News & Views

Citizen Advocacy Center

Fourth Quarter, 2009 A Health Care Public Policy Forum Volume 21 Number 4

Announcements

Our 2010 Annual Meeting will be held on Thursday and Friday, November 11 – 12, 2010, in Washington, D.C. Please mark your calendars.

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 21 – 22 of this issue.*

Although we encourage you to receive our newsletter by becoming a ***CAC member****, you may still subscribe to our newsletter without becoming a member. Please see page 23 of this issue.*

Editorial Note: In the past, the fourth quarter issue of our newsletter contained a summary of the plenary sessions at CAC's annual meeting. This year, the editorial board of CAC News & Views decided to offer digital recordings of the annual meeting sessions (see order form on page 20), and to do something different with the fourth issue of the newsletter. We asked leaders in the fields of licensure and certification to respond to three questions:

1) ***In your opinion, what was the most significant development in licensing (or certification) during 2009, both generally and in your field?***
2) ***What do you foresee to be the greatest challenges and opportunities in licensing (certification) in 2010, both generally and in your field?***
3) ***If enacted, how do you think federal health care reform legislation will impact licensing (or certification) in the short run? In the long run?***

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Their answers are presented below, followed by some of our own thoughts on the same topics.

(Note: When the questions were posed, federal healthcare reform legislation appeared to be on track for passage. As this goes to print, it is unclear what, if any, federal legislation will pass, but we are including the responses to question three anyway.)

Kathy Apple, MS, RN, FAAN, Chief Executive Officer, National Council of State Boards of Nursing

In your opinion, what was the most significant development in licensing (or certification) during 2009, both generally and in your field?

I think there has been in 2009 and will continue to be several important areas of focus for nursing regulation. One is supporting state based licensure while evaluating and agreeing on uniform licensure requirements implemented by all states and territories. Similarly, implementing the new consensus model for regulating advanced practice registered nurses is critical to improve access and mobility of safe and competent practitioners. It will also be important to support a model of transition of new nurses and continue the debate and exploration of an evidenced based mechanism for demonstration of continued competence of nurses throughout their careers.

What do you foresee to be the greatest challenges and opportunities in licensing (certification) in 2010, both generally and in your field?

The challenges will be obtaining data through dialogue, debate, and research to help us all better understand effective and efficient nursing regulation for the benefit of the public. All licensing bodies of all

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Citizen Advocacy Center
1400 Sixteenth Street NW
Suite #101
Washington, DC 20036
Phone: (202) 462-1174   Fax: (202) 354-5372
Email: cac@cacenter.org

Editor-in-Chief: Rebecca LeBuhn
Contributing Editor: David Swankin
Newsletter Layout and Subscription Manager: Steven Papier

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disciplines will need to demonstrate accountability in their regulatory models, policies, and laws. More data is needed to increase our understanding on how nursing practice goes astray and how to improve patient safety.

If enacted, how do you think federal health care reform legislation will impact licensing (or certification) in the short run? In the long run?

If enacted, the impact on licensing boards will be to efficiently implement their public protection mandate and increase access to and mobility of safe and competent healthcare providers. Regulators will have to remove regulatory barriers that are not based on sound evidence.

Dale J. Atkinson, Esq., Executive Director, Federation of Associations of Regulatory Boards

In your opinion, what was the most significant development in licensing during 2009, both generally and in your field?

Understanding my perspective is not based upon one field but rather legal representation of numerous associations of regulatory boards (many of which develop, administer and maintain a uniform licensure exam program for use by their membership), as well as FARB and its diverse membership of regulators across professions, I believe there are a few major developments in the area of licensure and public protection. First is an alleged need and corresponding request by licensing boards for more specific information regarding the licensure examination and related statistical data. Balancing the obligations of the regulatory boards to ensure the legal defensibility of the exam program for use as a minimum competence assessment mechanism with the exam owner's confidentiality rights and the potential for misuse of data or the reliance upon data that may not have the statistical significance can be very difficult. Complicating matters is the exam owner's loss of control over data revealed at the request of licensing boards, including the implication of Open Records/Freedom of Information laws that may subject otherwise confidential information to disclosure upon public request. Technology allows for the immediate dissemination of large amounts of data and testing programs must be wary of providing too much information that may not have statistical significance and/or may promote legal challenges. Somewhat related to this development is the impact of data disclosure on both the applicants for licensure and academia. Again, the potential for misinterpretation or misuse of data by both schools in recruiting individuals to enroll, comparing academic program to academic program, and the increased likelihood of exam breaches dictate that thorough assessments be made by all relevant entities to determine the impact of increased disclosure.

What do you foresee to be the greatest challenges and opportunities in licensing in 2010, both generally and in your field?

Again, referencing my above perspective as counsel to associations of boards and through FARB, the greatest challenge to licensure in 2010 are the budget issues and lack of resources available to regulatory boards charged with the essential public protection mission associated with regulation. With that said, opportunities exist in that the associations of regulatory boards, whose membership are made up exclusively of regulatory boards and which share the public protection mission, are developing numerous programs designed to promote uniformity in the licensure and renewal process, assist/alleviate burdens on state boards related to licensure functions, all while respecting the rights of states to govern the various professions. Associations of boards are faced with the

challenge of offering and promoting such opportunities in a manner that reinforces the autonomy of the boards while promoting the uniformity and benefits based upon collective approaches to regulation.

If enacted, how do you think federal health care reform legislation will impact licensing in the short run? In the long run?

As of now, I do not believe federal health care reform will impact licensing, per se. I do believe that federal health care reform may impact those who choose to enter into certain health related fields, which may have a long-term impact on licensure and public protection.

Carmen Catizone, M.S., R.Ph., D.Ph., Executive Director, National Association of Boards of Pharmacy

In your opinion, what was the most significant development in licensing during 2009, both generally and in your field?

The most significant development in licensing during 2009 for the profession of pharmacy and across other professions and occupations was the unprecedented reduction in resources for state licensing and oversight agencies. Unlike other years and periods of economic downturns, the impact of the falling economy on licensing agencies has been devastating. In the past, boards of pharmacy and other similar agencies were able to weather such storms without having to suspend or eliminate critical activities and services. Unfortunately, this was not the case for 2009. Vital and necessary services are being suspended or eliminated as states scramble to find funding from any source in order to keep states solvent. The funding for boards of pharmacy and other similar agencies has become a primary focus of state financial officers and almost without exception, the privy of the states and not the boards for which the funding is legislatively mandated. For the licensees and patients we serve and protect, the safety net is near its breaking point.

What do you foresee to be the greatest challenges and opportunities in licensing in 2010, both generally and in your field?

As I mentioned earlier, the reduction in state funding and resources is the most significant development and will be the most significant challenge for 2010. State boards of pharmacy and other similar state agencies cannot and will not survive beyond 2010 unless some revolutionary approach is developed to sustain and support the critical role of the state agencies that regulate the professions and occupations and protect the public. To this challenge comes an exciting opportunity for organizations like NABP and its member boards of pharmacy. NABP believes that public-private partnerships between with its member boards are innovative solutions and perhaps the only ways to address this economic disaster. Such partnerships will help to ensure that state boards will continue to exist and, more importantly, regulate effectively. Numerous programs are in place and being developed by NABP to generate public-private partnerships between NABP and its member boards. The primary goals of these partnerships are to maintain the current services and activities of the boards of pharmacy as well as to expand services and activities into other critical areas such as quality of care and patient care. The partnerships will also provide states with innovative means and resources to measure components of regulation and care that have never been measured before. This change in purpose and focus must be in place in order for state regulation and pharmacist care to be effective and meet the challenges of our changing health care system.

If enacted, how do you think federal health care reform legislation will impact licensing in the short run? In the long run?

From the information and reports we receive and study on health care reform, the short term impact on pharmacy boards will be minimal. The overwhelming objective of health care reform legislation appears to be access to care. For boards of pharmacy, access to care is important and always a concern, but not in the broad context or scope addressed in health care reform legislation. In the middle and long terms, changes to the health care system that result will certainly impact boards of pharmacy if the role of the pharmacist or desired outcomes of pharmacist care are expanded or changed. Similarly, any component of health care reform that involves or alters the present system for the dispensing or distribution of medications will have some impact on pharmacy practice and state boards of pharmacy. It would appear that other professions and occupations may foresee and experience the same impact unless such professions and occupations are specifically addressed in the legislation or the reimbursement for their services is included in the legislation. For those professions and occupations it would seem that their viewing of response to health care reform will be in a different, much more immediate light.

Long term, professions such as pharmacy need to redirect their practices and the subsequent regulation of pharmacy practice towards quality of care and objective, continual measurement of that quality. For NABP and the state boards of pharmacy, we are in the pilot project phase of a major initiative to develop standards and a program defined by those standards to accredit community pharmacies for patient care and quality of care. It is an effort to redefine the practice, business, and regulation of pharmacy practice as people have envisioned and with the patient at the center of all activities. It will allow pharmacists to provide patients with the care and expertise that pharmacists are educated and uniquely qualified to deliver, unfettered by some of the present restraints and restrictions. It will refocus standards to an evidence-based approach and seek uniformity across practice sites and the country in more ways than were ever possible or accepted in the past.

Martin Crane, M.D., Chair, Federation of State Medical Boards

In your opinion, what was the most significant development in licensing (or certification) during 2009, both generally and in your field?

State medical boards, like other segments of the health care system, find themselves in a fast-changing technology environment. Every sector of the American economy is being transformed by new ways to process, store and use information. This trend, coupled with the increased mobility of physicians from state to state in recent years, has spurred state medical boards to find ways to be more efficient and streamlined in their licensing of physicians. Medical boards are also very cognizant of the impact the rise of telemedicine on medical practice and, subsequently, the licensing process. Telemedicine can allow physicians to provide service remotely with patients, and thus they have the capability to practice in multiple states at the same time. Recognizing these trends, the Federation of State Medical Boards (FSMB) and state medical board community have been working diligently to develop systems to make it easier for physicians to become licensed and credentialed in multiple states. Many of these efforts began to come together during 2009 as the FSMB and state medical boards made major progress in developing the tools to make the concept of

"license portability" an actual reality in mainstream medicine.

Since its beginning nearly a century ago, the FSMB has worked to develop what today serves as the most robust and comprehensive verified central repository of U.S. physician licensing and credentialing information. At the core of this repository are the Federation Physician Data Center and the Federation Credential Verification Service (FCVS). The Physician Data Center receives data directly from an array of organizations throughout the United States, including state medical boards, government agencies and international medical licensing authorities. This nationally consolidated data bank then provides state medical boards and health care credentialing entities with critical information about physicians, including disciplinary and licensing data. The FCVS performs primary source verification of medical credentials, allowing physicians and physician assistants to establish a lifetime professional portfolio that is continuously maintained and updated by the FSMB in a secure environment. This service is designed to streamline the credentialing process and create a more efficient process for physicians who need their credentials primary-source verified efficiently and sent to institutions which are reviewing and utilizing these credentials. Realizing the importance of such a resource, in 2009, the FSMB undertook a major technology design and upgrade to significantly enhance streamline and make more efficient its capabilities for verifying physician credentials through the FCVS process.

During 2009, many medical boards implemented the Uniform Application for State Medical Licensure (UA). This application consists of one primary form common to all states with state-specific addendums, allowing each state to tailor the form to the needs of their jurisdiction while gaining the efficiencies associated with a standard electronic application. So far, 24 medical boards are either using or in the process of implementing the UA. When a physician elects to use the UA in conjunction with the FCVS credentialing services, further efficiencies are realized as the UA is pre-populated from the FCVS application and the credentials verification process is effectively reengaged when licensure is sought in additional states.

These efforts to improve license portability and informational exchange during 2009 are anticipated to help lay the foundation for a new era of more efficient and streamlined medical licensure and credential verification in venues across the U.S. health care system. By doing so, we can the FSMB can assist in the response to workforce and access to care issues as well as provide important and accurate resources to assist in the response and deployment of qualified, licensed physicians in the case of national emergencies.

What do you foresee to be the greatest challenges and opportunities in licensing in 2010, both generally and in your field?

Current FSMB policy states that State Medical Boards have an obligation to the public to assure the continuing competence of physicians seeking license renewal. The public wants physicians to be up to date in their medical practices and that state medical boards have the authority within their public mandate to require all physicians to periodically demonstrate their ongoing competence. There is current data that supports continued lifelong medical education as an effective means of physician learning and change if it is part of a system of continuous development that includes self-assessment, remediation and reassessment. There is also widespread national focus on improving quality of care and initiatives that are creating a "culture of improvement" in medicine.

Responding to the environment of accountability for the self-regulatory system

and the profession to the public, the FSMB embarked upon a bold initiative in 2003 called Maintenance of Licensure (MOL) which seeks to utilize the authority of state medical boards through the license renewal process to assure the public that physicians are maintaining their competency by a continuous assessment and learning process. Such an initiative also responds to a paradigm shift at state medical boards from a reactive approach to a more proactive approach, which encourages correction, improvement and prevention. This proactive approach will surly be more effective and more efficient in driving quality improvement. The MOL initiative will be brought to the Federation's House of Delegates in April of 2010 to adopt as policy and in parallel implementation plans are being developed for state medical boards that are "feasible, reasonable and consistent with several guiding principles" adopted by the FSMB's House of Delegates in 2008. These guiding principles state that MOL should support lifelong learning and improvement in physician practice, state medical boards should establish the requirements, not compromise patient care or create barriers to physician practice, be flexible with options and balance transparency with privacy protection. The basic framework for MOL would provide evidence of participation in a program of professional development and lifelong learning based on the 6 general ACGME competencies with 3 main components-reflective self assessment ("What improvements can I make"), assessment of knowledge and skills ("What do I need to know") and performance in practice ("How am I doing"). The entire House of Medicine, including the regulatory system, assessment and certification organizations, the profession and the pubic has been included in developing a comprehensive policy and setting implementation criteria for this in important initiative. Careful attention has been paid to impacts on all stakeholders and how to mitigate and respond to challenges.

Current streams of work include developing the evidence-based rationale for such a system, addressing all impacts and challenges and developing a "reasonable and feasible" start-up implementation framework for state medical boards.

The MOL initiative is certainly relevant to our current health care reform environment as a model for verifiable self improvement and a reinforcement of good behavior resulting in lifelong learning, practice improvement, patient safety and improved access to the highest quality of care.

State Medical Boards with the authority and experience to license must take a leadership role in this process. They carry a direct mandate from and trust of the public. They will, however, need to collaborate with other stakeholders who will be providing the necessary tools and resources for implementation. The process will more likely have success if it is an evolutionary one rather than a revolutionary one, starting off simple and then evolving as we learn more from it.

The Federation can and should commit to a leadership role with the state medical boards by providing significant human, financial and legal services and support to help with responding to new challenges and implementation.

If enacted, how do you think federal health care reform legislation will impact licensing (or certification) in the short run? In the long run?

Through the initiatives previously described, the FSMB and state medical board community are positioned to serve as key information and regulatory policy resources to assist in the development and implementation of changes that could occur from large-scale health care reform. For example, the FSMB's comprehensive and

robust database can serve as a major component in any implementation of workforce development portion of health care reform regarding the demographics and practice patterns of physicians. This database and our informational management systems could also be resources in the implementation of the expanded efforts in health care reform to curtail fraud and abuse in the Medicare and other program. And the Maintenance of Licensure policy initiative and its proactive relationship to physician quality of care and patient safety could serve as a significant part of the overall policy framework relating to the Physician Quality Reporting Initiative provisions under consideration by Congress. Finally, improved license portability with its positive workforce and access to care derivatives can help address some of the health care issues we now face, including the need to lower costs, provide care to underserved populations and facilitate well regulated and monitored telemedicine programs.

Donna DeAngelis, LICSW, ACSW, Executive Director, Association of Social Work Boards

In your opinion, what was the most significant development in licensing (or certification) during 2009, both generally and in your field?

Generally, the increased acceptance of licensure over all professions; the change to requiring credentials for tax preparers, as well as growing recognition by newspapers and the courts that licensing is essential to public protection, has been encouraging.

At the same time, state governments are experiencing the effects of the economic difficulties resulting from the recession during the last 18 months. Because professional regulation isn't as high a priority in governments as some of the other public services, state agencies are raiding the funds collected from licensure fees to make up part of the deficits. This can hinder professional regulation and enforcement, and even bring it to a halt.

The good news is that Association of Social Work Boards (ASWB) and many similar regulatory associations are increasingly willing and able to provide the licensing boards with services that assist them in fulfilling their mission of public protection. The discussion at the ASWB Annual Meeting last October illustrated that licensing and examinations are an accepted part of the social work profession, and a great deal of interest and reliance on ASWB not only as an exam developer but for its other services to its member boards. ASWB is prepared to help its member boards by providing services to help them do their work of protecting the public. We process licensing applications for the Massachusetts Board of Regulation for Social Workers for a contracted fee paid by the candidates. We also provide board member training without charge and cover all travel expenses for board members to attend. ASWB charges no registration fee for the Spring Education Meeting and the Annual Meeting of the Delegate Assembly, and for the Delegate Assembly ASWB pays the travel expenses for one delegate from each member board to attend. These services will continue in 2010 and ASWB will undertake strategic planning this year to determine what else its members need and whether ASWB can provide it.

What do you foresee to be the greatest challenges and opportunities in licensing (certification) in 2010, both generally and in your field?

The international interest and advances in licensure have increased dramatically over the last few years. ASWB has had a Chinese delegation visit its offices this year, a group greatly interested in how licensing of social workers is done in the U.S. The association has also participated in a new email group that was formed as the result of an

international meeting, and materials are being shared between countries. This year, the president and executive director will attend the conference of the International Federation of Social Workers in Hong Kong. An additional Canadian member board plans to begin using the exams, and discussion is underway about translation into French, an official language in some Canadian provinces.

Globalization will allow for consideration of new, different, and possibly better ways to do things; technology may be able to help regulatory boards make progress on some longstanding issues, such as how best to implement a true continuing competence program, how to speed up licensure, and how to effectively respond to complaints.

I think that the greatest challenge to licensing in general is exemptions. Governmental agencies are increasingly pressured to permit people to practice even some of the tasks associated with licensed professions without demonstrating that they have the appropriate education and knowledge.

Responding to the related issues of globalization and technical innovation, licensing entities will face increased pressure to respond to calls for “alternative pathways” to licensure from applicants and others who question long-accepted standards, and will have to make regulatory decisions about how technology may or may not be used in practice, and how and whether borders are “crossed” when that technology is used.

The implementation of professional regulatory elements of the Canadian Agreement on Internal Trade (AIT) – not only is this change significant for Canada, but it may become a kind of proving grounds for the development of similar mandates in the U.S. The AIT has pros and cons that impact a regulatory board’s ability to gate-keep. It requires a regulatory entity to accept the determination of another regulatory entity in another province. The positive side of this is that it increases professional mobility and promotes standardization of requirements among provinces.

If enacted, how do you think federal health care reform legislation will impact licensing (or certification) in the short run? In the long run?

We hope that better health care will include better controls of standards of practice. In the future, I think we can expect to see more standardization of licensing from state to state. Standardization would have a positive effect on professional mobility and public understanding of what each profession’s scope of practice is. For social work, the inclusion parity for mental health services as a part of total health care is very significant.

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

In your opinion, what was the most significant development in licensing during 2009, both generally and in your field?

Exam security has become an increasing area of concern to licensing test developers. Numerous examples exist in many health care professions that are experiencing exam breaches that serve to provide an unfair advantage to certain candidates, challenge the validity of exam results and threaten the item banks of test developers. These examinations that are used for determination of entry-level competency are an important pubic protection tool and the validity should and must be protected. In many cases these breeches have resulted in great cost to replace compromised items, ongoing psychometric forensic monitoring, Internet monitoring in multiple languages, and the associated legal cost to pursue these matters.

What do you foresee to be the greatest challenges and opportunities in licensing in 2010, both generally and in your field?

The concept of continuing competency beyond initial licensure has been conceptually accepted by many licensing authorities and professional associations. The details of moving this conceptual agreement to concrete and viable models and approaches will need further discussion and consensus building within the professional and licensing community. The development of models and tools can be an expensive and time consuming process as licensing authorities move to adopt necessary changes to their practice acts, rules and regulations. Because of this, movement to implement continuing competency may be strained due to the limited resources available to licensing authorities in our current challenging economic environment, as some states will have limited available funding. Collaboration with other health care professions and federations could serve as a vehicle to move the development of various successful approaches, models and tools forward to best serve our collective licensing authorities. The best model has yet to be developed. Through active dialogue and sharing of successes and failures between health care groups, including organizations in other countries, a model and strategy for implementation may be found. Successful development will need to be designed to ease the burdens placed both on licensing authorities and licensees.

If enacted, how do you think federal health care reform legislation will impact licensing in the short run? In the long run?

In the very short term, I do not believe federal health care reform will have an immediate impact on licensure. Past the very short term, it is possible that real or perceived access to care issues or shortages of healthcare providers will arise. If this is the case, licensing authorities may come under pressure from legislators, and the public, to adopt standards that allow freer movement of health care workers from other states and countries. It must be the responsibility of jurisdictional boards to develop and adopt acceptable uniform standards that addresses the real or perceived concerns but still provides for an appropriate level of consumer protection. If there is a need for unique standards for licensure on a jurisdiction-by-jurisdiction basis, these must be justified by data and research. The development of best practices and the development of technological systems to enhance service to both the licensee and the public will become increasingly important. State licensing is foundational to our system, and jurisdictional boards must remain relevant to consumer protection and responsive to the aforementioned legislative pressures or risk being challenged by or dictated to by the federal government.

Paul Grace, MS, CAE, President/CEO, National Board for Certification in Occupational Therapy, Inc.

In your opinion, what was the most significant development in certification during 2009, both generally and in your field?

- Publication of the ICE Handbook that details current certification concepts, principles, and program development and deployment strategy.
- Multi-agency leadership meeting, hosted by ICE in December 2009, that identified and subsequently discussed industry-wide issues and opportunities for future collaborate initiatives to address these issues and expand the industry's body of knowledge.

- Recognition by the Obama Administration of the vital role certification plays and can play in the future through its American Graduation Initiative.

What do you foresee to be the greatest challenges and opportunities in certification in 2010?

- Resolving confusion between professional certification and assessment based certificate programs.
- Indentifying and agreeing on industry-wide high quality research initiatives.
- Securing adequate funding sources to support the industry's research agenda.
- Inadequate resources and programs that are designed to provide the public with the tools they need to discern the characteristics of a high stakes certification program
- Transitioning the current certification model to meet the dynamic demands of the marketplace while maintaining program essentials of validity, reliability, fairness, and quality.

If enacted how you do think federal health care legislation will impact certification in the short run? In the long run?

- Agencies will have to demonstrate that their practice (and examination content) is grounded in evidence.
- Scope of practice conflicts will increase due to limited resources.
- New "professions" or spin-offs of existing professions will emerge seeking third-party or legislative recognition.
- The "wall" between certification and academic accreditation will be narrowed due the need for practices to be market responsive.
- Effective professional discipline will be challenged, as professionals will have the opportunity to be credentialed by more than one certification body.

Jill Martinson-Redekopp, OD, North Dakota State Board of Optometry, Chair, State Council on Optometric Practitioner Education, Association of Regulatory Boards of Optometry

In your opinion, what was the most significant development in licensing during 2009, both generally and in your field?

The biggest issue in optometry during 2009 was the ongoing discussion of continued competence. For a number of years, the profession has collectively researched the method by which continued competence may be measured. Traditionally, continuing education has been utilized by licensing boards as one measure of competence for maintenance of licensure. Recognizing a need for assurance of quality continuing education, the Association of Regulatory Boards of Optometry (ARBO) in 1993 developed the Council on Optometric Practitioner Education (COPE). COPE's mission is to assist member regulatory boards in the review and accreditation of optometric continuing education. COPE's objectives, in part, are to monitor programs to help assure high quality continuing education in appropriate settings with adequate administration. However, a general agreement within the licensing boards has been that continuing education alone does not guarantee continued competence. To this end, a resolution was passed by the ARBO House of Delegates in June 2009 which acknowledges the concern

and serves as a call to action for the regulatory boards. An improved system of demonstrating continued competence could be used by individual jurisdictions for the public welfare.

The regulatory boards of optometry were also represented in discussions with other leaders in optometry regarding the feasibility of Board Certification for optometry. A resolution was passed at the American Optometric Association House of Delegates in June 2009 for the formation of the American Board of Optometry. The end product of this board as a measure of advanced competence beyond entry level and its impact on the profession have yet to be determined; however, any Board Certification will not serve as a substitute for licensure nor will it usurp the authority of the licensing boards as final determinant for licensure.

What do you foresee to be the greatest challenges and opportunities in licensing in 2010, both generally and in your field?

In 2010, I expect that the licensing boards of optometry will continue to examine the issue of continued competence as it applies to maintenance of licensure. Maintenance of licensure is not the same as entry-level competence because of the ever-changing and evolving technology and knowledge base of any health field. In my opinion, all health care professions will look more stringently at criteria for maintenance of licensure in the upcoming years. Not only will the public likely demand accountability from licensing boards in this area, but it is the right thing to do.

Optometry is somewhat unique in the fact that it is largely a legislated profession. A study of practice acts across the nation demonstrates, in many cases, a great disparity from state to state. This is particularly true for the use of therapeutic medications for eye care. As state associations are successful in passing healthcare legislation to expand the scope of therapeutic practice, state licensing boards are obligated to ensure that licensees in those states are proficient and qualified to utilize the procedures and medications within the expanded practice act. Ultimately, the state licensing boards must meet their obligations to protect the public by ensuring the licensees are capable and competent.

As we as a society become more mobile, portability of licensure will become more important. I believe our profession will continue to see an increase in legislation which will allow for licensure by endorsement. As optometric practice acts become more uniform this will make endorsement more acceptable among state optometric licensing boards as well.

If enacted, how do I think federal health care reform legislation will impact licensing in the short run? In the long run?

At the time of this writing, it is unclear to me the impact of federal health care reform on licensing in the short term. Until more details of the final health care reform bill are revealed, any comment on this would be speculative at best.

In the long term, one of the components of health care cost containment that appeared in final white paper on health care reform authored by the Senate Finance Committee Chairman in 2009 involved the value of increased transparency from physician-industry relationships. To the degree that industry is often a financial supporter of health care education, licensing boards that utilize this continuing education as a component for maintenance of licensure will have a greater responsibility to ensure that the education is unbiased and free from commercial interest.

Adam Parfitt, Executive Director, The Council on Licensure, Enforcement and Regulation (CLEAR)

In your opinion what was the most significant development in licensing during 2009, both generally and in your field?

The effects of the financial crisis that engulfed much of the world during 2009 were felt in the regulatory community, as they were in the economy generally. From new regulations for occupations and professions deemed to have in some way contributed to the current crisis (in particular those unregulated parts of the housing and financial sectors), to budget cuts across agencies and boards, the crisis has left its mark on the regulatory community. More than 24 states have furloughs in place for employees, and 18 are planning or have enacted layoffs[1], part of a fiscal picture that is not expected to improve before FY 2013.

Against this backdrop, many regulators find themselves coming under increased scrutiny for perceived shortcomings in their compliance and discipline programs. High profile reorganizations at California's Department of Consumer and Regulatory Affairs and others resulted from press investigations and ensuing critical reports into delays in resolving complaints and investigations. Of particular concern was the threat to the public from professionals who continue to practice during lengthy delays (which in some cases averaged more than three years from receipt of the initial complaint to when, where warranted, disciplinary action was taken). Unsurprisingly, the effects of furloughs (in some cases three days per month) on enforcement backlogs were raised as a concern. Similarly, potential systemic problems were identified in California around the complex route via which complaints travel, and the way in which a relatively small pool of investigators address heavy caseloads from a variety of professional and occupational regulatory boards. The widespread adoption of the central agency model across the United States, which tends to share the characteristics of the compliance and discipline process in California, will alert other agencies to the potential for problems in this critical area. It also ensures any recommendations and corrective action will be of considerable interest across the regulatory community.

Given the vital nature of regulatory compliance and discipline in maintaining public trust and confidence in the regulatory process, it is critical that measures are set in place that will restore confidence in the efficacy of regulatory programs. The next round of legislative sessions will likely feature legislation to address perceived shortcomings, and it will be interesting to note both the outcomes resulting from changes in California as well as revisions to the compliance and discipline function elsewhere.

What do you foresee to be the greatest challenges and opportunities in licensing in 2010, both generally and in your field?

The financial pressures facing many of those agencies and boards tasked with the protection of the public via occupational regulation will likely provide the greatest challenges in the year ahead. Double-digit budget cuts are not uncommon, and the pressure on agency and board staff will be considerable. Further automation of much of the regulatory function (including online applications, renewals and continuing education/competence reporting that are already in place in some agencies) is inevitable, and commercial opportunities undoubtedly exist for those willing and able to offer solutions to aid this process.

[1] http://www.stateline.org/live/details/story?contentId=440784 (December 2, 2009)

Depending on the funding model in place, agencies may also be impacted by a declining licensee base, as regulated professions or occupations go out of business or are terminated, or decline to renew and thereby prompt unlicensed practice investigations. Fee increases for initial licensure, renewals and other administrative tasks are already evident in numerous agencies and jurisdictions. While many states ensure that their regulatory functions are revenue neutral, communication with licensees will be critical to avoid the perception that states are passing on financial shortfalls to those obligated to hold an occupational license.

Despite a difficult economic environment, opportunities will present themselves to further refine continuing competence programs, which remain of considerable interest to the international regulatory community. Many international jurisdictions are looking beyond continuing education requirements, to demonstrations of ongoing competency. However, questions abound regarding whether current programs, many of which rely on self-assessment principles, are entirely appropriate.

For example, in the United Kingdom, most doctors will undergo annual assessments by the regulator (the General Medical Council) in order to:

- "confirm that licensed doctors practice in accordance with the GMC's generic standards;
- confirm that doctors on the GMC's specialist register or GP register continue to meet the standards appropriate for their specialty; and
- identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist." [2]

The annual appraisal process will form part of a re-licensure process designed to begin after 2011, in which doctors will be relicensed every five years. Other components of the process include:

- "Participation in an independent process for obtaining feedback from patients (where applicable) and colleagues.
- Secure confirmation from the 'Responsible Officer' (usually the Medical Director) in the practitioner's local healthcare organization that any concerns about their practice have been resolved."[3]

If enacted, how do you think federal health care reform legislation will impact licensing in the short run? In the long run?

In both the short term and long run, federal health care reform legislation will likely further involve the federal government in the business of occupational and professional regulation, hitherto largely the province of the states. The creation of new agencies and new federal mandates make such an outcome all but inevitable.

Less certain might be the effect of the debate over healthcare reform that has brought us to this point. Largely ideological in nature, occupational regulation has appeared occasionally, highlighted by critics as a potential (and expensive) impediment to the functioning of the free market in healthcare. Some have suggested that this would be a more appropriate focus for healthcare reform.[4] Elsewhere the prevailing orthodoxy remains that where a profession or occupation poses a meaningful threat to the welfare of the public, some form of regulation is warranted. The regulation of

[2] General Medical Council website: http://www.gmc-uk.org/doctors/licensing/revalidation.asp

[3] General Medical Council website: http://www.gmc-uk.org/doctors/licensing/revalidation_relicensing.asp

[4] CATO Handbook for Legislators: http://www.cato.org/pubs/handbook/hb111/hb111-15.pdf

paraprofessionals continues to expand and the New Year's legislative sessions will undoubtedly see further moves in this direction.

The degree to which this economic argument embeds itself in the broader health policy arena in the months and years ahead is perhaps the larger question. Time will tell.

Editorial Board, CAC News & Views

We are struck by the variety of accomplishments our guest correspondents mentioned for 2009 and challenges they see upcoming in 2010. By far the most frequently mentioned challenges arise because of dramatically reduced financial resources. Suggested coping strategies include developing public-private partnerships and reliance by boards on associations of licensing boards to help their members with resources and services.

Several commenters mentioned continuing competence as an accomplishment in 2009 or as a challenge or opportunity for 2010. Other issues on their radar screens include uniform licensure requirements, license portability and information exchange, exam security, public scrutiny of board shortcomings, accountability, and globalization.

What do we at CAC consider to be the most important development in 2009?

We certainly felt the impact of the financial meltdown and reduction of resources in the states. For example, so many states had travel restrictions or outright bans that we had the poorest attendance at our annual meeting in many years.

Also of significance in 2009 was the continuing drive for accountability and transparency in licensure and certification. We saw critical state-sponsored audits of regulatory boards in such states as Texas, Georgia, and Maryland. Montana adopted uniform rules for disclosure of board discipline; Georgia considered legislation requiring scheduled reviews of licensing boards.

This trend had its most dramatic impact in California where state and media investigations of impaired professionals programs resulted in cancellation of the medical board's physician assistance program and more recently the adoption of extremely strict standards for impaired professionals programs which will apply to all the state's regulatory boards. Subsequently, exposes by ProPublica and the Los Angeles Times revealed serious problems with the disciplinary programs at the Board of Nursing and elsewhere, leading to improvements in disciplinary processes in the state. So, in California, we have seen the state make moves to be more accountable in reaction to public scrutiny.

What challenges and opportunities do we at CAC see in 2010?

Readers of CAC News & Views are aware that nearly every issue contains articles about scope of practice legislation in the states. We can anticipate an increase in 2010 in efforts on the part of non-doctor health care professions to expand their scopes of practice and a corresponding intensification of organized medicine's opposition to this trend. The January 18 issue of American Medical News (www.ama-assn.org/amednews) reports on the AMA's plans to fight scope of practice expansions in the legislatures and the courts.

CAC agrees with those who contend that arbitrary and unjustified scope of practice restrictions unnecessarily interfere with consumers' access to care and unnecessarily drive up the costs of care. We believe that health care professionals should be empowered to practice to the full extent of their training and skills and that scope of practice decisions at the legislative level should be made on the basis of evidence

rather than political muscle. We feel so strongly about this that in 2010, CAC is organizing a project to try to introduce more rationality and put the patient first in scope of practice decision making.

In 2010, we hope to see progress with another of CAC's priorities – continuing competence – spurred on by the new IOM report entitled *Redesigning Continuing Education in the Health Professions*, the excellent benchmark study by Jim Henderson published by the Institute for Regulatory Excellence (ICE, formerly NOCA), and the initiative underway at the Federation of State Medical Boards.

If enacted, how do we think federal health care reform legislation will impact licensing in the short run? In the long run?

The fate of healthcare reform continues to be uncertain. If more Americans do obtain insurance coverage and shortages of health care professionals continue or get even worse, changes in scopes of practice will become even more important for reasons of access and cost.

Ben Shimberg Memorial Lecture

Delivered October 28, 2009 by Sidney Wolfe, M.D., Director, Public Citizen Health Research Group and Consumer Representative on FDA's Drug Safety and Risk Management Advisory Committee

It is a real honor to receive this award from CAC because you are a group dedicated to patients and consumers. I have a long history of supporting what CAC does. Helping, training, and providing materials for board members – public and licensee – is a wonderful idea and worthy endeavor. You mentioned the Drug Safety and Risk Management Advisory Committee. FDA is another organization with an exemplary program for training consumer representatives on its advisory committees. It is really important to have effective public members on boards, not just a token representation or a quota, but people who have a history of advocacy, who can take on the professionals on the boards and can really make a difference.

I will start my talk by quoting from an Op-ed I wrote in The New York Times in 2003, entitled, A Free Ride for Doctors. The lead sentence refers to malpractice payouts and says, "From 1990 to 2002, just 5 percent of doctors were involved in 54 percent of the payouts – including jury awards and out-of-court settlements." Later on, I point out that, "Among the 2,774 doctors who had made payments in five or more cases, only 463 – one out of six – had been disciplined." This is data to which medical boards have access.

The Op-ed goes on to say that you rarely hear doctors say, "We want more doctor discipline." When is the last time you heard that, except from some of the better members of state medical boards? Generally, organized medicine doesn't go to the state capitol saying, "We want more doctor discipline." Organized medicine says, "We want more caps on malpractice payouts."

Back to the first sentence of the Op-ed: most doctors are practicing good medicine. Most nurses and pharmacists and other practitioners are practicing good medicine. A relatively small number are responsible for a disproportionate amount of the damage done to patients, a small fraction of which result in a malpractice lawsuit. Something like ten percent of cases involving negligence actually winds up in litigation.

So, the difference between states – and this applies also to nurses, pharmacists, and others – is the extent to which a licensing board actually investigates and does something. Health Research Group (HRG) – to the irritation of some people – issues annual rankings of medical boards based

on their disciplinary activity. We usually find about a ten-fold difference between the boards that do take the greatest number of serious actions (revocations, suspensions, probation) and the boards that take the fewest actions. Generally, the boards that do more are the same ones year in and year out and the boards that do less are the same ones year in and year out. HRG contends that more disciplinary activity by licensing boards would result in fewer people being injured or killed, and this would reduce medical malpractice litigation, as well.

Most of you know that, thanks to the American Medical Association, the data in the National Practitioner Data Bank (NPDB) is secret. Neither you nor I can learn the identity of doctors or hospitals from the NPDB. There is, however, a public file that is updated regularly and can be downloaded from the Internet, which is how we are able to acquire some aggregate data.

From the public data, we have learned about a group of licensed physicians who have made between 4 and 30 malpractice payouts each – totally more than $8 million for each doctor. None of these physicians had been disciplined by any state medical board between September 1, 1990 when the data bank began and the end of December 2004. All of the payouts were made in states where the physicians were licensed and actually practiced.

I encourage public members to take a look at the publicly available data for their states in the NPDB's files. If you did so, this is the kind of information you would find about physicians with large malpractice payouts, but no discipline by their licensing boards, either serious or minor discipline:

- New York Physician #24867 had 8 payouts totaling $12,712,000 between 1993 and 2002, four times for improperly performed surgeries, twice for unspecified monitoring errors and twice for unspecified surgical errors.
- Connecticut physician #183018 had four malpractice payouts totaling $12,625,000 between 2002 and 2003, twice for improperly performed surgeries, and once each for a wrong diagnosis and an unspecified surgical error.
- Kansas physician #14052 had fourteen payouts totaling $10,175,000 between 1991 and 2002, 12 times for delayed performance or improper management of obstetric cases, once for wrong treatment or procedure, and once for an unspecified obstetrics error.
- Pennsylvania physician #33059 had thirty payouts totaling $10,117,500 between 1993 and 2004, nine for failure to diagnose, five for unspecified errors, three for improper management of obstetrics cases, three for improper performance of surgery, two for failure to treat, one for surgery on the wrong body part, one for failure to obtain consent for surgery, one for delay in treatment of fetal distress, one for failure to treat fetal distress, one for an improperly performed delivery, and one for improper treatment.
- Arizona physician #493 had six payouts totaling $9,790,000 between 1992 and 2003, twice for improperly performed surgeries, twice for unspecified surgical errors, and once each for a failure to perform surgery and an unspecified treatment error.

Arizona was one of the worst states in our rankings in the late 1990s. Both print and electronic reporters in Phoenix and Tucson starting reading up on the board and asked why doctors with numerous malpractice payments hadn't been disciplined. State legislatures have the power to perform reasonable oversight of licensing boards. If there is inadequate staff, resources, or leadership, legislatures can try to do something about it. Because of the embarrassment heaped on them by reporters, the Arizona legislature began to exercise oversight over the medical board. As a result, they appropriated 24 percent more funds to the board. The executive director was let

go. Within three years, the board tripled the rate of serious disciplinary actions. It wasn't because there was an immigration of bad doctors into Arizona. It was because the board was more empowered to do what they are supposed to do. They went from 38th in our ranking to first. They are still among the best five or ten boards.

- Nevada physician #21426 had four payouts totaling $8,577,500 between 1991 and 2003, twice for delays in diagnosis, once for a failure to diagnose, and once for an unspecified obstetrics error.
- Washington State physician #71555 had four payouts totaling $8,435,000 between 1995 and 2001, twice for failures to diagnose and twice for delays in surgical performance.

In the other Washington, up until three years ago, there was not one full-time employee at the medical board in Washington, D. C. where I and 4,000 other physicians are licensed and the board didn't do any discipline.   The Washington Post did an expose and the City Council held hearings, changed the laws, and increased the appropriation. As a result, D.C. made the greatest improvement of any jurisdiction in our ranking because suddenly, they had the staff to do discipline.

- Illinois physician #127631 had four payouts totaling $8,285,000 between 1998 and 2003 for improper delivery, failure to treat fetal distress, improper management of an obstetrics case and a delay in diagnosis.
- Tennessee physician #35472 had seventeen payouts totaling $8,237,500 between 1991 and 2004, 12 times for improper performance of surgery, twice for improper management of surgery, once for equipment problems during surgery, once for failure to obtain consent for surgery and once for an unspecified surgical error.
- Texas physician #37949 settled or lost 13 medical malpractice suits involving improper treatment or improper performance of surgery between 1990 and 1997. Two of the suits involved the same allegation – a foreign body left in the patient during surgery. Damages to this doctor's patients exceeded $2 million. This doctor has not been disciplined by the authorities in Texas.

These are serious problems.   In a conversation earlier this evening, it was pointed out that there are different legal standards in different states. But, the infractions I just told you about are so gross that I don't think a difference in legal standards can begin to explain the inaction of the states. At a minimum, the malpractice data should be a trigger prompting boards to take a closer look at the practice and performance of the physicians involved.

Examples of physicians who committed serious offenses but were inadequately disciplined include:

- An Iowa anesthesiologist who fell asleep during a surgical procedure, inappropriately left the operating room during surgery, and falsified records was merely suspended for one month, fined $5,000, and placed on five years of probation.
- A Washington doctor who had inappropriate sexual conduct with three patients and attempted to perform a pelvic exam on a patient being treated for upper back pain was merely fined and subjected to restrictions on his license.
- A Maryland doctor who breached the standard of care for the delivery of quality anesthesiology to 21 patients out of 23 cases reviewed by his peers received a reprimand and had restrictions placed on his license.

- A Virginia doctor who twice used HIV-positive semen for artificial insemination was merely fined $5,000 and reprimanded.
- A South Carolina orthopedic surgeon who was caught using an amputated human foot for crab fishing was merely slapped on the wrist and fined.

Data through 2004 show that only 8.3 percent of doctors who had two or more malpractice payouts were disciplined by any board. Only 1/3 of doctors who had 10 or more payouts were disciplined by any board.

The rate at which doctors with numerous malpractice payouts are disciplined varies enormously from state to state, just as serious disciplinary activity by boards varies from state to state. The range of discipline of doctors with ten or more payouts is between 5 and 54.5 percent.

Just as alarming as the failure of boards to discipline practitioners with numerous malpractice payouts is the fact that only about half the hospitals in the United States have ever reported an adverse action against a doctor to the NPDB.

The problem involves more than data about doctors. And, it's not just the public that can't access practitioner-specific information about practitioners who have been disciplined. Secrecy at the NPDB prevents non-federal hospitals and nursing homes from learning about the disciplinary records of a variety of practitioners, including nurses, pharmacists and physician assistants. The data bank contains the names of more than 40,000 nurses and 49,000 LPNs who have been sanctioned for health care-related violations, including unsafe practice or substandard care, misconduct or abuse, fraud, deception, misrepresentation, and improper prescribing or dispensing or administering of drugs. There are numerous examples of nurses who move from one hospital to another because the hospital did not know of their disciplinary records.

Section 1921 of the Social Security Act would allow the nation's 5,000 non-federal hospitals and about 700 nursing homes to see data bank records on non-physician health professionals. But this provision of the Social Security Act has never been implemented.

HRG has been pressing for the implementation of Section 1921 for a couple of years. The Bush administration did nothing because the election was pending. HRG wrote to Secretary Sibelius on August 26, 2009 urging her to implement the law and give hospitals and nursing homes access to a comprehensive database so they could learn something about who they are hiring. We pointed out that keeping data about disciplined nurses and other allied health professionals confidential means that "though they have been disciplined one or more times, many in multiple states, such healthcare workers can get jobs at hospitals or nursing homes because their employers lack awareness of their previous unsatisfactory records."

So, while hospitals have access to data about doctors in the NPDB, this data about other professionals is sitting in the Healthcare Integrity and Protection Data Bank (HIPDB). The remedy is just to transfer this data to the NPDB, thereby allowing hospitals and nursing homes to access it. In October, Secretary Sibelius wrote to us saying they have sent a final rule to OMB and expect implementation of Section 1921 in the near future.

I conclude by quoting from an editorial that appeared in the Journal of the American Medical Association in 1987:

> The success of boards to improve medical discipline will finally depend, of course, on the funding, staffing, and authority of state boards. These can only come from state legislatures willing to act responsibly… Those who sit in the legislatures of the various

> states must recognize that the effective regulation of medical practice is in their hands. (JAMA, February 13, Volume 257 pp. 828-9).

A final word to this audience: I think part of every board member's responsibility – but more likely to be something the public members are going to do – is to make sure that the appropriate legislative committees are interested and informed so they can take legislative action to help make the boards more effective and make your job as a public members better and more satisfying.

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<u>CAC is Now a Membership Organization</u>

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. 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:

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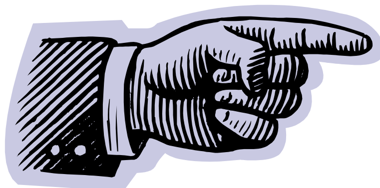

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