FINAL REPORT

STRENGTHENING THE COMMUNITY'S VOICE ON CALIFORNIA'S HEALTH CARE LICENSING BOARDS

I. Introduction

This report presents the findings of Strengthening the Community's Voice on California's Health Care Licensing Boards, a Project funded by The California Endowment to assess the feasibility of increasing the involvement of California's diverse communities in the policymaking process of the boards that regulate health care professionals. (See Attachment A for a concise description of the Project.) These boards set requirements and establish standards for health care professionals in order to promote patient safety and health care quality. The boards' actions also affect the health care marketplace by influencing the cost and availability of care. It is important that board members be fully informed about the needs of the state's diverse communities, especially underserved communities where board actions can either perpetuate or chip away at cultural, linguistic, and other barriers that interfere with access or undermine the quality of care.

Specifically, the project explored the feasibility of addressing this challenge by inviting community-based organizations (CBOs) to nominate qualified candidates for appointment to public member positions on health professional licensing boards. Once at the table, these members can help ensure that the community's health care concerns are factored into the board's deliberations and decisionmaking, and promote CBO participation in board rulemaking and other policy decisions.

II. Background

In 1876, the California Legislature enacted the Medical Practice Act, which created a licensing board to regulate medical practice in the state with the goal of protecting the public from unqualified and unfit medical practitioners. Other health care professions — including dentists, pharmacists, and optometrists — soon adopted the same license-based regulatory model.

At that time, each board was comprised entirely of licensees of the profession the board was charged with regulating. For example, the medical board was composed entirely of physicians; the pharmacy board included only pharmacists. This board composition reflected the then-undisputed view that public protection is achieved by limiting entry into a profession to candidates who are deemed qualified by those already in the profession.

By the late 1960s, a "grassroots" consumer movement emerged, led by activists who recognized the need for broader representation in the regulatory process. Even one conservative observer, William Simon, wrote at the time:
The dynamics of the political system favor groups that are concentrated and actively involved in the regulatory process, with high stakes in the outcome of some specific bureaucratic decision. Such people consistently prevail over those who are dispersed and far from the regulatory system, with a small stake in any given decision (although a big stake in the overall process) — in other words, American consumers.\(^1\)

In 1961, the California Legislature enacted Senate Bill 115 (Gibson, McCarthy), which — for the first time — set aside one slot on the then 11-member medical board for a non-physician; this slot was denoted as a “public member” (as opposed to a “professional member” or “licensee member”). Thereafter, legislation changed the composition of other health care licensing boards to require the appointment of one or a token number of public members on the boards. The addition of public members to regulatory boards was intended to inject an independent voice into the regulation of trades and professions.\(^2\)

During the past three decades, the state’s legislative and executive branches have continued this gradual transformation in the composition of the state’s occupational licensing boards to the point where most non-health care boards now consist of a public member majority. While today only two of the state’s health care licensing boards have public member majorities, the current percentage of public members on these boards has grown to an average of 44%. Further, during 2005, the Schwarzenegger Administration called for public member majorities on a number of health care boards, including the Medical Board of California.

This evolution in board composition has created an environment in which public members can profoundly influence regulatory policy and practice and help to expand the state’s sensitivity to consumer needs. Indeed, health professional boards are poised to move beyond public protection through their traditionally narrow licensing and enforcement roles and begin to proactively promote the interests of the state’s diverse communities in ways that were not previously foreseen.

While the composition of boards was changing, the makeup of the United States population was undergoing even more dramatic changes — nowhere more so than in California. As of 2004, no single race or ethnic group constitutes a majority of California’s population.\(^3\) One in every four Californians is an immigrant, a group that comprises at least 10% of the population in 36 of

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\(^1\) See Michael Pertschuk, *Revolt Against Regulation: The Rise and Pause of the Consumer Movement* (University of California Press 1982) at 133.

\(^2\) Subsequently, the Milton Marks Commission on California State Government Organization and Economy (commonly called the “Little Hoover Commission”) put it more accurately: “As early as 1961, the Legislature began to add non-professional members to the regulatory boards *in order to dilute professional bias.*” Little Hoover Commission, *Consumer Protection: A Quality of Life Investment* (June 1988) at 53 (emphasis added).

\(^3\) Public Policy Institute of California, *California’s Population* (July 2006).
California's 58 counties. The growing size and diversity of the population present considerable opportunities, and also many short-term challenges.

The health care challenges are immediate and urgent. Vast numbers of people struggle because of a lack of adequate insurance coverage or shortages of key health care personnel. Many also struggle to communicate across the divides of language and unfamiliar cultural norms that influence providers' and patients' understanding of health care. Cultural and linguistic barriers can be more imposing than other system shortcomings because they arise at a time of great vulnerability. Efforts are being made to address the problem of inadequate communication between providers and patients who do not share a common language or a common cultural history. These include health interpreter training, community health worker programs, and building workforce diversity. These are important undertakings, but additional efforts are needed on many fronts to address the complex challenges associated with establishing equitable access to quality health care.

The policies and regulatory activities of health professional licensing boards have a significant, often unrecognized, impact on the accessibility as well as the quality of health care. These boards are the only health care regulatory entities that deal with the competence of individual practitioners as opposed to health care provider institutions. Licensing boards determine the necessary qualifications and monitor the competence of physicians, nurses, pharmacists, optometrists, dentists, and other health care practitioners. Boards establish and enforce standards of practice, adopt regulations to implement new laws, investigate and respond to complaints, and discipline errant practitioners, sometimes revoking a license to practice.

A look at some of the specific functions performed by licensing boards helps convey the reach of their influence and its potential impact on health care delivery and quality:

Licensing

The Legislature typically establishes broad requirements for licensure, leaving it to individual boards to adopt more specific requirements through regulation. Standards set by the boards govern the education that must be attained, sometimes specifying the degrees and institutions that are, or are not, acceptable; examination(s) that must be passed, specifying required exam content if the examination is administered by another state or entity; and for some professions, practical work experience and/or continuing education that must be completed to qualify for and maintain a license.

Some argue that all the functions of a licensing board, the setting of standards for education, experience, and testing has the most far-reaching impact on health care access and patient safety. If standards are set too low, some — perhaps many — individuals will enter practice without possessing a level of competence necessary to safely treat patients. If standards are overly stringent or non-job-related, qualified practitioners will be screened out, thereby reducing the number of providers available and creating unhealthy competition for scarce services.

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4 Public Policy Institute of California, *Immigrants in California* (June 2008).
A tilt in either direction can have profound consequences for underserved communities that already struggle to find an adequate number of qualified health care providers to serve their populations. An unjustified reduction in the supply of providers undermines access to care; deficient standards that permit unqualified or incompetent providers to practice undermine the quality of care. Communities that lack adequate health care services or encounter cultural and linguistic barriers to access have an undeniable stake in who becomes licensed and what their qualifications are. Hoping for positive outcomes is no substitute for having a presence within the boards that make these decisions.

Rulemaking

Licensing boards play a significant role in the development and implementation of health care policy, a role not well understood by the general public. More often than not, advocacy groups, including many of California’s CBOs, which are well-versed and deeply involved in the legislative process, consider the job done when the bills they have supported are enacted. In fact, the passage of legislation is frequently the beginning rather than the end of the process. It falls upon administrative agencies such as licensing boards to hammer out the rules and regulations to implement the legislation.

Former U.S. Supreme Court Justice Robert Jackson wrote in a 1952 decision that “[i]t may help clarify the proper administrative function ... to think of ... legislation as unfinished law which the administrative body must complete before it is ready for application.” More recently, two professors of public policy wrote:

Sometimes public servants in the bureaucracy are deciding issues that can have life-and-death implications for an affected clientele. Government agencies offer an alternative venue to place issues on a government agenda, to shift the balance of forces on an issue, and to alter outcomes that have occurred or might occur in another government arena. Cast in this light, bureaucratic decision making is frequently exciting, an important element of political strategy, and potentially momentous in its results.

Not only do many people not realize the scope of the policymaking activities of the ... bureaucracy, they do not understand the procedures employed in making that policy and thus have little opportunity to participate meaningfully in bureaucratic policymaking. Instead, interest groups dominate the process, as they do the normal legislative process. Fortunately, however, not all interest groups are self-seeking

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economic ones, and consumer and public health groups may have a better chance to be heard in the bureaucracy than in the nation’s elected assemblies.\(^6\)

It is apparent, therefore, that administrative rulemaking is an opportunity for CBOs to influence health care policy and, significantly, to follow through on legislative accomplishments and ensure that the implementing rules and regulations are faithful to the original intent of the law.

**Enforcement**

In addition to licensing and rulemaking, boards enforce laws and standards of practice that govern how health care is delivered. Boards and their staff investigate complaints and in some cases proactively review actual practice. When warranted, boards can choose to impose varying levels of discipline, up to and including revocation of a license. In enforcement as in licensing, boards need to seek a reasonable balance between extremes. A zero tolerance policy that denies practitioners an opportunity to correct identified deficiencies will gradually deplete the number of licensees, making it more difficult to meet the needs of underserved communities. At the other extreme, laxity toward incompetent or negligent practice places patients at undue risk. Some regulators have suggested that underqualified practitioners seek out underserved and immigrant communities in which to work, hoping to be subject to less scrutiny. For all these reasons, enforcement is another area in which the voice of the community must be heard.

**Information and Outreach**

Boards have an important public information function. They have four important audiences. One is their licensees who need to be kept abreast of changes in rules, regulations, and policies. Also, by publishing disciplinary data, boards can help licensees learn from others’ mistakes and avoid practices that violate the law and harm patients.

A second audience is the Legislature. Elected officials will be asked to vote on legislation affecting licensing boards, so those who are unfamiliar with professional regulation need to be brought up to speed on the role and importance of boards and, crucially, the distinction between a licensing board and a professional association.

A third audience is the media. Too often licensing boards come into public view only when there is an exposé of their failures — failure to discipline dangerous practitioners, failure to execute their responsibilities efficiently, and so on. Boards that cultivate a positive relationship with the media are often able to place stories about their accomplishments so the public is informed about the constructive things boards do.

The fourth audience is the general public, which has scant awareness of the existence of licensing boards, not to mention their impact on the accessibility, cost, quality, and safety of health care. To fulfill their mission, boards need to promote better public awareness and understanding of their mission. It is not an easy task, but a combination of printed material, speakers’ bureaus, and savvy media relations helps educate the public. California’s boards have Web sites which, when consumer-friendly, provide easy access to information about individual licensees (including disciplinary information), the laws and regulations the board enforces, and consumer education materials. Public members of licensing boards are often the ones who press hardest for more outreach activities.

Other Functions

Although their primary responsibility is protection of the public through the licensing and regulation of health care professionals, boards also serve as a public forum for discussion of multiple aspects of health care delivery. Many standards of practice owe their patient-conscious dimension to the prodding of members of professional licensing boards, more often than not the public members who recognize their responsibility to bring the consumer/patient perspective to the discussion. Increasingly, California’s licensing boards are discussing how the professions can best serve an increasingly diverse patient population. The use of interpreter services, the disclosure of information identifying bilingual and culturally sensitive practitioners, and the promotion of practice in underserved communities are among the topics appearing with greater frequency on board agendas. Those communities that are most directly affected by the outcome of the board’s discussion of such topics are wise to participate in and influence the debate.

Practical Examples

The reasons that CBOs should want to be a presence in licensing board activities may be obvious to those who work in and around health care regulation. For those less familiar with the regulatory arena, it is informative to look at some practical examples of the kinds of issues boards are asked to tackle and how the decisions they make impact health care consumers.

Pharmacy

Legislation enacted in 2007 requires the Board of Pharmacy to adopt regulations directing pharmacists to use a standardized “patient-centered” label on all prescription medications. The Board is currently conducting a series of public hearings to gather information that will assist it in making decisions about the content and format of the required standardized labels so that they are understandable to the vast majority of patients. Optimally, the Board’s regulations will result in plain language labeling with appropriate translation for non-English speakers, and will factor in sensitivity to the distinctive ways diverse cultures relate to instructions issued by their health care providers. The rules the Board adopts will be determined by a vote of the thirteen members, six of whom are public members. The outcome of the
Board’s deliberations and vote will have a far-reaching impact on how readily patients understand the proper use of prescription medications.

**Medicine**

Following public discussion of the problems faced by medically underserved communities, the Medical Board of California in 2002 established a program that helps physicians repay their student loans in return for a commitment to practice a minimum of three years in an underserved community. With the support of the Board, the Legislature increased physician licensing fees to create a fund to support this program. In another public policy matter that has implications for California’s diverse populations, the Medical Board adopted regulations to implement legislation requiring the collection and posting of data, by ZIP code, on the number of practitioners who self-identify their cultural background and foreign language proficiency. Many consider this to be a first step toward the goal of identifying providers in a way that will allow patients to select those with whom they are more likely to share common language and culture. Each of these initiatives has attracted considerable interest on the part of other licensing boards, some of which have begun the conversation about adopting similar programs for their licensees.

**Optometry**

Until recently, optometrists were not required to give patients a copy of their contact lens prescription, thereby limiting a patient’s ability to comparison shop for their lenses. Consumer groups brought this concern to the Legislature during the Board of Optometry’s 2001 sunset review hearing. The result was a law that requires optometrists to make a copy of the prescription available to patients.

### III. The Project

It is against this backdrop that we conceived the *Strengthening the Community’s Voice on California’s Health Care Licensing Boards* Project. While many outstanding public members have served on California regulatory boards, there has been little conscious effort to assure that these individuals have some connection to diverse communities of interest, especially underserved communities.

The goal of the Project is to change that by establishing a process through which CBOs nominate qualified candidates for appointment to public member positions so they can be sure community needs and concerns are factored into licensing board policymaking. Licensee members of health professional boards are advocates for competent health care services, frequently in the face of challenging circumstances. Public members who have close connections with diverse communities can increase awareness and enrich the dialogue over how to deliver culturally and linguistically competent health care. Conversely, they can also increase awareness within the communities about the roles and importance of licensing boards.
In the course of studying the feasibility of this concept, the Project team has become convinced that simultaneously with establishing a system for vetting and nominating candidates for public membership, it is important to educate CBOs about the functioning and importance of licensing boards and encourage them, individually or in coalitions, to become regular participants in board policy development and other activities. The case for pursuing these parallel tracks is threefold. First, board actions affect the CBOs’ constituencies, so licensing boards should appear prominently in the organizations’ advocacy priorities. Second, it could take months or years for a critical mass of public member vacancies to be filled by CBO-nominated candidates. Third, sitting public members (those nominated by CBOs and those coming from other sources) enjoy greater stature and credibility with their boards when they can cite evidence drawn from the real world to support the opinions or positions they are advancing. In addition, the public members’ ability to advance the interests of diverse communities is greater when the CBOs that represent these interest groups are known to the board and are a regular presence.

Recognizing that there are opportunities to promote more discussion of community needs is not meant to imply that the current activities of these licensing boards are antithetical to the best interests of diverse populations. Many outstanding public and licensee members serve on California’s regulatory boards, and many boards work diligently to solicit input from all sectors when crafting policy. However, there has been inadequate representation of California’s widely diverse communities of interest, especially underserved communities, in the discussions that forge public policy in this arena. Combined with the fact that individually, CBOs have limited resources to routinely monitor the public policy activities of these boards, there is little that would suggest the discussions that take place have all of the community input that is desirable for the formulation of policies that will best serve these communities. Because of the impact that these boards have on health care delivery, it is important for communities that face cultural and linguistic barriers to health care to gain increased access to the policy debates and decisionmaking of California’s health care licensing boards.

The objective of the Project is to create a sustainable process for assuring that the interests of California’s broad spectrum of ethnicities and cultures are reflected in licensing board regulation, policymaking, and related activities.

IV. The Feasibility Phase

Working with The California Endowment, the Project team identified objectives and corresponding tasks to assess the viability of the Project goals and the best methods for their attainment. At the outset, we determined that we would interview representatives of the three parties most critical to the success of the effort — CBOs, licensing boards, and appointing authorities — in order to gauge their enthusiasm for pursuing the Project’s goals and their capacity to participate. These interviews profoundly influenced the Project team’s understanding of how to structure the implementation phase.
In addition, we established a Project Advisory Committee, and we interviewed a number of current and former public members to learn about their experiences as board members.

Community-Based Organizations

The team interviewed representatives of 26 community-based organizations, a sample that reflects California’s geographic and cultural diversity (Attachment B). The Project design anticipates that CBOs will play the most prominent role in making this endeavor successful. First, drawing upon their knowledge of health status within their communities and the nature and causes of barriers to the delivery of quality health care, CBOs will need to educate themselves about the powers and jurisdiction of licensing boards and advocate on behalf of their communities’ interests when a board is undertaking an action or developing a policy that affects them. In this way, CBOs can exert their influence from outside the board.

Second, drawing upon their familiarity with the talent pool within their communities, CBOs are in a position to identify qualified individuals to nominate for appointment to the boards. (See Attachment C for a brief statement of the attributes public members should possess.) Once appointed to public member positions, these individuals will be in a position to add the voice of their communities to those of the others who inform the discussions that take place within the board.

In addition to identifying, vetting, and nominating potential public members, CBOs will be expected to maintain ongoing communication with those nominees who are appointed to public member positions to provide support and encouragement and to keep the public member up-to-date about issues confronting the community.

Thus, CBOs will be expected to make a considerable investment to implement this Project. Indeed, several CBOs worried about the expenditure of time and resources that would be required on their part and by any individuals appointed to public member positions in order to achieve a beneficial payoff from the Project. Recognizing this, the Project team has given great weight to the opinions and recommendations of the CBOs in designing its recommendations for the implementation phase. In addition to the interviews with individual CBOs, the Project convened a series of regional workshops to which all of the CBOs were invited to work on the design of a final implementation model. (See below for a discussion of the outcome of these regional workshops.)

Licensing Boards

The various boards have very different histories and experiences working with diverse communities on issues related to the professions they regulate. We conducted interviews with the Executive Officer and the elected Chairperson of seventeen health care licensing boards within the California Department of Consumer Affairs (see Attachment D). The Executive Officer oversees the daily operations of the board and the Chairperson usually sets the policy
agenda. The Project team thought it important to interview both of these key individuals in order to better understand each board’s likely receptivity to our proposal and to find out whether they believe its implementation would enrich the discussions in which their boards engage.

Appointing Authorities

The Governor appoints the majority of health care licensing board members; at most boards, the Legislature appoints some public members. With the exception of the Osteopathic Medical Board, each board includes at least one public member appointed by the Speaker of the Assembly and one public member appointed by the Senate Rules Committee. The Project interviewed the staff responsible for managing the appointments for each of these offices to learn about their review process and the qualities they seek in potential appointees.

Public Members

Finally, the Project interviewed seven former public members and nine current public members (four in their capacity as board chair). We explored such topics as the degree to which they believe they have been accepted as full participants in the conduct of board business, the degree to which they believe that they have been able to influence outcomes, and the extent to which they as public members and their boards as a whole would benefit from being better connected to CBOs representing diverse groups.

V. Outcomes of the Feasibility Phase

The premise of the Project is that more effective representation of the interests of underserved communities that face linguistic, cultural, and other barriers to access to adequate health care would result in policies and actions on the part of professional licensing boards that are more sensitive to the needs of these communities. During the feasibility phase, the Project team set about to determine whether the goal of appointing individuals who originate from these diverse communities to public member positions on licensing boards is attainable. We conclude that this goal is attainable, but could take a significant period of time to be realized. Therefore, we believe the implementation phase of the Project should give equal emphasis to promoting the participation of CBOs, individually and in coalitions, in affecting board policy and decisions from outside the board while they wait for opportunities to nominate community representatives to public member positions.

The process leading to this conclusion began with interviews to establish the extent to which CBOs, licensing boards, and appointing authorities support the concept. We hoped each of these stakeholders would be able to articulate tangible benefits from the Project above and beyond thinking it would be “the right thing to do.” We were gratified by the immediate and enthusiastic engagement on the part of interviewees, many of whom were ready to talk about how the process would actually work and how its benefits could be measured.
The CBOs that we interviewed had varying degrees of familiarity with licensing boards and with the range of issues that come under their purview. One constant, however, was that none of the organizations had spent much, if any, time attending board meetings or monitoring board activities. Once they became aware of the boards’ ability to influence the manner and even the location of a professional’s practice and to generate initiatives related to cultural and linguistic competence, nearly all of the CBOs agreed that working through these boards offers an outstanding opportunity.

CBOs were especially impressed that public members of licensing boards serve in a policysetting role equal to the licensee members. Many CBO representatives commented that they expend considerable resources serving on advisory boards and committees where they can bring the needs of their communities to the attention of decisionmakers, but are ultimately frustrated by the limited real powers of advisory bodies. Many of the CBOs immediately recognized that public member appointees to professional licensing boards enjoy full rights and privileges, and not only engage in debate, but actually vote on policy matters. Board appointments last four years and often longer, enabling members to fully engage in policymaking and, perhaps more importantly, help to set the agenda for the topics and issues that will be considered by the boards on which they serve. This prospect contrasts sharply with the experiences CBOs say they have more routinely encountered on advisory boards.

Successful implementation of the Project would complement the leadership development initiatives being sponsored by a growing number of CBOs. Not surprisingly, they view leadership development as critical to effective advocacy on behalf of the aspirations of diverse communities. However, few positions are available in the public policy arena where future leaders can mature and hone their practical communication, advocacy, and governance skills. Positions on health care licensing boards are seen as an opportunity to fill this void and foster the development of future leaders.

Our interviews with licensing board officials revealed that many boards have engaged for some time in outreach to the very communities with which we have been speaking. They publish meeting notices in multiple languages, move their meetings around the state to facilitate attendance by licensee and citizen groups in various geographic locations, and attempt to get media coverage in community news outlets. While their good intentions have for the most part generated disappointing results, more knowledgeable and assertive boards are quick to recognize that if their membership were to include individuals who are fluent in issues of importance to California’s diverse populations, it would help their boards craft policies that are more consistent with the needs of diverse communities. Most board executives and chairs with whom we spoke expressed equal excitement about how their boards could be strengthened by the appointment of one or more public members nominated by CBOs.

It should be noted that some boards — a small minority — did not agree that more involvement by CBOs, including having public members nominated by these organizations, would add appreciably to the quality of their work. Because of their attitude, these boards
arguably would benefit the most from the appointment of members who are sensitive to the needs of diverse communities, and who might be the only members of the board to interject these perspectives in board deliberations.

A number of board officials, and also some public members, emphasized that any appointee, whether nominated by a CBO or some other interest group, should be prepared to work hard, be a fully functioning member of the board, engage on every issue affecting every California consumer, and not view themselves exclusively as a representative of only a limited population or an advocate for a limited number of issues. Boards have a great deal of work to do and cannot afford to have members who are not completely engaged in all aspects of that work. Some boards have prior experience with appointees who were perceived as “single-issue” members and who enjoyed little success during their tenures. It is important to recognize and guard against this possibility, but it does not appear to be of serious danger because many CBOs also mentioned during their interviews that they recognize from their own experience that being a “Johnny one-note” can undermine a representative’s effectiveness, and that one of the qualities they would look for in their nominees would be a commitment to the full job description and agenda.

Almost all of the sixteen current and former public members we interviewed agreed that they were fully accepted by the rest of the board, including the licensee members, and that their work was respected. Indeed, the majority of those we interviewed had risen to leadership positions on their boards, either through election or appointment, and feel that they left a positive legacy as a result of their service. To reiterate, these are working boards and the public members we interviewed confirmed that one reason they were accepted and became effective was because they worked diligently and collegially in pursuit of their board’s mission.

Finally, we interviewed the staff responsible for appointments in the offices of the Governor, the Senate Rules Committee, and the Assembly Speaker. They all reported experiencing periods when there are many and periods when there are very few applicants for positions on licensing boards. More importantly, they all said they would welcome receiving applications from individuals who have the backing of the communities from which they come. It is frequently challenging for these offices to determine which applicants have the aptitude for and personal commitment to service on a licensing board. Appointments officials we interviewed said they would give weight to the fact that CBO-nominated applicants have been vetted and have the community’s respect and support.

Educational Documents

The Project team recognized that many CBOs and the individuals they nominate for positions on boards will need some education to familiarize themselves with the operation of administrative agencies and to understand what it takes to be an effective public member. We prepared two documents to help fill this educational need: A Guide to California’s Health Care Licensing Boards (Guide); and Tapping the Full Potential of Public Members — A Tool Kit
for Boards and Community-Based Organizations (Tool Kit). These documents are attached separately. The Project team thanks the Advisory Committee for their comments and suggestions related to these documents.

The Guide is intended to acquaint readers with the operations of multi-member state boards that license and regulate health care practitioners. The Guide is current as of July 1, 2009. This slice of state government is often the subject of review and reform by the California Legislature and restructuring proposals by the Executive Branch. For example, the Legislature is currently considering a proposal by the Governor to consolidate some of California’s health care boards.

Aimed at community members who wish to serve as a public member on a health care licensing board, Part One of the Guide provides information about board responsibilities, governance, and operations; and describes the board member appointment process. Part Two of the Guide describes seventeen health care licensing boards within the Department of Consumer Affairs.

Most importantly, the Guide provides examples of actions by boards that have had a positive impact on health care access and quality. It reveals the untapped potential of this forum — health care licensing boards — that can and should be utilized by consumer groups, CBOs, and policymakers to improve the delivery of health care services to all Californians.

The Tool Kit was written with several audiences in mind. The material it contains is intended to help newly appointed public members hit the ground running with the perspective and skills to be confident, productive members of the team, remembering their responsibility to represent the public point of view. We hope the Tool Kit will also be of use to sitting public members with some experience under their belts. Because it is essential that everyone on a board — licensee and public members alike — have a common understanding and similar expectations about the role and importance of public member participation, we encourage licensee members to use this document.

The contents of the Tool Kit are relevant to boards in every profession and to their staff, who need to embrace the public members’ special contributions to the board’s work, and to board chairs, who can help with the smooth integration of public members into the board’s operations.

An important audience for the Tool Kit is CBOs with a stake in what health care professional licensing boards do and an interest in having an impact on their actions. The Tool Kit illuminates board operations and explains why involvement by outside groups can simultaneously advance their agendas and enrich a board’s decisionmaking.

Finally, the Tool Kit’s candid description of a typical public member’s challenges and opportunities should help people considering board service to decide whether they want to make
the commitment. This same material should help CBOs and others to vet and select qualified individuals to nominate for public member vacancies.

The Tool Kit begins with a brief historical overview of California’s health care professional licensing boards. It goes on to describe why licensing boards are important — why they impact the delivery of health care services to all segments of the population. The next sections address public members: why they are important, the challenges they face, and attitudes and techniques that will serve them well during board service and help them be effective representatives of the public interest. A section on actual public member experience in California provides illustrations of how public members have had an impact on their boards’ operations and public policy decisions. The next section discusses why and how community-based organizations can and should want to try to influence board decisions. The Tool Kit concludes with a section on why having effective public members and cultivating strong relationships with CBOs benefits licensing boards.

As required by the terms of the grant, we have distributed a hard copy of the Guide and the Tool Kit to each of the CBOs and licensing boards that we interviewed as part of our project. Additionally, the Center for Public Interest Law and the Citizen Advocacy Center will post both documents on their Web sites.

Our work during the feasibility phase of this Project only strengthened the belief that CBOs have a big stake in gaining access to the boards that regulate health care professionals. Board decisions affect the availability of an adequate number of qualified, culturally sensitive health care practitioners throughout the state. For example, licensing boards affect provider supply when they establish standards for entry to the profession; they can influence where professionals practice by offering incentive-based programs; and they can play a role in promoting cultural and linguistic competence. Most boards embrace their duty to address the concerns of all Californians, but they need to be made aware of the distinct needs of diverse population groups in order to fulfill this duty. The vocal presence of CBOs at board meetings and hearings and the appointment of members who understand the needs of our diverse communities and can articulate them before their policymaking peers will help regulators make decisions that improve health delivery for all.

VI. Implementation

The Project team’s research during the feasibility phase confirmed the desirability and viability of the concepts advanced by Strengthening the Community’s Voice. The challenge that lies ahead is to put the concepts into practice. Since the stakeholders within the community must take ownership of the project, the Project team convened several regional meetings with CBOs during the spring of 2009 to learn their views about the design of an implementation phase. At these meetings, CBOs continued to express enthusiasm for the project, but made it clear that the implementation plan must be one that gives them a realistic opportunity for
success. They don’t want to buy into an exercise that drains them of resources and fails to yield positive results.

Among the concerns that were raised is the fact that many CBOs have been engaged in a variety of endeavors they thought would advance their interests, only to be disappointed with the results or, worse, left with the feeling that they were invited to be “window-dressing” in order to give credibility to a predetermined outcome. Some attendees at the regional meetings feared they would have the same experience if their nominees were appointed to licensing boards because appointees coming from the community would never hold the majority of positions and could always be outvoted.

Although such concerns must be taken seriously, majority status cannot be promised nor should it be seen as required. Licensing boards are representative bodies that convene for serious and principled deliberations over how to promote public well-being through law enforcement and the development of public policy. Most often, respect for different perspectives and values combines with candid discussion of how to reach decisions that improve the lives of consumers. Public members can achieve their goals in the same way as other members do: by advancing positions that are of importance to their communities, educating their colleagues on the board, and arguing persuasively for the outcomes they seek. There are no guarantees that every issue of importance to the community will be successfully addressed; however, it is guaranteed that none of them will be addressed if they are not brought to the table. The goal of the Project is to bring the decisionmaking apparatus face-to-face with the needs of underserved communities and create the environment for improved health care delivery. This goal requires those who know the community to inform the debate and influence decisions about health care delivery.

Another subject of discussion during the regional meetings was the process by which nominations to public member positions would be made. Most CBOs we contacted are inclined to use existing coalitions to identify and evaluate potential nominees. These coalitions are accustomed to working together toward common goals; they meet regularly and have a history of promoting their policy positions in public forums, all of which is auspicious for project implementation.

The state’s CBOs have convened a number of existing coalitions organized around different purposes. Some advocate for programs and policies that would affect multiple communities and perhaps multiple programs that serve those communities. Others advocate for improved services in a specific area of care, such as oral health. Some coalitions are regional, while others have a statewide presence. Every one of these coalitions could play a role at any given time in the implementation of Project goals.

It is appropriate to reiterate here that the Project team became convinced during the feasibility phase that Project objectives would be achieved in the nearer term with a shift from the original primary emphasis on nominating candidates for public member positions to
simultaneous and equal emphasis on CBOs, individually and in coalitions, trying to influence board decisionmaking from the outside. Public member vacancies don’t occur frequently, and there is no guarantee that every coalition nominee will be appointed. But CBOs can have an immediate effect on board thinking, if not board actions, by attending and speaking at meetings, testifying at hearings, and taking positions on pending legislation that affects a particular board’s authorities or appropriations.

Whichever CBOs and coalitions choose to participate, they will require support on a number of levels, at least in the near term. First, they will need some financial support. CBOs, and/or a coalition secretariat, will need to commit resources and staff time to learning about and monitoring board operations, and to managing the nomination process and maintaining communication with any nominees who earn appointment to a public member position. Several CBOs told us they would have difficulty redirecting scarce resources away from other priorities in order to pursue this one. Providing seed money to support CBO and coalition efforts would recognize their commitment and provide the extra incentive they need to dedicate the resources to integrating this Project into their priority agendas. Most importantly, financial support will allow CBOs to develop a cadre of leaders so that when the implementation phase ends, the CBOs will be in a position to continue their participation in health professional licensing board activities without relying on permanent outside funding by TCE or any other source. Bluntly, the goal of the implementation phase will be to make the project self-sustaining.

In addition, the Project team has the experience to help CBOs and their coalitions learn to identify opportunities to impact board policymaking and to identify promising strategies for achieving the appointment of their nominees to board vacancies.

Finally, training will be essential to the success of this endeavor. The Project team anticipates a great deal of energy will be devoted to training CBOs and their coalitions, as well as public member appointees at various stages of their transition to tenured membership on a board. Both the Guide and the Tool Kit are intended to be “living” documents that are regularly updated to reflect new developments. The Project team will be available to give in-person training to CBOs and coalition members — probably “train-the-trainer” sessions to empower them to carry the Project forward on their own. The team is also available to tutor nominees and newly-appointed public members about the substantive matters they are likely to encounter and prepare them to function effectively in the board setting. The team believes it would be beneficial to offer training to others — for example, sitting board members, both licensee and public, and board staff — in hopes of getting everyone on the same page about the public member role and the positive contributions to be made by CBOs.

The implementation phase will need to be evaluated by a third-party reviewer using an evaluation tool that is able to identify successful and unsuccessful aspects of the program at a discreet level so that modifications that might enhance the success of the community’s participation in health care policymaking can be made in a timely fashion.
VII. Summary and Conclusion

During the feasibility phase, the Project team found considerable support among CBOs, licensing boards, and appointing authorities for the idea of seeking the appointment of CBO-nominated individuals to public member positions on the boards. Once at the table, these members can help ensure that the community's health care concerns are factored into the board's deliberations and decisionmaking. Community-nominated public members would commit to stay in contact with CBOs, which would in turn monitor board activities and participate, as appropriate, in rulemaking proceedings and legislative hearings. The cyclical turnover of membership on licensing boards is unpredictable and long-term, but in the interim, there are other avenues for CBOs to make their constituencies' interests known to boards. The next step is to turn these opportunities into reality and generate positive change.

During the implementation phase, *Strengthening the Community's Voice on California's Health Care Licensing Boards* will create a framework for CBOs to pursue two parallel strategies for impacting the work of licensing boards, in particular encouraging boards to enact policies and regulations that promote cultural competence by caregivers at all levels of the health care delivery system. The first strategy is for CBOs, either individually or through coalitions, to stay abreast of licensing board activities, attend and speak at meetings, and deliver testimony when a board is working on issues that concern the CBOs' constituencies. The second, longer-term strategy is for CBOs or their coalitions to identify, vet, and nominate qualified individuals to serve as public members on the licensing boards. If these two strategies are successful, the diverse constituency groups served by the CBOs would have two avenues for bringing their concerns and needs to the attention of regulators — advocacy from outside the board by CBO spokespersons, and support from within the board from one or more public members who are sensitive to the needs of California's diverse populations and who have an enduring connection to the CBO or coalition that nominated them. The Project envisions ongoing training and support for CBOs, their nominees, and board members (public and licensee) to help maximize the benefits of having public members on the boards.
Strengthening the Community's Voice
on California's Health Care Licensing Boards

California's health care licensing boards regulate doctors, nurses, dentists, pharmacists, physical therapists, and many other health care professionals. Composed of "professional members" (licensees) and "public members" (consumers unconnected to the regulated profession), the boards' primary responsibility is to protect the public health, safety and welfare.

"Strengthening the Community's Voice" is a project funded by a grant from The California Endowment. It aims to promote closer ties between licensing board public members and culturally diverse grassroots constituencies so as to increase the attention paid to cultural and linguistic competence in board policy deliberations and enhance the boards' understanding of the many ways their decisions affect Californians' access to safe, appropriate care.

The concept is to invite community groups to nominate qualified candidates for appointment to public member positions on the licensing boards. Once at the table, these public members can make sure the community's health care concerns are factored into their board's decision-making. Community-nominated public members would commit to stay in touch with their constituency groups, which would in turn monitor board actions and participate when appropriate in rule-making proceedings and legislative hearings.

Successful precedents include the long-standing consumer group consortium that vets and nominates candidates for consumer positions on scientific advisory panels to the U.S. Food and Drug Administration. Also, Medicare beneficiary representatives have helped their Medicare Quality Improvement Organization boards connect with consumer concerns through broadly representative citizen advisory committees.

In the coming months, we will interview community groups, appointing authorities, licensing board officials, and people who are now serving or have recently served as public members to assess their receptivity to implementing a project of this kind in California.

An important part of the project is to prepare training materials for public member candidates and community organizations to acquaint them with the regulatory system, the legal authorities given to licensing boards, and the kinds of issues they are empowered to address.

The project will be conducted by the Center for Public Interest Law at the University of San Diego School of Law and the Citizen Advocacy Center (CAC), a national nonprofit organization whose mission is to enhance board performance through more effective public member participation. For further information, contact Ron Joseph, Principal Investigator @ (916) 207-2242 or RJAdvisors@comcast.net.

January 2008

ATTACHMENT A
Community-Based Organizations

1) Applied Research Center
2) Asian Health Services
3) Asian and Pacific Islander American Forum
4) Association of Asian Pacific Community Health Organizations
5) Bay Area Immigration Rights Coalition
6) California Black Health Network
7) California Immigration Policy Center
8) California Pan-Ethnic Health Network
9) California Partnership
10) California Primary Care Association
11) California Rural Indian Health Board
12) Chinatown Service Center
13) Filipino American Service Group
14) Fresno Works for Better Health
15) Greenlining Institute
16) Health Consumer Alliance
17) K.W. Lee Leadership Center
18) Latino Coalition for a Healthy California
19) Latino Issues Forum
20) Literacy Works
21) National Health Law Program
22) National Immigration Law Center
23) Orange County Asian Pacific Islander Community Alliance
24) PALS for Health
25) Promotoras Network
26) South Asian Network

Attachment B
Qualities to Look for When Selecting Public Members

Most statutes that mandate the appointment of public members to state health licensing boards (include those in California) talk only about qualities or experience that would disqualify an individual from appointment. For example, an individual who is a registered nurse, or is married to a nurse, or derives financial gain from the nursing profession would be ineligible to be appointed as a public member on the Board of Registered Nursing.

But, experience shows that disqualifying criteria, however important, are not enough to ensure the appointment of effective public members. Over the years, the Citizen Advocacy Center (CAC), AARP, the Pew Health Professions Commission and others have stressed the importance of considering positive characteristics and attributes that make for an effective public member.

The following list of desirable attributes draws on the findings of a national survey CAC conducted to ascertain the views of governors' appointment secretaries and sitting public members about the most important qualities to look for when selecting public members:

- a track record of consumer and/or public service advocacy;
- communications and negotiating skills;
- a willingness to commit the time necessary to fully participate in all board activities;
- an interest in health care, including access and quality of care issues;
- an awareness of the health care concerns of diverse population groups;
- connections to, or a willingness to cultivate connections to grassroots organizations representing diverse population groups; and
- "boardsmanship" skills gained from experience serving on civic, educational, benevolent, or other organizations.

ATTACHMENT C
Health Care Regulatory Boards

Board of Registered Nursing
Medical Board of California
Board of Podiatric Medicine
Physician Assistant Committee
Speech-Language Pathology and Audiology Board
Board of Pharmacy
Dental Board of California
Respiratory Care Board
Board of Occupational Therapy
Physical Therapy Board of California
Board of Psychology
Board of Optometry
Board of Vocational Nursing and Psychiatric Technicians
California Acupuncture Board
Board of Behavioral Sciences
Committee on Dental Auxiliaries
Osteopathic Medical Board

ATTACHMENT D