News & Views

Citizen Advocacy Center

Second Quarter, 2012 A Health Care Public Policy Forum Volume 24 Number 2

ANNOUNCEMENTS

On Wednesday, Thursday and Friday, October 24, 25 and 26, 2012, CAC will hold its 2012 annual meeting in Seminole, Florida. *Seminole is on Florida's Gold Coast, near St. Pete Beach. The Wednesday meeting will be a training day for recently appointed board members. Please visit www.cacenter.org in early July for more details and registration materials.*

CAC is now a membership organization *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership.*

Although we encourage you to receive our newsletter by becoming a CAC member, ***you may still subscribe to our newsletter without becoming a member.*** *More information is at http://www.cacenter.org/view/newsletter.*

CONSUMER INFORMATION

Changes to Missouri Medical Practice Act Give Consumers More Information

According to legislation that became effective in September 2011, the Missouri Board of Professional Registration for the Health Arts now makes more information about licensees available online. The new disclosures include information about licensees' education, specialty certification, disciplinary history, and practice restrictions.

The legislation also empowers the board to conduct its own hearings into allegations of incompetence, mental illness or substance abuse. Previously, a

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state administrative hearing commission, not the board, was first to act on such cases.

More information about the changes to the practice act can be found at:

http://pr.mo.gov/boards/healingarts/Practice%20 Act%20Changes.pdf.

Advocates Seek More Transparency and Process Reform from Joint Commission

Patient advocacy groups including Consumers Union, Health Watch USA, and individual physicians wrote to Senator Tom Harkin (D-IA) seeking a change in the Social Security Law that would allow the Joint Commission to publicly disclose all of its hospital accreditation survey findings. A second letter to the Joint Commission's President, Mark Chassin, MD, asked for amendments to the Commission's complaint process to achieve a "compassionate, open, honest disclosure and transparency throughout the complaint process."

The advocates content that accreditors of healthcare facilities should be subject to the federal Freedom of Information Act as a condition of their having authority to conduct accreditation surveys and complaint investigations. In some states, hospitals can opt to be accredited by a state agency, whose reports are available to the public, creating a double standard, according to the letter to Senator Harkin.

The letter to President Chassin identifies 11 steps the Commission should take to improve its complaint process. These include:

- A consumer-friendly link on the commission's homepage for filing patient complaints;
- Procedures for keeping complainants fully informed during the investigation and resolution of their complaints;
- A defined time frame for investigating complaints;
- Disclosure to complainants of any illegal activity or falsification of medical records uncovered during the complaint investigation;

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- Allowing complainants to remain anonymous and to provide feedback after the investigation is completed;
- A commitment to continuous improvement in the patient complaint process;
- Consideration of including aggregate data about complaints in the Commission's annual report.

For more information, see: http://www.healthleadersmedia.com/content/HEP-271207/Groups-Call-for-Transparency-in-Hospital-Accreditation-Survey-Findings and http://www.healthcarefinancenews.com/news/patient-advocates-seek-public-access-hospital-accreditation-surveys.

Blog Advising How to Complain Directs Consumers to AMA

An article in *The Business Insider* posted November 15, 2011, on *Newstex Web Blogs* advises consumers "How to Complain About Your Jerk of a Doctor." The article suggests patients first approach the doctor in question and then a colleague in the practice to air their grievance or question. The third piece of advice is:

> Contact your state medical society or licensing board. Visit the American Medical Association's website to find yours. They'll give you instructions on how to file a grievance in your state, then perhaps weight in on whether or not you have a case. According to Sharon Tanenbaum in Real Simple, filing a formal complaint online or by mail sends it directly to the medical board, who then reviews it.

Editorial Note: This kind of advice is likely to compound the already prevalent confusion between medical societies and licensing boards. A visit to the American Medical Association Web site reveals no link to licensing boards – at least on the home page. Also, it is questionable to refer consumers to their local medical society for advice about whether they have a complaint worthy of consideration by the state licensing board.

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Study Looks At Availability of Data on Board Web Sites

A study by Denise E. Strong of the University of New Orleans, published in the Journal of Health and Human Services Administration in the spring of 2011, analyzes the availability of disciplinary data on the Web sites of boards of medicine, nursing and dentistry. Entitled, Access to enforcement and disciplinary data: information practices of state health professional regulatory boards of dentistry, medicine and nursing: The study explored the current state of transparency by specifically examining the availability of disciplinary data on the websites of state boards of medicine, nursing and dentistry. Web sites were reviewed regarding availability of enforcement and disciplinary data on the aforementioned state boards in each of the 50 states and the District of Columbia. The study found that there is more information about individual practitioners available from the boards than ever before. On the other hand, there has not been a comparable increase in information about the administrative practices and the work of the boards. Increased availability of this information would allow public administration and policy researchers to develop performance indicators of state boards and assist in improving policy decisions and allocation of resources.

The study found that there is more information about individual practitioners available from the boards than ever before.

The study can be found at
http://www.ncbi.nlm.nih.gov/pubmed/21485614.

SCOPE OF PRACTICE

American Academy of Ophthalmology Fights Optometry Scope Expansions

Editorial Note: The following editorial is reprinted from the American Academy of Ophthalmology Web site:

The Surgical Scope Fund:
Have You Stepped Up to the Plate?
By Richard P. Mills, MD, MPH

Quite a number of us claim to be apolitical. Does this include you? I can attest that the apolitical ophthalmologists I know are talented and respected clinicians. How can they hold this view in spite of obvious evidence that legislatures and regulatory bodies have restricted our ability to deliver quality care? Some say they have been burned by political involvement. Some prefer to avoid conflict, on general principle. Some admit to being unwittingly apathetic, too busy with patient care to react to political events. Whatever the reason, most justify their position by saying that they provide excellent patient care,

have neither the time nor the inclination to become politically involved and prefer to leave advocacy to those who are "better at it."

If this describes you, let me first assure you that I respect your position. I understand that no amount of ranting and raving will change your views. But I know that you are feeling guilty. Yes, beneath the veneer of being apolitical often lies a guilt, a kind of unease that patients might be better off individually because of your expert care, but collectively worse off because of your political indifference.

How could patients be hurt by political inaction? When legislatures authorize surgery by other than fully trained surgeons, the patients will suffer. Has it happened? Yes, in Oklahoma, where optometrists may perform surgical procedures as defined by the optometry board, at its sole discretion. Can Oklahoma's OD intrusion into medicine be stopped? Can other states be convinced that Oklahoma's action is an isolated anomaly? Yes to both, but only if we wage expensive political battles on behalf of our patients.

Enter the Surgical Scope Fund, created by the Academy to supplement local funding in states facing imminent threats to quality surgical patient care. In the few years since its inception, it has been remarkably successful. In 14 states, optometric surgery initiatives have been defeated. Other states have received help with regulatory battles. Even if your state is not among those helped so far, you could be next, and the Fund will be there for you in your time of need.

In fact, the Surgical Scope Fund has been an essential component of the "Surgery by Surgeons" campaign that rallied support of the nation's veterans organizations. The result? The VA reversed its directive on laser eye surgery by optometrists.

A donation to the Surgical Scope Fund requires no time out of the office, so even the busiest ophthalmologist can participate. Donations to the fund are not subject to campaign disclosure laws, since the funds are not used for political contributions. Thus, donors and their contribution amounts are not disclosed. So ophthalmologists worried about their referral sources can still advocate for their patients. Corporations may contribute as well, though the donations are not tax-deductible. And finally, for the apolitical, sending a lot of money is a great way to assuage guilt.

For the apolitical, sending a lot of money is a great way to assuage guilt.

See: http://www.drbicuspid.com/index.aspx?sec=sup&sub=hyg&pag=dis&ItemID=309389&wf=33.

New England Journal Article Examines Health Care Labor

An article in the October 13, 2011, edition of the *New England Journal of Medicine* by Robert Kocher, M.D. and Nikhil R. Sahni, B.S asserts that "improving the labor structure in health care can be achieved in three ways: reducing the number of workers, lowering wages, or increasing productivity." The most promising of these three options, they write, is improving productivity:

> If the health care sector is to achieve even the average improvement in productivity seen in the overall U.S. economy, we will need to redesign the care delivery model much more fundamentally to use a different quantity and mix of workers engaging in a much higher value set of activities… A large obstacle to such a wholesale redesign is the complexity of the federal and state reimbursement rules and requirements for scope of practice, licensure, and staffing ratios. One example of the current inflexibility is the requirement that all imaging centers have a physician on hand at all times if intravenous contrast may be administered, owing to the 0.1% probability that a patient will have a severe, life-threatening allergic reaction. Surely, other health care professionals could be trained to respond effectively to such an allergic reaction, which would liberate these physicians to fill higher-productivity roles…

If the health care sector is to achieve even the average improvement in productivity seen in the overall U.S. economy, we will need to redesign the care delivery model.

For more, see: http://www.nejm.org/toc/nejm/365/15.

USA Today Exposes Doctors Practicing Outside Their Specialty

A lengthy article by Jane O'Donnell, first published in *USA Today* on September 14, 2011 described the problem of doctors with questionable qualifications entering the lucrative business of cosmetic surgery, with serious consequences (including disfigurement and death) for their patients. O'Donnell writes that lax regulation of office-based surgeries in Florida make it possible for dentists to perform breast implants, ophthalmologists to perform eye-lifts, OB-GYNs to do tummy-tucks and radiologists to perform liposuction.

In addition to raising public awareness of the significance of specialty certification by one of the boards belonging to the American Board of Medical Specialties, O'Donnell informs readers of one legislator's intention to re-introduce legislation that would subject outpatient surgi-centers to regulation and inspection.

A cosmetic surgeon who trains for the American Academy of Cosmetic Surgery told O'Donnell that physicians should self-regulate and not

practice outside their specialty. On the other hand, he said it's not unreasonable for an OB/GYN to learn to perform tummy-tucks.

The full article can be found at: http://yourlife.usatoday.com/your-look/story/2011-09-13/cosmetic-surgery-investigation/50395494/yourlife.usatoday.com/.

APRNs Have Similar or Better Outcomes than Physician Colleagues

A review of literature published between 1990 and 2008 found that "care provided by APRNs indicates patient outcomes of care provided by nurse practitioners and certified nurse midwives in collaboration with physicians are similar and in some ways better than care provided by physicians alone for the populations and in the settings included."

The authors write that, "The results indicate APRNs provide effective and high-quality patient care, have an important role in improving the quality of patient care in the United States, and cold help to address concerns about whether care provided by APRNs can safely augment the physician supply to support reform efforts aimed at expanding access to care."

The research was published in the September/October issue of *Nursing Economics*. Here is the introduction and abstract:

> Quality, access, and cost of health care are high-priority global concerns. In the United States, these issues are pressing due to the escalating cost of managing chronic diseases (Department of Health and Human Services, 2009), the variation in quality of care delivered (Kuehn, 2009), and the inadequate number of primary care physicians (Freed & Stockman, 2009; Kuehn, 2009; Lakhan & Laird, 2009). At this critical time, we still do not know which models of care are best, how to integrate advanced practice registered nurses (APRN) providers, or to what extent APRN providers can contribute to improved access to and quality of health care. These deficits are untenable when the health care needs of society are great and the health reform debate progresses in legislative arenas. How to expand health care services for the American public, at an affordable cost, is central to this dispute.

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> Advanced practice registered nurses have assumed an increasing role as providers in the health care system, particularly for underserved populations. APRNs complete specialty-specific graduate programs that include education, training, and practice experience needed to complete a national board certification examination before entry into practice. Nurses practicing in APRN roles include nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives

(CNMs), and certified registered nurse anesthetists (CRNAs). Several systematic reviews have assessed what is known about NP practice (Brown & Grimes, 1995; Horrocks, Anderson, & Salisbury, 2002; Laurant et al., 2005; Sox, 1979). Similar or better outcomes are found for patient satisfaction (Brown & Grimes, 1995; Horrocks et al., 2002; Laurant et al., 2005; Sox, 1979), patient health status (Horrocks et al., 2002; Laurant et al., 2005), functional status (Brown & Grimes, 1995), and the use of the emergency department (Brown & Grimes, 1995; Laurant et al., 2005). A Cochrane review indicated midwifery care outside the United States was associated with a reduced risk of losing a baby before 24 weeks, a reduced use of regional analgesia, fewer episiotomies or instrumental births, increased chance of a spontaneous vaginal birth, and increased initiation of breastfeeding (Hatem, Sandall, Devane, Soltani, & Gates, 2008). No systematic reviews of CNS or CRNA outcomes have been published.

Although these reviews provide some information about the effects of APRNs on specific outcomes, an updated comprehensive review of the scientific literature on the care provided by APRNs in the United States is needed to inform educational, public, and organizational policy. This review is the most current and complete assessment of the comparability of APRNs to other providers, strengthening and extending the conclusions drawn from previous reviews by including evidence from over a span of 18 years on all types of APRNs and all outcomes, patient populations, and settings.

This systematic review compared the processes and outcomes of care delivered by APRNs to a comparison provider group, most often physicians. The intent was to consider the broad range of studies and outcome measures across these groups using a systematic, transparent, and reproducible review process.

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Aim. The aim of this systematic review was to answer the following question: Compared to other providers (physicians or teams without APRNs), are APRN patient outcomes of care similar?

The complete article is available online by registering at www.medscape.com and going to www.medscape.com/viewarticle/751807.

Physician Assistants under New Regulation in Oregon

Oregon Senate Bill 224, which became effective in June 2011, modifies certain provisions relating to regulation of physician assistants. The legislation requires physician assistants to enter into a practice agreement with a supervising physician that enumerates a number of items related

to the physician assistant's scope of practice. The physician assistant also acknowledges in the agreement that a violation of laws or regulations governing the practice of medicine may subject the physician assistant and supervising physician or supervising physician organization to disciplinary actions.

UK Polls Profession and Public on Scope Expansion for PTs

The Department of Health in collaboration with the Medicines and Healthcare Products Regulatory Agency issued a "Consultation on Proposals" in 2011, which solicited opinions from the profession and the public on several questions related to a proposal to give physiotherapists authority to prescribe and mix medications.

It has already been established that there is a patient need to give physiotherapists prescriptive authority. This consultation was designed to clarify questions having to do with educational preparation and regulatory governance.

The document can be found at: http://www.dh.gov.uk/publications.

Editorial Note: Readers of CAC News & Views are aware that CAC encourages experimentation with evidence-based scope of practice decision-making outside the political arena. We are intrigued by the Consultation on Proposals approach and would like to see it adapted to this country.

Virginia Physicians Support Freer Collaboration with Nurses

Writing in the online *dailypress.com*, Prue Salasky reported on January 12 2012 that the Medical Society of Virginia is willing to embrace a more flexible approach to collaboration with nurse practitioners. The group supports HB 346, which would replace strict supervision with a consultative relationship. It would increase the number of nurse practitioners who can work with a physician from four to six and would remove restrictions on nurse practitioner practice in nursing homes and free clinics.

The Medical Society of Virginia is willing to embrace a more flexible approach to collaboration with nurse practitioners.

In a more restrictive vein, legislation soon to be introduced in the General Assembly will define surgery and limit which professionals can perform it. The definition will be based on one developed by the American College of Surgeons. A spokesperson for the medical society told Salasky that the definition will not create barriers for oral surgeons, podiatrists, physician assistants and nurse practitioners in consultation from performing surgery.

See the article at: http://www.dailypress.com/health/dp-nws-msv-legislation-0113-20120112,0,4685274,print.story.

School Nurses Have Expanding Roles

The following article is reprinted from the December 15 2011 issue of *California Healthline*, a service of the California HealthCare Foundation.

> December 15, 2011 - Topic: Doctors and Nurses
>
> California School Nurses Caring for More Serious Medical Conditions
>
> School nurses in California are caring for more students with serious health conditions, ***HealthyCal*** reports. At the same time, state budget cuts are leading schools to reduce their nursing staffs.
>
> **Details of School Nurses' Challenges**
>
> Advances in the medical field mean that more children with health conditions such as cerebral palsy can attend school. School nurses increasingly offer services that include administering insulin shots and changing urinary catheter bags.
>
> Meanwhile, state budget shortfalls have led to lower funding for schools. Linda Davis-Alldritt, President of the National Association of School Nurses, said schools facing tight budgets often choose to cut nursing staff. California does not have a law mandating that a nurse work at each school, nor does it require a specific nurse-to-student ratio. According to 2009 data from the National Association of School Nurses, the ratio of school nurses to students in California was one to 2,187.

Nurses who are working with students with more serious medical conditions might have less time to care for those with milder conditions that could indicate larger issues such as chronic hunger, child abuse and bullying.

> **Implications**
>
> According to *HealthyCal*, nurses who are working with students with more serious medical conditions might have less time to care for those with milder conditions that could indicate larger issues such as chronic hunger, child abuse and bullying. Patricia Gomes, Health Services Coordinator for the Central Unified School District in Fresno, added that teachers are being asked to treat minor conditions, such as scrapes, in the classroom. Davis-Alldritt said that the National Association of School Nurses is seeking ways to help provide funding for school nurses, such as securing funds from the state or insurance companies (Bookwalter, *HealthyCal*, 12/14).
>
> Read more: http://www.californiahealthline.org/articles/2011/12/15/california-school-nurses-caring-for-more-serious-medical-conditions.aspx?p=1#ixzz1lBHQMjnl

Editorial Note: The Supreme Court of California recently heard arguments in a case involving the question as to whether unlicensed assistive personnel should be authorized to administer insulin shots to school students.

Institute of Medicine Looks at Allied Health

The Institute of Medicine (IOM) held a workshop on the allied health workforce in May 2011. The IOM describes the workshop this way:

The demand for health care is growing as the nation ages and seeks to provide coverage for the millions of Americans who lack health insurance. At the same time, escalating costs have led to a variety of initiatives to make the delivery of health care more effective and efficient. The allied health workforce is critical to the success of these efforts. The allied health workforce includes thousands of professionals employed in many different professions with different job duties and different amounts of education and training, but there is no single definition for *allied health* or list of allied health occupations.

Given the importance of allied health, particularly in light of health care reform, the IOM held a workshop May 9-10, 2011, to examine the current allied health care workforce and consider how it can contribute to improving health care access, quality, and effectiveness. Among other topics, speakers at the workshop examined the following questions:

- What is allied health, and who is part of that workforce?
- What workforce strategies could improve access to select allied health services?
- How can policy makers, state and federal government, and allied health care providers improve the regulations and structure?

A copy of the workshop report can be found at: http://books.nap.edu/openbook.php?record_id=13261.

Center for the Health Professions Issues Two New Workforce Reports

The Center for the Health Professions at the University of California San Francisco has issued new reports about workforce scopes of practice. One describes an experiment with dental professionals in California:

> New workforce models in dentistry are being explored as potential solutions to improving the dental care delivery system for underserved populations. In 1998, California officially recognized a new dental health profession: the Registered Dental Hygienist in Alternative Practice (RDHAP). RDHAPs may practice without the supervision of a dentist in private

New workforce models in dentistry are being explored as potential solutions to improving the dental care delivery system for underserved populations.

homes, schools, residential care facilities and other institutions, and in Dental Health Professional Shortage Areas. However, to gain licensure, RDHAPs are required to have a "dentist of record," on file with the Dental Hygiene Committee of California for use in consultations and in emergencies. The report provides a detailed look at RDHAPs' demographics, education, professional activities, practice data, and issues around professional development and advancement. This study was supported by the Center for Special Care at the Arthur A. Dugoni School of Dentistry, University of the Pacific.

The second report is about medical assistants:

Medical Assistants are the most common clinical support staff in community clinics and the major type of non-licensed personnel found in small and large physician outpatient practices. Medical assisting is one of the fastest growing occupations in the United States with large numbers of annual job openings. As the nation seeks to increase the number of primary care providers and improve access to primary care services, Medical Assistants will be a critical component of that growth and development. However, little published attention has been paid to improving the Medical Assistant occupation from the workforce perspective. Medical Assistants are among the lowest paid health care workers, training is often of uneven quality and the length can range from on-the-job training to an Associate Degree. Job turnover can be high and career development is limited. In our previous research, Medical Assistant focus group participants mentioned low pay and the lack of career development and growth as major reasons for leaving the profession. Several health care practices in the United States have significantly developed the roles of medical assistants. These new models vary, and include expanding the roles of Medical Assistants to serve as health coaches in chronic disease management; training Medical Assistants to conduct care coordination, risk assessment, and home visits for frail elderly; cross-training Medical Assistants to take on multiple clerical and clinical roles in team-based models; and training Medical Assistants to serve as dual role Medical Assistant/interpreters. From June 2010-June 2011, we visited 14 of these pioneers and conducted in-depth interviews with administrators, providers, nurses, Medical Assistants, and other representatives at each site. We visited urban, suburban, and rural sites across the United States from Alaska to West Virginia. Sites visited included community health centers, academic medical centers, an HMO, hospital-affiliated physician groups, and a private clinic network.

Several health care practices in the United States have significantly developed the roles of medical assistants.

> Selection criteria included a) improved wages and benefits, associated with expanded job responsibilities and career progression for medical assistants; b) improved clinical functions such as patient caseload flow, operation costs, clinical outcomes and/or patient satisfaction; and c) collected data that demonstrate impact in these areas…

The reports can be found at: http://www.futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=Registered_Dental_Hygienists_in_Alternative_Practice_in_California_2009_Descriptive_Report, and http://www.futurehealth.ucsf.edu/Public/Center-Research/Home.aspx?pid=539.

PAIN MANAGEMENT AND END OF LIFE CARE

Washington State Law Complicates Pain Care

Pain care advocates say that a law passed in Washington State to curb deaths from overdoses is discouraging doctors from treating their patients with pain. According to a December 11, 2011, article in *The Seattle Times* by Michael Berens and Ken Armstrong, lawmakers also thought that limiting the ability of doctors to prescribe opioids would save the state government money for prescriptions for workers covered by medical compensation.

The law requires prescribers to document patient backgrounds and track their behavior. They must conduct urine screens and consult with a pain specialist when daily doses of medication exceed the equivalent of 120 milligrams of morphine. The law exempts cancer patients and those recovering from surgery or a sudden injury. The law has been criticized for not doing enough to curb deaths from methadone, primarily among Medicaid beneficiaries.

Kaiser Sued For Ignoring Advance Directive

Compassion & Choices, the nation's oldest and largest nonprofit organization working to improve care and expand choice at the end of life has joined a lawsuit against Kaiser Permanente seeking monetary damages and an order that Kaiser institute policies to ensure that their providers respect patient's treatment instructions. The suit is described on the Compassion & Choices Web site:

> Compassion & Choices has joined a lawsuit against Kaiser Permanente.

> DeArmond v Kaiser Permanente
>
> Compassion & Choices Legal Director Kathryn Tucker is consulting counsel with California trial lawyer James Geagan in bringing this

case against Kaiser Permanente, seeking monetary damages and an order that Kaiser, one of the nation's largest health plans, institute policies to ensure their providers respect patients' treatment instructions.

The case concerns Emily DeArmond, who lived with brain cancer for most of her young life. As she approached her final months, her parents, doctors and a medical ethicist met to discuss Emily's care in light of her rapid decline. Together they completed a Physician Orders for Life-Sustaining Treatment (POLST), which documented their decisions in official physician instructions.

She endured the tube until she was transferred to another Kaiser facility, where doctors withdrew it and allowed her to die.

Several weeks later, Emily's parents found her unconscious in bed. They rushed her to a nearby emergency room affiliated with Kaiser, Emily's provider. They told the staff about her POLST, which included the order: Do Not Intubate; they did not want Emily to endure any painful, invasive procedures in her final days. The emergency physician failed to honor the order, and forced a breathing tube down Emily's throat. She endured the tube until she was transferred to another Kaiser facility, where doctors withdrew it and allowed her to die.

This case is believed to be the first of its kind in the nation that seeks to hold a provider accountable for failing to honor a POLST. Compassion & Choices brings cases like this to raise awareness of critically important healthcare issues, to improve end-of-life experiences and create needed social change. These cases establish important principles of end-of-life care and choice.

For more, see: http://www.compassionandchoices.org/page.aspx?pid=1014.

New Jersey Reorganizes to Fight Drug Diversion

Beginning in January 2012, the New Jersey Division of Consumer Affairs will have an enhanced Enforcement Bureau to improve monitoring of prescription drug abuse. The Bureau will have three investigative divisions – the Drug Diversion Section, the Pharmacy Inspection Section, and the Quality Healthcare Section – all of which will be increased in size.

LICENSURE

Oregon Offers Service Oriented Licensure

The Summer 2011 Oregon Medical Board Report contains an article encouraging physician retirees and out-of state licensees to consider volunteering their services under one of two limited licenses:

> Licensees who retire from active practice but wish to continue volunteering their medical services should consider changing their license status to Emeritus. Holders of this license may not receive monetary compensation for medical services…
>
> Volunteer Camp Physicians are limited to volunteering their medical services for no more than 14 days in a calendar year at a camp operated by a non-profit organization. This license is available if the physician has a current license in good standing in another state and abides by all Oregon laws governing physicians.

Governor Vetoes EMS Legislation

Governor Chris Christy vetoed legislation on January 9, 2012, that would have imposed requirements on voluntary emergency medical service (EMA) units to bring them into closer conformance with licensed EMS units. According to a post on January 12, 2012 by Steven Maginnis on the *Baristanet* Web site, the governor's veto message said, in part:

> While this legislation is well-intentioned and suggests several potential changes that seek to create a more coherent regulatory structure for the State's EMS system, I am advised that implementation of the requirements and commitments provided for in the bill would cost the State and municipalities across the State millions of dollars.

Among the requirements contained in the legislation were global positioning systems in every ambulance, background checks for all EMTs, and licensure (rather than certification) for EMTs under the Department of Health and Senior Services rather than the Division of Consumer Affairs.

Among the requirements contained in the legislation were global positioning systems in every ambulance.

Proponents of the legislation characterized it as a patient safety measure. Opponents claimed the requirements would accomplish nothing except adding red tape.

For more information, see:
http://www.baristanet.com/2012/01/controversial-ems-bill-vetoed-by-christie/.

South Dakota Considers Board to Regulate Emerging Professions

Bill HB 1171 was introduced in the South Dakota legislature on January 26 2012. Excerpts of the legislation are reprinted below:

> **FOR AN ACT ENTITLED**, An Act to establish a board to regulate certain emerging complementary health professionals with no current state regulatory board.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. For the purposes of this Act, an emerging complementary health professional is a person practicing, or seeking to practice, a nationally recognized health profession not currently regulated in South Dakota.

Section 2. The Emerging Complementary Health Professionals Licensing Board is established. The board may regulate newly emerging complementary health professions that are not regulated by any other board. The board shall be composed of seven members appointed by the Governor. The Governor shall appoint one person regulated by each of the following boards: Board of Chiropractic Examiners, Board of Massage Therapy, Board of Medical and Osteopathic Examiners, Board of Nursing, and Board of Pharmacy. The Governor shall also appoint two representatives from the public, with consideration to consumers using the services, or from the professions regulated by the board…

Section 4. The board shall annually elect one member to serve as chair, one member to serve as vice chair, and one member to serve as secretary. The board shall be under the supervision of the Department of Health. The board shall submit such records, information, and reports in the form and at such times as required by the secretary of health. However, the board shall report at least annually.

The board shall submit such records, information, and reports in the form and at such times as required by the secretary of health.

Section 6. With approval by the Legislature, the board shall regulate a group of emerging complementary health professionals if the board determines:

1) The unregulated practice of the profession creates a direct, immediate danger to the public health, safety, or welfare;
2) The scope of practice is readily identified and easily distinguished from the scope of practice of other professions;
3) The professional group has a national certification program or some other means to ensure a minimum quality of service; and
4) The practice of the profession requires some specialized skill or training, and nationally recognized standards of education and training exist.

Section 7. The board may issue a license to any applicant who is at least eighteen years of age and who meets the educational, moral, and competency standards of the profession.

A license issued under this chapter is valid for a period of one year from the date it was issued and automatically expires unless it is renewed. The board may refuse to grant a license to any person based on failure to demonstrate the requirements of this section. An applicant may appeal the denial of a license in compliance with chapter 1-26.

Section 9. Any person holding a valid license under this chapter may renew that license by paying the required renewal fee and providing proof of compliance with the continuing education requirements set by the board at least thirty days prior to the expiration of the current license.

Section 10. The board may cancel, suspend, or revoke a license following a hearing in compliance with chapter 1-26 upon satisfactory proof of incompetence, unprofessional conduct, or a violation of any provision of this chapter. The board may waive the requirement of prior notice and an informal meeting set forth in § 1-26-29 if the licensee presents an immediate threat to the public or has engaged in willful misconduct. Any person may appeal the cancellation, suspension, or revocation of a license in compliance with chapter 1-26.

Section 11. The board shall promulgate rules pursuant to chapter 1-26 based on the accepted national standards in the following areas:

1) Scope or practice of each regulated profession;
2) Application procedure, examinations, licensure, and license fees;
3) Professional conduct;
4) Safety standards; and
5) Education standards.

Section 12. The board shall maintain a list of recognized facilities or instructors who may provide training or instruction required for licensure.

Section 13. The board may inspect the place of business of any person with a license issued pursuant to this chapter during normal business hours, or upon written notice.

The board may inspect the place of business of any person with a license.

Section 14. All moneys coming into the custody of the board each calendar month shall be paid by the board to the state treasurer on or before the tenth day of the next month. The state treasurer shall credit the moneys to the Emerging Complementary Health Professionals Licensing Board account of the general fund, which account is hereby created. The moneys in the Emerging

> Complementary Health Professionals Licensing Board account are hereby continuously appropriated to the board for the purpose of paying the expense of administering and enforcing the provisions of this Act. However, the total expense incurred may not exceed the total moneys collected by the board.

Find the entire bill at: http://legis.state.sd.us/sessions/2012/Bills/HB1171HHE.htm.

QUALITY OF CARE

Ambulatory Care Quality Control Gaining Attention

The American Medical Association has published a study entitled, *Research in Ambulatory Patient Safety 2000-2010: A 10-Year Review*. The study was inspired by consensus recommendations in 2000 by a group of experts sponsored by the Agency for Healthcare Research and Quality. The experts agreed upon eleven recommendations for research, including insurance data, risk management experiences, patient and patient family perspectives, the role of teamwork in patient safety, and the role of institutional culture in patient safety. The authors of the report conclude that a decade later, there remains room for improvement in research into ambulatory care patient safety.

For more, see: http://www.ama-assn.org/go/patientsafety, and http://www.healthleadersmedia.com/print/QUA-275588/8-Reasons-Why-Ambulatory-Care-Quality-Matters-More-Than-Ever.

Patient-Reported Outcomes Gain Credence

Writing in the Commonwealth Fund's online *Quality Matters* column, Martha Hostetter and Sarah Klein explore the growing use of patient-reported outcomes measures:

Patients might be asked to assess their general health, ability to complete various activities, mood, level of fatigue, and pain.

> Patient-reported outcomes measures (PROMs) are a critical component of assessing whether clinicians are improving the health of patients. Unlike process measures, which capture provider productivity and adherence to the standards of recommended care, or patient experience measures, which focus on aspects of care delivery such as communication, PROMs attempt to capture whether the services provided actually improved patients' health and sense of well-being. For example, patients might be asked to assess their general health, ability to complete various activities, mood, level of fatigue, and pain.
>
> Until now, state and federal governments as well as private payers attempting to assess outcomes have mostly relied on measures of avoidable readmissions, hospital-acquired infections, and mortality.

They have also turned to objective measures of improvement such as changes in blood pressure among those with hypertension or hemoglobin A1C levels in diabetics. Patients' views of their health status have rarely been sought outside of clinical trials for new drugs or medical devices and medical specialties that focus on conditions for which there are few objective measures of improvement. Yet the ultimate measure of health system performance is whether it helps people recover from an acute illness, live well with a chronic condition, and face the end of life with dignity – and people's reports are the only way to gauge success.

In coming years, patient-reported measures are expected to play a more prominent role in assessing performance and determining the comparative effectiveness of different treatments, in part because of a growing emphasis on patient-centered care and value-based payment approaches. For example, by 2015, health care providers participating in accountable care organizations will have to provide evidence that the care they've delivered produced value for the patient – as reported by the patient.

The Department of Health and Human Services' Office of the National Coordinator for Health Information Technology also plans to incorporate PROMs into meaningful use standards, which is likely to prompt more widespread use.

They are also expected to be used to benchmark the performance of health care providers, potentially allowing payers to link reimbursement to evidence of the effectiveness of their treatment. "I see patient-reported outcomes as creating a brand new feedback loop and really for the first time creating measures of quality out of the eyes of the patient – not the eyes of the doctor," says Kristine Martin Anderson, senior vice president at the consulting firm Booz Allen Hamilton.

"I see patient-reported outcomes as creating a brand new feedback loop."

For more, visit:
http://www.commonwealthfund.org/Newsletters/Quality-Matters/2011/December-January-2012/In-Focus.aspx.

ADMINISTRATION

Georgia Considers Radical Revision of Investigative Structure

According to an article by Christopher Quinn in the January 24, 2012, *Atlanta Journal*, and by the online Associated Press, Georgia's Secretary of State has proposed taking away the State's licensing boards' authority to issue licenses, investigate complaints and move those powers to his

office (he already staffs the boards) and a newly formed Georgia Board of Licensing and Regulation. The new board would also hear appeals of disciplinary orders. Kemp's rationale for the proposal is to make the licensure and discipline processes more efficient.

Representatives of some of the State's licensing boards expressed concern about taking these responsibilities away from people with expertise in the professions.

The Associated Press describes the proposal in this way:

> ATLANTA – Georgia Secretary of State Brian Kemp announced a plan Monday to streamline the application process for professional licenses, saying that will greatly reduce the time it takes for a license to be granted.
>
> "One of the biggest frustrations I've had being secretary of state is that it takes us a minimum of 25 to 30 days to license somebody who's a qualified applicant," Kemp told The Associated Press in an interview.
>
> About 460,000 Georgians and businesses are required to obtain professional licenses to do business. Kemp said he consistently hears complaints about the need for increased efficiency throughout the licensing process.
>
> Kemp's new plan includes converting the state's 43 professional licensing boards to professional licensing policy boards. Currently, the licensing boards are appointed by the governor and they have both licensing and rulemaking authority. Under the new plan, that authority will shift to the director of professional licensing in the secretary of state's office.

Under the new plan, that authority will shift to the director of professional licensing.

> The secretary of state's staff will continue to review new license and renewal applications and will issue a license if there are no problems. That cuts out an additional step of having to send the applications to licensing boards for ratification, which Kemp estimates should reduce the time it takes to get a license to about a week from at least 25 days currently.
>
> This streamlining also will speed up the complaint and compliance process because the secretary of state's office will be able to act on the findings of the investigations it carries out without having to wait on a board decision.
>
> The boards will shift their focus to provide professional and expert opinions to the licensing staff Kemp's office to help with licensing and investigations rather than focusing on paperwork, Kemp said.
>
> The plan also creates the Georgia Board of Licensing Regulation, which will have seven members who are not licensees and who are

> appointed by the governor. This new body would have rulemaking and oversight authority for the secretary of state's office. It will hold hearings to approve certain professional licenses and hear appeals of rulings made by the director of professional licensing, as well as approving rules recommended by the policy boards.
>
> The creation of this board will make the process more transparent because its meetings will be streamed online, there will be set agendas and it will be made up from people outside of the industries, Kemp said.
>
> The changes are not expected to cost any additional money because they involve a reshuffling of responsibilities, Kemp said. The policy boards will meet about half as often as they generally met as licensing boards, and Kemp's staff will be able to focus on reviewing and processing applications rather than doing administrative tasks for those board meetings, he said…

For more, see: http://onlineathens.com/local-news/2012-01-23/kemp-announces-changes-professional-licensing-process.

Irish Boards Sign Collaboration Agreement

The Federation of State Medical Boards' *Journal of Medical Regulation* (vol. 27, No. 3. 2011) reports that the Pharmaceutical Society of Ireland and Ireland's Medical Council have signed a memorandum of understanding aimed at improving collaboration on issues of public safety and public health. The Medical Council wrote that the MOU "provides a framework to assist the joint working of the two statutory regulators to ensure maximum effectiveness regarding public safety and public health issues when carrying out their statutory functions." The two agencies will collaborate more closely in executing their regulatory responsibilities and will do more to share information.

DISCIPLINE

Disruptive Physicians A Growing Problem

According to an article by Carol Yne Krupa in *American Medical News* (June 13, 2011), more than 70% of physicians surveyed by QuantiaMD and the American College of Physician Executives witness disruptive physician behavior at least once a month in their facilities. Eleven percent of respondents say they see disruptive behavior daily.

Ninety-nine percent of respondents say disruptive behavior affects patient care.

Ninety-nine percent of respondents say disruptive behavior affects patient care. Sixty percent said patients or family members had filed complaints regarding disruptive behavior. Twenty-one percent said they have seen disruptive behavior contribute to an adverse event.

Disruptive behavior in the survey included insults, discriminatory behavior, substance abuse, incompetence, physical assault, profanity, spreading of malicious rumors, throwing objects, and yelling. A majority of the respondents said the behavior that concerns them most is doctors making degrading comments or insults, refusing to cooperate with other medical professionals, or refusing to follow established protocols.

Krupa interviewed a hospital and a professional association executive who both said such behavior is too often tolerated by institutions.

For more, see: http://www.ama-assn.org/amednews/2011/06/13/prsb0613.htm.

Fallout from Delaware Case Increases Reporting

Legislation passed in Delaware in the aftermath of child disciplinary action against pediatrician Earl Bradley for multiple instances of child sexual abuse (known as the "Bradley Bills") have caused an increase in awareness and reporting to regulatory authorities. Professionals, including physicians, mental health and chemical dependency professionals, nurses, dentists, social workers, psychologists, dentists and dental hygienists, and physician assistants are in danger of losing their licenses for misconduct or failure to report child sexual abuse.

Other provisions in the legislation include a requirement that another adult be present when a physician examines a disrobed patient 15 years old or younger. It requires physicians to undergo the same background checks required of teachers and other professionals who work with children. It strengthens the reporting process at the Board of Medical Licensure and Discipline, and the board's ability to police misconduct and work with law enforcement authorities.

PUBLIC MEMBER

Family of Medical Error Victim Joins Hospital Safety Review Committee

The hospital was forthright about the errors and rather than seek redress, the family decided to join the hospital's Safety Review Committee.

An article Deborah Shelton in the *Chicago Tribune* on October 7, 2011, featured the parents and sister of a woman who died from preventable medical errors at the University of Illinois Medical Center. The hospital was forthright about the errors and rather than seek redress, the family decided to join the hospital's Safety Review Committee. They bring a patient/family member perspective to the review of medical errors and help devise strategies for preventing similar errors in the future.

IN DEPTH

CAC's President Discusses History and Future of Regulatory System – "Where Have We Been? Where Are We Going?"

Editorial Note: CAC's President and CEO, David Swankin, delivered the keynote address at the 2012 annual meeting of the Federation of Associations of Licensing Boards (FARB). The title of this talk was "Regulation of the Professions: Where Have We Been? Where Are We Going?" This quarter's In Depth Feature consists of the first two sections of Swankin's remarks, "How Did the Current Regulatory System Evolve?" and "Problems and Flaws in the Current Regulatory System." The concluding section of his talk, "Changes That Could Improve the System" will appear in the Third Quarter 2012 issue of CAC News & Views.

Good Morning!

It is a pleasure to be with you this morning at the 36th Annual FARB Forum. I want to especially thank you Executive Director, Dale Atkinson, for extending this invitation. Dale has been a friend for many years, and I hold him and the entire FARB organization in the highest esteem. FARB meetings are always chock full of important discussion topics, and this year is no exception. I feel highly privileged to start the meeting off with an address entitled "Regulation of the Professions – Where Have We Been? Where Are We Going?"

In my remarks this morning, I will

1) Talk briefly about how our current system of occupational and professional regulation evolved;
2) Discuss some of the problems and flaws in the current system; and
3) Share with you my views on desirable changes that could make the system more accountable, credible, effective, and efficient.

Citizen Advocacy Center is a not for profit organization serving the public interest.

Citizen Advocacy Center (CAC) is a not for profit organization serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies, through training, research, and networking opportunities for public members and for the health care regulatory, credentialing, and governing boards on which they serve. CAC also promotes major public policy initiatives: Two of CAC's current initiatives are ensuring continuing competence of health care professionals, and involving consumers and their advocacy organizations in scope of practice reforms.

1) HOW DID THE CURRENT REGULATORY SYSTEM EVOLVE?

In his seminal 1980 treatise "Occupational Licensing, A Public Perspective," Ben Shimberg, whom I consider to have been one of, if not the world's leading expert on the subject, succinctly described the evolution of the U.S. occupational licensing system. I think Ben's book should be required reading for everyone appointed to a licensing board.

Ben describes how the leaders of a number of medical societies urged their legislators to pass licensing laws that would make it illegal for unlicensed individuals to practice medicine. State legislators were willing to do so because they were convinced that continued practice by unqualified "doctors" could be harmful to the public health, safety, and welfare. Since legislators were themselves not equipped to oversee the administration of licensing laws, they vested regulatory power in boards made up of physicians. It was only natural that the governor should appoint to these boards leaders of the societies that had spearheaded the efforts to obtain passage of the regulatory laws.

Thus was born the tradition of occupational self-regulation in the United States. As other professions and occupations sought licensure, they too asked for, and were usually granted, self-regulatory powers.

Ben Shimberg (who was the first Chair of the Citizen Advocacy Center's Board of Directors, and has since his death in 2003 been Chair Emeritus of CAC) documented the phenomenal growth of state occupational licensing laws – 130 new laws regulating health-related occupations between 1910 and 1920; non-health related occupations also began to be regulated, so that by 1980 more than 800 occupations and professions were regulated by state law, and today that number is even higher.

Until the middle of the 20th century, most state occupational and professional licensing boards were composed exclusively of members of the regulated occupation or profession.

Until the middle of the 20th century, most state occupational and professional licensing boards were composed exclusively of members of the regulated occupation or profession. It was a system of self-regulation under the authority of the state. Because the legislatively mandated purpose of the regulatory boards is the protection of the public health, safety, and/or economic welfare, a movement began in some states (California was first) to change the composition of the boards by adding one or more "public" members. The rationale for adding public members was to make the boards more accountable in carrying out their mission. In

virtually every case, boards continued (and continue to this day) to be populated by a strong majority of licensee members. Again, California has been the major exception, where for non-health licensing boards, board composition was converted to a majority of public members.

From the beginning, most boards were given autonomy, and were neither part of, nor accountable to, established government agencies such as Departments of Health or Departments of Commerce. The boards were granted executive, legislative (via rule-making), and judicial (via discipline) powers, and have been called by some experts in administrative law "the fourth branch of government."

Three other points are worth noting:

First, the regulation of individual practitioners through the establishment of licensing boards was not, in the great majority of cases, connected to regulatory oversight over places and products. In the case of health regulation, for example, the regulation of facilities such as hospitals, nursing homes, and freestanding clinics came about much later, and the authority for facility regulation was given to agencies of government other than occupational licensing boards, and sometimes not even at the state government level. (There are a few exceptions: boards that regulate pharmacists, veterinarians, and funeral directors often have jurisdiction over the places where licensees practice, i.e., pharmacies, veterinary clinics, funeral homes). Neither were the occupational and professional licensing boards given jurisdiction to regulate products. Referring again to the health professions, regulation of medications and medical devices was placed in a federal regulatory agency, the Food and Drug Administration. Thus, the regulation of individual practitioners was carried out in silos, not as part of a comprehensive, all-inclusive system of oversight. CPAs, to cite another example, are regulated by state licensing boards, not by the same agencies that regulate banks, insurance companies, investment companies, or other financial institutions. Contrast this with the systematic regulation of the airline industry, where a single agency, at the Federal level, regulates people (pilots, air traffic controllers), places (airports), and products (aircraft). I will discuss some of the consequences of this lack of systematic regulation later in this talk.

The regulation of individual practitioners was carried out in silos, not as part of a comprehensive, all-inclusive system of oversight.

There has been some movement away from regulatory board autonomy in the past 50 years. Some states have created what are known as "umbrella" agencies, called Departments of Regulation or something similar. Sometimes, these umbrella agencies have powers over the fiscal aspects of regulation, with no authority to oversee the

establishment of policy. A few umbrella agencies were granted policy oversight. I'll have more to say about this later.

Second, in the beginning, most professional and occupational regulatory boards were financed exclusively by licensure fees. Over time, there has been some movement toward funding regulatory boards partly through general appropriations (and a few attempts to dip into licensure fees to make up shortfalls in general revenues), but to this day, the primary funding mechanism has been licensure fees. One of the consequences of this method of funding has been that there is significantly less legislative oversight than for most other activities of government.

Third, for the most part, the powers given to occupational and professional licensing boards are passive rather than proactive. The boards were set up to monitor the marketplace by responding to complaints and, in some cases, mandatory reports from facilities. With some notable exceptions (pharmacy boards, for example), licensing boards do not have large staffs to make unannounced visits to licensees' offices or places of employment to observe whether licensees are performing in compliance with the practice act. Contrast this with the regulatory scheme utilized by other types of regulatory agencies: For example, city and county health departments that visit restaurants and food retailers on a regular basis; weights and measures agencies that inspect gas stations; occupational health and safety agencies that regularly visit factories, construction sites, coal mines, and shipyards.

Some licensing boards have staffs of 10 or fewer, and most investigatory work is to follow-up on complaints or other information received in the mailroom.

But, occupational and professional licensing boards were set up to be dependent on complaints and reports from third parties to monitor the marketplace. There are numerous reasons for this, not the least of which is financial. Some licensing boards have staffs of 10 or fewer, and most investigatory work is to follow-up on complaints or other information received in the mailroom. It is a fact of life, and must be taken into account in evaluating how well the current regulatory system is performing. Resources aside, the complaint-driven nature of professional licensure can be traced primarily to the origins of professional self-regulation. It was initiated by the regulated professionals, who were okay with responding to complaints (the "bad apples") but didn't and still don't envision, much less support, periodic visits to every practitioner at his or her place of employment, to monitor each licensee's practice to determine compliance with practice acts.

PROBLEMS WITH AND FLAWS IN THE CURRENT REGULATORY SYSTEM

Periodically, state occupational and professional licensing boards are subjected to 3rd party evaluation. A few states (for example, California, Colorado, and Washington), have well-established "sunset" review programs that periodically evaluate the performance of their state boards. In other states, the State Auditor conducts periodic evaluations of some or all functions of the licensing boards. In some states, Governors have created blue ribbon commissions to evaluate boards, sometimes in the wake of in-depth investigative reports by the media. In recent years, newly elected governors have initiated reviews of existing rules and regulations in an effort to get rid of rules that no longer serve their original purpose. Oversight by legislative committees occurs far less frequently than legislative oversight of well-established cabinet departments. As I mentioned earlier in this talk, the lack of oversight by state legislatures is partly due to the fact that many occupational and professional licensing boards are fee-financed, so state legislators have less incentive to fulfill their oversight role because they don't directly provide funding for regulatory boards.

The most comprehensive 3rd party evaluation of the occupational and professional regulatory system was conducted in the 1990s by the Pew Health Professions Commission, and even its review was limited to examining health care licensing boards. I served as a member of the Commission, and I recall that this question arose early on during our deliberations: Should we write a report that accepted the existing system, or should we take a more "ivory tower" approach and write a report that would, in effect, lay out a blueprint for fundamental change. In other words, if we were starting from scratch, what would a fair, effective, and accountable regulatory system look like? We chose the first option, believing that the more idealistic approach would be likely to fall on deaf ears, at least in the short term. I often wonder if we made the wrong decision! Be that as it may, our recommendations are on the table, and I believe many of them are applicable to all types of occupational and professional licensing boards, not just to the health licensing boards.

If we were starting from scratch, what would a fair, effective, and accountable regulatory system look like?

The first taskforce report, published in 1995, entitled "Reforming Health Care Workforce Regulation – Policy Considerations for the 21st Century" (UCSF Center for the Health Professions, San Francisco, CA 1995), examined ten issues in depth, and offered recommendations for each:

2) DESIRABLE CHANGES

Standardizing regulatory terms

Recommendation: States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.

This problem identified by the Commission continues today, with little, if any improvement. Confusing terminology is one of the reasons the public has so little understanding of the regulatory system. As Ben Shimberg put it:

"The terminology used in regulation is often bewildering. Many occupations are licensed, others are certified or registered. What is the difference? How much confidence can consumers place in the people who hang these government credentials on their walls?

There is no consistency among the states or between governmental and nongovernmental bodies in the definitions being used.

To confuse matters further, many nongovernmental organizations – such as trade and professional organizations and other nongovernmental credentialing bodies – also "certify" practitioners, ranging from auto mechanics to travel agents, dieticians, and occupational therapists. The fact is that there is no consistency among the states or between governmental and nongovernmental bodies in the definitions being used."

Unfortunately, I seriously doubt we will make much progress in this area in the foreseeable future, thus perpetuating the public ignorance or confusion about the oversight system, to the detriment of the licensing boards as they pursue their mission to protect the public.

Standardizing entry-to-practice requirements

Recommendation: States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.

Here we have made, and continue to make, considerable progress. A century ago, it was common for each state licensing board to create its own entrance exam, and establish its own criteria for license eligibility. The great majority of professions have created national entry exams, supplemented in some cases by unique state-by-state add-on requirements. In some cases, bold new approaches have been developed and put into place – for example, the National Council of State Boards of Nursing's "Compact" program through which about

half the states have enacted legislation along the lines of driver's licenses, where the participating states recognize the license issued by any other participating compact state. In summary, real progress has been made in standardizing entry to practice requirements.

Removing barriers to the full use of competent health professionals

Recommendation: States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.

We have a long way to go in addressing scope of practice reform. The 1998 report of the full Pew Commission, "Recreating Health Professional Practice for a New Century" (Fourth Report of the Pew Health Professions Commission, UCSF Center for the Health Professions, San Francisco, CA 1998), made additional recommendations regarding scope of practice reform.

It recommended the creation of a national policy advisory body that would "develop standards, including model legislative language, for uniform scopes of practice authority for the health professions. These standards and models would be based on a wide range of evidence regarding the competence of the professions to provide safe and effective health care," and went on to urge states to "enact and implement scopes of practice that are nationally uniform for each profession and based on the standards and models developed by the national policy advisory body."

Recognizing that the creation of such a national advisory would take some time, the Commission went on to say "Until national models for scopes of practice can by developed and adopted, states should explore and develop mechanisms for existing professions to evolve their existing scopes of practice and for new professions (or previously unregulated professions) to emerge. In developing such mechanisms, states should be proactive and systematic about collecting data on health care practice."

States should be proactive and systematic about collecting data on health care practice.

Unfortunately, there has been no movement to implement this recommendation on the national level, although a handful of states are experimenting with ways to bring rationality to decisions about changes in scopes of practice. But in most jurisdictions, scope of practice decisions continue to be "turf battles," resolved by political clout rather than by evaluating proof. The Citizen Advocacy Center (CAC) has developed a White Paper suggesting ways to implement

this call for a national advisory body (Building a Better Mousetrap to Address Scope of Practice Issues, available at http://www.cacenter.org/files/ReformingScopesofPractice-BuildingaBetterMousetrap.pdf, and CAC plans to convene a national meeting on this subject during 2012 to try to move the idea forward. Information about this meeting will be posted on the CAC website early in 2012, and you are all encouraged to attend and participate.

Redesigning board structure and function

Recommendation: States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.

I will have more to say about this in the final part of today's address, when I talk about where I believe the regulatory system should be headed in the months and years ahead. "Team practice," "interdisciplinary cooperation," and "accountability" are, like motherhood and apple pie, concepts we all subscribe to, but the proof is in the pudding. The challenge identified by the Pew Commission is a valid one, but we still have a long way to go to get there.

Informing the public

Recommendation: Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.

It is widely recognized that the public is poorly informed, misinformed, or uninformed about regulatory boards, including the fact that they exist, never mind about their activities. Informing the public is no easy task, but websites and social media offer the opportunity to make inroads. At CAC, we have examined many board websites, and while there are some excellent ones, many others are still designed to inform licensees, not the public. There are many board websites that do not have a consumer page that is easily accessible from the home page. Toll-free telephone access seems to have disappeared in many states, due to financial considerations. The first question boards need to ask and answer is "Have we made public education and public information a priority?" Until this is answered in the affirmative, we will continue to lag in this area.

The first question boards need to ask and answer is "Have we made public education and public information a priority?"

Collecting data on the health professions

Recommendation: Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.

Far too many boards fail to collect important workforce data, and thus cannot fashion regulatory programs that take workplace data

into account. Ask yourselves, does our board know where in the state licensees are located? Where they are employed? The specific nature of their practices? Without this information, boards are handicapped in understanding where there are shortages, and the demographics of the underserved populations. So, for example, if a dental board were considering allowing dental hygienists to work in a setting where they are not directly supervised by an onsite dentist (for example, a nursing home, or assisted living facility), it would be valuable to have data on hand to determine the needs of the citizens who live in those facilities. There does seem to be some movement to collect this data in some states, but we have a long way to go.

Assuring practitioner competence

Recommendation: States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.

Let me once again quote Ben Shimberg on this subject:

"The fact is that state governments… …do not impose specific requirements on licensed professionals to demonstrate their continuing competence. Many state boards do require licensees to take continuing education courses to maintain their licenses. However, with some significant exceptions, these requirements ask only that a licensee show that he or she has attended approved courses. Whether the chosen courses are relevant to the licensee's specific practice, or whether the information presented in the course has been understood, is not subject to regulatory review. Private certification and specialty boards have paid much more attention to continuing competence… …than have state health licensing boards. More and more observers concerned about continuing competence are asking the licensing system to reassess its responsibilities in this area."

While there are encouraging signs of progress, the fact is that we still rely too much on mandatory continuing education as a surrogate for continuing competence. The public is not aware that in most cases the licensing system does not require demonstrations of current competence as a condition of license renewal.

We still rely too much on mandatory continuing education as a surrogate for continuing competence.

A statewide survey in Virginia sponsored by AARP a few years ago found that a large majority of citizens over the age of 50 believe that the license hanging on the wall indicates that the state has confirmed that the licensee is currently competent, even though the original license may have been issued 20, 30, or 40 years ago. Asked if licensees should be required to provide evidence of current

competence as a condition of license renewal, well over 90% of respondents answered "yes, they should." So, consumer expectations are not consistent with reality. This presents us with a choice: We could try to change consumer expectations, or we could take steps to meet those expectations.

The issue has been with us a long time; at least since the early 1960s, when participants in a meeting at what was then called the Department of Health, Education, and Welfare strongly endorsed the need for regulators to evaluate the current competence of licensees at the time of license renewal. We seem to be moving in that direction, but still at a snail's pace.

Reforming the Professional Disciplinary Process

Recommendation: States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.

This past October, CAC's annual meeting was devoted entirely to examining licensing board discipline systems. When I opened the meeting I said:

"While licensing boards engage in many important activities, it is the disciplinary function that most frequently attracts media attention. This makes discipline the most important determinant of the public's perception of your boards. Whether you like it or not, you don't see many people asking what you do in connection with testing, licensing, education or other functions. It is discipline they are aware of.

And, in fact, nothing is more important to a board's statutory mission to protect and promote the public health, safety and welfare than a well-functioning disciplinary program. The public wants assurance that licensing boards are undertaking appropriate interventions when practitioners fall below minimally acceptable standards of practice.

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Boards are often accused of being too lenient. *The Saint Louis Post Dispatch* carried an editorial on July 17, 2011, which pointed out that "In twenty-five years, the medical board has not one time used its authority to summarily suspend a license of a dangerous doctor."

During the course of the two-day meeting, we covered many elements of disciplinary programs, including processing complaints; keeping complainants informed; investigating complaints; negotiating settlements; enforcing board orders; using disciplinary data to improve a board's program; dealing with errors using the

"just culture" approach; handling minor complaints via non-public interventions; and using summary suspension. Our agenda also included a talk by your executive director, Dale Atkinson, entitled "Staying on Top of Developments in the Law."

During the meeting, a number of best practices were put on the table. One could not help but walk away from that meeting with the feeling that collectively, we certainly know how to operate fair, effective, efficient, timely, accountable discipline programs. The challenge to the boards is to make the best practices common practice. It is a challenge every licensing board faces on an ongoing basis.

Evaluating regulatory effectiveness

Recommendation: States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.

This recommendation speaks for itself. Earlier, I spoke of external audits conducted from time to time, by state auditors, sunset review committees, special gubernatorial commissions, and yes, by investigative reporters.

But what about periodic self-evaluation, or 3rd party evaluation commissioned by the regulatory boards themselves? How many boards commit time and resources to program evaluation? How many boards periodically schedule retreats where they can step back from the day-to-day business of the board and ask the question, how can we do better? Thorough, regular evaluation happens when boards make it a priority.

Understanding the organizational context of health professions regulation

Recommendation: States should understand the links, overlaps and conflicts among their health care workforce regulatory systems and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.

Read this recommendation, leaving out the words "health care," because the recommendation is applicable to every occupational and professional licensing board. Its central point is more than simply "understanding the links, overlaps, and conflicts" with other elements of oversight systems. It is, rather assuring that these links exist, overlaps are coordinated, and conflicts resolved. In other words, it is about creating an integrated system of regulation, something that does not now exist in far too many cases. That leads me to the concluding section of my address.

(Continued in the next issue of CAC News & Views).