News & Views

Citizen Advocacy Center

Third Quarter 2018 – Health Care Public Policy Forum – Volume 30 Number 3

Announcement

Our 2018 Annual Meeting was held on October 16, 2018, and October 17, 2018, at the Washington Plaza Hotel in Washington, DC. The theme of the meeting was Interprofessional Teams and Collaborative Practice. The PowerPoint presentations from that meeting are now available at www.cacenter.org.

Look for a summary of the meeting in the Fourth Quarter issue of Citizen Advocacy Center News & Views.

SCOPE OF PRACTICE

Pharmacists & Physicians Treat Hypertension at Barber Shops

The March 13, 2018, MedPage Today reported on the success of a collaboration between pharmacists and physicians to provide African Americans with diagnosis and medication for hypertension when they visit select Florida barbershops. The program succeeded in significantly lowering the mean systolic blood pressure of participants. The program represents a clever way to reach African American men who rarely seek care at healthcare institutions.

For more, see: http://tinyurl.com/ybl2j62e.

Alaska Considers Expanding Scope for Naturopaths

The Alaska legislature is considering HB 326, which would increase the scope of practice for naturopathy in the state. The

~ TABLE OF CONTENTS ~

~~ Continued on Page 2 ~~

~~ *Continued from Page 1* ~~

~~ *Continued on Page 3* ~~

bill's sponsor says her motivation is to increase access to care and stimulate price competition in the healthcare marketplace.

For more, see: http://tinyurl.com/ycxp9u6p.

Diabetes Care by NPs and PAs Comparable to Physicians'

A March 16, 2018, post on Practice Management News reports findings in Veterans Administration facilities that diabetes care by nurse practitioners, physician assistants, and lay health workers is comparable to care by physicians. The point of the article is that using non-physicians to make up for a physician shortage can save facilities money while not reducing the quality of diabetes care.

For more, see: http://tinyurl.com/y73q4y3v.

Despite findings such as these that show care by NPs and PAs to be comparable to physician care, the Tennessee legislature was swayed by a letter from the American Academy of Family Physicians (AAFP) warning that permitting an expansion of scope for PAs with supplemental education would expose patients to "grave danger."

For more, see: http://tinyurl.com/y7n9eazq.

CMS Urged to Rescind Authorization for Nurses to Read Lab Tests

On March 28, 2018, the National Council of State Boards of Nursing's *Good Morning Members* contained the following entry:

In response to a CMS Clinical Laboratory Improvement Amendments (CLIA) request for information, hospital laboratory workers are urging CMS to eliminate an Obama-era regulation that allowed nurses

to analyze clinical laboratory tests. Specifically, the request for information sought feedback on whether personnel requirements, testing standards, and industry fee structures for clinical laboratories need to be updated. The CLIA regulation was originally issued in response to testing personnel shortage concerns in rural areas.

A comment from Baylor Scott and White Health Testing noted that some staff did not hold the educational requirements to analyze laboratory tests and stated "clinical judgement of results cannot be made if the laboratory scientist has no understanding about molecular biology, genetics, and polymerase chain reaction testing." However, some nurses commented that they had extensive biological science education and were qualified to read lab tests while others emphasized that a registered nurse with a bachelor's degree had adequate training to analyze clinical laboratory tests.

For more, see: http://tinyurl.com/yb86gwbn.

Study Says Including Midwives Improves Care

NCSBN's *Good Morning Members* reported on May 9, 2018:

> According to a first-of-its-kind study, Mapping Integration of Midwives across the United States: Impact on Access, Equity, and Outcomes, there is a strong connection between the role of midwives (certified nurse midwives, certified midwives and certified professional midwives) in the health care system -- what the researchers call "midwifery integration" – and birth outcomes. Specifically, researchers found that states with midwife-friendly laws and regulations tended to coincide with lower rates of premature births, cesarean deliveries, and newborn deaths. For the study, a multidisciplinary team of researchers created a midwifery integration score based on 50 criteria covering factors that determine midwives' availability, scope of practice and acceptance by other health care providers in each state.

~~ Continued from Page 2 ~~

Regulatory Reform in Three Nations 16
National Council Releases 50-State Authorization to Practice Data 17
States Respond to the Supreme Court's Ruling in NC Dental 17
FSMB Supports Bill to Relieve Boards of Anti-Trust Liability 18

TELEHEALTH
Benchmark Survey Documents Growth of Telehealth 18
Center for Connected Health Policy Issues 50-State Report 19
E-Consult Tool Published 19
Department of Veterans Affairs Issues Telehealth Rule 20

SUBSTANCE ABUSING AND IMPAIRED PRACTITIONERS
Is Alzheimer's a Disqualifying Illness? 20
Doctors Admit Mental Health Issues 20
Physician Burnout Jeopardizes Patient Care 20

CONSUMER INFORMATION
California Doctors Must Inform Patients of Probation 20

IN-DEPTH FEATURE
FTC Policy Perspective: "Options to Enhance Occupational License Portability" 21

2019 MEMBERSHIP INFORMATION 25

2019 MEMBERSHIP ENROLLMENT FORM 26

NEWSLETTER SUBSCRIPTION FORM 27

Researchers found that "states with high midwifery integration, like Washington and Oregon, generally had better results, while states with the least integration, primarily in the Midwest and South, tended to do worse." Saraswathi Vedam, lead author of the study, stated, "In communities in the U.S. that are underserved – where the health system is stretched thin – this study suggests that expanding access to midwifery is a critical strategy for improving maternal and neonatal health outcomes."

See more here: http://tinyurl.com/y8oa6s5a.

CONTINUING PROFESSIONAL DEVELOPMENT

American Board of Medical Specialties' Vision Initiative Summarizes Stakeholder Testimony and Survey Results

Editorial Note: What follows are excerpts from Findings released by the American Board of Medical Specialties' Vision for the Future Commission. https://visioninitiative.org. ***The Commission was created by ABMS to re-evaluate Maintenance of Certification (MOC) programs administered by its 24-member medical specialty boards in light of complaints by some certified physicians that MOC requirements are burdensome, unnecessarily expensive, and insufficiently relevant to every day clinical practice. As the name implies, the Commission will project how MOC programs can be improved in the future. According to ABMS, "The Commission brings together multiple partners to vision a system of continuing Board Certification that is meaningful, relevant and of value, while remaining responsive to the patients, hospitals and others who expect that physicians are maintaining their knowledge and skills to provide quality specialty care."***

The Commission "is charged with reviewing and understanding continuing certification programs within the current context of the profession of medicine. Commission members are involved in health care leadership and/or clinical practice in health systems, academic medicine, group medical practices, state associations, health advocate organizations, professional organizations, and the public."

At its initial meetings, the Commission heard testimony from a variety of stakeholder groups. These are its findings based on that testimony:

Physician Findings

When asked if they value MOC, one in 10 physicians (12%) said they value the program, nearly half (46%) said they have mixed feelings about it, while 41 percent said they do not value the program.

The survey asked physicians about their concerns regarding the MOC program. Participants were allowed to choose up to four options from a set list. The most frequently cited response was "costs" (58%). "Burdensome" was next highest (52%), followed by "does not accurately measure my ability as a clinician" (48%). "Does not help me improve my practice in a meaningful way" (43%) was the fourth most popular response.

CAC *News & Views* is published quarterly by

Citizen Advocacy Center
1601 Eighteenth Street NW
Suite #4
Washington, DC 20009
Phone: (202) 462-1174
Fax: (202) 354-5372
Email: cac@cacenter.org

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

Physicians were also asked to select which activities from a set list should be considered by the Vision Initiative Commission for continuing certification. The most popular responses were "continuing medical education" (84%) and "self-assessment questions delivered at regular intervals" (52%). Less popular choices were "open-book exam" (34%) and "assessment of the quality and safety of care provided" (24%), among the other choices.

Of the physician respondents, 96 percent are Board Certified. Additionally, 69 percent of respondents noted they are currently enrolled in a primary specialty MOC program, and 33 percent are currently enrolled in a subspecialty MOC program. Sixteen percent are lifetime certification holders. These categories are not mutually exclusive. Finally, six percent are not enrolled in an MOC program or are a lifetime certificate holder.

In summary, approximately half of physician respondents see MOC as too costly, burdensome and not a true reflection of their abilities as clinicians. Some physicians want continuing certification to focus on practice-relevant continuing medical education (CME) opportunities, self-assessment, open-book exams, and quality of care assessments.

Other Healthcare Stakeholders Findings

When asked how familiar they are with the requirements that physicians must fulfill to maintain their Board Certification, 39 percent of stakeholders said they were "very familiar," 46 percent said they were "somewhat familiar," nine percent said "somewhat unfamiliar," and five percent said they were "not at all familiar" with the requirements.

When asked if they consider Board Certification when selecting a physician, more than half of the stakeholder respondents (57%) said they always consider it, more than a

quarter (27%) said they sometimes consider it, and 15 percent said they never consider it. Next, when asked if Board Certified physicians provide higher-quality care than non-Board-Certified physicians, nearly six in 10 respondents (59%) believe they do; one in five (22%) didn't know. One in five (19%) said Board Certified physicians don't provide higher-quality care.

Consumer Findings

When asked if they consider Board Certification when selecting a physician, more than half of the general public respondents (56%) said they always consider it, more than a quarter (28%) said they sometimes consider it, and 16 percent said they never consider it. Next, when asked if Board Certified physicians provide higher-quality care than non-Board-Certified physicians, more than eight in 10 respondents (84%) believe they do; the remaining 16 percent said Board Certified physicians don't provide higher-quality care.

General public respondents were also asked about the activities physicians should be required to do to stay up to date and maintain clinical skills and expertise. The participants were given a set list and asked to select all the options that may apply. More than half of general public respondents selected the following options: "participate in a minimum number of CME hours each year" (85%), "periodic exercises to measure, and if necessary, improve quality of care" (74%), "periodically assess performance to compare with other doctors in the specialty" (64%), "have communication and clinical skills rated via patient surveys" (59%), "have performance rated via colleague surveys" (56%), and "take exam at regular intervals assessing clinical knowledge" (56%). The only activity not selected by more than half of the respondents was "self-assessment activities to determine how well he or she is doing" (48%). Two percent said, "None of the above."

CONCLUSIONS

While these data must be interpreted with caution, the results provide important insights for the Vision Initiative Commission. The Commission will consider these results as part of their overall continuing certification testimony.

Physicians

While a small percentage of physicians value MOC, a larger portion has either mixed views or do not value MOC. They currently see MOC as too costly and burdensome, not an accurate depiction of their abilities or relevant to their practice, and duplicative. However, physicians see some value in MOC for its CME opportunities and tracking, focus on lifelong learning, keeping physicians up to date, and self-assessment programs. Respondents want continuing certification to include a focus on relevant CME opportunities, self-assessment delivered at regular intervals, open- book testing, and an assessment of the quality and safety of the care provided.

Other Health Care Providers and Consumers

Board Certification is a recognized credential and plays an important role in selecting a physician. In fact, both groups strongly indicated that Board Certification is important when selecting a physician and they believe Board Certified physicians provide a higher quality of care.

Research Shows Passage of MOC Exam Linked to Fewer Disciplinary Actions

Research by the American Board of Internal Medicine has found that the risk of disciplinary action is lower for physicians who pass the Board's Maintenance of Certification exam.

See: http://tinyurl.com/yd59arbx. See also data showing variation in performance among physicians who maintain certification vs, those who don't http://tinyurl.com/y9bkyabt.

ABMS Member Boards Use Article-Based Assessments

ABMS Insights reported in March 2018 that some of its member boards are using article-based assessments to help physicians obtain the latest evidence quickly, and conveniently:

> How are physicians expected to keep current with medical knowledge when it is estimated that as many as 10,000 new studies are published each month?
>
> Some American Board of Medical Specialties' Member Boards are helping Board Certified physicians by hand selecting journal articles for their relevance and timeliness, such as safe opioid prescribing or addressing the Zika virus. The certifying boards are then using these articles as part of their educational and assessment process to help physicians acquire the latest evidence to use in their clinical practice.
>
> Learn how the American Boards of Obstetrics and Gynecology, Pediatrics, Ophthalmology, Emergency Medicine, Allergy and Immunology, and Psychiatry and Neurology have incorporated article-based assessments into their continuing certification process, and the positive feedback they are receiving from Board Certified physicians.

Physicians not only benefit from having key information filtered by their peers, saving them time from having to track it down themselves, but it is delivered to them via the latest technology, allowing them to access the information anytime, anywhere, and on many electronic devices. Moreover, physicians view the knowledge gained from article-based assessments as valuable and relevant to their practice.

For more, see: http://tinyurl.com/y9m96ox5. See also: http://tinyurl.com/ybx2n6na, and http://tinyurl.com/yd98lwkk.

See other changes to ABMS Board approaches to MOC: http://tinyurl.com/yb5qbs37, http://tinyurl.com/ybco4n7a, https://www.medscape.com/viewarticle/896709, and http://tinyurl.com/ycwhkeq2, http://tinyurl.com/y7yd83ut. See also: http://tinyurl.com/yc85ocbj.

See this for column supporting legislation challenging MOC requirements: http://tinyurl.com/ydhhzz62.

Editorial Note: Citizen Advocacy Center is a founding member of the Right to Safe Care Coalition (http://righttosafecare.org), which educates the public about the dangers of legislation like this.

Texas Medical Board Amends CE Requirements

The Texas Medical Board announced several rule changes in March 2018. Among them:

> The amendments to §186.10, concerning Continuing Education Requirements, add language to subsection (a) to state that at least two hours of the required 24 hours must be in the topic of ethics. Additionally, the amendments add subsection (b)(2)(C) to give non-traditional continuing education credit to those who teach or instruct a course in an accredited respiratory care educational program. The amendments also add language to subsection (b)(3) to clarify that credit may be awarded for credentialing or re-credentialing examinations listed in this subsection. The National Asthma Education Certification Board (NAECB) Certified Asthma Educator (AE-C) and neonatal resuscitation program (NRP) examinations are also added to this subsection. Language is also added to subsection (b)(3)(J) to explain how often credit may be awarded when the same examination is taken for initial credentialing purposes and re-credentialing purposes.

For more, see: http://tinyurl.com/yb2o75fb.

ABMS Officials Report on International Revalidation Conference

The March 2018 issue of ABMS News distributed to those who sign on to an email list contained the following Observations and Reflections written by Lois Margaret Nora, MD, JD,

MBA, ABMS then President and CEO, and Thomas Granatir, Senior Vice President for Policy and External Relations:

> **International Perspectives on Revalidation of Clinical Competence**
>
> We recently had the privilege of attending an international conference about recertification sponsored by the International Association of Medical Regulatory Authorities in association with the General Medical Council in the United Kingdom (UK). Regulatory authorities across the English-speaking world are grappling in their own way with how to maintain physician competence throughout a lifetime of practice. More than 100 attendees from nearly 40 countries learned from authorities primarily in England, Ireland, Scotland, Australia, and New Zealand.
>
> The conference largely featured governmental programs that, unlike the voluntary process of specialty certification in the United States (US), are required by law and therefore more akin to state licensure. Nevertheless, there were four notable differences in the approaches taken by systems outside the US that may resonate here:
>
> They are formative. They have prioritized physician trust and engagement and therefore rely primarily on formative and activity-based requirements rather than performance-based assessments. A small percentage of physicians are removed from practice or recommended for remediation, but for the vast majority of physicians the emphasis is on the improvement of clinical skills.

They are decentralized and collaborative. Recertification decisions are based on workplace assessments conducted locally. In the UK, the highly decentralized process requires deep collaborative relationships with medical and specialty societies as well as hospitals and other employers. In some countries, the graduate training programs also play a role.

They use multiple data sources to address competency domains. None of the systems assesses medical knowledge. Decisions to revalidate (re-license) are based on a portfolio of formative activities that include development of a learning plan, participation in quality improvement activities, feedback from patients, and 360o or multi-source feedback evaluations, as well as clinical performance data, including complaints and adverse events. Failure typically results from lack of engagement in the process of assessment, learning, and improvement, and not performance on high-stakes assessments.

They strive for proportional regulation. All of the systems aim to vary regulatory intensity based on the level of risk represented by each physician. That way, more resources are devoted to those who pose the greatest risk or threat to patients. Some systems use structural risk factors (i.e., age, practice isolation, etc.) and limit formal assessment to a smaller, more manageable percentage of physicians. Some conduct a small number of purely random reviews. In England, the normal five-year review cycle may be shortened to three years, depending on the level of physician engagement.

Whether these choices actually result in more trust and engagement from physicians remains to be seen. Early results from an evaluation of revalidation in the UK suggest that while participation rates are high, physicians are divided on whether the process has improved patient safety or patient care, and the majority claim that they did not change their practice, behavior, or learning as a result of the process.

The challenge for the Member Boards - how to create an economical system of recertification that improves care and is valued by physicians - appears to be a challenge for health systems across the globe.

Sincerely,
Lois and Tom

See also "the online home of a major evaluative research study into the regulatory impacts of medical revalidation, commissioned by the General Medical Council, and delivered independently by a UK-wide collaboration:" http://umbrella-revalidation.org.uk, and http://tinyurl.com/y75b243r. See this report from the Medical Board of Australia: http://tinyurl.com/y9als6hg.

CRNA Recertification Examined

NCSBN's *Good Morning Members* reported on March 29, 2018, that:

> An article in the *Journal of Nursing Regulation* examines recertification and re-entry to practice for nurse anesthetists by evaluating performance through high-fidelity simulation technology and determining core competencies. Researchers set out to:
>
> - Validate a set of clinical activities for their relevance to re-entry and determine if they could be replicated using simulation;
> - Evaluate the content validity of an existing simulation scenario containing the proposed clinical activities and determine its substitutability for a clinical practicum; and
> - Evaluate the validity of two methods to assess simulation performance.
>
> To address each of these study aims, researchers surveyed three unique expert certified registered nurse anesthetist groups and found that "27 clinical activities gained consensus as necessary to be assessed in the simulation." Additionally, "all 14 survey questions used to determine simulation content validity exceeded the minimum content validity index value of 0.78, with a mean value of 0.99." Researchers conclude that these "findings add to the existing literature supporting the utility of simulation for high-stakes provider assessment and certification."

See more here: http://tinyurl.com/y8q8uvzz.

Rand Corporation Releases Study of Recertification

In October 2018, the Rand Corporation released a study of recertification conducted under contract with the American Association of Physician Assistants. Entitled, "Identification of Alternative Physician Assistant Recertification Models," the study is described as,

"An Analysis of the Landscape and Evidence Surrounding Approaches to Recertification in the Health Professions."

See the study here: http://tinyurl.com/ycqc9gpn.

QUALITY OF CARE

Misdiagnosis is Major Cause of Liability Claims

HealthLeaders Media reported on March 18, 2018, that an analysis of malpractice claims reveals that:

> Misdiagnoses are the root cause of one-third of all medical liability claims and account for nearly half of all indemnity payments, according to a new report by (insurance company) Coverys.

See the article: http://tinyurl.com/y99kowdw, and the report: http://tinyurl.com/y8av6q5l.

Study Finds Nurses Deficient in Evidence-Based Competencies

The Agency for Healthcare Research and Quality's Patient Safety Network reported on the following study published in December 2017:

> Although the practice of evidence-based medicine is an important strategy for improving the safety and quality of health care, consistent use of known best practices does not occur. In this study, researchers sought to assess nurse competency throughout the United States across 13 evidence-based practice competencies for nurses as well as 11 additional competencies for advanced practice nurses. They administered an anonymous online survey and received responses from 2344 nurses across 19 hospitals or health systems. In general, nurses reported a lack of competency across all 24 domains, but younger nurses and those with more training reported better competency. A recent PSNet interview discussed the role of nurses with regard to patient safety and outcomes.

For more, see: http://tinyurl.com/y7s6cosz.

Nurse Practitioners Inappropriately Prescribe Antibiotics Less Often

Findings reported in Becker's Hospital Review in June 2018 indicate that nurse practitioners prescribe antibiotics inappropriately less often than doctors do. Joyce Knestrick, PhD, certified registered nurse practitioner and president of the American Association of Nurse Practitioners commented that she thinks the difference may be explained by training NPs receive that enables them to explain the patients when antibiotics would not be an effective treatment.

Editorial Note: CAC News & Views sees some irony in this story because the medical establishment so often argues that physicians are better trained than other healthcare professionals. We note also that NPs are evidently more skilled at engaging patients in their care.

For more, see: http://tinyurl.com/yaugq6zh.

DISCIPLINE

USA Today Publishes Exchange about National Practitioner Data Bank

On March 14, 2018, the USA Today editorial board published its opinion that dangerous doctors go unidentified, let alone unpunished, despite the presence of the National Practitioner Data Bank (NPDB). A response by Federation of State Medical Boards CEO Humayun Chaudhry argues that medical boards should be able to access the NPDB without charge.

See the exchange here: http://tinyurl.com/yajegazk. See also: http://tinyurl.com/ybq66phg,

Doctors Keep Licenses Despite Sexual Misconduct

Research by Azza Abbudagga of Public Citizen uncovered multiple cases in which doctors accused and sometimes convicted of sexual abuse faced no disciplinary action by their licensing boards and continued to practice. Reports of this research appeared in numerous newspapers across the country.

See an article here: http://tinyurl.com/y8taybc4. See also: http://tinyurl.com/y9jecgkh.

Discipline Can Vary from State to State for Same Offense

On April 16, 2018, JD Supra reported on a judicial decision to vacate a disciplinary action that mirrored an action in another state because it was excessively harsh:

> The ***LaBrot*** decision is important because it tells medical practitioners licensed in multiple states that they do not necessarily have to accept an additional state discipline that "mirrors" the discipline imposed by another state. The decision provides a nice outline of the kinds of arguments that, if the circumstances warrant, can be made to defeat additional discipline.

See more here: http://tinyurl.com/y7voncaw.

Louisiana Considers and Rejects (for now) "Physician Bill of Rights"

The Louisiana Senate passed, but the House rejected legislation that would strengthen due process protections of physician under investigation by the medical board. These include provisions about investigator bias, restrictions on contact between investigators and board members, and a guarantee that individuals that preside over hearings be independently selected.

Significantly, the proposal would have required that physicians be notified of the identity of the complainant within 10 days of the receipt of a complaint. This could have a chilling effect on complaints by patients and colleagues.

Observers anticipate that the bill may be reintroduced in 2019 or 2020 and that it could be a precedent for other states.

For more, see: http://tinyurl.com/y893ddsy, http://tinyurl.com/yax98l4n, and http://tinyurl.com/y7hqeqvz. See the Federation of State Medical Boards written testimony in opposition to the legislation: http://www.fsmb.org/globalassets/communications/fsmb-letter-re-la-sb286.pdf.

Medicare Slow to Cut Physicians with State Disciplinary Action

Reporters from the Milwaukee Journal Sentinel and MedPage Today, John Fauber, Matt Wynn, and Kristina Fiore, wrote on May 17, 2018, that Medicare is "Slow to Boot Docs with State Sanctions." This article is part of an investigation by the two journals into physicians who continue to practice despite serious licensure actions against them.

See more here: http://tinyurl.com/yaub5ka5, and here: http://tinyurl.com/yaub5ka5.

OPEN NOTES

Majority of Patients Uninformed about Medical Records

AANP SmartBrief reported on March 19, 2018, that:

> A poll of 800 US patients found almost 62.8% reported not knowing who has access to their medical data or where it is stored, and more than 90% indicated they don't know if their data is being sold for a profit by the software their provider's office uses, according to a survey released by Australia-based health technology firm ScalaMed. Almost 80%

> of respondents reported that they should be the owners of their health data, and nearly half indicated feeling "sidelined" when it comes to managing their medical records.

See the report here: http://tinyurl.com/yd4z42gz.

Editorial Note: Facilities that participate in the OpenNotes program or something similar make their patients aware of the content and location of their medical records and the opportunity to make any needed corrections.

Physicians Warned About Electronic Medical Records Shortcuts

Health IT and CEO Report warned physicians in March 2018 about six "Pitfalls" physicians should know about to avoid legal exposure.

See: http://tinyurl.com/y8qf6ghj. See also: http://tinyurl.com/ybz9dzzk.

Editorial Note: Giving patients access to their records via OpenNotes would enable them to double check for accuracy.

Case Made for Giving Context to Online Notes

Sandra Boodman of Kaiser Health News asked in a March 27, 2018, post, "Without Context of Cushion, Do Online Medical Results Make Sense?"

> Are portals delivering on their promise to engage patients? Or are these results too often a source of confusion and alarm for patients and the cause of more work for doctors because information is provided without adequate — or sometimes any — guidance?

Boodman points out that notes may increase patient engagement, but when the note lacks an explanation or context, especially when the patient is the first to see a note indicating an abnormal test result, it can cause the patient unnecessary stress.

For more, see: http://tinyurl.com/yd5lw9of.

Effect of OpenNotes on Patient Engagement

On October 4, 2018, NEJM Catalyst published an article entitled, "OpenNotes, Patient Narratives, and Their Transformative Effects on Patient-Centered Care." The discussion of the impact of OpenNotes on patient engagement includes the following:

> Studies on transparency in patient-clinician communication, such as OpenNotes, where patients have online access to their primary care physician's visit notes from home, revealed an overall high patient activation and positive attitude toward self-care and patient engagement even among those with a heavy disease burden. Higher activation scores correlate positively with preventive or disease-specific self-management behaviors. In general, high-use patients often appear to be motivated, involved, active, and engaged in their care.

See the article here: http://tinyurl.com/y9jsvmvf.

LICENSURE

More States Consider "Right to Earn a Living" Legislation

The movement is growing at the state level to reexamine licensure requirements to eliminate unnecessarily rigid barriers to entry into an occupation or profession. Legislation has been introduced in several states in 2018, including Colorado,

See: http://tinyurl.com/y9kdkjyp, http://tinyurl.com/ycuszbau, http://tinyurl.com/ydfkevl9, http://tinyurl.com/yavl456e, http://tinyurl.com/ydxswlm7, http://tinyurl.com/yd8k9s67, http://tinyurl.com/yb9jrm6t, and http://tinyurl.com/yb9jrm6t,

See this FTC report: http://tinyurl.com/yax7rtc6,

Editorial Note: Bucking the trend toward reducing licensure restrictions is this appeals court decision upholding licensure requirements for hair braiders: http://tinyurl.com/y7lhuqou***, and*** http://tinyurl.com/ycncgwj9. ***Contrast this with a court victory for eyebrow threaders seeking relief from licensing requirements:*** http://tinyurl.com/yaay5sto***.***

Model Law Would Relieve Consequences for Criminal Offenders

The American Legislative Exchange Council (ALEC) has proposed a model Collateral Consequence Reduction Act. The preamble reads:

> A bill for an act relating to occupational regulations; establishing a process to review criminal record to reduce offenders' disqualifications from state recognition; and proposing coding for new law as _____, chapter ____.

See the model bill here: http://tinyurl.com/yd3lm7ts.

Editorial Note: CANews rarely agrees with recommendations emanating from the ALEC, but we see some merit in reducing unintended consequences from licensure restrictions.

Department of Labor Announces Grants to Streamline Licensure

NCSBN's *Good Morning Members* announced on April 25, 2018, that:

> The U.S. Department of Labor recently announced $7.5 million in funds available to states, and associations of states, to aid in reviewing and streamlining occupational licensing rules. Specifically, the funds will be available to review, eliminate, and reform state licensing requirements, and to promote portability of state licenses. In addition, funding will be available to post-secondary institutions and occupational licensing partners to address licensure barriers for veterans and transitioning service members.
>
> U.S. Secretary of Labor Alexander Acosta stated, "Excessive licensing raises the cost of entry, often prohibitively, for many careers, barring Americans from good, family-sustaining jobs. These grants are part of the Department of Labor's efforts to eliminate and streamline excessive licensing requirements. If licenses are unnecessary, eliminate

them. If they are necessary for health and safety, then streamline them and work with other states for reciprocity."

See the press release here: http://tinyurl.com/y96usv8b. See also legislative proposals to help ex-convicts work in healthcare fields: http://tinyurl.com/yakb2862.

Voluntary Certification Subject to Legislative Challenges

On April 25, 2018, Institute for Credential Excellence (ICE) CEO Denise Roosendaal posted this message on the ICE message board:

> Louisiana House Bill 748, the Occupational Licensing Review Act, was introduced last month and passed the House there. The legislation appears to be on its way toward passage in the Senate. The bill includes language that would prohibit certificants from referring to themselves as "certified" unless their certification is used in conjunction with licensure in that state.
>
> Thanks to ICE Member Ulric Chung of the American Board of Industrial Hygiene®, who informed ICE of the bill last Friday, we were promptly able to alert the Board of Directors at their meeting yesterday. The Board authorized funds for ICE to join a coalition being established by Pillsbury Winthrop Shaw Pittman LLP, legal counsel for ICE's accreditation services, to amend this bill.
>
> Please read this short summary:
> http://www.credentialingexcellence.org/d/do/2475?source=5
>
> Further information about the bill:
>
> - The legislation bans the use of the term "certification" issued from professional credentialing bodies unless such certification is used in conjunction with licensure
> - Possible sunsetting procedures would be required every five years for certification programs used in conjunction with professional licensure
> - Louisiana may not include certification as a prerequisite to licensure law unless there is empirical evidence of systemic harm to consumers from the absence of a certification requirement.

Additional background is available here:
http://www.credentialingexcellence.org/d/do/2476?source=5

If this bill passes, the risks to voluntary certification programs could eventually expand far beyond the Louisiana borders. ICE will keep you informed as the establishment of the coalition evolves. Feel free to contact Craig Saperstein at craig.saperstein@pillsburylaw.com if you wish to join the coalition.

On May 10, 2018, Ms. Roosendaal posted this update:

> About a month ago, the Louisiana House of Delegates passed House Bill 748, which banned the use of the term "certification" issued from professional credentialing bodies unless such certification is used in conjunction with licensure. ICE is now pleased to inform you that Louisiana House Bill 748 has been amended to address the concerns of the credentialing community! The concerning language regarding the use of the term

"certified" was deleted entirely by amendment, and a subsequent amendment then deleted most of the bill. That amendment was adopted and now leaves us with a bill that reads as follows:

"Pursuant to the authority in this Chapter, the governor shall review on an annual basis not less than twenty percent of the agencies engaged in regulatory and licensing activities. Within five years, the governor shall have reviewed all such agencies."

In addition, a related bill, HB 378, has been amended to remove all references to the term "certification" other than to say that, "nothing shall be construed to restrict a licensing board from requiring, as a condition of licensure or renewal of licensure, obtaining/maintaining credentials from an organization that credentials individuals in the relevant occupation, field, or industry."

We are pleased with the outcome and resolution of the concerns raised by the credentialing community. We would like to thank our members as well as other organizations in our industry who collaborated in the rapid mobilization of a coalition and made a difference! ICE and our partners at Pillsbury will continue to keep you informed of any new developments as these amended bills move forward to the Louisiana Senate.

FSMB Issues Guidelines for Medical Boards

The Federation of State Medical Boards delegates adopted Guidelines for the Structure and Function of a State Medical or Osteopathic Board at its April 2018 annual meeting. Notably, the guidelines recommend a minimum of 25% public members on a medical or osteopathic board.

See the Guidelines here: http://tinyurl.com/ycjkkvd8.

Regulatory Reform in Three Nations

On April 4, 2018, NCSBN's *Good Morning Members* announced that:

> An article in the *Journal of Nursing Regulation* provides a comparative analysis of recent reform to the health profession regulatory frameworks in Australia, U.K., and Ontario, Canada. Researchers conducted a comparative multiple case study analysis "to identify the factors influencing reform and underlying aspects to current reform proposals," in addition to analyzing policy documents and legislation.
>
> Researchers found four common themes existing across the regulatory reforms in all three countries, including:
>
> - A shift in each jurisdiction towards a more overt primacy of the public interest over professional interests;
> - Greater independence of regulation from the professions;
> - A push towards collaboration and consistency between professional regulators; and
> - A focus on articulating principles to aid in assessing regulatory quality.

> Researchers conclude that, "these findings allow regulators and policymakers to understand the factors and forces that influenced these divergent reforms and the common underlying themes contributing to reform proposals internationally."

See the article here: http://tinyurl.com/yd3rcs8g.

National Council Releases 50-State Authorization to Practice Data

The National Council of State Boards of Nursing announced in May:

> NCSBN recently unveiled a new interactive Nursys Authorization to Practice Map, which provides a visual representation of all the states where a nurse has authorization to practice. The free resource uses licensure status data provided by participating boards of nursing and state agencies and is automatically updated. Detailed instructions on how to utilize the map are available on NCSBN's website.

See more here: https://www.ncsbn.org/Authorization_to_Practice_Step_by_step.pdf.

States Respond to the Supreme Court's Ruling in *NC Dental*

The Federation of State Medical Boards reported in May 2018 about actions in several states to conform to anti-trust and supervision requirements in the Supreme Court decision in *North Carolina Board of Dental Examiners v. Federal Trade Commission:*

> States are continuing to examine and debate ways on how to respond to *North Carolina Board of Dental Examiners v. Federal Trade Commission*. In the 2017-2018 biennium, there have been more than 25 bills introduced regarding antitrust and active supervision, including:

- **California AB 2483** (https://track.govhawk.com/public/bills/1034229) would require a public entity to pay a judgment or settlement for treble damage antitrust awards against a member of a regulatory board within the Department of Consumer Affairs for an act or omission occurring within the scope of the member's official capacity as a member of that regulatory board. The bill would specify that treble damages awarded pursuant to a specified federal law for violation of another federal law are not punitive or exemplary damages within the act. The bill was introduced on February 14 and passed the Assembly unanimously on May 3. It awaits legislative action in the Senate.
- **Kentucky HB 465** (https://track.govhawk.com/public/bills/1041867) creates a Department of Professional Licensing within the Public Protection Cabinet to provide oversight of licensing boards. Each board would be organized within an authority for purposes of providing administrative services, technical assistance, and personnel staffing. The Medical Licensure Authority would be comprised solely by the State Board of Medical Licensure. The executive director of the Board of Medical Licensure would be appointed by the board and with the consent of the secretary. The bill was introduced on February 26 and passed the House on March 19 by a vote of 47-33. It awaits legislative action in the Senate.
- **Nebraska LB 299** (https://track.govhawk.com/public/bills/839727), also known as the Occupational Board Reform Act, states that it is the policy of the state to use the least restrictive regulation necessary to protect consumers from undue risk of present, significant, and substantiated harms that clearly threaten or endanger the health, safety, or welfare of the public when competition alone is not sufficient. It also allows individuals

with a criminal conviction to submit to an occupational board a preliminary application to determine whether the conviction would disqualify the applicant. The applicant is able to provide information regarding the circumstances and evidence of rehabilitation and testimonials. The board shall make a determination in writing within 90 days. Additionally, beginning in 2019, the Legislature shall analyze and review approximately 20 percent of occupational regulations each year. The bill was signed into law on April 23.

FSMB Supports Bill to Relieve Boards of Anti-Trust Liability

On August 3, 2018, Federation of State Medical Boards CEO Humayun Chaudhry posted this message online:

> The FSMB is pleased to announce the introduction of important new federal legislation addressing the unsettled regulatory landscape created by the Supreme Court's 2015 decision in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*. The "Occupational Licensing Board Antitrust Damages Relief and Reform Act of 2018 (HR 6515)," was introduced this week by Rep. Mike Conaway (R-TX) and is co-sponsored by Rep. Lamar Smith (R-TX).
>
> The bill seeks to protect members and staff of state licensing boards from personal liability and treble antitrust damages for actions they may take as part of their service on boards to protect the public. State medical board members and members of other professions indicated that the potential for personal liability has dissuaded individuals from serving on regulatory boards.
>
> In 2016, the FSMB House of Delegates passed a resolution calling for the development of appropriate responses to the application of antitrust principles at both the state and federal policy level. Since that time, the FSMB's Advocacy Office worked tirelessly to support the drafting and introduction of this bill, coordinating its efforts with organizations representing state licensing boards of various professions. Our member boards are well served by their efforts to support state-based regulation and protect the ability of state regulatory boards to protect the health and welfare of the public.

See the legislation here: http://tinyurl.com/y6up2h92.

Editorial Note: CAC supports giving board members immunity from antitrust damages, but believes that giving the boards immunity would be mistaken because the liability is the incentive to be careful about avoiding anti-competitive conduct.

TELEHEALTH

Benchmark Survey Documents Growth of Telehealth

The annual REACH Health survey of attitudes toward telehealth shows strong support among healthcare executives, physicians and others. Among other findings, 70% of respondents view telehealth as a top or number one priority.

For more, see: http://tinyurl.com/ybewwnqy. See also: http://tinyurl.com/y8ha26vy, http://tinyurl.com/yb496m6h, https://www.jdsupra.com/legalnews/telemedicine-potential-expansion-with-59569/, http://tinyurl.com/y7y8xarm, http://tinyurl.com/yaltufr7, http://tinyurl.com/ya7uuwjb, http://tinyurl.com/yd5uffto , and http://tinyurl.com/yazy5gst.

Center for Connected Health Policy Issues 50-State Report

In May, the Center for Connected Health Policy issued a survey of state laws and reimbursement policies related to telehealth. CCHP reported these highlights:

Significant findings for this Spring 2018 update include:

- **Forty-nine states and Washington, DC** provide reimbursement for some form of live video in Medicaid fee-for-service. This has increased by one (RI) since CCHP's Fall 2017 edition of this report.
- **Fifteen states** provide reimbursement for store-and-forward. This number remained the same since Fall 2017. While Georgia was added to the list, as they now provide reimbursement for some store-and-forward, Hawaii was removed from the list because CCHP could not locate any official Medicaid policy that indicates they are actively reimbursing for store-and-forward.
- **Twenty state Medicaid programs** provide reimbursement for remote patient monitoring (RPM). This number has decreased by one since Fall 2017 because CCHP could not locate any official Medicaid policy indicating that Hawaii is actively providing reimbursement for RPM. No new states were added.
- **Twenty-three states** limit the type of facility that can serve as an originating site. This number has remained steady since Fall 2017.
- **Thirty-two state Medicaid programs** offer a transmission or facility fee when telehealth is used. This number has not changed since CCHP's Fall 2017 update.
- **Thirty-eight states and DC** currently have a law that governs private payer telehealth reimbursement policy. This is an increase of two (Iowa and Utah) since Fall 2017, although both laws don't go into effect until January 1, 2019.

See the entire report here: http://tinyurl.com/y8dwwugo.

E-Consult Tool Published

The Center for Connected Health Policy announced on March 28, 2018, that an E-Consult Toolkit is now available online:

> The E-Consult Toolkit funded by the Blue Shield of California Foundation, is now accessible online. E-consult is an asynchronous exchange between physicians or other health professionals seeking specialist consultation while avoiding a face-to-face patient encounter with the consultant. The toolkit is a comprehensive collection of tools, best practices, and case studies to assist health care administrative professionals, physicians, and specialists with implementing e-consult. It was developed as part of an initiative to create a roadmap for e-consult sustainability in partnership between BluePath Health Inc. and the Center for Connected Health Policy (CCHP).

See the toolkit here: http://tinyurl.com/yaukbb4l.

Department of Veterans Affairs Issues Telehealth Rule

On May 10, 2018, the Department of Veterans Affairs announced a final interstate telemedicine rule that opens up practice across state boundaries.

See the rule here: http://tinyurl.com/ybo2fy9d. See also: http://tinyurl.com/y9nsq7pd, and http://tinyurl.com/y98c8jjg.

SUBSTANCE ABUSING AND IMPAIRED PRACTITIONERS

Is Alzheimer's a Disqualifying Illness?

The March 22 *New England Journal of Medicine* contained an article making the case that Alzheimer's disease progresses differently in different patients and a diagnosis is not necessarily a reason for physicians to abruptly cease practice.

For more, see: http://tinyurl.com/y7tdbt7b.

Doctors Admit Mental Health Issues

Nathaniel P. Morris wrote in The Washington Post, about a survey of U.S. physicians showed that roughly half believed they had at some point met the criteria for a mental health disorder — but had not sought treatment, worried about being stigmatized or even putting their medical licenses in jeopardy.

See more: http://tinyurl.com/y9mrgqad, http://tinyurl.com/yc9omjhk, and http://tinyurl.com/y8uncva9.

Physician Burnout Jeopardizes Patient Care

Dennis Thompson, reporter for *HealthDay News* reported on September 5, 2018, that physicians experiencing burnout are twice as likely to endanger patients or act unprofessionally. The article is based on the largest study to date of the implications of physician burnout.

See: http://tinyurl.com/y8cf5leg. See also: http://tinyurl.com/ybz24t5m.

CONSUMER INFORMATION

California Doctors Must Inform Patients of Probation

In a major victory for consumer advocates Governor Jerry Brown signed legislation in September 2018 requiring doctors on probation for serious offenses to so inform all their patients. Applicable offenses include sexual misconduct, substance use that could jeopardize patients, criminal offenses, and inappropriate prescribing. Consumer advocacy groups have pressed for this legislation for several legislative sessions. SB 1448 was written by Senator Jetty Hill of San Mateo.

For more, see: http://tinyurl.com/y8xrp8nw.

IN-DEPTH FEATURE

FTC Policy Perspective: "Options to Enhance Occupational License Portability"

Editorial Note: This quarter's In-Depth Feature consists of excerpts from a Policy Perspective authored by Karen A. Goldman of the FTC's Office of Policy Planning. Entitled, "Options to Enhance Occupational License Portability," the paper was developed under the auspices of the FTC's Economic Liberty Task Force. The complete document can be found here: http://tinyurl.com/yc3qf7jp***. We recommend that readers of CAC News & Views read this important Policy Perspective, which is the latest in a number of policy papers and legislative initiatives at the state and federal levels to identify and rectify unintended negative consequences of occupational and professional licensure.***

The FTC explains that the Economic Liberty Task Force addresses regulatory hurdles to job growth, entrepreneurship, innovation, and competition, with a particular focus on the proliferation of occupational licensing. The Task Force was convened in March 2017 by former Acting Chairman Maureen K. Ohlhausen as her first major policy initiative for the agency. The Task Force builds on the FTC's long history of urging policymakers to reduce or eliminate unnecessary occupational licensing requirements.

Executive Summary:

Occupational licensing, which is almost always state-based, inherently restricts entry into a profession and limits the number of workers available to provide certain services. It may also foreclose employment opportunities for otherwise qualified workers. This reduction in the labor supply can restrain competition, potentially resulting in higher prices, reduced quality, and less convenience for consumers.

For some professions, licensing can nevertheless serve a beneficial role in protecting the health and safety of the public. However, even when state licensure serves a useful role, some aspects of licensure may create significant and unintended negative effects. In our increasingly mobile and interconnected society, state-by-state occupational licensing can pose significant hurdles for individuals who are licensed in one state, but want to market their services across state lines or move to another state. The need to obtain a license in more than one state can reduce interstate mobility and practice, and may even lead licensees to abandon an occupation when moving to another state. These effects fall disproportionately on licensees who are required to move frequently, such as military spouses. The challenges of multistate licensure are also particularly acute for professionals who are more likely to provide services across state lines, such as telehealth or accounting services. The deleterious effects of state-by-state licensing are not borne only by those who wish to provide services in a new state. This thicket of individual state licensing regulations can reduce access to critical services or increase their prices to ordinary consumers.

Recognizing the costs to both consumers and licensees of overly burdensome multistate licensing requirements, the FTC's Economic Liberty Task Force held a Roundtable, Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License Portability, to examine ways to mitigate the negative effects of state-based occupational licensing

requirements.3 This Policy Perspective builds on the key points that emerged from the Roundtable regarding the development of effective license portability initiatives.

The earliest initiatives to improve license portability were model laws, some of which have been adopted by almost all U.S. jurisdictions. More recently, a number of occupations, primarily in the health professions, have developed interstate compacts authorized by the compact clause of the U.S. Constitution. Unlike model laws, which need not be identical, interstate compacts, as contracts between the states, must be adopted verbatim; thus, they offer great uniformity and stability, but limited flexibility. In addition to model laws or interstate compacts for individual occupations, the U.S. Department of Defense's State Liaison Office has proposed a number of initiatives to encourage state adoption of measures to improve portability for military spouses in multiple licensed occupations. Regardless of the legal structure of a portability initiative, strong support from within the profession is likely to be critical to nationwide adoption.

Adoption and effectiveness of a licensure portability initiative also depend on how it achieves portability. Model laws and interstate compacts generally rely on either a "mutual recognition" model, in which a multistate license issued by one state affords a privilege to practice in other member states, or a procedure for expedited licensure in each member state. Mutual recognition of a single state license poses a lower barrier to cross-state practice than expedited licensure, and thus could be more effective in enhancing cross-state competition and improving access to services. On the other hand, expedited licensure could ease relocation to another state. A successful portability initiative could be crafted to achieve both goals.

Whether a portability initiative is based on mutual recognition or expedited licensure, supporters can build confidence in an initiative by incorporating coordinated information systems and procedures to ensure that licensees are held accountable for complying with state law wherever they provide services. Harmonizing state licensing standards also builds confidence in the qualifications of those who provide services in a state pursuant to the initiative. By selecting the least restrictive licensing standards that can gain the support of states nationwide, developers of portability initiatives can limit unnecessary restrictions on labor supply and reduce barriers to competition that arise from state licensing.

For occupations that generally require state licensing as a public protection measure, FTC staff encourages stakeholders – such as licensees, professional organizations, organizations of state licensing boards, and state legislatures – to take steps to improve license portability. Each type of portability initiative has advantages and disadvantages, and all take time and effort to develop and implement. However, a thoughtful consideration of the needs of a profession and the consumers it serves is likely to lead to a solution that can gain the support of licensees, licensing boards, the public, and state legislatures. Moreover, by enhancing the ability of licensees to provide services in multiple states, and to become licensed quickly upon relocation, license portability initiatives can benefit consumers by increasing competition, choice, and access to services, especially with respect to licensed professions where qualified providers are in short supply.

Conclusion:

Occupational licensing can protect consumers from health and safety risks, generally in situations where consumers lack sufficient information to assess the qualifications of professionals. That said, licensing occupations also restricts competition. By establishing the entry requirements for an occupation, licensing regulations tend to reduce the number of market participants. In turn, this reduction in supply leads to a loss of competition, potentially resulting in higher prices and lower quality and convenience of services.

A key barrier imposed by licensing is the inability of qualified professionals licensed by one state to work in another state. There is little justification for the burdensome, costly, and redundant licensing processes that many states impose on qualified, licensed, out-of-state applicants. Such requirements likely inhibit multistate practice and delay or even prevent licensees from working in their occupations upon relocation to a new state. Indeed, for occupations that have not implemented any form of license portability, the harm to competition from suppressed mobility may far outweigh any plausible consumer protection benefit from the failure to provide for license portability.

Moreover, a slow and burdensome process for cross-state practice is unnecessary. There are many options to enhance license portability. Individual states have adopted initiatives to streamline licensing of military spouses in many occupations. Some professions have developed model laws or interstate compacts that improve licensure portability nationwide. These examples of successful portability suggest further liberalization and reform is both possible and beneficial.

Accordingly, for occupations that generally require state licensing as a public protection measure, FTC staff encourages stakeholders such as licensees, professional organizations, organizations of licensing boards, and state legislators to consider the likely competitive effects of options to improve license portability. As stakeholders evaluate those options, we suggest that they consider the following points:

- Both model laws and interstate compacts have been used to improve licensure portability for individual occupations
- For reducing barriers to multistate practice, consider the use of a mutual recognition model, in which licensees need only one state license to practice in other member states and are not required to give notice of their intent to practice in another state
- Alternatively, consider easing multistate practice by expediting licensure in each intended state of practice
- Take steps to ease licensure upon relocation to a new state, whether by expediting the process or by allowing licensees to practice in the new state of residence under an existing multistate license during processing of the application
- Harmonize state licensure standards, using the least restrictive standard that can gain the support of states nationwide
- State-based efforts to reduce barriers to licensing of relocated military spouses often address multiple occupations that require licensing
- At the state level, consider expanding the use of temporary licensing and other procedures that have helped reduce the burden of licensing for relocated military spouses to all applicants licensed by another state

Each type of portability initiative has advantages and disadvantages, and all take time and effort to develop and implement. However, a thoughtful consideration of the needs of a profession and the consumers it serves is likely to lead to a solution that can gain the support of licensees, licensing boards, the public and state legislatures. Moreover, by enhancing the ability of licensees to provide services in multiple states, and to become licensed quickly upon relocation, license portability initiatives can benefit consumers by increasing competition, choice, and access to services, especially where providers are in short supply.

2019 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 our 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

Assistance in **identifying qualified individuals** for service as public members.

Fee Schedule:
The annual membership fees are as follows:

Individual Regulatory Board	$325.00
"Umbrella" Governmental Agency plus regulatory boards	$325.00 for the umbrella agency, plus $275.00 for each participating board.
Non-Governmental organization	$425.00
Association of regulatory agencies or organizations	$500.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	$100.00

2019 MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for the remainder of 2018 and all of 2019, please complete this form and emailing, mailing or faxing it us. (See page 5 for contact information).

CAC

1601 18th Street NW ● Suite 4
Washington, D.C. 20009
Voice (202) 462-1174 ● FAX: (202) 354-5372

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

Payment Options:

- Mail us a check payable to Citizen Advocacy Center for the appropriate amount (see Fee Schedule on previous page);
- Provide us with your email address so that we can send you an invoice and a payment link that will allow you to pay using any major credit card; or
- Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	
City, State, Zip:	

Signature: _____

Date

Our Federal Identification Number is 52-1856543.

WE WANT YOU EITHER WAY!

We hope your board or agency decides to become a member of CAC. Membership includes a subscription to our newsletter for all of your board members and all of your staff, as well as many other benefits. But if you decide not to join CAC, we encourage you to subscribe to CAC News & Views by completing this form and emailing, mailing, or faxing it to us. (See page 5 for contact information).

Subscribe to CAC News & Views through the end of 2019 and access all available online issues for $240.00.

NEWSLETTER SUBSCRIPTION FORM

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

Payment Options:

- Mail us a check payable to Citizen Advocacy Center for $240.00;
- Provide us with your email address so that we can send you an invoice and a payment link that will allow you to pay using any major credit card; or
- Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	
City, State, Zip:	

Signature: _____

Date

Our Federal Identification Number is 52-1856543.