



# News & Views

## Citizen Advocacy Center

Second Quarter, 2011 A Health Care Public Policy Forum Volume 23 Number 2

**SAVE THE DATES:** Our annual meeting “Achieving Regulatory Excellence – Effective Discipline Programs” will be held on **Thursday, October 20, 2011, and Friday, October 21, 2011**, at our offices in Washington, DC. You may download a **Preliminary Program and Registration Form** or register online at <http://www.cacenter.org/cac/meetings>.

**Audio recordings and PowerPoint presentations** from past CAC webinars are now available. More information is at [http://www.cacenter.org/cac/webinars\\_past](http://www.cacenter.org/cac/webinars_past).

**CAC is now a membership organization** and we invite your board to join. For information about the benefits that are available to our members, and for a membership enrollment form, please see [pages 20 and 21](#) of this issue.

Although we encourage you to receive our newsletter by becoming a **CAC member**, you may still subscribe to our newsletter without becoming a member. Please see [page 22](#) of this issue.

## SCOPE OF PRACTICE

### Colorado Legislature Votes to Expand Scope of Direct Entry Midwives

**Editorial Note:** Readers will recall that CAC sent written testimony in support of an expansion of the scope of practice of Colorado’s certified direct entry midwives. We coordinated our testimony with a Colorado consumer group, Delivering Natural Care for Families.

Colorado’s House and Senate have now voted to expand the scope of practice of direct entry midwives. Melanie Asmar of the Westward Blog wrote the story on May 13, 2011. Indra Lusaro of the group Delivering Natural Care

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for Families told the Blog that she feels good about the final bill:

The vast majority of things we were aiming for would up in the bill. I think it was a definite success – not just in terms of the outcome of the bill, but in terms of **the organizing we did and the people we activated, and in terms of having a consumer group, which I believe changed the conversation.** (*Emphasis added*).

## Vermont Mandates Insurance Coverage for Home Births

The Vermont legislature passed a bill that requires insurance companies to provide insurance for all home births, regardless of whether a doctor is present. This legislation was supported by the Vermont Midwives Alliance and by a national campaign, called the Big Push for Midwives, which advocate for legal home births and midwife licensure in the states. Vermont is one of four states that have passed legislation mandating insurance coverage. The others are Washington, New York and New Hampshire.

The legislation was also supported by the Vermont Public Interest Research Group (V-PIRG). V-PIRG posted this notice on its Web site on May 2, 2011, when the bill was under consideration in the House (it passed two days later):

The House Committee on Health Care has just passed the Midwife Bill (S.15). This bill would allow more couples to choose home births for their babies by requiring insurance companies to cover midwifery services, including home births.

The bill (S.15) is about choice, fairness, and cost savings. Here are four reasons why VPIRG is strongly backing this bill:

- Women are fully capable of making wise choices about where and how to give birth.

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## NOTICE

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- Midwives have been licensed by the state for 11 years and their practice is heavily regulated.
- By law, licensed midwives can only deliver a baby at home for a healthy mother during a low-risk pregnancy.
- Midwifery has the potential to save us a lot of money. Home births cost just one- third the price of a hospital birth on average.

S.15 passed through the Senate with resounding support, but in these last few days of the session opponents are threatening to stall its progress in the House. We need your help to keep it moving!

Although midwifery services are already covered by VHAP and Medicaid, private insurance companies have refused. This means that a healthy mother paying her monthly insurance premium, co-pay, and deductible, will be forced to pay for her home birth out of pocket, even though she has been guaranteed comprehensive maternity coverage by the State of Vermont.

S.15 will simply put an end to this discriminatory insurance policy. Midwifery and home birth is not for everyone. But healthy women in low-risk pregnancies should be able to rely on insurance coverage if they choose this option.

***Editorial Note: The success of this legislation is another indication that it makes a difference when consumer and citizen groups make their views and influence felt in the state legislatures.***

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***The legislation also shows that changing laws to give health care practitioners authority to practice to the full extent of their training and skills is an important step, but often only a first step. Insurance reforms, such as this mandate may also be necessary to truly affect the healthcare marketplace and expand consumer access and choice.***

***See also the following article about insurance coverage for chiropractic services in Arizona.***

## **Chiropractors Sue Arizona Department of Insurance**

A change in the operations of two major insurance companies threatens chiropractic benefits in Arizona, according to the Arizona Chiropractic Society (ACS). Cigna Healthcare and Blue Cross Blue Shield have outsourced the management of chiropractic benefits to a California company, American Specialty Health Inc. Chiropractors fear American Specialty Health will limit the number of covered visits per year and reduce reimbursement rates.

In a lawsuit against the insurance commission, ACS alleges that chiropractic services are judged by a different standard than the medical doctors offering the same or similar services. The suit claims that chiropractors must seek authorization for office visits in excess of the first five visits. This is not the case for medical and osteopathic doctors. The suit also alleges that the insurer allows \$44 per visit, with \$40 being covered by the patient's co-pay.

Information about the lawsuit is available at the Arizona Chiropractic Society Web site: [http://www.azchiropractors.org/file\\_open.php?id=998](http://www.azchiropractors.org/file_open.php?id=998).

## **Dental Health Groups Agree to Compromise**

The Oregon Oral Health Coalition and the Oregon Dental Association agreed in March to draft compromise legislation (SB 738) that calls for pilot projects to address dental care workforce shortages in the state. Originally, the Oral Health Coalition wanted to establish a new mid-level provider, but the Dental Association objected. According to the bill's summary, the legislation:

- Directs the Oregon Health Authority to approve one or more pilot projects relating to dental health.

- Allows a person not licensed to practice dentistry or dental hygiene to practice dentistry or dental hygiene in approved pilot project.
- Changes the title of a limited access permit dental hygienist to community health dental hygienist.
- Modifies requirements for permit and scope of practice of permit holder.
- Makes changes operative on January 1, 2012.
- Requires insurance policy covering dental health that provides coverage for services performed by dentist to cover services when performed by community health dental hygienist.
- Directs Oregon Health Authority to compile data relating to community health dental hygienists.
- Directs Oregon Board of Dentistry to establish pilot project for training and certifying community dental health coordinators.
- Sunsets pilot project January 2, 2018.
- Declares emergency, effective on passage.

For more information, see:

<http://www.leg.state.or.us/11reg/measures/sb0700.dir/sb0738.intro.html>.

## **PUBLIC MEMBER**

### **Regarding Comment on: Launching Accountable Care Organizations — the Proposed Rule for the Medicare Shared Savings Program**

*Editorial Note: CAC and 19 organizations and individuals signed on to the following letter sent to CMS Administrator, Donald Berwick, MD on April 21, 2011. Note*

***especially the recommendation in the fifth paragraph that the boards of Accountable Care Organizations include at least 51% people with a history of citizen representation:***

Donald M. Berwick, MD, MPP  
Administrator  
Centers for Medicare & Medicaid Services

Dear Dr. Berwick,

We are writing you regarding concerns that adequate patient protections will be incorporated into the governance and staff responsibilities of Accountable Care Organizations (ACO). The dominant ACO structure which is emerging is a hospital organization with physician employment.<sup>1</sup> A major change is the loss of the independent medical staff. We feel that three safeguards should be incorporated into Accountable Care Organizations.

First, the physician or healthcare provider's primary fiduciary responsibility should be to the patient and not the ACO. Fiduciary responsibility encompasses quality, finances, and loyalty. In other words, the physician can counsel the patient and refer the patient out of the ACO without fear of retaliation. Every patient would want their physician to have the patient's interests as paramount importance. An example of such a regulation would be as follows:

"A registered nurse, licensed practical nurse, advanced nurse practitioner, doctor of allopathic medicine, doctor of osteopathic medicine or other healthcare provider with substantially similar responsibilities shall have their primary fiduciary responsibility to the patient and not to an institution or

corporation which employs them, or to an entity which reimburses them for their services."

Second, is requiring key personnel in auditing and quality assurance functions to be employed by and report directly to the ACO's Board. This is similar to the banking industry. This quality assurance structure is an important consideration with the rapid disappearance of the independent medical staff. It removes the CEO as the supervisor of those who measure and assure the facilities quality.

Finally, similar to non-profit hospitals, all ACO Boards should be comprised of at least 51% of individuals without a conflict of interest with the ACO. Moreover, a substantial number of the individuals comprising the 51% should have a history of citizen representation on civic, educational, benevolent or other types of non-profit boards, such as consumer and community advocacy organizations, the League of Women Voters, parent-teacher organizations, and the American Association of University Women.

Even with this percentage, the institutions of many non-profits are profit driven, which has prompted the IRS to generate new guidance on the responsibilities of non-profit hospitals.<sup>2</sup>

According to Lois Lerner, Director of the IRS Exempt Organization Division, for hospitals:<sup>3</sup>

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<sup>2</sup> IRS Exempt Organizations Hospital Study, Executive Summary of Final Report (February 2009)  
[http://www.irs.gov/pub/irs-tege/execsum\\_hospprojrept.pdf](http://www.irs.gov/pub/irs-tege/execsum_hospprojrept.pdf)  
<http://www.irs.gov/charities/charitable/article/0,,id=203109,00.htm>.

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<sup>1</sup> Mathews, A.W., When the Doctor Has a Boss, Wall Street Journal, November 8, 2010.  
<http://online.wsj.com/article/SB10001424052748703856504575600412716683130.html?KEYWORDS=hospital+ownership+of+physicians>.

<sup>3</sup> Statement by Lois Lerner, Director of the IRS Exempt Organizations Division, on the IRS Report on Nonprofit Hospitals, at a Press Briefing, Feb. 12, 2009  
[http://www.irs.gov/pub/irs-tege/lernerstatement\\_hospitalproject\\_021209.pdf](http://www.irs.gov/pub/irs-tege/lernerstatement_hospitalproject_021209.pdf).

“To qualify for tax-exemption, they must show that they provide benefit to a class of people, broad enough to benefit the community, and they must be operated to serve a public rather than a private interest.” The Boards of Non-Profit Institutions have as their primary fiduciary responsibility charitable purposes of the community and not the facility. ACOs composed of at least one non-profit organization should have Boards with the same fiduciary responsibility as non-profit organizations. Boards of For-Profit hospitals have the facility as their primary fiduciary responsibility but this should be required to be the patient. Similarly, a For-Profit ACO Board’s primary fiduciary responsibility should also be to the patient and not to the ACO.

Thank you for this consideration.

## QUALITY OF CARE

### Blogger Doctor Challenges Basing Pay on Patient Satisfaction

In her blog on the Reporting on Health Web site, *Doc Gurley's Urban Health Beat*, Dr. Jan Gurley challenges Medicare’s plan to peg reimbursement rates to patient satisfaction surveys. After describing the case of a patient who preferred a prescription for Librium to the demands of detoxification and abstinence, Dr. Gurley questions the notion of treating doctor pay differently than that of other professionals:

It’s hard to fathom how we got to the point where we actually pay popular people more for our healthcare.

No such system exists in any other professional or non-professional field. Not for lawyers, not architects, not nurses, not teachers. You can’t even pay

your plumber less if she has a lower customer satisfaction score.

In client satisfaction surveys, 70 percent of practicing lawyers have very low satisfaction ratings. But we don’t pay less for our justice system, and I, for one, would argue strongly that we shouldn’t — at least not based on popularity. (See <http://www.lawmarketing.com/pages/articles.asp?Action=Article&ArticleCategoryId=58&ArticleID=495>).

There’s an even nastier, and more insidious, result from basing compensation on patient satisfaction. As Kevin Pho, writing as KevinMD, states, “Already, more than 80 percent of doctors, according to a survey from HealthLeaders Media earlier this year, said patient pressure influenced their medical decisions. And in primary care, linking bonus pay to patient satisfaction could cause physicians to be more selective in who they see, subtly keeping patients who they know will score them well, and referring disagreeable ones to other providers.” (See <http://www.kevinmd.com/blog/2010/04/oped-patient-satisfaction-medical-care.html>).

Dr. Gurley’s blog can be found at: [http://www.reportingonhealth.org/blogs/patients-rating-doctors-lets-pay-popular-people-more?utm\\_source=newsletter110525&utm\\_medium=email&utm\\_campaign=thedoctorsays](http://www.reportingonhealth.org/blogs/patients-rating-doctors-lets-pay-popular-people-more?utm_source=newsletter110525&utm_medium=email&utm_campaign=thedoctorsays).

**Editorial Note:** *Doctor/Blogger Jan Gurley writes for Reporting on Health, a USC Annenberg School of Journalism online community for journalists and thinkers. Her blog explores the practice of medicine on the margins of society and what we can learn from it. You can see more of her posts at <http://www.reportingonhealth.org/blogs/25332>.*

## CONTINUING PROFESSIONAL DEVELOPMENT

### Oklahoma Accepts Certification for Licensure Renewal

*Editorial Note: Melissa Biel filed the following report on the American Board of Nursing Specialties (ABNS) Groupsite on May 6, 2011:*

Effective July 1, 2011, the Oklahoma Board of Nursing has passed regulations that allow nurses to use specialty nursing certification to renew their licenses.

Revisions for sections 485:10-7-3 and 485:10-9-3 establish a mechanism to evaluate continuing qualifications for practice for licensed nurses. Each licensed nurse will be required to verify that he/she was employed in a position that requires a nursing license with verification of at least 520 hours, or has completed at least twenty-four (24) contact hours of continuing education applicable to nursing practice, or is certified in a nursing specialty area, or has completed a Board-approved refresher course, or has completed at least six (6) academic semester credit hours of nursing coursework at the licensee's current level of licensure or higher.

**CONTACT PERSON:** Gayle McNish, Oklahoma Board of Nursing, 2915 N. Classen, Suite 524, Oklahoma City, OK 73106 (405) 962-1800.

## PAIN MANAGEMENT AND END OF LIFE CARE

### Obama Administration, FDA Act to Curb Prescription Misuse

The online publication *Formulary ENews*, published by *Modern Medicine*, reported on

April 29, 2011 that the Obama administration launched an initiative to reduce the “epidemic” of prescription drug abuse. The initiative includes an FDA education program aimed at reducing the misuse and mis-prescribing of opioids.

According to *Formulary ENews*,

FDA estimates that more than 33 million Americans aged 12 and older misused extended-release and long-acting opioids during 2007, up from 29 million just 5 years earlier. In 2006, nearly 50,000 emergency department visits were related to opioids. FDA experts say medications including Oxycontin, Avinza, Dolophine, and Duragesic are extensively mis-prescribed, misused, and abused, leading to overdoses, addiction, and even deaths.

The initiative will include:

- expanded of state-based prescription monitoring programs;
- recommended removal of unused medications from homes;
- education for patients and healthcare providers;
- law enforcement aimed at reducing the number of “pill mills” and doctor-shopping.

Also, the FDA announced a Risk Evaluation and Mitigation Strategy (REMS) addressing extended-release and long-acting opioid medications. REMS includes educating doctors about proper pain management and patient selection, and improving patient awareness of how to use the drugs safely. Manufacturers will be expected to provide patient and prescriber education materials.

*For more information, see:*

<http://formularyjournal.modernmedicine.com/formulary/article/articleDetail.jsp?id=718215&sk=b1ac853ea65eaf73ba1d4d6acfe1c536>

*Editorial Note: In May 2011 the Ohio legislature considered legislation that would require the State Board of Pharmacy to license and oversee pain management clinics. In February, 2011 the Maryland legislature began considering a prescription drug monitoring program that would help with the identification of “doctor-shoppers.”*

## **Oregon Pain Management Commission Offers Practitioner Education**

The mission of the Oregon Pain Management Commission is to improve pain management in the State of Oregon through education, development of pain management recommendations, development of a multi-discipline pain management practice program for providers, research, policy analysis and model projects. The Commission shall represent the concerns of patients in Oregon on issues of pain management to the Governor and the Legislative Assembly. The Commission shall develop a pain management education program curriculum and update it biennially. The Commission shall provide health professional regulatory boards and other health boards, committees or task forces with the curriculum and work with health professional regulatory boards and other health boards, committees or task forces to develop approved pain management education programs as required.

As directed by ORS 409.560 and 409.565, the Pain Management Commission provides one (1) hour of Oregon specific training required for certain licensed health care professionals. Completion of an online Pain Management Module fulfills this requirement.

*For more information, see:*

<http://www.oregon.gov/OHA/OHPR/PMC/index.shtml/index.shtml>

## **BOARD AUDIT**

### **Los Angeles Times Blasts California Regulatory System**

In the first of what will be a series of articles, *Los Angeles Times*’ Michael Hiltzik appeals to the Medical Board of California in the May 4, 2011, edition to “go public about the decimation of its enforcement capabilities.” Calling the medical board a “failed regulator,” Hiltzik wrote:

In 2009, the last year for which these statistics were compiled by the Washington consumer group Public Citizen, California ranked 41st, down from 22nd in 2004 – one of the worst plunges in rank of any state in the union. (See <http://www.citizen.org/documents/1905.pdf>).

Hiltzik cites the board’s own statistics that on average it takes more than 400 days to complete an investigation of a complaint and another year to complete a disciplinary proceeding. In the meantime, the doctor continues to practice – potentially exposing patients to harm. Moreover, the number of cases referred to investigation declined from 1,443 in 2004-05 to 1,123 in 2008-09.

In addition to disciplinary case backlogs, the board is taking on a new responsibility: regulation of more than 700 physician-owned outpatient clinics, which used to be the responsibility of the Department of Public Health. The board has chosen to outsource this responsibility to four independent accreditation organizations who, Hiltzik points out, have none of the legal enforcement authority enjoyed by the board.

According to the *Los Angeles Times* article, the Medical Board of California (MBC) has two vacant positions and it is “pitifully

understaffed, and has been for years.” There are currently 12% of its allocated staff positions are vacant. “What’s worse,” writes Hiltzik,

...in 2008, Schwarzenegger raided the board's bank account, money that's supposed to be used to enforce health and safety laws, by "borrowing" \$6 million from the agency to balance the state budget. It hasn't been paid back, according to the California Medical Assn., which sued the governor in state court to overturn the loan (and lost). Gov. Jerry Brown, knowing a good thing when he sees it, is proposing to "borrow" another \$9 million.

Like most medical boards, the MBC's funds come from licensure fees, not the state's general fund.

Distinguishing himself from other investigative reporters, Hiltzik makes a novel appeal to members of the board to publicize this plight and demand more resources – confronting the opposition of the California Medical Association. The reporter suggested to the current board chair, Barbara Yaroslavsky, that she make a public plea for more resources. She replied that she had spoken to a responsible legislator, but balked at the idea that an individual board member would act independently of the board.

“But why not?” asks Hiltzik. “What would it cost the board members to take a public stand against the frittering away of their regulatory resources? They're unpaid, after all. By the way, there can't be many members of appointed state regulatory bodies with as much political juice as Barbara Yaroslavsky. The longest-serving member of the board, she's a prominent Los Angeles community activist whose husband, Zev, is a Los Angeles County supervisor widely considered a front-runner to become Los Angeles mayor next year.

One speech by Yaroslavsky, one threat to resign over fiscal raids on the board, and she'd get a lot more public attention than with a thousand unpublicized meetings with the legislative leadership.”

***Editorial Note: Please let us know what you think of the recommendation that board members should take a public stand about the governor appropriating their operating funds, and other barriers to doing their jobs.***

***Do you agree with the board chair that it is inappropriate for board members to speak unilaterally, or to criticize the administration of which they are a part? Or, do you agree that the situation facing the Medical Board of California is of the kind that warrants making a public statement?***

***Michael Hiltzik's article can be found at: <http://www.latimes.com/health/la-fi-hiltzik-20110504,0,1050646.column>.***

***In a follow-up article on May 8, 2011, Hiltzik decries the division of authority over doctors and outpatient clinics whereby the medical board outsources inspection of clinics to independent accreditation organizations.***

## **LICENSURE**

### **FSBPT Settles Suit over Exam Cheating**

***Editorial Note: Readers will recall that CAC News & Views gave Spotlight recognition to the Federation of State Boards of Physical Therapy (FSBPT) for taking decisive action when it discovered test security irregularities associated with schools in the Philippines.***

***The following article from the May 2011 issue of FSBPT's online federation News Briefs explains that a lawsuit filed against FSBPT by disgruntled candidates has been***

*settled. (See <http://clients.criticalimpact.com/newsletter/newslettercontentshow1.cfm?contentid=5029&id=709>).*

### **FSBPT resolves dispute with three Philippines-educated Georgia licensure candidates**

On May 6, 2011, FSBPT finalized a settlement agreement with three Philippines-educated candidates for licensure in Georgia and the American Association of International Healthcare Recruitment (“AAIHR”). The settlement brings to an end a lawsuit filed by the three candidates (funded by the AAIHR) on November 2, 2010 in the Superior Court of Fulton County Georgia against the FSBPT and the Georgia State Board of Physical Therapy (“Georgia Board”). *Dakanay v. Georgia State Board of Physical Therapy*, No. 2010 CV 192875. That lawsuit challenged the implementation of the FSBPT’s decision to require candidates educated in the Philippines, Egypt, India and Pakistan to take the NPTE-i form of the National Physical Therapy Examination (“NPTE”).

As a result of the May 6 settlement agreement, the Plaintiffs have agreed to dismiss the remainder of their lawsuit (Counts III through VI) with prejudice, including their claims of breach of contract and alleged violations of their due process and equal protection rights under the Georgia constitution. In exchange, FSBPT has agreed to dismiss its pending appeal of the state court’s February 9 ruling with respect to Counts I and II of the lawsuit.

The injunction prohibiting enforcement of the NPTE-i requirement will remain in force in Georgia. The NPTE-i is currently a requirement in all other

jurisdictions for graduates of affected programs. As previously announced, however, FSBPT will begin fixed-date PT NPTE testing for all candidates from all programs, and in all jurisdictions, on July 1, 2011. As a result of FSBPT’s conversion to fixed-date testing, the NPTE-i form of the NPTE will not be a requirement in any jurisdiction as of July 1.

## **DISCIPLINE**

### **Public Citizen Issues Annual Report**

On May 12, 2011, Public Citizen announced the release of its annual ranking of medical boards:

#### **Most States Do Not Protect Patients from Substandard Physicians, Public Citizen’s Annual State Medical Board Ranking Finds**

#### ***Minnesota Is Overall Worst While Louisiana Is Best; Rates of Disciplining Doctors Decline Slightly Over Last Year***

WASHINGTON, D.C. – Most states, including one of the largest – Florida – are not living up to their obligations to protect patients from doctors who are practicing substandard medicine, according to Public Citizen’s annual ranking of state medical boards, released today. (See <http://www.citizen.org/ranking-of-state-medical-boards-serious-disciplinary-actions-2008-2010>).

Public Citizen’s analysis found that the rate at which doctors are disciplined by state medical boards has declined significantly over the past 10 years, and some of the worst states have been consistently poor performers. Nationally, in 2010 state medical boards took 2.97 serious actions per 1,000 physicians – down 3 percent from last year and 20

percent from the peak rate of discipline in 2004 of 3.72 per 1,000 physicians. Had the national rate of doctor discipline remained at the 2004 peak rate, there would have been 745 additional serious disciplinary actions in 2010 against U.S. physicians compared to the number actually taken.

Minnesota was the worst state when it came to disciplining doctors and, along with South Carolina and Wisconsin, has consistently been among the bottom 10 states for each of the past eight rankings. Connecticut has been in the bottom 10 for each of the past five rankings. For the third time in a row, Florida – one of the largest states in the country – is among the 10 states with the lowest rates of serious disciplinary actions. And for the first time ever, Utah joined the ranks of the worst-performing state medical boards, with a rate of 2.15 serious actions taken per 1,000 physicians.

The worst states, in order, are Minnesota, South Carolina, Wisconsin, Connecticut, Massachusetts, Rhode Island, Florida, New Hampshire, Utah and Vermont. The states whose rank has declined the most since their peak rate are Vermont (8 to 42), Utah (10 to 43), Massachusetts (23 to 47), Montana (8 to 32) and Georgia (15 to 40).

Louisiana was the best state when it came to disciplining doctors, taking 5.98 serious actions per 1,000 physicians. Five states – Alaska, Arizona, Colorado, Ohio and Oklahoma – have been in the top 10 for all eight rankings. Only one of the nation's 15 most populous states, Ohio, is represented among those 10 states with the highest disciplinary rates. Other states in the top 10 are Wyoming, North Dakota, New Mexico and Nebraska.

The best states when it comes to doctor discipline, in order, are Louisiana, Alaska, Ohio, Oklahoma, Wyoming, North Dakota, New Mexico, Arizona, Nebraska and Colorado. The states whose rank has improved the most since their lowest rate are Hawaii (51 to 11), Delaware (50 to 13), Maine (46 to 19), North Carolina (41 to 16), Washington (42 to 18) and Arkansas (45 to 23).

“One reason for medical boards’ declining rate of discipline is likely tighter state budgets,” said Dr. Sidney Wolfe, director of Public Citizen’s Health Research Group. “The ability of certain states to rapidly increase or decrease their rankings, even when calculated based on three-year averages, can only be due to changes in practices at the board level. The prevalence of physicians eligible for discipline cannot possibly change so rapidly.”

“There is, unfortunately, considerable evidence that most boards are inadequately disciplining physicians,” Wolfe said. “Action must be taken, legislatively and through public pressure on medical boards themselves, to increase the amount of discipline, and thus, the amount of patient protection.”

The annual rankings are based on data from the Federation of State Medical Boards, specifically on the number of serious disciplinary actions taken against doctors in 2008-2010. Public Citizen calculated the rate of serious disciplinary actions (revocations, surrenders, suspensions and probation/restrictions) per 1,000 doctors in each state for each of these three years, and then averaged the rates over the past three years to establish the state’s rank.

Boards are likely to do a better job disciplining physicians if most, if not all, of the following conditions exist:

- They receive adequate funding (all money from license fees going to fund board activities instead of going into the state treasury for general purposes);
- They have adequate staffing;
- They engage in proactive investigations, rather than only reacting to complaints;
- They use all available/reliable data from other sources such as Medicare and Medicaid sanctions, hospital sanctions and malpractice payouts;
- They have excellent leadership;
- They have independence from state medical societies;
- They are independent from other parts of the state government; and
- A reasonable legal framework exists for disciplining doctors (the “preponderance of the evidence” rather than “beyond reasonable doubt” or “clear and convincing evidence” as the legal standard for discipline).

*For more information, see [www.citizen.org](http://www.citizen.org).*

## IN THE COURTS

### Pharmacy Board Sued for Civil Rights Violations

The Supreme Court of Washington ruled in November 2010 that a civil rights suit against the state’s pharmacy board and its investigators could go forward. As reported in the April 2011 *Professional Licensing Report* (<http://www.plrnet.org/>):

Citing a large variance in scores for a single pharmacy and a lack of detailed inspection records, the Supreme Court of

Washington in November allowed a pharmacist whose license had been suspended in an emergency proceeding by the State Board of Pharmacy to continue with a civil rights suit against board inspectors (Michael S. Jones v. The State of Washington, et al).

The ruling reversed a lower court that had granted the board a summary dismissal of all of the claims brought by pharmacist Michael Jones in response to an emergency board action to shut down Jones's pharmacy, an action that resulted in the loss of the business and a five-year suspension of Jones's license.

The case began in December of 1998, when board Inspector Phyllis Wene gave Jones's pharmacy a score of 79 out of 100, an unsatisfactory total that subjects a pharmacy to discipline if not upgraded to 90 or better at the next inspection. By the time of Wene's second inspection in February of 1999, Jones had apparently pulled things together and scored a 94.

The events leading to the lawsuit occurred during two later inspections in July and August of 1999. Wene and fellow inspector Stan Jeppesen gave the pharmacy a terrible score, a 48, during an inspection which Jones described as excessively antagonistic, saying "Jeppesen yelled at me and banged his hands on the pharmacy counter while Jones was working, and "Wene and Jeppesen stood on either side of me and made repeated demands in rapid-fire succession."

More information is available at:

[http://www.wasupremecourtblog.com/uploads/file/807876\\_opn.pdf](http://www.wasupremecourtblog.com/uploads/file/807876_opn.pdf).

### Surgeon Settles Dispute with Hospital

Brain surgeon Dr. Hrayr Shahinian and Cedars-Sinai Medical Center have been

engaged in a long-standing dispute, with the doctor accusing the hospital of unsafe clinical practices and attempting to ruin his career in retaliation. In May, 2011, the California Court of Appeals ruled in favor of Shahinian by upholding a multi-million dollar lower court verdict against the hospital.

In his original suit, Shahinian alleged that the hospital failed to properly sterilize surgical instruments, pressured him to unnecessarily extend overnight stays to increase revenue, encouraged referrals to hospital staff physicians even when not qualified, and withheld information from officials investigating these allegations.

The hospital restricted Shahinian's privileges and terminated his position on the medical faculty. In a separate matter, the doctor is faced with an \$800,600.00 malpractice lawsuit alleging that he performed inappropriate surgery and altered pathology reports to conceal that he had failed to remove a tumor during the surgery.

For more information on these lawsuits, see: <http://www.businesswire.com/news/home/20110516005067/en> and <http://articles.latimes.com/2010/apr/09/local/la-me-malpractice9-2010apr09>.

## **Medical Group Petitions to Protect Licensure Funds**

On May 16, 2011, the California Medical Association announced that it had petitioned the California Supreme Court to prevent officials from raiding medical board funds:

The California Medical Association (CMA) has petitioned the California Supreme Court to review an appellate court decision concerning the boundaries of the state's authority to borrow from special funds. The petition argues that the state has unlawfully misappropriated

physician fees from the Medical Board of California, earmarked for processing physician licensing applications and enforcement activities.

"CMA is a vigilant advocate on behalf of patients and physicians to ensure that these funds are spent to protect patients and properly regulate the profession and no organization in the state has spent more time or funds fighting to ensure the medical board has the resources it needs to achieve its critical mission," said James Hinsdale, M.D., president of CMA.

"Physicians and the public depend upon this important regulatory function and the state cannot continue to solve the budget deficit with fees that physicians pay to support licensing and disciplinary actions," Hinsdale stated. "There are already nearly \$2.65 billion in outstanding special fund loans and the budget act of 2011-2012 includes about \$2.5 billion in more loans. When will it stop?"

CMA's petition challenges a 2008 loan of \$6 million in physician license fees taken from the medical board. Under the Medical Practice Act, physician fees may not be transferred to the state's general fund and can be used only by the medical board and only to regulate the practice of medicine. These statutory requirements are designed to ensure that the medical board can operate effectively in licensing physicians and protecting patients.

In 2009 CMA filed a lawsuit to end furloughs for medical board staff, stressing that the medical board must have the resources to alleviate the backlog of physician license applications and perform other important work affecting the quality and accessibility of

medical care. The state intends to borrow another \$9 million from the medical board for the next fiscal year and physicians are concerned about the impact of that loan.

"As long as these fees continue to be diverted by Sacramento elected officials for the purpose of plugging California's perennial budget hole, we will be repeatedly refilling a gas tank with a massive leak—then wondering why the car isn't running. Taking more funds from the Medical Board of California harms all Californians," Hinsdale added.

## IN DEPTH

### Use Credentialing to Enhance Patient Safety

*Editorial Note: This quarter's In-Depth Feature consists of excerpts from an article that appeared in the online publication Open Medicine. The article was written by three officials at Ottawa Hospital, and a medical student at the University of Alberta: (FORSTER, A., TURNBULL, J., MCGUIRE, S., HO, M., WORTHINGTON, JR, Improving patient safety and physician accountability using the hospital credentialing process. Open Medicine, North America, 5 May. 2011. Available at: <http://www.openmedicine.ca/article/view/410/403>. Date accessed: 23 May. 2011.)*

*The article describes a hospital-wide approach being implemented at the Ottawa Hospital to improve physician oversight. The authors write that:*

Our program could be extended to non-hospital physicians through regional health or provider networks. **Central licensing authorities could help to coordinate these programs on a province – or state-wide basis to ensure**

**uniformity of standards and to avoid duplication of efforts.** (Emphasis added.)

*CAC has previously encouraged licensing boards and hospitals to collaborate in pursuit of enhanced patient safety and quality of care through its PreP 4 Patient Safety (Practitioner Remediation and Enhancement Partnership) program. We are pleased to see the seeds of a similar collaboration possibly taking root in Ontario, a Province already known for its innovative approach to professional scopes of practice.*

*Canadian spelling and syntax are unchanged.*

On 12 Nov. 2005 nurse Lori Dupont was stabbed to death in Windsor, Ontario, by Dr. Marc Daniel as she left the hospital where they both worked. Dr. Daniel subsequently took his own life. A coroner's inquest identified many unheeded warning signs: Dr. Daniel had been the subject of numerous complaints to the hospital regarding serious inappropriate behaviour and he was known to have a severe mental disorder, putting him at risk of harming himself and others.

While this case is particularly stark, there are several other high-profile examples of physicians who continued to practise medicine despite a long history of inappropriate behaviour or a reasonable suspicion of incapacity or incompetence. We believe that these cases exemplify an opportunity for the medical profession to improve its willingness and capacity to oversee its performance.

We describe a novel approach for physician oversight currently being implemented at The Ottawa Hospital. In our model, medical staff are responsible for leading the process and for supporting the activities necessary to make it a success. Physicians are delegated the

critical task of determining whether performance-based criteria are met and whether maintenance-of-competence activities are appropriate. Our model is fair and transparent and provides many benefits to the public, physicians and hospital administrators. It is built on quality improvement principles and acknowledges that most physicians perform at a high standard and that only a small minority cause problems. Physicians in the latter group, however, give rise to considerable litigation costs and pose an unacceptable risk to their patients and co-workers. Furthermore, managing this group diverts attention from the real goal of the organization, which is to improve the quality of care offered by all providers...

We designed our model with several principles in mind. First, we wanted to support the vast majority of physicians who are functioning at a high level. Thus, we have made the program formative rather than punitive. Second, we wanted to ensure a high level of physician accountability. Thus, physicians will be responsible for clinical performance assessments and for setting related targets, rewards and remedial actions. Third, we wished there to be real consequences for physicians who do not comply with the program. Thus, we have established explicit, defensible processes.

### **The problem**

...(I)t is estimated that preventable adverse events lead to between 9250 and 23,750 deaths in Canada annually. In addition, significant numbers of patients experience increased pain or decreased functional ability as a result of preventable adverse events.

It would be wrong to attribute these preventable adverse events solely to inadequate physician oversight. In most instances, these events are the result of

systemic problems, including communication and technology infrastructures that are inadequate to support care processes, inadequate training, and insufficient resources. Even injuries resulting from provider error are usually the result of predisposing system factors (also termed latent factors) that make error all but inevitable.

A perceived lack of effective oversight process reinforces the impression that physicians are part of the problem. At times, there are valid concerns about professional behaviour and communication problems, which can be brought to the attention of hospital administrators or regulatory bodies. However, the management of these complaints can be adversarial, protracted and poorly coordinated. This can leave complainants with the impression that the organization and the profession are self-protectively concealing facts. In addition, the absence of a transparent process for sanctioning physicians makes it difficult for the profession and for administrators to respond to complaints in a fair, consistent and defensible manner.

At other times, there may be concerns that a particular physician is practising outside his or her scope of practice, that his or her outcomes are worse than those of peers or that he or she may not be keeping current with evolving professional standards. There are often few data to validate or disprove such concerns. Even when there are data, they are usually not collected systematically in a scientifically sound manner.

Another problem is the reactive nature of the current oversight system. As there are relatively few formal methods for practice review, and because proactive, constructive feedback is not routinely available, physicians are left to decide for themselves when they

need to adopt changes in their practice and may realize this need only when there is a complaint.

### **Current approaches to practitioner oversight**

Once physicians leave their training environment, there are few structured programs to monitor their capacity and performance... Incremental changes in some jurisdictions have been designed to improve the system. For example, there are peer review programs directed toward randomly selected or high-risk physicians in some jurisdictions. There are also initiatives in several Canadian provinces to enhance participation in continuing medical education and link it to the annual licence review process. Finally, one jurisdiction in Canada requires a “360°” review on a regular basis, in which colleagues, other health professionals—including subordinates—and patients answer standardized questions pertaining to a physician’s character and behaviour.

Although these efforts are moving the system in the right direction, we believe they do not go far enough. Credit for participating in continuing medical education activities typically recognizes the act of taking part in the education program, not the content studied or the actual uptake of learning into practice. Furthermore, communication between the education program providers and the provincial regulators is not always ensured.

More importantly, the majority of practitioners function in private settings where there are few opportunities for meaningful peer assessments and timely, constructive feedback. Ideally, communities of practice could support ongoing learning, especially in the context of maladaptive behaviour.

An opportunity to regulate physicians more closely exists within hospitals, where there is a legislated requirement for physicians to

obtain privileges annually... Unfortunately, the current system of credentialing physicians within hospitals is largely administrative, despite efforts to enhance the system through the development of accreditation standards... By combining some existing strategies with other components such as complaints and physician behaviour, we believe we can significantly improve the effectiveness of credentialing programs.

### **A proposal to improve hospital credentialing programs**

Our program consists of four components: a system to monitor clinical performance, a system to monitor professional behaviour, a complaints management system and a system to manage administrative requirements. All four systems will be managed by the medical leadership. Active engagement by physicians and their leaders is essential...

**Monitoring clinical performance.** The first component of our program involves assessing whether physicians are providing the best possible care... Our program specifies two broad areas in which it is to be assessed: scope of practice and performance.

*Scope of practice* refers to the tasks and procedures a physician is capable of performing safely and effectively. We consider scope of practice to include procedures, such as surgeries, and cognitive tasks, such as patient assessments and prescribing. Physicians must be able to prove that they have had training appropriate to qualify them to perform a particular procedure or task.

The term *performance* refers to whether physicians are meeting a standard of care consistent with those of their peers... Measurement is a major challenge in performance assessment. In general, performance can be measured explicitly by assessing pre-specified outcomes within particular diagnostic groups or by assessing compliance with evidence-based treatment

guidelines. This approach can be inexpensive and is relatively straightforward...

Alternatively, performance can be measured implicitly by peer review: the reviewer rates whether overall care quality met the standard of care. This method is also easily performed but can be expensive, as it requires physicians to act as peer reviewers. Both methods of assessment are well supported by evidence, assuming that appropriate case-selection methodologies are used to identify charts for review and assessors use appropriate rigour while performing the chart review. Our model uses both the explicit and implicit approaches...

**Monitoring professional behaviour.** The second component of our program is a system to monitor professionalism. Professionalism encompasses a wide range of behaviours and thus is challenging to measure. For simplicity, we have focused on two domains of behaviour: maintenance of competence and interpersonal relationships.

Well-established lifelong learning programs exist to monitor participation in maintenance-of-competence activities. These have been instituted at a national level in many countries. We feel that local activities should be harmonized with national standards to increase adherence and, more importantly, to create real consequences for physicians—namely, the loss of hospital privileges—if they do not comply.

We recommend that the responsibility for monitoring maintenance-of-competence activities be left at the divisional level as long as the activities are part of an accredited program. This ensures that learning activities appropriate for the particular physician group will be selected, and peer pressure will help to create and sustain interest in the learning activities.

We also feel that interpersonal relationships can be assessed relatively simply. We recommend using a 360° approach in which

several patients, and fellow providers, are asked to provide input using a standardized and validated question set... Part of the question set would evaluate a physician's adherence to the standards of conduct. This is particularly important because many interpersonal problems and complaints arise from a physician's failure to show respect or to consider the patient's interests first...

**Complaints management system.** The third component of our program is a system for managing complaints. Although this component is the most reactive and least constructive aspect of our program, we feel it is important for maintaining accountability. It also has the potential to capture aspects of physician performance and behaviour that are missed with other components of the program. Furthermore, the systematic use of patient complaints is an excellent engine to drive improvements in quality of care.

We have modelled our complaints management system on one built at Vanderbilt University. This system standardizes the processes for complaint intake, complaint triage (to distinguish between important and frivolous complaints), investigation, and communication.

At our hospital, managing the complaints management system is predominantly the responsibility of the patient relations department. We feel it is important, for two reasons, that the physician leadership not be responsible for managing complaints. First, there is an inherent conflict of interest in investigating one's peers, which might limit or cast doubt on objectivity. Second, there is a need to create a standard process across the entire organization. The role of the physician leadership in this system is to reach agreement on corrective action with the physician involved in the complaint and to monitor improvements. Optimal functioning of a hospital's complaints management system therefore requires a joint effort by the

physician leadership and the patient relations staff.

**System for managing administrative requirements.** The final component of our program is a system for managing administrative tasks. It includes two main tasks: the administration of the overall credentialing program, and the administrative collection of documents required to prove that practitioners are qualified. These tasks are managed entirely with hospital resources...

**What are the barriers to implementing this credentialing system?**

The comprehensive credentialing system we have described will require significant financial resources and a trusting and constructive relationship between physicians and hospital management. It is critical that the governance of the system be clearly described so that stakeholders will trust the program and participate fully. The roles and responsibilities of each member of the administrative staff and medical leadership in the credentialing program must be articulated. The assessment methods and complaints management processes must be communicated, so that all who are affected fully understand the processes and recognize their responsibilities. Finally, all involved must make an unwavering commitment to work collaboratively and to follow the program processes to improve care quality...

The credentialing program must be coordinated with the existing processes of the provincial or state organizations responsible for licensure. There is a concern that physicians will not understand the relationship between these processes or that there could be duplication of effort. It is also possible that conflicting recommendations could arise. We feel that these risks can be managed and that they are outweighed by the benefits arising from local administration of the credentialing program.

A final absolute requirement for our credentialing program is clinical leadership and engagement. Clinicians need to be responsible for the credentialing process, as only clinicians can judge the technical proficiency of other physicians.

**Expected benefits and limitations**

Our approach has five main benefits. First, the system will identify physicians who are having difficulties much earlier than the current system. Although continuous monitoring may identify problems even faster, we believe an annual performance assessment balances effectiveness with practicality. Second, our program provides a greater capacity for the institution and its physicians to learn about quality problems and thereby improve hospital care. Because physicians will be accountable for performance, there will also be a greater incentive for them to participate in the development of systems solutions to improve care delivery. Third, it will be easier for hospital administrators and clinical leaders to take action against physicians who repeatedly perform poorly and do not respond to feedback. Fourth, our system might provide protection against litigation by sanctioned physicians because it is more explicit, objective, consistent, fair and transparent than the current system. Finally, and perhaps most importantly, public trust in our health care institutions will improve.

Our proposal has at least three limitations. First, not all physicians are affiliated with hospitals large enough to implement such a program. Ambulatory care physicians and physicians working in smaller hospitals require as much oversight as those in large hospitals—and perhaps more, given they are often quite isolated from their peers. However, we argue that it may be possible to adapt the processes developed in large hospitals to other settings, such as regional health authorities or health networks of providers or hospitals.

A second limitation of our approach is that it does not specifically address physician health. Other industries or professions regularly evaluate physical and mental health as part of assessments of worker fitness. We believe such regular evaluations should be incorporated into credentialing systems once they are established. Although the program at our hospital does not directly evaluate physician health, we believe that it will nevertheless identify cases in which significant health issues are affecting a physician's performance...

A third potential limitation of our approach is the paucity of valid measures for clinical performance and professional behaviour. Physicians should design the indicators and monitor data collection. They should agree to be measured by the methods that will be used. This will increase the likelihood that they will accept the results of the evaluation and be willing to act on them.

### **Conclusion**

The current credentialing system for physicians is highly administrative and is

mostly reactive in its interventions. We believe this results in a lack of systematic oversight of physician performance, which is a serious quality gap in our health care system.

The program we have proposed for oversight of physician credentialing is systematic, comprehensive, proactive, transparent, objective and practical. In the long term, it is designed to help physicians across the performance spectrum: the goal is not to oust problematic physicians, but to help them address their weaknesses. We acknowledge that this system will require significant financial and human resources, changes in governance and increased collaboration between hospital leaders and physician leaders. We also recognize that our model has certain limitations. Nevertheless, we believe a process such as the one we propose is necessary to bridge the quality gap that currently exists and to help fulfill physicians' fiduciary obligation to ensure the highest standard of professional conduct and care by all practitioners.

**SAVE THE DATES:** Our annual meeting "**Achieving Regulatory Excellence – Effective Discipline Programs**" will be held on **Thursday, October 20, 2011**, and **Friday, October 21, 2011**, at our offices in Washington, DC. You may download a **Preliminary Program and Registration Form** or register online at <http://www.cacenter.org/cac/meetings>.

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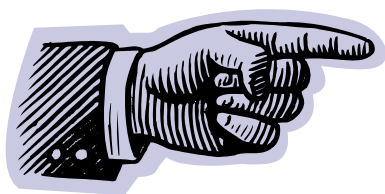
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