News & Views

Citizen Advocacy Center

First Quarter 2017 – Health Care Public Policy Forum – Volume 29 Number 1

ANNOUNCEMENT

The Citizen Advocacy Center is pleased to announce that our 2017 Annual Meeting will be incorporated into CLEAR's Annual Educational Conference in Denver, Colorado on September 13, 2017 – September 16, 2017. In addition to CAC's public member-oriented activities, one registration will also entitle CAC Annual Meeting registrants to attend CLEAR-sponsored sessions of their choosing.

The CAC portion consists of eight meeting hours: A 3-hour session on Wednesday afternoon, September 13, 2017, a 1-hour session on Thursday morning, September 14, 2017, a 3-hour networking dinner meeting later that evening, and a 1-hour session on Friday morning, September 15, 2017.

The CAC sessions do not compete with any of the sessions offered on the CLEAR agenda, so CAC meeting attendees will be able to attend any of the CLEAR sessions, and CLEAR meeting attendees will be able to attend any of the CAC meetings without there being a conflict.

The CAC Program and Registration Form is now on our website. Visit www.cacenter.org for more information.

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IN DEPTH

Shimberg Memorial Lecture by Kathleen Haley, Executive Director, Oregon Medical Board

Editorial Note: This quarter's "In Depth" feature is the text of Kathleen Haley's remarks on the occasion of receiving the Ben Shimberg Public Service Award at CAC's 2016 Annual Meeting in Portland, Oregon.

Some song lyrics haunt us. Even years after we first hear them. Leon Russell's "Tight Rope" 1970's era lyrics have reverberated with me.

I'm up on a tight wire,

One side's ice and one is fire…

…I'm up on a tight rope,

One side's faith and one is hope.

Don't those lines embody the role of the regulator? A constant balancing act. Before we enact rules, policy and position statements, we inch forward on the tight wire. Hoping the public and professionals we regulate are with us. Or that we can bring them along. All of us learning as we go.

Dr. Ben Shimberg, for whom this award is named, understood the need for fair and validated procedures to protect the public and the need to treat applicants and licensees equitably. A tall order. I am deeply honored to receive this award in his name.

While I remember Dr. Shimberg from CAC meetings, in preparing for this presentation I read more about him. He came from upstate New York, as did I and graduated from the University of Rochester like my mother and nephew. His research focused on tying our requirements for licensure to the safe practice of a profession.

Dr. Shimberg was instrumental in founding CLEAR and served as chair of the Board of Directors of CAC. How appropriate that both meetings are back to back here in Portland. I believe Ben would have been delighted.

In my remarks, I will discuss creative engagement and the necessity of mirroring what we expect of our licensees.

There is general lamentation about the erosion of the provider-patient relationship in favor of the bottom line. Any transition causes us to wring our hands. And we have been in transition in health care in the US for two decades.

What sets us apart as members and staff of health boards is that we are motivated by our missions. While the words may vary, the essence of public protection is omnipresent. Health regulatory boards have the benefit of not having to be influenced by financial gain. With that benefit comes the responsibility to oversee the professions, while engaging the other players and most importantly the public. The other players: health systems, practice groups, hospitals, insurers and professional associations sometimes operate in competitive silos.

Health regulatory boards, rather than being perceived as an integral part of the patient safety movement, may be thought of as the entity to avoid. I would maintain that we are the original patient safety organizations and that we have the facility to remain nimble.

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One particular example of our flexing with the times is telehealth. Well over a decade ago, the Medical Board was approached by a hospital in rural Oregon that wanted to use a robot in the ICU. The robot or R2D2 would relay patient information to a physician specialist out of state. At the bed side of the patient was a licensed health care professional. The Board had a demonstration. And telemedicine licensure was well on its way.

Perched on that tight wire, let's hold our poles balancing faith and hope. Having strong, invested, well-trained public members is the first step. For decades, CAC has been my go-to organization for public member training, support and encouragement. I urge you to take a look at the recent newsletter, which has an excellent feature article by Becky LeBuhn on

the role of the public member. Executives of all the health boards meet monthly. From Becky's piece, I am inspired to hold a meeting of all our public members.

Another thought raised in the piece is having our public members take the work of the boards to community groups. Do we do an adequate job of true public outreach? Our Web sites are the gateway for the public. They need to be as user-friendly as possible, relevant and current.

How easy is it for the public to call your board and talk with someone about their concerns? Is it like calling an airline? Yes, it costs more to have a person assist. It is a reminder of who we exist for.

While I recognize that resources are limited and quite frankly the professions often keep us dancing to their tunes, I challenge all of us to some meaningful public outreach. Not presentations to the professional organizations or schools but community organizations. Let's aim for a meeting with a public group once a quarter.

Because our roles are an amalgam of law, medicine and public policy we are drawn into politics. I have seen a number of colleagues removed because of a political issue, whether it be something as charged as abortion or someone's desire for perceived power. On that tight rope we inch forward, sometimes hesitating. Yet we must not retreat.

We communicate openly with fellow boards. One current example here in Oregon is need to a scope of practice issue. We regulate acupuncturists. There is a disagreement about whether "dry needling" is acupuncture. Physical therapists want to practice dry needling. My counterpart gave me a heads up that his board was asking for a legal opinion on the issue.

We need to cultivate relationships with legislators. Be the resource for health care issues in your state. We all certainly here from legislators when there is a disgruntled applicant or licensee. Having those relationships can ease those struggles. We had a new one last week. A real estate agent emailed me regarding an applicant for licensure.

Funambulism is not for the faint of heart. It is thanks to the collective wisdom and courage of Board members, public and professional, who donate countless hours in service of patient safety that we remain inspired. That wobbly but perfect balance of faith and hope.

In Oregon, our mission, like yours, reflects the tension inherent in regulating professionals providing care in a complex, multi-faceted health care system. Balancing public protection while helping to ensure access to quality care. In a back room meeting with an educated rural legislator he confessed, "I would rather have a bad doc than no physician at all." Words borne of desperation and frustration. The fireside of that tight wire.

We maintain requirements for licensure, not wanting "bad providers," but following Dr. Shimberg's guidance we need to be able to demonstrate improvement in care as a result. We must acknowledge that there are many parts of the country where some care, even bad care feels better than none. We ignore those sentiments at our peril.

Following that meeting (and I would like to say we were ahead of the curve but not in that instance) we did a study of what documents took applicants the longest to obtain: medical school, residency and employment. We were able to address two of the three with expedite endorsement.

Continuous examination of our rules, processes and procedures for licensure and practice is essential. Weeding out those that are no longer necessary and updating with acknowledgement of the pervasive use of technology. For example, we recently implemented a secure portal for applicants to submit confidential information to licensing staff.

In interviewing some physicians under investigation, I have heard phrases such as, "that's what the clinic required" or "that's how the other physicians in the clinic practice." Professional responsibility and board expectations did not enter into their thinking before poor practice. It is a mind-set that challenges us to educate and educate some more, our licensees. We need to annually visit the professional schools both to provide information and to learn what is on the minds of our new care providers.

An osteopathic student asked me last week if the board only acted punitively. I was able to tell him that sometimes the board required community service or to draft and teach a course involving their particular ethical transgression. It takes patience and fortitude to develop rules and creative solutions to thorny disciplinary issues. Our staff have sometimes spent years involving stakeholders in rule writing. The result is worth the effort. In particular, our rules on office based surgery.

I am deeply honored to receive the Benjamin Shimberg Award. It is as always a collaborative effort to walk the tight rope. We do it as a team. Each person on the board and each staff member has to be part of that effort. We offer staff members, regardless of whether they are in accounting or licensing, the opportunity to sit in on parts of our Board meeting. It is each person's contribution that makes the Board successful. To witness the decision making process adds meaning to that contribution. In turn, it is helpful to the Board to get their perspectives.

Leon Russell's lyrics go on, (and here I take license), "We're united by life and the funeral pyre." How true. We all have the opportunity to be patients at some point in our lives. Collaborating across the silos can provide that safety net under the tight wire.

All of us need to assume the role of public members. And just as we hold our professions to a high standard, so too must we mirror those expectations: professionalism, competence, maintaining our personal health and the health of our organizations.

Special thanks to my inspired friends the Oregon Board and staff, and the CAC Board of Directors Becky LeBuhn, Barbara Safriet, Mark Yessian and Dave Swankin.

TELEHEALTH

Arkansas Considers Different Standards for Children and Adults

Legislation under consideration by the Arkansas legislature would remove a requirement that an initial telemedicine examination to establish a physician-patient relationship must take place at a physician's office or a licensed health care facility. This would remove one barrier to providing telehealth services in the state. The same legislation would erect a barrier in the way of providing telehealth services to children in schools. It would require authorization by a child's primary care physician prior to conducting an examination via telehealth means. One justification for this restriction is to protect physicians from competition by telehealth providers. This is especially a concern in rural areas, where families want to keep local doctors in practice. For more, see the article by Andy Davis in the Arkansas Democrat-Gazette.

See: http://www.arkansasonline.com/news/2017/feb/02/telemedicine-bill-removing-adult-part-o/.

Texas Medical Board Withdraws Teledoc Appeal

The National Council of State Boards of Nursing *Good Morning Members* reported on December 2, 2016, that:

> The Texas Medical Board has withdrawn an appeal that questioned whether Teladoc could challenge the state's telemedicine restrictions. The Teladoc suit alleges that the Texas Medical Boards' proposed telemedicine rule requiring physicians to meet face-to-face with patients before they can prescribe treatment remotely violates federal antitrust laws. The Texas Medical Board argued that the board was immune from federal antitrust laws; however, the federal court ruled that the board was not immune from federal antitrust laws in this instance. The Texas Medical Board appealed that ruling and now has withdrawn that appeal.
>
> The Texas Medical Board said its board voted to withdraw the appeal before the U.S. Court of Appeals for the 5th Circuit. The medical board stated that although this appeal of the interlocutory order is over, it will continue to fight Teladoc's challenge in court and claimed it is immune from federal regulation. The antitrust case will continue to be litigated in U.S. District Court in Austin, Texas.

Benefits of Telehealth Applauded by Medical Educators

In an article entitled, "Telehealth Helps Close Health Care Disparity Gap in Rural Areas" in the December 6, 2016 issue of the *Association of Medical Colleges News*, Nicole Lewis writes that academic medical centers are finding telehealth technologies succeed in reaching patients in underserved rural areas.

For more, see: https://news.aamc.org/patient-care/article/telehealth-health-care-disparity-gap/.

Medical Boards Say Telehealth Top Issue for 2016

The Federation of State Medical Boards polled its membership and found that:

> Telemedicine is currently the most important medical regulatory topic to state medical boards. The announcement comes after analyzing results from the Federation's 2016 State Medical Board Survey. This year's survey, completed by 57 of the 70 state medical and osteopathic boards in the United States and its territories, identifies a number of important issue areas and topics impacting the work of boards as they carry out their mission to protect the public…
>
> The survey found that the top five most important medical regulatory topics to state medical boards in 2016 were:
>
> 1. Telemedicine
> 2. Resources related to opioid prescribing
> 3. The Interstate Medical Licensure Compact (IMLC)
> 4. Physician reentry into practice
> 5. Medical marijuana

See the press release here: http://www.fsmb.org/Media/Default/PDF/Publications/20161215_annual_state_board_survey_sesults.pdf.

Michigan Adopts Telehealth Standards

The *National Law Journal* commented in December 2016 on a telemedicine law adopted in Michigan:

> Michigan is ringing in 2017 with a new telehealth law. Governor Rick Snyder signed into law (SB0753) on December 21, 2016, imposing new telehealth practice standards, including restrictions on prescribing controlled substances via telemedicine. The new Michigan telemedicine law will take effect March 21, 2017, (a 90-day delay from signature to effective date). Previously, Michigan law and regulation was silent on delivering health care services via telehealth and virtual care technologies. The law applies broadly, not just to physicians, but to all health professionals in Michigan.

For more, see: http://www.natlawreview.com/article/top-5-takeaways-new-michigan-telehealth-law.

Telehealth Association Publishes State by State Gaps Analysis

In January 2017 the American Telemedicine Association published *State Telemedicine Gaps Analysis: Physician Practice Standards and Licensure*. Per the report:

> Our analysis indicates that decades of evidence-based research highlighting positive patient compliance, clinical outcomes and increasing telemedicine utilization have been met with a mix of strides and stagnation in state-based policy. Since the first version of this report in 2014, medical boards have moved towards a

trend of developing different regulations or guidance for medical practice via telemedicine when compared to in-person practice. Further, states are removing telepresenter requirements, while also becoming more prescriptive in the types of modalities permitted for appropriate clinical practice when using telemedicine. Because of changing guidance and regulation for telemedicine when compared to in-person practice, more states have improved a letter grade since the report in 2016.

See the entire report here:
https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/State%20Policy%20Resource%20Center/2017%20NEW_50%20State%20Telehealth%20Gaps%20Analysis-MD%20PGL_FINAL.pdf.
See more:
https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/State%20Policy%20Resource%20Center/2017%20NEW_50%20State%20Telehealth%20Gaps%20Analysis-MD%20PGL_FINAL.pdf.

Criminal Background Checks Create Glitch in Medical Board Compact

The Center for Connected Health Policy announced in February 2017 that the Federation of State Medical Board's inter-state compact to facilitate multi-state licensure encountered a delay in implementation over access to a criminal background check database. The solution, according to the CCHP is for medical boards to become the repository of criminal background check information.

For more, see: http://us9.campaign-archive2.com/?u=c9fa99b7520aedfca5c453103&id=fd283beb4c&e=d903860d49.

IN THE COURTS

Vermont Court Rules State Agency Can Appeal Board Ruling

The Vermont Supreme Court has ruled that the state Office of Professional Regulation (OPR) has the power to appeal a decision by the state board of nursing. The court reached this conclusion because the OPR acts in behalf of the citizens of the state.

For more, see: http://www.journalofnursingregulation.com/article/S2155-8256(17)30018-2/fulltext.

SCOPE OF PRACTICE

Nursing Professor Opines About Forces Influencing Nursing

In an interview with Laurie Larson in *Hospital and Health Networks*, healthcare economist and professor of nursing at Montana State University Peter Buerhaus, R.N. spoke about "The 4 Forces That Will Reshape Nursing."

> I see four major changes. First is the retirement of one-third of the nursing workforce over the next 10 years, which has never happened before and is going to take a lot of knowledge and know-how out of the workforce. Second, 70 million baby boomers will be retiring with multiple chronic and degenerative conditions, which will add to the complexity of care and increase the number of nurses needed to care for them. The third big change is health care reform. We will always need hospitals, but delivery systems are changing; there will be less hospital care, and everyone accepts that they will have greater accountability for cost and quality. And finally, there's the physician shortage — and this will all be happening at the same time. It's going to be challenging. Nurses will play a greater role in preventive care, patient education and [working with] the social determinants of health care — they will be more affected by that as access to care expands. More nursing work will be done electronically, and payment changes based on cost and quality also will affect them.

Commenting on the changing scope of nursing practice, Buerhaus observed, in part:

> Many states are in a battle over those laws, but the trajectory has been to open them up. It's slow, but it's not going to go away, because of the projected primary care and medical specialty shortages. Those shortages only will increase demands on state legislatures to give up scope-of-practice restrictions and, as they do, both registered nurses and nurse practitioners will move in to fill more of those provider roles. In addition, the Institute of Medicine, the National Governors Association and others have called for expanding the use of nurse practitioners, so there's a growing policy force behind this as well.

See the entire interview here: http://www.hhnmag.com/articles/7522-the-4-forces-that-will-reshape-nursing.

See also:
http://www.nber.org/papers/w22780?utm_campaign=ntw&utm_medium=email&utm_source=ntw and https://www.cato.org/blog/these-scope-practice-laws-dont-improve-health-outcomes-serve-mainly-barriers-entry.

Nurse Practitioners Needed to Meet Healthcare Demand

The October 26, 2016, *Health Affairs Blog* posted an article entitled, *Primary Care Workforce: The Need to Remove Barriers for Nurse Practitioners and Physicians.* The article makes the case that nurse practitioners are positioned to meet the demand for primary care stimulated by the Affordable Care Act. This prediction is based on comparative graduation rates of NPs and physicians.

> Large increases in NP graduates each year are the good news in the midst of the inadequate numbers of physicians entering primary care. The challenge remains, though, to maximize the practice potential of physicians and NPs so that they both are practicing to the fullest extent of their education and training. Only then will the nation reap the full benefit of expanded access to quality primary care services and a reduction in unnecessary costs to the health care system.

For more, see: http://healthaffairs.org/blog/2016/10/26/primary-care-workforce-the-need-to-remove-barriers-for-nurse-practitioners-and-physicians/.

Editorial Note: This article assumes the individuals who gained insurance coverage from the Affordable Care Act and its Medicaid expansion will continue to participate in the healthcare market.

Australia Reviews Pharmacy Scope of Practice and Other Regulations

In the closing months of 2016, regulators in Australia reviewed pharmacy remuneration and regulation policies in search of better ways to compensate pharmacists and utilize their skills. The review also considered relaxing regulations limiting pharmacy location. Recommendations will be made in May 2017.

The Australian Medical Association (AMA) is pushing back against some of the changes under consideration.

> If, in the future, pharmacists' core education and training covers medical services, and pharmacists wish to have those services attract Government subsidies, then those services should be assessed for safety, efficacy and cost effectiveness in the same way as other health practitioner services. That means evaluated and funded under Medicare. In the meantime, the AMA will continue to defend against profit-driven and unevaluated expanded scopes of practice.

For more on the review, see: http://www.health.gov.au/pharmacyreview. For more on the AMA's position, see: https://ama.com.au/ausmed/bigger-risk-no-reward-expanding-pharmacist-scope#.WAVkSKnC-sk.twitter, and https://ajp.com.au/news/no-turf-war-ama-claims/.

Health Plan of the Future Could Depend on Variety of Professions

> Up until a few decades ago, drivers needing service or repairs had to take their cars to the repair shop. Then came companies (Midas in 1956 and Jiffy Lube in 1971) that offered inexpensive, routine services such as oil changes and replacement mufflers.
>
> Now drivers had options.
>
> Speakers at an NCQA Quality Talks event Monday suggested that a similar service delivery model could apply to medicine and lead to better, more efficient, less-expensive care.

> Others said we are already headed in that direction through telemedicine, urgent care clinics, and programs designed to keep patients out of that human repair shop known as the hospital.
>
> "The health plan of the future" was one of three themes explored at the event.

So begins an article in *Health Leaders Media* entitled, *Three Ways to Reimagine Healthcare Delivery*, posted on October 27, 2016. Speakers addressed medical homes, patient-centric care, and reducing disparities in care. Delivery models include using a variety of professions to provide care and employing techniques such as telehealth.

For more, see: http://www.healthleadersmedia.com/quality/3-ways-reimagine-healthcare-delivery?spMailingID=9777868&spUserID=MTMyMzQxODk4MTExS0&spJobID=1022249740&spReportId=MTAyMjI0OTc0MAS2.

Nurse Practitioners and Physician Assistants Authorized to Administer Buprenorphine

The November 23, 2016, online post from the National Association of Boards of Pharmacy e-News reported that:

> The US Department of Health and Human Services (HHS) news release indicates nurse practitioners and physician assistants who complete the required training and seek to prescribe buprenorphine for up to 30 patients will be able to apply to do so beginning in early 2017. Once nurse practitioners and physician assistants receive their waiver, they can begin prescribing buprenorphine immediately.
>
> HHS' action will expand access to medication-assisted treatment (MAT). "Allowing nurse practitioners and physician assistants to prescribe buprenorphine will greatly expand access to quality, evidence-based treatment methods for those most in need of assistance," states Substance Abuse and Mental Health Services Administration (SAMHSA) Principal Deputy Administrator Kana Enomoto.

For more, see: http://nabp.bmetrack.com/c/v?e=A5E556&c=8AB9&t=0&l=193A29E6&email=ykfSJIUqLGX%2FpmSHZOtaW%2FANyf4zh32MmMYADqvCF08%3D.

Study Finds Less Skilled Nursing Mix Compromises Care

Researchers in Europe investigated the association of hospital nursing skill mix with patient mortality, patient ratings of their care and indicators of quality of care. They found that:

> A bedside care workforce with a greater proportion of professional nurses is associated with better outcomes for patients and nurses. Reducing nursing skill mix by adding nursing associates and other categories of assistive nursing personnel without professional nurse qualifications may contribute to preventable deaths, erode quality and safety of hospital care, and contribute to hospital nurse shortages.

For more, see: http://qualitysafety.bmj.com/content/early/2016/11/03/bmjqs-2016-005567.

Expanded Dental Hygiene Scope Improves Oral Healthcare

Research published in *Health Affairs* in December 2016 found that expanding the scope of practice of dental hygienists improves the quality of oral healthcare. In a paper entitled "Expanded Scopes of Practice for Dental Hygienists Associated with Improved Oral Health Outcomes for Adults," researchers from the University of Albany's Center for Health Workforce Studies examined 2014 scopes of practice for dental hygienists in the U.S. and found a statistically significant association with positive oral health outcomes when scope of practice rules were aligned with dental hygienist professional competence.

For more, see: https://medicalxpress.com/news/2016-12-scopes-dental-hygienists-oral-health.html.

Veteran's Administration Rule Expands Scope for Some Nurses

In December 2016 the Veteran's Administration finalized a rule authorizing some advanced practice nurses to practice to their full authority in all VA facilities. Succumbing to lobbying from anesthesiologists, the VA failed to include nurse anesthetists in the scope of practice expansion. The American Medical Association opposed the rule in its entirety. The American Society of Anesthesiologists apparently persuaded the VA that there is no shortage of anesthesiologists available to practice in VA facilities and that opening practice to nurse anesthetists would lower the standard of care.

The VA solicited public comment on the final rule. CAC submitted the following comment January 5, 2017:

> The Citizen Advocacy Center (CAC) submitted comments on the original VA proposed rule to allow full practice authority to all four types of APRN providers. CAC supported this proposed rule. We were pleased to learn that the VA FINAL RULE did exactly that for all types of APRN nurse practitioners EXCEPT for CRNAs. Congratulations to the VA for going three-quarters of the way in better assuring timely, safe, quality access by veterans to advanced nursing care. We were, however, disappointed that VA refused to extend full practice authority to nurse anesthetists. This comment is to urge VA to re-consider and extend the coverage of the new rule to CRNAs. There is no justifiable reason to treat nurse anesthetists differently than all other types of APRNs. In fact, there is more evidence supporting full practice authority for CRNAs than for any other type of APRNs. Moreover, the IOM Future of Nursing landmark report cannot be read or interpreted to carve out CRNAs from their major finding that ALL nurses should be allowed to practice to the full extent of their capabilities. We are aware of the organized pushback by the medical profession, and in particular anesthesiologists, to remove CRNAs from the final rule. Strong lobbying efforts, however, is not a justification for the VA carve-out in its December 14, 2016, proposed final rule. VA does violence to the concept of evidence-based medicine (and evidence-based rules) by taking this position. Veterans deserve better.

For more, see:

http://www.modernhealthcare.com/article/20161213/NEWS/161219974.

See also: https://www.forbes.com/sites/brucejapsen/2016/12/13/nurse-practitioners-win-direct-access-to-vas-patients/#fe0471c6edd4 and http://www.healthleadersmedia.com/nurse-leaders/va-grants-aprns-full-practice-authority-almost#.

Oklahoma Considers Unrestricted APRN Practice

Legislation supported by the Association of Oklahoma Nurse Practitioners would eliminate the collaborative practice agreement requirement for nurse practitioners in the state.

See the legislation here: http://c.ymcdn.com/sites/npofoklahoma.com/resource/resmgr/docs/2017_files/WebPage.pdf.
See the commentary here: http://www.normantranscript.com/news/oklahoma-nurse-practitioners-push-for-greater-health-care-access-across/article_155b5b42-d764-11e6-8c72-1b5682d8a027.html.

FTC Supports Relaxation of Supervision of Iowa Physician Assistants

Responding to a request from the Iowa Department of State, the Federal Trade Commission commented on a proposed rule defining physician supervision of physician assistants. In its comment, the FTC supported the proposed rule because it would permit flexibility in tailoring supervision to practice situations...

See the full comment here: https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-professional-licensure-division-iowa-department-public-health-regarding-proposed/v170002_ftc_staff_comment_to_iowa_dept_of_public_health_12-21-16.pdf.

New Issue Brief on Nursing Services in Long Term Care Facilities

Three long-term care resident advocacy organizations cooperated in producing an issue brief entitled "A Closer Look at the Revised Nursing Facility Regulations." According to a release from The National Consumer Voice for Quality Long Term Care:

> The new issue brief looks specifically at nursing services. The regulations failed to include a numerical minimum staffing standard, instead maintaining the previous requirement that “sufficient staff” be available. The regulations do, however, place a greater emphasis on establishing minimum competencies and skill sets for all nursing personnel. Facilities must assess their resident population and resources to determine both the number and competencies of staff needed to care for residents.

> In addition, the regulations have increased requirements for in-service training of nursing personnel. Finally, the revised regulations require that the resident and resident representative be notified of any waivers of nursing staff requirements.

See the brief here: http://theconsumervoice.org/uploads/files/issues/Revised-Nursing-Facility-Regulations_Nursing_Services.pdf.

DISCIPLINE

Publication Explores Aspects of Medical Board Discipline

The October-November 2016 issue of *The Practical Professional in Healthcare* published by Professional Boundaries, Inc. contains articles examining physician discipline from a variety of perspectives. The feature article is entitled, "The Value of Rehabilitation: those who dismiss it as inadequate fail realize what is involved." Other articles explore board powers, focusing on the powers to sanction licensees. Other articles explore the legal landscape and the disciplinary process.

Read the articles here: https://professionalboundaries.com/articles/Practical-Professional_Issue8_October-November-2016.pdf#page=4.

Study Relates Post-Graduate Education to Likelihood of Discipline

The Federation of State Medical Boards' *Journal of Medical Regulation* (vol. 102 #4) published an article entitled, "Training Matters: A Retrospective Study of Physician Disciplinary Actions by the Louisiana State Board of Medical Examiners, 1990–2010."

The authors say this about their findings:

> Our study indicates that physicians who do not complete a minimum of three years post-graduate training are more likely to be the subject of a disciplinary action, and that these physicians are more likely to be sanctioned for competency/standards-related issues. Because medical knowledge and training expectations have increased over time, licensing authorities may want to delay full licensure status until applicants have had a minimum of three years PGT in an ACGME or AOA-accredited training program.

See the article here: http://jmr.fsmb.org/wp-content/uploads/2017/02/JMR-102_4_FINAL.pdf.

TEAM PRACTICE

Hospital Readmissions Reduced by Combination of Nursing and Physician Follow-Up

Research supported by the Agency for Healthcare Research and Quality found that hospital readmissions of cardiac patients within 30 days was reduced by 8% when patients received *both* home health nursing and early physician follow-up after discharge. These variables had no appreciable effect independently, but in combination resulted in reduced readmissions.

See more: https://www.ncbi.nlm.nih.gov/pubmed/?term=Reducing+Readmissions+among+Heart+Failure+Patients+Discharged+to+Home+Health+Care%3A+Effectiveness+of+Early+and+Intensive+Nursing+Services+and+Early+Physician+Follow-Up.

Interprofessional CE Improves Team Collaboration

The Accreditation Council for Continuing Medical Education (ACCME) issued a report in November 2016 entitled, "By the Team for the Team: Evolving Interprofessional Continuing Education for Optimal Patient Care – Report from the 2016 Joint Accreditation Leadership Summit," which concludes that interprofessional teamwork is improved by interprofessional CE (IPCE). Specifically, the Joint Accreditation Leadership Summit reached these conclusions:

- An inclusive team: IPCE builds team collaboration across multiple professions, from chaplains to community health workers, from physicians to psychologists, from safety experts to social workers.
- Patient-centered teams: IPCE creates a safe space where all learners—including patients—have a voice. Education that includes patients as planners, teachers, and learners motivates powerful and lasting change.
- Cultural care, compassionate values: By bringing together teams, IPCE effectively build skills that are essential for improving care for patients and communities, such as cultural competency, compassionate values, and communications.
- Public health priorities: IPCE programs partner with institutions and communities to address quality, safety, and public health concerns such as sepsis, obesity, end-of-life care, heart disease, and cancer.
- Results: Case examples and research data show how IPCE contributes to improvements in team performance and patient care.

See the ACCME report here: http://www.jointaccreditation.org/sites/default/files/2016_Joint_Accreditation_Leadership_Summit_Report_0.pdf.

See also: http://www.accme.org/news-publications/news/new-report-demonstrates-effectiveness-interprofessional-continuing-education and http://journalofethics.ama-assn.org/2016/09/ecas1-1609.html.

CONSUMER INFORMATION

Disclosure of Probation Again Before California Legislature

California State Senator Jerry Hill has revived his proposal to require the state's doctors disclose to their patients when they are on disciplinary probation. The proposal was defeated last spring, but the medical board launched a PR campaign to encourage consumers to check their doctor's disciplinary status by calling the board or accessing the information online.''

Lisa McGiffert, director of Consumers Union's Safe Patient Project continues to advocate in favor of disclosure of probationary status in the interests of transparency and accountability. The California Medical Association opposes the legislation, preferring a different bill that would require the board to take egregious cases through a full hearing.

For more, see: http://www.sacbee.com/news/local/health-and-medicine/article134643834.html and http://www.10news.com/news/team-10/hundreds-of-california-doctors-on-probation.

Growing Number of Doctors Share Notes with Patients

The February 22, 2017, issue of *Medical Economics* looks at the growing number of doctors and health plans participating in the OpenNotes program that advocates for healthcare practitioners to share their notes with patients. In the article, "Should Physicians Share their Notes with Patients?" the benefits of doing so are explained in depth:

> According to the Robert Wood Johnson Foundation, the creators of the OpenNotes study, when physicians share notes with their patients, it allows for a more open dialogue between doctor and patient, which can build trust and lead to more motivated and adherent patients. Additionally, it may enable patients to feel empowered and be more willing to discuss topics that may be difficult for them.

The article also counters some of the arguments against sharing notes and discusses logistical considerations.

For more, see: http://medicaleconomics.modernmedicine.com/medical-economics/news/should-physicians-share-their-notes-patients.

FSMB Issues Regulatory Trends Report

On January 17, 2017, the Federation of State Medical Boards announced:

> The Federation of State Medical Boards (FSMB) has released the *2016 U.S. Medical Regulatory Trends and Actions Report.* The report, published every two years, provides detailed and current information about the make-up, policies, and work of state medical boards, as well as national aggregated data on physician licensure and discipline.
>
> "As our health care environment continues to evolve, it is increasingly important that the public understands the role state medical boards play in protecting them,"

said FSMB President and CEO Humayun Chaudhry, DO, MACP. "Thanks to the dedication of our member boards, this year's expanded report is the most inclusive and informative resource to date. Our goal is to strengthen the engagement and participation between state medical boards and the public they serve."

The report is structured in three sections, including background about the work of state medical boards, basic national discipline and licensing data, and detailed information about the make-up and policies of each state medical board.

The report also offers valuable information for consumers, aimed at helping them gather information about physicians, file complaints, and utilize the services of their state medical board. In an effort to provide consumers with the greatest amount of useful information possible, Section III of the report has been expanded by more than a dozen new categories.

See the report here: http://www.fsmb.org/Media/Default/PDF/FSMB/Publications/us_medical_regulatory_trends_actions.pdf.

LICENSURE

Nursing Boards Environmental Scan Published

The National Council of State Boards of Nursing published its 2017 Environmental Scan in January 2017:

> Rapid technological innovations led to the theme of the 2017 Environmental Scan - *Imagining the Future: 2017 and Beyond.* The environmental scan aids boards of nursing in anticipating future needs and planning strategically by capturing the current environment in which regulators work. The report also serves as a resource for nurse leaders in practice and education. Using information from numerous resources, the 2017 Environmental Scan identifies critical information needed for the next year and beyond.

See highlights here: http://www.journalofnursingregulation.com/article/S2155-8256(17)30014-5/fulltext.

Chicago to License Pharmaceutical Reps

The Chicago City Council voted unanimously in November 2016 to license pharmaceutical representatives as a way of getting a handle on opioid abuse by limiting aggressive marketing of pharmaceuticals. The regulation will require pharmaceutical representatives to report contacts with healthcare professionals, gifts and samples distributed, and any compensation to healthcare practitioners for spending time with the reps. They will be required to attend continuing education in topics including ethics and will be prohibited from engaging in misleading advertising and marketing, among other things.

For more, see: http://www.chicagotribune.com/business/ct-pharma-sales-licenses-chicago-1117-biz-20161116-story.html.

Illinois Competitiveness Council to Oversee Regulatory Review

Executive Order 2016-13 creates a Competitiveness Council in Illinois to "Cut the Red Tape." Under the order, agencies are instructed to use the following guidelines to review regulations:

> All agencies, boards, commissions, and authorities of the Executive Branch of the State of Illinois under the jurisdiction of the Governor (each an "Agency") shall conduct a comprehensive review of their administrative rules and policies, (collectively "Regulations"), as part of the Cutting the Red Tape Initiative. All other State agencies are also urged to conduct a similar review. In conducting such review, each Agency shall ensure that all current and new regulations meet the following guidelines:
>
> 1. Regulation is up to date and reflective of current Agency functions and programs.
> 2. Regulation is drafted in such a way as to be understood by the general public.
> 3. Regulations should be clear, concise and drafted in readily understood language. Regulations should not create legal uncertainty.
> 4. Regulation is consistent with other rules across Agencies.
> 5. Agencies should coordinate to ensure rules are not conflicting or have duplicative requirements.
> 6. Regulation should not cause an undue administrative delay or backlog in processing necessary paperwork for businesses or citizens.
> 7. Regulation does not impose unduly burdensome requirements on business, whether through time or cost, or have a negative effect on the State's overall job growth. In considering this criterion, the Agency should consider whether there are less burdensome alternatives to achieve the Regulation's purpose.
> 8. Regulation does not impose unnecessary burden on social service providers or recipients, whether though time or cost. In considering this criterion, the Agency should consider whether there are ways to revise the Regulation to make it easier for social service providers and recipients to provide or receive services.
> 9. There is a clear need and statutory authority for the Regulation. Regulation should not exceed the Agency's statutory authority and should be drafted so as to impose statutory requirements in the least restrictive way possible. In considering these criteria, the Agency should also consider whether the Regulation exceeds federal requirements or duplicates local regulations or procedures.

Read the Executive Order here:
https://www.illinois.gov/Government/ExecOrders/Pages/2016_13.aspx.

Law Journal Weighs in on "Right to Earn a Living" Trend

The December 5, 2016, *Yale Law Journal* contains an article by Clark Neily entitled, "Beating Rubber Stamps into Gavels: A Fresh Look at Occupational Freedom." In it, Neily looks at several trends he believes may portend changes in jurisprudence related to regulatory law. He believes these trends may remove unjustifiable restrictions on entry into occupations and professions:

1. The reappraisal by academics and judges of Lochner v. New York as a paradigmatic case of judicial overreach;
2. Increasing concerns about the legitimacy of the rational basis test;
3. A growing number of cases where the fundamental right to free speech meets the no fundamental right to occupational freedom; and
4. The recent application of federal antitrust law to anticompetitive policies for which states have been accustomed to receiving a free pass in most constitutional settings.

Read the full article here: http://www.yalelawjournal.org/forum/beating-rubber-stamps-into-gavels-a-fresh-look-at-occupational-freedom?mc_cid=5aee8d0dea&mc_eid=1c53263409.

See also: http://www.knoxnews.com/story/opinion/columnists/2016/12/15/s-time-protect-right-earn-living/95051830/,

http://www.michigansthumb.com/news/article/Licensing-laws-prevent-poor-from-accessing-health-10799279.php,

http://www.nashvillepost.com/politics/lobbying/article/20848376/beacon-unveils-legislative-agenda, and

http://www.commercialappeal.com/story/opinion/contributors/2017/01/08/tennessee-needs-follow-recipe-prosperity/96157572/.

Washington State Considers Bill Restricting Rule-Making

The Washington State Legislature is considering a bill that would severely restrict the ability of administrative and regulatory agencies to write and/or extend the life of regulations on the grounds that regulations can be burdensome to commerce.

Portions of the bill read:

> (1) Agency may initiate rule making or adopt a rule that is subject to this chapter, except to the limited extent such a rule is necessary for:
>
> (a) The implementation of the terms of a governor-declared state of emergency;
>
> (b) The preservation of the public health, safety, or general welfare in response to a public health emergency; or
>
> (c) The setting of time, place, or manner for the taking of wildlife, fish, or shellfish.

(2) (a) By December 31, 2017, all agencies must report to the legislature all existing and pending rules identified by the agency for an extension or enactment into law, including any new rule or amendment adopted pursuant to an exception under subsection (1) of this section

(b) The legislature may review any rule during the 2018 legislative session to determine which rules should be enacted into law, including which rules, if any, are necessary to meet any federal requirement, or deadline for the receipt of federal funds.

(c) All agencies must set for expiration any rule not reported to the legislature for an extension or enactment into law. All such rules must expire no later than August 1, 2018.

(d) Beginning on the first day after the end of the 2018 legislative session, all agencies must set for expiration any rule reported to the legislature for an extension or enactment into law, unless the rule was expressly authorized for an extension by the legislature. All such rules must expire no later than December 1, 2018.

(3) Any new rule or amendment adopted after December 31, 2017, pursuant to an exception under subsection (1) of this section, must be reported to the legislature by December 31st of the year in which it was adopted. Any such rule must be set to expire by July 1st of the following year, unless the legislature specifically authorizes an extension of the rule. The legislature may review any such rule to determine which rules should be enacted into law.

(4) By December 31, 2018, all agencies must submit proposed legislation to the legislature that incorporates changes to the agency's duties and authority regarding rule making consistent with the terms of this section.

See the complete bill here:
http://app.leg.wa.gov/billsummary?Year=2017&BillNumber=1005.

New York Licenses Advanced Home Health Aides

The National Council of State Boards of Nursing announced on January 6, 2017, that New York State has licensed Advanced Home Health Aides:

> A bill was recently signed into law in New York that establishes the AHHA job designation. The law defines an AHHA as a certified home health aide who meets certain regulatory requirements, is listed on the New York State Department of Health Home Care Services Worker Registry and meets any other requirements established by the Commissioner of Health. In addition, the law authorizes an AHHA to perform advanced tasks, which include the administration of medications that are routine, pre-filled and relatively easy to administer.

The new law also authorizes registered nurses (RNs) to assign and supervise the advanced tasks and includes additional requirements. Additional requirements include:

- Completion of a nursing assessment by the RN before assigning an advanced task;
- Providing the AHHA written, individual-specific instructions for performing the task; and
- Providing the AHHA criteria to identify, report, and respond to problems.

See the legislation here: https://www.nysenate.gov/legislation/bills/2015/S8110.

Massachusetts Establishes Board of Registration in Naturopathy

On January 11, 2017, the Governor of Massachusetts signed a law creating a Board of Registration in Naturopathy.

For details, see: https://malegislature.gov/Bills/189/S2335/BillHistory

Also see: https://malegislature.gov/Laws/SessionLaws/Acts/2016/Chapter400 and https://www.bostonglobe.com/metro/2017/01/11/naturopaths-get-their-own-licensing-board/Lk12PKB7jAYN1z8alxTw9K/story.html.

Colorado Considers Fingerprinting for Prescribers

Legislation before the Colorado legislature would require finger printing for physicians, nurses, dentists, anesthesiologists, physician assistants, veterinarians, and others with prescriptive authority. Colorado is one of a handful of states that don't yet require finger printing of doctors and nurses. The legislation was requested by the head of the Colorado Department of Regulatory Affairs (DORA) and is supported in concept by the professional associations for both physicians and nurses.

For more, see: http://www.bizjournals.com/denver/news/2017/01/18/colorado-could-require-fingerprinting-of-doctors.html.

2017 Survey of Pharmacy Regulations Available

On December 28, 2016, the National Association of Boards of Pharmacy announced the availability of the 2017 *Survey of Pharmacy Law:*

> Serving as a convenient reference source for individuals seeking an overview of the laws and regulations that govern pharmacy practice in 53 jurisdictions, the updated 2017 *Survey of Pharmacy Law* is now available. The *Survey*, which is produced as a digital PDF, is now provided on a USB drive.

The *Survey* consists of four sections – a state-by-state overview of organizational law, licensing law, drug law, and census data. In addition, the updated Survey includes four new questions. The new questions and their corresponding sections are listed below.

1. Section 17, Wholesale Distributor Licensure Requirements: "Does State Require Verified-Accredited Wholesale Distributors®Accreditation for 503B Outsourcing Facilities?"
2. Section 17, Wholesale Distributor Licensure Requirements: "Does State Have a Third-Party Logistics Provider Law?"
3. Section 28, Miscellaneous State Pharmacy Laws: "Does State Require Pharmacies to Conduct Self-inspections?"
4. Section 29, Minimum Standards of Practice: "Does Board Require Compliance with USP Chapter Hazardous Drugs—Handling in Healthcare Settings?"

Updates for the 2017 *Survey* were graciously provided by the state boards of pharmacy. In addition to the boards' support, NABP requested data from relevant health care associations for the Survey's prescribing authority and dispensing authority laws in Sections 23 and 24 and laws pertaining to the possession of non-controlled legend drugs and possession of controlled substances in Sections 25 and 26.

The *Survey* can be purchased online for $195 by visiting the Publications and Reports section on the NABP website at www.nabp.pharmacy. All final-year pharmacy students receive an electronic copy of the Survey free of charge through a grant from the NABP Foundation®. In addition, NABP will provide a complimentary copy to board of pharmacy executive directors for board use.

PATIENT SAFETY AND MEDICAL ERRORS

Medical Education Focuses on Diagnostic Errors

The *Association of American Medical Colleges News* reported on October 25, 2016, about advancements in understanding the causes of diagnostic errors and an initiative to develop educational curricula to teach ways to avoid such errors. A leader is this movement is Mark Graber, MD, founder and president of the Society to Improve Diagnosis in Medicine. According to the *News*:

> Graber, a member of the report's authoring committee, said diagnostic error typically occurs for one of two reasons: a breakdown in clinical reasoning, such as jumping to a conclusion, or an issue in the health care system, for example, a lack of communication between members of a care team. The National Academies

> report on diagnostic error notes that the "diagnosis process often involves intra- and inter- professional teamwork." There are strategies to prevent diagnostic errors through improved cognitive reasoning, but few medical schools have incorporated such education. To fill that gap, Graber is in the process of creating a diagnostic error curriculum for medical students.

For more, see: https://news.aamc.org/medical-education/article/new-focus-recognize-causes-diagnostic-errors/.

See also this article on using computers to help reduce diagnostic errors: http://medicaleconomics.modernmedicine.com/medical-economics/news/can-computers-help-doctors-reduce-diagnostic-errors,

http://www.psqh.com/analysis/unraveling-diagnostic-error-delving-deeply-to-identify-hidden-human-factors/?spMailingID=10050280&spUserID=MTY3ODg4NTU4MDUzS0&spJobID=1061269422&spReportId=MTA2MTI2OTQyMgS2, and

http://journals.lww.com/academicmedicine/Fulltext/2017/01000/The_Causes_of_Errors_in_Clinical_Reasoning__.13.aspx.

CERTIFICATION

ABMS Issues 2015-2016 Summary Report

In January 2017, the American Board of Medical Specialties issued its annual *Certification Report*:

> The *ABMS Board Certification Report* offers information and data about the certification programs administered by the Member Boards of the American Board of Medical Specialties (ABMS). ABMS may from time to time delete, modify, or add tables. To obtain specific information for research, media, or other purposes, please contact the ABMS Communications team.
>
> The *ABMS Board Certification Report* includes the official list of specialties and subspecialties approved by ABMS for issue by the ABMS Member Boards. Prior publications containing this information include *ABMS Certificate Statistics* (2006-2012); *ABMS Annual Report and Reference Handbook* (1980-2005); and *American Board of Medical Specialties Annual Report* (1973-1979), all published by ABMS.

See the report here: http://www.abms.org/media/131568/2015-16-abmscertreport.pdf.

RESPONSE TO SUPREME COURT DECISION IN NC DENTAL

Ohio Considers Massive Changes in Licensing Boards

Legislation introduced in the Ohio legislature in November, 2016 would restructure several licensing boards and give the Ohio Department of Administrative Services authority to review regulatory board actions. The changes are proposed because," according to the *Dayton Daily News* November 15, 2016, "most Ohio licensing boards are dominated by members of the industries they regulate, opening them up to challenges under state and federal anti-trust laws because of perceptions they serve to limit competition instead of serve the public."

The legislation would consolidate several existing licensing boards into new multi-profession boards. For example, the boards of Optometry, Optical Dispensers, Hearing Aid Dealers and Speech-Language Pathology and Audiology would be eliminated and replaced by a State Vision and Hearing Professionals Board. The boards of Psychology, Chemical Dependency Professionals, Counselors, Social Workers, and Marriage and Family Therapists would be consolidated under a new State Behavioral Health Professionals Board. A State Physical Health Services Board would replace existing boards of Occupational Therapy, Physical Therapy, Athletic Trainers, Orthotics and Prosthetics, and Pedorthics. The duties of the boards of Dietetics and Respiratory Care would be subsumed under the medical and pharmacy boards.

For more, see: http://www.daytondailynews.com/news/state--regional-govt--politics/bill-would-abolish-boards-overhaul-professional-licensing-ohio/rLcsn8Cp2fMpD148ow1PwL/.

See also: http://www.dispatch.com/content/stories/local/2016/11/25/kasich-lawmakers-want-to-reduce-medical-licensing-boards.html, and http://www.dispatch.com/content/stories/editorials/2016/11/25/leaner-boards-make-sense.html.

Editorial Note: Contrast these stories with Kansas, where the legislature decided to make only minor changes to the regulatory structure:

http://www.gctelegram.com/news/state/legislators-recommend-few-changes-to-health-licensing-boards/article_4f1454dc-fd9e-554e-905c-b3b57884d12d.html.

Also, see the Licensure section of this issue for articles about "competitiveness" and "right to earn a living" legislation.

CONTINUING PROFESSIONAL DEVELOPMENT

Evidence Mounts Related to Value of Maintenance Certification

An article in the December 29, 2016, *New England Journal of Medicine* entitled, "Knowing What We Don't Know – Improving Maintenance of Certification" makes the case that maintenance of certification improves patient outcomes. Richard J. Baron, M.D., and Clarence H. Braddock, III, M.D., M.P.H. make the case that rigorous third-party assessment is a necessary part of maintenance of certification because self-assessment by individuals is not reliable.

> Despite critics' claims to the contrary, we believe the evidence is convincing, albeit incomplete, that certain outcomes are better for patients treated by board-certified physicians. Published data show, for example, that the risk of both death and emergency coronary artery bypass grafting is lower when patients undergoing percutaneous coronary interventions are treated by board-certified interventional cardiologists, and the cost of care for Medicare beneficiaries is 2.5% lower among physicians who were obliged to complete MOC than among those who were not.

For more, see: http://www.nejm.org/doi/full/10.1056/NEJMp1612106?query=TOC.

AUDITS OF BOARD PERFORMANCE

Audit of California Nursing Board Finds Unacceptable Delays

In December 2016, the California State Auditor submitted a report to the legislature and governor highly critical of the performance of the state board of nursing. The auditor's cover letter reads, in part:

> Our review found that BRN consistently failed to achieve the California Department of Consumer Affairs' 18-month goal for processing complaints. During our review of 40 investigated complaints resolved between January 1, 2013, and June 30, 2016, BRN failed to resolve 31 of the 40 complaints within the 18-month goal. In addition, 15 of those 31 complaints took longer than 36 months to resolve. Further, BRN took longer than 48 months to resolve seven of those 15 complaints, six of which included allegations of patient harm resulting from a nurse's actions. These delays primarily occurred because of BRN's ineffective oversight of the complaint resolution process and its failure to move the complaints through the various stages of the process in a timely manner.
>
> Delays such as these have contributed to a backlog of complaints. Specifically, as of the end of July 2016, we identified a backlog of more than 180 complaints that BRN had not yet assigned to one of its investigators. In fact, nearly 140 were

pending assignment for more than 10 days and, of these, roughly 70 involved urgent- or high-priority allegations, such as patient death, harm, or criminal activity, and had been waiting to be assigned for an average of nearly 80 days. Unnecessary delays in the complaint resolution process enable nurses who are the subject of serious allegations to continue practicing and may risk patient safety.

See the full report here: http://www.auditor.ca.gov/pdfs/reports/2016-046.pdf.

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 onsite training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities; and
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 2017 please complete this form and email, mail or fax it to:

CAC

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

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

Payment Options

1) Mail us a check payable to Citizen Advocacy Center for the appropriate amount;
2) Provide us with your email address so that we can send you an invoice, 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.

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 <u>all</u> of your board members and <u>all</u> of your staff, as well as many other benefits. But if you decide <u>not</u> to join CAC, we encourage you to subscribe to CAC News & Views by completing this form and mailing or faxing it to us.

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Credit card number:	
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Our Federal Identification Number is 52-1856543.