INTRODUCTION

This Training Day was designed for recently appointed board members – public and licensee members - who have served for a year or two and want to discuss board related topics and hone their skills. That said, we believe that anyone interested in licensure will benefit from exploring these excerpts from the conversation that took place between a distinguished faculty and an audience consisting of licensing board members and staff, certifiers, academicians, consumer advocates, and others.

The agenda for the day called for a discussion of many aspects healthcare licensure and credentialing. It ranged over the history of healthcare professional regulation, the parameters of licensing, the rulemaking process, outreach activities, relationships between boards and sister agencies and with legislatures, and the important area of board discipline, which was the subject of main annual meeting sessions during the following two days.

Participants were given copies of the manual entitled “Tapping the Full Potential of Public Members” prepared by CAC and the Center for Public Interest Law. The manual was written under a grant from the The California Endowment, so there are California-specific examples in it, but the substance is relevant nationwide. This document is available on our Web site: www.cacenter.org under publications/training materials.

The Training Day and subsequent Annual Meeting were co-sponsored by the Florida Department of Health and St. Petersburg College Institute for Strategic Policy Solutions.

WELCOME

Joe Baker, Florida Department of Health - Welcome to this training day for newly appointed board members. But wherever you are on your journey as a board member, you will benefit from today’s conversation. The goal is to make you a stronger board member, which will result in better protection of the public through effective regulation.

I have worked with hundreds of board members over the last 18 years and truly appreciate theirs and your dedication to this important regulatory work. Several public members of the boards I have worked with have served as chair. A personal goal of mine is to make sure that public members have an opportunity to fully participate in everything that goes on in their boards. The staff associated with your boards takes pride in
providing excellent administrative support of your efforts to protect the public. But, only you as board members get to vote – to approve an applicant to sit for an exam or to impose discipline against a licensee who has violated the law. Actively participating in discussions at the board level and then casting an informed vote on each case is your job as a board member. We hope that participating in the conference during the next three days will help you be a more confident and secure board member.

If you are like me when you become part of a new group, you like to know what that group’s mission and purpose is. For regulators, we look to what the legislature has defined as our role. In Florida, for example, the Nurse Practice Act states that: “The sole legislative purpose in enacting this part is to ensure that every nurse practicing in this state meets minimum requirements for safe practice. It is the legislative intent that nurses who fall below minimum competency or otherwise present a danger to the public shall be prohibited from practicing in this state.”

In Florida, the Division of Quality Assurance has an umbrella legislative chapter (456), which gives the responsibility for regulation to board members. ‘Board’ means any board or commission or other statutorily created entity, to the extent such entity is authorized, to exercise regulatory or rulemaking functions.” In combination with the statutory charge to board members, it becomes clear that the board’s role is to carefully monitor the profession through regulation and rulemaking and to therefore protect the public from folks who do not meet minimal standards for licensure or who might present a danger to our residents or visitors.

A favorite quote of mine is from John Wesley: “Do all the good you can by all the means you can in all the ways you can in all the places you can at all the times you can to all the people you can as long as ever you can.” That is my charge to you as board members.

David Klement, Director Institute for Strategic Policy Solutions - I bring regards from St, Petersburg College’s Provost, Jim Oliver. The College and the Institute are partnering with CAC to present this workshop and the Annual Conference. I know it will be a stimulating program and we hope you make the best of it while you are here.

As you know, this is a crucial time for health care boards. It has never been more challenging for those responsible for ensuring the safety of healthcare delivery and enforcing the standards of practice for individual professionals who deliver care. We are proud to partner with the CAC to present this workshop. Better public policy is one of the primary missions of the Institute that I head. Certainly this area of policy implementation and oversight is crucial to good healthcare outcomes. We are proud to be associated with an organization that has a long history of developing professionalism on healthcare advisory boards.

Becky LeBuhn, Citizen Advocacy Center - By way of welcome, let me relate a bit of background about CAC, which originated in the mid-1980ies in association with AARP. At the time AARP was looking for opportunities for retired people to serve on a variety of boards and commissions. At that time, Congress mandated that Medicare Peer Review
Organizations (now called Quality Improvement Organizations) appoint beneficiary members to their boards of directors. AARP was asked to help the states designate beneficiaries to serve on PRO boards. These consumer representatives came to AARP and said it is fine to appoint us to these positions, but we need backup, support and training. So, CAC came into being. A decade or so later, we became a 501(c)(3) organization with an independent board of directors.

Our mission is to “Increase the accountability and effectiveness of healthcare regulatory, credentialing, oversight and governing boards by advocating for a significant number of public members, improving the training and effectiveness of public and other board members, developing and advancing positions on relevant administrative and policy issues, providing training and discussion forums, and performing needed clearinghouse functions for public members and other interested parties.” Our values are transparency, oversight and accountability, collaboration, and meaningful consumer representation and participation.

We produce a number of publications, including a quarterly newsletter called CAC News & Views and research reports on policy issues. We hold annual meetings and conferences. We provide consultant services and tailored training. Examples of some current public policy issues in which CAC is involved are continuing competence, scope of practice, and the regulatory management of chemically dependent practitioners.

We have worked with public members of Quality Improvement Organizations and certification bodies, but why do we concentrate on licensing boards? It is because boards are the only institution with jurisdiction over everyone practicing in a particular profession. They are the only institution that deals with individual practitioners as opposed to the facilities and institution where practice occurs. Also, the actions of licensing boards impact the accessibility, quality, and cost of care.

Ben Shimberg, who was the first Chair of CAC’s Board of Directors wrote:

It is difficult to conceive of a society in which so many matters of enormous consequence – matters of life and death, financial security and personal happiness – are safeguarded by the work of thousands of unpaid volunteers who make up the regulatory boards of our nation. Licensure and certification, despite their many imperfections, continue to be marvelous institutions serving the public interest. There is certainly room for improvement, which will come, even though all such institutions are the creations of mere mortals who must do the best they can despite their own shortcomings and imperfections.

Our primary focus over the years has been public members. Let me quote what one public member of a specialty certification body said about his role and impact:

The question is: why have public members? The short answer is that they bring a perspective to decision-making that is different from that of members of the profession. My challenge, as your public representative, will be to examine every
issue considered by the board from the viewpoint of the healthcare customer. My job also includes bringing public issues and problems to the attention of the board.

A public member of a licensing board said:

The public member, fully supported by the statutory mandate to protect the public health safety and welfare, must be an open-minded guardian of the social conscience of the board. Our role is not that of the policeman. Rather, we must be integrally involved with board deliberations and decision-making. We must have the confidence that our reasoned opinions are meaningful. Hopefully having earned the personal and professional respect of our colleagues on the board, we will bring a slightly different viewpoint.

Our emphasis has been public members, but we fully appreciate the importance of the contribution made by licensee members of boards and staff, and we have been gratified over the years that licensee members and staff members have appreciated what CAC does and have participated in events such as our annual meeting, where we focus on what we think are some of the public policy issues that all regulators ought to be focusing on.

**FACULTY**

**Discussion Leader:** Mark Yessian, Former Regional Inspector General, Department of Health and Human Services and CAC board member moderated the day’s discussion,

Whitney Hausske, public member of the Idaho Board of Nursing and active in community activities,

Ron Joseph, veteran of numerous jobs in California state government including a decade as Executive Director of the Medical Board of California,

Becky LeBuhn, Chair of CAC’s board with experience as a public member on a licensing board, technical standards writing committees, and a variety of boards of directors,

Donna Moody, Director of Discipline for the North Carolina Board of Nursing and former President of the Council for Licensure, Enforcement and Regulation (CLEAR),

Brian Stiger, Director of Los Angeles County Consumer Affairs Division and former director of the California Office of Consumer Affairs,

Zeno St. Cyr, public member of the Maryland Board of Pharmacy and formerly a public member of that state’s Dental Board, and

David Swankin is President of CAC and a member of the Pew Health Professions Commission, Institute of Medicine panels.
HISTORY & EVOLUTION OF LICENSING BOARDS

LeBuhn

The first medical licensure laws were passed in New Jersey in the late 18th century. They arose because people were concerned not only about doctor’s qualifications, but also about their fee schedules. Early in the 19th century, states ceded the power to test health care practitioners to medical schools and medical societies. In the 1830’s the growing distrust of government authority caused states to eliminate regulation. After that, educated doctors and charlatans practiced side by side.

The mid-19th century saw a renewed effort to differentiate people by their qualifications and licensure laws as we now know them were enacted first in the medical field. The professional societies that had been controlling access to practice and adopting standards for education and practice had no enforcement authority, so they couldn’t crack down on the less-education people and snake oil salesmen. So, the professional societies asked legislatures to give them legal enforcement authority, which the legislatures were happy to do, believing they did not have the necessary expertise. As time went by, other professions liked this self-regulation model where the government appoints members of the professions to enforce regulation.

Some of the issues associated with this system include:

- **Self-regulation** has been characterized as the fox watching the hen house. Only over time was it decided to put public members on licensing boards to serve a watchdog function and bring a different perspective to regulation. Initially, the professions resisted this development, but over time, the value of public members has come to be appreciated and embraced and there are now as many as 50% public members on some boards.

- Another issue is **lenience**. Even with public members, many boards are accused by the public and sometimes exposed by the media for being too lenient in enforcing their statutes and too ready to overlook infractions of the state practice act by their colleagues. Some of the causes of this are the old-boy-network phenomenon, weak laws, limited resources, inadequate numbers and types of available sanctions, and inadequate reporting from hospitals and other institutions about possible problem professionals.

- By definition, licensing is **exclusionary** and restricts who can practice. In effect it creates a monopoly. Board rules can restrict competition and on occasion, the Federal Trade Commission has scrutinized what regulatory boards are doing at the state level.

- **Scope of practice** provisions in licensing laws define what an individual practitioner can do and sometimes the effect is to prevent some professionals from practicing to the full extent of their training and skills.
Another issue is **continuing professional development**. Not only do boards grant initial licensure, they also renew licenses. Originally, the only requirement for license renewal was to pay the required fee. Legislatures eventually enacted continuing education (CE) requirements, but these have been discredited as a surrogate for competence. Now, organizations like CAC are urging regulatory authorities to require more meaningful demonstrations of actual competence as a condition of licensure renewal.

**Obscurity** is another issue. The public knows very little about regulatory boards and very often confuses them with professional societies, even though the two have distinctly different missions.

A final issue is **limited mobility**. Because licensure is a state responsibility, most professionals have to take affirmative action to practice in another state. Only nursing has a “compact” system that enables nurses to easily float from state to state.

So, it is the professions that seek licensure, not the public. Boards are powerful government agencies that have legislative, executive and judiciary powers. The regulation of individuals is not well linked or coordinated with the regulation of places, except in the case of pharmacy boards, which have jurisdiction over the pharmacy as well as the pharmacist.

**Swankin**

I will mention four things related to the history and evolution of licensing.

- Boards were created to be **responsive instead of proactive**. There are proactive government agencies. In almost every major city, restaurants are closed down if they are unclean. Many cities require that a rating be posted. Government employees check gas station meters for accuracy. The Occupational Health and Safety Administration sends inspectors into workplaces. But, licensing boards can only respond to complaints.

- The second point is that we **regulated people a long time before we regulated products and facilities**. There was no such thing as hospital regulation when they started regulating doctors and nurses and pharmacists. When regulation of products and facilities did occur, the responsibility was given to different agencies. So, it is rare when a licensing board can do anything about an adverse incident unless the problem is attributable to the individual they license. This is not the case in airline regulation. The FAA regulates pilots and other individuals. It also certifies the equipment. It has control over the design of the runway and the operations of the airport. When there is an accident, the report of the National Transportation Safety Board usually identifies numerous things that went wrong with individuals, equipment, and facilities – across the board. This is system
regulation, administered by one agency. The nearest we get to this in healthcare regulation is pharmacy boards, which do have jurisdiction over pharmacies as well as pharmacists.

- The third point is **title protection**. In Ontario, Canada and several European countries, practice acts don’t specify what different professions can do. Instead, they license “Acts.” So anyone qualified to perform a given technique (with the exception of invasive procedures) is authorized to do it, regardless of the individual’s title. So the regulation is based on what people can do rather than who they are. So these other countries don’t have the political scope of practice fights we have here.

- My fourth point is that licensure concentrated originally on issuing a license in the first place. No attention was paid to **continuing competence**. So long as they paid their renewal fee and avoided board discipline, people were licensed for life. Consumers think a license on the wall is the government’s guarantee that the practitioner is competent. They don’t realize that it could be decades earlier that the practitioner was asked to demonstrate knowledge or skills.

I think these are four limitations on what boards are able to do. Your boards have to function within the confines of this system.

**Yessian**

Traditionally, there has been much *de facto* delegation to the profession. This is consistent with how we view government in the United States. Regulation in the UK is by the British Medical Society, which is much more assertive, even in the way they involve public members. The General Medical Council believes that half the members have to be public members. The rationale is that the public won’t have confidence in them unless they perceive parity. Furthermore, it is only fair to the professional members that there be parity, so the professional members don’t feel put-upon.

**LICENSURE**

**Yessian**

Consumers think a license to practice means the individual is competent, even if he or she has been practicing 30 or 40 years. Let me ask Brian Stiger two questions:

Based on your experience, is the public’s expectation of competency warranted? How well does our licensure system identify early on those licensees who are in some danger zone, where there is reason to be concerned about their practice abilities?
Stiger

I think the public does expect that folks who are licensed are competent. Certainly that was my expectation when I started working for the Department of Consumer Affairs. I don’t think the system lends itself well to identifying those licensees who have a problem.

One of my jobs was executive director for the Board of Chiropractic Examiners. This board talked a lot about continuing education. I actually attended a couple of CE courses and recognized early on that many courses did nothing to help licensees stay competent. I did think CE was a great moneymaker, by the way.

I attended a national nursing board conference a few years, where they discussed continuing competence. It made all the sense in the world to me that there must be a better way to make sure licensees stay competent. California’s Board of Podiatric Medicine had been requiring continued competency for almost 10 years. I was amazed to learn that in that 10-year period, the number of complaints decreased by over 50%. I wouldn’t say that change was entirely attributable to the board’s continuing competency program, but it certainly played a role. I think this is something all healthcare licensing boards need to think about because it would improve public protection.

Comments

- At the Board of Acupuncture, our requirements for degrees have intensified. People who went to school 20 years ago have less than half the education that I do now. They are not mandated to enhance their competence, other than through CEUs. I am hoping the board will require those who graduated ten years ago to stay on the same level as acupuncturists who graduate today. We are not paying more attention to monitoring the content and quality of CEUs.

- Along the same lines, I think many professional associations have started to take some responsibility for CE. So, specialties such as nurse practitioners need to show practice hours and education in order to maintain their certification. Medicine has been a model through the American Board of Medical Specialties.

St. Cyr

An Inspector General of the Department of Health and Human Services used to infuriate the medical profession by reminding them that 50% of medical school graduates graduated in the bottom half of their class. Healthcare is evolving. There was a time when CE was viewed as the way to ensure that professionals stay current. But, those of us who have served on health professions boards recognize that CE credits no longer serve the purpose they once did. Maybe the next step in assuring to the public that practitioners are competent is this notion of continuing competence. Many health occupations certification boards are already doing this. Dental as well as medical certification bodies have begun to test for current competence.
Yessian

Do you think the public is more aware that boards exist?

Joseph

Imagine how the Massachusetts Board of Pharmacy would have answered that question a month ago before the medication compounding scandal and how they would answer it this morning. Media attention is the driver. It seems that the public doesn’t care about what regulators do until a personal encounter drives them to focus.

On the subject of continuing competence, we tend to equate the concepts of CE and competence. Originally, it was thought that education would support competence. However, CE never was expected to actually promote competence. It was expected to keep professionals current in evolving technologies and practices. But, professionals probably learn more during actual practice than they do in academic settings.

The difficult question about continued competence is how to measure it. A license is a property right. You can re-rest, but you’ll be hard-pressed to pull a license if someone fails the test.

Yessian

What about the institutions where professionals work? Are they becoming a force in checking current competency?

Joseph

With the implementation of the Affordable Care Act, systems will have more incentives to assure competence.

Swankin

Most seat time CE requirement came from legislatures, which knew they had to do something and mandating CE hours was an easy thing to do. In some fields (mostly non-healthcare), this makes some sense. You would like to think that CPAs take courses to stay current on tax law.

Most of the world is moving away from thinking CE by itself is the answer. CE is one aspect of a bigger concept, which is Continuing Professional Development (CPD). Many countries require CPD where professionals do many things in addition to CE to stay current.
St. Cyr

I think public members are important to making the shift to CPD because practitioners simply don’t want to do it. They have passed the licensure exam and taken their CEs and they don’t see why they have to do more to demonstrate that they are competent. It is the public that must demand CPD.

Comments

- In Florida, we are ending CE audits. Starting next year, licensees who have not documented their CE in our electronic repository won’t have their licenses renewed.

- I’m a retired high school teacher and we had to get CEUs to renew our licenses. I have to be honest that a lot of those CEUs were really easy to get and often they didn’t apply to what I was doing. Some were fabulous, but many weren’t. I presume it is the same way in the health professions.

LeBuhn

CAC has compared what licensing boards and specialty certification bodies require in the way of continuing professional development. There is a lot of activity in the specialty certification world. Someone mentioned ABMS, which is way out front. Some specialty nursing organizations are looking at what requirements they can persuade their certificants to accept that will truly demonstrate competence as a condition of recertification. To a great degree, these private organizations have more flexibility than do regulatory boards for pioneering new ways of demonstrating competence.

There are several publications about continuing competence on CAC’s Web site. Several of them, advance the idea that regulatory boards – not only because they have less flexibility, but also because many of them are small and have very limited resources – should try to work with the certification agency in their field, or an institution that does credentialing or quality control. A board may even recognize or “deem” a private entity’s competence evaluation, if it adequately protects the public.

Comments

- CE providers have to apply to the board to offer a CE course to Florida’s pharmacists. Regional committees throughout the state comprised of licensees and faculty from pharmacy schools critique and approve or disapprove the course work. Board screening means the course work is more stringent.

In order to become licensed, physician assistants have to graduate from an accredited program, pass our exam, and obtain our certification. To maintain their certification, PAs have to test every six years, and fulfill a CME requirement of 100 hours every two years.
Whether or not a Physician Assistant has to maintain certification to renew their licenses varies from state to state. Whether a state requires maintenance of certification to renew a licensure raises another issue that was mentioned earlier. That is an employer’s willingness to hire someone who is not certified. Most often they will not.

Our current challenge is that PAs who can work for the government or the military without having to obtain a license. There is not as much regulation as we would like.

I think there are good and bad CMEs out there. Being able to take courses online has probably elevated the not-so-good CMEs.

Joseph

A few years ago, ABMS was moving in the direction of encouraging all their member boards to require recertification at least every 10 years. Most are now moving toward every 6 years.

Certification of PAs has been very effective method of encouraging PAs to maintain competence over time. This was my experience in CA, and I’m told it is true in other states. Linkages between boards and certifying agencies can be very positive because you have a shared interest in the competence of the professional members. Over time, it can encourage states to work certification requirements into their system. For the state to adopt a re-licensure process based on competence is a huge challenge. But, the commercial incentive for the profession to maintain currency so they can be hired by hospitals or health systems is very motivating.

Mooney

This is a good point. One thing that has always bothered me about the term “continued competence” is that it is so broad. Are we expecting professionals to be at a minimum competence level 10-15 years into their careers? You have to differentiate between generalists and specialists. What we should be talking about is continued professional development. I’m not sure it is the board’s role to measure CPD. That sounds more like an employer role. We need to come up with a mechanism where boards and employers are in some type of contractual agreement to ensure professionals are safe where their practice is at the current time in their career.

Yessian

Am I correct that it is the board’s role to assure minimum competence, rather than assuring that each licensee is the best possible practitioner?

Swankin

I think there is a growing understanding that we have to go someplace different than we have been. We can’t just require X number of hours of CE for all the reasons we have
talked about. But, there is resistance within the professions. The only way ABMS was able to require maintenance of competence is by grandfathering professionals who have been certified for a long time. They figured that in another generation, those who have been grandfathered will no longer practice and MOC requirements will apply to everyone. Medicine is different because of the large percentage of practitioners who are board-certified. Only about 25% of nurses are board-certified and fewer than 10% of pharmacists. So, maintenance of competence can’t be accomplished the same way in every profession.

Airline pilots re-demonstrate competence every year – on the equipment they are flying. It is more complicated in medicine because professional skills differ so greatly.

My point is that it is no longer a question of whether to demonstrate competence, it is a question of how. In the case of PAs, we are lucky to have the certification organization we can rely on. I agree that employers also have to be involved. The problem for board members is to determine what they are going to require as a demonstration of competence.

Yessian

We can assume that most professionals are conscientious and want to keep up. They don’t need government to push them to do it. If they see requirements coming, it turns them off all the more to the world of bureaucratic requirements. So, boards have quite a challenge fashioning requirements in a way that will seem relevant to the professions and also be meaningful to the public as an assurance of at least a minimum level of competence.

I return to the question of what the public can rely on. Is the regulatory system likely to flag those professionals whose practice is in a danger zone and could do patients harm? Are we even close to having that capacity?

Comment

How does a professional show me he or she is competent? How is anyone competent to do any job? We are asking the professions to give us the answer, but there are so many variables.

Yessian

Does that bring us back to the point that the entity most able to evaluate competence is the practice setting -- a professional’s peers?

LeBuhn

There are people looking not only at individual competence, but team competence, which is even more complex, but it is where the rubber hits the road.
St. Cyr

Across all fields, the professionals know who the bad actors are – whether it is an attorney, a dentist, a physician, a nurse. Professionals know which of their co-workers are only marginally competent and they steer family and friends away from them. Some of these people come to the attention of the boards and sometimes they are sanctioned. We are talking about a small number of practitioners who may need to be taken out of the system – have their licenses revoked, or have major remedial training.

Mooney

Returning to the subject of public awareness. My board has seen a significant increase in complaints, not always associated with a specific incident. Increasingly defense attorneys are advising people to report to the board, so the board becomes the investigator for the civil action that has occurred somewhere else.

Another concern is that the public does not understand what boards do. So, when they don’t get the relief they seek at the hospital or long term care facility, they report it to the board, thinking the board is all-powerful. But, in many instances their complaint is not within the board’s jurisdiction. We can’t get someone’s money back or get a nurse fired. I don’t know how we educate the public to understand what we really do.

Comments

- I was formerly a malpractice attorney. Plaintiffs came to me asking for a license to be taken away, or for a doctor to be taught how to do something correctly, or for me to prevent a repeat of the problem they encountered. These things are not within the power of malpractice. On my board, I often find that the public members don’t always understand the system issues. They oftentimes think the licensee members are trying to be lenient when they see an incident as a system issue instead of the fault of a particular nurse.

SCOPE OF PRACTICE

Yessian

Another hot topic in the licensure world is scope of practice. Scope of practice exists to protect the public by defining the area of acceptable practice based on the training and skills of individual practitioners. But we also know that scope of practice can be overly rigid as practice settings and technologies change and as new professions emerge. Scope of practice laws can actually get in the way of enabling professions to practice to the full extent of their skills, and it can restrict access to care and add to costs.

How does one find the right balance between public protection and unnecessary restrictions? How can scope of practice laws enable the right balance and enable
overlapping scopes of practice? Are you aware of changes that are being made to achieve this kind of balance?

Comment

Most people know that nurse practitioners cannot practice to the full extent of their education in Florida, mostly due to the difficulty with getting legislation passed over the opposition of another profession.

Swankin

I’ll share some positive stories. It wasn’t that long ago that in most states patients could not go to a physical therapist without a doctor’s prescription. There are only a handful of states where that is still the case. In many states, a dental hygienist can clean teeth in a nursing home without being under a dentist’s direct supervision.

So, scope of practice is changing, but still needs to change more in professions such as nursing. In many states, nurses can practice without direct supervision; they have prescriptive authority. There is a lot of evidence that nurses can do this safely.

I don’t think there is a profession where there isn’t some scope of practice issue, so the real question is how do we deal with it? This is a good example of the importance of the relationship between legislatures and boards. It is common for legislatures to pass a statute and instruct boards to develop the implementing rules. So, boards have tremendous authority.

Joseph

This is all evolutionary. Just because you are not where you want to be today doesn’t mean you’ll never get there. My own experience is that if you want to advance an issue, it can be more effective to work across professions, across boards, across associations in a smaller, quieter, if possible private setting to really sort out any bridge issues. That avoids a public fight where people draw lines and don’t give any quarter.

Comment

In Florida, there are no private meetings. The sunshine law applies to everything. So, a meeting between the boards of nursing, pharmacy and medicine is public; it’s recorded.

St. Cyr

There are advantages to trying to accomplish things cooperatively. The biggest fights are not so much with the legislature. The problem is territorial fights between boards. An example in Maryland involves authority for dental hygienists to administer anesthesia to their patients while cleaning teeth. This was fought by the nurse practitioners, who did not want dental hygienists to be able to administer injections. The dental hygienists
convinced the dentists to agree to it. Legislation was drafted, but the nurse practitioners killed the bill. Ultimately, it was passed.

Another example from the pharmacy board is a success story, but not without some wrangling. The proposal was to allow pharmacists to administer flu shots. The medical profession fought it, but it ultimately passed and the physicians found they weren’t losing a lot of revenue.

**Comments**

- When you talk about boards influencing scope of practice, I am not clear about the proper role of board members *vis a vis* lobbying legislators. In Florida, we generally depend on professional associations to be involved in the legislative arena.

- I recently participated on a task force in dealing with the nurses’ authority to inject insulin. The board considered the views of public health nurses, the school system, and parents about whether nurses could administer injections and delegate that authority to unlicensed personnel. We held hearings across the state. The nursing board issued an advisory opinion opposing permitting RNs to delegate injections to unlicensed personnel.

**Yessian**

Here’s another issue having to do with licensure. Combat medics in Iraq and Afghanistan gain all kinds of experience in difficult situations. When they return, they are at ground zero when it comes to gaining licensure. How should the system deal with special populations like this – people who have relevant experience – so society can benefit from their skills without putting them through all the hoops?

**Comments**

- Let them take the test. If they have the needed experience and can pass the certification test, why wouldn’t they be qualified?

- There is another hurdle – for PAs, at least. Before you even get to a certification exam, you are required to complete an accredited education program. The PA programs have increasingly demanding requirements. It is not unusual for them now to be Masters programs. So, one would think that by the time you complete the PA program, you are more than capable of passing the certification exam. If you can’t pass within the prescribed time frame and the permitted number of attempts, you are required to start over from the beginning. In other words, you can’t take our exam based solely on experience.

- In Minnesota, medics have tried to become EMTs, which is more in line with what they did in combat.
An army medic is often in the field doing surgery. Very often, medics have training equivalent to or better than hospital doctors. So, there should be some way for this training to be appreciated.

Mooney

This is a broader issue. The title combat medic doesn’t equate to titles like nurse or EMT, which demand a different skill set. I sit on a committee with the Departments of Defense, Labor, and Veterans Affairs. Our task is to look at the credentials individuals have in the military and translate them to the civilian world. This is difficult. A combat medic who may be taught to stitch and sew and transport is not the same as doing surgery in a hospital. We have the same issue domestically looking at EMTs and why they can’t be nurses. What we need to do is to make sure there is an easy pathway to provide the education individuals need.

Comment

We are doing that same task in Washington State, where we are looking at all the credentials, working with DoD, trying to find ways to transfer these skills into licensed healthcare professionals. And, if they don’t exactly transfer over, can we fill the gap by providing just the training that is needed, rather than sending them through a comprehensive training program.

Comment

If we really want to help veterans and other people with experience find work, there should be programs to meet their needs. Florida International University in Miami has a unique program for foreign-trained physicians to train them to become RNs. We can’t just automatically license people because skills are not interchangeable.

RULE-MAKING

Yessian

Boards are often given responsibility to flesh out rules and regulations to implement legislation. Sometimes this forces boards to deal with controversial issues that affect access to care and the cost of care. We know the affected professions have an intense interest in rulemaking, so they don’t need to be coached to become involved. How can we achieve broader input into rulemaking? How can we encourage consumer participation in hearings? How do diverse groups that have a stake in rules and regulations become aware that they are being drafted?

Swankin

It is a big challenge to stimulate public input. A couple of years ago there were hearings in Washington State to explore whether optometrists should be authorized to perform
laser therapy. At one hearing there were 38 witnesses – 19 optometrists and 19 ophthalmologists and no one from the public. Boards can have much more confidence in their rules if they have a full record representing the views of multiple stakeholders.

**Joseph**

One problem is that laypeople don’t have the expertise to testify on something like an optometrist’s ability to perform laser surgery.

However, I would encourage public members to link up with community-based organizations and create working relationships so that when issues come up, the public members can attest that there is an important public stake that needs to be heard and they can reach out and draw in people who can speak for the public. Once a rule is being considered, it is too late to gather momentum. There is an advantage to creating relationships that can be drawn on at the time they are needed.

**Stiger**

I found it impossible to get the public in the room. We tried to advertise as much as possible – publish information on the Web, develop an email list, talk about issues at board meetings held in public settings. The more folks are involved, the better the rulemaking ends up being. People testify at legislative hearings, but rarely attend rulemaking hearings. We need to get advocacy organizations involved to speak for the public.

**Joseph**

There was public involvement in a rulemaking by the pharmacy board in California. California has a very diverse population where multiple languages are spoken. This affects people’s ability to understand medical care. The legislature passed a law requiring prescriptions to be more accessible to patients in terms of language, type size, and so on.

The pharmacy board conducted an excellent rulemaking process involving public hearings around the state. The board proposed a rule. Opposition arose and in an 11th hour appointment, the governor packed the board and the regulations were not adopted. Eventually, a watered-down version was passed. So, even with an excellent process, the politics can overwhelm.

**Swankin**

The pharmacy board did it the right way. They solicited a lot of input. They invited Consumer Reports and AARP to testify, so it was strong, sophisticated testimony. The board wanted a full record. Not all boards could invest this time and money for every rulemaking, but this set an example. The outcome didn’t turn out as we would have
liked. But, it still was a good process (except for the packing of the board) – better than most.

In the end the compromise was not unreasonable. The original legislation required pharmacies to have someone in the store to make prescription information available in multiple languages. The compromise allowed pharmacies to make translators available by phone.

**St. Cyr**

Trying to get the public or consumer advocacy organizations involved is difficult at the federal and state levels. Some of you may be familiar with the Deamonte Driver case where a young man died when an infection in an impacted tooth migrated to his brain. The mother was moving from one jurisdiction to another, so her Medicaid was not in effect. So, they slipped through the system. Eventually, Maryland put some regulations in place to try to prevent something like this from happening again. Although the public and consumer advocates spoke up, most of the impetus for the fix came from the provider community, which stressed the need for increasing some of the reimbursement rates. In the end, there was a good outcome, but caused by a tragedy.

There seems to be a lot more advocacy, at least in Maryland, by manufacturers to pass legislation or rules that would benefit their companies. I’m seeing more of that kind of advocacy that I am consumer-related patient safety advocacy.

There is an organization called Mission of Mercy (MOM) that sponsors dental health fairs across the country. Some dentists take their entire staffs to provide services to indigent patients. Such fairs were not possible in Maryland because there was no volunteer license. As the board’s public member, I approached my state senator who proposed legislation. The dental society and hygienist society worked out some disagreements and the legislation ultimately passed. This is an illustration of advocacy public members can do to help improve public safety.

**Yessian**

The need for public participation is going to intensify, particularly as the US undergoes rapid demographic change. The ethnic and linguistic mix of the population is changing so fast that by 2020, we will be a majority minority country. If boards don’t have a membership mix that looks like the population, how do we get better attuned to the world of service delivery that meets the needs of diverse populations?

**Comment**

Doctors without borders and acupuncturists without boarders have found ways to make care available across jurisdictions.
Yessian

Do you sense in your states any percolating awareness of the need for public involvement in regulatory rules and legislation?

Swankin

One of the things we learned in California was that few people, regardless of ethnicity or income level, had any idea what licensing boards do. Advocacy groups were active at the legislature, but they had no idea that the legislation instructed the boards to finish the job.

Ron mentioned the importance of developing relationships early in the game. Part of this is to let the public and community groups know what you do and why it is important.

Hausske

NCSBN published a brochure on social media. Our board came to the conclusion that we had to address communication in a more serious way. We appointed a committee, which is about to publish a board communications statement. One of the things that we agreed is that we want to communicate proactively with our public and our legislators, so we will next look at strategies for fostering communication and dialogue with the public.

Stiger

At the chiropractic board, we were able to get a more full record on controversial proposed regulations by giving the executive director authority to develop a task force. So, I was able to invite in all the individuals and organizations I thought were going to be relevant. This task force reported back to the board in a public setting. I thought this was an effective way to get people to the table.

Yessian

We have been talking about rulemaking in the context of a legislature instructing a board to develop rules and regulations to implement statutes. This is not the only way rules come about. Boards may reexamine existing rules or initiate new rules. Perhaps it is a role for public members to initiate rulemaking procedures.

Mooney

Our Board of Nursing initiated a rule affecting certified nurse midwives. We had several negative outcomes related to midwives. Three of the incidents were related to lay midwives, who are not recognized in our state. One of the midwives was a certified nurse midwife. The supervising physician in this case was also supervising 7 other midwives, some at long distances from his location. A committee from the boards of nursing and medicine determined this was inappropriate. The boards chose to develop
rules to address the permissible number of supervised midwives and the distance away from the supervisor. If you are going to initiate rules, be sure the people you want to protect want to be protected. The people who showed up at the hearing were the patients of midwives who didn’t want us to take action.

Swankin

Has anyone had experience with two different boards working successfully together in a rulemaking? It is common for legislatures to instruct two boards to engage in a joint rulemaking to implement a scope of practice expansion. An example is New Mexico, where psychologists were given prescriptive authority. Psychiatrists fought against the legislation and when it came to developing implementing rules, the board of medicine stalled about holding a meeting with the psychology board. So, psychiatrists continued at the board level the fight what they lost in the legislature.

Comment

In Florida, the statutes that govern medical doctors and osteopathic doctors are very similar and their rules are almost identical. I don’t know whether they get together and try to promulgate consistent rules or whether one board follows the lead of the other.

LUNCHEON TALK

Phil Nicotera, Provost, St, Petersburg College, Caruth Health Education Campus

Licensing boards impact all of our health programs because our curriculum is based on what you tell us is necessary for a student to know to get licensed. We actively watch what is going on with licensing boards. This helps us produce competent graduates.

In the last 3-4 years there has been a tremendous interest in health programs on the part of young people and others who have been displaced from jobs. So, we are graduating students at a pretty high rate. We do a great job in providing them with the skills to practice, but we have noted that some of the younger students lack “soft skills.” This includes knowing how to communicate with patients, how to be professionals. Maybe that is something that individuals on licensing boards can include in licensing and certification exams so soft skills will help drive what we teach.

Accreditation is important to the health professions. Many schools do not meet the standards for specialized accreditation. This is something licensing boards should take into account. Accreditors hold us to standards affecting the curriculum, student-faculty ratios, and graduation rates. These are important because students who graduate from accredited programs will make the best practitioners. We have found that healthcare delivery facilities are beginning to recognize this and only hire graduates from accredited programs. In many professions, applicants cannot sit for a licensure or certification exam unless they come from an accredited program. It is very expensive and demanding, but it protects the public.
Swankin

You talk about the ability to communicate. Medicine now requires graduates to pass USMLE III, which includes demonstrating an ability to communicate and to write notes. Originally this requirement applied only to foreign graduates, but it now applies to all aspiring physicians. Your program teaches many allied health professions. Do you believe this communication requirement should apply across the board?

Nicotera

Yes, I do. Allied health professions are going to become more prominent and important in the next decade as fewer people choose to become physicians and fewer physicians are willing to practice in rural areas. All the allied health professions except Lab Techs have direct patient contact.

Non-accredited programs are popping up. This makes it difficult for accredited programs because we compete for clinical space. As much as 50% of each program is taught on site, so when we can’t place our students in facilities, it hurts our program.

Comment

We recently had a fairly large investigation of licensure fraud involving massage therapists. The fraud occurred because someone in the registrar’s office of an accredited college prepared fraudulent transcripts and diplomas for submission to the licensing board. What measures can boards take to ensure that certificates, transcripts, and the like are legitimate?

Nicotera

Some accrediting boards that are more “valid” than others. Do you know what body accredited the school involved? For example, the standard for a two-year program in nursing is from the National League of Nursing, but this is not the only accreditor of nursing programs. So, licensing boards need to be aware of the standards followed by various accreditors in their profession.

Comment

Assuming the school is properly accredited and someone in the registrar’s office is doing this kind of thing, what can the board do about the fraudulent application? How can they ensure that the documents before them are legitimate?

Nicotera

This is a challenging situation because many records can be falsified.
Comment

I work for a career college with allied health programs. Typically there is a tiered approach to accreditation. The school is either regionally or nationally accredited and then individual programs are accredited. A good programmatic accreditation will look at a school’s campus management system. They can’t falsify, although a school not yet accredited may be able to. We are careful about transfer credits we accept.

St. Cyr

Most of the professions know who the accrediting agencies are and typically there is a regulatory body in the state that will assure any academic institution meets the state’s criteria for being accredited. My experience is that this is not something the state licensing boards need to be concerned with because it is taken care of by another state regulatory body.

Comments

- A human trafficking task force discovered the massage therapy fraud. Federal and local law enforcement inspected establishments and found individuals who were being subjected to a form of indentured servitude. Many didn’t speak English well enough to take courses or take the exam, so how were these people able to obtain licenses? We checked their applications with the schools and learned that the individuals didn’t attend. It turned out the registrar’s office employee was being paid a kickback for fraudulent documents. We suspended 161 licenses in a span of two weeks, and we think this was just the tip of the iceberg.

- I don’t think this is an isolated case. Credentials are being sold all the time.

Nicotera

I wasn’t aware it was that pervasive. People can counterfeit a credential from a respected institution.

Comments

- We have a similar problem with massage therapists in Washington State, but it is cheaper to buy a diploma in Washington State than it is in Florida.

- PAs regularly have to provide their credentials either to their employer or licensing board. I don’t mean to suggest that it happens all the time, but I am now looking at two cases where the PA submitted fraudulent credentials. We find out about it because the folks in charge of verifying credentials will go to our Web site and see that in fact a PA is not currently certified. They notify us.
There is a national exam for massage therapists and this was sort of a package deal they offered for about $15,000 guaranteeing they would pass the national exam and obtain a document saying they had the necessary college credits to obtain a license.

The point is there will always be fraud. Our objective is to catch it and protect the public.

Joseph

If you have a fraudulent actor putting out fraudulent documents, you will never run it back to ground. It may be possible to address part of the problem of fraudulent documents through your source document process – going back to the institution seeking source documentation and gaining a higher degree of confidence the documents are legitimate.

We take a national exam in acupuncture. In 1994, some of the test questions were leaked out, so they did not test for a year while they rebuild the data bank.

Stiger

What happened to the school where the registrar worked?

Comment

We contacted the school and terminated the individual. They claimed no knowledge this was happening because the computer system did not reflect the issuance of the fraudulent transcripts. As far as they knew, these people were not students. We believe the problem is not isolated to this one college. We believe organized crime is behind this because of the $15,000 per person cost. The massage parlor advances the money and the individual works off the debt, primarily through prostitution.

Stiger

I am wondering what motivates the school to change its system. It is almost impossible for licensing boards to determine whether documents are fraudulent. The individual will be prosecuted, but what about the schools?

Comment

The media is doing a good job of holding them accountable. The school has lost a lot of credibility. It is in their interest to make sure it doesn’t happen again.
OUTREACH

Yessian

Boards say the public doesn’t know what they do. This includes the media, the legislature, and anyone else who is not on the board.

Does this matter? Is there anything that can be done about it? Does the public know how well boards are doing what they should be doing? Is it true that people don’t care about boards until something bad happens? Can boards take advantage of these “teaching moments?”

Comments

- I think most of the public doesn’t know about what the boards do until it affects them in some way, either personally or because they saw something in the media. But, where can they go then to learn more? In the case of someone being disciplined, there may be outrage, but the public doesn’t want to listen to how the process works. Last year, all the Minnesota boards had to report to the Sunset Commission. The board of nursing created a fabulous document that is on our Web site. The public can access that document and gain valuable information.

- Florida is developing Web sites for each board. They all have practitioner profiles that will show whether a disciplinary action is in effect, what the discipline is, and how the decision was reached. It’s all public record in Florida and easy to find.

- After the media coverage of “Pill Mills,” Florida passed legislation restricting what practitioners can dispense in what settings. Agents began arresting pharmacists and doctors, who became leery of dispensing. Patients are now calling licensing boards to see how to get their medication. This has never happened before. Recently, the New England compounding situation has caused another flood of calls. This makes me realize that I need some good outlet to disseminate information.

Joseph

Back to your question about how to get the public interested. I believe it is difficult to engage the public if they don’t have an immediate issue before them. This will always be an uphill battle. I repeat, this is why it is important for boards to have established relationships with community-based organizations, membership organizations such as AARP, and so on.

LeBuhn

A former executive director of the Ohio medical board wrote a Resource Brief for CLEAR advocating establishing a good relationship with the press before catastrophe
happens. He advocates trying to place articles about the positive things boards do, in addition to disciplining practitioners.

**Yessian**

So, there are two spheres. One is proactive and one reactive. Some of the larger boards have public information officers who reach out proactively.

**Comment**

The National Council of State Boards of Nursing held a conference call when ProPublica wrote exposes about the California Board of Nursing. NCSBN gave advice to boards about how to deal with the media, so I agreed to an interview in Tennessee. The media made it appear as if the board was hiding, so I agree we need to work to establish relationships.

**Swankin**

CAC gives Spotlight awards to boards for various initiatives. We once honored a pharmacy board for publicizing the top ten things that get pharmacists in trouble with the board. The board’s rationale was that everyone should know the top causes of disciplinary action because that might help licensees avoid violating the practice act. This is a story that could attract attention in the mainstream media.

**Joseph**

All boards would be well served to take time to discuss your mission and the resources you have available to accomplish it. It will give you some benchmarks against which to judge how well your program is doing. So, when ProPublica comes along, your board will be able to demonstrate a record of accomplishment and make clear to the public your abilities and limitations.

**Yessian**

Let’s focus a while on Web sites. If a reporter is initiating something about a board, it is likely to be negative. Board Web sites are positive. It’s good that Florida has practitioner profiles. But, how about this kind of information: data that shows how timely your complaint processing is; information about your handling of backlogs; data comparing how you are trending over the last three-five years? When the media is examining a board, the reporter who looks at the Web site could find that information. Ditto for the public. Isn’t this a worthwhile initiative – even one that could attract some funding for data gathering capability?
Comment

We are data-rich in Florida. Executive directors are evaluated on trends, such as average time to process applications, volume, number of days to get minutes to the Web site, and so on. There is probably no component of what we do that is not measured. A lot of this is reported on the Web site. I present progress at every board meeting.

Hausske

Idaho does a good job with data. We have partnered with the Department of Labor because they recognize the Board of Nursing keeps good statistics on workforce. Not only are we collecting data, we are engaged in strategic partnerships with other state agencies.

Yessian

This is a good area where public members can be active. They might suggest a database that would be of interest to the public.

Comments

- Lack of state funds makes it difficult to collect and disseminate data. Some of the nursing boards don’t have the infrastructure to maintain a database regarding discipline, so NCSBN is developing a database that it will pass on to the boards to make this kind of data more readily available. I have been dumbfounded that even some licensees are unaware that there is a board. They think their license comes from the state. So outreach is needed to licensees also.

Hausske

I think it is important to be clear about the purpose of outreach. Is it to recruit a public member for a committee? Is it to get legislation passed? There are three simple steps: create a really clear action-oriented message to generate buy-in; target the audience and leverage relationships; actively engage with the audience.

LeBuhn

Medicare Quality Improvement Organizations established Beneficiary Liaison Committees consisting of representatives from senior organizations, provider organizations, hospital associations, and others who were in a position to communicate the messages QIOs wanted to convey to beneficiaries about access to care, coverage, etc. Would it be a good idea for licensing boards to create advisory committees composed of consumer organizations, people from the media, legislative staff, and other constituencies the board has or wants to have as ambassadors to carry messages to the audiences that licensing boards want to reach?
Swankin

The good beneficiary liaison committees worked because there was two-way communication. The QIOs talked to the community and the community representatives expressed their needs and desires to the QIO. Also, the QIOs always reported back when a recommendation from the community was accepted or not rejected and explained why.

St. Cyr

Several years ago public members of all the boards in MD met every couple of months. One of the group’s goals was to get out to the public and talk to groups about regulatory boards and how the public could engage them. The group published a pamphlet with general information about all the boards and how to contact them.

The MD pharmacy board has a PR committee. One thing they do is attend public events, such as a flower mart in Baltimore, where clinicians can answer questions and provide brochures and other information about the pharmacy board. The board participated in a Baby Boomer Expo attended by thousands of people. Clinicians are needed at these booths to answer questions, but public members can provide general information.

Hausske

When I get home, I’m going to suggest that our board establish a consumer advisory committee. Building partnerships in the community is a positive thing that staff cannot always do alone.

Yessian

In the UK, there are “patient and public reference groups” consisting of appointees from advocacy groups, facility regulators, and so on. They are called in by the General Medical Council to address topics on which the Council wants broader feedback and extended discussion. Often, they are controversial topics. An example might be how the Council can do a better job interacting with ethnic minorities. People apply to be members of these groups and the Council decides whom to appoint. Perhaps state laws would make this model difficult in the US. If it would have to be a public meeting, for example, discussion may be inhibited.

Swankin

In New Jersey there was a lot of interest in health fairs where pharmacists did oral counseling about people’s medications. The pharmacy board agreed that retired pharmacists could be given a limited license to supervise pharmacy students to deliver this service. These fairs helped acquaint the public with the work of boards.
Hausske

Are any boards using social media to communicate with the public?

Comment

Some boards of nursing have. Alternatively, some people have established unauthorized Facebook pages that the regulatory board was not aware of.

Hausske

We have strict guidelines about who can speak for the board – the Executive Director and the Chair.

Yessian

Dr. Nicotera commented earlier about the relative immaturity of some students. This may explain inappropriate comments about and even photos of patients on social media sites.

Mooney

This is unprofessional conduct that leads to discipline. We had 4 such cases in 2011 and many more this year. The sanctions include such things as reprimand and mandatory continuing education. In April, the North Carolina Board of Nursing is convening a regional meeting with CLEAR on the subject of social media and the board’s responsibilities.

INTERACTION WITH OTHER AGENCIES AND LEGISLATURES

Yessian

Let’s talk about interactions between boards and facility regulators, whether it is accrediting bodies, health departments, or other agencies. Some years ago, there were predictions that quality assurance belongs with the facility and that licensure boards would disappear. Facilities have their own internal oversight mechanisms and external bodies accrediting or reviewing them and intervening when things go wrong. Delivery of care involves teams interacting and it is hard to isolate the individual’s role from the rest of the team. Are the licensing boards that regulate individuals doing enough to work with facilities and facility regulators?

Some years ago, CAC encouraged medical boards to establish relationships with Medicare Peer Review Organizations. It was a huge uphill battle. This was complicated by federal rules affecting the Medicare entities.
Joseph

I know it is resource-intensive but there is tremendous reward from interaction with other agencies as often as possible. Healthcare delivery is increasingly overlapping and issues arise across disciplines. The more boards interact with other agencies, the more credibility they have when an issue arises that affects more than one board or a facility and individual practitioners.

In the mid 90ies when cosmetic surgery was becoming increasingly popular there were problems with outpatient surgery. Physicians were operating in locations not prepared to handle semi-major surgery. There was no law in CA that allowed us to address this. There were lots of stakeholders: physicians, plastic surgeons, dermatologists, anesthesiologists, etc. We knew that we weren’t going to regulate offices. However, malpractice insurers and professional societies had a stake in bringing the situation under control. The legislation that ultimately passed regulated outpatient surgery centers where anesthesia was used. The law permitted the board to accept accreditation from an acceptable organization. It worked because we cooperated with external agencies.

Comment

To your point about collaboration, last week in DC was the first-ever Tri-regulators Symposium were regulators for medicine, pharmacy and nursing came together for two days of excellent dialogue. The path was laid because the CEOs of the licensing board associations had been meeting for months discussing common issues. We hope this will continue at the national level.

Swankin

In Washington State, the licensing boards and facility regulators are in the same agency and they share information. It has to be a priority, and if it is, coordination is possible whether or not you are in the same agency.

The compounding scandal in Massachusetts has focused attention on the interaction between a federal agency, the FDA, and state pharmacy boards. This is a priority now because neither of them wants to look as if they dropped the ball. To make cooperation a priority, raise this subject in a board meeting and ask how to interact with facility regulators. What would it take to do it? Have we ever done it before?

Comment

I can see how there could be better coordination. Some things that come to the nursing board appear to be cases that should have been handled by the facility, such as medication errors.
Yessian

Here’s where the worlds are so different because it is central to the philosophy of the medical error people is that everybody makes errors and punishment is archaic. You want people to be free to acknowledge errors so the system can be improved based on learning from mistakes.

Comment

The Florida pharmacy board is required to inspect establishments at least yearly. We have a very stringent protocol for inspecting facilities that do sterile compounding, which could be a model for other states. Drugs, devices, and cosmetics inspectors can enter any establishment where drugs are stored.

Yessian

Most boards depend on complaints to initiate disciplinary action. The majority of complaints don’t result in any action, either because they aren’t in the board’s jurisdiction or because an investigation doesn’t find any cause for action. Nevertheless a lot of data come to the boards through the disciplinary route, some of which may signal a problem that either the board or another regulatory agency should examine further. Is it feasible for boards to share this information?

Comments

All investigations in Florida are confidential until the board determines there is probable cause for the department to move forward. We get calls from the press asking about a particular individual and we can’t reveal whether we are investigating. We can’t share information with other regulators, either. There are very limited circumstances in which we share information. We share information with agencies such as the Agency for Healthcare Administration and with law enforcement.

There are other things that can be done. For example, sometimes we have multiple complaints against an individual, but the board closes each case individually because no one of them rises to the level of prosecution. Sometimes we will go back and incorporate the previous cases into one case and present them to the probable cause panel as a group.

We can communicate with the complainant. If we are investigating someone who works at a facility, we will interview the supervisor, so there is some awareness at the facility that an investigation is going on.

- Often the board doesn’t know about a complaint until the probable cause panel has made a decision.
Yessian

Is it right to conclude that there may be missed opportunities to recognize, or even prevent, something from going wrong because this information cannot be shared?

Comments

The NCSBN is looking at this and has drafted a regulatory action pathway modeled after Just Culture. We are asking the boards to look at the system issues and, when discipline is entered, to communicate that to the affected facility. The next step is to take this out to the facilities to inform them when it is appropriate to report the nurse to the board. We hope that eventually we can work closely with facilities on discipline.

- People call my board regularly with complaints, but I have to stop them because if I hear anything about the facts, I have to recuse myself from the case.

- Another thing we have to be conscious of is the complaints that have no basis. So, if we disclose even the existence of these complaints to the public, we may be destroying someone’s career when that person may not have done anything wrong. We have to be careful about that.

Swankin

We make a mistake if we don’t separate out in our minds and our actions and our laws the sharing of information among agencies and sharing it with the public. These are very different things. State laws differ, but the idea that boards are prevented from working jointly with other law enforcement agencies makes no sense. I think it is a mistake to think that confidentiality protections vis a vis the public automatically translates into agencies not being able to share information and address complaints and errors in a collaborative way. If laws prevent this, changing those laws would be way up on my legislative agenda.

Comment

I am a big proponent of sharing information with law enforcement and will speak about this on Friday. We do share information with other regulatory agencies. In fact, we have a mandate from the legislature to share information about criminal activity by a licensed practitioner. There has been some resistance to this, but my interpretation is to collaborate on things like pill mills, bad pharmacies, and other matters.

Yessian

Let’s turn to relationships between boards and legislatures, and board members themselves playing a more proactive role with legislators. Can this be done well? Can board members, particularly public members, be a resource for legislators?
Comment

Legislative advocacy is usually done through the professional association rather than the board. I can speak as an RN, but I am not the designated representative of the board.

Swankin

Legislation was proposed in Florida by the physician assistants to add a PA to the medical board. They knew the legislature would resist expanding the board, so they proposed replacing one of the public members with a PA member. One of the sitting public members on the medical board objected to the legislature and the media. The PAs withdrew the bill. This raises the question of who speaks for the board. Some boards say the staff, others say board members; others make a strategic decision based on the issue at hand. Some boards don’t attempt to influence the legislature, but will testify if invited. The question is what is the responsible accountable way to do it?

Comment

In Florida, when a board member wants a piece of legislation passed, staff relays that to the Department of Health’s legislative affairs people. The other avenue is going through the professional association.

Stiger

We talk about how the public doesn’t know what boards do. I was shocked to learn how many legislators don’t know what licensing boards do. The boards that I have worked on made it a priority to have board members talk to legislators. It is frustrating when boards don’t have an opportunity to have input on controversial legislation.

LeBuhn

Years ago, I was the public member on the funeral board in the District of Columbia and was also affiliated with a consumer organization advocating funeral industry reform. There was legislation pending before the City Council to change the funeral board legislation. I informed the board that I was going to testify on the proposed legislation as a representative of the consumer organization, which I did. I identified myself as the public member of the funeral board, but made it clear I was not speaking for the board. I didn’t feel any conflict and neither did the board.

St. Cyr

Many of the boards in MD have legislative committees. The pharmacy board legislative committee is very active. It has regular meetings and works closely with the chairpersons and staff of the house and senate oversight committees and has numerous rules changes every year.
The dental board has a legislative committee, but it doesn’t proactively meet with legislators. A precipitating event – always negative – prompts the pharmacy board legislative committee members to visit the general assembly.

Here is an example of a bad outcome because of not having a good relationship with members of the oversight committee. A dentist was accused of some very serious offenses. The dentist happened to have an office in the same building as a member of the House of Delegates oversight committee. The day of the disciplinary hearing, the Delegate came unannounced to speak as a character witness for the dentist. She was denied an opportunity to speak on advice of the board attorney and subsequently retaliated by making trouble for the dental board in the legislature. It has taken years to repair the relationship.

**DISCIPLINE**

**Yessian**

We will explore discipline briefly this afternoon, since the next two days of the annual meeting are devoted exclusively to this topic. One challenge of any good discipline system is to treat the same kinds of cases with some consistency over time.

**Mooney**

This is one of the most complicated parts of discipline. There are new board members each year and often the licensee members and the public members don’t agree on what action to take. Beyond that, it is not easy to be consistent. Our attorneys tell us that each case is distinct and should be treated on its merits. If you use that standard, it is possible that every decision could be different. However, when a case goes up for judicial review, the first thing a judge asks for is to see cases over a period of years to see if there is consistency.

One of the ways the North Carolina Board of Nursing has tried to deal with this dilemma is to develop sentencing guidelines, which have to be blessed by the board. Staff uses these guidelines to determine whether to go for a consent order consistent with what the board would be likely to order, based on experience. If the licensee refuses a consent order and the case goes to settlement, the board has to prepare a written rationale if it deviates from the guideline.

The sentencing guidelines are public. We discuss them with defense attorneys.

**St. Cyr**

All Maryland boards are required to have sanctioning guidelines. Not only do board members have to look for patterns and practices, defense attorneys are also looking to see if boards are being consistent.
Swankin

Sanctioning guidelines are especially important because this is one of the few areas of law where there is no reporting system. Boards often rely on institutional memory. It is hard to be consistent without data. It is important because more and more cases are appealed.

Comment

North Carolina’s guidelines were first developed around our complaint evaluation tool, which goes to the employers who report to the board. There are five different areas: general nursing practice, the nurse’s understanding level (length of practice), internal policies of the facility, decisions the nurse made, and ethics and willingness to accept responsibility. We then look at aggravating and mitigating factors. Investigators will use the same tool. The sanctioning tools distinguish between human error, at-risk behavior and reckless behavior. If there are two incidents in reckless behavior, there is likely to be a sanction. Sanctioning criteria are: low risk the public, moderate risk and high risk, each with criteria that suggest what sanction is appropriate based on the history of board action. Looking back, we have been pretty consistent so we have confidence in our system.

St. Cyr

In Maryland, sanctioning guidelines were reviewed by the Department of Health and were then published for public comment under the state Administrative Procedure Act. Professional associations may comment, but rarely, if ever, do we hear from the public.

Comment

Washington State published sanction guidelines and held rulemaking hearings on them. I don’t recall many comments, even from defense attorneys.

Mooney

North Carolina differs from everyone else because we are an independent agency, so we have a lot of discretion about how we do things. We don’t have to go to the legislature for approval of things of this sort.

Swankin

You would think that every board would have written priorities for investigations in addition to sentencing guidelines. We surveyed boards several years ago and were surprised at how few had written priority policies. This is especially important for large states with numerous licensees. It shows how much things have changed for the better if many boards have sentencing guidelines.
Comment

Consistency within a board is one thing. I look for consistency in actions against PAs by boards across the country, but there isn’t a lot. North Carolina is fabulous to deal with. Documentation is good and actions are consistently in the public interest. There are other states that don’t take action even in egregious cases.

Yessian

Discipline is primarily a complaint-driven process. As public-protection agencies, boards should want to make the complaint process as user-friendly as possible in terms of how to file a complaint, accessibility, cultural sensitivity, etc.

Mooney

Most boards have tried to make the complaint process user-friendly. Our board has staff that answers calls from the public. I am concerned when I see complaint forms that have to be notarized and dated. Even worse, some boards share complaints with the licensee. This discourages complaints.

Comments

Florida allows anonymous complaints, but we can keep the complaint confidential. We don’t have to notify the respondent if the behavior is criminal in nature. This helps when we are cooperating with law enforcement and don’t want to jeopardize law enforcement’s investigation. Also, the Department can generate complaints, so we don’t have to wait for consumers to complain.

- We don’t do a good enough job telling the public what the board can intervene on. We need to consider how a complainant feels being told their concern isn’t within our jurisdiction. We need to supply information about where to direct complaints. Some are more appropriately directed to the employer.

Complaints increased greatly after the boards of medicine, nursing and pharmacy had a booth at a state fair, but many were things we didn’t have jurisdiction over. We make an effort to refer these people to the right place. Sometimes we forward complaints to the right place.

- It is also helpful to explain the discipline process. How long it will take, whether the complainant will receive progress reports, whether the complainant can appear before the board, and so on.

St. Cyr

Public members can advocate for consumers who submit complaints. Oftentimes, they don’t know how to navigate the system and lodge a complaint in the right place. Boards
are busy, so it may be easy to dismiss a case where there is no jurisdiction. But public members can intercede and suggest that the complainant be referred to the appropriate agency. This is an important customer service public members can persuade other board members to recognize.

Yessian

Should boards do more to disseminate information about how and where to complain? The Medical Board of California requires a notice in doctors’ offices telling patients they can complain to the state medical board. This is exceptional.

Comment

The medical and osteopathic boards in the state of Maine have an employee whose whole job is the assist complainants and keep them informed. Florida also mandates that complainants be notified of the outcome of a complaint within a designated period of time.

Joseph

Acknowledging receipt of a complaint and notifying complainants of final disposition is one thing. What can be done to maintain communication during the intervening time?

Comment

Florida requires periodic updates, but the complainant has to opt in to this service. There still can be long periods of time between notifications. Updating the status code in the computer system triggers the sending of a notification letter.

Swankin

The gold standard is in Maine. The ombudsman also calls complainants when a settlement conference is scheduled and invites the complainant to attend. When cases are dismissed, he writes the letter in plain English with a full explanation of the board’s reasoning.

Comment

That is a fantastic idea, but may not be feasible in Florida because of the volume of complaints.