News & Views

Citizen Advocacy Center

Fourth Quarter, 2008 A Health Care Public Policy Forum Volume 20 Number 4

Announcements

***CAC is now a membership organization**, and we invite your board to join. For information about the benefits that are available to our members, please see pages 46 – 47 of this issue, or go to www.cacenter.org/files/membership.pdf.*

***Our 2009 Annual Meeting** will be held on Wednesday, Thursday, and Friday, October 28, 29, and 30, 2009, at the Royal Plaza Hotel in Lake Buena Vista, Orlando, Florida. For more information please see http://www.cacenter.org/cac/meetings.*

Editorial Note: This issue of CAC News & Views is a report from our 2008 Annual Meeting held in Asheville, North Carolina. The meeting was co-hosted by North Carolina's Boards of Acupuncture, Dental Examiners, Medicine, Nursing, Occupational Therapy, Pharmacy, and Physical Therapy. While not a verbatim transcript, it is faithful to the speakers' remarks. The final program and PowerPoint presentations may be downloaded from our Website at www.cacenter.org.

Session One – How Can Licensing Boards Promote Quality of Care?

Kathy Apple, Executive Director, National Council of State Boards of Nursing

David Watt, Vice President of Professional Services, Federation of State Medical Boards

Barbara Safriet, Public Member, Federation of State Boards of Physical Therapy

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The speakers represented three major associations of licensing boards – medicine, nursing, and physical therapy. Each speaker embraced the idea that rather than passively wait for reports and complaints to come to them, licensing boards should become more proactive in promoting health care quality – and to the extent possible access and affordability. They suggested several opportunities for licensing boards to become more prominent players in the effort to improve health care quality. Among these are:

Helping to improve healthcare delivery systems

- Licensing boards can use the information they glean from disciplinary investigations to identify measures that will help health care delivery systems to improve quality and avoid errors.

- Licensing boards can monitor the environments in which care is delivered and help ensure that those environments help licensees to practice at the peek of their abilities.

Helping to improve healthcare education

- Licensing boards can influence the curriculum at academic centers to break down the system where professions are taught in separate silos and encourage the teaching of multidisciplinary team practice.

Helping to promote professional development and continuing competence

- Licensing boards can promote quality of care by ensuring that all their licensees possess the up-to-date knowledge and skills needed to practice in their current positions.

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- Licensing boards can work with certification bodies, professional associations, academic institutions and others to further our understanding of the most effective, least burdensome ways to ensure current competence.

Helping to expand consumer awareness of the existence and role of boards

- Licensing boards can redouble their efforts to improve the public's understanding of what they do and how much they accomplish.

- Licensing boards can cultivate relationships with the media and encourage positive stories to increase consumer confidence in and support for the regulatory system.

Helping to maximize the efficient use of the healthcare workforce

- Licensing boards can weigh in with their legislatures to encourage empirically-based decisions about the scopes of practice of health care providers.

After their prepared remarks, the panelists explored some of these topics more deeply, led by moderator David Swankin.

Swankin: How important is educating the public as a means of improving quality? In general, people can discern whether the services they receive in a hospital are quality services. However, many people rate nursing homes according to whether the food is warm, which indicates to me that the public needs some instruction in how to evaluate quality.

Watt: I think consumer education is essential to align the expectations of the professional and the public. When some very high profile instances of negative clinical outcomes were brought to the attention of the public in the U.K., for example, the public concluded the regulatory system for physicians was not working. In an attempt to get the system back on track, the authorities wrote a document entitled, *Good Medical Practice,* which was essentially bullet points setting forth what the public should expect and the profession should deliver. This has since evolved into a living document that is constantly re-written.

This was the model for a *Guide to Good Medical Practice* which an alliance of physician groups in the U.S. has been developing around the subject of competence. It is incredibly important to have consistent expectations as the foundation for a social contract between professions and the public. Otherwise, we don't know what to expect of each other. If everyone's expectations are aligned, it is going to be much easier to manage professional behaviors because even professionals will recognize misbehavior by one of their peers. If expectations are clear about what is and is not professional behavior, everyone knows that behavior outside agreed-upon boundaries should be reported.

Whether or not these incidents are reported is a matter of professionalism. A recent survey of board-certified specialists probed their opinions about what types of behaviors would and would not be acceptable. There was clear agreement that certain types of behaviors which put patients at risk are not professional. Yet, when asked whether they report such behavior when they see it, only forty percent said they do. Documents such as the *Guide to Good Medical Practice* USA can help instill a common understanding of what behaviors are unacceptable and need to be reported.

Apple: Boards absolutely have a role in educating the public. I know a number of nursing boards do a wonderful job providing information on their Web sites and building relationships with consumer organizations within their states. These efforts require resources, and I think the National Council has

a role in helping to support boards in this endeavor.

It is one thing to encourage the public to report the bad things that happen. There is a whole lot more that should be part of public education if we are going to teach people how to assess the quality of the care they receive.

Swankin: A century ago, nursing boards spent most of their time evaluating educational programs. Boards of nursing still have that responsibility. Do you consider this to be a productive way in which boards can enhance the quality of care?

Apple: Boards of nursing continue to have a role in oversight of education programs. Consumers and others outside the educational community recognize that the board of nursing has the authority to do something when a school is in trouble, whereas accreditation, because it is voluntary, is not positioned to be as influential.

Would changes in education promote improved quality? I think this is certainly a conversation that needs to be held among nursing boards and all the affected stakeholders, including educators.

Watt: The fact that graduates must pass a test prior to licensing affect academic curricula. For the last decade or so, all medical licensing boards have accepted the standard of the U.S. Medical Licensing Examination (USMLE) as an indicator of a knowledge base for physicians applying for licensure. A few years ago, a nationally standardized clinical skills assessment was added. Curricula will have to be adjusted so that the students are able to demonstrate the skills and knowledge necessary to pass the assessment.

The USMLE is co-owned by the Federation of State Medical Boards and the National Board of Medical Examiners. Those two organizations use about 600 clinicians on a regular basis to develop the assessment tool and to anticipate where the assessment tool is going in the future. That is one way we have some impact on education.

Safriet: To promote competence, we use education and examinations as filters. They are proxies for competence. How better to assess competence than to look at people while they are doing professional tasks. This would be extraordinarily difficult and expensive, but that doesn't mean that we shouldn't strive to do clinical assessments.

British Columbia has a clinical assessment examination for nurses. Of the first eight nurse practitioners who went from the U.S. to British Columbia to practice – all with advanced degrees and five to eight years of clinical practice under their belts – only two passed BC's clinical assessment examination. Should we be disturbed by this?

There are huge issues with standards for clinical assessment examinations. In British Columbia, the people developing the examination were no longer in practice but were now in academia. Accrediting groups have their own goals. Standards are often raised, sometimes for the benefit of the public and sometimes for the benefit of those raising the standards.

Should licensing boards be involved in assessing education and curriculum? Boards would say yes, but educators would say no. I think there has to be a link between regulatory entities and the educational institutions that produce the people who sit for licensure exams. There should be constant feedback in both directions. Politics enter into it because state legislatures have a say in many licensure issues. In addition, many health care educational programs are located in community and state colleges.

Comment from the Floor: Barbara Safriet mentioned that six national groups came

together to look at scope of practice from the public's perspective. How was the public represented in this endeavor?

Safriet: I was the public member from the Federation of State Boards of Physical Therapy.

Apple: The National Council of State Boards of Nursing organized this effort. Its objective was to develop an interdisciplinary approach to help state legislators understand the questions they need to ask when they consider legislation related to expanding the scope of practice of a health care provider.

Comment from the Floor: Would it be possible or advisable to gather hard data about public views and aspirations related to health care delivery and professional behaviors?

Watt: I think it is important to have valid input from a public perspective. One of the ways in which we do that is to poll the public using a standardized method, such as a Harris poll. During the past ten years, we have had three or four major polls, some of the specific to initiatives we are pursuing and some more general.

Safriet: The worst thing for the public is to learn of the regulatory system through a failure. The media loves sensation, and so does the public. But, sensation is the worst thing possible when ninety-nine percent of what licensing boards do is appropriate and acceptable. But, if the public learns of the regulatory board role only through well-publicized failure, this reduces public confidence in the law, regulation, and professional behavior. It is worthwhile to cultivate relationships with the media and ask for good stories about positive initiatives the board has undertaken.

Apple: Consumer members should be asking questions at their board meetings about what the board can do to help consumers in your state understand the role and operations of licensing boards.

Comment from the Floor: Coming from a public health background, I really appreciate what has been said about being proactive and looking at the context of problems, such as staffing patterns. We also need to look more at individual practitioners. Knowledge does not necessarily lead to behavior change. An individual's attitude or makeup determines whether he or she is a good provider or is prone to errors in judgment or misconduct.

Watt: An interesting white paper published two weeks ago by the Commonwealth Fund relates the system of medical practice to clinical outcomes. The researchers found that multi-specialty integrated systems tended to have better outcomes than single-specialty groups or solo practice. An ideal system creates conditions in which the easiest thing for a clinician to do is the right thing. Also, the system detects when this does not happen and points to modifications that will enhance optimal behaviors. The more a systems approach is applied, especially to a complex situation such as clinical medicine, the greater the standardization of outcomes.

Apple: Your comments bring to mind at least two things that need more exploration. At least in nursing, the twelve-hour shift needs attention. Research shows that fatigue leads to error. Yet, we really haven't asked whether it is okay for nurses to work twelve-hour shifts. We do know anecdotally that nurses don't do just one twelve-hour shift and then get some rest, they do several twelve hour shifts in short sequence and this only adds to the fatigue issue.

Also, universities struggle with how to be proactive about screening who gets into health care training programs. When I went to school, I had to take the Minnesota Multiphasic Personality Inventory which diagnoses all sorts of psychological and mental health disorders, so I assume I was screened. We know that

schools sometimes identify chemical dependency. I know they sometimes identify very serious mental health issues. Shouldn't they play a more assertive role in screening out students who show signs that they might become unsafe practitioners?

Safriet: I am reminded that one of the things our licensure process does not deal well with is people who I call "spit bugs." These are people who have excellent clinical skills, but the personality of a spit bug *vis a vis* their colleagues and their patients. How do you screen for that? I think it is important because communication with patients is a quality of care matter. The burden for dealing with this may fall on the facility where the individual works rather than on the licensing board.

Comment from the Floor: Has there ever been any body of knowledge developed regarding the roles and responsibilities of public members on either licensing boards or credentialing boards?

Swankin: There is not a good body of literature on this topic, although it is beginning to be developed. Tomorrow, we will describe a project CAC is involved with funding from The California Endowment. One of the tools to be produced under that grant will address the roles of public members. Also, the National Organization for Competency Assurance (NOCA) will soon publish a revised *NOCA Handbook*, which has a chapter on the role of public members on certification bodies.

Not only is there little written about the role of the public member, but most statutes do not include any information about the qualifications appropriate for a public member. The statutes generally stop at specifying what would disqualify someone from being a public member, such as having a family member in the profession.

Session Two – Do Programs for Chemically Dependent Health Care Practitioners Promote Quality?

Richard Fantozzi, President, Medical Board of California

Thank you for the opportunity to talk about the California Medical Board's efforts to promote healthy lifestyles for physicians. Before 2008, the medical board focused on monitoring impaired physicians. However, the rehabilitation program went through five audits and failed each time. In 2008 and beyond, our focus will be on prevention models and education beginning in medical school and continuing throughout a doctor's career.

In 1980, the mission statement and the board's statutory mandate was physician re-habilitation, but not at the expense of public health and safety. The priority then was to keep doctors in practice because there was a shortage of caregivers. In 1990, the state Senate changed our mission to consumer protection. When physician rehabilitation is in conflict with consumer protection, consumer protection is paramount.

In California, there is a statutory mandate that each hospital have a "wellness committee." They rarely have mission statements and many of them don't understand their role or know what to do. The majority of them see there role as trying to find the one bad seed in the group and somehow get him or her to help. The medical board's goal now is to determine how to utilize the wellness committees and give them new direction, a mission statement and policy. My view is that instead of trying to find the one bad seed, wellness committees should become educators and make policy directed at all the doctors in the hospital system, not just one or two.

A major trend in the physician-patient relationships is to pay greater attention to

communication. The public now expects transparency and accountability. Patients now have access to information online. An informed consent form is expected and routine. Second opinions are common. Malpractice insurance is virtually mandatory. Electronic personal health records are now on digital cards. Along with these changes, consumers are now demanding to know if a doctor is impaired. In 2003, the State Senate mandated that there by an independent audit of our enforcement and diversion programs. The board failed miserably. The report was picked up by the media and consumers became aware that there is such a thing as an impaired physician. There was public outrage that the medical board had a confidential monitoring program and that a physician's impairment was not disclosed.

The California Medical Board is the only body entrusted to provide a medical license and the only body that can impose discipline. Diversion had nothing to do with treatment. The purpose of diversion was to monitor people in the treatment programs. Diversion meant that if a doctor who would have been subject to discipline came before the board, we could "divert" him or her into the monitoring program – not discipline them and not report them to the public. That is where the conflict of interest occurs. If a doctor came before us who had a tremor or dementia, hypoglycemia, or asthma, or a reaction to a medicine, we had no ability to divert that person into a monitoring program for his or her disability. That person would be subject to discipline.

When a patient goes to a doctor and sees a plaque on the wall with a gold seal, they assume the state has vetted that person and the person is appropriate and qualified to be in that position. When consumers found out that there are a certain percentage of doctors whose disability was being kept secret, that's when they got angry because they are not being told and they have no choice in the matter.

The concept that participants' identities would be kept confidential from the public was based on the assumption that confidentiality guarantees would induce doctors to voluntarily enter the program. With all due respect to the people who wrote the statute, I have to question why somebody would volunteer to the same body that is entrusted to give them a license and to discipline them.

The state of California has one hundred and twenty-seven thousand doctors. According to the director at the Betty Ford Clinic, there are ten to fourteen thousand doctors at any time in the state of California who need some kind of help. If that's true, there are three thousand seven hundred and forty who should be in some kind of resident treatment. At last count, we had about two hundred and five people in the program. Why didn't doctors take advantage of the confidentiality guarantee and enter the program? I think part of it is that they didn't want to come to a state administrative and disciplinary agency. The point is, it didn't work. We didn't get the numbers we should have.

On paper the program didn't look so bad. The failure of the program was the human element. What failed is that colleagues did not report their impaired co-workers.

The people who did use the program were the defense bar. If a doctor got into a DUI accident over the weekend and called the lawyer in Monday morning, the lawyer would advise going to the diversion program right away. When we researched where the people in the program came from, we found that the majority of participants are actually referrals from the Department of Justice, the defense Bar or hospitals. Board staff looked at the participant records and out of the hundred or so they looked at, they thought they might have found one person who had truly volunteered to enter the program.

The human element failed for many reasons. Some of the treatment that was done by group facilitators, managers in the field. One example of failure involved a participant who called up the specimen collectors to say he was going to be on vacation for two weeks. By doing so, he effectively suspended himself from the program because maybe he went away and maybe he didn't.

Unfortunately, there are no addictionologists on the board, so the expertise needed to monitor was not available. We have been told that addicted people can be manipulative, controlling, they learn how to get what they want. When you provide them a system, they learn how to work around it. Doctors who were interviewed in audits admitted that they learned how to game the system.

It sounded like a great idea to have practice monitors. The problem was with implementation. Can the practice monitor be the doctor's secretary? Her nurse? Her spouse? What are the standards for specimen collectors? What is their accountability? You can buy specimens on the internet. How does the collector know whether the specimen comes from the person or was bought online?

Our monitoring program called for case managers; it required treatment facilities approved by the board; it required worksite monitors, biologic testing, and attending 12-step program meetings. The program was set in statute in 1980. There were three audits in the 1980ies and we failed them all. Each time the board made changes, trying to address the specific problems. Still, the next audit pointed out the same problems.

The audit that was conducted in 2003 and presented in 2004 found the same problems all over again. At that point, the board hired a new program administrator, increased the budget for the program by fifty percent, made many changes in the field, and wrote a new policy manual. The board member who headed the committee went through so much stress, she eventually resigned from the board. The statute following that audit called for a re-audit two years later. That audit was delivered in 2007 by the Bureau of State Audits. After all our effort and despite the changes that were made, the same problems surfaced again.

Our board asked how much tolerance the board and the legislature have for failure. Treatment programs talk of success rates of forty to sixty percent at the best places in the country. Our program had a seventy-five percent success rate. The addictionologists in California championed how good the program was. Looking at it differently, one quarter of the participants in the program were failing. These are doctors with scalpels and prescription pads.

We asked ourselves, whether we, as a state agency, could take responsibility for knowing that patients are seeing the doctors who are failing, and not disclose this. When the legislature said they wanted zero tolerance for failure, the board determined it had to end the program.

The board decided what it could do was work through the wellness committees at the state's four hundred and fifty hospitals. Doctors who are not part of a hospital system can be reached through the county medical societies. Under this new approach, all the doctors in the state will become educated about addiction and recognize who among their colleagues might need to get some help.

The new approach changes the emphasis to a healthy lifestyle. Regulatory bodies can do the education and leave the treatment in the hands of clinicians and people who know how to do it. Closing down the board's program does not leave chemically dependent physicians with no place to go. The one thousand three hundred treatment programs in California continue to exist.

We met with the medical schools which all agreed to introduce a graduate medical education module on addiction. This has been passed in statute. At the CME level, we have met with malpractice carriers who have overwhelmingly agreed to work with us to disseminate information about addiction. One of the carriers will offer a five percent fee reduction to practitioners who study addiction and we hope the others will follow suit. They see the value of risk management by becoming involved with the board's new approach.

So, the board is partnering with the medical schools, the California Hospital Association, and the malpractice carriers. We are now the grand facilitator, getting a message out about changing and empowering the healthy doctors to be educators and mentors to the ones who are under stress.

The statistics on physician burnout and depression show high numbers of stressed physicians, many of whom wish they could get out of practice. The numbers are in the forty to seventy percent range. The board could sit back and wait for people to volunteer for a diversion program, or it can pursue a more proactive prevention and early intervention model.

A study by the University of California San Francisco found that the best predictor of future discipline is evidence of dysfunction in residency. So, if the medical schools become involved, we have a better chance of preventing a problem down the road. The shift we see is that wellness committees will become education committees.

The socio-psychological model says when you know you have a problem in a group of people (in this case, four to five percent), you can create a program to change cultural behavior hoping to reach seventy-five percent, or you can develop a program hoping to reach one hundred percent. If you direct a program at one hundred percent of the group, the four or five percent of deviants have to choose to be part of the group or to continue to be dysfunctional. Most people will want to be part of the group.

Kaiser Permanente already has this kind of wellness program in place. Virtually every doctor in Kaiser North has been exposed to education about the culture of addiction. At least fifty percent of the doctors at Kaiser north have taken some education module on the subject. In my medical school training in the 1970ies, I didn't have five minutes of exposure to any of this. In my twenty-two years of practice in a prestigious organization, I didn't have a minute of exposure to any of it. I didn't know what diversion meant when I was appointed to the medical board. Doctors who don't have a problem don't even know what it is.

The diversion program catered to a microcosm of people, satisfying a certain number of people who felt this is the way it has to be. We feel it is important to support doctors in practice. Early intervention is critical. So is encouraging treatment, promoting education during medical school and throughout one's career.

Comment from the Floor: What is your board doing with physicians who come to you asking for help? Are you telling the public? Are you allowing them to work? You can't prevent one hundred percent of practitioners from getting this disease.

Fantozzi: Not everyone agrees that this is a disease. There are people who believe it is a cultural/behavioral phenomenon. It acts like a disease because people become addicted, but there is not universal agreement that it is a disease.

Regarding the heart of your question, if someone came before us with an impairment issue, the board would investigate. If impairment was found, the board would determine an appropriate disciplinary action. It might be anything from no discipline because there was no harm done, to a letter of reprimand in the individual's file, to an interim

suspension if the board felt the public was a risk. But, there is no diverting and no adjudication of the issues. If someone came to the board asking for help, he or she would be referred to one of the treatment facilities in the state. If somebody goes into treatment, it is none of the board's business. If there is a quality of care concern, under the old program, they would have been diverted into the monitoring program. Currently, we would investigate. If there is no patient harm, nothing is done. There may be a letter of reprimand to get something into the file. If there is serious patient harm, we would probably issue an interim suspension order while the investigation proceeds. We have the authority to order fluid testing, psychological evaluation, and clinical competency evaluation as part of a stipulated agreement. The critical thing is that any discipline arising from the investigation would be publicly disclosed and not kept confidential as it would in the diversion model.

Comment from the Floor: Who are the members of a wellness committee?

Fantozzi: The members of the committees are the physician staff, not the hospital personnel. Our vision is to reclaim the wellness committee as a life coaching committee.

Monday Luncheon Address
"Just Culture" and Quality of Care

David Marx, President, Outcome Engineering and Author of *Patient Safety and the "Just Culture:" A Primer for Healthcare Executives*

I am going to talk about Just Culture and quality of care. In the Just Culture model, we want to design good systems and we ask people to make good choices within those systems. Then, we live with the outcomes that occur, good outcomes and the bad outcomes.

So, we set out to build a healthcare system with redundancy, recovery and barriers to prevent harm from ultimately reaching the patient. We ask the actors in the system to make good behavioral choices in three areas that I will talk about: producing outcomes, following procedures, and doing the right thing.

The duty to produce an outcome is the simplest of human-created duties. An example is a restaurant serving the dishes you order off the menu.

The second duty – following the rules – is more complicated because we partner with others. One person designs the system and another works in the system. Pilots fly from one city to another according to a highly scripted procedure including checklists and procedures. One group, typically the employer, designs the system and its procedures and the employee is expected to follow procedures to attain good outcomes. Examples in the hospital setting are patient identifiers, hand hygiene, dietary protocols, patient restraints, and other areas where an employer tells employees how to do a job.

Tasks are generally one or the other – duty to produce an outcome or duty to follow rules, but they are unlikely to be both.

The third duty is to avoid putting other people in harm's way. This is the overarching duty that supersedes any procedural or outcomes-based duty that humans create. This is the duty we are supposed to pick when caught in a conflict between the first two duties. Consider a situation in which a nurse witnesses a patient about to fall out of bed. Should she dash over and prevent the patient from falling, or should she follow the rule that says practitioners should wash their hands for a full fifteen seconds before touching a patient? Preventing the fall would be doing the right thing. But, the nurse should then wash her hands before leaving the room.

What about regulation? We create systems of learning and accountability that tie back to the

regulator to make the health care system work well. The 1999 "Errors" report from the Institute of Medicine (IOM) estimated ninety-eight thousand preventable deaths per year in hospitals. For every one person who dies each year in war, four will die in an automobile accident. For every one who dies in an auto accident, five will die from a medical error or hospital-acquired infection. So, in the U.S., for every person who has died in war in the last five years, two hundred and fifty have lost their lives as a result of a preventable error or hospital-acquired infection.

Are we doing what we need to do to get to a safer health care system? We stand in judgment of our health care system and ask whether it is doing what we need. Should we be more punitive? Should we create more learning systems? Should we say it is the system's fault? Should we blame politicians for not giving it enough funding?

Lucian Leape told Congress that "The single greatest impediment to error prevention is that we punish people for making mistakes." He said the culture at Harvard was that you report only what you cannot hide. He says we need a system for learning from mistakes.

On the other hand, Lord Denning, a judge in the UK, said "There are activities for which the degree of professional skill which must be required is so high and the potential consequences of the smallest departure are so serious that one's failure to perform in accordance with standards is enough to justify dismissal."

Which should be our standard in healthcare? It is estimated that one hundred thousand people die each year from hospital-acquired infection. The number one thing we can do to prevent such infections is wash our hands. Yet, the CDC says national compliance with its hand-washing rule is forty percent. Probably close to ninety-percent of employees may violate this standard in any given week, so if one breach were enough to require dismissal, the hospital couldn't retain its staff.

Don Norman, author of *The Design of Everyday Things,* advises that the problem of accidents leading to errors is not with individuals, but with the system: change the people without changing the system and the problems will continue. Regulators may ask, "Is it always the system's fault?" What is the standard of care?

The statute in the State of Washington defines "unprofessional conduct" on the part of a healthcare provider to include any act involving moral turpitude, dishonesty, or corruption; misrepresentation or fraud; willful betrayal of a practitioner or patient privilege; use of a client or patient for sexual misconduct; and incompetence, negligence, or malpractice which results in an injury to a patient or which creates an unreasonable risk that a patient may be harmed.

What is meant by negligence? Is there a difference between a person who makes a mistake and a person who deliberately chooses to sexually abuse a patient? The statute does not distinguish between these two types of people; it simply lists various types of unprofessional conduct.

The Texas Board of Nursing Web site lists medication error cases. The disciplinary actions taken are disclosed not in terms of what the nurse did, but in terms of how badly the patient was harmed and the identify of the nurse who caused the harm. This tells society that nurses are judged not on what they do, but on whether there was a bad outcome. In other words: "no harm, no foul."

At one end of the spectrum, we have a punitive culture saying one breach is enough to justify dismissal, but if we applied this standard, we'd lose almost all practitioners. At the other end of the spectrum is a "blame-free" culture. Somewhere in the middle is a system of justice that best facilitates system safety.

The Just Culture model balances system and individual accountability. Hospitals in North Carolina that have experimented with Just Culture still have accountability in the system, but they look behind an incident to see why it has occurred. They aim to create a learning culture and at the same time hold employees accountable.

Consider the notion of the "reasonable man." He first appeared in English common law in 1837 in a case involving a fire caused by one person's unwise placement of a hay stack, even after being warned that what he was doing was dangerous. The English judges created the notion of the reasonable man against which to assess the fellow's decision making. What precautions, they asked, would a reasonable man take in locating a haystack? If, after repeated warnings, someone placed a haystack in a risky location, he fails the reasonable man standard.

In 2008, the reasonable man wears all the right protective gear, he looks both ways before crossing the street, and he never puts other people at risk. But, what about fallible mankind? Shouldn't we recognize that people don't necessarily behave the way we expect them to do? What about *inadvertent actions*? What about *at risk behavior*, such as not washing one's hands because there isn't time? What about *reckless behavior*, such as ignoring a recognizable risk.

To the FAA and under the Washington State unprofessional practice statute, all three types of behavior are against the rules. The Just Culture model tries to differentiate between the inadvertent running of red light and the willful risk-taking decision to go through a red light.

In a Just Culture, we *console* an inadvertent error. The threat of punishment does not deter people from making inadvertent mistakes. Live with the error, analyze how it occurred and how the system design and individual choices led to the error.

In a Just Culture, we *coach* at risk behavior, when the behavioral choice increases risk, where the risk is not recognized, or when the risk is mistakenly believed to be justified. Coaching means directly confronting the person engaging in at risk behavior and talking about the risks and consequences.

In a Just Culture, we *punish* reckless behavior. What is key in this model is that the treatment of the behavior is not related to the outcome of the incident. People are accountable for making reckless choices, even if the choices do not result in harm.

Currently, the single greatest indicator of a hospital's willingness to take action against a doctor or nurse or pharmacist is the severity of patient harm. The authorities turn a blind eye toward at risk or reckless behavior if no harm has occurred. The Just Culture model abandons the concept of "no harm, no foul." It makes the actors in the system live with their behavioral choices.

What is the role of regulators in a Just Culture model? In a free market, consumers can go from one health care provider to another. The tort system does not work as a deterrent. Self regulation is not appropriate for health care.

So, there is a role for the regulator. Ultimately, this role is to influence the behavioral choices of the group. Some of the tools that help people make the safest possible choices are reporting, public disclosure of compliance, taxation, fines, incarceration, competing in the market, or taking over the market.

In the Just Culture model, punishment is appropriate for *reckless* behavior. But, what does the regulator do when he or she finds a nurse engaging in *at risk* behavior, such as a private practice nurse in a home health situation making a medication error or not engaging in hand hygiene practice?

The classic model says the regulator creates duties to produce outcomes. Essentially, this

means rules related to hand hygiene, patient identifiers, and other behaviors related to patient care. If practitioners don't engage in these behaviors, they can be reprimanded or punished, as the case may be. The Just Culture model distinguishes between organizations and assemblies of people. Organizations have systems for quality assurance, reporting, and so on. An assembly of individuals, such as a small medical practice, may not have educational systems, inter-communication, etc. In that model, one looks at outcomes. In the organizational model, those in charge want to learn from individual practitioners' mistakes in order to perfect system design.
Under Just Culture, we ask organizations to console errors and coach at risk behavior. These are not disciplinary actions. They are part of the learning culture. So, the regulated organization creates procedural duties for its members and expects them to come forward when there are errors or at risk behaviors.

The problem today is when regulators do not align with the Just Culture concepts. Even when practitioners can safely come forward within their institutions, they may still be inhibited by worry over what the regulatory board will do with a self-report. So, it may be safer to hide mistakes and at risk behaviors.

In a Just Culture model, regulators support hospitals that pursue the Just Culture path. If there is an error, the board allows the institution to console the actor, but we need to know what led to the error. If it is at risk behavior, we and the institution will coach you, but we need to know what circumstances led to the behavior.

The institution partners with the regulator. If an individual practitioner goes into the zone of reckless behavior, the hospital takes action and the regulator takes action. The difficulty in healthcare is that the Department of Health regulates the organization while licensure boards regulate individual practitioners.

Just Culture is about error and drift. People make mistakes and they also drift into at risk behaviors. Healthcare providers tell us that the biggest threat to patient safety is not inadvertent mistakes, but risky behavioral choices. Isn't it better to have reports of at risk behaviors before patient harm occurs? Just Culture asks what do we do with people before they have caused harm and how do we stand in judgment of their behavioral choices before harm has occurred to help them get onto a safe path.

Just Culture applies to more than safety. It applies to privacy and other values and patient rights. It applies to management competence. It applies to system design. It is about provider and staff choices.

Session Three – Promoting Quality and Safety via Cooperation between Licensing Boards and Hospitals

Linda Burhans, Director of Education and Practice, North Carolina Board of Nursing,

Carol Koeble, Director, North Carolina Center for Hospital Quality and Patient Safety,

David Marx, President, Outcome Engineering and author of *Patient Safety and the "Just Culture:" A Primer for Healthcare Executives*

Burhans: The North Carolina Board of Nursing (NCBON) has begun to adopt a Just Culture approach. Our traditional regulatory model has been retrospective, very reactive, and focused on placing blame on the last person to touch a patient before an adverse event occurs. The severity of punishment has been very dependent on the severity of patient harm.

In 1999 – 2000, after the first IOM report, ***To Err is Human***, NCBON began to look at innovative and proactive ways to approach regulation. In 2001, we initiated a pilot project using CAC's Practitioner Remediation and Enhancement Partnership (PreP 4 Patient Safety) model. This is a voluntary,

collaborative program that focuses on patient safety and quality improvement. It offers nurses a non-public and non-disciplinary approach to addressing errors in their practice and competency concerns. Nurses can self-report into the PreP program, or they can be reported by their organizations, usually by their nurse manager, or their chief nursing officer. They are referred for issues that are very diverse, but are typically a need for increased competence that is brought to light by a medication error, a delegation error, or a similar problem. There is not an issue about the nurse's overall competence to practice nursing, but rather an identified need for remediation and improvement from a proactive standpoint before there is a need for disciplinary action. To be eligible for the program, a nurse's practice cannot pose any risk to patient safety. The nurse needs to accept responsibility for his or her actions, and needs to exhibit the basic skills and knowledge to practice safely.

Subsequently, the board became aware of David Marx's work and looked at ways to embrace the Just Culture concepts in our work, building upon what we had already done in the PreP program. Our board was committed to balancing non-punitive learning with individual and system accountability and included in the board's strategic plan a goal to embrace and promote Just Culture accountability across our state.

We developed a pilot project and created a complaint evaluation tool for participating hospitals to determine whether the board needs to be contacted for particular practice incidents that occur. It helps the hospital nursing leadership and the board to differentiate incidents that result from human error from those that result from at risk or reckless behaviors. Together, the board and the hospital determine whether to engage in remediation or file a formal incident report. In either case, we assure employers that our mandatory reporting requirements will have been met. This approach facilitates the retention of nurses where possible and does not needlessly undermine nurses' confidence or remove them from their positions.

There are four corrective actions from which we choose: One is to permit the employer to support and console the affected employee. The second option is for the employer to use its internal systems to support and remediate the individual. The third option is a more formal corrective action that might include referral to our PreP program. The fourth option is formal reporting.

We had five cooperating hospitals in the fist phase of our pilot, which started in September, 2007 and formally ends in December 2008. We have already begun enrolling additional hospitals and talking with long-term care facilities to expand the program.

The desired outcomes from the pilot are 1) to develop a common framework we can use to review practice issues and to ensure continuous quality improvement; 2) to balance non-punitive learning with individual and system accountability; and, 3) to enhance patient safety by providing safeguards in the event a licensee should fail to follow through with the remediation they agree to.

Koeble: The North Carolina Center for Hospital Quality and Patient Safety, or the North Carolina Quality Center, for short, is an initiative of the North Carolina Hospital Association. The Center was established in late 2004 under a grant from the Duke Endowment and a donation from Blue Cross Blue Shield of North Carolina. Our mission is to make North Carolina hospitals the highest quality hospitals in the country. We do this through collaborative learning opportunities and clinical measurement services.

The Quality Center has created a Foundation for Change which focuses on four strategic areas. These are 1) promoting a fair and just culture, 2) optimization of team work and

communication among all healthcare workers, 3) ensuring evidence-based practice and care processes through reliable system design, and 4) gaining knowledge through organizational learning. The Just Culture model supports all four strategic elements.

Our journey has been going on for almost three years. We have partnered with the Board of Nursing to support what they are doing with the PreP program.

The flagship of our programs is our collaboratives. The first one started in 2006. Nine hospitals joined the first collaborative, six of which remained for the full 18 month cycle. The Just Culture collaborative included a "gap analysis" at the beginning and again at the end of the collaborative to determine how well human resources and risk management policies and procedures align with the Just Culture model. We also conducted event investigations and surveyed hospital staff to see whether the hospital employed the Just Culture model to look at behavior or looked at outcomes. In addition to the gap analysis, we conducted educational sessions, provided a Web site with learning tools, and managed a Listserve so members of the collaborative could discuss topics and issues.

One of the participating hospitals did a patient safety survey at the start and at the end of the collaborative. At the end of the collaborative, there was more open reporting of near misses and errors than there had been at the beginning. Staff reported more willingness to report a mistake that they caused or that they witnessed and risk managers approached the people involved in near misses or errors with a new degree of understanding and compassion.

Another hospital put together an inter-disciplinary Patient Care Council composed of key leaders and staff in both clinical and non-clinical areas. The Council analyzed reported incidents and applied the Just Culture algorithm to each event. This hospital also found more reporting of incidents over time. One incident involved a pharmacist who always followed the rules but who worked three shifts over a day and a half and at the end of the last shift made a medication error. The Council concluded that the pharmacist had been set up to make an error by being asked to work too many shifts in a row. The Council concluded it was the system that needed to be redesigned so a pharmacist cannot work that many shifts in a row. Another hospital developed a Risk Matrix, patterned on American Airlines' risk matrix, which helps them prioritize which events to focus on first, depending on the level of risk involved.

This first collaborative ended in early 2008 and the second began in August, 2008. We learned from the first collaborative that it is important that senior management be on board from the beginning. We also learned that all staff needs to be trained, from the senior management level to the online staff level. We will replace the gap analysis with a new tool called a Benchmark Survey, which looks at how well people understand risky behavior. We also provide participating hospitals with a timeline showing the milestones expected of them.

The lessons we have learned are that 1) communication is key; 2) organizations need to link this program with their strategic goals and understand how the Just Culture model fits in; 3) it is important to get key hospital players engaged early, such as the human resource manager, the risk manager, and senior leaders; 4) it is useful to have a physician champion; 5) it takes time to change a culture; 6) to be self-sustaining, there needs to be a consistent guiding coalition; 7) organizational change can occur only when definitions of behavior and responses to that behavior are consistent.

Comment from the Floor: In the real world, if there is a really terrible outcome, even though it might have been caused by an innocent error, wouldn't the authorities be forced to treat it as a disciplinary matter rather than as an incident calling for consoling the perpetrator?

Marx: We are creating a culture that for the present may not necessarily align with the public's perception of what a regulator should do. In California, the California Patient Safety and Action Coalition is doing regional training across the state with the Department of Health and the Hospital Association. One concern is public accountability, part of which is to teach the public how to think about the Just Culture concept. In Pennsylvania, we worked with the Governor's Office of Health Care Reform trying to get the legislature to buy in to Just Culture model.

Comment from the Floor: I find this to be counter-intuitive. I understand that "no harm, no foul" is wrong. But I think the severity of injury or harm should have some effect on the level of discipline or sanction. Under the tort system, if there is a medical error but no harm, there is no claim. Maybe in the regulatory setting, it makes sense to look at the conduct rather than the level of harm. In the real world, if I exceed the speed limit, I get stopped for speeding. The penalty would be different if I were to hit a pedestrian while speeding. So, I think the presence of injury and the severity of it does have a place in the equation.

Marx: The tort system is a form of social insurance, arguably the one that has the highest administrative cost. The regulatory system strives to deter bad behavior and encourage desirable behavior. Mothers Against Drunk Driving penalizes drivers who drink, whether or not they have an accident. They are concerned with harm, but it is *potential* harm.

Comment from the Floor: How does the Just Culture model hold accountable the people who are responsible for the system – those people who should have instituted safeguards to prevent mistakes?

Marx: Just Culture is not just for practitioners. CEOs can be reckless, too. It applies to all levels of the organization. Adverse events will occur at the organizational level. We look at the quality of the institutional choices to see if they are reckless.

Session Four – Promoting Quality via Cooperation between Licensing Boards and Certification Bodies

Jim Kendzel, Executive Director, National Organization for Competency Assurance (NOCA) and the National Commission for Certifying Agencies (NCCA)

Joe Baker, Executive Director of several licensing boards, Florida Department of Business and Professional Regulation

Paul Grace, President and CEO, National Board for Certification in Occupational Therapy

Douglas Scheckelhoff, Vice President of Professional Development, American Society of Health-System Pharmacists

Kendzel: The National Organization for Competency Assurance (NOCA) was founded in 1978 under a federal grant to develop standards for accreditation in specialty health care professions. Since then NOCA has grown into an organization with almost 400 member organizations that certify individuals in a broad range of professions, including health care, construction, engineering, physical fitness, financial services, and others. Health care professions now represent a little less than fifty percent of our membership. Through the National Commission for Certifying Agencies (NCCA), NOCA's accreditation arm, we have accredited more than one hundred and fifty different programs provided by more than ninety certification organizations.

NOCA and NCCA are strong advocates for having public members involved in certifying organizations. It is a requirement in NCCA's standards that to be accredited, certifying organizations must have at least one voting public member on their governing body. We

have always had a public member on NCCA and have recently added a public member to the NOCA board of directors.

When I first came to NOCA two years ago, I worked hard to understand the groups that have compatible interests. I quickly realized that certification bodies and licensing boards share a significant amount of similarities and mutual interests. They contribute to each others success.

For both institutions, the ultimate customer is the public whose safety and welfare we promote and protect. We are both in the business of verifying knowledge, skills and competencies of individuals in specific professions and occupations. We take a high level of care in the preparation or approval of assessment tools to be sure they are viable, valid, and otherwise psychometrically sound. We each assume a liability risk when we give individuals the right to bear our credential in their profession. Some of us are involved in renewal cycles and assessing continuing competence. We have complaint mechanisms in place. We deal with disciplinary issues related to the individuals who bear credentials provided by our bodies. These similarities underscore the desirability of credentialing bodies and licensing boards working together to serve the public and provide the safety they deserve.

Recently NOCA convened a leadership forum attended by more than eighty leaders in the credentialing field who discussed the future of the industry. Prior to the meeting, we surveyed our membership on industry trends and issues. More than sixty percent of the respondents project growth rates of more than four percent over the next three years. Thirty-two percent project growth rates of more than eight percent.

Eighty-two percent of the respondents indicated that accreditation of their program is part of their strategy. Their reasons for this include the value of third-party verification of their programs, distinguishing quality in the marketplace, and the increasing demand for accreditation in regulatory requirements.

Asked to name the top three issues with the potential to impact their programs, many cited the value of enhancing public awareness and understanding of certification and credentialing. This is something in which licensing boards also have a strong interest. If the public truly understands credentialing, certification and licensing, they will recognize the value of these institutions. Certification bodies see and welcome a growing public demand for quality.

Asked what regulatory trends will have the biggest impact on credentialing, sixty percent responded that achieving recognition of certification by state licensing boards is the most significant trend. Fifty-three percent indicated that certification mandated through states is the next most significant trend. Recently, several states have enacted regulations requiring that individuals in various professions and occupations carry certifications from accredited certification bodies. These regulations cover many professions including midwifery, crane operators, drug and alcohol abuse counselors, senior advisors, IT security specialists and pharmacy technicians.

When asked about the top three regulatory barriers that will impact certification, the following general concerns were expressed: limiting requirements from the regulatory sector, reluctance to write new requirements, misunderstanding by state legislative bodies of what certification is and how it works, and inconsistency of requirements from state to state.

The outcome of the forum was a draft strategic objectives document for the industry. Several objectives relate to regulatory trends. NOCA and its members would like to work with regulators in achieving these objectives. The key issues and trends identified during the forum are: increased use of private sector standards in programs and regulations, the need

for public awareness of the value of credentialing, federal funding of state programs, increased reference to accreditation programs in regulations, and the need for a common standard of accreditation that defines a quality system of credentialing and certification.

Out of those key issues and trends, several objectives were agreed upon. The first objective is to ensure that regulatory bodies and other agencies are fully aware of the value of accreditation as a third-party verification of the quality of certification programs and are aware of the various forms of accreditation. In other words, we want to educate the regulatory bodies on how we police our business, how it could be a value to them, and what it means. Some of the tactics to pursue include developing credentialing standards for use by regulatory communities to evaluate accreditation and determine whether it is appropriate in any particular sector. It was also suggested we sponsor a forum specifically for regulatory and other government bodies to discuss the credentialing industry and how we can work together. A third tactic is to develop a tool kit to be used by credentialing organizations to advance reliance by state boards and other agencies on certifications and appoint a task force to study federal and state regulations, statistics, court cases, etc. that point to the use of accreditation and certification programs around the country.

Objective two is to have in place communication mechanisms to ensure the credentialing industry is fully aware of opportunities where certification is or should be considered in regulation so we can be there and assist regulators in understanding what we do.

Ultimately, I believe the important question for us – and why I jumped at the chance to be here today – is how we can contribute to each other's successes and work together to help ensure public safety and welfare. I think developing mechanisms that allow us to learn from each other about governance issues and requirements, about the use of assessment tools and how they are changing, and about how we can help each other maintain the integrity of our programs and assure public safety.

We all deal with complaints and disciplinary actions. Having an open line of communication can help us both. We can work together to educate the public to make sure they understand the value of credentialing, licensing and certification and understand what is available to them when they have issues and feel their public safety has been compromised. When appropriate, we should work together to develop programs that complement rather than duplicate or conflict with each other. Finally, we can collaborate on research so we possess sufficient data to enable us to make the right decisions about our future as credentialing organizations.

Baker: The Florida Department of Health is an umbrella agency with eight different board offices. I am the executive director of one of those offices with six health care regulatory boards for which I am responsible. Some of our offices interact with national certifying bodies much more often and in a much more structured way that do others. I am hoping to learn some best practices today so we can all work in harmony to protect the public health, safety and welfare.

The primary means though which regulatory boards in Florida interact with certifying agencies are through sharing disciplinary data and utilizing examinations prepared by the national certifying organizations. Florida law specifically mandates that if an exam exists at the national level, we are to use that examination for licensure purposes instead of developing our own state-administered exam. In the last few years, based upon that statutory mandate, more and more of our boards are utilizing national certification examinations in lieu of our own exams.

The boards can initiate the process of approving a national exam. Or, a certifying body that has a national exam can initiate the process with the Department of Health. We are lucky to have a testing unit with psychometricians who evaluate national exams to make sure they meet criteria established in Florida laws and rules. Whichever entity initiates the process pays for this psychometric review.

Some examples of national certifying organizations with which our Florida regulatory boards interact on a regulation basis are the National Board of Certified Counselors, the National Commission for Certification of Anesthesiologist Assistants, the National Commission on Certification of Physician Assistants, the National Board for Certification in Occupational Therapy, the National Certification Commission for Acupuncture and Oriental Medicine, the National Certification Board for Therapeutic Massage and Body Work, the American Society of Clinical Pathology, the American Board for Certification in Orthotics and Prosthetics, American Medical Technologists, and the American Association of Bioanalysis. There are numerous organizations in the clinical laboratory personnel field whose exams we use for licensure.

We share disciplinary data after one of our boards files a final order disciplining a licensee. When we are aware that the licensee is certified by a national organization, we share that final order either through hard copy or email distribution. We don't always know when someone holds a national certification because we do not require that they hold a national certification for licensure.

Several of our boards are able to access data from the national organizations online. The National Board of Respiratory Care and the National Board for Certification in Occupation Therapy, for example, have secure Web sites where state administrators can check discipline and certification information.

Many professions in Florida, such as the Board of Medicine and Board of Chiropractic Medicine are closely involved with their boards' national associations which house disciplinary information for particular professions. These national associations are sometimes closely involved with national certification agencies and interact with them in behalf of the regulatory community.

Grace: NBCOT is a non-profit corporation governed by a board of directors which includes four public members. We have a very aggressive public member program. A public member chaired the search committee that brought me to NBCOT.

I have been asked to talk about our relationship with regulatory agencies. Our examination is used for state licensing purposes in forty-nine states; the remaining state recognizes our exam for certification, but does not license occupational therapists. We also share our disciplinary action data base which contains information about all occupational therapists who are either licensed at the state level or certified by us. When therapists move from state to state, the states look to us to provide a history of the individual's record from the time of examination to the present. Many therapists or therapy assistants aren't aware of this, or forget about it, and may fail to report discipline on their records. We feel it is serving the public interest to share a complete file.

We host an annual conference of occupational therapy regulators where we bring together administrators and board members to talk about issues of competency, discipline and the sharing of information and best practices. We just concluded our fourteenth such meeting. The consensus of the group is that there is confusion around continuing competence and if we can develop a national voice about what this means for occupational therapists, the states will be able to work from that and we will have a national standard.

In addition to sharing information around discipline, we also work on best practices. We look at what is working in some states and consider how it can be packaged to work in other states, including those where there are fewer resources available.

About six thousand new therapists enter the workforce annually, so we are small in numbers compared to other allied health professions. We can help occupational therapists get organized so they have a meaningful voice in therapy settings and with regulatory issues.

We also administer what is known as the Visa Credential Verification Certificate program. Through this, we evaluate the credentials of foreign-educated occupational therapists. The states rely on us to provide them with information when a foreign-educated therapist moves into their jurisdiction. This has been a challenging task because it involves dealing with so many jurisdictions outside the U.S. One of our primary responsibilities to the states is to assure them that individuals who are certified have met the same educational standards as U.S.-educated therapists. So, we have a rigorous process of review and documentation of an individual's prior educational history before they can be issued a certificate that enables them to apply for a work permit in the U.S.

We have a very open relationship with the states. Our policy is that we have representatives from state licensing boards on our committees as participants or observers so they can assure their peers that NBCOT is following the practices and policies set forth in our literature.

For example, our bylaws designate a spot on our Education Committee for at least one representative from a regulatory entity. We have representation from the states on our Practice Analysis Task Force. We want to build this partnership and earn trust by being inclusive in our process. We have three board members who were at one time regulators.

The future for NBCOT and most certification boards that provide an examination for licensing purposes is to think about who its public is. To me, our public is the jurisdictions that rely on our credential. Obviously, certificants are a part of it, but when we look for public members to serve on our board, we look for individuals who have had experience in the public sector to help our board make the strategic decisions it needs to make around advancing reliance on our credential not only among employers, but also with regulators.

Scheckelhoff: ASHP is a professional association with about 35,000 members who are primarily pharmacists who work in hospitals and health systems. ASHP has undertaken an advocacy initiative in the last year related to a significant part of the pharmacy workforce – pharmacy technicians. Regulatory requirements differ by state, but for pharmacists and the practice of pharmacy, they are fairly consistent. This is not true for pharmacy technicians.

There are about 220,000 pharmacists across the country. The Doctor of Pharmacy has been the entry level degree since 2000. About 6,000 per year also pursue residency training. About one fourth of pharmacists work in hospitals and health systems; about two-thirds work in the community setting. There has been a pharmacist shortage that peaked in about 2000. New schools of pharmacy are opening and now there are about 10,000 new graduates each year.

The role of the pharmacist is shifting from being a distributor of product to being a provider of direct patient care. In hospitals, that is often team-based care. In the community setting, it is management of medication therapy. The Asheville project which occurred about eight years ago involved city employees with chronic conditions seeing pharmacists regularly. As a result, there was a

dramatic drop-off in emergency room visits among this patient population and the overall cost of care was reduced.

It is estimated that there are about 400,000 pharmacy technicians. Training varies greatly from setting to setting and employer to employer. Certification requirements vary greatly and registration is not required in all states. The average hourly salary as reported by the Bureau of Health Professions is $12.75, but there are many people who work in this profession who are paid $8.00 to $9.00. Historically, the pharmacy technician's role has been to prepare medications for dispensing. They often work side by side with pharmacists, but their role is expanding as pharmacists move more toward taking care of patients. Technicians need to be capable of assuming some of the distributive responsibilities and in some cases, managing pharmacy automation and information technology.

Well-qualified, competent pharmacy technicians are involved in virtually every pharmacy setting, whether it is hospital, home care, community pharmacy, chain drug store, and so on. ASHP believes there needs to be standardized, uniform education, training, certification and registration for pharmacy technicians in the interest of patient safety.

There have been some well-publicized errors associated with technicians. There was an expose on the TV show, 20/20 about a year ago involving technicians in chain drug stores doing tasks they weren't legally authorized to do. There was a fatal medication error in Cleveland about two years ago where a two-year old child was given an inappropriately prepared dose of chemotherapy. That error prompted "Emily's Law" and federal legislation introduced last year around the issue of pharmacy technician qualifications. There are a number of advocacy groups that focus on medication errors, with some concentrating specifically on technician errors, including Families Launching Action Against Medication Errors, Mothers Against Medication Errors, and so on.

ASHP's House of Delegates adopted a professional policy position that a well-qualified, competent pharmacy technician is important to the safe provision of medications in all settings. There are three key elements: standardized, uniform training in an ASHP-accredited training program; certification through the Pharmacy Technician Certification Board; and registration through the state board of pharmacy. Ideally, pharmacy technician preparation and recognition should proceed in this order. In reality, it is more likely to be in the reverse order.

Pharmacy technician training is generally employer-based, although there are some structured pharmacy technician training programs. Training ranges from two to three weeks of on-the-job training up to a two-year community college degree that includes calculations and professionalism, drug classification, and so on. There are videos, workbooks, and other self-study materials available. Only about one hundred and twenty-five of the roughly four hundred structured training programs are accredited. This is a fraction of what is needed.

State training requirements vary greatly. Twenty-nine states do mention education and training of pharmacy technicians, but the language is usually very general and vague, leaving the responsibility to the employer. Even when requirements are prescribed, there is no mechanism for verifying compliance. Three states specifically recognize ASHP-accredited training – South Carolina, Nevada, and North Dakota.

ASHP accredits both pharmacy and pharmacy technician training programs and pharmacy residency programs. Our model curriculum is based on a task analysis of what technicians do in the workplace. It includes goals and objectives, a curricular map, descriptions of

modules that should be included, a didactic laboratory, and experiential training. The model requires at least six hundred hours of instruction.

The next step is technician certification, a voluntary process by which a non-governmental agency or association grants recognition to an individual who has met pre-determined qualifications. The Pharmacy Technician Certification Board has administered an examination for thirteen years. It is NCCA-accredited and has been used to certify over 300,000 pharmacy technicians. It is based on a task analysis of pharmacy practice across all settings and has a re-certification requirement for continuing education.

Thirty states recognize certification as one option for registration of pharmacy technicians. This has helped to drive certification, but it is generally not a requirement. It often is linked to being able to assume additional responsibility in the work setting. Another exam just became accredited by NCCA.

Technician registration involves having technicians pay a fee to the state and register. This usually involves a background check. About thirty-nine states require registration or licensure. Eleven states have no requirements.

ASHP is working with each of our state affiliates to establish requirements for education, certification and registration. We launched the initiative in May and so far seventeen states have signed on. The actual advocacy has to happen at the state level where there is increasing discussion which indicates a growing consensus that the bar needs to be raised – and in some states needs to be established in the first place,

Comment from the Floor: Paul, you talked about the data base of complaints that NBCOT shares with the states. Where do these complaints come from and how do you make people aware that you are willing to receive complaints?

Grace: Complaints come from three sources. One is state agencies. A second is self-reported issues. These may be contained in responses on the certification renewal questionnaires. Or, they may come to our attention as a result of inquiries from individuals enrolled in an academic program who want to know if prior difficulties with the law would disqualify them from becoming certified after graduation.

The third area of reports comes from employers or colleagues. Most of these complaints allege problems with reimbursement or patient safety. A small percentage comes from the public. Our Website is pretty accessible and it explains how to submit a complaint.

The general public knows of our existence in a couple of ways. We have a very aggressive marketing campaign to payers and have publicized occupational therapy certification in general distribution magazines. We also exhibit at the National Conference of State Legislators and school board association conferences.

Comment from the Floor: Is there any significant trend in the managed care or heath insurance industries toward certification in professions other than physicians?

Grace: We have found that managed care employers like the fact that NBCOT has a national standard for certification renewal, so they are requiring their occupational therapy staff to maintain their national certification so that all their occupational therapists meet the same standard of ongoing professional development regardless of which state they work in. Also, the military wants its therapists to maintain this national standard.

Comment from the Floor: The North American Registry for Midwives has an NCCA-accredited credential for direct-entry midwives. Our credential is now used as the basis for licensure of direct-entry midwives in twenty-four states. That still leaves more than half the states that do not license direct-entry

midwives. What do you think is the most persuasive argument to make to the legislature to use a national credential as the basis for licensing a profession in a state?

Baker: One strong argument is the cost savings.

Kendzel: Cost savings is definitely important. So also is the fact that a national standard provides a framework for consistency from state to state. Furthermore, the disciplinary component and requirements for ongoing competence for recertification make certification attractive.

Comment from the Floor: Creating a test is a great deal of work and expense. The tests are directed specifically at a specialty certification. Does it compromise the test to use it on the licensing level? And, who pays for the use of the test?

Grace: For occupational therapy, the results of our test are recognized by the states for licensure purposes. I don't see how the results could be compromised. You are correct that test development is very expensive. If a certification entity would like to have its credential recognized by regulatory authorities, it is important for the certification entity be as transparent as possible so the regulators can view and participate in the process. The goal is to have one national test used as the basis of regulation in all fifty states.

Baker: For many smaller professions, it is prohibitively expensive to develop a state-administered exam. It is better to recognize a national psychometrically defensible exam consistent with state law and rule. That is why the Florida legislature mandated their use. The applicant pays for the test.

Grace: If a person is nationally certified, the credential is portable to every state that recognizes the national credential.

Kendzel: The expense of developing a sound, reliable assessment tool discourages some organizations from getting into certification. Licensing boards don't administer the tests developed by certification bodies. Rather, they recognize those who have passed the certification bodies' tests as being qualified for licensure. Certification bodies strictly protect item-writing and maintain the security of their examinations.

Comment from the Floor: For those boards that require certification as a condition of licensure, should maintenance of certification be a requirement for maintenance of licensure?

Grace: In occupational therapy there is one state (South Carolina) that currently requires individuals to maintain their certification as a condition of relicensure. Other states require passing our examination for initial licensure and have their own relicensure requirements and may not be able to recognize our recertification standards. When we crafted our certification renewal requirement, we tried to take the best of what the states are currently doing and piece together a uniform standard.

Comment from the Floor: CAC has long advocated strengthening the way licensing boards go about assessing and verifying current competence. One thing we have recommended is that licensing boards and certification bodies collaborate. A licensing board, for example, might choose to recognize a certification body's recertification, assuming the certification body's processes met the licensing board's standards for consumer protection. That would avoid duplication of resources, and save the professional from having to jump through the same hoops twice for two different organizations. How do the members of the panel react to this notion?

Kendzel: I react positively. From NOCA's perspective, we are strongly committed to recertification and ongoing competency assurance. The revision of the NCCA

standards in 2002 placed a greater emphasis on recertification. However, we recognize that there is not yet a lot of good solid research to support what makes a sound, good recertification program.

Scheckelhoff: Currently, pharmacists are required to obtain continuing education credits. There is growing support for continuing professional development models, but there are still many countries, such as the U.K. and Canada, where pharmacy is ahead of the U.S. in that they have mandatory CE and use techniques to regularly assess competence over time. As pharmacy scope of practice grows, there will be a greater need to maintain and demonstrate their competence. Pharmacy technicians also should have a recertification process built into the process, but in most states, registration is a one-time deal.

Grace: Yes, I think there should be collaboration. For a number of reasons, certification has to take the lead. One is that certification bodies tend to be a bit more nimble and are not as limited by the political environment. Starting this year, we are developing a self-assessment tool for occupational therapists and therapy assistants. It is an online tool matched to the competencies validated in a practice analysis study. At the end of the assessment, the individual gets a diagnostic report of strengths and weaknesses. Hopefully they will use this report in their professional development choices. We are making this available free of charge.

Occupational therapists work in a number of practice settings, from skilled nursing facilities to school settings, to long term care. So, we are developing practice area self-assessments which will measure a practitioner's knowledge against best practices. Therapists who are transferring from one setting to another will be able to use the assessment tool to identify the critical skills and competencies they need in the new setting. Licensing authorities are excited about this because most of them do not have the resources to develop anything comparable, and they are hopeful that having this available will help drive a national perspective around continuing competence.

Comment from the Floor: In the area of product certification, Underwriters' Lab spent an enormous amount of time policing the marketplace in order to protect the integrity of their mark. Also, pharmacy boards send inspectors out to look at the pharmacy as well as the pharmacist, so they can proactively monitor the practice setting. Is there any effort on the part of credentialing bodies to go out and determine what is actually happening in practice settings in order to protect the integrity of your certification?

Grace: No, this is not happening, but it is an idea that I will take back to our board. The only thing that comes close is when a facility is undergoing a Joint Commission accreditation process, but that doesn't really get at how certificants are performing.

Kendzel: NCCA standards require certification organizations to have some type of mechanism to determine whether their credential is being used properly in the marketplace. But, the common way of doing this is through complaints rather than proactive monitoring.

Comment from the Floor: Some professions look to certification as a way of obtaining licensure and others look to certification for registration. Why is ASHP seeking registration for pharmacy technicians and why do direct entry midwives seek licensure?

Scheckelhoff: I suppose it would be possible to develop a licensure examination, but for now, it is felt that certification is a step in the right direction. The registration piece is simply to find out who the pharmacy technicians are.

Comment from the Floor: For midwives, it is a legal issue, because every state has medical practice and nursing practice acts. The issue

we face is whether practicing midwifery is the practice of medicine. Midwives have to have a practice act of their own so they won't be found in violation of the medical or nursing practice act. Several states use terms such as "registered midwife," but the regulatory status is still licensure.

Baker: In Florida, it doesn't matter whether it is called licensure, registration or certification, the law is applied equally.

Session Five – Promoting Quality via Ensuring Current Competence

David Watt, Senior Vice President of Professional Services, Federation of State Medical Boards

Linda Burhans, Director of Education and Practice, North Carolina Board of Nursing

Mark Lane, Vice President of Professional Standards and Assessment, Federation of State Boards of Physical Therapy

Watt: The authority of the Federation of State Medical Boards is not based in law, it resides in our ability to pull together information and data, and thereby influence the activities of our member boards. Like many of your organizations, we have a policy-making house of delegates where we discuss issues such as competence and maintenance of competence. We recognize that, unlike what many of them may think, physicians do not have a *right* to practice once they have completed their long educational preparation. They are given the *privilege* to practice by the public through the legislative process.

In 2003, the Federation of State Medical Boards created a special committee on the maintenance of licensure to look at the issues related to demonstrating competence throughout a physician's career. There is rigorous assessment of the initial licensee, but once licensed, it is possible to stay under the radar and not have to demonstrate competence for the rest of one's career. Many states do require continuing medical education, but there is not a requirement for demonstration of competence for relicensure.

The special committee concluded early on that to demonstrate professional commitment, physicians should be expected to periodically demonstrate competence beyond that required for initial licensure and that the state medical boards are the sole entity with the authority to require this. In 2005, the Federation sponsored a summit that pulled together about forty-five representatives of about thirty-five different agencies and organizations in education, certification, and regulation to talk about how physicians might demonstrate competence. This has become known at the "National Summit" or "Physician Accountability for Physician Competence" and has occurred six times so far.

Supporting the activities of this group are several polls conducted during recent years to learn the public's point of view on the subject. The findings have been very consistent. A poll the Federation conducted in late 2007 asked the public how often doctors are assessed to make sure they qualify to practice medicine. The majority said they aren't sure. Those who did respond indicated that doctors are required to demonstrate their competence every two to five years. The next question was, "How often *should* doctors be reassessed to make sure they remain qualified to practice medicine?" Seventy-three percent responded that it should be an interval at least less than every five years.

We asked how doctors are assessed. Fifty-four percent said they didn't know. Those who did answer suggested that the medical license renewal was the process through which doctors were assessed. Then we asked, "How *should* doctors be assessed?" Most suggested there should be a periodic clinical skills examination and a periodic medical knowledge examination. We asked what indicates that a doctor remains qualified. Seventy-one percent said that if they

remain licensed, this indicates that they remain qualified. Seventy-four percent said board certification is an indication that doctors remain qualified.

It has been demonstrated that physicians' knowledge and skill development, which rises steeply during their education years, tends to decline as their careers progress. We hope that they maintain their skills well enough that they do not fall below minimal acceptable levels. Assessment would drive the maintenance of knowledge and skills if it were required.

AARP also conducted a survey of Virginia residents in 2007. The findings were similar. More than half assumed there is already periodic assessment to remain licensed. Two-thirds definitely believe this is required by law. Ninety-five percent said assessment should be done at intervals of five years or less.

The maintenance of licensure special committee submitted a report on their findings to the Federation board of directors and House of Delegates which endorsed the principle behind the maintenance of licensure. It asked for another report next year as well as a review of the implications of instituting a maintenance of licensure program for the state medical boards.

The foundation of professionalism is the social contract between the profession and the public. That social contract should be transparent and available to everyone involved. Numerous organizations, including the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education and the American Association of Medical Colleges, National Board of Medical Examiners, and the Federation have reached consensus around six competencies which represent expected professional behaviors and have become the framework for medical education and assessment. The six competencies are: medical knowledge, patient care, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice.

Most professionals keep up with what is required of them. That is not only expected, it is the reality. A distinct minority has to be given an additional incentive to maintain their competence. So, if we can build on activities that are already commonplace, we can have an evolutionary rather than a revolutionary transition. This brings us to the collaboration between certification and licensure. The Federation has been working closely with the ABMS which has had an initiative for some time now looking at maintenance of certification. Board certification initially distinguished those who were above the basic competence required for licensure so one question that needs to be resolved is whether board certification is an appropriate proxy for maintenance of licensure.

The summit group continues to work. The state medical boards support the effort, but are concerned about implementation because it would represent a considerable change to enter a proactive mode for the demonstration of competence.

Burhans: Continuing competence is important to the North Carolina Board of Nursing because of our public protection function and because we see it as important to assuring patient safety and supporting quality nursing care. In spite of this, prior to 1998, North Carolina did not require any type of continuing education or continuing competence for nurses to renew or reinstate their licenses. In 1998, the board's strategic plan included an initiative to address continuing competence. The subsequent years of work were important to laying the foundation for the continuing competence program now in place.

Stakeholders having an interest in continuing competence and in nursing practice were brought together to discuss the initiative and this was critical to building a consensus among educators, professional associations, regulators,

the public, and others over the approach we wanted to take. Although there was some information in the literature saying that continuing education contributed to continuing competence, the data was clearly showing that continuing education alone was insufficient. The stakeholders looked at many different approaches to continuing competence and in 2001 recommended a reflective practice model which the board then approved.

We spent a year developing tools, building upon what was being done in other states and in Alberta and Ontario, Canada. In 2003, we took the tools and documents to focus groups of nurses of various specializations in a variety of practice settings. In 2004, we conducted a Web-based pilot with about thirteen hundred volunteers whose licenses were up for renewal. In 2005, legislation was passed and rules promulgated to create the program. The law and rule apply to all North Carolina nurses.

The reflective practice approach relies on individual responsibility. Agencies that employ nurses have no direct responsibility related to the individual nurse's accountability for maintaining competence. Many agencies and organizations offer opportunities nurses can use as a part of their continuing competence, but that is not part of our regulatory requirement.

Our rules require a periodic self-assessment at the biennial licensing renewal. Nurses identify their strengths and their opportunities for continued growth and then to implement an individual learning plan. Continuing competence is defined as the ongoing acquisition and application of knowledge and the decision making, psychomotor and interpersonal skills expected of the licensed nurse that result in nursing care that contributes to the health and welfare of the clients being served. Self-assessment is the process whereby the individual nurse reviews his or her practice and identifies the knowledge and skills they possess as well as those skills they need to strengthen.

Personal assessment is based on four dimensions: professional responsibility, knowledge-based practice, legal and ethical practice, and collaboration. It is not a skill list kind of assessment. It is very broad. All of the work we did with our stakeholders across the state indicated how important it was that whatever we put into place for continuing competence needed to usable to nurses regardless of the practice setting and their role. So, this assessment process has that breadth.

We ask nurses to look at the standards in their area of specialization as they do their self-assessment and to collect feedback from their peers, their colleagues, and their patients so they can validate their strengths and their opportunities for growth. Then, nurses are required to develop and implement a learning plan and they select a learning activity to be used to demonstrate their continuing competence. The board has identified eight learning activities that are acceptable. The first is national certification, so a nurse who is certified in a practice area can use that national certification to meet their continuing competence requirement and does not need to do anything in addition.

The other alternatives include continuing education. The requirement can be met totally with continuing education, or through a combination of continuing education and other activities, such as special projects, publication, presentation, or the nurse's own active practice. We also recognize academic education and board-approved refresher courses

We began formal implementation in July 2006. Beginning July 1, 2008, all licensees will attest to the fact that they have completed their continuing competence requirements and a random group of nurses would be selected for audit at the time of renewal or reinstatement.

We have only a few months of experience with the random audit, but it is clear that nurses in general are very honest because many in the random audit sample tell us they have not met

their requirements. These individuals are given sixty days to comply.

When nurses are audited, they do not send in their self-assessment or learning plan. They send only the documentation that confirms the completion of the elected learning activities and they tell us in general terms what their goal and plan was. We are not asking people to tell us weaknesses they are afraid to reveal to the board of nursing. We want to know the goal, the plan and how they accomplished it.

Nurses in the focus groups told us that it was very threatening to think of revealing weaknesses to the board. So, the board feels that by not requiring the self assessment and learning plan, nurses are able to be honest with themselves and can put together a learning plan that may span several licensing periods as they work on the developmental needs they have identified.

Our biggest lesson is that there is never too much education and communication. We spent most of 2006 talking with nurses across the state. We also launched a Website in 2005 which included a PowerPoint presentation with one contact hour of continuing education credit, all the documents nurses needed to understand the continuing competence program. We have also had information about continuing competence in every issue of our Nursing Bulletin since 2006. Nevertheless, the phone rings constantly with questions from nurses, many of whom are totally surprised by their continuing competence responsibilities.

We will continue to do whatever we can to educate nurses about how the reflective practice model can benefit them in their practice. We anticipate that we will still be doing educational presentations into 2010.

While our continuing competence model does not accomplish all our goals, we feel it is an excellent start and that nurses in North Carolina are building an excellent foundation and a continuing learning environment for themselves.

Lane: The Federation of State Boards of Physical Therapy is a member organization composed of the fifty-three jurisdictions of physical therapy licensing boards. One of our goals is to identify and promote effective regulation in physical therapy to assure the delivery of competent physical therapy.

We have a charge to promote continued competence with physical therapy regulation. We are very much like the Federation of State Medical Boards in that we have no authority to mandate continued competence or anything else. Our desire is to develop models that our jurisdiction members can use. One thing we work hard at is establishing some sort of uniformity because if we have fifty-three different models for continued competence, it is cumbersome for practitioner mobility.

Currently, only thirty-one out of fifty-three jurisdictions require continuing education. When I started working at the Federation over ten years ago, about twenty-one jurisdictions required CE, so in the last decade there has been a strong move toward CE, but it is still not universal. We have only nine jurisdictions with the statutory authority to require more than continuing education and to require continued competence. One of our strong drives is for all the boards to acquire the statutory authority to mandate continued competence requirements.

The Federation started working on this topic in 1996. In 2000 standards of competence were developed and adopted. This is our blueprint for continued competence activities. These standards were revised in 2006. In 2007, our delegate assembly passed a motion charging our board of directors to move forward, at a substantial cost, with developing a continuing competence model.

One thing we have determined is that there no one answer to continued competence so our

models are not prescriptive and offer a variety of options and approaches. Also our conversations with licensees and others reveal and many people are already engaged in continuing competence activities. Within the profession, only a few individuals need to be urged to stay current. We don't want to make licensees go through additional hoops and hurdles. We want the process to be as effective and efficient as we possible can and so do our member boards, who have let us know they will not adopt a cumbersome plan that is not administratively feasible.

A model needs both competency assessment as well as development. The delegate assembly motion in 2007 established a four-pronged model. One of these is related to organizational structure. The other three prongs call for the development of a model and of tools for assessing and developing competence, and of a system that can make this feasible for the boards. A substantial financial commitment was made.

There were no votes in opposition to this motion.

The model will be developed by a continuing competence committee. They have identified continued competence activities, or ways that someone can either assess, demonstrate, or develop their competence. These activities must meet certain criteria in order to be acceptable. Two of the nine criteria are mandatory and the rest are voluntary, but the value of the activity is gauged according to how many criteria it meets. We are trying to get away from valuing an activity according to the amount of time spent.

The committee is struggling to decide whether to limit various activities. We know that continuing education has its problems, but it is also a valuable activity so we don't want to throw the baby out with the bath water. But, should there be a limit? If so, should other activities be limited, such as activities that are not certified? The more limitations, the more complex the model becomes and the more difficult it is for the licensee to understand and the board to administer.

Among the tools we are developing is a practice review tool which enables licensees to assess their strengths and weaknesses through a scenario-based multiple choice assessment taken at a secure test center. We have completed a general practice tool and are working on various others, including orthopedics, neurology, and so on. The jurisdictions with statutory requirements for continuing education are having a difficult time reconciling this tool to their statutes.

Some states are giving credit for taking the tool; others give credit if the licensee meets the standard for the tool, and others are giving credit for those who take the tool and remediate in the areas of weakness. Jurisprudence exams are an assessment tool we encourage all states to develop. We believe this should be a relicensure requirement.

Our competency assessment portfolio system is a reflective practice tool we started to develop several years ago. We put it on hold for several reasons, one of which was that it was a paper-based system. Also, the literature doesn't support that people are very good at self-assessing and identifying their own weaknesses.

We are also developing a system which will allow licensees to track their adherence to continued competence activities in any state or jurisdiction. It will allow jurisdictions to verify whether someone has met the requirements. Our ultimate goal is one hundred percent audit. By far, the largest percentage of discipline cases I see involve failure to meet continuing education or continuing competence requirements. This is based on auditing a very small percentage of the licensee population. Clearly, a significant number are gambling that they won't be audited.

We are developing a system where continued competence activities are approved and re-approved. Vendors will be able to submit their activities for approval. The challenge with one-hundred percent audit is the verification process. Some of the self-directed activities, such as literature review, are difficult to verify. Continuing education or certification exams are easily verified.

In the beginning, many of our members were opposed to our continued competence initiative. They felt it was unnecessary, expensive, and inscrutable. Licensees were opposed having additional hurdles in the way of their practicing. Statutes were a problem to the extent they require continuing education rather than continued competence.

To get stakeholder buy-in, timing is everything, communication (listening as well as talking) is everything, education is everything and involvement is everything. Without all four of these, there won't be stakeholder buy-in.

Sometimes it is necessary to step back and let some time go by. Originally, the professional association was involved, but then decided to pull out, and then questioned whether continued competence is our role. They considered it professional development and therefore the professional association's role. Every time I spoke on the topic, I emphasized that this is everyone's responsibility. As the profession has evolved toward autonomous practice and developed the doctor of physical therapy degree, the profession has recognized that it needs to get on board with continued competence if it wants to be recognized by the public and legislators. The only institutions that can require continued competence are the licensing boards. The professional association does not have one hundred percent membership. We have much more dialogue about continued competence now than ever before.

We are encouraging legislators to understand the issue and to make the changes that will authorize licensing boards to require continued competence rather than continuing education alone.

Lessons learned: Keep communication continual. Deal with the rumors. Make sure people become involved. Be sensitive about timing – don't move too quickly or too slowly.

Comment from the Floor: What is the role of the employer in continued competence?

Burhans: We have no jurisdiction over employers, but we do recognize employer-sponsored continuing education and allow licensees to obtain up to half of their continuing education from employer-sponsored education that is formal, organized, has at least one objective and is at least thirty-minutes in length. Many employers make it possible for nurses to attend state conferences and other educational opportunities.

Watt: Until this year, the majority of physicians have been independent practitioners. As of this year, the majority are now company employed. There is an impetus among employers to use not only indicators of maintenance of competence, but also continuing professional development as a marketing tool.

Lane: We have involved employers in some of our focus groups because we recognize that employers have a responsibility to ensure the competence of their employees. Some of our tools could be useful to employers, perhaps in meeting Joint Commission requirements.

Comment from the Floor: Do you feel that collecting feedback from peers and colleagues adequately addresses concerns about the validity and reliability of self-assessment?

Burhans: I hope that obtaining feedback from peers and colleagues is helpful in validating self-assessment, but I don't think we are able to say that we know nurses in North Carolina are unable to discern what their strengths and

weaknesses really are. This is an ongoing concern with any self-assessment process.

Comment from the Floor: How will you measure whether continuing competence requirements and new approaches actually improve public protection?

Watt: That is a fantastic question and I wish I had an answer. Part of what is driving this is internal. What are external are public expectations about what a license represents. I'm sure that in the future we will be able to measure the impact as the process evolves, but we are now taking just the preliminary steps. There is some evidence to suggest that indicators of quality and indicators of competence are related to better clinical outcomes. This is primarily in the area of board certification, especially for physicians where there is evidence suggesting that certified physicians' clinical outcomes are better than non-board-certified physicians.

Burhans: I agree it is too early in the implementation to have developed the metrics to show the impact.

Lane: As we focus more on the assessment of competence, this will help with the development of measures.

Comment from the Floor: One of our goals as a board is to keep our costs down as much as possible. How much do you anticipate the Federation of State Boards of Physical Therapy will be charging licensees to do assessments? What percentage of licensees do you think will participate?

Lane: We aren't far enough along for me to answer. There will be a cost to licensees, but by spreading it out across licensees, it will cost less. It will begin as a voluntary program, but a state board could decide to require participation.

Comment from the Floor: To what extent have certification boards been helpful allies in carrying the message to state legislators and others about the need for continuing competence?

Watt: In medicine, the specialty boards were the impetus for this to begin. Their motives are not only the professional aspect but also for the recognition of the quality of medicine.

Lane: In physical therapy, the professional association offers certification. By far the majority of physical therapists are not board-certified. So, there hasn't been a lot of involvement with licensing boards.

Burhans: In nursing certification boards are natural allies, but a small number of nurses are certified, so the impact has been minimal.

Comment from the Floor: When boards think about different types of continuing competence activities, I encourage them to think about what the statute says and what your rules say. The North Carolina Board of Pharmacy supports continuous professional development as an alternative to traditional continuing education. We are fairly liberal about what activities we recognize. What I have discovered is that many pharmacy boards, either in statue or in rules, say that continuing education required for renewal of a license must be accredited by a particular agency. Be careful about linking continuing education to a monolithic accrediting body. Such restrictions can make it difficult to experiment with other forms of professional development.

Session Six – Promoting Quality and Access via Evidence-Based Scope of Practice

Basil Merenda, Commissioner of Pennsylvania's Bureau of Professional and Occupational Affairs

Jay Campbell, Executive Director, North Carolina Board of Pharmacy

Len Finocchio, Senior Program Officer for the California HealthCare Foundation's Innovations for the Underserved Program

Merenda: I will talk today about the scope of practice provisions in Pennsylvania Governor Rendell's health care reform initiative, called the "Prescription for Pennsylvania." I have organized my presentation around several questions:

What does Prescription for Pennsylvania consist of?

The program creates a cabinet-level office of healthcare reform. There are several best practice components, including one which requires institutions to address healthcare associated infections and another which precludes payment of fees for preventable serious adverse events. The Prescription attempts to provide health care for everyone in the State. This provision has not yet been enacted. The final component is the scope of practice provisions which focus on allied health care providers – non-physicians.

What did the governor want to do?

One of his campaign promises in 2002 was to address the healthcare crisis in Pennsylvania which impacted the state budget. The problems included a malpractice premium crisis, reduced access to care, large numbers of uninsured.

What is the basic principle for scope of practice provisions?

The goal of the scope of practice component was to permit practitioners other than physicians to practice to the full extent of their training, education and experience.

What did we face in implementing the program?

We encountered fear of change and the territorial mentality on the part of physicians groups, which are influential with the legislature.

How did the governor overcome those obstacles?

It was important to bring everyone to the table to express their points of view. We held public hearings and involved the policy office, the medical society, the allied health professions, the Bureau of Professional and Occupational Affairs, and other stakeholders in the development of the legislation. The licensing boards did legislative analysis that the Bureau that was used in the legislative drafting.

What is the key to getting this reform enacted?

The key is to be flexible and open to compromise. We carefully examined each practice privilege under consideration. It was a tedious process but the only way to get it done.

What are the scope of practice provisions and what are their side effects?

First, Pennsylvania increased from two to four the number of physician assistants a physician can supervise under a collaborative agreement. Certified registered nurse practitioners are allowed to practice to the fullest extent of their education, training, and experience. They are allowed to order home health and hospice care, durable medical equipment, oral orders according to a health care facility's guidelines, make referrals for physical or occupational therapy, respiratory care, perform disability assessments, initial methadone treatment and evaluation. With this increase in scope, the certified nurse practitioners are required to carry the same level of liability insurance as do physicians. Hopefully, this will result in the opening of CRNP-managed clinics based in pharmacies and other areas of the state.

Clinical nurse specialists are also provided with title protection which permits them to bill for some services. They are content at this time to

have title protection with no added scope of practice.

The legislation created the certified public dental hygienist practitioner which permits hygienists to practice unsupervised in a public health setting such as nursing homes, schools, correctional facilities, public health clinics. The dental associations opposed this legislation, saying hygienists are not trained to practice without direct supervision. Companion legislation permitting expanded function dental assistants to do additional work in a dental office under the supervision of a dentist was supported by the dental associations, but opposed by dental hygienists who used the same argument that expanded dental assistants were not qualified. This legislation is still pending.

Another provision finally provides nurse midwives with prescriptive authority. Pennsylvania may have been the only state where nurse midwives still did not have this authority.

The side effects include momentum for other legislative initiatives. After Prescription for Pennsylvania was introduced, the legislature finally enacted legislation to create a massage therapy board and legislation to permit physical therapy assistants to practice under indirect rather than direct supervision.

Prescription for Pennsylvania gave BPOA a higher profile and gave me the opportunity to push for legislation to increase our boards' authority to impose various disciplinary penalties. Our boards have the authority to impose fines up to a maximum of $1,000, which is merely a slap on the wrist for someone who is practicing without a license or is a repeat offender. We introduced legislation to increase the maximum fine to $10,000 and enable our boards to impose the cost of investigation on disciplined licensees.

Where are we now?

Now it is the responsibility of BPOA's boards to enact regulations to implement the scope of practice statutes granted in Prescription for Pennsylvania. We have been making good use of the committee process to draft regulations. Consumer and provider groups will have input.

Campbell: The "Asheville Project" in 1998 was not designed to provide evidence for the extension of scope of practice for pharmacists. Rather, it was a demonstration project intended to show that there is an economically feasible model of pharmacy practice geared not toward the moving of a commodity, but toward disease state management through close supervision of drug therapy in patients with chronic disease.

Pharmacists in Asheville entered into agreements with a number of self-insured employers who agreed to pay a per-patient fee to pharmacists to manage the drug therapy for employees with diabetes. Effective treatment of diabetes is complicated by poor adherence to treatment, including drug therapy. Pharmacists went to employers and said, give us a chance to show you that by engaging your employees through monitoring and coaching in how to more effectively manage their therapy, we will save you far more money than you will spend paying our fees.

The program was a total success, more so than even the pharmacists expected. The employers were interested in investigating how they could reduce health costs. The medical community and their patients were interested in improving care. After about ten months of this program, every objective data point showed a significant across-the-board improvement in diabetes patients. This was measured by such numbers as blood sugar levels and various co-morbidity issues. The amount of money employers saved was six to seven times as much in health care costs compared to what they paid pharmacists to engage in the diabetes coaching.

The program expanded to include a number of other chronic disease states that are similarly labor intensive for the patients and more expensive to treat if they are not managed properly. Two examples are asthma and hyperlipidemia. Not surprisingly, the results were the same as with diabetes management. The program was expanded to other cities and the data consistently showed that pharmacists who chose to focus on a model of practice focused on clinically oriented services rather than moving a commodity across the counter was not only clinically effective but also cost-effective.

The training for this sort of pharmacy practice model was more than adequate both from the standpoint of the amount of training pharmacists receive in their doctor of pharmacy education these days, but also from post-graduate training that many of the pharmacists in Asheville underwent to be sure they were equipped to deal with the different practice model.

The Asheville Project was also the precursor for what now is widely discussed in pharmacy as "medication therapy management" based on clinical services instead of "count, pour, lick, and stick." This wasn't a scope of practice issue because there was never any question that this type of drug therapy management was well within the definition of pharmacy practice. There were no objections from other practitioners that pharmacists were somehow overstepping their bounds.

All professions engage in turf fights. What kind of scope of practice issues are pharmacists trying to deal with? If pharmacy practice is going to move into a more clinically oriented health care profession – which is exactly what pharmacists are trained to do – there has to be some mechanism whereby the mechanical functions of the practice of pharmacy are delegated to appropriate paraprofessionals to free pharmacists to engage in those things for which they are trained in modern pharmacy curricula and which studies such as Asheville prove are most beneficial to the patient.

There remains a schism in pharmacy between the merchant aspects of what pharmacists do versus the health care provider notion of what pharmacists do. Those who focus on the mercantile practice of pharmacy and believe they will make money by pushing product resist the idea of delegating more to pharmacy technicians. However, others question how long the old model will be economically viable. Resistance to expanding the role of pharmacy technicians tends to be opinion-based rather than evidence-based.

In North Carolina, the Board of Pharmacy can waive enforcement of certain rules to allow a pilot project that the board believes is likely to show improvement in health care delivery to patients while not jeopardizing safety. Our board has been inching toward increasing the pharmacy technician role, for example, in hospitals where technicians who have additional training are allowed to do things such as cart-fill, and certain dispensing that is not directly supervised by the pharmacist. Our board is also supporting an initiative in the Winston Salem area in which hospitals and the county community college are putting together an associate degree in pharmacy technology. The goal is to create a higher trained class of technicians who will be able to take on expanded roles. Presently pharmacy technicians simply have to register with the board. The only training they receive is after that.

Finocchio: The California HealthCare Foundation is an independent philanthropy that works on improving the health care system in California through promoting greater transparency and accountability, improving clinical outcomes and quality of life for Californians with chronic disease, and reducing barriers to efficient, affordable health care for the underserved. We are both a think tank and grant-making organization.

Some of our recent work on regulation is stimulated by the following questions and ideas:

- How do we optimize the use of the health care workforce?
- How do we promote lower cost models of care?
- How do we expand access to affordable care?
- How do we bring transparency to public policy and promote regulatory innovation.

One of our projects has been to look at nurse practitioner scope of practice in California with two questions in mind: First, are we optimizing the use of nurse practitioners in California, and if we aren't how would we do so? Secondly, are there other models by which to help the legislature make decisions about scope of practice?

As you know, there is wide variability between nurse practitioner regulation from state to state. California laws put nurse practitioners in about the middle in terms of the following: physician involvement, physician supervision, physician collaboration, written practice protocol, authority to diagnose, explicit authority to order tests, authority to refer, solicit diagnosis, and so on. We made a taxonomy of how each state addresses such matters and put it on CHCF's and the University of California San Francisco Web sites.

The reason this is a public policy issue in California is that we have serious workforce shortages in rural areas. We also need to contain health care costs. We spend $7,000.00 per capita in the U.S. to provide services, which is about $1,500.00 more than other industrialized nations. In the interest of using the workforce differently to provide the same quality services more economically, we have recommended that nurse practitioners should move along the continuum of independent practice in California so that they can see more people in both underserved and urban areas.

The next paper we commissioned from the UCSF Center for the Health Professions looked at what other states are doing to help create a more empirical basis for making scope of practice decisions. We looked at the Minnesota Health Occupations Review Program, the New Mexico Scope of Practice Review Commission, the Iowa Scope of Practice Review Committee, and the Virginia Board of Health Professions which adjudicates scope of practice decisions across their thirteen boards. There was unsuccessful legislation in Texas to create a Standard Review Committee. In Ontario, there is a completely nonpartisan board composed entirely of public members which makes scope of practice decisions.

Several principles are shared by these various models. The legislature retains decision making authority, but the process includes the affected practitioners, the public, impartial health care practitioners, and health policy researchers. The process is intended to be efficient, credible, objective, and evidence-based.

What are some of the remaining questions? Who decides who is on a review committee? What guidelines would be used to review applications submitted for a changed scope of practice? What principles would guide the process? How would evidence be weighed?

We also asked UCSF to identify types of evidence that might be used for scope of practice decision making. There are educational curricula, accreditation standards, demonstration projects, research studies, controlled trials, the list goes on. It isn't that there is no evidence; the question is how you use it in a meaningful way.

Legislators and their staffs in California like the idea of improving the process, but aren't sure how to go about it. Resistance comes from the

professions themselves, even the professions interested in advancing their scope of practice. When we queried them later, they explained that they know the legislators and their staff. They know how they think and believe they have some control over the present process and could lose control if a new process is introduced.

The Heath Workforce Pilot Project Act was enacted in 1972 in response to workforce shortages. It allows studies of the potential expansions of professional scopes of practice to facilitate better access to health care, expand and encourage workforce development, test and evaluate new or expanded professional roles or new delivery alternatives, and to inform the legislature when it is considering changes to existing legislation in the business and professions code. Since 1972, there have been one hundred and seventy applications from a number of different professions and occupations. We think a good pilot would be to permit nurse practitioners to practice completely independently, study this, present the results to the legislature and ask them to consider a scope of practice change. Another pilot could permit physical therapists to refer and diagnose. Others could allow PAs to prescribe controlled substances, and paramedics to administer IVs. These are just four pilots we think could be advanced around improving access to services.

We funded a project a couple of weeks ago that will use this law for what we are calling a distance collaboration between dentists and community based dental professionals. Under the project, a hygienist and an assistant working in a community setting will provide and document services digitally and send the documentation to the dentist for review and, if necessary, a diagnosis. If there is a cavity, the hygienist would be allowed to do a temporary restoration and assistants would be allowed to do sealants. The whole idea is to take some part of dental practice into the community and provide as many services as possible to people who are home bound, in school, or otherwise unable to travel to a dentist's office.

Tuesday Luncheon Address Professionalism and Licensure: Friends or Antagonists?

David Leach, Retired CEO of the Accreditation Council for Graduate Medical Education

In this dynamic time for health care it is especially important to have a very healthy and highly functioning interface between the public and the various professions. The professions are struggling to be faithful to their values and also to effectively fulfill their missions in the face of daunting changes in context.

The poet James Stevens said, "Originality does not consist in saying what no one has ever said before, but in saying exactly what you think yourself." What does it mean to be a professional and how can society effectively regulate professionals?

I will share some of the lessons I have learned about fostering professional identity over thirty years of practice and teaching and ten years as the executive director and CEO of the Accreditation Council for Graduate Medical Education, which sets standards and accredits the nation's eight thousand residency programs. I am now retired and free to speak my mind and perhaps some of my observations will be of use to you.

I begin with a disturbing story. In May 2002, a wonderful sociologist named Parker Palmer facilitated a retreat for residency program directors who had received ACGME's Parker Palmer Courage to Teach Award. During the retreat a case was presented in which a liver transplant donor had died while in intensive care. He died despite the fact that the surgery had gone smoothly and despite the fact that his wife who was with him during the entire post-surgical period had insisted repeatedly and to

no avail that he was going downhill fast. Three months later, the state health commissioner issued an incident report saying, "The hospital allowed this patient to undergo a major, high-risk procedure and then left his post-operative care in the hands of an overburdened, mostly junior staff without appropriate supervision."

On the day the donor died, a first year surgical resident, three months into her residency and twelve days into her experience in the transplant unit, had been left alone to care for thirty-four patients. She could not and did not monitor every patient with the care and precision required.

I present this as a case of abandonment, which I think is a problem in many of our professions, especially in training programs. This may be an extreme example of abandonment of the patient, the patient's wife, the young resident, and really society at large. It brought to my mind a poem. It is said that poetry permits an intimate conversation with the world and this requires an intimate conversation.

This poem is by Rilke, who was born in 1875 in Prague and wrote poetry in German. Don't look at a picture of him; it will put you off. He looks like an effete aristocrat. His mother was crazy. She insisted that he wear dresses throughout his childhood. Although she was not Catholic herself, she raised him as Roman Catholic but took an extreme view and filled the house with statues and worshiping practices that made it impossible for Rilke to take religious seriously. Yet, he hungered for God and many of his poems confront both the need for and the impossibility of having a relationship with God. He, too, struggled with abandonment.

Rilke fell in love with a married Russian Countess. Rilke, the Countess and the Countess's husband would travel throughout Europe and Russia. One evening, he found himself in Trieste on the northeast corner of the Adriatic at Duino Castle. He walked along the roof of the castle on a very cold winter night and he wrote the first of the *Duino Elegies.*

> If I cried out, who would hear me up there among the angelic orders?
> And suppose one suddenly took me to his heart, I would shrivel. I couldn't survive against his greater existence.
>
> Oh, who can we turn to in this need? Not angels. Not people. And the cunning animals realize at once that we aren't especially at home in the deciphered world. What's left? Maybe some tree on a hillside, one that you see every day, and the perverse loyalty of some habit that pleased us and then moved in for good.
>
> Oh, and the night. The night when the wind, full of outer space, gnaws at our lifted faces, she'd wait for anyone.

Rilke has captured the sense of abandonment that the clinical case asks us to confront. I present this case not only as an example of abandonment, but also because it typifies the complexity of the system we are trying to regulate. Our regulatory system developed profession by profession, state by state, and, in my view, lacks the coherence needed to respond to and prevent events like this.

Licensure and professionalism are not antagonists. They are not yet friends, either. They are more like Pen Pals, friendly but living in different countries and speaking different languages. We need to do better.

William Stafford, an American poet, wrote these lines:

> I call it cruel, and perhaps the root of all cruelty, to know what occurs, but not recognize the fact.

We know what occurs, but we have not yet recognized it enough to fix it. We know that

we are in a different time – economically, politically, socially. Our system which was built slowly in an earlier time has not yet caught up. As we sort out what we need to do to be faithful to our values and effective in our missions, a few guiding principles may be helpful.

Dee Hock has the first guiding principle, which is:

> Substance is enduring, form is ephemeral. Preserve substance; modify form; know the difference.

Healthcare has and is undergoing chronic, rapid, and profound change in its forms and we are not always clear about its substance. When we fail to be clear about substance and form, we tend to resist changes in form and let substance dribble away unnoticed. I have modified Dee's comments to read, "Values are enduring. Rules are ephemeral. Preserve values. Modify rules. Know the difference."

Both licensure and professional self-regulation are grounded in values and have developed rules. As we try to improve the current system, it will serve us well to preserve those values and modify the rules. I am hopeful that our profession can survive and even thrive if we are clever enough to carry this mantra in our back pocket and use it to inform decisions.

Another set of guiding principles comes from Paul Bataldan of Dartmouth. He offers five themes that can be useful in our journey forward. The first is to focus on the basics. We have a problem in our regulatory system. We are each doing our own little piece of regulation and we do not, in my opinion, pay one fact sufficient attention, namely, that three things are inextricably linked – the quality of patient care, the quality of system performance, and the quality of health professional formation. For the latter, I am not limiting myself to young health professionals, but rather to any health professional working in health care.

If I give shabby care to a patient, my formation is made shabby by that encounter. If I give excellent care to a patient, my formation is made excellent by that encounter. If I function in a system that cannot reliably deliver high quality patient care, my growth as a professional is compromised. The piecemeal nature of our regulatory system makes it difficult to recognize this fact, even though we know it to be true. In Stafford's words, it is cruel.

Bataldan's second theme deals with waste. The larger health care system, and I would argue the regulatory system governing it, is laden with waste. I offer as exhibit A the several acronyms associated with regulation. They go on for page after page for each profession and state by state for licensure. Bataldan once had a visitor from Bosnia who asked, how can you spend this much on health care? Paul answered, "It's easy; just create enough categories." Each category has to have its own overhead.

Regulating the whole by regulating each piece is based on a machine model of organizations – a model that is outdated, expensive and dangerous. Waste could be reduced if we developed a common language and a set of operating principles that each organization can agree upon. Redundancy is not bad, per se, if it is exact redundancy, reinforcing redundancy, which exact language and exact expectations that are identical. What happens, though, is that we have similar aims and each is associated with similar but not exactly the same language and waste occurs as each regulatory agency's rules are met.

Bataldan's third theme involves the use of good science. In the case of regulators, I would consider this a call for us to learn from experience and to build knowledge about

regulation. Our various communities have tremendous experience in regulation and yet we lack a systematic method of learning from that experience. We tend to be formed and shaped by political processes - both licensure and professional organizations. Optimal functioning may be better served by using data and good management principles rather than votes.

The fourth theme is that good regulatory systems should enable change. Instead, I'm afraid, we inhibit it. An example from my own organization is that at any given time, about eight percent of the country's residency programs are in trouble with ACGME. Residency review committee members review these programs and encounter venal behavior. They then write a requirement to make sure that venal behavior is never repeated. Over fifty years, the residency review committees generate a lot of requirements. These requirements are imposed on all programs, including the ninety-two percent that are in good stead with us. Eventually, you get in a box where everybody has to look the same and innovation is inhibited.

Recently ACGME introduced an educational innovation project in which programs in especially good standing are relieved of as much as forty percent of our requirements and in exchange are asked to submit annual educational outcome data and are encouraged to modify and improve their programs. We need more examples of actually using a regulatory agency to foster innovation instead of dampening it.

Bataldan's fifth theme is that we should build community. New levels of cooperation are needed. We have to break out of our silos and move forward together for the common good. Too often regulation means protecting the profession's interest instead of protecting that of the patient or the public.

In addition to Dee Hock's adage to preserve substance and modify form, and Paul Bataldan's five points about what is needed, I would like to suggest another guiding principle: regulators should work with and not against human nature. All humans come equipped with three faculties which are naturally aligned with the goals of professionalism. These are the intellect, the will, and the imagination. The object of the intellect is truth. The object of the will is goodness, and the object of the imagination is beauty.

The job of good professionals and of good regulators boils down to discerning and telling the truth. Putting what is good for the patient or the public before what is good for the professionals and making judgments that harmonize in ways that are creative and sometimes even beautiful the particular needs of a situation with the generalizable scientific evidence at hand. This construct invites a new – or rather very old – framework for organizing experiences. How good a job did I do in discerning and telling the truth, in putting the patient's and the public's interests first, and in accommodating the particular realities of the situation in my judgments?

The current context in which health care and professional regulation occur does not make the task of fostering professionalism easy. Relentless pressures of time and economics, fragmentation of data and relationships, increasing calls for even more external regulation, exciting but disruptive new knowledge and technologies, and above all, the broken systems of health care dominate conversations and characterize the external environmental context.

The internal context of this system of care is also daunting. We lie regularly. Justifiable lack of trust pervades the system. Beth McGlynn estimates that only fifty-four percent of the time do patients receive care that is known to be best. A number that falls to two to three percent of the time when evidence based guidelines are considered. Yet, hospital Websites proudly boast that they provide the best care with the best doctors, the best

technology, etc. Some of these Web sites are so detached from acknowledging human suffering that they make it seem as though a hospital might be a fun place to visit. As a profession, we have tolerated that message, forgetting Hannah Arendt's adage that every time we make a promise, we should plan for the forgiveness we will need when that promise is broken.

The context of our work can be described in one word: frenzy. Fostering institutional as well as professional values requires that we be in regular contact with our inner wisdom. Frenzy makes that problematic. Thomas Merton has this to say about frenzy:

> There is a pervasive form of modern violence to which the idealist most easily succumbs. Activism and overwork, the rush and pressure of modern life are a form – perhaps the most common form – of its innate violence. To allow oneself to be carried away by a multitude of conflicting concerns, to surrender to too many demands, to commit oneself to too many projects, to want to help everyone and everything, is to succumb to violence. The frenzy of the activist neutralizes his or her work. It destroys the fruitfulness of his or her work because it kills the root of inner wisdom which makes the work fruitful.

This work will require that the regulatory community move from frenzy to wisdom. This is a very heavy task, which requires another poem, *The Journey*, by Mary Oliver:

> One day you finally knew what you had to do and began. Though the voices around you kept shouting their bad advice, though the whole house began to tumble and you felt the old tug at your ankles. Mend my life, each voice cried. But, you didn't stop. You knew what you had to do. Little by little, as you left their voices behind, the stars began to burn through sheets of clouds and there was a new voice which you slowly recognized as your own, that kept you company as you strode deeper and deeper into the world, determined to do the only thing you could do, determined to save the only life you could save.

I think when we find our inner voices, you can see things more clearly and it helps on the journey forward as you find your voice and recognize it as your own. In our journey to authenticity as a regulatory community, we must call institutions to account as we call ourselves to account. We must resist unprofessional institutional behavior, not because we hate our institutions, but because we love them too much to let them fall to their most degraded state.

Cultivating communities to discern and tell the truth to each other, to enable and facilitate altruism, to make good promises and to seek forgiveness and to harmoniously integrate our various systems of regulation depends on paying attention to small groups as well as individual formation. Otto Scharmer describes how we usually relate and has developed a social technology to foster healthier communities.

I am *me* in my internal world. Something arrives called *it* and I go to the extreme boundary of my own world and look at *it.* It could be scope of practice or workforce shortage. From my safe vantage point, I can look at it and return to my internal world. If we are going to get beyond that, I have to actually step out of my comfort zone and become interested in *you* and figure out what you think is going on and stop advocating and start inquiring. The next step is to let all the boundaries down, because if we sit with one another, respect one another, pay attention, we can discover the larger reality in a way that he would call "presencing."

The "I" and "me" behavior is habitual behavior. If I view scope of practice from a crack in my window, I engage in rational behavior. Then I go to relational behavior and finally authentic behavior. What we really need is an authentic regulatory community rather than one that is run by habit or one that is just rational, and even just relational. Cynicism and fear are barriers that prevent one from getting to authenticity.

The Greeks had two words for time: chronos and kairos. In chronos time, life comes at us and we process it. Occasionally one can have kairos time, which is depth or quality in time, so one doesn't know how much time has passed. When people join together and try to understand an emerging reality, it is possible to enter kairos time.

Scharmer feels that organizations function this way also. They can function within the organizational boundary, reenacting patterns from the past (an autistic organization). Or, they can function from the periphery and consider some exterior data (an adaptive organization). They can sometimes become interested in other organizations (a reflective organization). And, they can abandon organizational models and connect to reality across open boundaries (a generative organization).

Merton said we exhaust ourselves supporting our illusions. So, we have organizational habits that become idols that are illusions and we defend them. Letting all this go is a source of authenticity. We need to be generative if we are going to fix regulation in this country. Authentic conversations can lead to clarity and clarity can lead to courage.

Goethe said, "Once one commits, providence moves as well." And once we commit to rationalizing regulation of the health professions, others will come and help. Getting back to Rilke, even God's angels will help us succeed.

When I was a teacher, my favorite mantra was from Abba Felix: "To teach is to create a space in which obedience to truth is practiced." Teaching creates a space, claims the ability to discern the truth and the moral fiber to obey it. I have modified this thought:

To teach, or to learn, or to lead is to create a space, or to create a community, in which obedience to truth is practice. That's what you are doing here today. You have created such a community. Congratulations and thank you.

Session Seven – Public Members and Their Boards Relating to Constituencies

Ron Joseph, Principal Investigator for *Strengthening the Community's Voice on California's Health Care Licensing Boards*

Helen Savage, Associate State Director for AARP North Carolina

Joseph: The project we call "Strengthening the Community's Voice on California's Health Care Licensing Boards," as conceived by CAC, is about looking forward to what boards might be able to do in the future as they enter their next generation of effectiveness in representing and safeguarding the public.

The project begins with this question: Does public membership on professional licensing boards offer an opportunity for improved representation of the needs of multiple communities? "Multiple communities" replaces the term "public." The public is really made up of many diverse communities: seniors, immigrants, different cultures and languages, and so on.

The Strengthening the Community's Voice recognizes how influential public members are. It recognizes the broad influence the boards have over the way in which health care is delivered by licensed practitioners. We often think and speak in terms of the board's core

functions of licensure and enforcement. But, licensing boards actually deal with core public policy issues brought to you by the public, by the legislature, by policy makers who are looking to you for your input and wisdom.

Earlier, we heard about the legislation necessary to change scopes of practice. Boards influence and inform that legislation through their debates and discussions. Boards also have a responsibility for the promulgation of regulations that implement new laws. It is against this backdrop that we look at who the public members represent and where they come from. Do they come from diverse communities within the broad public? Do they represent the varied interests of the community that looks to the health care system to meet their needs? This goes to the heart of how a public board functions and how it serves the entire public. Why? Because when your board discusses public policy issues, it receives information typically from staff, from the profession, from the public members and occasionally from the public that comes forward to express an opinion about issues before the board.

With this background, CAC proposed working with the Center for Public Interest Law at the University of San Diego to conduct a study of opportunities to expand the representation to include a broad range of communities that may have needs that are not routinely represented before the boards. Consider your own experience. How often do diverse community groups come before you to express their need and interests and attempt the influence policy decisions?

In California, we have many diverse communities. Like the rest of the country, we have a growing senior population. The latest data shows that twenty-five percent of Californians are foreign-born. In the Los Angeles public school system alone, a hundred and ten languages are spoken. This diversity needs to be reflected in the way in which health care is delivered.

The first regulatory board in California was established in 1876. It was not until 1961 that the first public member was appointed to the Medical Board of California. It wasn't until the early nineties that there was more public membership. Among the seventeen health care boards, there is a majority of public members on two of the boards and an average of forty-four percent public membership.

So, we have numerous public member positions on our boards, which will enable an expansion of representation on those boards. I recognize that many of you come from boards with one or two public members and may not have the capacity to add public member representation. While that may make the outcome of our study not immediately transportable to your state or your board, certainly the considerations that go into this discussion – the review of community needs and how the communities of interest communicate with the board – are something you will still want to consider.

The project is funded by The California Endowment, which was founded in 1996, and is very active in the administration of grants and funding studies related to health care access. Their priority program areas are access to health services, culturally competent health systems, community health and elimination of health disparities. Given these priorities, our project is structured to focus primarily on communities that face barriers to health care access related to language and culture.

The project has the following vision: To evaluate the viability of a system in which community-based organizations recruit and nominate people to serve as public members to sit on health care licensing boards and commit to stay connected to those members throughout the term of their appointment to provide support to the public member and ensure a constant flow of communication to better inform the community about their rights and opportunities within the health care system. Information would flow from the community to

the board member so he or she could be an effective voice representing various communities during the public policy discussions by the board.

We went in with the expectation that we would get a positive response, but we are nevertheless impressed by the extent to which our concept has been embraced by the licensing boards, the appointing authorities and the community-based organizations. Still, some of the licensing boards cautioned that appointees need to be fully functioning members, not single-issue advocates.

Community organizations spend much of their time working with the legislature, but rarely, if ever, appear before licensing boards, even when boards are developing rules to implement legislation the community organizations have worked to have enacted. Many of them are aware of licensure boards but may not have the resources to regularly monitor them and attend meetings. Nevertheless, they expressed an interest and enthusiasm at the prospect of having a place at the table, particularly on a policy-making body as opposed to an advisory committee. They understand that their nominees cannot be single-issue candidates; that ultimately it would work against their interests if their nominees were not viewed as full participants in all of the board's responsibilities.

Under the grant, we are developing a primer that explains the function of professional licensing and regulatory boards and describes the issues California's seventeen health care boards expect to be addressing in the next few years. This document will enable community organizations to identify and inform prospective recruits and to track the issues before the boards to determine which are most compelling to them and where they wish to put their resources. We are also developing a training manual for public members and community organizations. The community-based organizations are very enthusiastic about having these two documents.

One of our accomplishments to date is to unveil a new way of looking at the public members' role as one of representing multiple communities to help inform debates, help influence discussion in directions that will more broadly reflect the needs of diverse communities which experience linguistic, cultural, geographic, and other barriers to access to quality affordable care. We have created a positive interest on the part of appointing authorities and many of the boards. We have energized community-based organizations around an opportunity to have a greater voice. We anticipate that interested community organizations may choose to form collaboratives or a consortium that will put forth candidates who are able to represent the interests of several demographic communities.

Shortly, we propose to hold regional meetings with community-based organizations to talk about how collaboratives might come together. We will then begin the process of identifying potential candidates and providing the training that will make them as effective as possible as early in their term as possible.

Savage: I am here today to share with you an example of a way that AARP has interacted with the regulatory process. I hope that you will glean from this some ideas for how your board might relate to the public.

My impression is that the boards are waiting for people to knock on their doors and ask to be included. Meanwhile, the public is sitting on the sidelines and hoping that the boards will tell them when something important comes up. So, there is a disconnect about who will take the initiative.

A few months ago, I received a call from Jean Fisher-Brinkley who now works for the North Carolina medical board. I had worked with her on many health issues in her previous job as a reporter. She called to tell me that the medical board was considering rules she thought might be important to AARP's constituency. The

proposal was to post on the Web site the malpractice histories of licensees. She asked if AARP might want to write a letter, or if I might want to testify on the proposal.

The board knew it was a controversial proposal. They had done some public opinion polling to see if people cared about having access to this information. AARP has a data base of about fifty thousand people who tell us they want information from us about what is going on politically, alerts about frauds and scams, new publications, and so on. They want this information electronically. I asked the people who manage the data base to include an article about the proposed regulations. From this source, the board received some feedback from consumers.

I contacted colleagues in other organizations who work on health issues to see if they were interested in the proposal. I found that these organizations have little or no relationship with the medical board. I realize that my personal relationship with the board is not really with the board, but is because I now know someone who works there.

I think that many boards are in exactly this same position; they have a relationship with citizen groups when there is a crisis or scandal, or they know the groups related to the public members on their board. So, the groups I contacted told me they are working on retaining Medicaid benefits, health care reform, and other such issues. They told me if AARP is going to testify, they don't have to.

The day of the hearing, the room was packed. I could tell from side conversations that most people were there because they hate the proposal. AARP was the only group that testified as an organization in support of the regulations. There were some aggrieved consumers who told stories of obtaining care that resulted in a bad outcome and wished they'd had access to malpractice histories ahead of time. There were two plaintiff's attorneys who testified in favor.

It wasn't an unusual situation for a consumer advocate to be in, but neither was it a comfortable one. I felt as if I were in a foreign land and wished there had been more allies to speak to the issue. Sometimes an experience like this discourages members of the public from becoming engaged in these issues.

I have heard comments at this meeting that boards have difficulty finding the right people to serve as the public members. I know this is a challenge. The landscape for consumer advocacy as I know it has changed in recent decades. Even in this state, we no longer have a group called a consumer council. However, when I think about groups with which boards share common cause, the list is pretty long. For example, AARP, the Older Women's League, the Coalition on Aging, and Friends of Residents in Long-Term Care all have an interest in what you do. After this meeting, I know I plan to follow up with many boards in North Carolina to find out what they are doing and what they plan to do in the future about quality of care.

The Carolina Center for Medical Excellence has an advisory council made up of consumers. This entity, or a similar one in your state, may be a source for public input into boards' discussions. Every county has a local Council on Aging which is involved with every service paid for under the Older American's Act. They have a community advisory board which is an important source of community participation on things relevant to aging.

I haven't even touched on the network of organizations working to be sure that the needs of people with disabilities are addressed. They are planning similar kinds of training for their members and part of it includes advocacy on issues relevant to health regulatory boards.

As I think of a "ToDo" list, I have three entries. First, for public members, I think you should identify the constituency you represent and interact with it. If my friends and colleagues aren't asking me what I am working on these

days, I know that I am not communicating and connecting enough with people. Part of your role as a public member is to be accountable to your constituency and let them know what your board is working on.

Second boards have an obligation to support the public members, to make sure they have the training, the mentoring, and the other things they need to do the job well. I challenge boards to cultivate the public's involvement as aggressively as you cultivate the involvement of the regulated professionals and their trade associations.

Third, consumer and advocacy groups need to think about how to recreate the environment we used to have where we offered an opportunity for public members to get together occasionally and have a support system to think about their role and brainstorm issues.

Comment from the Floor: From the perspective of the North Carolina medical board, it was great to have Helen at the hearing speaking effectively in favor of our proposal. I think the board members who were there paid the most attention to what the relatively few consumer representatives said. We have twelve members on our board, three of whom are public members. Until recently, we had difficulty finding public members, partly because of the time commitment. The Boards and Commissions office was overwhelmed and couldn't spend much time locating and recruiting public members. However, the staff and the board are interested in having good, strong public members recognized statewide as consumer advocates who would enhance the credibility of the board. My question is, is it appropriate for medical board members and staff to become actively involved in identifying and recruiting public members for their board?

Joseph: Some might say that you have a vested interest in the outcome and shouldn't be engineering who gets appointed to the board. However, I don't think this should interfere with your outreach to potential sources of board members, such as AARP or community-based or consumer organizations, to let them know of the board's interest and of the importance of participating in board activities.

One thing about licensing boards is that participation doesn't cost anything. In fact, some boards pay a per diem in addition to expenses. So it does not cost a community-based organization any resources.

Savage: I think it is absolutely acceptable for boards to recruit. You know much better than the governor's assistants what you are looking for. I urge you to reach out to groups such as AARP. We are always interested in finding interesting assignments for volunteers. It is important to pay expenses.

Comment from the Floor: I'm a public member of the medical board. I have gone to speak to various community groups, public housing residents, and long-term care facility residents to educate them about what a medical board does.

Comment from the Floor: It seems to me that as we listen to the diverse needs of the boards represented in this room, think about the range of skills needed by these boards; think about how we keep track of people with the qualifications to be board members. Shouldn't CAC be keeping a data base of potential board members?

Comment from the Floor: My suggestion is to submit names of good qualified people to your governor's office. Retired people are ideal because they have the time and many times they embrace the opportunity to be occupied after retirement.

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)