



News & Views

Citizen Advocacy Center

Second Quarter, 2016 – Health Care Public Policy Forum – Volume 28 Number 2

Announcement

Our 2016 annual meeting will be held in Portland Oregon on Saturday afternoon and Sunday morning, September 17 and 18, 2016. The meeting will be co-sponsored by CLEAR, and the theme will be “Modernizing the Regulatory Framework for Telehealthcare Delivery.” It will take place immediately following the CLEAR Annual educational conference, which ends at noon on Saturday. The Program and Meeting Registration Form can be accessed from www.cacenter.org.

SCOPE OF PRACTICE

Veteran’s Administration Proposes Full Practice for APRNs

On May 29, 2016, the Veteran’s Administration announced a proposed rule to grant full practice authority to Advanced Practice Registered Nurses (APRN) when they are acting within the scope of their VA employment. VA Undersecretary for health, Dr. David J. Shulkin said:

“The purpose of this proposed regulation is to ensure VA has authority to address staffing shortages in the future. Implementation of the final rule would be made through VHA policy, which would clarify whether and which of the four APRN roles would be granted full practice authority. At this time, VA is not seeking any change to VHA policy on the role of CRNAs, but would consider a policy change in the future to utilize full practice authority when and if such conditions require such a change. This is good news

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for our APRNs, who will be able to perform functions that their colleagues in the private sector are already doing.”

CAC submitted the following statement in support of the VA’s proposal:

The Citizen Advocacy Center (CAC) supports the Veterans Health Administration (VHA) proposal to amend its regulations to allow APRNs to practice to the full extent of their education, training, and certification, regardless of individual State restrictions that limit such full practice authority, except for applicable State restrictions on the authority to prescribe and administer controlled substances, when such APRNs are acting with the scope of their VA employment. The proposed rule would use the term “full practice authority” to refer to the APRN’s authority to provide advanced nursing services without the clinical oversight of a physician when that APRN is working within the scope of their VA employment. Such full practice authority would be granted by VA upon demonstrating that the established

regulatory criteria are met. In addition, full practice authority would be granted appropriate to the clinical service setting. We believe VA has the legal authority to exercise Federal preemption of State nursing licensure laws to the extent such State laws conflict with the full practice authority granted to VA APRNs while acting with the scope of their VA employment.

Citizen Advocacy Center (CAC) is a 501-C-3 not for profit organization which, since 1987, has been serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. We offer training, research and networking opportunities for public members and for the health care *regulatory*, *credentialing*, and *governing* boards on which they serve. By emphasizing the public members’ special contributions, CAC keeps the focus on the public protection mission shared by all health professional oversight bodies.

CAC believes that the proposed rule is consistent with the recommendation of the Institute of Medicine (IOM) of the National Academy of Sciences to remove scope of practice barriers. Specifically, the 2010 IOM report, “The Future of Nursing: Leading Change Advancing Health,” (IOM Report) available at <http://iom.nationalacademies.org/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>, recommended that “[a]dvanced practice registered nurses

(APRNs) should be able to practice to the full extent of their education and training.”

For the past decade, CAC has actively monitored and weighed in on numerous scope of practice issues. We believe that the involvement of consumer advocacy organizations in scope of practice decisions is necessary to counterbalance the heretofore unchallenged raw political power enjoyed by the affected professions and their associations. We have published thirteen papers addressing a wide variety of scope of practice issues involving many different health professions, including advanced practice nursing. (Visit www.cacenter.org, where all of our papers are available to read or download under PUBLICATIONS). As we wrote on page 3 of our very first scope of practice paper, “Reforming Scope of Practice,” “The productivity of the U.S. healthcare system is constrained by an inability to make full and appropriate use of its professional workforce. Artificial scope of practice restrictions prevent healthcare professionals from performing the full range of skills for which they have been trained, limit consumer access to care and choice of providers, and inflate the cost of healthcare. These problems are greatest in times, as now, of workforce shortages, and they especially impact already underserved rural areas. Two looming developments will only compound healthcare workforce challenges. These are the gaining of the Baby Boomers (including many physicians and nurses of that generation, whose retirement will compound workforce shortages), and the surge in the number of insured Americans as a result of healthcare reform.”

In our paper, “Scope of Practice FAQs for Consumers – Advanced Practice Registered Nurses (APRNs),” we wrote, “What are the scope of practice issues around APRNs? The APRN profession encompasses a wide variety of advanced nursing specialties; hence a wide variety of scope of practice issues is associated with this profession. However, the main scope of practice issue across all APRN specialties is *independent practice*.” This means enabling APRNs to provide direct patient care services without supervision by or

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forced collaboration with physicians, whether the services are provided in a hospital, a private office, a clinic, an outpatient center, or a patient's home. All APRNs collaborate, consult with, or refer to physicians. Many APRNs practice in health care teams with physicians and other types of health care providers. The issue is whether specific legal requirements for physician involvement limit the services APRNs can provide and areas where they can practice, thereby making it more difficult for consumers to access a full range of care from these providers.”

In justifying its proposed regulation, VA is correct when it states, “By permitting APRNs throughout the VHA system a way to achieve full practice authority in order to provide advanced nursing services to the full extent of their professional competence, VHA would further its statutory mandate to provide quality health care to our nation's veterans. This proposed regulatory change to nursing policy would permit APRNs to practice to the full extent of their education, training and certification, without the clinical supervision or mandatory collaboration of physicians. Standardization of APRN full practice authority, without regard for individual State practice regulations, would help to ensure a consistent continuum of health care across VHA by decreasing the variability in APRN practice that currently exists across VHA as a result of disparate State practice regulations. As of March 7, 2016 CRNAs have full practice authority in 17 states, while CNPs have full practice authority in almost 50% of the nation, which includes 21 states and the District of Columbia.

It would also aid in fully maximizing VHA APRN staff capabilities, which would increase VA's capacity to provide timely, efficient, and effective primary care services, as well as other services. This would increase veteran access to needed VA health care, particularly in medically-underserved areas, as well as decrease the amount of time veterans spend waiting for patient appointments. In addition, standardizing APRN practice authority would enable veterans, their families, and caregivers to understand more readily the health care services that VAS APRNs are authorized to provide. This preemptive rule would increase access to care and reduce the wait times for VA appointments utilizing the current workforce already in place.”

CAC strongly supports the proposed new regulation, and we look forward to its formal adoption.

For more, see: <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793>, and <https://www.washingtonpost.com/news/powerpost/wp/2016/05/27/to-cut-wait-times-va-wants-nurses-to-act-like-doctors-doctors-say-veterans-will-be-harmed/>.

Pharmacists Authorized to Dispense Anti-Overdose Med

In the April 6, 2016, issue of *e-News* the National Association of Boards of Pharmacy reported:

Pharmacists in Florida May Dispense Opioid Antagonist Pursuant to Standing Order

Pharmacists in Florida may dispense an emergency opioid antagonist pursuant to a nonpatient-specific standing order prescribed by a health care provider, according to a recently passed law that goes into effect on July 1, 2016. The standing order would be for an auto-injection delivery system or intranasal application delivery system, which must be appropriately labeled with instructions for use, indicates the law (House Bill 1241).

and

Certain Utah Pharmacies to Offer Naloxone Under Collaborative Practice Agreement

Naloxone, the opioid overdose reversal drug, is available at Associated Food Stores retailer's pharmacies in Utah under a collaborative pharmacy practice agreement with prescribers. Further, each pharmacist has been trained to provide patient counseling on the drug, indicates the company. A list of participating pharmacies is available in the Associated Food Stores press release. Patients under the age of 18 are required to bring an adult family member, notes *Deseret News*. The price of a kit ranges from \$50 to \$70, but patients who have insurance can get some of the cost covered, indicates *Deseret News*.

The state's collaborative pharmacy practice agreement is defined under Senate Bill 158. Further information about dispensing naloxone in Utah is available in House Bill 119.

California Pharmacists to Dispense Birth Control

In April 2016 a law passed in 2013 became effective in California authorizing pharmacists to dispense certain birth control meds directly to women without a physician's prescription. Washington, Oregon and Washington DC have similar laws.

For more, see: http://www.latimes.com/local/lanow/la-me-ln-birth-control-law-20160408-story.html?utm_campaign=CHL%3A+Daily+Edition&utm_source=hs_email&utm_medium=email&utm_content=28278922&_hsenc=p2ANqtz-8RyvrrqBfaCzJZpokRgkcKdxPvY9mPctGChYt749ixAM1keUoLu-8ZlrCHtVJxzPtHdIA-xae7aLsxeb4E3zyYrfy8-qyElWR6IyVrDBITfOwp16nY&_hsmi=28278922

Research Extols Pharmacist Role in Medication Reconciliation

Research reported by the Agency for Healthcare Research and Quality demonstrates the valuable contribution pharmacists make to medication reconciliation and the reduction of medication errors:

Medication reconciliation has been available since 2005, but its adoption has lagged. The Institute of Medicine estimates that at least 1.5 million preventable adverse drug events occur within the health care system each year, and the estimated cost is greater than \$4 billion annually. The process of medication reconciliation involves a "qualified individual" comparing the medications that should be ordered for a patient to the new medications that are currently ordered and resolving any differences.

For more, see: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4771087/>.

Dental Therapists Provide Care to Underserved Native Americans

On May 22, 2016, Kirk Johnson, reporter for *The New York Times*, wrote an article entitled, "Where Dentists Are Scarce, American Indians Forge a Path to Better Care." In it, he describes the difficulty of providing adequate oral healthcare remote tribal lands. One potential solution is to permit dental therapists like Daniel B. Kennedy to provide basic services, including fillings and extractions. The American Dental Association, according to the article, questions the safety and quality of care by dental therapists. Significantly, reporter Johnson quotes the dentist who supervises dental therapist Kennedy.

“I was leery,” she said. But after watching Mr. Kennedy for the past four months and visiting the training school in Alaska, she has changed her mind. By practicing procedures over and over — more than most dental school graduates, who must also study a broad range of diagnostic and disease issues — therapists can hone procedures, she said, to an art.

“Their fillings are better,” she said. “Are we providing substandard care by providing a therapist? Actually, I would say it’s the opposite.”

Read Mr. Johnson’s full article here: http://www.nytimes.com/2016/05/23/us/where-dentists-are-scarce-american-indians-forge-a-path-to-better-care.html?_r=0.

TELEHEALTH

Utah Considers Telepharmacy Legislation

In the April 6, 2016, issue of *e-News* the National Association of Boards of Pharmacy reported:

Iowa Bill Would Bring Telepharmacies to Rural and Underserved Areas

A pharmacist could remotely supervise a pharmacy technician practicing at an approved telepharmacy site in Iowa and provide pharmaceutical care services, including drug regimen review and patient counseling, through the use of technology, according to new legislation that passed in the Iowa Senate and in the Iowa House of Representatives.

Under the proposed law, state pharmacy regulators could routinely approve telepharmacies rather than treating them as limited pilot projects, notes *The Des Moines Register*. The Iowa House amended Senate File 453 to include a mileage requirement, which states that a telepharmacy site cannot be located within 10 miles of a licensed pharmacy that dispenses prescription drugs to outpatients. The Iowa House amendment indicates that a waiver can be granted by the state board if an applicant can demonstrate that a proposed telepharmacy site is located in an area where there is limited access to pharmacy services. Approximately 80 communities in Iowa would be eligible to set up a telepharmacy, states *The Des Moines Register*. The bill is expected to go back to the Iowa Senate for review and approval.

FTC Supports Alaska Legislation Expanding Telemedicine

On March 25, 2016, the Federal Trade Commission sent a comment in support of legislation under consideration in Alaska that would allow licensed Alaska physicians located outside the state to provide telehealth services the same as physicians located in-state. The comment reads in part:

By allowing out-of-state physicians licensed in Alaska to provide telehealth services to Alaskans, SB 74 would expand access to telehealth services, supporting the goal of Alaska’s telehealth program “to bring quality primary care and specialty services to remote areas of the state, where it might not otherwise be feasible to do so. A potential expansion of access to telehealth services pursuant to SB 74 would also be consistent with the recommendations of the Alaska Health Care Commission (“AHCC”), which has identified telehealth as one of its top priorities for increasing health care value as well as enhancing access to behavioral health and primary care providers, the Institute of Medicine supports the expanded use of telehealth throughout the United States, because

“[a]ccess to high-quality primary and specialty care for beneficiaries in medically underserved metropolitan and nonmetropolitan areas would be improved by increasing the availability of telehealth technologies.”

Read the entire comment here:

https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alaska-state-legislature-regarding-telehealth-provisions-senate-bill-74-which/160328alaskatelehealthcomment.pdf.

Telehealth Advocates Support Nurse Licensure Compact

Twenty-five states have joined the Nurse Licensure Compact since it was launched in 1999 and at least six now belong to a newer version of the compact. Telemedicine supporters, including hospitals, are encouraging more states to join this multi-state licensure mechanism, according to *Becker Hospital Review*.

Read more here: <http://www.beckershospitalreview.com/human-capital-and-risk/telemedicine-advocates-lobby-to-allow-nurses-to-practice-out-of-state-with-a-single-license-6-things-to-know.html>.

CONTINUING PROFESSIONAL DEVELOPMENT

ABIM to Modify its Maintenance of Certification Requirements

Confronting intense push-back from its certificants, the American Board of Internal Medicine plans to modify its MOC requirements beginning in 2018. Other medical certification boards belonging to the American Board of Medical Specialties (ABMS) are also reformulating their requirements in response to complaints that the current system is unnecessarily burdensome and costly.

According to the ABIM, the new option will:

- Take the form of shorter assessments that doctors can choose to take on their personal or office computer—with appropriate identity verification and security—more frequently than every 10 years but no more than annually;
- Provide feedback on important knowledge gap areas so physicians can better plan their learning to stay current in knowledge and practice; and
- Allow physicians who engage in and perform well on these shorter assessments to test out of the current assessment taken every 10 years.

Furthermore, ABIM will continue to:

- Seek physician input about MOC assessment content through the blueprint review process;
- Study the feasibility of offering “open book” assessments;
- Investigate ways to provide secure assessments at a physician’s home or office;
- Determine how best to offer physicians immediate feedback on their assessment performance and learning activities to help them improve; and
- Work with societies to expand the number of continuing medical education (CME) activities available for MOC credit.

For more, see: <http://www.abim.org/news/abim-announces-plans-to-offer-physicians-moc-assessment-options-in-january-2018.aspx>, and <http://www.healio.com/internal-medicine/practice-management/news/online/%7Ba90a28a0-e618-4de2-ab05-b29c3cc8639e%7D/abim-to-offer-new-moc-assessment-options-in-january-2018>.

UK Nurses Embrace Revalidation

A revalidation system for United Kingdom nurses has been well-received. More than 90% of nurses due to revalidate in April 2016 successfully did so, according to the Nursing and Midwifery Council (NMC).

NMC Chief Executive and Registrar, Jackie Smith, said:

“Nurses and midwives are clearly embracing revalidation, which should reassure patients and the public they are receiving safe care at the hands of professionals who regularly reflect on their practice.”

“We have had overwhelmingly positive feedback from those who have gone through the process, with nurses and midwives telling us that they find it realistic, achievable and beneficial.”

For more, see: <https://www.nmc.org.uk/news/news-and-updates/introduction-of-revalidation-for-nurses-and-midwives-a-major-success/>.

Ohio Medical Board Posts Human Trafficking Educational Videos

The May 5, 2016, *Ohio Med Bd E-News* encouraged licensees to watch two educational videos about how to identify human trafficking and what to do when it is found:

Human Trafficking Awareness Videos Launched

Two new human trafficking educational videos for licensees are now available on the Medical Board’s website. The Labor Trafficking Awareness and Sex Trafficking Awareness videos define human trafficking, identify red flag behaviors that may indicate either labor or sex trafficking, provide clinical steps to follow if trafficking is suspected, and include reporting requirements and contact information. We encourage you to check out the short videos.

See: <http://www.med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/Publications/E-News-NewsLetters/5-2016-MedBdE-News%20.pdf>.

PAIN MANAGEMENT AND END OF LIFE CARE

Studies Confirm Disparity in Treatment for Pain

A new study from the University of Virginia has found an enduring difference in how blacks and whites are treated for pain. This study confirms previous research and places at least some responsibility in medical schools where doctors in training acquire (or are not disabused of) misperceptions about racial differences in the experience of pain and other anatomical phenomena.

For more, see: <http://readersupportednews.org/news-section2/318-66/36254-the-pain-gap-why-doctors-offer-less-relief-to-black-patients>.

CONSUMER INFORMATION

Reports Show Variation in Medical Board Websites and Disciplinary Performance

Consumer Reports Safe Patient Project and the Informed Patient Institute joined to conduct a survey and analysis of medical boards websites. They found a wide variation in the amount of information included and the ease of using the websites.

“Consumers living in every state should have easy access to complete information about their doctors’ histories,” says Lisa McGiffert, director of the Safe Patient Project. “But we found that most medical board websites don’t make it easy to find profiles on individual doctors and when you get there, you don’t get easy-to-understand explanations of what, when, and why the board took disciplinary actions.”

Another review of medical board discipline was conducted by researchers at the University of Michigan led by John A. Harris, M.D. Published in the *British Medical Journal Quality and Safety*, this study found a four-fold variation in the frequency of disciplinary actions from state to state.

See the *Consumer Reports* article about both studies here:

<http://www.consumerreports.org/doctors-hospitals/can-you-rely-on-your-state-medical-board/>.

See also: <http://qualitysafety.bmj.com/content/early/2016/05/04/bmjqs-2016-005589.full>.

LICENSURE

Delaware Governor Appoints Professional Regulatory Review Committee

In April, 2016, Delaware Governor Markell announced the creation of a review committee charged with “conducting a comprehensive analysis of the composition, State oversight and licensing requirements of all commissions, boards and agencies that are regulated by the Delaware Division of Professional Regulation.” The committee will submit a report to the Governor and General Assembly in October covering the following:

- Recommendations for legislative or regulatory action that will remove any unnecessary or overly burdensome licensing or certification requirements;
- An examination of the relative burdens of licensing and certification requirements of regulated professions in Delaware as compared to those in neighboring states;
- Recommendations as to whether Delaware’s current system of professional regulation could or should be replaced by an alternative methodology; and
- Recommendations as to the process by which the State considers proposed regulatory or legislative changes that would either add a new profession to the list of regulated professions or increase the licensure or certification requirements for existing regulated professions.

The committee's review will also recommend legislative and regulatory changes to bring Delaware into conformance with the requirements of the Supreme Court's *North Carolina Dental* decision.

For more, see: <http://news.delaware.gov/2016/04/20/governor-markell-creates-professional-regulatory-review-committee/>.

California Considers Law to Implement U.S. Supreme Court *NC Dental* Decision

Legislation proposed in the California State Senate in February and amended in April and June would give the director of the state's Department of Consumer Affairs to provide supervision over regulatory boards in a move to conform to the U. S. Supreme Court's decision in the *North Carolina Dental* decision. The legislation reads in part:

This bill would instead authorize the director, upon his or her own initiative, and require the director, upon the request of the board making the decision or the Legislature, to review any non-ministerial market-sensitive decision or other action, except as specified, of a board within the department to determine whether it furthers state law and to approve, disapprove, request further information, or modify the board decision or action, as specified.

The Center for Public Interest Law at the University of San Diego School of Law wrote a letter in support of the pending legislation. Read the letter here:

[http://www.cpil.org/download/SB_1195_\(Hill\)_SUPPORT.pdf](http://www.cpil.org/download/SB_1195_(Hill)_SUPPORT.pdf).

Pastoral Doctor "License" Raises Eyebrows

On April 25, 2016, National Public Radio (NPR) reported that the issuance of "licenses" by the Pastoral Medicine Association to practitioners of "Bible-based healthcare" concerns the Texas Medical Board because the public may confuse these practitioners with individuals who have attended medical school and earned licenses from a legitimate licensing board. The Texas Board of Chiropractic Examiners has also taken action against at least one chiropractor who also holds a PSC.D or D.PSc designation for offering treatments beyond the scope of his training and chiropractic licensure.

See more here: <http://www.npr.org/sections/health-shots/2016/04/25/475165193/pastoral-medicine-credentials-raise-questions-in-texas>.

Illinois Legislature Passes Bill to Permit Ex-Offenders to Earn Licenses

Both the Illinois House and Senate have passed legislation that would permit individuals convicted of certain felonies (not including felonies related to sexual offenses). Decision-makers would be able to decide on a case-by-case basis whether licensure applicants have been fully rehabilitated. The legislation was sent to the governor for his decision at the end of June, 2016.

For more, see: <https://www.illinoispolicy.org/illinois-house-votes-to-reform-health-care-licensing-for-ex-offenders/>.

Maine Joins Trend to Require Licensure for Certified Midwives

Maine's legislature overrode a gubernatorial veto of legislation that requires certified midwives to satisfy the requirements for licensure by 2020. According to a May 29, 2016 article by Patrick Whittle in *Boston.com*, this legislation is consistent with a national trend as the frequency of out-of-hospital births increased dramatically (nearly 50%) in Maine between 2000 and 2013 and by 29% nationwide between 2004 and 2009. Eleanor Davis, president of the National Association of Certified Professional Midwives whose practice is in Maine, said that the benefits of licensing include accountability and oversight and easier access to medication and insurance reimbursement.

For more, read: <https://www.boston.com/news/health/2016/05/29/maine-midwives-license>.

MEDICAL ERRORS

Medical Errors Third Largest Cause of Death in USA

Research published in the *BMJ* on May 3, 2016, concluded that medical errors in healthcare facilities result in 251,000 deaths a year in the United States. As Ariana Eunjung Cha reported in *The Washington Post*, the Centers for Disease Control and Prevention does not require the reporting of errors in the mortality data it collects. Martin Makary, professor of surgery at the Johns Hopkins University School of Medicine and lead researcher believes gathering nationwide data is the first step in effectively addressing medical errors.

For more, see: <https://www.washingtonpost.com/news/to-your-health/wp/2016/05/03/researchers-medical-errors-now-third-leading-cause-of-death-in-united-states/>, and <https://www.propublica.org/article/study-urges-cdc-to-revise-count-of-deaths-from-medical-error>, and <http://www.npr.org/sections/health-shots/2016/05/03/476636183/death-certificates-undercount-toll-of-medical-errors>.

AHRQ Reports Successful Test of Tool to Identify Diagnostic Errors

The Agency for Healthcare Research and Quality (AHRQ) reported on May 17, 2016 on a study that resulted in the development of a tool to detect diagnostic errors. In its May 17, 2016 *Electronic Newsletter*, AHRQ reported:

New Tool Helps Identify Diagnostic Errors in Primary Care, AHRQ Study Finds

An AHRQ-funded study resulted in the development of a successful tool, called the "Safer Dx Instrument," to measure diagnostic errors in primary care settings. Diagnostic errors are defined as missed opportunities to make a correct or timely diagnosis based on the evidence, regardless of patient harm. After creating a tool with 12 elements, the researchers tested it for accuracy against 389 patient records, some of which had previously been identified as having diagnostic errors. The Safer Dx Instrument had a reasonably high accuracy and predictive value to detect the presence or absence of diagnostic error. The study's authors concluded that this instrument could be useful to identify high-risk cases for further study and quality improvement. Because of its reduced reliance on subjectivity, the authors said that the Safer Dx Instrument could serve as a standard for assessing a wide spectrum of diagnostic process breakdowns. The researchers emphasized that the Safer Dx Instrument is a much-needed first step in

analyzing diagnostic processes in the primary care setting through comprehensive record review. "Accuracy of the Safer Dx Instrument to Identify Diagnostic Errors in Primary Care" appeared in the *Journal of General Internal Medicine*.

See the report abstract here:

<http://www.ncbi.nlm.nih.gov/pubmed/?term=Accuracy+of+the+Safer+Dx+Instrument+to+Identify+Diagnostic+Errors+in+Primary+Care>, and <https://psnet.ahrq.gov/resources/resource/29877/35500/2>.

CHEMICALLY DEPENDENT PRACTITIONERS

Ohio Pharmacy Techs Called Out for Drug Thefts

On July 24, 2016, *Columbus Dispatch* reporters Ben Sutherly and Holly Zacharias reported that at least 217 Ohio healthcare workers were implicated in prescription drug thefts in 2014. Of these, pharmacy technicians, presumably stealing drugs to feed their own habits, are more difficult than other professions to monitor and discipline. The article provides two explanations for this phenomenon. First, pharm techs are not licensed, certified or registered in Ohio, leaving them beyond the jurisdiction of the pharmacy board. Second, the identity of pharm techs under court orders to enroll addiction treatment are kept confidential, enabling them to seek other employment without revealing their status.

Sutherly and Zacharias report that:

The pharmacy board received reports of 52 pharmacy technicians who stole prescription medications from their employers in 2015. Since 2012, the board has investigated two pharmacy technicians for repeat offenses. But those cases likely represent a fraction of the number of pharmacy technicians losing their jobs for stealing prescription drugs.

For more, see: <http://www.dispatch.com/content/stories/local/2016/04/17/employees-stealing-drugs-from-pharmacies-health-care-facilities.html>.

QUALITY OF CARE

Experts Call for Better Quality Measures

The April 21, 2016, *HealthLeaders Media* blog reported that CMS delayed the release of hospital quality data because of questions about how well the data actually measures quality of care.

There's been a "striking" rise in the number of quality measures that are publicly reported, "but no standards on how accurate or inaccurate a measure needs to be," says Peter Pronovost, MD.

For more, see: <http://www.healthleadersmedia.com/quality/does-measuring-quality-really-ensure-patient-safety?spMailingID=8889261&spUserID=MTMyMzQxODk4MTEwS0&spJobID=920647530&spReportId=OTIwNjQ3NTMwS0>.

Online Patient Comments Rarely Mention Quality of Care

A review of online reviews of physicians reveals that the patients who post them comment predominantly about customer service rather than quality of care. Conducted by Vanguard Communications, the nationwide study analyzed nearly 35,000 patient reviews of doctors, medical practices, clinics and hospitals. Ninety-six percent of patient complaints were customer service-related while only 4 percent addressed the quality of care.

Find the study results here: <https://vanguardcommunications.net/patient-complaints/>.

IN DEPTH FEATURE

The Role of Public Members

Editorial Note: This In-Depth feature is based on a Webinar presentation by CAC's co-founder and Board Chair Rebecca LeBuhn. The Webinar was one of two focused on public members that were co-sponsored by CAC and CLEAR on June 13 and 14, 20016.

This webinar will cover the public member role, training needs, networking with one another, and evaluation.

I will speak from my experience with CAC, which since 1987 has been providing services and materials to (1) support the work of public members and the boards on which they serve and (2) facilitate a discussion of public policy issues by all interested parties.

I will also draw on my personal experience as a public member in a variety of settings, and I will quote numerous other public members on licensing boards, certifying bodies and Medicare QIOS I've known and interviewed over the years.

PUBLIC MEMBER ROLE

In many ways, the public member role is just the same as every other board member:

Public members have all the same responsibilities rights and privileges as other board members. All board members:

- Support the board's public protection mission
- Faithfully attend meetings
- Do homework in between
- Serve on committees – hold office
- Vote – support the board's positions
- Abide by confidentiality rules
- Etc.

My experience is that the more effective public members expect to be actively engaged in the work of their boards. And, if the organization wants the public member's perspective, it should want that perspective in every dimension of organizational work. Public members expect to hold office – including the chairmanship. I don't see any reason why the chair of a regulatory board or certifying body needs to be a member of the affected profession. There is plenty of specialized professional knowledge already around the table.

But, in important ways the public member role is distinct - unique

Most often, public members are defined by what they may NOT be. There is a reason for the disqualifiers – not a present or former member of profession; not related to a member of the profession; no financial stake in the profession, etc. This is true because public members make a valuable contribution to their boards precisely because they are not members of the profession

There is also a reason for what I call “qualifiers” – or a statement of attributes to look for in public members. What an organization aspires to find in a public member says a lot about the role that public member is expected to play.

Qualifiers are important to discourage appointments that are purely political patronage, which are all-too-common – or appointments solely to bring certain talents or experience to the board – e.g., legal, financial – that the board could acquire in other ways while keeping the public member position for what it is intended to be.

Qualifiers are also important to help reinforce a common understanding – among appointment authorities, the boards, and the public members -- about the attributes conducive to effectively performing the public member role. It is important that the board and its public members have the same or a complementary view of the public members’ role and the value of their contributions.

What kind of qualifiers are we talking about?

A few years ago, CAC provided support services to beneficiary representatives on Medicare Peer Review Organizations (now QIOs). One of the things we were able to do was introduce into CMS’s PRO Manual a description of the qualities to look for in a beneficiary representative. It’s a pretty good list that applies in other settings, as well:

- Have a track record of advocacy in behalf of furthering consumer interests, especially in the area of healthcare
- Be knowledgeable about the organizations representing or advocating for seniors in the state
- Be knowledgeable about the needs and concerns of the diverse groups of Medicare beneficiaries and their caregivers in their state
- Have a basic understanding of the Medicare program, and
- Have previous experience serving on the governing board of a business, religious organization, union, consumer organization, community service organization; or have previous experience serving on a governmental or non-governmental policy-level commission or advisory council; or have held a governmental management position that involved working with boards or advisory commissions.

This “boardsmanship” experience can be very important. As one public member who has served in several different health care related settings recently told me he credits his time on hospital boards and as an advocate for a state AARP chapter for acquainting him not only with how to function in a board setting, but also with the substance and politics of the issues he has encountered as a public member on boards involving healthcare professionals.

How do organizations with public members define their role?

Accepting an award from the National Organization for Competency Assurance (now the Institute for Credentialing Excellence) in 2000, Ben Shimberg delivered an address in which he said this about public members:

Are they on the board to serve as a sounding board and to express what they believe to be consumer concerns or are they there to serve as watchdogs to make sure that the occupational members on the board do not try to put something over on the public? From the earliest conception of having public members serve on boards, their role has never been clearly delineated, and this has been the cause of many problems. For example, should they vote on disciplinary matters? Should they be involved in standard setting? What role, if any, should they play in the examination process?

Ben asked those questions back in 2000. As public membership has evolved, it has become clear that public members have a multi-dimensional role shaped in part by the experience and talents of the individuals who occupy the positions. In other words, the answer to Ben's questions is "all of the above."

In his first term as governor of California, Jerry Brown was a powerful advocate for public membership. He said the public member's role is to "separate the privilege from the professionalism, to separate quality from restriction, and to ensure that the first order of every profession and every occupation which you have responsibility for is service of the people."

But, in California and most other states professional practice acts typically say very little about what public members are expected to do. It would be helpful if they did have some role definition.

California's Nursing Practice Act says only: Four members (out of 9) shall represent the public at large, and shall not be licensed under any board under this division or any board referred to in Section 1000 or 3600 and shall have no pecuniary interests in the provision of health care services.

The state's board of engineers and land surveyors says: Each member of the board shall be a citizen of the United States. Five members shall be registered under this chapter. One member shall be licensed under the Professional Land Surveyors' Act, Chapter 15 (commencing with Section 8700), one member shall be licensed under the Geologist and Geophysicist Act, Chapter 12.5 (commencing with Section 7800), and eight shall be public members who are not registered under this act, licensed under the Geologist and Geophysicist Act, or licensed under the Professional Land Surveyors' Act. Each member, except the public members, shall have at least 12 years active experience and shall be of good standing in his or her profession. Each member shall be at least 30 years of age, and shall have been a resident of this state for at least five years immediately preceding his or her appointment.

Contrast this with the Consumers' Health Forum of Australia which has a comprehensive and rather daunting statement about the consumer representative's role:

The role of a consumer representative is to provide a consumer perspective. This often differs from a bureaucratic, service provider, industry, academic or professional perspective. The role of the consumer representative involves:

- Protecting the interest of consumers
- Presenting how consumers may think and feel about certain issues
- Contributing consumer experiences
- Ensuring the committee recognizes consumer concerns
- Reporting the activities of the committee to consumers
- Ensuring accountability to consumers
- Acting as a watchdog on issues affecting consumers, and
- Providing information about any relevant issues affecting consumers.

Other institutions closer that are fairly explicit about the public member role include the National Commission for Certifying Agencies (NCCA). This accrediting body requires at least one public member on the board of a certifying body in order to qualify for accreditation. The NCCA standards read:

A public or consumer member's role is to bring a perspective to the decision-making of the certification program that is broader than the certificants' and to help balance the certification program's role in protecting the public while advancing the interests of the certificants. Effective public or consumer members also represent the public's, consumer's, or user's perspective and interest; bring new ideas and goals to the certification board to ensure the public's interest is valued; contribute an unbiased perspective; encourage consumer-oriented positions; and bring additional public accountability and responsiveness. The public member's regular involvement in board actions and decisions should be documented.

The American Board of Nursing Specialties' call for nominations specifies that it is looking for individuals who:

- Will champion the perspective of the healthcare consumer
- Are knowledgeable about the certification process
- View specialty nursing certification as a means of public protection
- Have an interest in healthcare as it relates to protection of the public
- As a voting member ... will freely voice their input into policies and decisions

Arthur Levin, Director, Center for Medical Consumers and CAC Board member served on a committee of consumer advocates who vetted and nominated public members to serve on FDA consumer advisory committees. In a talk in 2006 about the role of those Consumer Representatives, he made several important points. One was that:

The consumer representative is not a patient representative. Consumer representatives are "generalists" with an interest in the broad range of public policy agenda items that come before that committee. They represent the public at large...

On the consumer representative's contributions, Levin said they can:

- Present information on how consumers may think and feel about the issue under discussion;
- Contribute consumer experiences that have relevance to the discussion;
- Ensure consumer concerns are considered by the committee when making decisions; and
- Report on the activities of a committee to consumers and advocates.

And, he pointed out that being a solo consumer representative or public member is a lonely job. Boards and other organizations that want to maximize the benefit of having public members should consider appointing more than one – enough to be a critical mass that can help inform and reinforce one another and share the workload. Sharing the workload is important, especially in organizations that specify that there be a public member represented on certain committees or involved in certain kinds of decisions.

What do public members say about their role? (why it matters; their impact on the board’s agenda and what they have accomplished)

One of the clearest articulations of the public member role was by Richard Morrison whom many in CLEAR will remember from his years of service to the organization. He was a public member of a board that certifies specialty nurses. He wrote a brief paper to introduce himself to the group and explain his perception of his role. He called it “Public Members: Who Needs Them? Why Have Them?” In it he wrote:

The question is why have public members, and the short answer is that they bring a perspective to the decision-making that is different from that of members of the profession. My challenge as your public representative will be to examine every issue considered by the board from the viewpoint of the health care consumer. My job also includes bringing public issues and problems to the attention of the board, especially when specialty certification may offer a part of the solution to the problem.

I want to be convinced that specialty certification is in the public interest as well as the interest of those who choose to be certified. How, exactly, does the public benefit from certification? For example, can certification be demonstrated to improve health care outcomes? If it can, I intend to carry that message to the public – to employers, accreditors, insurers, consumer organizations and the media. If it cannot, then we should look at ways to modify the program so that it can and does.”

So, Dr. Morrison said that part of a public member’s role is to:

Ask the Big Picture Questions

One of the publications on CAC’s website was produced in collaboration with the Center for Public Interest Law for a project funded by the California Endowment. The publication is entitled *Tapping the Full Potential of Public Members – A tool kit for boards and community-based organizations* (<http://www.cacenter.org/files/TrainingToolKit.pdf>). It is useful for public members and individuals considering volunteering to be a public member, board staff, appointing authorities, community based organizations and others. The tool kit suggests that to be effective in their role, public members need to “Ask the Big Picture Questions.” Such as:

- Why are we doing things in a certain way? How could we do them better?
- How can we determine that licensees are currently competent at license renewal time?
- Are we learning from complaint trends so we can identify opportunities for more proactive, preventative actions that reduce both problems and the need for discipline?
- Are we restricting entry into the profession in ways that unnecessarily limit access to services?

The tool kit and other CAC publications contain more examples of ways in which public members could and do make a difference in the way their boards do business.

Broaden a board’s agenda – introduce different priorities and ideas members of a profession may not think of

Here are some things public members have told us:

“It’s easier for me to be objective in discipline cases because I don’t have to shed any professional or institutional biases.”

“I used to preface my remarks by saying, ‘I’m not a member of the profession, but...’ I soon recognized that that is precisely why other board members value my views.”

“When I joined the board, I was amazed to learn there were no requirements associated with licensure renewal. I put it on the agenda for a board retreat. Now we have a legislative proposal for a “Continuous Professional Development for License Renewal” Act.”

This is a really good example of public members and licensee members coming from different points of view. Most consumer groups say, of course a license should mean that a licensee has demonstrated current competence. But, when such requirements are proposed, the first people to object are the members of a profession and their associations because they perceive this is to be another test their members are going to have to pass. So, there is a definite difference between approaching this topic from the public protection point of view versus a protect-the-profession point of view. Another example of a different priority involved permitting school nurses to administer shots – the professional association opposed the idea; the public member supported this approach and won the day.

“I feel the professionals on my board listen to my opinion as much as they do the opinions of the other professionals. I see things differently than they do on some issues, but that’s why I’m there. My constituency, in my opinion, is everybody in my state. For the sake of citizens and visitors, we have to make sure we have competent people practicing in the health professions.”

A public member of a specialty certifying body advocated for a rule requiring the organization to publicize sanctions assessed against certificate holders. Professionals on his board opposed the action, but he’ll continue to press the point because he believes the public has a right to know when people have been disciplined.

Other public members have helped their boards to include consumer information on their websites, such as an explanation of the differences between various subspecialties within the profession. Also, practitioner profiles revealing professional credentials and disciplinary information.

One public member told us, “A public member can ask questions, especially questions about what is in the best interest of the patient. My state was trying to post public profiles of physicians on the internet. It was one thing for the general assembly to pass the law and another for us to write the regulations determining exactly what was to be posted.” In that example, physicians might have concerns about limiting information while the public member would advocate that the public has a right to know as much as possible.

Scope of practice disputes are another example where public members and members of the profession may come from different places. “As a public member, I have no interest in the turf battle aspect. Instead, I have some obligation to try to weed out the turf issues from the healthcare safety and access issues surrounding scope of practice decisions.”

Pressure from public members has focused attention on making programs for chemically dependent practitioners more transparent and accountable.

Public members on California’s regulatory boards interviewed for the California Endowment-funded project say that they are sensitive to the fact that they have been put on their boards to make a distinctive contribution – to enrich their board’s deliberations and decision making – to raise subjects that licensee members wouldn’t advance and maybe wouldn’t think of - so that the results reflect the interests of the entire public, not just those of the regulated profession.

- “My role is to think like a client would, to ask the questions a client would ask.”
- “The public member role is to protect the interests of the public and present a public-oriented point of view.”
- “When it comes to discipline, I try to think of what the public would expect the board to do.”
- “Many times I raise something that hasn’t been thought about by licensing board members.”
- “Our role may not be different when it comes to disciplinary cases, but there are differences on public policy issues.”
- “The board wasn’t used to having a public member like me. Nor are the professional organizations that are closely associated with the board. They don’t necessarily appreciate everything I say. It has taken the board time to see me as a colleague.”

Sometimes the public member role involves resisting attempts at co-optation by members of the profession, as this recollection indicates:

“During my first year on the board, I learned early to walk the stairs to avoid riding the elevator with members of the profession who were trying to pressure me to vote a certain way. When this happened to me, I told the members of the profession that I had done my homework and could make a decision on my own. But, the encounter was intimidating, so I walk the steps now.”

Enhance the credibility of the board

Public members can contribute to the credibility of the board with the public and with other branches of government.

A newly elected chair of a board of nursing that was at the time undergoing an audit told us that in support of her candidacy, she pointed out that having a public member as chair would underscore to the state auditors that the board takes seriously its role as a protector of the public as opposed to the profession.

Another nursing board public member believes her support for a bill authorizing independent practice for APRNs was influential with state legislators because of her role as a representative of the public interest.

Still another public member says: “My board adopted a mission statement expounding the vision and values of the board. As a public member, I was able to bring them along further than they would otherwise go.”

At a CAC annual meeting, a public member said this about credibility and integrity:

“What we as citizen members of our respective boards bring to the table is character and impartiality. We did not receive the same education as the health care practitioners we work with on the board. We don’t understand the intricacies and technicalities of their practice. We sit on these boards because we bring a different perspective, a different common sense, a different level of judgment. The one thing we cannot compromise is the integrity that we, as citizen members, bring to the equation. We have to be forthright about the relationships we bring with us to the table. We cannot ever be reluctant to step back from the table when our integrity might be compromised.”

Links to constituency groups

Public members are supposed to articulate consumer concerns – the public perspective. Beyond their own personal opinions, how can they do that?

One way is to cultivate connections with consumer groups. Personally, I sought appointment to the District of Columbia Board of Funeral Directors and Embalmers because of my affiliation with an association of consumer cooperatives that supported reforms in the funeral industry.

Public members can also help encourage public participation in the conduct of board business. As a public member at a CAC training session a few years ago pointed out “At my board’s meetings and hearings, there is often a member of the professional association present. I think it would be a good idea for consumer groups or coalitions in the state to attend board meetings and have input the way professional associations do.”

At that same training session, another public member had this to say to his counterparts:

You want to be active rather than passive in attempting to understand the needs and expectations of the general public. You may want to address questions to the public through letters to the editor or by speaking to community groups. If your board happens to wind up in the news, that might be the time for you to step forward and engage people in order to understand their concerns. There is a concept called “management by walking around.” Perhaps constituent service is accomplished by walking around, not reading the morning paper and using your own gut feelings about things, but trying to engage people who may be affected by the issues you are dealing with, trying to understand what their concerns may be.

You should know how you know what your constituents are thinking, what they need, and what is in their best interests so you can be the most effective possible public advocate. It should be a thoughtful and deliberative process of engaging in dialogue and staying in tune. When your fellow board members ask, “How do you know that?” you should have the answer.

The primary goal of the California Endowment project was to establish communication and collaboration between community based organizations and regulatory boards. One way to make this happen would be for community based organizations to nominate people to public member vacancies who will represent the interests of the community. We still think that is an idea worth pursuing in every state.

Here is an example of how advocacy by outside groups can help a board: A coalition of advocacy groups, including Consumers Union, AARP, CALPIRG, California Center for Public Interest Law, California Pan-Ethnic Health Network and the Latino Coalition for A Healthy California wrote to Governor Brown in 2012 urging him to fill vacancies on the Medical Board of California (MBC). Nearly half of the public member slots were vacant at the time. The group's letter catalogued public policy matters coming before the board and had this to say about the significance of having a full complement of public members:

The MBC's public members have the responsibility to bring the public perspective into the MBC's work, rather than the health care provider perspective. We believe MBC needs public members who have demonstrated an historic commitment to working on behalf of consumers and who have no conflicts of interest.

They attached criteria for appointment of public members consistent with those I mentioned earlier.

Currently Consumers Union's Safe Patient Project is pursuing legislation in California mandating that MBC require physicians on probation for serious violations to disclose this to their patients.

It goes without saying that part of the public member role is to foster outreach and education through speakers' bureaus and other means so that consumers and their organizations know that boards and other credentialing organizations exist, what they do, and how to access them.

Public members can influence their boards to do seemingly simple things like getting their board listed on search engines using words or tags where people would be likely to find the information. CAC has been advocating that licensing boards consider creating consumer advisory panels to institutionalize two-way communication with the public they serve. (For more, see <http://www.cacenter.org/files/PublicOutreachConferenceProceedings2014.pdf>).

TRAINING NEEDS

None other than Ben Shimberg once said, "Most public member appointees do not have the foggiest notion of what they are supposed to do."

He also wrote in his classic book, *Occupational Licensing: A Public Perspective*, "It is sheer folly to appoint just anyone as a public member and expect him or her to serve as a guardian of the public interest. At least four conditions must be met if the public member concept is to work. These involve recruitment, orientation and training, provision of support services, and morale-sustaining activities."

We've talked about recruitment – now we come to orientation, training and support.

Demand for training is well-established. Two surveys in the early 1990's – one by CLEAR and the Virginia Department of the Health Professions and one by AARP confirmed that public

members want training and ongoing support – on substantive issues rather than “leadership” or “assertiveness” training.

All board members need training – as CLEAR members well know. And CAC welcomes everyone to its annual meeting and subject-specific conferences and webinars.

But, public members have special training needs because they lack the professional identity, collegiality and networks that licensee board members enjoy – and significantly to help them understand and fulfill their role.

CAC has attempted to meet this demand over the years through training sessions, conferences and seminars, webinars, written materials, our newsletter and our website.

One CAC meeting attendee had these words of praise for public member-oriented training:

I am in my second term on the psychology board. When I first attended a board meeting, I felt as many of you have probably felt, “I know I’m here to help the public and protect public welfare, but what is my role?” After attending a couple of meetings, I found myself feeling like *agreeing* with whatever the members of the board had discussed and decided. I guess I wanted to be liked, since I was a newcomer. I wanted them to respect me because I was the consumer member.

Then I attended a CAC meeting and I came back with a completely different feeling about who I was, why I was there, and what I was going to do. I had a whole new sense of self-assurance and I knew that I should, and did see things differently than the licensees on my board. I am not a gadfly. I am not a rabble rouser. But, I see things as a *user* of services, not as a provider. I saw that I had room to perceive things differently and to let my voice be heard. I believe that I am respected by the rest of the board.

I brought back to the board many suggestions from CAC meetings. We have used the CAC evaluation tools and this led my board to agree to hold a meeting in different parts of the state. We are changing our newsletter completely to include a consumer outreach section and information about discipline actions. Not only should the licensees see this information as a red-flag, but it also shows that the board is doing its job. We are distributing our newsletters in public libraries and are thinking of other venues. We are putting out information that has never been published before. We are asking for information to come back to us – issues the public feels the board should address to help the public.

All of these ideas are being applied because I suggested them after having been to CAC meetings. I felt transformed from someone sitting there and trying to understand what was going on to someone who can truly contribute for the benefit of the public. Now, by taking our meetings to different areas in the state, I think we can publicize them and have professional schools encourage students to attend.

My board is a very ethical, competent, and effective. It’s just that they didn’t have anyone who came to them with these kinds of suggestions. In all fairness, I did make suggestions with an earlier chair on my board, and they fell on deaf ears. I was never blatantly refused, but I wasn’t *heard*. I didn’t give up, I would repeat suggestions, without being annoying, and eventually my ideas and suggestions were heard and my board is now acting on them. I feel absolutely thrilled about that.

As that public member stated, training and networking help public members become grounded in the role(s) they expect to play, the perspective they represent, the contributions they hope to make, and the directions in which they would like to influence their boards.

At CAC we have found that orientation when first appointed is not enough. Follow-up training and support may be even more meaningful after board members have been on the job for a while and know the areas where they need more information and support. The surveys mentioned earlier revealed a desire for such things as a newsletter, objective background papers, opportunities to network with other public members, suggestions for accessing unbiased expertise, connecting with a constituency, and getting information about how other boards operate and address current issues.

CAC convened a gathering of experts in 1995 to explore strategies for making public members successful in fulfilling their role. Of course training was discussed and this is part of what the proceedings of that meeting had to say about training:

The top priority is to offer issue-specific training that would address subjects currently before boards. In addition, participants suggested several topics as priorities for a core training curriculum that would be especially useful for new appointees as part of their orientation. It was suggested that some of these topics could be covered in a “how to” workbook for board members. Although such a workbook of necessity would be general in nature, it could be supplemented and updated to enhance its usefulness as a reference or a textbook. Suggested core topics include (and these will sound familiar):

- How to keep the public informed of board activities and how to elicit public views on the issues;
- How to develop a communications network linking public members with the citizen groups that have an interest in the work of the board;
- How to develop a framework for decision-making that assesses the impact of a board’s decisions on cost, access, and quality of care;
- How to evaluate a board’s performance;
- How to avoid becoming coopted;
- How to evaluate the effectiveness of discipline programs; and
- How to identify and correct for inconsistencies and irrelevancies in the board’s laws and regulations.

It is helpful to send public members to conferences and meetings – of course to CAC and CLEAR meetings, but also meetings of licensing board federations and professional association meetings. Not only can public members learn from these experiences, they may be able to contribute a fresh voice to national dialogues where public policy issues are addressed usually with only members of the profession present.

NETWORKING OPPORTUNITIES

Public members often feel isolated and want to communicate with one another.

Networking public members is a big part of CAC’s mission because it is a great way to reinforce the public members’ role identity and provide the morale support Ben Shimberg mentioned. CAC makes networking possible at our annual meeting as well as other settings. And our annual

meeting in 2016 will be held in conjunction with CLEAR's conference in Portland, OR.

Our experience is that this kind of networking sends public members home with new ideas about how to make meaningful contributions to the work of their boards. We've also found that the other people who participate in our public member networking meetings – licensee members, board staff – take away 1) a better appreciation for the value of having well-chosen, well-qualified public members and, 2) new ideas about how to fully integrate the public member into the board's activities.

A public member told this story about what can result from public member networking:

I would like to tell you about something I was inspired to do after attending one of the CAC meetings and networking with other public members. I asked someone to send me their board newsletter and was impressed to learn that that board requires that a notice be posted in all psychologists' offices telling the public how to reach the board, should they have a problem. I wrote to one of my state senators to say that I was impressed with this idea. I pointed out that our state's auto shops are required to post similar information regarding auto repairs and that, obviously, the same information should be readily accessible to the public when public health, safety and welfare is at stake. This senator like the idea, but was committed to handling several other pieces of legislation and couldn't take on another. However, she referred me to other senators. When I told my board about this, I thought they might be miffed that I hadn't come to them first. I hadn't because I feared they would try to talk me out of it and I wouldn't have wanted to go against something they wanted. I needn't have worried because when I mentioned the idea of a mandatory notice, the board seemed to be impressed with the idea.

Both CAC and CLEAR provide opportunities for in-person, inter-state networking. Intra-state networking is also important. The public member I quoted earlier about the payoff from training was instrumental in creating and sustaining a Consumer Advocacy Group for Maryland's 17 boards and commissions. The group enabled public members to connect and communicate with one another. She described it this way: "We meet regularly and talk about issues pertinent to consumers. It is not 'us' and 'them' at all, but we talk about things such as, "How do you get them to explain what acronyms mean?" We give each other confidence to ask questions. We go to senior centers, PTAs, and other places and give talks about what boards do."

Given the expense of travel, electronic and online networking becomes more attractive. One vehicle is webinars like this one. Another possibility is to develop online communities or discussion groups where public members can exchange questions, ideas, success stories, frustrations, and so on. Just such a community is in the process of being formed among the public members on boards of directors of the credentialing bodies belonging to the Institute for Credentialing Excellence.

EVALUATION

There's been lots of evaluation of boards – informal and formal, by legislatures and government auditors, by the media, and occasionally by consumer advocacy groups. I am not aware of mechanisms for the evaluation of public member performance – or, for that matter, every board member's performance. This is certainly worth thinking about.

If there were more awareness and involvement by citizen organizations in board activities, one would expect them to evaluate how well public members represent their interests.

Is there a role for appointing authorities to evaluate their appointees? Is there an evaluation role for the board chair? The CEO? Should there be self-evaluation?

By what standards would they do this?

I'd be interested in what you listeners think about this subject and whether you think pursuing the concept of evaluation of public members - or all board members - might be a project that CAC and CLEAR could undertake collaboratively.

CONCLUSION

Let me close by referencing again CAC's 1995 report on *Public Representation: Strategies for Success*. The experts attending that meeting suggested an agenda for follow-up action. Here is what they said about addressing the problem of inadequate role definition for public members:

- Develop a written statement delineating a set of expectations for public members;
- Publish a handbook and other materials dealing with roles and responsibilities and distribute it to newly appointed public members;
- Seek to place the subject of roles and responsibilities on the agendas of the annual meetings of consumer and other public service organizations as well as licensing board, professional, and provider associations. Seek to place articles on the subject in the journals and in-house publications of these organizations;
- Begin to collect and publish anecdotes to illustrate ways in which public members fulfill their various roles and meet the expectations of the public they represent, e.g., an illustration of performing a watchdog function, an illustration of testifying in favor of improved statutory authority, an illustration of improving the board's public information program;
- Use consortiums of consumer organizations for accountability and feedback to public members' and
- Include the subject of roles and responsibilities in appropriate training offerings.

Some of these things are being done – certainly we try at CAC -- but we can't really say they have been fully accomplished. There is a lot of turnover within regulatory agencies and on boards -- so refining role definition; reaching more people with training; finding better ways to network and engage the public – all these things will be continuing challenges.

MEMBERSHIP INFORMATION

CAC offers memberships to state health professional licensing boards and other organizations and individuals interested in our work. 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.

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 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) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
- 2) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
- 3) A \$20.00 discount for **CAC** webinars.
- 4) If requested, a **free** review of your board’s website in terms of its consumer-friendliness, with suggestions for improvements;
- 5) **Discounted rates** for **CAC’s on-site training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;
- 6) Assistance in **identifying qualified individuals** for service as public members.

The annual membership fees are as follows:

Individual Regulatory Board	\$275.00
“Umbrella” Governmental Agency plus regulatory boards	\$275.00 for the umbrella agency, plus \$225.00 for each participating board.
Non-Governmental organization	\$375.00
Association of regulatory agencies or organizations	\$450.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	\$100.00

MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for the remainder of 2015 and 2016, please complete this form and mail or fax it to:

CAC

1400 16th Street NW • Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 • FAX: (202) 354-5372

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

Payment Options

There are three ways to pay for your membership:

- 1) Mail us a check payable to **CAC** for the appropriate amount;
- 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;
- 3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature

Date

Our Federal Identification Number is 52-1856543.



WE WANT YOU EITHER WAY!

We hope your board or agency decides to become a member of CAC. Membership includes a subscription to our newsletter for all of your board members and all of your staff, as well as many other benefits. But if you decide not to join CAC, we encourage you to subscribe to CAC News & Views by completing this form and mailing or faxing it to us.

NEWSLETTER SUBSCRIPTION FORM

Downloaded from our website: Calendar year 2016 and back-issues for \$240.00.

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

Payment Options:

- 1) Mail us a check payable to **CAC** for the \$240.00;
- 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;

or

- 3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature

Date

Our Federal Identification Number is 52-1856543.