News & Views

Citizen Advocacy Center

First Quarter, 2009 A Health Care Public Policy Forum Volume 21 Number 1

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, and for a membership enrollment form, please see pages 33 – 34 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 www.cacenter.org/cac/meetings.*

SCOPE OF PRACTICE

Minnesota Legislature Considers Oral Health Practitioner License

In 2008, the Minnesota Legislature passed legislation establishing a new oral health practitioner discipline to practice under a dentist's supervision and to be licensed by the Board of Dentistry. The legislation also created a work group to advise the commissioner of health and the legislature on the training requirements and practice details for oral health practitioners. The 13-member work group was composed of dentists and dental hygienists practicing with varied populations and in a variety of demographic settings, educators, and representatives of the commissioner of health and commissioner of human services.

On January 15, the Department of Health and Board of Dentistry submitted to the legislature oral health practitioner recommendations based on the outcome of the work group's eight meetings. The work group considered ten issues identified by the legislature and developed "recommendations and proposed legislation (using) evidence-based strategies to

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address the issues to improve access for Minnesotans who are low income, uninsured and underserved; control the cost of education and dental services; preserve quality of care; and protect patients from harm."

The work group had difficulty reaching consensus on some issues, particularly those related to scope of practice and supervision. Some of those recommendations were determined by majority vote. The executive summary of the report explains that:

> The 2008 legislation directs the work group to recommend the scope of practice, level of supervision, medications that may be prescribed, administered and dispensed, and extractions that may be performed by oral health practitioners, under the auspices of a collaborative management agreement.
>
> The Board of Dentistry developed a list of potential procedures that might be performed by oral health practitioners under a collaborative practice agreement with a supervising dentist. Following unsuccessful efforts to reach consensus, work group members reached decisions by voting on procedures to be included in the scope of practice and minimum levels of supervision required. Majority vote resulted in the inclusion of 52 procedures under general supervision; one under indirect supervision; one with supervision level undetermined by the work group; and two procedures excluded from the scope of practice. Work group members also identified perceived benefits and risks for scope of practice decisions….and created a list of recommended elements to be included in collaborative management agreements.

In general terms, one or more members of the work group identified eleven significant benefits from the proposed scope of practice, seven significant risks, and three additional concerns that support indirect or direct levels of supervision.

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NOTICE

The perceived benefits include:

- A lack of documented safety or quality problems of oral health practitioners in over 50 countries;
- Providing access to an array of needed services in community settings, rural communities, areas where no dentist is available, and in non-traditional settings, such as Head Start, institutions, reservations, and remote areas;
- Freeing up a dentist's time to practice "at the top of their license;"
- Improving general access to dental care and making access more convenient, especially in urgent cases;
- Enhancing system capacity, cost performance, and disease management;
- Avoiding complications resulting from no dental care.

The perceived risks or downsides include:

- Costs to the educational system;
- A risk of improper diagnosis, complications resulting from performing procedures without a diagnosis (which is perceived to be the exclusive purview of a dentist);
- Potential inability to properly train oral health practitioners;
- Complexity of patient needs and concerns about follow-up and referrals.

Additional concerns include:

- Consider deferring initially to a more conservative level of supervision and move to expanded supervision in the future if the experience so warrants;
- Training students to operate under general supervision requires more intensive education and places greater requirements on the educational system;
- Allowing extractions under general supervision may create a potential safety risk.

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In addition, the report identifies perceived benefits and risks associated with each specific procedure permitted under the recommended scope of practice. As to licensure and regulatory requirements, the report states that:

> The work group determined that licensure requirements for the oral health practitioner will parallel established standards for other regulated dental professions. The oral health practitioner will also be subject to the statutes and rules related to the practice

> of dentistry, and may be disciplined by the board for noncompliance with those requirements and standards established for health care professionals.

The Minnesota legislature began considering legislation sponsored by Rep. Kim Norton of Rochester in February 2009. If it is approved, the first class of oral health practitioners would enter the University of Minnesota's School of Dentistry in the fall.

Editorial Note: CAC is pleased to see a fairly wide variety of interests represented on the 13-person work group, including representatives of the Departments of Health and Human Services. However, we are disappointed that there were no public members to represent the perspective of consumers of dental services, particularly those in the targeted populations where oral health care practitioners will be working.

The draft legislation and full work group report, including rationales for majority and dissenting votes related to scope of practice and supervision can be found at www.health.state.mn.us/healthreform/oralhealth/index.html.

Physicians Provide Dental Care

According to a publication entitled ***The Role of Physicians in Children's Oral Health***, issued in December, 2008 but the National Academy for State Health Policy, twenty-five state Medicaid programs reimburse physicians for performing basic preventive oral health care on children during routine office visits. The extent of services varies from state to state. Most common is application of fluoride varnish to prevent cavities. Some states also reimburse for additional services such as risk assessments, oral exams, and general guidance on dental care. "By encouraging the dental and medical communities to share responsibility for children's oral health," the publication says, "policy makers hope to decrease the startling rate of caries in low-income children, who disproportionately bear the burden of dental disease."

Despite the fact that Medicaid covers dental care for young children, only a fourth of them see a dentist no later than age one, by which time cavity risk can already be established. Low-income children are five times more likely to have cavities than are children from more wealthy families.

Describing the benefits of adding preventive oral health care to the scope of practice of physicians, nurse practitioners, and physician assistants, the report observes that "Physicians can play a key role in combating dental disease:"

> The early and frequent contact that most young children typically have with physicians presents a unique opportunity to evaluate their oral condition and perform basic preventive services. The American Academy of Pediatrics' Bright Futures guidelines recommend that children see a physician eleven times by age two. Since many children have not seen a dentist by this age, the timing and frequency of physician's checkups provide great opportunities to assess the health of a child's mouth, provide appropriate preventive dental services, such as oral examinations and fluoride varnish, and screen children for referrals to dentists when disease is identified. One study found that physicians trained to identify the signs of dental disease where ninety-three percent accurate in identifying young children with disease and referring them to a dental care provider. Some states also reimburse nurse practitioners and physician's assistants for performing these services, further expanding the

pool of providers available to deliver preventive dental services to young children.

For more information, see* The Role of Physicians in Children's Oral Health *which can be found at www.nashp.org

Washington State's Group Health Cooperative is collaborating with Washington Dental Service and the Washington Dental Service Foundation in a three-year pilot program to train pediatricians and family physicians to provide dental disease prevention services during well-child visits. Physicians and other clinicians will be trained to conduct oral health exams and perform basic preventive services, such as applying fluoride varnish which can prevent or retard decay. Group Health Cooperative supplies parents with oral health tips and referral information as well as a customized summary based on the visit.

Preliminary evaluation of the pilot has been positive, although there is variation in performance from one delivery setting to another. It is anticipated that these variations can be eliminated and that delivery of dental services will be expanded throughout Group Health's medical centers.

For more information, visit www.ahiphiwire.org/News/Print.aspx?channel=Dental&doc_id=232694&utm_source=1%2f16%2f2009&utm_medium=email&utm_campaign=HiWire_Newsletter&uid=TRACK_USER

"Doctor Nurses" Certified by National Board of Medical Examiners

Katherine Mangan wrote in the January 16, 2009, issue of the ***Chronicle of Higher Education*** (www.chronicle.com) about the growing phenomenon of doctoral-level nursing practice. Her article, "A New Degree and Exam Create 'Doctor Nurses,' Irking Physicians," explores several controversies associated with this new practice level, including opposition by the medical establishment based on a concern that patients will believe care delivered by doctoral level nurses could in any way be comparable to care delivered by a physician. Moreover, the American Academy of Family Physicians is annoyed with the National Board of Medical Examiners for developing a certification examination for PhD nurses which is based on a portion of the medical licensing exam that tests how well applicants apply knowledge to patient scenarios.

Nursing certification bodies are also upset with NBME on the grounds that there are already numerous nursing certification organizations that assess and certify nurses in multiple areas of practice. They feel there is no need for a medical credentialing organization to become involved in certifying nurses.

In defense of its examination, NBME posted the following announcement and links on its Web site (www.nbme.org):

> **NBME Development of a Certifying Examination for Doctors of Nursing Practice**
>
> The NBME announced in March 2008 that it had entered into a contractual agreement with the Council for the Advancement of Comprehensive Care (CACC) to develop a certification examination for qualified graduates of Doctor of Nursing Practice (DNP) programs across the United States. The certification examination will assess the knowledge and skills necessary for nurse clinicians to provide safe and effective patient-centered comprehensive care. An article describing NBME services in development of this examination appeared in the spring/summer edition of NBME's newsletter, the *NBME Examiner*, available at www.nbme.org/publications/index.html

The NBME board of directors, the Executive Board, has supported NBME's efforts to collaborate in the development of the DNP certification examination and has approved a white paper describing its rationale for providing these services. The paper, "NBME Development of a Certifying Examination for Doctors of Nursing Practice," is available at www.nbme.org/PDF/NBME-Development-of-DNP-Cert-Exam.PDF

The long-range plan of the American Association of Colleges of Nursing calls for the Doctoral degree to replace the Masters degree as the standard for advanced practice nurses by 2015. Other professions, including pharmacy and psychology have also transitioned to doctoral degrees as the entry level.

Midwifery Practice Expands in Wyoming and North Carolina; in Jeopardy in Kansas

The Wyoming Senate approved a bill in February 2009 that would create a board of midwifery in the state. Previously, only certified nurse midwives have been permitted to attend home births. The new legislation would allow professional midwives who have graduated from certified midwifery schools and passed the North American Registry of Midwifery examination also to perform home births.

A legislative study committee in North Carolina has recommended that that state also license certified professional midwives. The study group concluded that a system limiting this practice to certified nurse midwives is insufficient to meeting the needs of North Carolinians wishing to deliver at home, particularly those in rural areas where there is a limited supply of obstetricians and certified nurse midwives. The American College of Obstetricians and Gynecologists and the North Carolina Medical Society have both come out in opposition to licensure of certified professional midwives, arguing that this would lower the standard of care.

Meanwhile in Kansas, midwifery confronts a possible step backward. On February 5, 2009, Virginia Young, staff writer for the ***Saint Louis Post Dispatch*** reported that Representative Mike Talboy of Kansas City introduced legislation to repeal a provision of a 2007 health insurance bill which permits people who hold a ministerial or tocological certification by an organization accredited by the National Commission for Certifying Agencies to perform obstetrical services. The effect is to authorize practice by lay or "direct entry" midwives as well as midwives who also hold certain specialty nursing credentials.

Talboy's initiative could reawaken a longstanding tug of war in Kansas between midwives and the medical profession, which contends that all midwives should be regulated by the Board of Health Arts which is dominated by doctors.

Nurse Comments on AMA Opposition to Scope of Practice Expansion for Midwives

The following item appeared in a March 11, 2009, blog called nursingbirth at www.nursingbirth.wordpress.com/2009/03/11. Its author is not identified. Rather, it is called "one labor and delivery nurse's view from the inside." The Blog entry is entitled, **The Scope of Practice for Midwifery in America (or, Why Physicians Are Shaking in Their Boots).** ***In the interest of full disclosure, Len Finocchio, who is quoted at the end of the Blog, is a member of CAC's Board of Directors.***

I recently read an article published on amednews.com (a publication of the American Medical Association) entitled *Scope of practice expansions fuel legal*

battles (www.ama-assn.org/amednews/2009/03/09/prl20309.htm) by Amy Lynn Sorrel. The article reports on the increasing number of physicians and professional medical associations bringing forth court cases against state boards of health on what they refer to as "scope of practice expansions" by a growing number of health care professionals. Two examples of this phenomenon that are highlighted in the article include the right of nurse anesthetists to provide interventional pain management services to their patients and the right of certified professional midwives to practice independently (as was passed in the State of Missouri in 2007). If you have 10 minutes, the article is pretty short can be found at the link above.

This article immediately caught my eye as the main initiative behind these recent physician led court cases happens to be one of the greatest hurdles that both Direct-Entry Midwives and Certified Nurse Midwives find themselves trying to overcome in many states around this country every day. This hurdle is played out in a battle waged by physicians to protect their own interests (including the "business" of medicine) by fighting to legally prevent other health care professionals from their right to practice independently and within their scope of practice.

Attorney Timothy Miller, the Federation of State Medical Boards' senior director of government relations and policy, states in the article that, "There is this overall push by allied health professionals to try to increase their scope of practice, and what's landing people in the courts is when they actually meander outside of their scope into areas considered the practice of medicine." What is particularly frustrating about this statement is that throughout the relatively brief history of modern medicine, it is *physicians* who have defined the "scope of medicine" which really is just a fancy term for "anything that physicians want complete monopolized control over". Talk about job security…if you lobby for legislation to make it illegal for any other healthcare professional to perform any service that *you* perform as a physician, then every consumer by default has to come to *you* to receive the service… *Cha Ching*!

Author Sorrel continues by stating the physicians' side of the story, which is that "in many cases physicians warn that allied professionals are overstepping their bounds without appropriate medical expertise," and AMA Board of Trustees Chair Joseph M. Heyman, MD states "Non-physician health care providers serve a vital role on a physician-led health care delivery team but [scope of practice expansions] put patients at risk." Not only do these statements skew the facts, but they promote a gross misconception of what these healthcare professionals are actually fighting for.

In **truth** these allied health professionals are fighting to gain legal support for what they feel they ARE appropriately educated to do and are not just trying to "skip medical school"! In regards to the fight for the legalization and independent practice of both Direct-Entry and Certified Nurse Midwives, these professions aren't just fighting for legal support to perform services they have the education, expertise, and authority to do as well and as safe as physicians, they are fighting for the legal support to perform services they have the education, expertise, and authority *research has proven* they do BETTER and SAFER that physicians

(i.e. attending the prenatal care and normal vaginal deliveries of low risk, healthy pregnant women in any venue they see appropriate, including the home, out of hospital birthing center, and hospital.)

Furthermore calling allied health providers part of "physician-led" health care delivery teams automatically puts them in a subordinate role which is an antiquated and borderline offensive school of thought. More appropriately, research has found that patients get the best results, both in and out of the hospital, when cared for by an interdisciplinary health care team that combines the expertise and experience of many health care professionals (including nursing, nutrition, physical therapy, complimentary medicine, management, pharmacy, etc.) to attain a more holistic delivery of care. The physician might be the one writing the final "orders," but the best patient outcomes are obtained when all member of the team are considered to be professional "equals."

Len Finocchio, DrPH, a senior program officer at the California Health Care Foundation states, "These battles are not going away, and the challenge for professions is to accept that we are going to have overlapping scopes in some practices." He states, "We should be using every resource to its optimum to provide health care to everyone possible at the lowest cost possible. And it boils down to: If a professional can demonstrate they have the judgment, competence and skill to provide certain services, they should be able to do that."

And in today's world with today's economy, who in their right mind can argue with that!?

IN-DEPTH

Annual Ben Shimberg Memorial Lecture: *Moving Regulation into the 21st Century*

Delivered by Shimberg Public Service Award Recipient, Polly Johnson, Executive Director, North Carolina Board of Nursing (retired), October 27, 2008

I am indeed humbled to be recognized as the 2008 recipient of the Ben Shimberg Public Service Award. It is also quite an honor to be in the same company as the previous recipients of this award. I well remember one of the first times I read an editorial written by Ben in a CLEAR publication in the early '90s. His comments on the purpose of regulation resonated with me as I struggled with the direction I thought regulation should be going and the realities of where it was at that time. I also remember not only his presence at many of the CAC meetings I attended in the early years of my career in regulation but the genuine respect that he was afforded by all those in his presence. As many will affirm, Ben was not only a wise man for his time but his wisdom and vision for regulation extended well beyond "his time" in our evolving regulatory journey.

Tonight I would like to reflect a bit on our past history of regulation, consider the role of regulation in the present and future context of our fast-paced and interconnected world of the 21st Century; and share some of my beliefs about transforming regulation if we want it to remain an important element of consumer protection in this new age. I will assume that all of us here tonight believe there is an important role for health professions regulation. Given the current economic crisis that began in this country and now expands the globe, the role of governmental regulation is a "hot political topic" on the minds of many Americans in these final days before our 2008

state and national elections. During this unsettling economic time, we are being reminded that regulation attempts to provide safeguards when there is potential (or sufficient) risk involved in the services being provided. As defined by *Schmitt and Schimberg in 1996* and quite applicable to both the financial world as well as that of healthcare*:*

"The Heart of Regulation is to:

- Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners (and practices);
- Offer some assurance that the regulated individual (or organization) is competent to provide certain service in a safe and effective manner; and
- Provide a means by which individuals (or organizations) who fail to comply with the profession's standards can be disciplined, including revocation of their licenses."

As we move forward in regulation, it is helpful to be mindful of our past…

As a quick review of health professions' regulatory history, the "modern" framework for regulating health professions began post Civil War and continued into the early 20th Century at a time of limited transportation when travel across many states as well as state to state took days or even weeks.. Few communication networks existed, other than the postal system, the newspaper, other printed information and word of mouth. In rural and small town settings as well as in the neighborhoods of large cities, people tended to know everyone they had to deal with in their everyday lives. Some of us here may even remember when "credit" was granted informally by the merchant according to the customer's character rather than through mega financial institutions. (In fact some of us might like to see the re-emergence of this old model in this current period of financial instability!) But to go back to that earlier time, the automobile, the radio and telephone were having their debut and life was beginning to change. The concept of regulation evolved with the development of a complex, more urban world where goods and services were provided to the consumer by a variety of, and often unknown individuals.

Our early laws were primarily registration acts that outlined the criteria necessary for one to become registered or be licensed as a health professional; for some this included licensure examinations written by the board members.

Nursing regulation began in 1903 with registration acts; it expanded to include the establishment of statewide standards for education programs between the 1920s – 1940s, moved from permissive to mandatory licensure as well as national licensure examinations by the end of the 1950s. For the next 20 to 30 years we focused on defining, refining and expanding the scope(s) of nursing practice based on educational preparation as well as more clearly articulating both the criteria and processes for disciplinary actions by boards. During these years there was continual advancement in medical knowledge and improvements in the delivery of care but the pace was not such that one was in a constant struggle to keep up with the changes.

But in the 1980s, the delivery of healthcare began to change dramatically with the explosion of information and medical technologies. These new technologies became the underpinnings of the fast-paced world we now live in. By the late 1990s we were finding ourselves challenged with trying to figure out how to provide for consumer protection and patient safety in a new age of "hi tech", connectivity, real time communication, mobility, consumer choice, distance learning, telehealth, and globalization – to name a few – while still using a regulatory framework that had been created in a very different time in our history.

Over the past 15 years, much attention has been given to consumer protection and patient safety in this country. In 1995 and then again in 1998, the Pew Health Professions Commission issued major reports on policy considerations for reforming Health Care Workforce Regulation to strengthen consumer protection in the 21st century. Our own David Swankin was a member of the Pew Commission Taskforce that challenged us to envision future workforce regulation as "**S.A.F.E. –** that is

> **Standardized** where appropriate; {especially national core licensure standards and scopes of practice};
>
> **Accountable** to the public; rather than to the profession
>
> **Flexible** to support optimal access to a safe and competent health care workforce; and
>
> **Effective and Efficient** in protecting and promoting the public's health, safety, and welfare".

Next came the hallmark IOM Report "To Err is Human" in late 1999 that not only got the attention of health care practitioners but shocked the public at large about the realities of healthcare in this country. And in 2001, the IOM Committee on the Quality of Health Care in America laid out the fundamental changes needed for a quality health care system in the 21st Century in their second report "Crossing the Quality Chasm". Art Levin, a CAC Board member, was on that committee. Thanks to the work of these and other leaders in healthcare reform, regulatory bodies have been challenged to carefully rethink how we do our business of public protection.

As for my history in regulation, I started my journey toward regulatory excellence when I stepped into the role of Practice Consultant with the North Carolina Board of Nursing in 1988. At a time when the only reasons for Board staff to step into the "real" world of health care were to investigate complaints or review and approve educational programs. I found myself with an exciting, enabling, and proactive opportunity – to help nurses, their coworkers, employers and other regulators better understand the legally-defined scope of nursing practice and the responsibilities that each nurse has for providing safe, effective care in an ever-changing and increasingly complex health care delivery environment. I could only do that work within the context of the various settings in which care was being provided so I made visits to nursing homes, hospitals, ambulatory surgical centers, cardiac cath labs, public schools, prisons, day care centers etc. to better understand the clinical and environmental resources or barriers to the delivery of safe, effective care in the "real" world of healthcare.

Early in my regulatory career, I recognized that such a "consultant" role was not seen as the "norm" for a regulatory body that spent the majority of its resources on licensing and discipline-related activities. But through all my years in regulation, I have been committed to the Board's being a proactive partner in assuring the delivery of safe patient care for all of our citizens. Doing the right thing for public protection requires regulatory bodies to partner with professional associations, credentialing bodies, providers, other healthcare related organizations, and the public in new ways if we wish to be a key player in the overall patient safety movement and contribute positively to the health of our citizens in the 21st Century. Gone are the days when meaningful work can be done in organizational silos. The issues are too complex, and no one group has the only "right" answer or "right" set of answers!
As we think about our consumer protection history, most of us would agree that the evolution of regulation has been primarily reactive in nature. We get involved "after something has happened". This is basically the modus operandi for our society, from families to all sizes of organizations and governing bodies. We generally set down rules or restrictions… …after something has happened.

Discipline is primarily "an after the fact" activity. As part of our public protection responsibilities, regulatory bodies will always be involved in reactive disciplinary activities, to remove individuals from practice who are unfit to provide safe care because of professional misconduct or reckless behavior. However, I believe we must envision our role of assuring the delivery of safe, effective care in a much broader, collaborative and proactive framework. National organizations, including the IOM, NPSF, NQF and IHI are leading the way in cross-system and cross-disciplinary efforts to create safer healthcare delivery systems. CAC's model for practitioner remediation and practice enhancement put forth in 2000 provided health professions regulatory boards one framework for becoming more collaborative and proactive in our efforts to assure the delivery of safe, effective patient care.

We all know that the number of complaints related to practitioner competence and judgment in the delivery of care, i.e. "practice or quality of care issues not related to personal misconduct", have significantly increased in the past 15+ years. How should our regulatory bodies manage these complaints in a manner that improves the delivery of safe care to the public? Does taking one out of practice truly enhance safety or is it more of an immediate reaction "to do something"? Are we primarily reacting to a bad or potentially bad outcome and if so – what and how does the practitioner learn from this experience? How does the system improve? Given my core belief in the inherent dignity and worth of every human being, I believe we as regulatory bodies must take up the challenge to move beyond our reactive system of discipline, which is primarily punitive in nature, and create a proactive framework that focuses on learning and competence enhancement as the route to improving the quality of our outcomes and the delivery of safe, effective healthcare in this country. As we know, "to err is human". In fact it is predictable and measurable. But, as humans, we can all learn from our errors in judgment especially when we do that within an environment that supports learning and quality improvement.

Through the development of a strong working relationship with providers and nurse leaders, in 2001, the Board of Nursing was able to successfully launch our version of the CAC-envisioned Practitioner Remediation and Enhancement Partnership (PREP 4 Patient Safety) project – to work with nurses who have provided unsafe care due to deficits in their knowledge, skills and judgments, and with their employers through non-punitive, non-public practice improvement plans that provide the nurse the opportunity to improve his/her competencies while remaining in the workplace. In 2004, we expanded that program to all licensees and work settings based on the very positive feedback of the nursing and healthcare community. Now it is an integral part of the Board's regulatory activities.

As you have heard today, there is exciting work going on across our country to build a more "***Just Culture"*** within the healthcare delivery environment to help us move from a culture of blame and shame to one of accountability and quality improvement. Building such a culture requires collaboration among providers, health professionals and regulators (of licensees, delivery systems, and reimbursement systems) to analyze the cause (or causes) of adverse events and near misses in a predictable and systematic manner. This framework focuses on the behavioral choice of the practitioner in an attempt to answer the following: Was it simply a human error? If not, what degree of risk-taking occurred and why? Was the risk-taking unintentional or intentional? Did the practitioner deliberately disregard a substantial risk? Once the cause(s) is determined, then accountability (individual and/or system) is assigned and an appropriate action plan implemented to prevent a future occurrence.

You have already heard about the North Carolina Board of Nursing's partnership with the North Carolina Center for Hospital Quality

and Patient Safety to support Just Culture Collaboratives with hospitals in our state. Equally important, the Board of Nursing is using these tools to evaluate complaints received and formulate action plans based on that evaluation. The appropriate action may occur at the employer/system level, in combination with both employer and regulator, or primarily at the regulatory level – particularly if the cause is reckless behavior.

I am proud of the new pathways the North Carolina Board of Nursing has been forging with its internal complaint review and action processes as well as with our provider community in an effort to shift the fabric of our healthcare environment from a no-win culture of blame and shame to the win-win patient safety culture of quality improvement, learning and competence enhancement.

To further this work, The North Carolina Foundation for Nursing Excellence, created by the our Board of Nursing in 2002 to enhance the practice of nursing in our state through leadership development, research and demonstration projects, has begun to implement an action plan to create a Just Culture Healthcare Community statewide within the next five years. We have introduced this concept to other health professions regulatory boards as well as to those governmental agencies that license healthcare facilities, and begun working with key members of the long-term care community to implement this learning and accountability model. Our ultimate goal is to build a consistent (and predictable) approach to evaluating adverse actions at the provider as well as regulatory levels. We must also introduce this concept into health professions education as well as begin educating the public to this new paradigm if we wish to be successful in moving to a more "just" culture of learning, accountability and quality improvement. I am very excited with the commitment of our healthcare leaders in North Carolina to work collaboratively to enhance the delivery of safe care through a system that more objectively evaluates the reasons why a bad outcome occurred and implements a plan to improve the quality of care we provide – both by the individual practitioner as well as at the systems level. Health professions regulators are critical to the success of this paradigm shift!

As I reflect on what regulation looked like in the late 80s and where we are today, I believe we have come a long way in better positioning ourselves as key players in the delivery of safe, effective care in the future. Back then, regulation (at least in nursing) focused mainly on licensing, disciplining, approving education programs, monitoring the licensure examination process, and providing guidance related to scope of practice and the performance of new tasks as hi-tech emerged into the healthcare arena. We were basically reactive and opinion-based in many of our decision-making processes and functioned entirely within a single-state regulatory model.

Health professionals now practice in knowledge-driven, hi-tech, hi-touch and interconnected environment that demands competency in the areas of working in interdisciplinary teams to deliver evidence-based care, use of informatics, practicing within a quality improvement framework with the mandate to deliver safe, effective patient-centered care. These core competencies, first laid out by the IOM, must be integrated into educational preparation and ongoing competence development of our current and future healthcare providers. We know that new information expands at such a fast rate that half of what is useful today will be considered obsolete within the next 3 – 5 years. Knowing how to access the most current, applicable and reliable information to support one's practice is a daily challenge for all health professionals. Because of the demands of delivering care in this fast-paced, complex healthcare environment, all practitioners must be involved in continuous learning in order to maintain as well as enhance our competencies.

Until recently, the North Carolina Board of Nursing had no requirements for showing evidence of continuing competence at the time of licensure renewal which certainly did not reflect congruence with the ever-changing healthcare environment. After more than 4 years of collaborative work with our professional and public colleagues, the board implemented a reflective practice model for assuring that all licensees engage in learning activities to support either maintenance or enhancement of their competencies.

However, we know this is just the beginning of our journey to better assure the competence of licensees over the lifetime of their practice. The Citizen Advocacy Center and other leaders in consumer protection are challenging licensure bodies to move aggressively toward more objective assessment of competencies on a periodic basis as part of our public protection role. Many national certification, quality and regulatory organizations are working diligently to develop more objective tools for measuring continuing competence. I applaud the commitment of CAC to lead this important regulatory initiative.

As we all know, the world has dramatically shrunk over the past 15 to 20 years (or become flat as Tom Friedman so well describes). We live in a world driven by communication and connectivity – where geographic lines between states and nations take a backseat to the expanding possibilities of living and learning in a connected as well as virtual world. In healthcare alone, this provides so many new horizons that we struggle daily to keep up with just a few of them! I am particularly excited about the possibilities of simulation to transform learning, enhance critical thinking skills and assess competence/confidence development in a safe environment where we can truly learn without fear of harming patients. Thank goodness we are finally paying attention to how other industries prepare safe practitioners for hi-tech, hi-risk professions!

We all know about our changing demographics in America – about the "browning" and "graying" of America and the shrinking of our American workforce age group. A recent study showed that between 1976 and 2006, the 75 and older age group grew from 9% to 24% of our total population while the 15 to 44 year age group shrunk from 43% to 31% of our population. Our average age in the US grew from 40.7 years in 1976 to 52.5 years in 2006. By 2050, it is projected that 72 of every 100 individuals in the US will be outside the workforce (too young or too old) and there will no longer be one majority ethnic/racial group in this country. This means that 28% of our population will be expected to provide all the services in our country (education, healthcare, transportation, communication, and financial, to name a few). How are leaders in healthcare preparing for these shifts in our population? How do we build a more diverse healthcare workforce and transform a "sick care" insurance system into one that places its priorities on prevention and wellness as well as universal access to services? How do we assure that our future health professionals are adequately prepared to provide care in the new era of the 21st Century? Safety – scarcity – technology – mobility – chronicity in a growing aging population – prevention – diversity – access to affordable care… The list is daunting. Will health professions regulation continue to be a valued contributor to public protection in this rapidly changing world?

As we look at the next 15 to 20 year horizon in relation to globalization and the mobility of a scarce healthcare workforce, I believe we must commit to not only achieving national regulatory standards but also international standards for education, entry-level and continuing competencies for our respective health professions. We are at critical point in time when it is essential that we transform not only health professions education but also how care can be delivered by a shrinking healthcare workforce in order to be better positioned for

the future. Transformation in our regulatory standards and processes is also a must to facilitate the delivery of safe, effective care!

If we wish to be strategic partners in the delivery of quality healthcare for all of our citizens in the years ahead, there is no sitting still or being complacent about the "things we do well today". We must continually ask the key questions – Are we doing the right thing for the future? How are we reshaping our regulatory models that were developed at the late 19th and early 20th century to be meaningful in the very different world of the 21st Century? How do we strategically position health professions regulation for the future? James L Morrison from the World Future Society challenges us to *"Futurize our organizations – that is, create organizations that think in the future tense, and act in the present – as a prerequisite for success in a rapidly changing and uncertain world."* How many of our Boards truly think in the future tense? How many do strategic planning, set clear goals for what they want to achieve in the next 3 years, the next 5 to 10 years? How much time do you as Board members and staff spend in generative thinking and transformative work?

If health professions regulation is to remain a viable element in the healthcare landscape of the 21st Century, we must build more flexible regulatory structures and models that remove unnecessary barriers to the practice of qualified health professionals in this new age of connectivity, real time global communication, mobility and a shrinking health care workforce. This includes building models to accommodate multistate and, ultimately, cross-country practice. The multistate, mutual recognition model for nursing regulation that has been implemented in 23 states is a working example of a more flexible regulatory model in the US. There are a number of cross-country and regional models being implemented internationally – for example, in Europe, between Australia and New Zealand, and among the Canadian Provinces.

We must also become more flexible by moving beyond "turf battles" related to expanding and overlapping scopes of practice across health professions. Although it may be an "inconvenient or uncomfortable truth" for some health professionals, there is ample scientific evidence that many aspects of health care services can be safely performed by a variety of health care professionals. It is not the job of regulators to protect professions but, as articulated by Ben Shimberg, it is our job to set standards that assure the consumer, to the extent possible, that the regulated individual is competent to provide certain services in a safe and effective manner.

And lastly, we must move beyond making regulatory decisions based primarily on opinion to making decisions based on the best available evidence… This requires us to build a scientific base of regulatory best practices through research that is context-sensitive, policy-relevant and, applicable to all health professions. I would like to especially recognize the NCSBN for supporting the development of this regulatory science through a Regulatory Fellows Program, analysis of member boards' core regulatory practices and their Center for Regulatory Excellence grant program. I would suggest that now is a great opportunity to partner across health professions to build this scientific base for regulation. Certainly expanding our base of evidence will assist all regulatory boards in improving their processes, customer service and accountability to the public we serve.

Transforming our regulatory structures and practices for the 21st Century may seem like an overwhelming challenge to some of you but if you have the commitment to transform your processes, you can do it! You will be amazed with what can be done to build more efficient and effective organizations once you get started on this journey. And thanks to national organizations such as the CAC, and our respective professional associations of regulatory bodies, the foundational work to

help us all move into the 21st Century has already begun. It is up to us to make it happen!

In a recent conversation I had with David Swankin, he was reflecting on what he has learned over his many years in the area of consumer protection and regulation. He said: *"Good regulatory programs depend on the people who run them; models are important but there is 'no single best' one; and, most importantly, public protection requires collaboration among regulators, providers, professional associations, credentialing bodies and consumers."* I could not have said it better! AND, if Ben Shimberg were here today, I am sure that he would challenge all of us to move beyond the status quo of our 20th Century framework and think in the future tense as we continue our journey toward regulatory excellence in this complex world of the 21st Century. It is an exciting time to be involved in this important work!

Thank you to the Board of the CAC for honoring me with the Ben Shimberg award. Thanks also to the members and staff of both the National Council of State Boards of Nursing and the North Carolina Board of Nursing who have been "future thinkers" and willing to open up new pathways in our continuing journey to better serve the public. And thanks to you in the audience for being part of this journey. The future of healthcare regulation is in your hands. For the sake of the public, may you manage it wisely!

PAIN MANAGEMENT AND END OF LIFE CARE

Pain Care Advocates Publish Opioid Guidelines

The American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) have published the first comprehensive, evidence-based clinical practice guideline to assist clinicians in prescribing opioid pain medications for patients with chronic non-cancer pain. The guideline appears in the February issue of *The Journal of Pain* at www.jpain.org/article/S1526-5900(08)00831-6/abstract. The guideline is based on a literature review of more than 8,000 published and unpublished studies.

"This guideline was a true multidisciplinary effort that sought to address in a balanced manner the many challenging issues that clinicians face with regard to when and how to prescribe opioids for chronic non-cancer pain," said principal investigator Roger Chou, MD, Oregon Evidence-Based Practice Center, Oregon Health and Science University, Portland, Oregon.

The expert panel that developed the guidelines concluded that opioid pain medications are safe and effective for carefully selected, well-monitored patients with chronic non-cancer pain. The guideline advises clinicians to determine if the pain can be treated with other medications before considering chronic opioid therapy. If opioids are determined to be appropriate, the clinician should conduct a thorough medical history and examination, and assess potential risk for substance abuse, misuse or addiction. Continuous follow-up monitoring for pain control and level of function is recommended.

CAC Joins in Supporting National Pain Care Policy Act

CAC joined with numerous organizations concerned with pain management and end-of-life care to support the following consensus statement in support of the National Pain Care Policy Act of 2009 (H.R. 756):

> Pain touches every member of our society at some point in life. The National Center for Health Statistics estimates that 76.2 million one in every four Americans have suffered from pain that lasts longer than 24

hours; millions more suffer from acute pain. Left untreated, pain can rob quality of life and affect every aspect of daily living, including work, sleep, and social relations.

NOW is the time to educate healthcare professionals, people in pain and their loved ones, as well as the general public about the importance of achieving appropriate pain assessment and management and addressing the barriers that prevent pain control in every instance, particularly among minority and other medically underserved populations, and to coordinate research on the causes of pain and development of improved therapies to manage it adequately.

As members and representatives of the pain care community, the undersigned organizations support and urge passage of the National Pain Care Policy Act, which includes the following four actions:

1. **Convene an Institute of Medicine Conference on Pain Care, with a Report Summarizing Findings and Recommendations;**

2. **Expand through the Pain Consortium at the National Institutes of Health an Aggressive Program for Basic and Clinical Research on Causes and Potential Treatments of Pain.**

3. **Create an Education and Training Grant Program to Improve Health Professionals' Understanding and Ability to Assess and Appropriately Treat Pain; and**

4. **Develop and Implement a National Pain Management Public Outreach and Awareness Campaign.**

Editorial Note: On March 19, 2009, Senators Orin Hatch and Chris Dodd introduced the National Pain Care Policy Act of 2009.

Palliative Care Survey

The Center for Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC) have produced a state-by-state survey of palliative care across the nation. Its purpose is to document the prevalence of and access to hospital palliative care in the United States.

Visit www.capc.org to check on the availability of palliative care in your state.

Pain Medication Expenditures Increase

According to the Medical Expenditure Panel Survey (www.meps.ahrq.gov), expenditures for outpatient prescription analgesics increased three-fold from $4.2 billion to $13.2 billion between 1996 and 2006. The average annual expenditure increased from $83.00 to $232.00 for people who purchased one or more prescription analgesics. For each analgesic purchased, the average expenditure increased from $26.00 to $57.00. The total number of prescriptions purchased increased from 164 million to 231 million.

FDA Plans Restrictions on Opioid Prescriptions

The Food and Drug Administration announced on February 9, 2009, its intention to impose new rules for the prescribing, dispensing and distribution of extended-release opioids, including oxycontin, methadone and some morphine tablets. The announcement was made by Dr. John k. Jenkins, director, office of new drugs, center for drug evaluation and research, U.S. Food and Drug Administration. Testifying February 12, 2009, before the Senate

Committee on Health, Education, Labor and Pensions, specifically about oxycontin, Dr. Jenkins explained actions directed at consumers and at health care professionals:

> To help in the effort to curb abuse and misuse of OxyContin, FDA has worked with Purdue Pharma to implement other specific changes in the OxyContin labeling. The new labeling is intended to highlight to physicians, other health care professionals, and patients that OxyContin should be used for the treatment of moderate to severe pain in patients who require around the clock narcotics for an extended period of time. As part of the labeling changes, a patient instruction sheet was added, which contains information to assist patients in the proper use of OxyContin. These labeling changes are an effort to educate pharmacists, other health professionals, and the general public regarding just how important it is to use this drug properly. The new warnings are intended to lessen the chance that OxyContin will be prescribed inappropriately for pain of lesser severity than the approved use or for other disorders or conditions inappropriate for a Schedule II narcotic. FDA has developed a patient-information page on its website (www.fda.gov/cder/drug/infopage/oxycontin/default.htm). This site provides important information to patients regarding how to safely use OxyContin, urges patients to keep their supply of OxyContin in a secure location, and instructs patients to destroy unneeded tablets.
>
> …There have been numerous reports of OxyContin diversion and abuse in several states. Some of these reported cases have been associated with serious consequences including death. In an effort to educate health care providers about these risks, Purdue Pharma has issued a warning in the form of a "Dear Healthcare Professional" letter. The "Dear Healthcare Professional" letter was distributed widely to physicians, pharmacists, and other health professionals. The letter explains the changes to the labeling, including proper prescribing information and highlights the problems associated with the abuse and diversion of OxyContin.
>
> FDA approved indication for OxyContin is for the treatment of patients with moderate to severe pain who require around-the-clock opioids for an extended time. An important factor that must be considered in prescribing OxyContin is the severity of the pain that is being treated, not simply the disease causing the painful symptoms.
>
> FDA continues to recommend that appropriate pain control be provided to patients who are living with moderate to severe pain. Although abuse, misuse, and diversion are potential problems for all opioids, including OxyContin, they are a very important part of the medical armamentarium for the management of pain when used appropriately under the careful supervision of a physician.
>
> …The Agency recognizes OxyContin as a valuable product when used properly. We need to do all we can to ensure that the prescriptions get to the appropriate patients and that labeling and promotion are appropriate for the product. FDA is working closely with the manufacturer to take appropriate action to curb the misuse and abuse of OxyContin. In addition, FDA is

involved in the strong interagency effort to address this issue and we are aware we cannot solve this problem by ourselves.

Dr. Jenkin's complete testimony is at www.fda.gov/ola/2002/oxycontin0212.html

Living Wills Often Ignored

New research reported in the ***Journal of Emergency Medicine*** (February 2009) confirms previous findings that living will requests that no extraordinary measures be taken to prolong life are often ignored by medical personnel in hospitals, nursing homes. The newly published study is based on research conducted with 150 emergency medical technicians and paramedics. The authors, led by Dr. Ferdinando Mirarchi of Hamot Medical Center in Erie, PA, found great confusion about the intent of living wills. Most emergency medical technicians (EMT) interpret the presence of a living will to mean the patient wants only palliative care, even when the will does not specify "do not resuscitate." In 2008, New York State enacted a law aimed at clarifying and enforcing the instructions in living wills. It calls for a form called Medical Orders for Life-Sustaining Treatment which is signed by a physician and has the effect of a medical order. Prior to this law, the only binding instruction EMTs could obey was a Do Not Resuscitate order which applies only in the case of cardiac arrest.

Requirements to comply with Washington State's Death With Dignity Initiative Measure1000 have been adopted by the Department of Health and became effective March 5, 2009. Under the initiative, the Department is responsible for collecting information regarding compliance with Measure 1000 and to define qualifications of witnesses designated by long-term care facilities. The rules clarify definitions and reporting requirements for health care providers. Several other states, including California, North Carolina, Oregon, West Virginia and Wisconsin, have established programs that enable physicians to clarify end of life treatment requests.

PATIENT SAFETY AND MEDICAL ERRORS

Most Common Medication Errors Involve Prescribing

Researchers found that most of the medical errors in primary care practices are prescribing errors, according to a report in the Agency for Healthcare Research and Quality (AHRQ) February 2009 report of research activities. The research, led by Grace Kuo, Pharm.D., was reported in the publication *Quality and Safety in Health Care*.

As explained by AHRQ (www.ahrq.gov), the researchers combined reports of medication errors from a twenty-week medical error study involving forty-two family physicians at forty-two practices with those from a ten week study involving four hundred and one clinicians and staff from ten diverse family medicine offices. Of a total of one thousand two hundred sixty-five medical errors reported, one hundred and ninety-four reports concerned medication errors and seventy percent of those involved prescribing errors. Ten percent involved medication administration or documentation errors, seven percent involved dispensing errors, and three percent involved medication monitoring errors.

Pharmacists were most likely to prevent the error from reaching patients (forty percent of the intercepted errors), while physicians (nineteen percent) and patients (seventeen percent) intercepting the error before it reached a patient.

Editorial Note: The researchers concluded that electronic tools are necessary to reduce the rate of medication errors. CAC News & Views suggests it would be equally effective in preventing prescribing errors for medical

boards to require licensees to demonstrate current competence in pharmacology on a regularly recurring schedule. We suggest also that medical boards and pharmacy boards put their heads together to explore collaborative approaches to preventing prescription errors.

Nurses Should Be Included in Discussions of Medical Errors

Reported in the January 2009 issue of *The Joint Commission Journal on Quality and Patient Safety,*) a research team led by Sarah Shannon, of the University of Washington School of Nursing found that nurses are often left our of medical error talks with patients. Nurses interviewed by the researchers want to be included in such discussions to facilitate their open and honest communication with patients and their families. According to the article abstract on the Joint Commission Website:

> **Background:** Disclosure of medical errors has been conceptualized as occurring primarily in the physician-patient dyad. Yet, health care is delivered by interprofessional teams, in which nurses share in the culpability for errors, and hence, in responsibility for disclosure. This study explored nurses' perspectives on disclosure of errors to patients and the organizational factors that influence disclosure.
>
> **Methods:** Between October 2004 and December 2005, 11 focus groups were conducted with 96 registered nurses practicing in one of four health care organizations in the Puget Sound region of Washington State. Focus groups were analyzed using qualitative content analysis.
>
> **Findings:** Nurses reported routinely independently disclosing nursing errors that did not involve serious harm, but felt the attending physician should lead disclosures when patient harm had occurred or when errors involved the team. Nurses usually were not involved in the error disclosure discussion among the team to plan for the disclosure or in the actual disclosure, leading to ethically compromising situations in nurses' communication with patients and families. Awareness of existing error disclosure policies was low. Nonetheless, these nurses felt that hospital policies that fostered a collaborative process would be helpful. Nurse managers played a key role in creating a culture of transparency and in being a resource for error disclosures.
>
> **Discussion:** Nurses conceived of the disclosure process as a team event occurring in the context of a complex health care system rather than as a physician-patient conversation. Nurses felt excluded from these discussions, resulting in their use of ethically questionable communication strategies. The findings underscore the need for organizations to adopt a team disclosure process. Health care organizations that integrate the entire health care team into the disclosure process will likely improve the quality of error disclosure.

More information can be found at www.jcrinc.com/Periodicals/THE-JOINT-COMMISSION-JOURNAL-ON-QUALITY-AND-PATIENT-SAFETY/847

Boston Hospital Cited for Multiple Safety Violations

Boston's Beth Israel Deaconess hospital has been cited by state investigators for multiple safety lapses, some resulting in infections involving antibiotic-resistant staph aureus infections of at least nineteen infants and eighteen mothers who gave birth in the hospital. An article by staff writer Stephen Smith in the April 11, 2009, ***Boston Globe***

documents numerous infractions witnessed by investigators from the Bureau of Health Care Safety and Quality during a surprise visit in March 2009. The errors and infractions occurred despite the hospital's campaign to reduce infections and other preventable errors.

Smith reports that the inspectors witnessed doctors and nurses reusing medical instruments without disinfecting them between patients, failing to change gloves between patients, performing transfusions on infants with no specialized training, a crowd of people swarming on operating room where a mother was giving birth prematurely. The investigators strongly criticized the hospital, saying that hospital executives failed in their oversight and in systems for infection control. A representative for the Boston Office of the Centers for Medicare and Medicaid Services warned that the hospital could be stripped of its participation in government health plans.

Editorial Note: This disturbing report shows an alarming lack of vigilance and attention to the most elementary rules of sanitation at one of the country's more respected hospitals. It is all the more unsettling in the one state where the board of medicine has authority to inspect health care institutions.

CERTIFICATION

Bibliography of Nursing Certification Resources

The American Board of Nursing Specialties (ABNS) recently published a useful bibliography of published sources that focus on nursing certification which can be found at www.nursingcertification.org/bibliography.htm

The bibliographic sources are grouped under the following headings:

1. General Information on Nursing Certification
2. Specialty Certification
3. Value of Certification
4. Role Delineation/Exam Development
5. Advanced Practice Certification
6. Descriptive Studies
7. Patient Outcome Studies
8. Certification and Recertification Methods
9. Continuing Competency
10. General Interest

Hospitalists Create Certification Board

The American Association of Physician Specialties announced on January 13, 2009, the formation of the American Board of Hospital Medicine (ABHM) which will certify hospitalists, physicians whose practice consists of providing care to hospitalized patients. The ABHM is North America's first and only board of certification devoted exclusively to hospital medicine – founded by hospitalists and governed by hospitalists.

According to ABHM Chair, Dr. Thomas G. Pelz, a hospital based physician at Boscobel (Wisconsin) Area Health Care, "The American Board of Physician Specialties recognizes the vital role that hospitalists play in the delivery of health care in the United States and Canada. Hospital medicine is one of the fastest growing and most dynamic medical specialties in North America and the ABPS is excited about taking the lead in the formation of the American Board of Hospital Medicine."

The ABHM has been in development for the last three years under the direction of dedicated hospitalists from the Unites States and Canada) The American Association of Physician

Specialists, Inc. (AAPS), and its official certifying body, the American Board of Physician Specialties (ABPS), is one of three nationally recognized multi-specialty medical organizations overseeing physician certification. It assists its 15 Member Boards in their efforts to develop and implement educational and professional standards for the evaluation and certification of physician specialists.

For more information, visit www.abhmus.org.

Editorial Note: See also the CONTINUING COMPETENCE section in this issue for news of an excellent document on that subject published by the National Organization for Competency Assurance (NOCA).

SPOTLIGHT

Occupational Therapy Certification Body Publishes Complaint Data

This quarter's Spotlight shines on the National Board for Certification in Occupational Therapy (NBCOT) for regularly devoting a page of its ***Report to the Profession*** to a compilation of complaints received from and about certificants and disciplinary actions taken by NBCOT. The data (which can be found at www.nbcot.org) reveals the subject of the complaint (e.g., an allegation against a certificant or a complaint by an applicant for certification), the sources of complaints (e.g., of the ninety-three cases, twenty-three came from state regulatory boards, thirty-six were self-reports on a renewal application, and so on), the types of allegations (e.g., practicing without a license, substance abuse, felony charge, misrepresentation of credentials, an so on), and the nature of any disciplinary actions.

Editorial Note: NBCOT also stands out among certification organizations for the large proportion of public members on its board of directors. Currently, four members of its thirteen-member board are public members.

AUDIT

Maryland Task Force Evaluates Board Discipline

House Bill 811 enacted by the Maryland General Assembly in 2008 session created a Task Force on Discipline of Health Care Professionals and Improved Patient Care which published twenty-four recommendations January 30, 2009. Task Force chair, Patricia M.C. Brown wrote in her introduction to the report:

> The Task Force met nine times and worked diligently to respond to the numerous issues raised by its authorizing statute. Composed of representatives of the health occupation boards, their executive directors, the Office of the Attorney General, the Department of Health and Mental Hygiene, the Office of Administrative Hearings, patient advocacy groups, attorneys who represent licensees before the boards, and consumers of health care services, the Task Force attempted to balance the goal of fairness to licensees who come before the boards with the boards' paramount goal of protecting patients and consumers from licensees who present a threat to the public's health and welfare. Recognizing that boards do their best, with limited resources, to carry out their mandate of public protection, throughout their deliberations the Task Force members strived to make recommendations that would improve the fairness, efficiency and transparency of board actions. The Task Force also made efforts to consider the impact of the recommendations on all relevant stakeholders and in order to reach

consensus often arrived at practical and creative solutions to controversial issues.

What follows is the Executive Summary of the report:

> The Task Force on Discipline of Health Care Professionals and Improved Patient Care (the Task Force) was created in September 2008 in accordance with House Bill 811 (the Act) which was passed by the Maryland General Assembly in its 2008 session and signed by Governor O'Malley on April 24, 2008. The Task Force was created to study and issue recommendations relating to Maryland's 18 health occupations boards. The Act instructed the Task Force to make recommendations regarding board discipline, the organizational structure of the boards and their relationship to the Department of Health and Mental Hygiene (DHMH), and to take measures to enhance fair, consistent and speedy resolution of complaints made against health care providers.
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> The Task Force used a problem-solving framework to facilitate reaching common solutions for improving the operation of the health occupations boards. Under this framework, the Task Force focused its deliberations on four areas: fairness (in both process and outcome of board disciplinary actions), timeliness of board action, communication between boards and respondents and complainants and between boards and the public, and data collection on various aspects of board actions. Fairness in process considerations included the fairness of the boards' disciplinary process to both consumers who make complaints against providers and to the licensees against whom those complainants are made. In assessing fairness in outcomes the Task Force considered the consistency and fairness of actions taken by boards in the sanctioning phase of the disciplinary process (in both informal and formal sanctions). The Task Force approached the concept of timeliness in two different ways – timeliness as it relates to the fairness of the disciplinary process and timeliness as it relates to case management. In terms of communication, the Task Force studied and made recommendations regarding the content and availability of information available to the public about individual boards.
>
> Data collection became a focus of Task Force attention when Task Force members found that they were hampered in their work by a lack of definitive data on board performance. Many boards do not have sufficient information to assess their needs or performance. This makes it difficult to render definitive solutions for such matters as case management, allocation of resources, and fairness of outcomes. Therefore, the Task Force made detailed recommendations in this area.
>
> Within these focus areas, the Task Force studied current board practices in Maryland, board practices in other states, and legal and policy issues relating to health occupation boards generally in order to make concrete proposals to improve the disciplinary process of Maryland's health occupation boards.
>
> In addition to making substantive recommendations, the Task Force also made recommendations as to how, ideally, each recommendation should be

implemented. In considering how a recommendation should be implemented, the Task Force recognized four possible methods of implementation – statutory change; action by the Secretary with legislative authority, action by the Secretary without legislative authority, and board action. A chart setting forth implementation recommendations appears below.

The Task Force recommended statutory changes for substantive recommendations that relate to matters already governed (or previous governed) by statute in some manner (e.g. nomination of new board members) or matters that are of sufficient magnitude or sensitivity that the authority of a statute would ensure their implementation.

For some recommendations, the Task Force recognized that the Secretary would be the most logical individual to develop and implement a framework for consistent implementation of a recommendation across all boards. In these cases, the Task Force recommended that the Secretary be given legislative authority to direct and/or work with the boards to implement the recommendation. In a few cases, e.g., those involving data collection and monitoring of data collection or the need for a collaborative process, the Task Force recommended that the Secretary take the initiative to implement the recommendation working closely with the boards but did not believe that legislative action was necessary.

Finally, the Task Force made a number of recommendations that it believed should be implemented by the individual boards through their policies or regulations. These recommendations relate to matters that are within the power of the individual boards to implement and require each board to implement them in the manner most appropriate to the specific needs of each board.

The following is a list of the recommendations made by the Task Force. In the body of the report, these recommendations are grouped according to subject area. Below, however, the recommendations are grouped based on how the Task Force suggests they be implemented.

CAC is pleased to see that the recommendations address such important items as communication with complainants, training for board members, prioritization of cases, information on Website, and other public information initiatives.

Summary of Recommendations

Recommendations requiring statutory change:

1. **Charging Committee**
   To the extent practicable, each board should have a subcommittee which will decide whether charges should be brought against a licensee. The members of this subcommittee shall not participate in any hearing on the charges or any final decision by the board on the charges or sanctions imposed based on those charges. Only members of this subcommittee can participate in investigations and pre-adjudication case resolution conferences.

2. **Timeliness of Charges**
   - Absent unusual circumstances, Boards should not charge based solely on events that occurred more than 6 years before the initiating complaint.

- The 6 year timeframe should not apply to cases involving criminal convictions, sexual misconduct and other boundary violations, reciprocal discipline matters, and ongoing substance abuse.
- This 6 years begins to run at the later of:
    - Actual discovery by the complainant of the facts complained of, or
    - The date when a reasonable person, if exercising due diligence, should have discovered the facts complained of.
- Unusual circumstances include:
    - Fraudulent concealment by the licensee of material information
    - Repressed memory by the patient
    - Acts that occur while a patient was a minor

3. **Board Membership**
   All licensees should be notified of board vacancies. Such notice can be achieved by an e-mail to all licensees or a notice on the board's webpage.

4. **Peer Review**
   In standard of care cases where peer review is conducted, licensees under investigation should be given the opportunity to review the preliminary peer review written report and the opportunity to respond to questions from or concerns expressed by the peer reviewer prior to the final peer review report being sent to the board. The manner of communication (in person meeting, telephone conference, or written communication) between the licensee and peer reviewer shall be determined at the discretion of the board. Neither board members nor defense counsel shall be permitted to participate in an in-person meeting of a licensee and peer reviewer.

5. **Single Case – Standard of Care**
   All boards shall be given the authority to adopt, and should adopt, a program in which practitioners who commit a single standard of care violation are provided with training, mentoring or another form of remediation rather than requiring the practitioner to participate in a formal hearing.

Editorial Note: CAC hopes the single case standard will be used judiciously. In some instances, a single standard of care violation may be so onerous that it warrants disciplinary action.

6. **Sanctioning guidelines**
    - Each board should adopt specific sanctioning guidelines that will be applied to that board and used to increase uniformity in board sanctions for similar infractions. All guidelines should conform to a general framework or incorporate a common set of elements.
    - This framework should include:
        - A range of sanctions for each type of infraction. (This can be done based on historical data or a normative process).
        - A list of mitigating and aggravating circumstances that may be used to decide when the sanction should fall within the range of sanctions or whether the sanction should fall outside the established range.

- Sanctioning guidelines should be used throughout the entire discipline process – during both formal and informal proceedings.

7. **Timeliness – Board Resources**
   Boards should be able to use their own financial resources to hire staff needed within state personnel guidelines. This should include the ability of boards to use their resources to obtain additional personnel time from the Office of the Attorney General.

8. **Collection of Racial and Ethnic Background Data**
   All Boards should collect racial/ethnic identity information on a mandatory basis as part of their licensing application process.

9. **Data Regarding Individual Practitioners**
   Each board shall make available on its website the final order for each licensee who is disciplined by the board after _____ (specify date).

10. **Secretary of DHMH – Appointment of Board Executive Directors**
    The Secretary of DHMH shall have the authority to confirm the appointment of the Executive Director of all health occupation boards.

Recommendations requiring legislative authority to authorize action by the Secretary of DHMH:

11. **18 Months for Decision to Charge**
    As a rule, a board should complete its investigation and the Charging Committee should vote on whether to charge within 18 months of the date a complaint is filed with the board. Delays caused by or requested by the licensee will toll this time period.

12. **90 Days to Issue Charges after Decision to Charge**
    After the board has voted to charge, absent good cause, charges should be issued no later than 90 days after the decision to charge.

13. **90 Days – Minimum Time from Charges to Hearing**
    Once charges have been issued by the Board, a hearing on those charges shall be set no earlier than 90 days from the date the charges are served on the licensee, except at the request of the licensee. The Administrative Prosecutor shall make reasonable efforts to contact the licensee or counsel (where the licensee is represented by counsel known to the Board) to arrange for (a) reasonable, agreed upon hearing date(s) prior to the issuance of the hearing notice.

14. **90 Days to Issue Decision**
    Absent good cause shown, the board should render its decision within 90 days of the later of:
    - The receipt of an opinion from the Office of Administrative Hearings, or
    - The final day of any hearing before the board (including a hearing on exceptions to a proposed opinion from an ALJ).

Recommendations requiring action by the Secretary of DHMH with no legislative authority required:

15. **Uniform Procedural Rules for Contested Cases**
    The Secretary shall convene a working group including representatives from

the Attorney General's Office, the health occupation boards and other relevant stakeholders to develop a set of uniform procedures for contested cases for adoption by all health occupation boards.

16. **Data Collection**
    Boards should collect data relating to the age of cases at various stages of the disciplinary process.

17. **Data Collection – Integration with StateStat**
    The data collection framework included in Appendix K should be integrated with the data currently collected by StateStat.

Recommendations requiring individual board action:

18. **Office of the Attorney General – Separation of Functions**
    The Policy of the Office of the Attorney General regarding separation of functions (OAG Policies and Procedures – Admin. Adjud. Proceedings 5.0) should be made publicly available. See policy at Appendix C.

19. **Communication Timeframes**
    With the exception of the Board of Physicians and Board of Nursing, each board should adopt the following timelines and guidelines for communication with complainants and respondents:

    - Complainant and respondent should be notified of the receipt of a complaint within 7 days of the receipt of that complaint.
    - A status update should be sent to the respondent and the complainant within 90 days of the receipt of the complaint.
    - After disposition, a final notification letter should be sent to the complainant and the respondent within 7 days of completion of the case.

    The Board of Physicians and the Board of Nursing should establish their own timeframes for each of the above actions.

20. **Model Letter Format**
    All boards should follow a model letter format (consistent with the letters provided in Appendix D) when corresponding with complainants and respondents.

21. **Training Materials**
    Each board should develop training materials and processes for new board members above and beyond what DHMH currently provides.

22. **Prioritization of Cases**
    Each Board should develop guidelines on timeliness for prioritization, investigation and prosecution of cases.

23. **Information Available on Board Websites – Aggregate Data**
    The data on disciplinary actions that the Task Force has recommended for inclusion in the StateStat data should be made available through each board's web site.

24. **Public Information about Boards**
    The Health Occupations Boards and the DHMH Public Information Office should be encouraged to utilize various methods, including for example, flyers in practitioner offices, public notices of board meetings, televised board meetings on cable TV, and outreach to the public through speakers to groups and organizations, to inform the public

how and when to contact the boards and how boards function.

Maryland Legislative Audit Report Faults Boards of Medicine, Nursing and Pharmacy

In January 2009 Maryland's Office of Legislative Audits published its ***Report on the Department of Health and Mental Hygiene, Health Professional Boards and Commissions, the State Board of Physicians, and the State Board of Nursing.*** The report contains eight findings and recommendations related to the boards of medicine, nursing and pharmacy.

Three of the findings have to do with deficiencies at one or more of the boards in fiscal control, record keeping, data base management, and with "controls to ensure that only qualified individuals were issued a new or renewed license."

One finding specific to the board of medicine is:

> The State Board of Physicians did not have procedures to adequately verify that physicians had obtained the required continuing medical education, and did not take appropriate administrative action when physicians could not demonstrate that continuing medical education requirements had been met.

Findings specific to the board of nursing include:

> The State Board of Nursing had not established adequate procedures to ensure that the license status of nurses who did not renew their licenses as change to non-renewed status in the Board's licensing system. As a result, the license status of four hundred and seventy nurses who had not renewed their licenses was still recorded as active in the system.
>
> The State Board of Nursing had not obtained an annual independent audit of the online license renewal system maintained by an independent contractor to determine whether the system's controls and related policies and procedures were suitably designed and properly operating and whether personal and licensing data were secure.

About the board of pharmacy, the audit found:

> The Board of Pharmacy did not begin registering pharmacy technicians until January 2008, even though State law required that practicing pharmacy technicians be registered by January 1, 2007.

Visit www.ola.state.md.us to read the entire report.

CONTINUING COMPETENCE

NOCA Publishes Recertification Benchmark Study

The National Organization for Competency Assurance (NOCA) has released an excellent benchmark study documenting requirements in use by licensing boards and certification agencies for licensure renewal and recertification. The study also contains a literature search summarizing other recent studies and analysis related to continuing competence. To announce the study, NOCA issued the following press release:

Practices and Requirements of Renewal Programs in Professional Licensure and Certification

by James P. Henderson, Castle Worldwide Washington, DC (March 3, 2009)

The National Organization for Competency Assurance (NOCA) announced today the publication of a benchmarking study, *Practices and Requirements of Renewal Programs in Professional Licensure and Certification*. The research into these renewal programs began in late spring 2008 as an effort to supply a logical basis for such programs as they may be developed and refined. Information was obtained from over 330 organizations, including licensure bodies, centralized state agencies that oversee licensure in many professions, free-standing certifying bodies, professional associations, corporations, and others.

This study is crucial to the credentialing industry as the public and stakeholders rely on certifying organizations to ensure that certificants participate in ongoing programs of recertification. Demonstrating appropriate rigor in renewal requirements enables certificants to show that they've met continued competence requirements in their profession and allows the public to have confidence in their skills. It was for this purpose that the research into current renewal program requirements and practices was undertaken. In addition to gathering data from an industry wide survey of licensure and certification organizations, the study includes a review of current literature on renewal requirements and practices.

"This study shows our commitment to producing high quality best practice information for the credentialing community and ensuring the public's confidence that certification programs are committed to ongoing education. If you are in the credentialing industry and you want to know what the best practices in recertification are, this study is a must have document," stated Paul Grace, MS, CAE, President of NOCA. "NOCA is grateful to the tremendous efforts and contributions of the study's author, Jim Henderson, of Castle Worldwide, the advisory committee and the project sponsors and supporters."

NOCA would like to thank the following additional sponsoring organizations who provided significant financial support to the project, National Board on Certification and Recertification of Nurse Anesthetists, and Oncology Nursing Certification Corporation. We would like to thank the following project supporters, American Nurses Credentialing Center, Financial Planners Standards Council, National Board for Certification in Occupational Therapy, and Pearson VUE, as well as contributions from Board of Certification in Professional Ergonomics, Dental Assisting National Board, and CASTLE Worldwide Inc. Finally, thanks to Jim Henderson, PhD, of Castle Worldwide Inc, who was the primary author of the study.

The study is available to NOCA members at no charge and to non-NOCA members for a fee of $75.00 per copy. To obtain a copy of the study please visit our website at www.noca.org.

DISCIPLINE

Judge Holds License Suspension to Maintain Access to Care

A judge in Upstate New York placed a hold on the medical board's suspension of Dr. Elliott S. Cohen's license on the grounds that the area would have a shortage of OB/GYNs if he were unable to practice. Cohen was charged by the board with professional misconduct consisting of prescribing medications over the internet to patient he had not examined. Cohen admitted the infraction, but challenged the license suspension.

Krista Kettle, an official at a local hospital told the ***Watertown Daily Times*** (www.watertowndailytimes.com) that Dr. Cohen had not applied for a reinstatement of his privileges to practice there. She also expressed the opinion that there were adequate gynecological services available to the local population because some OB/GYNs recently established practice in the community.

Consent Order Ends Doctor's Practice

A pediatrician respected for his work with learning disabled children agreed in March 2009 to surrender his license to the North Carolina medical board and never to practice anywhere again. Dr. Melvin D. Levine had a long history of complaints alleging sexual improprieties while practicing in North Carolina and, prior to that, in Massachusetts, according to an article by Tamar Lewin in the March 21, 2009, ***New York Times***..

Levine denied any wrongdoing and said he signed the consent order to be rid of the distraction of a proceeding before the medical board. He intends to continue writing and lecturing. The medical board was pursuing complaints lodged by five juveniles alleging that Dr. Levine conducted genital examinations that were not medically indicated and not documented properly in the medical records.

Editorial Note: Although Dr. Levine had not practiced actively for some time prior to signing the consent order, this case is nevertheless an illustration of the potential power of consent orders. (The next story shows potential weaknesses of weak consent orders.) A suspension or revocation of Levine's license probably would have been more expensive and time consuming for the board to pursue and could have allowed the doctor to apply for reinstatement in the future or to practice in another jurisdiction. The consent order is a blanket promise never to practice anywhere.

One worrying aspect to this case is that Dr. Levine's history of complaints lodged with the Massachusetts medical board and a lawsuit relating to his conduct at Children's Hospital in Boston in the 1980s evidently did not follow him to North Carolina. True, the Massachusetts board did not find sufficient evidence to pursue the complaint and the lawsuit did not result in a conviction. But even though his record may have been "clean," it is disturbing to think that a pattern of complaints like this would not remain on a licensee's record and be passed on when he or she moves to another jurisdiction.

Consent Order Covers Up History of Sexual Misconduct

In September, 2008, Dr. Dana Peterson signed a consent order with the New Mexico medical board agreeing not to see female patients or patients under the age of eighteen without a chaperone present. Paterson had a history of allegations of sexual misconduct dating to his time in medical school, according to the ***Albuquerque Journal*** (November 30, 2008).

The chaperone requirement was a public record, but because the agreement with the board fell short of a formal "notice of contemplated action," the reasons for the requirement were not public. In other words, patients were not informed that Peterson was

under investigation by the board for sexual misconduct.

The ***Albuquerque Journal*** approached the practice where Peterson worked and asked in a letter to interview him about the board's action and four police reports naming him. Peterson did not consent to an interview but did resign from the medical group within days after the interview request.

Editorial Note: It can be argued that this is an illustration of a poorly constructed consent order because under its terms, the infraction which led to the restrictions could be kept secret from the public. Surely, the public has a right to know when a practitioner in a position of power and trust has a history of sexual misconduct. One must also question the apparent willingness of the medical group to permit Peterson to continue to practice until they learned that his encounter with the medical board was about to be made public.

Contrast this with a ruling by the Medical Board of California to stay a license revocation and impose probation on the condition (among others) that the doctor have a chaperone present when treating female patients. The reason for this requirement was disclosed in an article in the* Chico Enterprise-Record *(January 27, 2009) listing a number of specific infractions which led to the board action. While the California regulations are to be praised for disclosing the basis for disciplinary action, the board's reasoning in this particular case involving Dr. Loren R. Morgan is puzzling. The board concluded that a mitigating circumstance that helped justify probation rather than revocation was the fact that the doctor had been licensed for forty-six years without any disciplinary actions on his record. However, the case against the doctor included allegations of five instances of unprofessional conduct dating to 1998, 1999, 2000 and 2002. It appears one reason Morgan's record was unblemished may be that the board was slow to take action despite numerous opportunities.

Dentist's Discipline Leads to Legislation

Donald R. Quinn, a Michigan dentist lost his license in 2002 after pleading guilty to two charges of criminal sexual conduct, one count of possession of Ecstasy, one count of delivery of Ecstasy, and one count of possessing a taser gun. In 2007, following the recommendation of an administrative law judge, the Michigan Board of Dentistry reinstated Quinn's license with restrictions for two years. Now, two state legislators, Representative Rick Jones and Representative Bettie Cook Scott have introduced a bill that would prohibit the reinstatement of the license of a health care worker convicted of criminal sexual misconduct. Rep. Jones' reasoning is explained in a press release at www.gophouse.com/welcome.asp?District=71:

> Rep. Rick Jones, R-Grand Ledge, a former Eaton County sheriff, today announced legislation to stop health care providers who are convicted sex offenders from getting their health occupation license reinstated.
>
> It is widely reported that a 44-year old Farmington Hills dentist was convicted of sexually assaulting a patient. The dentist reportedly drugged and raped the patient in a case that police called one of the most brutal they had seen.
>
> The victim contacted Rep. Jones asking for justice and a change in the law after the dentist was given a new license to practice in Michigan.
>
> "When I was contacted by the victim of such a horrendous attack and informed that the dentist was getting his license back, I was completely shocked," said Jones, R-Grand Ledge.
>
> "Health care providers who prey on their patients must never be given a

second chance to do harm. Michigan residents put their sacred trust in health care professionals, and those who betray that trust must never be allowed to practice again."

Jones has teamed up with Rep. Bettie C. Scott, D-Detroit, to introduce a bipartisan package of two bills to end the renewal of health occupation licensing of convicted sex offenders. Scott is a former Detroit Police sergeant.

"As a female legislator, I have received numerous statements from females who have been victimized by individuals who are in a position of control, such as health care professionals," Scott said. "I am appalled that someone convicted of a sex offense that was committed within the capacity of their professional occupation is able to continue to practice through a license issued by the state of Michigan. I am committed to making sure our state residents are protected against those who abuse their professional license to practice."

LICENSURE

National Council Adopts "Transition to Practice" Model

The National Council of State Boards of Nursing's transition to practice model is intended for all practice settings that hire newly graduated nurses of all levels of education. The objective is to teach the policies and procedures of the workplace and establish expectations. "Transition to practice" is defined as a formal program designed to support new graduates during their progression into practice.

As explained on the NCSBN Website:

> NCSBN's Transition to Practice model is intended to be collaboratively implemented with education and practice, but through regulation. Collaboration will be essential for this model to be successful. Educators are the experts in curriculum design and evaluation and will be able to assist with the design of the transition modules. Practice provides a crucial link that will provide new graduates with planned practice experiences with qualified nurses to mentor them. Nursing regulations provide new graduates with information on their scope of practice, the Nurse Practice Act, and maintaining their license throughout their careers. If adopted, regulation will be able to enforce the transition program through licensure.

A complete description of the model can be found at www.ncsbn.org.

Nursing Board Allows Felons to Practice

Late last year, the ***Los Angeles Times*** and the new nonprofit investigative organization ProPublica exposed lapses at the California Board of Nursing that permitted dozens of nurses convicted of crimes to remain fully licensed for years before taking action. Writing in the October 5, 2008 edition of the ***Times***, Charles Ornstein and Tracy Weber document numerous cases in which the nursing board failed to act until nurses had at least three and as many as five criminal convictions, including sexual misconduct and attempted murder:

> Reporters reviewed stacks of nursing board files and court pleadings, consulted online databases and newspaper clippings and conducted interviews with nurses and experts in several states. The review included an analysis of all accusations filed and disciplinary actions taken since 2002 – more than 2,000 in all, finding misdemeanors and felonies ranging

from petty theft and disorderly conduct to assault, embezzlement and bail jumping.

The reporters found one nurse who continued to renew his license after being imprisoned for attempted murder, a nurse with 14 convictions related to substance abuse before the board took action, a nurse arrested for possession of cocaine and burglary and for receiving stolen property before the board put him on probation, and a nurse with a clean license despite a felony conviction for lewd and lascivious acts with a child.

Reporters found two major flaws in the board's screening process. First, only those nurses licensed since 1990 must provide finger prints. Nearly 150,000 nurses were licensed before that date and avoid the fingerprinting requirement. Second, nurses are not required to disclose criminal convictions on their biennial renewal application form.

Spokespersons for the nursing board say they take the newspaper's findings seriously and intend to review their procedures and seek additional legislative authority to ask more questions and seek finger prints from nurses who haven't provided them.

Fitness Professionals Question Licensure / Certification

Reporter Sandy Seegers writes on ***www.dailyrecord.com*** (February 22, 2009) that a proposal to enact a Fitness Professionals Licensing Act in New Jersey is controversial among fitness professionals. The proposal would require fitness professionals to meet educational and internship requirements and pass an examination.

An early draft of the legislation would have created a seven-member licensing board. The act's sponsor is now considering placing fitness professionals under the jurisdiction of the medical board and calling for "certification" as opposed to "licensure."

Supporters of the legislation see value in standardization and elevated educational requirements. Opponents of licensure or certification fear that fitness professionals who have been teaching for years will be unable to qualify under the new rules and will be driven from practice.

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, and for a membership enrollment form, please see pages 33 – 34 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 www.cacenter.org/cac/meetings.*

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 **onsite** 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 Enrollment 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)