions should, in the long run, reduce the number of instances in which mandatory reporting becomes necessary.

Dr. George Barrett, former President of the Federation of State Medical Boards, praised PreP 4 Patient Safety as an impetus for creating "the infrastructure for ongoing assessment and education."

Hospitals at times identify but fail to report physicians whose problems do not rise to the level of suspension or restriction, instead suggesting they would benefit from additional education, training, or proctoring. This has created an environment that fails to protect the public. Under PreP 4 Patient Safety, hospitals would agree to inform licensing boards of every intervention to upgrade skills and knowledge, and boards would agree to inform hospitals when a physician with a problem is brought to the attention of the board.

E. Establishing a Statutory Basis for PreP 4 Patient Safety

There are four major reasons why it is important for PreP 4 Patient Safety to have a statutory base:

(1) The success of PreP 4 Patient Safety is dependent on enacting statutory confidentiality protections. California provides the best illustration of this. Both medical board officials and the medical director of Cedars Sinai, one of the hospitals that agreed to participate in California's PreP 4 Patient Safety pilot program, raised a very significant legal concern in conversations with CAC. The concern is so serious that, thus far, the hospital has hesitated to enroll people in PreP 4 Patient Safety.

Briefly, the problem is that California vigorously enforces the law that requires

hospitals to report privileging restrictions of 30 days or more to the medical board, or risk a $10,000.00 per incident fine for non-compliance. In many cases, PreP 4 Patient Safety provides for monitoring of some kind for up to a year or longer. Technically, keeping this remediation monitoring confidential under a PreP 4 Patient Safety agreement could be considered a failure to report a privilege restriction, not only to the board, but to the federal and state data banks. The hospital attorneys are not satisfied with an oral assurance by the licensing board that a particular PreP 4 Patient Safety case need not be reported as a privilege restriction. "What if", they ask, "the board leadership changes and the new people decide to bring a legal action against the hospital for failure to report?" Only a legislative solution clearly differentiating the reporting requirements for PreP 4 Patient Safety from non-PreP 4 Patient Safety cases will solve this dilemma and ease the hospitals' concerns about participating.

(2) If they are to give PreP 4 Patient Safety participants statutory protection with respect to confidentiality and mandatory reporting, it is essential that states statutorily distinguish PreP 4 Patient Safety cases from cases that call for discipline, and do fall under the mandatory reporting requirement. Otherwise, there is serious potential for abuse of PreP 4 Patient Safety. A blurry distinction between cases eligible for PreP 4 Patient Safety and cases that belong in the disciplinary track will be an incentive for physicians and their attorneys to try to put people in PreP 4 Patient Safety who shouldn't be there. This would run counter to the idea that PreP 4 Patient Safety is only for clinicians whose practice has not deteriorated to the point where discipline is appropriate, and it would destroy the credibility of the program. Writing the eligibility criteria into law eliminates subjectivity and helps all parties. One board executive publicly wondered whether a case handled by his state's PreP 4 Patient Safety program might have been more appropriately handled via discipline. While judgment will always be an element, that board (and every other) will be helped by having statutory guidance. To illustrate the need to clearly distinguish PreP 4 Patient Safety cases from those that should be in a board's traditional discipline program, consider a 2005 that passed the New York State legislature, but was not signed by the Governor. The bill would have required the medical board to offer a PreP 4 Patient Safety program to any physician who was being investigated by the medical board for a disciplinary action, except if the allegation of misconduct involved actions that were "egregious," or involved "gross negligence," "gross incompetence," or "sexual misconduct." The medical board opposed this legislation and recommended it be vetoed on the grounds that it would destroy the discipline system. They would welcome model language that would correctly distinguish between cases eligible for a PreP 4 Patient Safety-type program and those that should be handled in the traditional disciplinary fashion, reserving PreP 4 Patient Safety for cases where no serious harm has yet occurred. The model law we developed makes this distinction clear.

(3) In a related vein, it is necessary to statutorily create at least one exception to the confidentiality protections afforded participants in PreP 4 Patient Safety programs. This exception creates a statutory basis for sharing information between boards and healthcare organizations – hospitals, nursing homes, and perhaps the state department of health. The confidentiality exception has two dimensions. The first involves individual practitioners. Their identity, the deficiencies that led them to become participants in the program, and the remediation plan they are to follow, all have to be known to their supervisors and peers who are involved in their remediation. Thus, participants rarely, if ever, have absolute confidentiality. Their

participation in the program is not secret; it is non-public. Another way to put it is that participation is confidential, but not anonymous.

The second exception to confidentiality comes into play when the assessment of an individual practitioner's deficiencies leads to the identification of system problems. The individuals in the healthcare organization who are responsible for addressing those system problems need to be in the loop. On a macro level, other government agencies, such as departments of health and other licensing boards, need to be informed of the nature of identified deficiencies and corrective measures, or patterns of problems that occur throughout a region or state, so they can share this information throughout the healthcare community, enabling everyone to adopt error avoidance and quality improvement lessons, wherever they are learned. At this macro level, individual identities will not need to be revealed.

(4) A statutory base makes it possible for boards to finance a PreP 4 Patient Safety program through licensure fees. Thus far, the pilot programs have suffered because boards have to work them in under existing budgets. This may be manageable in the demonstration phase where there are only a handful of cases, but once PreP 4 Patient Safety becomes a statewide program, boards need to have a dedicated budget to administer the program.

In 2008, model statutory language was produced and distributed widely, along with a companion educational document. (Copies of these documents can be found at www.cacenter.org and www.4patientsafety.net.)

….Beginning in 2006, it became increasingly apparent that without specific statutory authority, state boards were having a difficult time establishing a PreP 4 Patient Safety program for the reasons explained in Introduction, Section 5, "Establishing a Statutory Basis for PreP 4 Patient Safety." The exception was the North Carolina Board of Nursing, which not only implemented a successful demonstration program, but expanded the program statewide, and no longer on a demonstration basis. Polly Johnson, who was executive director of the North Carolina Board of Nursing at that time, explained the success in these words:

> Why did the PreP 4 Patient Safety pilot work? The timing was right. We approached it carefully with the healthcare community. We approached hospitals with which we already had good relationships and strong support from chief nursing executives. We solicited support from the nurses' association and hospital association. We met with them and their attorneys to talk about the process. We asked them to talk with their risk managers. When we met again, they were even more excited about the possibilities of the project. Together, we established the framework for the program. The framework included memorandums of understanding, contractual arrangements with the employer and the licensee. Then we met with the nursing staff that would be identifying nurses with deficits needing attention who would be appropriate candidates for a PreP 4 Patient Safety intervention.
>
> The process flows first from identification of an incident or error involving the employee or a pattern of competency deficiencies. Often, the individuals referred to PreP 4 Patient Safety were returning to the hospital setting after an absence or were moving to a new assignment within the institution. Some were individuals who were not

progressing as they should in an orientation or mentoring program. The employer identifies the individuals and makes the referral to the Board of Nursing. Once there is a referral, the PreP 4 Patient Safety coordinator gathers the basic information, verifies eligibility, and discusses the opportunity with the licensee. During the pilot, we used existing resources to serve the 15 participating hospitals. The key is who you choose as the point person – the contact between the board, the employer, and the licensee. Think carefully before choosing someone who has spent their career doing investigations because that is a very different approach than a supportive, non-punitive, proactive environment. We used a practice consultant who blossomed in the role. Now that the program is going state-wide, a professional position and support position have been added to the board staff.

Announcements

Our 2008 annual meeting was held on Monday, Tuesday, and Wednesday, October 27, 28, and 29, 2008, at the Renaissance Hotel in Asheville, North Carolina. It was co-sponsored by various Health Licensing Boards of North Carolina. The final program may be downloaded from www.cacenter.org/files/AshevilleProgram.pdf, and the PowerPoint Presentations that were used at that meeting may be downloaded from www.cacenter.org/files/powerpoint/index.html.

NEW CAC BOARD MEMBERS

At our annual meeting in Asheville, North Carolina, CAC welcomed Barbara Safriet and Polly Johnson to our board of directors.

BARBARA SAFRIET

Barbara Safriet is the public member on the Federation of State Board of Physical Therapy. At Yale Law School, she served as Associate Dean for Academic Affairs and Lecturer in Law from 1988 to 2006, and was a Dean's Senior Fellow in Law for 2006 – 07. In addition to her academic administrative duties, she taught seminars on Health Law & Policy and The Regulation of Health Care Providers. She has served as a member of The Pew Health Professions Commission, and its Taskforce on Health Care Workforce Regulation, and as a Health Law Consultant and Presenter for the Rockefeller Foundation, the W. K. Kellogg Foundation, the Commonwealth Fund, the Association of Academic Health Centers, the U.S. Agency for Health Care Policy and Research, the U.S. Public Health Service, the National Rural Health Association, the National Council of State Legislatures, and the Office of Technology Assessment of the U.S. Congress. She has served as a member of the Data Safety & Monitoring Committees of the Wilmer Institute's Macular Photocoagulation Study and the National Eye Institute's Multicenter Trial of Cryotherapy for Retinopathy of Prematurity.

At Yale, she served as a Co-Director of the Project on Comparative Public Health Law Curriculum Development for China (1996-99), and as a member of the Board of Advisors of the Yale Journal of Health Policy, Law and Ethics, the Board of University Health, and the Executive Committee of the Center for Bioethics.

Prior to 1988, she was a Professor of Law for 12 years at Lewis & Clark Law School in Portland, Oregon, where she taught administrative law, constitutional law, and health law.

She earned a Bachelor of Arts degree in economics from Goucher College, a Juris Doctor degree with honors from the University of Maryland School of Law and a Master of Laws degree from Yale Law School.

Dean Safriet has published and lectured extensively on topics of administrative and constitutional law, issues of health care professionals' licensure and regulation, and health care workforce problems. Her law journal articles include Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice 19 Yale Journal On Regulation 301 (2002); Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing 9 Yale Journal On Regulation 417 (1992); Impediments to Progress in Health Care Workforce Policy: License and Practice Law, 31 Inquiry 310 (1994).

Most recently, Dean Safriet was one of the principal drafters of the monograph Changes in Healthcare Professions' Scope of Practice: Legislative Considerations (2006), developed through a collaborative effort by representatives of six healthcare regulatory organizations.

POLLY JOHNSON

Until her retirement in July 2008, Polly Johnson devoted the past 20 years of her nursing career to positioning regulation as a vital and proactive partner in facilitating the delivery of safe, effective patient care at the state, national and international levels. She served as the Executive Director of the North Carolina Board of Nursing for 11 years and took the lead in moving health care regulation from a culture of blame to one of quality improvement and from an opinion-based to an evidence-based public service. Under her leadership, North Carolina implemented the first early intervention program to address the competencies of individual licensees within employment settings as an effort to both retain nurses as well as enhance the delivery of safe patient care. This program now serves as a model for addressing deficits in practitioner competence by both nursing and medical regulatory boards in the United States as well as Canada and Australia.

Her commitment to achieving excellence in nursing regulation is also evidenced through her more than 15 years of leadership work with the National Council of State Boards of Nursing. Ms. Johnson continues to influence healthcare policy statewide as the founding President and CEO of the Foundation for Nursing Excellence, through her appointments to the boards of the North Carolina Institute of Medicine Board, North Carolina Center for Hospital Quality and Patient Safety, and numerous multidisciplinary taskforces. Nationally, she has contributed to quality improvement in healthcare through her appointments to national patient safety-focused organizations and committees including the IOM Health Professions Education Committee, and is a Fellow in the American Academy of Nursing.

CAC IS NOW A MEMBERSHIP ORGANIZATION

We are pleased to announce that we are offering memberships to state health professional licensing boards and other oversight agencies. **We invite your agency to become a CAC member, and request that you put this invitation on your board agenda at the earliest possible date.**

As you may know, CAC is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards. Many of you are familiar with our organization and the services we provide. Over the years, it has become apparent that our programs, publications, meetings and services are of as much value **to the boards themselves** as they are to the public members. Therefore, the CAC board has decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

(1) One **free** electronic subscription to our highly regarded quarterly newsletter, **CAC *NEWS & VIEWS*** (current subscribers receive a prorated credit);

(2) A **10% discount** for **all** of your board members and **all** of your staff who register for CAC meetings, including our fall annual meeting;

(3) **Free** electronic copies of all available CAC publications;

(4) A **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;

(5) **Discounted rates** for CAC's **on-site** training of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;

(6) Assistance in **identifying qualified individuals** for service as public members.

We have set the annual membership fee as follows:

Individual Governmental Agency	$275.00
Governmental Agency responsible for:	
2 – 9 regulated entities/professions	235.00 each
10 – 19 regulated entities/professions	225.00 each
20+ regulated entities/professions	215.00 each
Association of regulatory agencies or organizations	450.00
Non-Governmental organization	375.00

Please complete the following form if your board or agency is ready to become a member of CAC, or if you would like answers to any questions you may have before deciding whether to join. Mail the completed form to us, or fax it to (202) 354-5372.

CAC Membership Form

A) YES, our agency would like to join CAC:

Name of Agency:	
Name of Contact Person:	
Title:	
Mailing Address:	
City, State, Zip:	
Direct Telephone Number:	
Email Address:	

PAYMENT OPTIONS:

1) Make a check payable to CAC for the appropriate amount. (Current subscribers receive a pro-rated credit. If you are already a subscriber, call us at (202) 462-1174 before sending a check);
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card (including American Express);
3) Provide us with a purchase order number so that we can bill you. Our Federal Identification Number is 52-1856543;

Purchase order number:	

or 4) Complete the following form if paying with Visa or MasterCard:

Name:	
Credit card number:	
Expiration date and Security Code:	
Billing Address:	
City, State, Zip:	
Security Code:	

Signature Date

B) PERHAPS our agency will join CAC.

____ We would like to discuss this with you. Please call:

______________________________ at ______________________________
(name and title) (telephone number)