



News & Views

Citizen Advocacy Center

Fourth Quarter 2017 – Health Care Public Policy Forum – Volume 29 Number 4

Announcement

Please note our new office address:

*Citizen Advocacy Center
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In keeping with tradition, the Fourth Quarter issue of CAC News & Views is a report from our annual meeting. This year we held our meeting in Denver, Colorado, on September 13 – 15, 2017, in conjunction with CLEAR's Annual Educational Conference.

These proceedings are not a verbatim transcript, but are faithful to the presenters' remarks and the questions and comments from the audience.

The PowerPoint slides from the meeting are available on our website:

http://www.cacenter.org/cac/2017_annual_meeting.

EMERGING TRENDS

Implications for Professional and Occupational Regulation

Barbara Safriet, Professor of Health Law and Policy, Lewis & Clark Law School and CAC Board Member

In addition to being a member of the CAC Board of Directors, I am a public member of the American Academy of Nurse Practitioners Certification Board and I served for 10 years as the

first public member of the Federation of State Boards of Physical Therapy. I have taught administrative, constitutional and health law. So, I have experience looking at what is happening in professional and occupational regulation.

What is the public's interest in professional and occupation regulation? That's what it's all about. The public's health safety and welfare are the basis for authorizing the government to impose restrictions on who can do what for pay.

Additional questions that need to be asked:

Why do we have restrictions on professions and trades? There are two conceptual bases for this. One is to correct for informational asymmetries. The information relative to a profession is often hard to understand. Providers can create a demand for their own services because they have the expert knowledge to tell you what is wrong with your car, with your structural beam, with your spleen, whatever else.

A second reason for restricting who can do what for pay is to limit negative externalities. These include the cost to consumers, patients, and buyers as a result of poor choices made by consumers or poor services rendered by providers.

Are these justifications for licensure regulation still valid? There is far more information available now in the health field than there used to be. There is far more information available on the internet. In the past, all that information was in the control of the professionals. Are negative externalities still valid reasons for government to impose restrictions?

I think those reasons are still good, but they have less weight. They are based on old notions of a monopoly of information and knowledge. The informational mark has changed enormously, but there is still a basis for protecting the public based on informational asymmetries.

I also think limiting negative externalities is legitimate. Some think we should protect the most vulnerable person – or the most ignorant or goofiest person. That's why there are stickers on lawn mowers that say "Before cleaning the blades, turn the lawnmower off." Or, notices that

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warn “Do not take your hair dryer into the shower.” “Do not put your pet into the microwave to dry it off.” Most of those notices come from lawyers and risk managers because providers were sued over incidents when foolish people did foolish things.

The basic questions remain: How protective should government be and of whom? How much government force should be utilized to restrict who can do what? And, what level of restrictiveness is appropriate? There is cost to society, to consumers, to patients when government imposes regulatory restrictions.

At whose urging were licensure regulations adopted? It is the professions and professional associations. You almost never hear the voice of the public.

Consider the roles that purely private actors play in regulation. Who makes up curricular requirements? The professors. Who develops accreditation standards and requirements for educational institutions? Faculty members. The restrictions may not be valid, but they surely do increase the demand for faculty services. Often regulatory boards’ enabling statutes give boards the power to bless the accreditation of educational institutions. This is supposedly a stamp of approval by governmental actors. But it is often a rubber stamp because they take it on good faith that the accreditors are correct. Good faith is fine, but it should be knowledgeable good faith.

In the old days, state boards drafted their own licensing examinations. Given the proliferation of licensing agencies and expansion of knowledge, can you imagine eight members of a board of medicine or pharmacy or physical therapy writing a psychometrically valid examination?

Instead, we have national licensing exams along with curriculum, accreditation created by private actors. They may be knowledgeable people and some may come from licensing agencies. But, it is interesting to me to think about how much government delegates regulation, knowingly or not, to purely private entities.

What are the government and private associations’ roles in quality assurance and licensure? Let’s start with boards. Board members are drawn mostly from the regulated profession. It is a recent phenomenon to have public members – through the urging of the CAC and the Pew Health Professions Commission. I think it is harder to find good public members than it is to find good licensee members. It’s a tough role. The rationale for drawing most of the board members from the profession is to provide expertise. But this also involves the possibility, if not probability, that the profession’s interest will outweigh the public’s interest in drafting regulations. I think Justice Stevens in the *FTC v the North Carolina Dental board* said it most subtly. Nobody can deny it. The dilemma is expertise vs objectivity.

I don’t think boards are limited to protecting the public. I don’t think promoting professionalism is at odds with public protection, but the principal goal should be to protect the public. I have seen confusion not only among the public about the different roles of licensing boards and professional associations, but also among the members of the regulated profession.

What are the different roles? I have seen several examples. A typical one involves designing licensing examinations. Typically, you begin with a practice analysis, which the psychometricians love. I have seen professional associations object when the exam writers won’t include procedures, services, and/or techniques that didn’t show up in the practice analysis, but that the profession wants to persuade the legislature to include in the profession’s scope of practice.

Another example is adding requirements to be admitted to a licensed profession or occupation. Who is urging this? Seldom the public. It is those who are regulated, or the professors. We see more and more stringent entry requirements, but few regulators to this day require continuing competence assessments. And I did not say continuing education (CE). I'm not demeaning education. I'm an educator. Some states don't even have CE requirements. And if they do it is time in the seat.

I once lost track of my CE hour requirement so at the last minute I ordered tapes. I listened to the tapes. Many people just get them and run them through on fast forward and send them back. How did I choose the subjects? I chose them because the speakers my students 30 years ago and I wanted to see what they look like now. Or, I wanted to be pleasantly surprised that they had become expert in some aspect of the law. I got credit for listening to these tapes. I didn't get credit for teaching CE, or writing an article.

There is a difference between CE and continuing competence assessments. The latter are difficult. Intriguingly, there is little or no empirical evidence that continuing education improves quality. There is a host of evidence that it increases cost, diverts time from practice or services provided, and it often is not tailored to the areas you are practicing in. Lawyers are just like doctors. We were blessed with being there first. I have general undifferentiated authority to practice law just as physicians do to practice medicine in this country. I can practice family law, tax law, and I can be a criminal defense attorney. As a doctor, you can be an orthopedist or a pediatrician, according to your license. If you specialize and have to take an exam for maintenance of certification or licensure, will you be tested on organic chemistry or on the specialty you have chosen to practice? This is throwing a monkey wrench into medical practice acts.

In regulating for quality assurance, the majority of licensing board disciplinary actions, at least in this country, focus on sex, drugs and lies. Sex with patients is typically called a boundary violation. Let's call it what it is: inappropriate unethical potentially criminal sexual interaction with a patient.

Drugs means diversions, pill mills, diverting drugs for your own use or others. Those are illegal and unethical. Another is impairment.

Lies means fraud. Billing for things you didn't do and all the rest.

There is very little superintending of competence, which is why we have licensing laws to begin with. But most boards are underfunded, understaffed. They have crazy demanding requirements for information gathering and reporting. At least in this country, state legislatures will take money from licensing boards to fill gaps in the general funds.

Maybe national certification and continuing certification get at quality control, but competence gets little attention from licensing boards. Many practice acts require repeated or gross negligence as a basis for discipline. Does that protect the public? If a physician does something really negligent once, that is not repeated negligence. I think this very high standard is inappropriate.

Let's look then at private association roles. There are a lot of private quality assurance mechanisms. One is common sense and decency. I know that I am not competent to practice some areas of law. Malpractice insurers may deny insurance or restrict coverage to only certain

services where a practitioner has demonstrated competence. Or, they may charge higher rates. I think this is a quality assurance mechanism, but it is purely private.

There are also institutional review mechanisms, including hospitals, employers, your fellow workers. Another purely private quality assurance mechanism is the personal and monetary value of one's reputation. If someone is actively known to be terrible, they should not be practicing. But the professions have not done a good job of weeding out the bad apples. What they do is leave it to the licensing boards to jack up entry requirements rather than dealing with the bad apples. All that does is add cost, reduce access, etc.

There are surely ethical standards which I hope are quality assurance measures. And then, the catch all – liability, malpractice, negligence, torts. Liability has a weak relationship to improvement in quality for anyone other than the person who has been sued. It is supposed to send a signal to the profession that this is sub-standard care that doesn't meet the standards of the profession. Mostly, it is designed to compensate for a harm, not risk-prevention, which is what licensure is. I think it does a poor job of compensation.

What does competition have to do with regulation? It has everything to do with it. An increasing number of professions and occupations are subject to government permission to act in traditional and new roles and functions. We have gone from about 5% of the labor force twenty years ago to about 35% being subject to some form of governmental permission to practice a trade. This has lots of consequences. Not to say regulation is bad, but is it always needed? Were we in great peril 20 years ago when only 5% of the labor force was subject to government permission? Moreover, all these regulations are state-based. So, there are 51 boards of medicine or nursing or architecture, etc. Except for medicine they are not uniform.

Question – I'm from Idaho and I don't think we should all regulate the same. I don't want to regulate the same way every other state is regulating if my state doesn't have a problem.

Safriet – I bristle at the term “state's rights.” It is based in politics and ideology. If you are talking about Federalism, I am with you. I agree with you that states do not have to do everything the same way. Administrative agencies are better at policy making than legislatures. They need to identify a real, not imaginary, problem and go about addressing it in the least restrictive way possible.

The impetus for regulation comes from those inside the fence already or those who want to get into the fence. It is rarely consumer harm. It is vested interest.

But, having 51 different, non-uniform boards creates confusion among public. Why can't people who pass the same national exam do the same things regardless of the state in which they practice? State-based regulation also affects portability. Many professions are trying to get around the portability issue. Interstate compacts are trying to overcome the inevitable problems with state-based licensure. Telehealth, tele-practice is underscoring the artificial nature of state boundaries. Treating a spleen in Idaho should be the same as treating a spleen in Ontario or Florida. We talk about Federalism. Sometimes local control is better.

Question – That's because the local doctor thinks he knows best how to treat the spleen.

Safriet - Let's go back to the spleen. I'm told we all have one to start with. Let's say that nationwide data and data from other countries shows that 90% of the time this is the way to treat it. But, a doctor in Idaho has a different approach. If the guidelines are 90% reliable, that is the standard of care. Should that become a national standard? People didn't know long ago that

they were outliers, but now data shows them how their choices and performance compare to their counterparts. I believe that our state-based licensure system is under pressure because we have aggregated data and new technologies to enable cross-boundary services.

Another important question is: Are the regulations *reasonable*?

There is a new movement to review legacy regulations that were adopted before the number of professions multiplied (allied professions, if you want to use that term). The first-in-time legacy regulations have an effect on new professions' regulation. Most of the legacy regulations weren't based on evidence, but on politics. There should be a fundamental reassessment. Are they still needed? Are they outdated? Are there less restrictive ways to accomplish the goal?

What about constitutional issues? For the last 70 years, the standard for judicial review of a regulation has been if a law is challenged on due process or some other grounds, the challenger has to demonstrate that there is not even a hypothetical set of facts that would justify the regulation. The legislature doesn't have to justify its acts, but the challenger has to show unreasonableness.

There has been a movement in the courts in the last decade to evaluate regulations that benefit the profession but have no demonstrated need, based on due process, equal protection, or anti-trust. Let me give you one or two examples. Having to have a license to do floral arranging. Who does that serve? What does the public need? Protection against thorns?

Interior decorating – clashing colors? Hair braiding. In my state, you had to have a license. The cosmetology board took action against a hair braider for the unlicensed practice of cosmetology. Courts are beginning to strike such actions down because they are irrational. Hair braiding is not taught in school, it isn't dangerous.

St. Joseph's Abby builds wooden coffins. People wanted to buy them. But, selling caskets intra-state in Louisiana was not allowed except for licensed funeral directors. The court found no rational reason to restrict sale of caskets to licensed funeral directors. Louisiana didn't even require a casket for burial and didn't require funeral directors to have an expertise in caskets. All the requirement did was protect the rule makers' pocketbooks.

Another case involved a licensing board requirement that funeral homes must have embalming suites. In that state, those funeral homes that offered mostly cremation services employed a free-standing embalming service when embalming was requested. The funeral board took action. The same board also had a legacy rule prohibiting serving food in funeral homes. This dated to the years prior to refrigeration. Constitutionally required rationality is beginning to mean something to the courts under due process and equal protection. This is a new trend that many people think is overdue.

State-based licensure is being reconsidered given technology and the ever-expanding education of unlicensed providers of services. Who will be diagnosing cancer in the future? A cellular biologist. Just because you are unlicensed doesn't mean you are incompetent. Do we need to license? It involves a cost. Is it worth it? Is it rational to prosecute the unlicensed practice of X if there is no evidence of harm?

All of these issues are central to your mission to protect the public by assessing, proposing and adopting reasonable restrictions. You may impose stringent restrictions, but you need to be convinced they are necessary and aren't simply serving ideological or political goals.

Becky LeBuhn, Co-Founder and Board Chair, Citizen Advocacy Center

Barbara said she was speaking for herself and that she is a trouble maker, but there is a lot happening in the real world that confirms what she was talking about. I will focus on one trend which is “right to earn a living” legislation. The concept is that individuals have a right to practice a profession and that licensing regulations can interfere with that right by imposing unnecessary governmental restrictions on the ability to earn a living. Governments, the argument goes, have an obligation to justify restrictions when they impose them and to find a balance between regulating to protect public health and safety versus regulating to impose unnecessary restrictions on individuals’ access to a career.

There is a lot of conceptual background and basis for this. The conservative American Legislative Exchange Council (ALEC) has a few model bills. One is the “Occupational Licensing Relief and Job Creation Act,” which was finalized July 3 2012. As part of the rationale for this act, ALEC writes:

“Occupational licensing increases unemployment by about 1%, raises prices by about 15%, and offers no incremental consumer protection over a competitive market. This Act ensures that an individual may pursue lawful occupation free from unnecessary occupational regulations, and protects against the use of occupational regulations to reduce competition and increase prices to consumers. When enacting future occupational regulations, this Act requires state legislatures to find real harm, and select the least-restrictive regulation to address that harm. The Act also protects entrepreneurs by shifting the burden to the government to show in court and administrative hearings that it is enforcing occupational laws for health-and-safety reasons, and not solely as a barrier to entry.”

ALEC’s “Occupational Board Reform Act,” finalized January 16, 2016, is a bill having to do with anti-trust, which Dave will say more about later. This piece of model legislation is described by ALEC as:

A bill for an act relating to occupational regulations contrary to the Sherman (Antitrust) Act; establishing the state policy for the regulation of occupations, specifying criteria for government regulation to increase opportunities, promote competition, encourage innovation, protect consumers, and comply with federal antitrust law.

It goes on to say that:

For occupational regulations and their boards, it is the policy of this State that:

1. The State will increase economic opportunities, promote competition, and encourage innovation.
2. The State will use the least restrictive regulation necessary to protect consumers from present, significant and substantiated harms that threaten public health and safety.
3. An occupational regulation may be enforced against an individual only to the extent the individual sells goods and services that are included explicitly in the statute that defines the occupation’s scope of practice.
4. The attorney general will establish an office of supervision of occupational boards. The office is responsible for actively supervising state occupational boards.

5. The legislature will establish a position in its nonpartisan research staff to analyze occupational regulations. The position is responsible for reviewing legislation and laws related to occupational regulations.

The Goldwater Institute in Arizona, which Mark Speicher will talk more about, has published several papers on the topic of interference with the right to earn a living. One such paper by Clint Bolick, Associate Justice of Arizona Supreme Court, is entitled, “Right to Earn a Living Act.” Characterizing what he calls the problem that right to earn a living acts attempt to solve, Bolick writes: “Many licensed professions do not seem to present significant health and safety concerns, yet individuals who would like to join the profession must first fulfill costly and burdensome requirements.”

At the other end of the political spectrum, the Obama White House convened a group of experts to review regulatory policy and produced a paper entitled, “Occupational Licensing: A Framework for Policymakers,” which recognized health and safety benefits of regulation and a positive impact on the quality of services, but it also concluded that there are downsides. Regulation can create monopoly power, create guilds, raise costs, and reduce employment opportunities as well as consumer choice and access. There are also problems arising from inconsistencies in regulation from state to state. This White House report concluded that regulation should be limited to professions where there is risk to public safety; that governments should do cost/benefit analyses or sunrise-type review before enacting regulation and consider certification as an alternative to licensure. It recommended harmonizing regulations across states and eliminating unjustifiable scope of practice restrictions.

A significant paper written by Morris Kleiner at the Hamilton Project at the Brookings Institution, entitled *Reforming Occupational Licensing Policies* essentially came down on the side of certification over licensure, where feasible, for credentialing professions and occupations. He also recommended consumer protection measures, such as bonds to protect consumers from malpractice or shoddy performance.

More recently the Federal Trade Commission created what it calls the Economic Liberty Task Force which convened an event entitled, Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License Portability, about which I will say more later.

The Economic Liberty initiative is a favorite of Acting FTC Chairman Ohlhausen, who told an audience at George Mason University law school:

“I have committed to make economic liberty and regulatory humility touchstones of my leadership of the agency...with a particular focus on the problem of occupational licensing regulation.... Today, licensing requirements reach far beyond doctors, electricians, and other fields where public health and safety issues are clearer. Instead, licensing requirements extend to auctioneers, interior designers, make-up artists, hair-braiders and numerous other occupations. The public safety and health rationale for regulating many of those occupations ranges from dubious to ridiculous.... I challenge anyone to explain why the state has a legitimate interest in protecting the public from rogue interior designers carpet-bombing living rooms with ugly throw pillows. Market dynamics will naturally weed out those who provide a poor service, without danger to the public.”

This is happening at the Federal Trade Commission and is consistent with a lot of what Barbara said.

Attention to the concept of states being careful about who they regulate and thinking through the rationale for regulation is an idea that has been embraced recently by liberal and conservative political forces. It is certainly not a new idea. Many of you may recall a wonderful book written by Ben Shimberg and Doug Roederer in 1978 called “Questions a Legislator Should Ask.” At the time, I think they were thinking less about regulation being an impediment to people finding careers than they were about regulation creating problems for the consumers of goods and services by creating monopolies, raising prices, reducing access and similar considerations. Here are some examples of questions Shimberg and Roederer wrote that legislators should ask:

- What is the problem?
- Why should the occupational group be regulated?
- What efforts have been made to address the problem?
- Have alternatives to licensure been considered?
- Will the public benefit from regulation of the occupation?
- What assurance is there that credentialed individuals maintain competence?
- Will renewal require periodic examination, peer review, evidence of CE, etc.
- Will regulation be harmful to the public?

These are the very same questions being asked in 1978 as are being asked now.

Next, I want to talk about what is happening in the states. Not all of this activity is called “Right to Earn a Living” legislation, but the rationale and objectives are similar.

The Little Hoover Commission in **California**, which analyzes administrative law, conducted a review in 2016 of “the impact of occupational licensing on upward mobility and opportunities for entrepreneurship and innovation for Californians, particularly those of modest means.” They concluded that it would be important to look at “the results of occupational licensing on the cost and availability of services provided by licensed practitioners to consumers.”

In **Tennessee**, the “Right to Earn a Living Act” requires all state agencies to limit entry regulations for professions and occupations to “those demonstrably necessary and carefully tailored to fulfill legitimate public health, safety or welfare objectives.” State agencies will be required to conduct a comprehensive annual review of their entry regulations to determine whether they serve a public health, safety or welfare objective and repeal or modify those that do not. Individuals have the right to petition agencies to amend or repeal an entry restriction.

In **Missouri**, a bill was introduced that would allow new regulation only if a profession presents a risk of significant public harm and if the public would benefit from imposing requirements on the practitioners of the profession and if there is no alternative means to accomplish this end.

Arizona has enacted a number of regulations that Mark Speicher will tell you about in detail.

In **Ohio**, legislation introduced in November 2016 would restructure several licensing boards and give the Ohio Department of Administrative Services authority to review regulatory board actions. It would consolidate several 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 Health Professionals Board. The boards of psychology, chemical dependency professionals, counselors, social workers and marriage and family therapists would be consolidated under a State Behavioral Professionals Board. A State Physical Health Services Board would absorb the boards of Occupational Therapy, Physical Therapy, Athletic Trainers, Orthotics and Prosthetics, and so on.

Similar legislation was introduced in **Iowa** that would replace licensure requirements for numerous professions with certification or registration. **Indiana** considered legislation that would create a pilot project under which individuals who practice an occupation that is not a regulated profession under Indiana law (and who hold a certification or other credential issued by an approved organization) could become “state-registered.”

An Executive Order issued by the governor of **Illinois** established the Illinois Competitiveness Council. The order references The World Economic Forum’s *Global Competitiveness Report* which found that “excessive bureaucracy and red tape, overregulation, corruption, dishonesty and dealing with public contracts, lack of transparency and trustworthiness, inability to provide appropriate services for the business sector and political dependence on the judicial system impose significant economic costs to businesses and slow the process of economic development.” So, the focus on workforce is really giving regulation something of a black eye.

Interestingly, the order points out that other states, such as AZ, CO, FL, IN, KY, MA MI, NJ, and WI have a competitive edge over Illinois in attracting business and entrepreneurship because they have implemented comprehensive reviews and reforms of anticompetitive laws, rules and policies that impose unnecessary costs on businesses and citizens. The order also called for a “Cutting the Red Tape” initiative involving a review of all administrative rules and policies to be sure they do not impose unduly burdensome requirements on businesses and service providers.

Delaware’s governor appointed a regulatory review committee to review that state’s regulatory requirements and remove unnecessary or overly burdensome licensing or certification requirements.

Michigan’s Office of Regulatory Reinvention recommends de-regulating numerous professions, including auctioneers, community planners, interior designers, ocularists, dieticians and nutritionists, and underground storage tank qualified consultants and certified professionals.

Texas is an example of a state that uses Sunset Review to evaluate whether a profession should continue to be regulated. In its report to the Legislature, the Sunset Advisory Commission noted:

Following extensive analysis, testimony, and deliberations, the Sunset Commission recommends that the 85th Legislature pass legislation making significant improvements to the operations and oversight of 24 entities. Sunset recommends continuing 14 agencies and abolishing and transferring the functions of the Texas State Board of Podiatric Medical Examiners. Sunset also recommends consolidating four behavioral health boards into one agency to minimize duplication and address serious gaps in quality of regulation and public protection.

Currently under review are regulation of accountants, appraisers, plumbers, funeral directors, physicians, counselors, psychologists, social workers, marriage and family therapists, among others.

Kansas is an example of a state that considered but then decided against consolidating health professional licensing boards. A report from Kansas Health Institute News says:

A committee of legislators formed to study the consolidation of licensing boards for a dozen public health professions ultimately decided Wednesday to recommend few changes.

Consolidation of the boards was one of the recommendations from a government efficiency study lawmakers commissioned last year to help them identify cuts to close persistent budget deficits. (See <http://www.khi.org/news/article/efficiency-report-recommends-single-health-insurance-plan-for-state-employe>).

But most of the licensing boards involved strongly opposed consolidation, and Rep. Dan Hawkins noted that consolidation would not help with the state general fund deficits because the boards are almost entirely funded through fees on their members. (See <http://www.khi.org/news/article/proposal-to-combine-health-licensing-boards-draws-opposition>).

The committee ultimately recommended just one change: moving the board of hearing aid examiners under the Kansas Department for Aging and Disability Services, where it will join the board that regulates audiologists and speech pathologists.

That is a summary of what is going on in the states that could lead to deregulation of some professions – maybe not the high stakes professions in fields such as health care – but certainly some for whom it is more difficult to find a rationale for regulation.

Let me conclude by re-raising the topic of telehealth because of its implications for the state-based licensure system. Not only does telehealth permit people to practice across state lines, but the increasing involvement of the federal government affects the entire nation, regardless of state barriers by, for example, delivering telehealth through the VA and enacting telehealth reimbursement policies for Medicare. Legislation under consideration in Congress includes:

- Medicare Telehealth Parity Act of 2017 which would ease geographic and other limitations on the use of telehealth in the Medicare program,
- Creating Opportunities Now for Necessary and Effective Care Technologies for Health Act of 2017 (CONNECT Act of 2017) which promotes the use of telehealth and remote patient monitoring services by Medicare,
- The Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act (CHRONIC) of 2017 that would increase access to telehealth services in the home.

Similarly, interstate compacts and other initiatives to facilitate license portability across jurisdictional lines underscore questions about our 50-state licensure system. Is it rational? Most professions have national education standards, national qualifying exams; national specialty certification.

Inconsistent standards for advanced practice nursing from state to state illustrate the irrationality of the system. APRN certification is national, the exam is national. To the extent certification supplants licensure for some professions, credentialing will be national, not state-based.

As I mentioned, the FTC’s Economic Liberty Task Force recently held an event entitled “Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License

Portability.” The FTC staff prepared a series of questions on which they seek public comment. Here are just a few of those questions that we may want to discuss this afternoon:

- To what extent is the increased ability to provide certain services electronically (such as telehealth or telework) driving greater interest in mechanisms that ease the burdens of multistate licensing?
- How effective are compacts and model laws in reducing barriers to entry in licensed occupations, enhancing mobility of licensees, increasing the supply of licensees, and promoting competition among service providers?
- To what extent does the effectiveness of a compact or model law depend on harmonization of state licensing requirements?
- What, if anything, should the federal government do to encourage adoption of compacts and model laws that promote license portability across state lines?
- Are there some occupations for which it would be better to reduce or eliminate licensing requirements, rather than develop an interstate licensure compact or model law to ease licensing requirements across state lines? What factors would influence this analysis?

At this point, I will turn the microphone over to Mark Speicher to tell you about what has been happening in Arizona.

Mark Speicher, Associate Dean for Academic Affairs, Arizona College of Osteopathic Medicine at Midwestern University

I was the executive director of the Arizona Medical Board for ten years. Let me tell you a story to set the context for what I am going to talk about today. During my second year as the medical board executive, Sidney Wolfe and the Public Citizen Health Research Group came out with a ranking of state medical boards based on the number of actions they took to discipline physicians. Arizona was number 47. I did a lot of press interviews. I was asked why we were doing such a terrible job and putting the Arizona public in danger by taking so few actions. We worked very hard and started taking more actions, worked with our board to be sure they had the information they needed; worked with administrative law judges, and so on. A year later, the Health Research Group found that Arizona was number 8. So, Channel 12 asked to do a live remote from my office. The first question was, “Why does Arizona have so many more bad doctors than the other states?”

In general, in the public view, we don’t do much right. The best we can do is satisfy ourselves that we are working hard to do what we believe is the right thing. I have nothing but respect for the people who serve on and work for licensing boards and certification agencies.

Arizona is a fairly conservative state. We are very spendthrift in our policy decisions. We are a little bit libertarian. In 2012, the Institute for Justice think tank started looking at regulation and issued a report saying that lots of professional regulation isn’t necessary, but the amount of regulation is growing dramatically and it has negative impacts on entrepreneurship and employment.

We talked about the 2015 report from a fairly liberal White House, which also said that regulation has grown so much in the past 25 years that it is time to take a look at it. So, both

ends of the political spectrum are reaching the same conclusions about what should be happening with regulation.

The Goldwater Institute is an Arizona-based think tank that does a lot of small government kinds of white papers and think pieces and they agreed. Governor Ducey in his first year issued a moratorium on all state agency rulemaking.

In 2015, Arizona tried to reorganize the healthcare regulatory boards. All the medical specialties have their own licensing boards – medical doctors, doctors of osteopathic medicine, naturopaths, homeopaths, podiatric physicians, nursing, and so on. Lots of little licensing boards that the government wanted to “umbrella.” That didn’t succeed. It was opposed by the professional associations and the boards. The legislature saw a lot of lobbyists – all speaking in opposition. The lobbyists for the state licensing boards were often the same as the lobbyists for the professional associations and that left a poor impression on the legislature. The boards were opposing legislation supported by the governor and spending state money to hire lobbyists. In 2016, there were legislative attempts to prevent boards from doing several things, foremost of which was to prevent boards from hiring lobbyists.

In 2017, Governor Ducey issued an executive order that boards must review all their licensing requirements and in cases where those requirements could not be shown to be required for public health and safety, they either had to repeal those requirements or justify them. In other words, he wanted to see evidence-based regulation. Also in 2017, the legislature passed the Right to Earn a Living law, which codified the requirement that regulation be as least restrictive as possible.

The 2012 Institute for Justice Report concluded that the cost of occupational licensing was 300 million jobs and \$200 billion a year in higher prices. That is a huge cost. They didn’t devote as much attention to the benefits of occupational licensing as they did to the costs. In fact, they summarized the benefits in less than one page. They examined all the states and categorized Arizona as the sixth most restrictive state. We license 64 low to moderate income professions. That’s one of the ways they determined that we have too much occupational licensing.

The White House report says that 25% of occupations are licensed, 5 times more than were licensed in the 1950ies when only 5% of professions were licensed. This has resulted in increased prices, fewer jobs and reduced cross-state relocation. The benefits of licensure are less well defined in the report.

In his state of the state address, the governor said licensing laws result in a maze of regulations that harm Arizonans looking to earn an honest living. Nothing about public protection or public-private partnerships.

Senate Bill 1443, called “Transparency and Accountability in Licensing Agencies,” required a reduction in regulations. It combined a number of the boards and it reintroduced the concept of the umbrella health board. It was watered down so far that the governor vetoed it and asked the legislature to try again. Senate bill 1281 would have moved licensing functions to the Department of Health. That bill was withdrawn in the face of opposition.

During the 2017 legislative session, the cosmetology board investigated a retired man in Tucson who was giving haircuts to the homeless. He went to the media and the story went viral. Not only did the cosmetology board stop the investigation, but the Senate introduced and swiftly passed the Right to Earn a Living Law. Governor Ducey issued the executive order that all boards publish their regulations and defend the ones that exceed the national average.

I know what it is like to administer the “bad” state agency. You are always affected by what your brother or sister agencies are doing. So, anything like the cosmetology board action can lead to a hullabaloo for all state agencies. It happened when the medical board was the focus of attention for not regulating enough. Other agencies suffered for being in our shadow.

The Right to Earn a Living Act that passed in Arizona has components that will affect everyone in occupational regulatory agencies. The law made it much easier to appeal the effect of rules and enjoin the rules from taking effect. The standard was set at a preponderance of the evidence.

Rules must be shown to protect health and safety rather than business interests. The cost of proof, defense and penalties for both sides is borne by the agency, win or lose. Imagine what that will do to agency budgets.

This law went into effect September 1. There haven’t been any public attempts to enjoin new rules or sue agencies yet. The review of agency regulations has to be completed by December 31 and provided to the governor’s office. It is funny that an incident like someone washing hair for the homeless can set something like this in motion. There is little a state can do to defend against this because it is hard to establish that your regulations are reasonable. The potential for abuse is very large with this type of legislation. The potential for good is also there. But it hasn’t been implemented in Arizona in a cooperative way with the state agencies.

David Swankin. President and CEO, Citizen Advocacy Center

I am going to talk about how states are adapting to the Supreme Court’s decision in North Carolina Board of Dental Examiners v. Federal Trade Commission. Very briefly, this case arose when the dental board wrote cease and desist letters to people who ran teeth whitening kiosks in shopping malls, saying this was the illegal practice of dentistry. The Federal Trade Commission called this an unreasonable restriction. The case went to the Supreme Court. Many licensing boards joined an amicus brief opposing the FTC. CAC signed onto the single amicus brief that supported the FTC. Licensing boards didn’t want the federal government involved in what states are doing. The irony of that is that over the years the FTC has been vigorous taking on particular licensing board actions under its anti-trust authority and sometimes its deceptive practices authority. The economic theory is that licensing by definition restricts entry and raises prices and is therefore bad for open markets and competition.

The Supreme Court supported the FTC 6-3 and set forth general standards. There is an exemption from anti-trust laws for state actions. The Court ruled that to maintain this immunity, boards need to meet certain tests. First, there has to be an articulated state policy. There was no such policy in North Carolina related to teeth whitening. Suppose the North Carolina Board of Dental Examiners had gone through a rulemaking instead of issuing enforcement letters, there probably wouldn’t have been an FTC action. Barbara spoke about constitutional cases that say state policy has to be rational. There is nothing in the North Carolina case requiring the state policy to be rational.

Next, if the board is dominated by active market participants, which virtually all licensing boards are, the board must be actively supervised by the state. Supervision need not consist of day-to-day involvement in an agency’s operations or micro management of every decision. But, there has to be an independent body that reviews board actions. The review has to be substantive and the reviewer has to have the authority to reject or modify board actions.

According to the Court's decision, the four powers a supervisor must have are:

- They must review the substance of the decision, not just the process,
- They must be authorized to veto or modify any policy to make sure it meets state policy,
- There must be active supervision, not just the potential for supervision, and
- The supervisor may not be him or herself an active market participant.

The FTC's guidance document said that the supervisory responsibility can't simply be given to the attorney general, especially if the attorney general also provides legal services to the boards. There has to be a fire wall between individuals in the AG's office who are reviewers and those who provide legal services to the board.

I have been surprised that there is no pattern to how the states have chosen to adapt to the supervision requirement. A few are trying to give the responsibility to the AG, but that is not the prevailing pattern. I will describe some of paths states have chosen.

One thing states could do is to structure boards so they are not controlled by active market participants. The only state I am aware of that attempted to change the composition of boards is Kentucky. They did it in the engineering field. An executive order dated November 29, 2016 abolished 8 boards under the Department of Housing, Buildings and Construction and replaced them with a united single advisory committee. It has 17 members, including 7 public members. Membership includes at least one of the following: manufactured or mobile home retail, certified installer, architect, plumbing professional, engineer, elevator expert, HVAC professional, electric trades expert. These individuals are so diverse, they are not in the same profession. The committee also includes government officials: The Commissioner of the Department of Housing, Building and Construction, who is also the chair, the State Fire Marshall and the Director of Building Code Enforcement. Seven public members, three state officials and the rest of the members are not participants in the very same market.

A look at other states confirms that they are taking different approaches. In Montana, the Commissioner of Labor and Industry becomes the active supervisor. His role is to provide oversight and supervision of the duties and authority exercised by boards regulated by exercising active supervisory authority to approve or disapprove any board action identified by the department as restraining or potentially restraining competition. The Commissioner shall determine if the board action is taken pursuant to a clearly articulated state policy and if the restraint or potential restraint of trade or commerce is responsible and necessary to protect the public health safety and welfare.

Some states, including North Carolina, have singled out rulemaking and created independent rulemaking commissions. Usually they are governor appointed. Had the North Carolina dental board decided to act via rulemaking, its rule would have been reviewed by this independent commission. It has the same powers that the Office of Management and Budget has over federal agency rulemaking.

But, boards do a lot more than rulemaking. Is a licensing action, for example, subject to review? Could a board be in anti-trust trouble for a licensing action? For a disciplinary decision? Suppose there were a pattern of action, such as actions against alternative medicine practices. Could that raise anti-trust issues? I believe a pattern of board decisions should be subject to review.

Some states have considered giving supervisory power to the AG with a quick turnaround time and no extra appropriations or staff. Is that real review? Some states have given supervisory authority to the governor; others have given it to a senior health department official.

Many of the solutions states have adopted are likely to be challenged. The bottom line is that we aren't going to know for years what the impact of the North Carolina decision will be in the states.

Among the questions that still have to be answered are: Who has standing to appeal? How is the review mechanism triggered? Can an outside person trigger a review? What is the role of the legislature? Does it have the ultimate authority to bless a review ruling? Will the legislature become the independent supervisor? If the governor is the supervisor and the legislature does not approve, this would create a tug-of-war between executive vs legislative power.

Regulatory boards are in for challenging times. Challenges are coming from all directions and all political points of view. Let's hear from you about how you view these challenges.

Question – Part of me wonders how much money states need to spend to set up a working system just to keep an immunity. Part of me thinks this is a case of bad facts making bad law. What is the risk any particular board will face a challenge from the FTC if they are careful not to engage in an anti-competitive activity? The cheapest and easiest way out of this problem may be not to create an expensive new structure but to avoid anti-competitive actions.

Swankin – I don't think anyone knows how much this will cost states. I haven't seen any forecast. Second, even though there has to be the authority to look at everything and a record of action, it doesn't mean a reviewer has to look at everything. So, another unknown is what and how many actions would actually be reviewed. Doing nothing is obviously an option, but remember that anti-trust law is also enforceable by private actions. The remedy is treble damages. There is legislation pending federally to exempt board members from financial liability.

Comment – My understanding is the federal legislation only exempts the boards if they have active supervision and set up a separate, state-funded supervisory board to do that. It is a whole new reporting structure to get the immunities as part of the Restoring Anti-Trust Immunity Board Act. There is also a piece of legislation being advocated by the Federation of Associations of Regulatory Boards (FARB) and nine professional licensing organizations called the State Board Anti-Trust Licensing Act. We have support in the House and Senate and hope it will be introduced in the next few weeks. It takes a lighter touch on the supervision dimension.

Comment – Do I understand correctly that a board has to choose either oversight or having more public members than licensee members on the board? Why aren't boards choosing to have more public members because that wouldn't be expensive to implement?

Swankin – I think it is cultural. Remember there were no public members when the regulatory system was created. Originally, boards were a way legislatures granted authority to the professional associations to determine who could practice the profession. It wasn't easy at first to put even a single public member on a board. In California, there was an effort to put a majority of public members on non-health related boards. Rhode Island has 50% public members. But, these are the exceptions. The Federal Trade Commission staff guidance says it is more than a question of numbers. You have to look at quorum requirements, who attends meetings, how they vote, and so on to demonstrate that active market participants are not

controlling the board. One argument is that there must be members of the profession on the board to provide the necessary expertise. An alternative is to change board composition and obtain that expertise through an advisory committee.

Comment – It took many boards a long time to get even one public member on the board. The FTC guidance says that even one active market participant on a board can be in a controlling position. That suggests only 100% public members would be acceptable. I think we need to look for balance rather than extremes.

Swankin – I think Kentucky is the most interesting example of changing board composition. I think a good case can be made that the people on the board are in sufficiently diverse markets that no one profession can be considered to control the board.

Question – If a board is made advisory, is the anti-trust liability passed to the entity that the board is advising?

Swankin – I think you would have to review the record. Every time the advisory committee made a recommendation and it became policy, you could make the case that the advisory board is not advisory, but is the decision maker. The FDA has expert advisory panels who review new drugs and devices. Their recommendations are not always accepted, which confirms that they are advisory.

Comment – In Michigan we have an advisory committee called the Emergency Medical Services Coordination Committee. They have a subcommittee with the responsibility to help us with our disciplinary cases. You brought up a good point about the fine balance between their recommendations and my department's final decisions. If we agree with all their recommendations, are they really advisory?

Swankin – Years ago the Maryland medical board was required to send every quality complaint to the professional association. A hundred percent of the time, the medical association's recommendation became the policy of the board. This was challenged and the process was changed.

Question – I work in the field of nutrition and dietetics and was formerly active in the policy area in my state. I thought that Maryland had a good legal foundation when the NC Dental decision came down because a representative from the Attorney General's office sits in on every meeting of the Board of Dietetics. But, the Attorney General's office ruled that even having an attorney present at a board meeting did not constitute adequate supervision because they didn't have the authority to overturn or modify a decision of the board.

Swankin – The FTC staff guidance says that just being present does not qualify a representative of the attorney general to be the supervisor. There is also a philosophical question. Who is that attorney representing? The state or the board? If the attorney is representing the board, the board is that attorney's client.

SESSION II – EVALUATING LICENSING BOARD PERFORMANCE

Meeting Consumer Expectations

David Benton, Chief Executive Officer, National Council of State Boards of Nursing (NCSBN)

I will talk about performance metrics and how they influence the evolution of regulation. NCSBN recently completed a piece of work called Regulation 20/30. This is a complete analysis of the global literature about regulatory trends. We then convened a group of 80 stakeholders from around the world to discuss where the leading-edge trends may take us into the future and what it will take to move forward.

We identified 25 major trends and synthesized them down to big issues regulators need to move forward on. The first is collaboration. We can't do this on our own. We have to work with a variety of stakeholders. The second relates to the uses of technology and information. The third element is around governance. The governance models we currently use are not likely to serve us well in the future. The fourth element is what I will focus on this morning, which is performance metrics.

First, I will define who are the consumers of board services. Then, I will look at the state of the science. I will comment on all the current attention to the state of occupational licensure. Then I will move to what can be learned from the international research and give some examples.

Preparing for this session, I thought about the concept of “consumers.” Boards have multiple consumers. We may think first of the patient – the ultimate user of a service. Actually, you have a range of consumers you need to satisfy. I see both primary and secondary consumers.

Primary consumers include the government, which creates the regulatory entity. Legislators will often keep a watchful eye on what you do. Therefore, what do you need to do to meet their expectations? The metrics you need for that might be different from those you need for the licensees you deal with, which might be different for the educators who provide the education that results in licensure, or indeed the employers and patients.

There are also secondary consumers. We have to balance the individual vs the population. We have to know how we relate to entities such as professional associations whose purpose is to protect the profession, while your purpose is to protect the public. We have to work with trade union colleagues, as well. Their purpose is to protect the individual nurse. There are differences in the metrics people will judge us by. Today, when we work increasingly as part of complex and dynamic teams, the relationship between you as a regulator of a particular discipline with regulators of other disciplines is also a measure we need to look at.

What is the state of the science of occupational licensure? There is a technique which enables us to look at the published literature and distill the key component parts. What is it that the literature is focusing on at the moment? How might that inform us about some of the metrics we might need?

A lot of the literature about occupational licensure is coming from the economic perspective. There are basically four major domains. One is about scopes of practice. A second relates to market access, such as whether the licensure process discriminates against certain categories of individuals. Third, is licensure causing a problem in terms of restricting the marketplace? Finally, does licensure protect the public as it is intended to do?

The literature is dominated by the work of the economist Morris Kleiner. His particular angle is to observe that the number of licensed professions has increased markedly. He asks, are we licensing things we really shouldn't have to license?

Where does this literature appear and what does it focus on? It tends to be in the economics journals as opposed to the health journals. Some of it is in law and sociology journals. It's not the stuff that clinicians traditionally access. There is a little bit from the teaching profession and a little from allied health. The big message is that we aren't doing a very good job of telling the public – consumers – about why licensure is important and how regulators can be held to account.

Let's look at how we measure performance. Our study found four major buckets. Issues around legislation, advocacy and responsiveness. Issues around the organizational and internal governance of the organization. Issues around external governance and public accountability and issues around the way individual responsibility and functions are pursued. Each of these break down further.

Having a way of structuring metrics, particularly when linked to particular categories of consumer, you can begin to focus your discussion. For example, the legislator is probably more interested in how you are fulfilling your mission, but the licensee and the public are more interested in issues around competence and conduct.

We know from the global literature that a favored technique is to compare and contrast. Research done in Canada, Australia, the UK, U.S., Vietnam, and Thailand looks at particular models and how they relate to one another. This is difficult because different models are often underpinned by different legal traditions. For example, countries that operate within a common law structure are different from those that operate from a civil law or Islamic law structure.

We often see entities in places like the UK where there is an overarching body that undertakes systematic and recurrent reviews of the performance of different regulators. The Professional Standards Authority has produced numerous documents, which can be found at <http://www.professionalstandards.org.uk>. In many U.S. states and elsewhere in the world evaluations following the principle of Sunset Review look at the performance of the regulator and make a judgment about whether it should continue to exist or undergo changes. So, there are lots of ways the performance of an organization can be examined

At NCSBN, we have done some work looking at board profiles. We gather data on a regular basis from our membership and apply to it some work from the Organization for Economic Cooperation and Development. (See <http://www.oecd.org>). They have focused in recent years on the criticality of the independence of the regulator. This means independence from the government and from the profession or stakeholder group. Unbiased and fair judgment can be determined. We just completed an examination of some of the tensions that can occur when the professional association and the regulator are one and the same; in some countries the regulator, the professional association and the trade union are one and the same. We've been able to tease

out the dynamics and tensions. If you are coming at it from a trade union perspective, your metrics will be very different than they would be from the perspective of protecting the public or promoting the profession.

As part of our Commitment to Ongoing Regulatory Excellence (CORE), NCSBN does large scale surveys of employers, educators, and licensees, and provides information to boards to enable them to see how they perform in comparison to similar boards. Looking at board profiles, we were able to identify differences between umbrella and independent boards. The performance of independent boards with several exceptions is actually better than the umbrella agencies. We were able to demonstrate that statistically. One of the key findings from a consumer perspective is that independent boards are much better at providing information to the public than are umbrella boards. That doesn't mean to say that all umbrella agencies are bad and all independent ones are good.

The National Practitioner Data Bank requires boards to upload information within thirty days of the board's final decision. We looked to see whether there were differences between independent and umbrella boards in fulfilling this administrative function. Umbrella boards perform less well than independent boards. Those independent boards that don't perform as well can consult with the better performers to see how they might improve.

It is important to use data in a way people can understand. One of the things board members can do is plot performance over time. Executives need to look at more detailed data to refine interventions to improve performance.

The key messages are: performance metrics are improving. We can be more proactive about designing metrics that are sensitive to different stakeholder groups. We need to think about how to present information in an understandable form and at the right level in the organization. The data you present to the board needs to be at the governance level – setting the standard. The data that the executive officer receives needs to be much more granular because they need to be able to spot when things are going off track and bring them back.

Bridget Gramme, Administrative Director, Center for Public Interest Law (CPIL), University of San Diego School of Law

I am here to talk to you about consumer expectations. CPIL advocates for the public before California regulatory boards. We monitor a range of state licensing boards from the Bar Association to the medical board to the contractor's board. We have been doing this for a long time so we can see trends.

What does protection of the public really mean? When a board is controlled by the profession, they may be advocating for restrictions or certain regulations that are in reality better for the profession than the public. Think about who is advocating for regulations and restrictions. When we talk about board performance, I think this is an important question to ask.

For example, our Bar Association is a unified bar, meaning it is a trade association and regulatory body at the same time. This can cause a conflict of interest. There has been a lot of controversy about the cut score for the California Bar Exam. The pass rate has been going down significantly. Is California's the hardest bar exam to pass because we are protecting the public or because the professionals who set the cut score are trying to keep other people out of the profession? We have had public hearings about this and seen lots of op-eds in legal media. The

people who defend the cut score say they are protecting the public, but there is no data to show that this is the case.

Another question is whether the public is informed about what is happening at your agency. Can the public evaluate our performance if they don't have access to the necessary information? One thing the Center has advocated for over the years is posting information on board websites, such as physician disciplinary information. It took several years to get legislation passed so this is an example of professionals not necessarily wanting information disclosed to the public.

Thinking about ways to evaluate our performance, I have posed three questions:

- How do we make sure the public is informed and has access to the information it needs to assess our performance?
- Is the evaluation independent?
- How do we ensure that licensees continue to be competent during their careers?

To address these questions, I want to survey the audience to find out how you feel about the issues we are talking about and how you handle them in your state.

First, who is in the room? *What best describes your current role? Are you board staff, board members, educator, or other?* You are mostly staff, with some board members, including public members.

How do you feel about this statement: Regulatory board transparency is critical to public protection? Most of you strongly agree.

One issue we are facing in California is whether doctors need to disclose to their patients whether they are on probation. The public supports this. The California Medical Association strongly opposes it. Do any of your states require licensees to affirmatively disclose whether they are on probation? Some states do, depending on the nature of the discipline.

Question – Knowing that our provider is on probation, is that always conducive to healing? Isn't it the board's job to remove from practice people who are not safe to practice?

Gramme – That's a good point and the draft legislation in California covers this.

Does your state have a mechanism of some kind for independent review of your regulatory boards? About half of you responded yes.

In California, we have Sunset Review about every four years. An important question is who does the evaluation. A committee of Bar examiners in California hasn't changed the cut score for the exam in twenty years. There has never been any job analysis or other data to support the cut score. The Bar examiners investigated and held hearings and decided to keep the cut score the same, so that wasn't a truly independent review.

What best describes your view of journalists who cover your agency's activities? Friends, foes, or frenemies? Most of you see some tension.

My experience in California is that investigative journalists help move reforms through. In 2002, there was an expose entitled, "Doctors Without Discipline," which criticized the medical board for being lax on disciplining unsafe doctors. That prompted the legislature to appoint an independent enforcement monitor to review the entire discipline process. So, the media can play an important role in advancing reforms.

Does your agency assess licensee competence post-licensure? Most of you do not.

Comment – In Idaho, we do a random office review. Someone from the board staff does an inspection at least every five years. Also, licensees can post CE credits on the website. The office inspection can include a chart review to see if they are following the standard of care. If there is a complaint, the inspector may pull charts.

Comment – The college of Registered Nurses in Alberta has a reflective practice program. All members have to report on their progress with a tailored learning plan.

Gramme – The California Bar is considering requiring licensees to take a test after CE to determine whether they actually learned something and that the CE is relevant to a licensee's area of practice.

Comment – There is a risk of losing the benefits of self-regulation, where professionals bring their expertise and bias toward professionalism. Not all public is the same. We hired an ethicist who brings a helpful public interest lens.

Benton – One of the things we identified in our 2030 work was how to select board members to create an effective board and invite people to self-nominate to take it away from the profession and the legislature. You need to look at where you need professional input into decision-making.

Question – How common are umbrella boards?

Benton – In nursing, about half are umbrella and half independent. Legislation was introduced in Kansas to put the nursing board under the medical board. The BON executive was able to draw on data from our work to show that the independent board would be more efficient and effective.

Comment – Should physicians let their patients know they are on probation? I wonder what the climate is for public protection if these professionals were required to advertise where they finished in their class, or where they scored on their licensure exams. How would that affect their clientele.

SESSION III – HEARING FROM YOUR CONSTITUENTS

Techniques for Getting Input From the Public

Becky LeBuhn, Board Chair, Citizen Advocacy Center

I will briefly describe an outreach project CAC engaged in several years ago. The first public member network within CAC was the beneficiary representatives on what were then called Peer Review Organizations (more recently called Quality Improvement Organizations – QIOs) created by Medicare. There is one in each state to oversee the quality of medical services provided to Medicare beneficiaries. Congress mandated that each one have a beneficiary representative on its board of directors.

Each QIO was required to have a beneficiary outreach program to reach beneficiaries in their state. In the early 1990ies, we surveyed beneficiary representatives to learn about their outreach

programs. Most said that the most effective outreach was in-person meetings with the public. They also distributed pamphlets and wallet-sized cards; they attended health fairs. They published annual reports, some of which had data about beneficiary complaints. They all maintained a hotline that beneficiaries could use to contact the QIO and register a complaint and hope to get some satisfaction.

They weren't given a budget or technical assistance from the Centers for Medicare and Medicaid Services, but they used their imagination and many had effective outreach programs. One element they all had was a citizen advisory committee called a Beneficiary Liaison Committee. Its purpose was to facilitate two-way communication from the QIO to the public to disseminate information about its activities and from the members of the Beneficiary Liaison Committee to the QIO to influence its program and activities. The Beneficiary Liaison Committees varied a great deal in size from as few as 4 to as many as 20 people. They were composed of beneficiary organization representatives, such as senior citizen organizations, AARP, Gray Panthers, Retired Teachers Association, Department of Elder Affairs, Long-Term Care Ombudsmen. They typically included representatives of government agencies such as the department of health and social security administration, healthcare institutions such as the state hospital association, home health agencies, and retired healthcare professionals. They convened meetings where they would evaluate and tweak the outreach the QIO was doing and get feedback about community concerns.

Our experience with the Beneficiary Liaison Committees taught us a number of things, one of which is that a two-way communication vehicle can be very beneficial to both the community and the sponsoring organization. We learned that a number of qualities are important to the success of a citizen advisory panel.

One is that the membership needs to be broadly based. The membership must help develop meeting agendas and the strategic work plan for the organization. Likewise, communication at the meetings must be two-way. It is important to have feedback. If the community suggests an action or a policy, it is important for the organization to let them know what has happened to this recommendation and why. We also concluded that to the extent possible, these organizations should not be resource-intensive. There must be periodic evaluation to determine whether the advisory group is accomplishing its mission and identify where improvements were necessary.

A few years ago, we developed a How-To kit for boards of nursing on how to create a citizen advisory panel, believing that this institution could be as useful for a regulatory board as it was for a QIO. The How-To kit goes through the six qualities I just listed in more detail than I have. It recommends how to populate a citizen advisory panel, frequency of meetings, developing an agenda, getting feedback, staffing and budget, and the evaluation process. You can find this brief kit on CAC's website at

<http://www.cacenter.org/files/EstablishingCitizenAdvisoryPanels.pdf>.

If you were to create an advisory panel for your board, what would you achieve? You would get information about the concerns of your constituents. This could be important to policy development. You could get information about how to improve your outreach program to reach a broader segment of the population you serve. You might get advice on how to improve your website to make it more user-friendly. You might get early input from the public in advance of rulemaking proceedings. We hear from many boards that they are frustrated that they can't get public input into their rule making process. You might get some assistance in developing

positive relationships with the media. You might get some input when political or legislative issues come up. There are many possibilities.

Debra Allen, Senior Manager, Regulatory & Practice for the College and Association of Registered Nurses of Alberta

There has been much attention recently to innovation in the healthcare system. The challenge is how to implement changes that will shift the focus from “me” to “we.” How do regulators do that when we are in the weeds and the changes are really specific to our regulation or our profession? The literature suggests that those leaders who succeed in bringing about change have a clear evidence-based vision mixed with comforting ambiguity and experimentation. Most nurses are not comfortable with ambiguity and experimentation. It was a challenge for us to look for a made-in Alberta model for RN prescribing.

We received many requests from stakeholders even though we had just made changes in our regulation. The one I will focus on today is RN prescribing and ordering of diagnostic tests. We believed that when the conversation first started, it would improve access to care and allow for the development of innovative models of care. We thought it would create positive system change and would increase system efficiency and cost effectiveness. We built our model around those beliefs.

We needed to move beyond the traditional approach of bringing together experts primarily from the nurse profession and other healthcare providers. How could we shift away from a focus on us to a focus on what the change would mean for the public? I found an interesting quote when I was preparing for this talk. It is from Kristin Palmer Kanagy who said, “Instead of working to preserve the existing system, healthcare regulators need to ask how they can enable disruptive innovation to emerge.”

There are many approaches to prescribing. In England, Sweden and New Zealand, nurses have had prescriptive authority for a while. Nationally in Canada, there are jurisdictions that already have RN prescribing. In BC, they have introduced the concept of “certified practice,” which limits what a RN can prescribe based on the specific area in which they are authorized to practice. They use very detailed clinical support tools. Manitoba authorizes RNs to prescribe and are waiting for their regulations. Saskatoon has followed a model similar to BC, where they are looking to primary care and have tools to support them. Quebec authorizes RNs to prescribe for community and public health, contraception, and other conditions. So, in Canada, the model is specific to certain areas of practice where when I looked internationally it seems to be a bit broader.

In Alberta, NPs are already authorized to prescribe, but there is still inadequate access for the public. There are few physicians in remote areas and the majority of NPs in Alberta work in acute care facilities. So, in 2007, we did an online survey to assess the level of support for the idea of RN prescribing. Respondents included all the regional health authorities in the province, Health Canada, educators, specialty practice groups, the nurses’ union, other health professions. We also took a random sample of our own members. Nearly 77 % of the respondents said they supported RN prescribing. Those who opposed believe that only NPs should prescribe and that RNs don’t have the education to prescribe safely, or that this would create confusion with the role of the nurse practitioner.

We decided we needed to go to our board, explain the background, and ask whether board members agree we should move forward with this idea. They agreed. We conducted focus groups to see what kind of practice areas might be appropriate. We talked about the different models internationally and in Canada. At that time, around 2007, the College of Pharmacy was considering authorizing pharmacists to prescribe and we looked at their model, as well.

Registered nurse prescribing is just one of the changes we are proposing in our regulation. When the proposed draft policies to guide the regulation were sent to us, the government offered feedback from stakeholders. There was a lack of understanding about what was being proposed. We reminded ourselves why we thought this was a good idea for the public and for the system. It wasn't simply about scope of practice; it was about others.

We decided to establish an advisory committee with the goal of developing a shared vision that would have measurable value and would lead to scalable and sustainable outcomes. The committee was established in July 2015. The purpose of the advisory committee is to provide an opportunity for stakeholders to work collaboratively, to support the successful implementation of prescribing for RNs. Advisory committee members provide advice, expertise and feedback on the development of our organizational processes, identify issues that may impact successful implementation, and work to address issues with practical solutions.

The advisory committee includes a pharmacist a physician, a dental hygienist (a profession that had just recently been authorized to prescribe), a nurse practitioner, employer representatives from the large healthcare employers, Health Canada, educational institutions, the health advocate, the Health Quality Council of Alberta and the Canadian Patient Safety Institute. We felt that the committee would give us a broad look at the implications across the system.

Meetings are held approximately every two months. Each meeting concludes with a discussion about each member's view of three key takeaways. We use this to develop a key message information sheet. The key message sheets help manage expectations and influence attitudes.

Staff used a variety of communication tools. Two infographics were developed. One illustrates how RN prescribing could influence access to care and increase efficiency and cost-effectiveness. The target audience is primarily members of the Legislative Assembly. The other illustrates the process for putting RN prescribing into practice.

Others who attend the advisory committee meetings include the evaluation consultant, the education approval consultant, exam analytics consultant, and the policy and practice consultant. We have an evaluation framework aligned with expected outcomes so we know what we want to achieve and will be able to measure that at the end. Advisory committee members helped develop the education program for RN prescribers: what should be learned, how should it apply to practice, what support is appropriate in the practice setting? They provided advice and feedback on the standards for RN prescribing and input on the development of a framework for a clinical support tool. They recommended building on the Canadian Patient Safety Institute's safety competency framework and the Health Quality Council of Alberta's patient safety framework. The clinical support tool covers these areas: governance and leadership, safety management, people in teams, environment and equipment, and client engagement.

The lessons we learned are that change can be accomplished with commitment, focus, vision, and patience. Both the public and providers must have a clear vision of the goal and support a clear vision expressed in consistent key messages externally and internally. Understand that

change is constant and old silos need to be broken down to meet the public's needs. We engaged in open discussion, making sure the right stake holders were at the table, and agreed that no decision was absolutely final.

The advisory group will help us evaluate pre- and post-implementation of the demonstration project we have proposed once the new regulation is filed. There is overwhelming enthusiasm on the part of employers to participate. Collaboration, coordination and consultation require access to information, openness and transparency, and communicating with stakeholders on how this change will impact them.

Yanling Yu, Research Scientist, University of Washington and Public Member of the Washington State Medical Quality Assurance Commission

I will talk about our Commission's efforts to reach out to the public and to hear from them. I will describe a public survey we just conducted and what we learned.

Our Commission's primary purpose is to protect the public by ensuring the quality of care. The Commission is also responsible for establishing, monitoring and enforcing qualifications for the practice of medicine by physicians and physician assistants. We have 21 members, including 13 physicians from different specialties and geographic areas. We have two physician assistants and six public members. Historically, including public members has been viewed as assurance to the public of transparency, accountability, and the opportunity for the public to participate in medical regulation.

Can we do more to involve the public in medical regulation? Personally, I think we can do a lot more. Last year our Commission created a citizen engagement working group. It has eight members, four of whom are public members. We have a clinician, a PA, and two staff members. The purpose is to assess the Commission's visibility to the public and assess the public's concerns about accessing information about the Commission. The working group is also charged with finding out the public's understanding of medical regulation and the Commission's work.

The group met a few times and set forth priorities and milestones. We decided first to survey the public and follow up with focus groups. This is the first time the Commission has done anything like this. We developed a questionnaire focusing on three areas. The first one is the Commission's visibility; the second is the Commission's accessibility; the third is the public's understanding of medical regulation. We also have some demographic questions, and finally, we asked respondents if they would like to participate in a focus group study. We were happy to receive over 1,000 responses including more than 900 from Washington State.

The age distribution is interesting. Most were 60 – 70 years old. The average age is 66. Sixty-eight percent had never worked in healthcare. Twenty-four percent worked in healthcare in the past. Four percent currently work in healthcare and four percent responded "other."

We asked if they had heard of the Commission. Seventy-one percent in Washington State never heard of the Commission. We asked those who have heard of the Commission, what was the source of that information. Most people learned from reading news articles. Others learned from work, from their healthcare providers, from consumer advocacy groups, friends, family or an internet search.

We asked what information they would like to have. The majority want information about disciplinary actions. They also want to know about complaints filed against physicians. Next are criminal convictions, board certification, hospital privileging, and malpractice payments.

Our website is run by the Department of Health. Eighty-five percent of the people we surveyed did not know this resource is available to them. We asked those who know about the website, what information they search for on the site. The first response is to check the credential; actions against the license is second; selecting a doctor or physician assistant is third. Some search to verify CME requirements.

We asked how people search for information about medical regulation. Most search using the internet, family and friends, newspaper, social media.

To understand public perceptions or expectations from the Commission, we asked an open-ended question. Here are some of the words used most frequently: patient, investigation, public, standard, investigation, board, transparency. These are the things on people's minds.

Here are some comments: "They are transparent in the actions they take against physicians."

"Open and easily accessible for state's citizens to communicate issues and concerns with physicians." "Make the information about disciplinary actions against physicians and hospitals more publicly accessible." "I want the board to make available compliance and/or competence data to ensure me that practitioners meet the professional standard of care."

To summarize, we learned that very few people know we exist. Most of them learn about us from the media. So, we are working on establishing a more visible and user-friendly website to increase public engagement.

We learned most people turn to the internet to search for information about healthcare regulation. So, we want to make the Commission website more visible, and publicize it on social media.

We learned that people want transparency. So, we plan to make disciplinary information more accessible, to educate the public about the provider search function on our website, and to make them aware of our quarterly newsletter.

We learned people want to be heard. Our plan is to create an open public forum for Q&A and to undertake our focus group study.

Our Commission believes it is important to reach out to the public. The better we communicate with the public, the more we are able to earn public trust.

Question – How did you disseminate your surveys?

Yu – We decided who our primary stakeholders are. We thought about physicians, PAs, legislators, and patients. We decided it was best to focus on patients as our number one customer. We sent the survey link to consumer and patient group leaders who distributed it to their members. So, we really don't know how many people received the survey, but we do know we received more than 1,000 responses. We screened out those that did not come from Washington State.

Question – Did you ask about socio-economic background in doing your research? Do you take these factors into consideration in forming your citizen advisory groups?

Allen – One of our challenges was to find practicing physicians and pharmacists willing to volunteer their time. We did find a physician who recently retired. We have a very nice mix of members from those who are seasoned and those who are relatively new to practice, men and women, etc. It was serendipitous.

Yu – We didn't ask a question about socio-economic background. We did ask about gender and race. We were disappointed that 70% defined themselves as "white." That is a good question because socio-economic status influences how people search out and use information. I don't know how to get that information. Perhaps we could ask if the respondents are on Medicare or Medicaid to make inferences about age and economic status.

LeBuhn – In the case of the QIO Beneficiary Liaison Committees, the universe is Medicare beneficiaries. Within that group, most of the QIOs did make an effort to have representation from different socio-economic groups. It's a good idea to do so.

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