News & Views

Citizen Advocacy Center

Fourth Quarter, 2014 - A Health Care Public Policy Forum - Volume 26 Number 4

We Want You!

CAC is a membership organization *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership and on pages 41 and 42 of this newsletter.*

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 and on page 43 of this newsletter.*

PROCEEDINGS OF CITIZEN ADVOCACY CENTER'S 2014 ANNUAL MEETING

Editorial Note: These proceedings are not a verbatim account of the plenary presentations, but they are faithful to the speakers' remarks. Please go to http://www.cacenter.org, select "2014 annual meeting," and "Program Announcement and Meeting Registration Form" for links to the speakers' PowerPoint presentations.

WELCOME

David Swankin, President and CEO, Citizen Advocacy Center

Thank you to the Maryland Department of Health and Mental Hygiene for co-sponsoring this year's meeting. Our topic is collaboration. We have a fragmented oversight system – one board looks at

~ TABLE OF CONTENTS ~

pharmacists, another at doctors, another at nurses, another at psychologists, and so on. A separate set of agencies oversees institutions – hospitals, clinics, nursing homes, and so on. Contrast this with how we oversee airlines. A single agency investigates accidents and incidents from pilot error, to airplane design, to air controllers, to mechanics, to the runway, etc. We don't have that kind of cohesive regulatory system in healthcare so collaboration is essential.

We have an interesting mix of attendees. At least 25 public members; licensee board members; board chairs; executive directors from boards and umbrella agencies; a variety of board staff; and representatives of national certification organizations, the federal government and Canada. At least sixteen different health professions are represented and seventeen different states and the District of Columbia.

Recently, the director of the Center for the Health Professions at the University of California in San Francisco wrote an article entitled, "Driving Change by Leveraging the Workforce." In it she said,

> "Today's healthcare systems face increasing costs, an aging population, changing consumer expectations, and a greater demand for demonstrating performance. All of these factors create an urgent need for new models of care delivery, including alternate delivery sites and new roles for caregivers, improved processes and enabling technology. To succeed in this environment, organizations need to understand and manage their greatest asset: Their workforce. Without an understanding of the workforce, organizations cannot execute the needed changes and transform grand design into reality. Our Center has long recognized this. Our origins are steeped in research that is designed to describe, demonstrate, and evaluate changes in the healthcare workforce. We need this information to help organizations drive positive change by informing progress in policy."

I believe these observations apply to the healthcare regulatory and oversight system. The phrase "new roles for caregivers" translates to scope of practice reform. The phrase "a greater demand for demonstrating performance" translates to methods for assuring current competence of licensees. The term "enabling technology" translates to effective policy vis a vis telehealth. The phrase "evaluating changes in the healthcare workforce' translates to the role of the boards to take care of the needs of rural and disadvantaged communities.

I will make an additional observation about team practice, the new reality: Collaboration between entities is essential if the regulatory and oversight systems are to be relevant in the months and years ahead.

Paula Hollinger, Associate Director, Health Workforce at the Maryland Department of Health & Mental Hygiene

Welcome to Maryland and Baltimore City. I am delighted to have been involved with CAC, going back to the days when I was in the legislature dealing with bills affecting health licensing boards. We had fewer boards then. It seems every profession wants to be licensed. After twenty-eight years in the legislature I was lucky to find what I refer to as my exit job. I am the liaison from the Secretary of Health and Mental Hygiene with all the health licensing boards and commissions, which includes our new medical marijuana commission. I am delighted to be here today and to see so many Maryland board members and administrators, public members, licensee members.

KEYNOTE ADDRESS, Joshua Sharfstein, Secretary of the Maryland Department of Health and Mental Hygiene

Thank you for the chance to come here to speak. I appreciate what board members do here in Maryland and around the country. Your boards are of incredible and under-recognized importance for public health.

Maryland has eighteen boards, each of which has consumer representation. Boards play a critical role in protecting the public. In some ways, boards are the only line of defense against professionals who could really harm one or more members of the public.

In December 2010, the New Haven Independent wrote a series about the Connecticut medical board which permitted physicians to practice, even though they lost their licenses elsewhere. In the same month, the St Louis Post Dispatch published a series about the Missouri medical board for sending frequent confidential letters of concern that go into the physicians' files in lieu of more serious disciplinary actions. In February 2012, the Minneapolis Star Tribune reported that since 2000, the board of medical practice failed to discipline at least forty-six Minnesota physicians after authorities in other states took action against their licenses for such things as committing crimes or having inappropriate relations with patients. The story also noted that the medical board never disciplined more than half of the seventy-four physicians who lost their practice privileges at Minnesota hospitals. I don't think there is another area that is such a gold mine for journalists compared to medical boards.

In your day-to-day work, you may encounter board members who advance reasons not to take action, but at the end of the day, your board is there for the public and if something doesn't make sense to you, that is when it is time to speak up. It is important not just for individual cases to be resolved in a reasonable way, but for the system to prioritize protecting the public health.

The Maryland medical board underwent a tough audit. When this happens, one response is to ignore it. To its credit, Maryland's medical board stepped up and made the recommended changes.

The board had been focusing on debating the substance of the cases before them without noticing that it was taking years to resolve them. The expose prompted them to look at the way the board was structured and how it pursued its workload. They brought in an external group that reviewed the board top to bottom and made recommendations for changes. Just as a hospital is more than doctors and nurses doing individual things, a board is a system, not just individual cases. A board needs to be well structured so that cases move through, processes are fair, and so on. Now, the Maryland board not only processes cases more quickly, they are able to think about them more. It is reasonable for the public to hold a board accountable for setting up its system in a way that supports public health.

Another example. If you are thinking to yourself, "I wouldn't go to that doctor in a million years," but someone is telling you that there isn't anything the board can do legally, this is the time to question what is going on. Particularly public members are on boards to be able to say, "Wait a minute, that doesn't make sense."

I tell Maryland's board members if they are worried about the standards being set or decisions being made, I want to know about it and sit down with the senior lawyers in the state and figure out what can be done. I want board members to feel they are protecting the public. I am proud of the progress the Board of Physicians has made and I think it is a testament to the leadership of Dr. Singh and his colleagues and to the input we were able to get from the University of Maryland.

Here is an example from a different context. I was on a research review board in medical school. One of the doctors proposed a protocol for using ultrasound rather than surgery to remove breast masses thought to be benign. These masses might be malignant. The proposal was to randomize patients with this condition and see which did better, those with surgery and those with ultrasound. We asked the doctor who was doing the study if he would ever recommend that a patient choose ultrasound rather than surgery in case their tumor were malignant. Not a single person on the review committee thought this was a reasonable study, including the doctor proposing it who admitted he didn't understand why any patient would want to join it. I was just a student and was instructed not to say anything so I sat in silence while the committee approved the research. Ultimately, the doctor decided the study was unethical and abandoned it. The moral is that if something doesn't make sense, it is really important for public members to speak up.

After protecting public health, my second priority is scope of practice. If my job were a prime-time series, the subplot would be two boards fighting it out. Scope of practice is always there and it expresses itself in bizarre ways. Whatever side a board takes one day, it could just as well argue the opposite side the next. There is always territory involved. The best example playing itself out now in Maryland is the Physical Therapy board vs. The Acupuncture board. The issue is dry needling. The acupuncturists believe this is acupuncture. The physical therapists disagree. We held a public comment period. We usually receive about five or ten comments. In this case, we got 1,100 comments from around the country.

The way I think about it, it is wrong to decide these issues on purely professional terms. The right way to approach it from the public health perspective. Does it make sense for the people in the state? I think board members should try to keep that standard in mind. That does not mean that every scope of practice should be expanded. Nor does it mean that all requests should be denied. There should be a way reasonable people can get together and think through whether it would make sense given the circumstances in a particular state.

This is a hard one. Professional associations are often pretty dug in. There is a lot of lobbying. It is helpful for boards to be thinking about being reasonable negotiators. This includes saying no when there is a public health rationale. I would also recommend some process that people have confidence in. If it is all based on the comparative power of competing groups, it is likely to lead to escalating conflict.

We have worked well with the dental board to get certain privileges for unsupervised dental hygienists. It doesn't make sense for a profession to say that something can't be done when it probably can be done completely safely and there are no dentists in the vicinity. When I was the health commissioner, I approached the dental board to be sure they wouldn't object to pediatricians providing fluoride treatment. It helped that I was speaking from the public health perspective.

My next major topic is service to the professionals the board oversees. As much as I believe the key priority is public protection, it is also critical to recognize that healthcare professionals play an important role in keeping people healthy. All types of healthcare professionals are doing a job that can be dangerous. They deserve our respect. This can be demonstrated by making such things as complaint processing, licensure issuance, and renewal efficient. The board should expect good customer service from the staff, for consumers and licensees, who can then support the boards' request for the resources they need.

Another aspect of board service is prevention. Our goal is not to have more complaints. Our goal is to prevent problems. For example, the board of physicians has put out guidance around prescribing pain medication rather than waiting to catch people who get in trouble. Board members should know the common things people are disciplined for. Being up front about this is a helpful way to support the profession.

One last topic is military veterans who have very important skills and experience, but oftentimes these don't fit into professions when they transition to civilian life. In Maryland, we have legislation boards to expedite their applications and give serious consideration to equivalency standards. There is probably room for a lot of creative thinking. Some professional groups may be concerned about opening the door to more practitioners, but the right standard is not the professional territory standard, it is the public health standard.

Question – I'd like to follow up on your idea about reasonable people coming together from different professions and boards. I am involved with the Coalition for Patients' Rights, which is a group of professional organizations that share scope of practice concerns. Prescriptive authority is a common one. Do you think it would move the conversation forward if all the professions who believe they should have prescribing authority could come together and develop a set of core competencies across the professions and agree that this is what is required to be able to safely prescribe?

Sharfstein – I think there are two types of groups that can come together. One group is a stakeholder group, where people are speaking from specific interests. The other is an expert group. My experience with controversial issues is that it is very hard for a stakeholder group to be successful because people cling to their particular interests and have a hard time compromising. The expert group, which could include consumer members, is composed of people who can conduct a thoughtful review of the public health interest at stake. So, I don't think it is likely to be very helpful to bring together representatives from each board. Depending on the situation or the question, you may find people who are reasonable and credible who can come to examine any question. In Maryland, the Health Department has taken positions on some of these things based on public comment and consulting with experts. We have supported nurse practitioner and physician assistant prescribing and we allow for certain vaccinations by pharmacists. My intuition is that it is better tackled on a particular type of prescribing with a clear public health rationale. We have concerns about inappropriate prescribing. We share information with boards. We ask the boards to adopt specific CME requirements related to appropriate pain medication prescribing.

Comment – I am a public member of a dental board. I currently serve on a task force to implement legislation regarding accessing prescriptions when discharged from a hospital. We are looking at different models currently in use. This is an instance in which stakeholders and professionals have come together to tackle a problem.

Hollinger – Nurse midwives came to me with a bill that would give them prescribing privileges. I asked who was backing them up and who would oppose the bill. I asked them to come back after they negotiated with the physician and pharmacy associations and hammered out an agreement. They came back in a year united in support of a bill that passed easily.

Question – I am interested in the process improvement the Maryland board of physicians accomplished with the help of the University of Maryland team that came in and gave them guidance. Has any thought been given to publishing or otherwise sharing the process with the rest of us?

Sharfstein – The report is public. Many of the recommendations are particular to the medical board. Having said that, the general process of bringing in an external group is useful. It helps to have some external pressure on the board to request an outside review, as came from the Department of Health in Maryland. It helps to have the board chair support the idea. I encourage boards to think about an external review as they think about ways to restructure.

Question – The theme of the conference is collaboration. I continue to see boards acting parochial around scope of practice issues. Any time any board wants to do something that expands scope of practice – even if it make sense from a public health standpoint – the legislature has to get involved, the professional association gets involved. Even when the boards are able to work things out, the associations are at odds. In that environment, how would you recommend boards approach these issues so the lobbyists don't sabotage an agreement when it gets to the legislature?

Sharfstein – At one point, I got so many requests to intervene in scope of practice disputes we proposed legislation that would give authority to the legislature to appoint an expert group to look at a scope issue and decide it on public health grounds. There were many opponents, including the lobbyists for the professional associations, who helped kill the bill. I'd much rather see a process that is removed from political pressure. By the way, someone said to me, "Let's not call them silos, let's call them 'cylinders of excellence.'"

Question – The Citizen Advocacy Center held a meeting last spring on the subject of public outreach with the idea that regulatory boards and certification organizations should make an effort to inform the public about what they do and the impact on people's lives. As you have been talking, I have been thinking of public outreach as a public health issue because if you can get the public to weigh in on some of the things we have been talking about this morning, licensing boards and policymakers will know what concerns and motivates the public. Has the department of health in Maryland made any effort to try to make the public aware of regulatory boards and what they do? If so, has the effort been successful?

Sharfstein – That is a good point. Engagement with the public covers both making people aware and delivering prevention messages to the public. Suppose there were a group of professionals supporting a type of therapy that is outside the bounds of professional practice, the board might

issue a warning to the public. My suggestion would be to partner with the public health department, which already does a lot of messaging. In Maryland, we have done outreach to inform people how to complain about providers. We have a website around quality. We have made information available around boards. I would give our efforts a C-. We could do a lot more. You can send out hundreds of messages about what a board does, but if that information is contained in a larger announcement about a public health issue, people will pay attention.

Question – My board did a public relations campaign with the department warning about the illegal sale of contact lenses.

Sharfstein – If the only time policy makers hear from you is because of a scope of practice issue, you won't be nearly as effective as you would be communicating on public health issues.

SESSION 1 – COLLABORATION BETWEEN SISTER BOARDS IN DISCIPLINARY MATTERS

Jaime Hoyle, Chief Deputy Director, Virginia Department of Health Professions

Mary Jo Monahan, CEO, Association of Social Work Boards

Paula Schenk, Executive Director, Kentucky Board of Nursing

Janet Klein Brown, Assistant Attorney General, Administrative Prosecutor, Maryland Office of the Attorney General, Health Occupations Prosecution and Licensing Division

Hoyle – The Virginia Department of Health Professions is an umbrella agency housing thirteen health regulatory boards plus the Board of Health Professions. While each of the boards is autonomous, they share discipline, investigations, human resources, and administration. This allows economies of scale and helps with collaboration among sister boards. Our agency is structured to promote collaboration from the bottom up and the top down. This requires a willingness to talk about what works and what doesn't.

When we get a complaint, our investigators will determine whether it is within the jurisdiction of any one board. Sometimes incidents involve more than one profession, in which case the same investigators work with the appropriate boards. Investigators, enforcement, the Administrative Proceedings Division all work closely with every board. The board executives work with each other to find ways to streamline licensing, discipline, and other functions. This is especially helpful for smaller boards because often the larger boards get more attention.

Monahan – The Association of Social Work Boards is an international organization serving social workers throughout North America. We were founded in 1979 when the twelve states that then licensed social work came together to develop a single examination. Our charitable function is to relieve burdens on state governments and that's where we work with the social work licensing boards. Today, social work is regulated in all fifty states, the Canadian provinces, the District of Columbia, Virgin Islands and Guam and Northern Mariana Islands. There are 440,000 social worker licensed in the United States and 42,000 in Canada.

Collaboration is a key operating principle and value of the social work profession. We have always worked on interdisciplinary teams in various healthcare settings. We have always put the client in the center of treatment. We have always worked in communities.

I asked our members to help me prepare for this panel. What I found is that the regulatory community is not as collaborative. It all depends on how the board is set up within the jurisdiction. Many social work boards are autonomous and have the responsibility and authority to regulate. There isn't a lot of collaboration with other professions in those states. If a social work board is housed in an umbrella organization, such as the Department of Education in New York, it would collaborate with other professions by, for example, sharing investigators. There may be collaboration with other jurisdictions insofar as disciplinary information is shared in our public protection database.

There are also composite boards in social work. Florida recently moved from a title protection act to a practice act. This board licenses clinical social workers, marriage and family therapists, and mental health counselors. When there is a disciplinary hearing involving a social worker, it goes before the whole board. If the discipline ends up in a final order revoking the license, the practitioner has to sign a statement saying they will never apply for licensure in Florida. So, they couldn't be disciplined as a social worker and later apply for a license as a mental health counselor or marriage and family therapist.

In summary, social work regulation is more dependent upon the regulatory structure than the will to be collaborative. I believe our members would cooperate with an investigation if there were a healthcare team including a social worker, a nurse, and a doctor, but we would have to figure out how to do that within the current structures.

Schenk – I am here to talk about examples of cooperation between boards of nursing within the Nurse Licensure Compact. I will also share examples of collaboration among all the boards of nursing.

In the late 1990's, the National Council of State Boards of Nursing delegate assembly adopted the Nurse Licensure Compact. It is a legal agreement that nursing boards can enter into. It is a state-based mutual recognition model, rather like a driver's license. Currently, 24 jurisdictions are party to the compact. My state, Kentucky, and Maryland are both parties to the compact. I could work as a nurse in Maryland because I have been issued a multistate license by my jurisdiction. It permits me to practice and use my title in any of the other jurisdictions that are party to the compact. The compact has facilitated access to nursing care throughout the country.

Developing the compact involved tackling difficult issues. How can we make sure the compact enables nurses to move between jurisdictions without having to apply for multiple licenses? How can compact ensure that problematic individuals who are not practicing safely and competently cannot move from one state to another?

The National Council's "Nursys" discipline databank supports the compact. A recent case involved a nurse licensed in Kentucky who was under an order to have his practice monitored. His multi-state license was suspended while he was under the disciplinary order. He wanted to take a job across the state border in Virginia, also a compact state. A review of the case showed no obvious reason to deny the nurse's request to seek permission from the Virginia board of nursing to practice in Virginia. The paperwork took only a few days to accomplish.

This is an example of inter-jurisdictional collaboration with other states that are party to the compact. We also collaborate in this way with non-compact jurisdictions. "Nursys" is another

example of how all boards of nursing collaborate by sharing disciplinary data. We need to remember that nursing doesn't exist in isolation. We collaborate clinically with multiple healthcare professionals. The same is true as regulators.

We recently collaborated with our department of health to send out information about the Ebola virus. We work collaboratively with the agency that regulates healthcare facilities in Kentucky. It doesn't come naturally or easily. It has to be deliberate and requires being open minded.

Brown – A few years ago I prosecuted an individual who was dually licensed in Maryland by the boards of acupuncture and physical therapy. The licensee practiced physical therapy at a hospital during the day and had a private acupuncture practice in the evenings. Two female patients complained alleging sexual misconduct and boundary violations. The patients filed their complaints with the board of physical therapy and requested they be forwarded to the board of acupuncture. Rather than go forward with two separate cases, I decided to combine the allegations into a single case.

Counsel for the licensee raised due process issues and filed a motion to hold two separate hearings. I responded that it would unfairly burden the complainants to have to testify in two different proceedings on the exact same sets of facts. Also, from an evidentiary perspective there would be a risk of inconsistency in the complainants' and the defense's testimony if there were two hearings. The third rationale for a single hearing was to minimize the cost of the proceedings. What I envisioned was that both boards would sit in one room and hear the testimony of the complainants, the state's expert, the defense, etc. The plan was that the boards would deliberate separately because that would preserve their individual ability to confidentially assess the information and issue their own final decisions.

The licensee's challenge to the concept of a consolidated hearing was that it would not be fair and impartial, the defendant would suffer harm because of different philosophies underlying the fields of acupuncture and physical therapy, and that the defendant was entitled to separate hearings. I had responses to each of these arguments.

Maryland has a generic statute regarding sexual misconduct that applies to all boards, in addition to each board's own statute. If the cases were severed, the defendant could present different defenses. For example, he could say to the acupuncture board that he is permitted to do that as a physical therapist and when he is in front of the physical therapy board, he could say that acupuncture says I can do this. Some of the issues had to do with the amount of personal history he obtained, the amount of detail he gathered related to sexual history, and draping and exposure of body parts.

The motion to sever was denied and we did go forward. The state's expert was also dually licensed and could address the issues from the perspective of both professions. The next step was a settlement conference. There were two separate settlement conferences, which, from a prosecutor's perspective did not go well. Each board made a different kind of decision as to the discipline. One voted for a more harsh sanction. So, this was an attempt at collaboration, but we never progressed to the hearing stage.

Hollinger – Did each board get to do its own discipline?

Brown – Yes, there were two separate settlement conferences and the panels' recommendations differed. One panel recommended a reprimand and CE and the other recommended a period of suspension. The board that favored reprimand was persuaded by defense counsel's argument that the other profession permits the conduct in question.

Hollinger –I have a question about the Nurse Licensure Compact. We have background checks in Maryland. Do Kentucky and Virginia have background checks?

Schenk –Kentucky does.

Hollinger –So, if someone comes from Virginia to either Kentucky or Maryland, how do we handle the differences in the laws?

Schenk – If a jurisdiction party to the compact has been unable to implement criminal background checks and one of their licensees with a criminal background comes to Kentucky, we don't know the history of the licensee. This underscores the need for all jurisdictions to obtain the statutory authority to perform criminal background checks, including finger printing.

Hoyle – Virginia is one of the four or five compact states that do not require federal background checks. This is one of the things preventing other states from joining the compact. The basis for collaboration is trust and shared values. Our board of nursing is trying to get the authority to conduct background checks. Because we are an umbrella board, our legislative package comes from the governor. We have asked to have this in the governor's package.

Schenk – Revising the Nurse Licensure Compact is under discussion to address the elements in the compact that may discourage other jurisdictions from joining and to seek other changes and improvements. The promotion of telehealthcare makes revisiting the compact especially timely. No date has been set.

Of all the jurisdictions party to the Nurse Licensure Compact, there are four or five that don't implement the federal background check. I don't think it is because they don't want to. The impediment comes from the legislative side.

Monahan – Back in the mid-1990's, the Association of Social Work Boards produced a Model Social Work Practice Act. It is suggested legislative language for best practices in regulating social work. It includes an application form that asks if you have ever been licensed in another state. It strongly recommends background checks for all candidates. We ask our boards to consider this model in the interests of consistency among the jurisdictions. We recently published some regulatory language around telehealth and e-practice. Also in the 1990's, we established the public protection database to which boards report disciplinary actions. We send that information to the National Practitioner Data Bank. This has been helpful for collaboration.

Hoyle – None of Virginia's thirteen licensing boards require federal background checks. I think that is surprising to many, especially the public, whom I think assumes it happens. There is a requirement on all applications to self-report. Our research in states that require federal background checks found that about thirty percent of licensees required to self-report don't do so.

Schenk – If there were a violation by a Tennessee licensee that took place in Kentucky, we would initiate action against the licensee's privilege to practice in Kentucky. That information would be shared with the Tennessee board of nursing. It is up to Tennessee to follow its procedures to take action against the multi-state license. Once we enter a complaint, it is sent to the disciplinary database. We send a speed memo to all the jurisdictions in which we are aware the individual is licensed. To my knowledge, every state in the compact has the authority to take immediate interim action to protect the public. Either the state granting privilege to practice or the state issuing the multi-state license can initiate action, depending on which learns of the incident first.

Hoyle – Our investigators generally have a law enforcement or health background. One of the goals of our director of enforcement is to have certain specialized investigators.

Question – The North Carolina legislature is considering different umbrella agency models. In Virginia, are you more of a center for best practices, or do you have administrative means to compel boards to do something you think is in the public interest? Where is the best place to house such an authority? Is it better under the governor's authority through the appointment process or under the attorney general?

Hoyle – The boards are autonomous and we cannot direct them to do something. We facilitate new board member training and best practices related to processes.

Hollinger – Maryland has been through a few configurations. Out boards are self-funded, but they still come under the health department. The appointments are made through the governor's office. Many of the appointments need the senate's approval. The board of physicians has been reconfigured several times. Some boards designate that certain geographic areas or specialties need to be represented. The nomination process is much more open now than it was when the professional association submitted names.

Hoyle – The Department of Health Professions falls under the secretary of health and ultimately the governor. The governor appoints agency heads.

Brown – A social work board would relate to social work boards in other states. There is also collaboration among boards within a state and consumer members can play an important role in that. At one time Maryland had a committee open to all consumer members of all health boards. I encourage consumer members to try to get such a thing going in your states. I urge executive directors to encourage their consumer members to participate in such a committee.

Question – Was there consideration of consolidating the settlement conference in the case before the acupuncture and physical therapy boards?

Brown – We did not do that. There might have been a greater chance of consistent settlements.

Question – What have you done to try to make criminal background check requirements more consistent from jurisdiction to jurisdiction?

Hollinger – Maryland has sanctioning guidelines.

Hoyle – Virginia has sanctioning reference points for all disciplines. The resistance that I hear to background checks is the fear that they take away some of the boards' discretion in how they discipline. There is an argument in favor of consistent outcomes; the counter argument is that boards need discretion to evaluate each case on its merits.

Schenk – Our Kentucky board and staff developed guidelines for disciplinary action based on the nature of violations. The board has adopted a Just Culture philosophy that calls for evaluating each case on an individual basis, taking into account extenuating circumstances and mitigating factors. When a case falls outside the guidelines or the investigator believes the board should review the case directly, we have the flexibility to appoint a panel of board members to give guidance. We fight against a cookie cutter approach. A criminal violation may be a felony in another jurisdiction, but a misdemeanor in Kentucky. Some jurisdictions bar licensure of felons, so this is a major concern and may prevent a state from becoming part of the compact.

Our approach in Kentucky is that if someone is moving to the state seeking licensure, they are required to do the federal background check. They are also required to report it on their application. If they report they have a criminal conviction, they are required to provide certified copies of the court records. We then make a determination how to proceed.

SESSION II – COLLABORATION WITH VOLUNTARY CERTIFICATION ORGANIZATIONS

Grady Barnhill, Director of Examination Programs, National Commission on Certification of Physician Assistants

Justin Elliott, Director, State Government Affairs, American Physical Therapy Association

Mark Lane, Vice-President, Federation of State Boards of Physical Therapy

Carol Hartigan, Certification and Policy Strategist, AACN Certification Corporation, American Association of Critical Care Nurses

Barnhill – Regulators can enjoy an economy of scale by working with national certifying bodies. It is very expensive to do something like a practice analysis or cut score study well. Using products developed by certification bodies also helps provide the benefits of standardization across participating states.

Currently, all fifty states use NCCPA's initial certification exam for licensure. Twenty-five of those states require continued NCCPA certification in order to retain a license. We are pleased with this because we think it is a good thing to demonstrate competence and knowledge all the way through a career instead of just one time at the beginning.

We deal with three different types of practitioners. There are the angels, who stay up at night reading journals and attend every available CE activity. They are already doing more than we require. What we need to do with them is to stay out of their way.

At the other end of the scale are the insects who sign up for a CME course at Aspen and spend the whole day skiing and get their buddy to sign the attendance sheet. They have a way to work around every requirement. They are the miscreants. They are the reason regulators exist.

In the middle is the Average Joe. These people want to be good practitioners and keep up with their CE reading, but they have three kids and it's hard to find time for all the things that need to be done to be a good professional. We help them the most by having structures in place so they have an excuse to do their CE reading rather than watching the kids.

NCCPA's first opportunity for collaboration was at the inception of the credential. Back in 1975 David Glaser was our visionary CEO who approached legislatures to write recertification testing into statutory requirements. Think about the difference between a national certification body and a federation of licensing boards. It's pretty difficult to get fifty states to agree to anything, which makes it cumbersome to get models in place. A certification body has uniform requirements for all certificants, regardless of where they practice.

We have developed physician assistant competencies, based largely on the competencies developed for physicians. We focus on medical knowledge, but are looking for ways to test more competencies. We recently revised our maintenance of certification process. We changed from a six-year to a ten-year cycle and got more specific about the kinds of CE that are acceptable. Every two years, PAs need one hundred CME hours in specific categories. Twenty of these need to be designated either "self-assessment" and / or "performance improvement." By the end of the fourth two-year CME cycle, PAs need to have a minimum of forty category one credits that are self-assessment and a minimum of forty that are performance improvement activities. There is some flexibility about when these are accumulated, but they must be completed by the end of the fourth cycle. We expect most of the time during the fifth cycle will be spent preparing for the certification exam.

Why are we excited about self-assessment? There are things you know you know. There are things you know you don't know. The most dangerous area and the things you don't know you don't know. This is where practitioners are unconsciously incompetent. Hopefully, the value of having self-assessment is to help dial practitioners into what they don't know.

A 2012 study concluded that more than twenty percent of core information guiding clinical practice is changed within one year based on new evidence or new practice guidelines. This really puts pressure on keeping up with what one knows and being aware of what one doesn't know.

Some self-assessment is formative in nature. Practitioners answer questions, find out why they missed an answer, and get links to resources for education.

Performance improvement activities include PICME, which is an active learning experience and the application of learning to improve practice. It is a three-step process beginning with comparing one's practice to a national benchmark. The incentive is to pick an area where you know you need improvement. Second, based on the comparison, you develop and implement a plan for improvement in that area. Third, compare the results of the original comparison with the new test results to document the improvement that has occurred.

I believe that in the future, a lot of learning will be driven by assessment. An article in The New York Times, entitled "Why Flunking Exams is Actually a Good Thing" explains how helpful it is to take an exam and focus learning on what you don't know. Many certificate management programs involve a pre-test, followed by an online study module. Those who pass the test can go to a workshop where they learn more. Those who pass the post-test get a certificate. The quality of offerings is going up.

NCCPA does practice assessment using 120-question practice exams. The feedback includes a probability profile showing where a certificants performance compares to those who have passed

the recertification exam. Practice competencies are becoming more prevalent. These include some of the softer things that practice analyses often ignore, such as how well you communicate or how ethical are you.

Many professions see a tension between core knowledge and practice vs specialty knowledge and practice. We are designing this into the competency structure in hopes of doing something with it downstream. We developed a goal wizard, which asks questions about where people practice and what they like to do to steer them toward competencies they want to have in their practice. It helps certificants develop their own learning plan.

We are headed toward a model where there will be some assessment of general core activities and also assessment of specialty areas of practice or a focused area of practice because that resembles the reality that practitioners are learning more and more about less and less. A hybrid model could include documenting core knowledge through an online assessment while doing a periodic formal assessment of focused areas of practice.

We also collaborate with regulators in the usual ways about discipline. We count on the states to let us know when they discipline a certificant. We will include that in our database and de-certify the individual if it is serious enough.

Lane – Justin and I are going to tell a story of collaboration between regulators and the professional association. We have not always been successful in our efforts to collaborate, but we have learned from the past and the current association some things about how to make it happen.

We have minor differences in our mission statements, which lead to potential conflict and disagreement. But, there are things we can do to mitigate and avoid disagreements. The Federation of State Boards of Physical Therapy is the membership group for fifty-three licensing boards. We have the standard structure with a board of directors and delegate assembly. Our mission is to protect the public and make sure physical therapists are competent and safe to practice.

Elliott – APTA is the national professional association for the physical therapy profession. We have approximately 89,000 members, with chapters in all fifty states and the District of Columbia. We are guided by our vision statement, which was adopted in 2013. It says the role of physical therapy is "to transform society by optimizing movement to improve the human experience." To try to make that vision happen, we do everything from ensuring that patients have access to the full scope of practice for physical therapists to promoting excellence in education and research, promoting ethics and professional behavior, and educating the consumer about how physical therapists' services can assist them.

As a membership organization, we listen to our members and they are very involved in how we make decisions. We have a board of directors tasked with the operation of the association. We have a 440-member house of delegates, which makes policy for the association. The third element in our governance is committees and task forces appointed by the board of directors. The largest is the public policy committee, which advises and recommends to the board of directors on issues surrounding public policy, such as licensure or Medicare issues.

Lane –The topic we will talk about today is license portability and the problems created by our state-based licensure system where therapists can't easily move across state boundaries without obtaining another license. It is burdensome to maintain multiple licenses and fulfill different jurisdictions' renewal and continuing competence requirements. We found one practitioner who maintains thirty different licenses.

New healthcare models don't necessarily lend themselves to state-based practice. Accountable care organizations and other new delivery structures generally operate across state boundaries. Physical therapists who want to practice in adjoining jurisdictions like Virginia, Maryland and Washington, DC need to be licensed in all three. Our delegate assembly started bringing this problem to our attention in 2010 and suggested we look at the Nurse Licensure Compact and other portability models for ideas.

Elliott – APTA's House of Delegates has adopted a lot of positions over the years, including several related to licensure and consumer protection. But, it had never adopted a position on portability or inter-state practice, even though our members do complain about having to obtain multiple licenses to travel between states. In the last two years there has been an uptick because of the increased use of telehealth. Some recommended supporting a telehealth license. Others wanted us to think in terms of the broader issue of portability.

Lane – As we searched for a solution from the regulatory perspective, we noticed that the Federation of State Medical Boards' delegate assembly passed a resolution in 2013 to pursue a compact. We learned that the National Association of State EMS Officials was also pursuing a compact. We talked to these organizations and the National Council about adopting a compact simultaneously, or at least in sequence, rather than having each organization approach portability differently. This is an example of collaboration not only with the professional association but also with other professions.

We believed a key to our success, which nursing didn't necessarily have when they pioneered this approach in 2000, would be having the professional association on board with the idea. This is because a compact will require legislative action.

Elliott – In conversations with Mark and APTA staff, we saw the potential and recognized that this involves a new way of looking at licensure and inter-state relations. We had to make sure our members understood where we were going and had buy-in. With the support of the House of Delegates we can go to policy makers and say the profession is behind the concept.

The first step was to get the APTA public policy committee involved. We put it on their agenda about a year ago and provided background information. Mark came and made a formal presentation. The committee voted to recommend to the board that APTA support models of portability including an interstate licensure compact for physical therapy. The board adopted the recommendation and voted to submit it to the House of Delegates.

Lane – I wasn't very happy with this response because I knew that things can get convoluted in the House of Delegates and the outcome can be different that originally intended. We appointed an advisory task force, which met twice in 2014 to explore what a physical therapy licensure compact would look like. Justin and another representative from APTA served on that advisory task force and contributed greatly to the final decision, as did a state senator from Tennessee.

Elliott – The board moved forward with the resolution. We got background information to the delegates. We had an online town hall to answer questions. The public policy committee members talked to their delegates. The motion passed in June without any problem.

Lane – We held a Leadership Issues Forum in August to discuss current issues, including the compact. Our task force had recommended that the Federation move forward with a model similar to the nursing model. The Leadership Issues Forum embraced the idea but had questions about how the discipline element would work. We had a panel at our annual meeting in September with speakers from the Council of State Governments, the Federation of State Medical Boards, and others. We had a town meeting so we could listen to member reactions and take notes.

Elliott – APTA had its annual State Government Affairs Forum at the same time. We had a session on the compact, understanding that if everything went according to plan, we would be looking at pulling the trigger on potential state legislation in 2016. From a professional association standpoint, we need to start training our lobbyists and state chapter presidents and legislative chairs on the proposal and any concerns and questions.

The next task was developing a communication plan to inform the 89,000 members of APTA. The last thing we want is an unhappy member going to a legislator with misinformation about the model. Last week we rolled out an interstate compact resource page, which hyperlinks a lot to the Federation's page. We used social media to highlight it. Within 24 hours we had something like 240 'likes," eighteen comments, and seventy-five shares on our Facebook posting alone. This was the greatest reaction to a Facebook posting in a long time. Our six-month communication plan includes a feature article in our monthly magazine, sessions at APTA meetings in 2015 to educate chapter leaders and general members on what this is and what it means to them.

Lane – Of the eighteen comments, all were positive except one person who said, "I don't believe it will ever happen." We have developed a drafting team and hope to have draft language to bring to our members by mid-2015.

Elliott – If everything stays on the timeline, next fall we will be ramping up state chapters with model legislation and encouraging them to work with their state boards. At this point we are thinking that a minimum of ten states need to enact compact language for it to become effective. We hope to accomplish that in 2016.

Lane – One reason both our organizations are getting such traction is because it is a collaborative effort. Among the things we have learned is that it is important for the professional association and regulatory body to communicate. The first lesson is "Keep each other informed – no surprises."

Elliott – Understanding that most professional associations have a governing process that is pragmatic and can be frustrating, but if the wheels turn the right way, you have buy-in. Policymakers like to know that the membership has discussed, debated and supports the proposal.

Lane – A second lesson is "Don't make assumptions." Also, honesty and transparency are critical, even in subjects where you might disagree. Another lesson is that joint board meetings

are helpful. We get our boards together to talk about potential areas of collaboration. This example has shown the value of getting each other involved in projects that further overlapping aspects of our missions. Where our missions differ, it is okay to disagree.

Hartigan – I want to talk about how nursing and nursing regulators have moved toward a consensus on regulation of advanced practice nursing. We have had confusion and lack of cohesion in nursing. I am going to talk about how we have moved toward a consensus model to solve these issues.

Nursing started the licensure process back in the early 1900s. When nursing roles advance, or someone is needed to do something like give anesthesia, nurses say, "We'll do it!" It may not have been in their nurse practice act, but if someone was needed, nurses stepped up. Between 1900 and 2000, the US population increased but the physician population didn't keep up with that increase. We kept training more nurses and having advances in medical science, so nurses started doing more things to keep up with the influx of patients. Doctors didn't want to stay in the hospital all night and watch critical care patients, so they let the trained nurses interpret heartbeats and defibrillate patients and give them IV medicines and so on. In 1965, a pediatric nurse practitioner program was started because there were 4 million babies born every year. Subsequently more nurse practitioner programs were established. In 1971 Idaho recognized diagnosis and treatment as part of the nurse practice act. Nurse midwives and nurse anesthetists were certified.

Nurse practice acts weren't keeping up with the increase in the number of nurse practitioner certifications. In 1973 I started working in the ICU. The nurse practice act said I would work under the supervision and direction of somebody who was authorized to sign birth and death certificates. It didn't say I could shock someone after interpreting his or her heart rhythm, but that is what I did. In 1975, thanks to the American Nurses Association, more modern nurse practice acts calling for the independent practice of nursing were enacted in some states. The federal government and others supported advanced practice roles. In 1983 the Missouri Supreme Court ruled in a case involving a complaint against nurse practitioners educated in the advanced practice role for practicing medicine without a license. The Missouri Supreme Court overruled the complainants because the state had enacted (over the governor's veto) an advanced practice act that talked about the independent role of nursing. The statute was intentionally vague because the hallmark of a professional is knowing where one's scope of practice stops and when you need to refer to another practitioner.

After this time, state boards of nursing began to develop advanced practice- specific statutes or rules. The National Council of State Boards of Nursing began to work with advanced practice certification organizations to make certification exams sufficient for regulatory use. At this time I was working for the National Council of State Boards of Nursing, which provides the licensure exams for all RNs and LPNs. But, there was no similar exam for Advanced Practice Registered Nurse. Certification organizations for nurse anesthetists and nurse midwives had their exams and nurse practitioners had a variety of exams developed by such organizations as the American Nurses Credentialing Center and the American Academy of Nurse Practitioners Certification Program. The quality and depth of these exams was all over the board, so the National Council asked that they be standardized and accredited.

In 2004, a group of stakeholders got together to develop a consensus model for advanced practice regulation. There were complaints that nurse practitioners were breaking off into specialties that were so small the situation was unmanageable. In the meantime, the National Council was working on a vision paper for advanced practice regulation. In 2007 these two groups got together and agreed to develop a cohesive vision of advanced practice regulation that would protect the public and be a forward looking model.

These groups recognized the need for common definitions, standardized educational programs, and some uniformity in scopes of practice from jurisdiction to jurisdiction. There were so many different requirements and rules on the books that it was impossible to develop one big APRN consensus document. But, we needed something that would ensure safety, increase access, and facilitate mobility.

Here's an example of telehealth that we have been doing in critical care for a long time. In a virtual ICE, a nurse sits in an office building monitoring a critical care unit in three or four hospitals, sometimes in faraway states. They are monitoring vital signs and can camera in and talk with patients. What state are they licensed in? Employers in non-compact states are having these nurses get licensed in every state they service remotely. MDs direct most units, but on some shifts in some units, the MD may be spelled by an acute care nurse practitioner. What would be the scope of practice if they can't prescribe in one of the states where they are monitoring? So, when we talk about telehealth, it is not just about doctors. Nurses are doing it, too.

The definition of Advanced Practice Registered Nurse does involve direct care. This is important because APRNs need legal protection to diagnose and prescribe – legal protection beyond what is needed by an RN.

The regulatory model covers basically four roles: Nurse anesthetists, nurse midwives, clinical nurse specialists, and nurse practitioners. There are six population foci: Family/individual; adult/gerontology; women's health/gender-related; neonatal; pediatrics; and psychiatric/mental health. Those who want to be certified in a specialty such as oncology, orthopedics, or nephrology can do that in addition to licensure.

The most controversial thing is that boards of nursing will license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision. This is causing legislation to be introduced in a number of states. The implementation date was scheduled to be 2015. But, new certification exams needed to be developed. That has been done. Education programs had to develop new curricula. Accreditors had to develop accreditation standards. The biggest sticking point has been making regulatory changes in the states.

Another 2015 deadline is the American Association of Colleges of Nursing's initiative to make graduate education at the doctoral level.

We learned some lessons. Just because you think something is a good idea doesn't mean everyone will agree. Some say this is just a moneymaking idea by the boards of nursing and certifiers and educators. Some oppose unsupervised practice. Second lesson: No changes will be made to the model until after it is implemented.

The most important thing we learned is that we had to have crucial conversations with the stakeholders. In certification, we have traditionally collaborated through the American Board of Nursing Specialties. Coalitions are critical. This is not a turf battle. Satisfied consumers matter; it isn't all about us. The IOM incorporated the consensus model in its report on the Future of Nursing. The Citizen Advocacy Center has source documents that have helped immensely. The Federal Trade Commission has been an advocate. So have the Coalition for Patients' Rights, AARP, nursing association chapters, and so on.

Comment – This is how nurses are their own worst enemy. Just as advanced practice nurses are needed to meet the demand for primary care, we are upping the ante from Master's Degree to PhD. Aside from the expense, this is a non-starter in Maryland when nurses can be filling the gap in access.

Hartigan – A PhD is not required. Many of the doctoral programs are post-graduate programs for people who already have a Master's degree and APRN. I know that the University of Maryland switched over to a generic Doctorate of Nursing Practice (DNP) program where it had traditionally been an MSN program. Having the same implementation date as the consensus model implementation date of 2015 has caused much confusion. It caused some people to earn a doctorate in the mistaken belief that it was required.

Comment – It has been very confusing in Maryland. The University of Maryland obliterated the Master's program. The DNP is not the same as a doctorate of advanced practice. On top of this is the issue of scope of practice. This is a time when nursing needs to come together and be creative about delivering care, such as taking the care to where the patient is.

Hartigan – The consensus model emphasizes the importance of taking the care to where the patient is. We need to stop being so setting-specific because the nurse competencies need to match patient needs. We know there are critical care patients in long-term acute care hospitals and in the home. We don't know where patients are going to be in five years.

Question – What third-party entity would manage a physical therapy licensure compact and how would it be constructed?

Lane – This is under discussion now with the nurse licensure compact and the Federation of State Medical Boards. It would be a governmental entity. We are getting legal opinions about it.

Question – As a patient, I find it disconcerting that the standards vary so much from state to state. Are you seeking the public's perspective as you work toward more consistency? Would it facilitate your work – especially before legislatures – to be able to document what patients' need? How have you involved patients in the process so far?

Barnhill – I think you are right about the public protection angle. CAC is one of the few places where there is a public focus. Even at the certifying agency level, it is mostly practitioners who are driving the train. Practitioners also dominate on licensing boards. The competency models NCCPA is working on offer opportunities to capture patient input more than do tools such as multiple-choice tests.

Lane – For the PT compact, it is really the public that has been the focus from the get-go. Our goal is to increase access for the public, not to make it easier for physical therapists. We have been diligent about involving public members on our task forces throughout the process and will continue to do so.

Hartigan – Certifying bodies in nursing have one public member. I have focused on public input in the access area through work with the Coalition for Patient Rights. We sought out patient testimonials regarding access. We need to do more and this is a recommendation I will take home.

SESSION III – COLLABORATION WITH INDEPENDENT OUTSIDE GROUPS FOR PROGRAM EVALUATIONS

Sandra Evans, Executive Director, Idaho Board of Nursing

Julie George, Executive Director, North Carolina Board of Nursing

Devinder Singh, Chair, Maryland Board of Physicians

Evans – Up until 1985, nurses who were known for either drug use or mental health disorders had their licensed revoked in Idaho. Following the lead from Florida, the Idaho board adopted a belief statement, which identified the two disorders as primary illnesses that, if treated, would allow practitioners to return to safe practice. With that, we began the implementation of an alternative to discipline program for chemical impairment and mental health disorders.

The Idaho program was implemented in 1985 at which time it was managed in-house by board staff. As competent as the staff was, none of us specialized in either of these disorders. In 1996, the board decided to outsource the day-to-day monitoring of the program to an independent contractor, but we maintained the administration of the program in-house using an appointed advisory committee as our overseeing entity.

The successful bidder has held the outside monitoring contract since 1996, even though we go out for bids every four years. From 1996 to the present we have done comprehensive in-house audits of the program. The contractor did a self-audit. The advisory committee did an audit. The board did an audit. We feel confident that what we are doing is what we should be doing and that we are appropriately protecting the public. All the responsible parties work and talk together, including the contactor, the advisory committee, board staff, and the board members.

As with any internal process, at some point the board questions whether or not they are accurately seeing what is going on. This was especially the case because the California medical board's and the Oregon and Indiana nursing boards' alternative programs ran into trouble. Our concern was that unless we have an outside eye looking at the program, we couldn't be absolutely certain that we were doing the degree of due diligence a regulatory board should do.

We wanted to retain accountability for the initiative. We wanted to be fully informed of what was going on with the program. We also wanted to strategically position the board to be able to address either the media or the legislature if any issue came to light. We also wanted to minimize any risk to the board of nursing if accusations were to come forward or media attention was focused on the program. We also wanted to identify and address problems before they arose.

We undergo fiscal audits by the state on a triennial basis. This always is enlightening and identifies any issues that could become potential problems. The issue with our alternative program was who to invite to do the audit. There wasn't a state entity we thought we could rely on that would be knowledgeable about the program and the subject. We wanted someone who knew about regulation, as well as the risk of chemically or mentally impaired nurses. We also wanted somebody who could be an advocate for public safety. Thanks to our colleagues in North Carolina who had a faster process for securing funding for an initiative like this, we knew that CAC could do this and that CAC's mission is very much like ours. CAC had experience helping regulatory boards improve their performance to shore up public confidence in regulatory boards. They share many of the core values we rely on. In fact, we have turned to CAC for a lot of the information we seek as we move ahead with regulatory issues.

This was not an inexpensive venture. The Idaho board is small. We have a limited budget, but we knew up front from CAC what the anticipated cost would be and they were willing to work with us to help us best manage the resources. We also became aware that the National Council of State Boards of Nursing was willing to help support the initiative.

It took us a couple of years to approve the project through the board of nursing and to advance the budgetary proposal. By the time we secured the budget for the project, North Carolina had moved ahead and we had a very good idea of how the process would work. We spread the project over two years so it would involve two site visits by CAC and two reports. The total cost to our board was about $30,000, which was very manageable for this small board with some help from the National Council.

Prior to the audit, CAC asked us to do a self-study and pull together all the documents needed to better inform CAC before they came on site. At each phase of the audit, we asked the site survey team to provide us with two sets of recommendations. The first set addressed what needed to be done today to stay out of the headlines tomorrow. The second set of recommendations addressed what the board could do over the longer term to continue to make this program better. We jumped on the first set of recommendations immediately. We continue to work on the other recommendations.

What was so important to us was that we did this as a collaborative effort, first between the board, our contractor, our advisory committee, the staff, and also with the outside entity that was knowledgeable about our mission and our responsibility to the public, aware of what these kinds of programs do and don't accomplish and how they could do that better. The partnership with CAC was a perfect one for that project.

George – The important aspects of regulation for public protection include investigation of complaints, case resolution, and effective disciplinary remedies. As regulators, we all know the importance of our public protection mission and recognize that all our programs and procedures must have the necessary rigor to inspire public confidence and credibility. Today, I would like to share with you our experience of engaging CAC to conduct external reviews of both our alternative program for substance use disorder and our disciplinary proceedings.

In 1994, our board authorized a pilot project to monitor nurses with substance use disorder without resorting to disciplinary action. In order to maintain integrity and control of the pilot, we operated our program in-house and continue to do so today. We now have over twenty years of

experience with our alternative program and take pride in our success operating what we feel is a tight and credible program. We also recognize the need for external review. The purpose of the review was to assess the accountability of the program.

We did our review in two parts. First, CAC reviewed the "architecture" of the program. CAC evaluated the program governance. They looked at the law, administrative code and rules and our policies. They solicited feedback from participants in the program, board members, and advisory committee members. They looked at how we informed our board members and the public of this program's mission and results. After the in-depth review, they came on-site and did a two-day intensive review of our architecture through interviews and came out with recommendations for us. From those recommendations, we developed an action grid so we could measure our progress in moving forward.

The second evaluation occurred in 2010. This time, CAC came to look at the implementation of the program. Were we doing what we said we are doing? The scope of this review included how individuals are admitted to the program, what the workforce monitors do, the integrity of the reporting process, the integrity of drug / alcohol screening reports, criteria for successful completion or termination from the program. The second phase yielded about twenty recommendations and more than twenty-five action items. We recently completed all the action items. Since 2010, the board has received a progress report at every meeting.

As we found so much value from that review, we decided to look at our disciplinary processes. We did this in one review, both architecture and operations. The scope ranged from examining our processes for complaint review through case resolution and reporting of our actions. The review of the disciplinary processes culminated in seventeen recommendations. We have now completed fifteen of twenty-five actionable items, but we continue to work on the recommendations. A lot of them were related to our transparency to the public. We have made changes to our Web site. We have developed FAQs for consumers. We have assured consistency and equity in actions. As a result of the audit of disciplinary processes, we convened an ad hoc committee of board members and staff to continue to look at those items that weren't actionable items, but were things we wanted to work on.

Henry Ford once said, "Coming together is a beginning; staying together is progress; working together is success." I think this speaks to our experience with the external review of our programs. I think we had a very good fit with CAC. As Sandy said, they understood our mission; they had the public perspective at heart; and it felt as though we were full partners working together. It was a respective, collegial review that brought a fresh perspective to us.

I truly believe that regulators cannot rely on self-evaluation to get a full, impartial, objective evaluation of their programs and stand before their legislators and claim to do continuous quality improvement. Outside review gives a level of assurance, compliance, and integrity and also provides board members with impartial data on which they can base their decisions. One of the greatest benefits of an external review is that you are not letting the fox guard the henhouse. You had someone come in and look at what you are doing, why you are doing it, and how well you are doing it. We found that incredibly valuable.

Singh – I am a plastic surgeon and the chair of the Maryland Board of Physicians. The mission of the board is to assure quality healthcare through efficient licensure and effective discipline… You are professional regulators, but I am just a plastic surgeon. It took me a long time to figure out what a regulatory agency actually does and how to think about it. For me, it wasn't straightforward that we do three things: We license. We discipline. We create policy. That last aspect is the most interesting part to me.

The Maryland Board of Physicians also regulates nine allied health specialties, including athletic trainers, nuclear medicine technologists, physician assistants, sleep medicine technicians, and more. The Maryland board is the third largest medical board in the United States. We issue close to 30,000 initial and renewal licenses per year. We have three huge academic medical centers in the state – Johns Hopkins, the University of Maryland, and NIH. For fiscal years 2011 through 2013, we have issued licenses in less than ten days ninety-five percent of the time. This is an accomplishment.

The anatomy of the board has changed. It is now twenty-two members, eleven of whom are physicians, one Department of Mental Health representative, one physician assistant, one risk manager nominated by the Maryland Hospital Association, and five public members.

I think of discipline as policing the turkeys. Most healthcare professionals do a good job and maintain the standards of their licensure. But, the turkeys fall below those standards. We receive about one hundred and twenty new complaints per month. The truth is we pull a lot of those because they are very minor, like "The doctor made me wait," or "The doctor's office wasn't clean." But there are some very significant complaints. Most complaints come from patients, but we also generate investigations from other sources, including "yes" answers to character questions on applications, inter-agency referrals, and insurance payouts of over $150,000.

The most common thing the Maryland Board of Physicians charges licensees with is immoral or unprofessional conduct. The second most common is failure to meet the standard of care. Some of these cases are better than reality TV -- a case of a secretary performing laser hair removal, sexual misconduct, a gynecologist who performed liposuction and stabbed the intestine eighteen times, and many cases of disruptive physician behavior. We see pill mills, failure to meet CME requirements, and a lot of substance abuse. The Maryland state rehabilitation program has both voluntary and mandatory enrollment.

The disciplinary process is complex and has completely changed. By law each step is allowed to take up to ninety days. We are criticized that we take too long to resolve cases.

In 2011, the day I was appointed, the Department of Legislative Services released its sunset audit of the Maryland Board of Physicians. It was an extremely negative report. There were forty-six significant areas where the board could improve operational efficiencies. The trouble was that multiple previous sunset reviews had identified many of the same deficiencies. One major issue was the backlog of cases. Another was inconsistency in sanctioning communication and transparency. The board was threatened with dissolution unless urgent and innovative action was taken.

The board finally got the message and entered into a memorandum of understanding with the University of Maryland at Baltimore's President, Dr. Jay Perman. Essentially, the board admitted

there was a problem and asked for help, which is an invitation for more criticism. Secretary Sharfstein recommended we go to Dr. Perman, who was also the Dean of the medical school in Kentucky, which meant he was automatically a member of the medical board. He pulled in a lawyer, a public policy expert, and another physician to interview staff, board members, and others. They generated a report in July 2012. (http://www.mbp.state.md.us/forms/final_bop_report.pdf) It contains eighteen concrete recommendations for the board to adopt, if possible.

Between 2012 and 2013, the board was in Annapolis almost every day trying to push through this legislative agenda. In 2013, a bill was passed to reauthorize the board for another five years. So, this was a huge success for the board. There is still work to be done.

What have we done? We completely eliminated our case backlog. We divided the board into two panels so we could double our workload and quickly reduce our backlog. We worked with the Secretary and the governor to fill board vacancies. We engaged the services of a CPA firm to address fiscal and financial issues that we can't handle. We filled staff vacancies. We initiated an audiovisual process for board members to telecommute. We have promulgated all the regulations that we are supposed to be promulgating and we implemented expedited licensure processes for various specialty groups, such as veterans, military service members, and their spouses.

The two-panel system was not easy to implement. It is an incredible challenge for the staff to keep track of the process. A case comes in. It is assigned to a panel, which investigates and tries to settle the case informally. If it cannot be settled, the case proceeds to a hearing. After the hearing, if the case comes back, it comes back to the other panel. That crossover increases due process for the licensee because the panel that investigates and charges is not the same panel that adjudicates. In FY 2011, we had eighty-five cases that were more than eighteen months old. Now, we have no cases in backlog.

Our current legislative agenda includes criminal background checks. The governor has issued an executive order prescribing topics for CME. This is controversial because we have had many special interest groups saying doctors should learn about their issues. In Maryland, there were eight hundred overdoses related to opioids. Many of them were related to prescription drugs, so the governor has asked that one hour of the CME requirement teach safe prescribing.

What lessons have I learned? Many positive things can result from a negative audit. I teach my residents in the operating room that it is not the first mistake it is how we respond that will determine patient outcomes. We redoubled our efforts, we asked for help, and we were open to reform. It wasn't easy and we have HR issues with our staff because of the increased workload. We try to keep public health central to our mission. Collaboration with independent review has helped us to license and discipline more efficiently. Because we have no cases in backlog, we have time to perform outreach and focus on policy. By being more efficient on the front end, we are able to focus more on prevention and policy.

The agency also works better when the board members have a good relationship with the staff. We formed an executive committee composed of interested board members and the executive leadership of the staff, which meets monthly.

Keeping the focus on public health and not the interests of the professional association has been the most important thing. About fifteen years ago, the medical board was actually run out of the state medical society.

Question – Could you talk a bit more about the very notion of an outside collaborative review? To many, that may sound suspect. If the reviewer is collaborative, are they compromised? What can make a collaborative external review special?

Evans – In Idaho's case, we sought the review because we thought it was necessary. There was no urgency. When we entered into our dialogue with CAC and eventually our contract, we were very clear about our need and our expectation that we would receive a thorough, honest review of the architecture, processes and outcomes that could help us improve our performance. We entered into it fully recognizing the roles of each entity. Our expectation was information that would be helpful to us. Our expectation from CAC was that its work be honest, thorough, affordable, and timely. Had there been a crisis in the state that prompted the review, we might have thought about it differently.

Singh – If an agency has to invite in an agency like the Office of the Inspector General, the stakes are much higher than if it invites in someone who is consulting and providing recommendations. So, the reason the review is under consideration can affect who is chosen to do the review.

George – I think there is added value to the review if it begins in a respectful collaboration and sharing of information and ideas with clear outcomes in mind, the communication is richer.

Evans – We weren't looking for anyone to come in and tell us how good we were. We wanted somebody to tell us how we were. It felt like a partnership.

Question – May I ask each of you to explain briefly about the structure of your agencies? For example, do you have your own investigators and attorneys, or do you have to share them with other agencies?

George – We have our own resources, including investigators, prosecutors, and attorneys.

Singh – I don't think our backlog occurred because our investigators were overworked. It was the processing of some cases. Some were buried in in-boxes or lost behind a file cabinet. Others simply weren't assigned to hearing or hearings were cancelled and re-scheduled.

Question – Dr. Singh, you spoke about mandatory ninety-day intervals between steps and you said you couldn't do anything about it. Why couldn't you go to the legislature and have that changed?

Singh – We could. That is part of what the new two-panel process has achieved. It is not that there must be ninety days between steps; it cannot take more than ninety days to complete each step.

Question – Were there any findings regarding the consistency of the medical board's discipline decisions? Have you found inconsistencies since you created two panels?

Singh – It is too early to determine whether the two-panel system will produce inconsistencies. The initial audit did find inconsistent sanctions and recommended sanctioning guidelines, which we created for each of our nearly 50 available charges. We set ranges for various sanctions.

SESSION IV – MULTI-BOARD COLLABORATION FOR JOINT RULEMAKING

Ruth Ann Arty, Executive Director, Maryland State Board of Morticians and Funeral Directors

Carlton Curry, Executive Director, Maryland Board of Physical Therapy Examiners

Marilyn Harris-Davis, Executive Director, Office of Cemetery Oversight, Advisory Council on Cemetery Operations, Department of Labor, Licensing and Regulation, Division of Occupational and Professional Licensing

Penny Heisler, Executive Director Maryland Board of Acupuncture

Nicole Krishnaswami, Operations and Policy Analyst, Oregon Medical Board

Krishnaswami – Our board's mission is to protect patient safety. Our secondary aim is to promote access to quality care. Our board has twelve members appointed by the governor and confirmed by the senate. We have ten professional members, seven of whom are medical doctors, two osteopathic physicians and one a podiatrist. We have two public members. Our board works through standing committees that advise the board.

The overwhelming majority of our licensees are MDs and DOs. We also regulate acupuncturists, physician assistants, and podiatrists. The first rulemaking I will talk about entailed defining the scope of practice of podiatric physicians. This took place over six years. There were two issues to tackle. The first was arriving at a definition of the ankle and the second was determining who is authorized to perform ankle surgery.

Our medical board assumed responsibility for regulating podiatrists in 1981. Before that, they had their own board. In 1995, the podiatric association sponsored a bill to expand their scope of practice to include ankle surgery. The bill never gained traction and ended in a study group of the podiatric association and medical association, overseen by the medical board. The group met two times in 1996 and then asked the medical board for a definition of the ankle. The board sent a highly technical definition back to the study group, which met a third time and thought it had reached a consensus. They proposed another bill in 1997. The medical association opposed the bill because they decided that they had not reached consensus after all. A revised bill was proposed in 1999 calling for establishing qualifications for those podiatrists who would be authorized to perform ankle surgery. This narrowly passed the state legislature, on the condition that the Oregon Medical Board would determine the qualifications.

The legislation already established that only board-certified podiatrists were to be authorized to perform ankle surgery. But, certification standards changed in 1991, so there were two different groups of ankle-certified podiatrists. The medical association wanted only those certified after 1991 to perform surgery. The podiatric association wanted all certified podiatrists to be included. The medical board developed two different tracks in its rules, one for those certified before 1990 and a second for those certified after 1991.

The second rulemaking involved office-based surgery. This evolved over a ten-year period. In 2004, the state medical association asked the board to adopt rules requiring accreditation of facilities where office procedures are performed. This followed some deaths in other parts of the country when physicians weren't properly trained, didn't have resuscitation equipment, and didn't have good criteria for patient selection. In 2005, the board presented draft rules and held a public hearing.

Numerous issues were identified. First, tumescent liposuction regulations were addressed. The board had to decide whether to require hospital privileges for providers and to determine the board's jurisdiction over providers not licensed by the board and facilities. In 2006, the rules were completely re-written and another public hearing was held. Then in 2010, an internal medicine doctor in Oregon injected anesthetic into a patient in preparation for a tummy tuck. The physician offered the procedure to the patient (who was also her employee) for free in the clinic after hours. The clinic had no emergency equipment. The physician had no way to resuscitate the patient or transfer the patient in case of an emergency. There were no other personnel in the office at the time. The patient had a reaction to the anesthetic and ultimately died.

The board ordered an emergency suspension and later revoked the physician's license. The physician was also convicted of criminal charges and can never again practice medicine anywhere. Following that high profile case, the board went into rulemaking and in 2011 presented a set of more detailed draft rules. By the end of the year the rules were tabled again because they didn't adequately address cosmetic procedures. By early 2012, the plastic surgeons began providing public comment. By spring, the rules were redrafted to address lipoplasty. The board also began working with the other boards that might be affected by office-based surgery, including the nursing board, the pharmacy board, cosmetology, and dental boards to identify potential overlap in scope and make sure we weren't proposing anything that would contradict their rules or infringe on their territory.

Stakeholder interest really peaked during 2012 and we began receiving public comment. The issues were chiefly the same as those identified in 2005, mostly around liposuction regulations, such as hospital privilege requirements, and the limits of board jurisdiction. By the end of 2012, we had multiple public groups submitting letters and attending public meetings. These included national professional associations, national accrediting bodies, state medical association and licensees, patients, the media, lawyers from elsewhere in the country.

In 2013, we held a public hearing, formally received comments, and published an official document responding to each in a public document. We continued research throughout 2013, reviewing other state regulations, the medical literature on safe anesthesia practices and dosage, and so on. In October 2013, the rules were ultimately adopted. Today education continues on these rules.

To what do we attribute the success of these proceedings? The first principle is to be transparent and maintain communication. Our board posted notices on newsletters, email ListServes, with the Oregon Secretary of State, and more. We also maintain a list of interested parties, who we keep updated before and after each public meeting. We also respond to every phone call and email, explaining the rulemaking process and the content of the rules.

Second, whenever possible, the board incorporates requested changes or responds to requests that cannot be accommodated. We also solicit feedback from stakeholders and notify providers when they are subject to rules. Sometimes we reach out to licensees for their specialized expertise.

The third principle is to find common ground. Our board was the mediator between opposing viewpoints in each of the proceedings I described.

The fourth principle is to take your time. Even non-controversial rules take at least six months so that the public has time to be informed and board members have at least two committee and two board meetings to review and discuss the rules.

Finally, let the mission guide every alternative being considered. Patient safety is the ultimate goal. We often ask public members their opinion about which alternative best protects patient safety.

Curry – I am the Executive Director of the Maryland Board of Physical Therapy Examiners. The goals of our board are public protection, defining the scope of practice, and showing that there is reasonable regulation. My board collaborated with the acupuncture board on a therapeutic intervention called "dry needling."

The proposed regulations define dry needling as "a therapeutic intervention known as intramuscular manual therapy that involves insertion of one or more solid needles, a type of mechanical device, into or through skin to effect change in muscles and tissues for the purpose of alleviating identified impairment." Dry needling is used only where there is impairment. It is not used for things like smoking cessation or depression. That's the legalese. The reality is that physical therapists take needles known typically to acupuncturists and insert them into muscles – hence, the problem.

Dry needling is an evidence-based practice with a lot of literature to support its efficacy. Maryland was the first state to permit dry needling by physical therapists in the late 1990's. By July 2013, twenty-six jurisdictions, including the District of Columbia permit physical therapists to perform dry needling.

Heisler – I am the Executive Director of the Maryland Board of Acupuncture. You may be wondering why it took the acupuncture board twenty years to question why physical therapists were performing dry needling. We received a complaint from the physical therapy board claiming that an acupuncturist was performing a physical therapy technique called dry needling. We weren't sure what they meant so they gave us a demonstration. One of the acupuncture board members said this is an acupuncture technique called lifting and thrusting. My board questioned why physical therapists were inserting acupuncture needles into patients when it was not within their scope. Not one accredited PT school teaches dry needling. It is only offered in continuing education courses of thirty hours. In Maryland, physicians need 250 hours to practice acupuncture and acupuncturists have to have more than 3,000 hours.

So, we decided to seek an opinion from the Attorney General's Office. We asked whether it was appropriate for health professional boards to expand their scope of practice to include an invasive procedure without first seeking statutory authority to do so and also whether they had the authority to insert needles in patients, especially acupuncture needles. We were not happy with the AG opinion, but the physical therapy board was.

Curry – Ninety-eight percent of all PT programs in Maryland require doctoral degrees. In August 2010, the AG ruled that the authority to insert a needle is not exclusive to acupuncture and the law gives boards broad authority to define what is in their scope. However, a board must adopt regulations and develop a statutory definition for dry needling for physical therapy and must specify standards of education at least as strict as those for physicians.

So, we assembled a task force including the boards, the public, educators, and other stakeholders. It took more than a year to develop the first draft of regulations. Everybody was unhappy. But, we kept working. Every draft was sent to the acupuncture board. Secretary Sharpstein called for an informal public comment period to get input early in the process. We received more than 900 comments from the profession and the public. Eight hundred were in support of physical therapists performing dry needling. The majority of the supporters were persons who had benefitted from the technique. So, the public's voice was heard. Secretary Sharpstein asked the board to further tweak the regulations before he signed the regulations. The regulations were published September 19, 2014, for a 90-day public comment period. The state acupuncture association had an online petition opposing the regulations. The physical therapy association was copied on about 250 comments. In all, there are about 1,700 comments from as far away as South Africa. This is a big issue for our boards and an opportunity for the public to be heard. Where are we now? I received an email and phone call last week from the Office of Legislative Review saying the regulations are on hold until a further review of up to 105 days.

Our boards' priority in all of this is protecting the public while providing access to care.

Arty – I am the Executive Director of the Maryland Board of Morticians and Funeral Directors, which is responsible for individuals and funeral establishments, crematories, and transporters.

Harris-Davis – I am the Executive Director of the Office of Cemetery Oversight, which regulates and licenses cemeteries, some crematories, and sellers of monuments and burial goods.

Arty – Consumers believe that one board regulates the death care industry, but not only are there two boards, the boards are in different departments of government. In 1999, the legislature instructed the Board of Morticians (Board) to issue a pamphlet on the scattering of cremains. At the time, crematories had no oversight except for emissions and pollution. In 2000, a senator proposed a bill at the urging of the Office of Cemetery Oversight (OCO), which felt it should regulate the crematory industry because this is a method of final disposition. All the funeral industry lobbyists opposed the bill, citing health concerns. The legislature did nothing for two years, even though the percentage of residents choosing cremation was rising. Another bill was submitted assigning regulatory authority to the Board, who would know how to handle and store unembalmed bodies. Eventually, a joint bill was proposed calling for some crematories to be regulated by OCO and those owned by licensees would be regulated by the Board. The bill failed twelve years in a row.

At that time I was the investigator for the Board. On my way home one evening, I stopped by a mortuary / crematory that needed its refrigerator re-checked to see if deficiencies had been corrected. I found a large pile of human remains in bags on the floor outside the crematory. I reported to the board, but there was no regulation for crematories, so we had no authority to do anything. But, we did have authority over the mortician's license, which was suspended. This

was the week before the sixteenth vote on regulating crematories. This time the bill passed and the job of writing regulations was given to the board. OCO said it had already written regulations.

Harris-Davis – The regulations had come from the Attorney General's Office. There had been no collaboration between OCO and the Board until this time.

Arty – The Board rejected OCO's regulations, which essentially said, "Pay and you are licensed." By this time, I had become the Executive Director of the Board. I knew the regulations needed to stop the kind of conduct I had seen as investigator. OCO rejected the regulations we wrote.

Harris-Davis – When I took the job, cemetery oversight was primarily business regulation. What I have come to find out is that there is an obligation to protect the health and welfare of the public – that is the people who are left behind. Ruth Ann and I took the crematory tour all over the state. This opened my eyes and we started to revamp our regulations with a different perspective.

There are important fundamental differences between our agencies. The Board is a self-regulatory board. OCO is not actually a board. People call it a board, but it is an advisory council. We have different statutory mandates and restrictions to overcome in terms of writing regulations. The Office of Cemetery Oversight advisory council has five for-profit cemetery members, one non-profit and one religiously oriented cemetery member, five consumer members, and a crematory operator.

Arty – After the crematory tour, we collaborated on drafts of the regulations. We formed committees including board members, investigators, staff, inspectors and a representative from each board who owned or managed a crematory. We met many times and held about ten public meetings before we finally agreed on regulations.

Harris-Davis – OCO is not mandated to have public meetings, so we didn't. The statute is clear that we have to have the identical regulations. It would be unfair for the regulations to be different. We worked hard to maintain a level playing field for the crematories regulated by the two different government entities.

Arty – I had an additional task because not only do I care about protecting decedents and their families I also have a responsibility to support the Board's licensees. The funeral establishments will carry the major liability for what happens in the crematories because it is the funeral home that is sued when something goes wrong in a cremation.

Harris-Davis – We got to a point in the development of our regulations where the Office of Executive Legislative Review put a hold on the regulations. It wasn't until January 2014 that the regulations were put in the Maryland Register. When they were put on hold, there were five issues left.

There are two areas of licensure: The business and the crematory operator, who is required to take certification classes and become licensed. One area of contention arose because we were told that OCO could not impose educational requirements. The Board wanted the equivalent of a high school diploma for the operator of the crematory. The compromise was that crematory operators had to prove that they could read and write.

Arty – When the regulations were finally signed in April 2014 we had to decide how to inspect and permit the thirty-eight crematories in Maryland. The Board regulates thirty-five and the OCO regulates three, but we decided to inspect together. Almost 40% of Maryland residents are choosing to be cremated so we fully expect there will be more freestanding crematories that are not operated by licensed morticians. On our initial inspection tour only three crematories passed inspection. Today, they have all passed. The operators actually say that their establishments are much better now that they conform with regulations, such as impervious walls and shelving, hot and cold running water, compliance with OSHA requirements, and so on.

Question – Mr. Curry, is your rulemaking informing curricular changes in DPT programs across the United States?

Curry – We are seeing a shift. The rules state that dry needling is an advanced technique and a PT must have two years of advanced experience prior to taking any continuing education course. Dry needling technique is now being taught in at least one of the approved schools. The grounding in anatomy and physiology that PTs have is sufficient for performing dry needling. The reason doctors need to have 250 hours because almost 2/3 of those hours are devoted to understanding traditional Chinese medicine ideas and theories. Physical therapists do not talk about energy fields, chi or meridians. They talk about muscles, tendons, and things of that nature. Our regulations say CE courses need to be approved by one of three entities, the professional association, the Federation of State Boards of Physical Therapy, or a program already approved to teach physical therapy at a doctoral level.

Question – My question is about interstate collaboration. How is what you have learned been shared with other states?

Arty – The funeral industry's international conference board has a committee of all the executives of all the states and Canadian provinces. We share information about legislation, changes in scope, and so on.

Harris-Davis – In the cemetery and crematory industry, there is an organization called the Death Care Regulators of the United States and Canada, which also meets annually. There is cross-state collaboration through this entity, but there is considerable variety in regulation from state to state.

Curry – The Federation of State Boards of Physical Therapy meets annually. With respect to dry needling, my board has been in contact with most states.

Question – I have heard recently of methods for disposing bodies in more ecologically sound ways. Will you regulators have to deal with this?

Arty – You are talking about alkaline hydrolysis. Maryland is one of several states where the definition of cremation satisfies both heat cremation and chemical cremation, so our statute allows us to regulate alkaline hydrolysis, but the current regulations are for heat cremation. Both of us earned the crematory operator certification, which has helped us with the development and enforcement of the regulations.

KEYNOTE ADDRESS – HONORABLE JOAN CARTER CONWAY, MARYLAND STATE SENATE

We are all about patient safety and the quality of healthcare, but I am here today to talk about issues. Legislators try to protect their constituents, but we don't always get it right. We passed a bill two years ago that dealt with sterile compounding. There are still some questions about the legislation, so we suspended implementation. I submitted a bill that exempted oncology patients so they wouldn't have to leave their doctors and go to specialized facilities. Also, physicians are concerned about being able to comply on the proposed effective date. We will work with the boards of medicine and pharmacy to iron out problems with the legislation.

Another issue is background checks for physicians, who are the only practitioners exempt from that law. There was a case in which a physician who had committed a crime in California applied for licensure in Maryland. The board did not know he had attacked one of his patients and was accused of rape. The board and many physicians now support legislation mandating background checks. Other physicians are concerned about who pays for criminal background checks and how often checks will be done.

We need to raise physician licensure fees, but don't want to do so until the board's technology is upgraded so we don't have to raise fees twice in a short period of time.

Another issue is dry needling. There is a fight about who is permitted to do it. Although we are consistently about patient safety, there are so many turf battles among the healthcare professions. Another issue involves mortuary science. We had a big fight with the morticians over whether and when to inspect. Why should we tell the licensee when the inspection is scheduled to take place?

Question – People talk about the cost to licensees of criminal background checks. We need to think about the cost to government associated with evaluating the criminal background checks, investigating questionable findings, and disciplining offending licensees.

Carter Conway – There are cost implications, but knowing a professional's background is an important public protection. This isn't just about the professional; it is about the quality of care.

Question – The media does a good job reporting sensational stories when things go wrong. How interested are they in reporting positive outcomes of regulation and educating consumers about what regulators do?

Carter Conway – The media sensationalizes. Very rarely does the media cover good acts with positive outcomes.

Question – When you send turf battles back to a task force, how do you expect them to proceed and what do you anticipate the outcome to be?

Carter Conway – When there is a turf battle, we would like the two parties to come up with a compromise. If they can't work it out during a legislative session, we will defer it until the next session and look at the task force recommendations. If they can't agree, the legislature will make the decision for them. This is usually an incentive to compromise.

SESSION V – COLLABORATION WITH FACILITY REGULATORS

Zeno St. Cyr, Public Member, Maryland Board of Pharmacy

Brian Ditzler, Vice President and Director of Communications and Government Affairs, Funeral Consumers Alliance of Maryland and Environs

St. Cyr – I am currently a consumer member of the Maryland's pharmacy board. Previously, I served ten years on Maryland's dental board.

The Maryland pharmacy board's vision is "to set a standard for pharmaceutical services which ensures safety and quality healthcare for the citizens of Maryland." Its mission is "to protect Maryland consumers and to promote quality healthcare in the field of pharmacy by licensing pharmacists, registering pharmacy technicians and issuing permits to pharmacies and distributors, setting standards for the practice of pharmacy through regulations and legislation, receiving and resolving complaints, and educating consumers."

Pharmacy boards are a little different from other boards in that they regulate both people and places. Dental boards have some regulatory authority over places in that they investigate violations in dental offices that don't use infection control procedures as recommended by CDC.

There are about 22,725 licensees and permit holders (about 43% pharmacists, 44% pharmacy technicians, about 9% pharmacies, and about 5% wholesale distributors). The bases for discipline are not only complaints, but also pharmacy board inspections. All facilities are inspected annually, and / or when they open, relocate, or close down. We also work with the National Association of Boards of Pharmacy (NABP) to inspect distributors.

The advantages of the pharmacy model are that our inspections allow for a review of places and people. The board can look at a pharmacy's operations, policies and principles, and procedures. This means we can provide more equitable sanctions. Is it really the pharmacy technician or the pharmacist who is responsible for the violation, or is it the policies or procedures in place at the facility that contribute to the problem? Because of the board's ability to sanction the facility as well as the individual, sanctions can be more equitable and patients are better protected. We don't have to refer a case to another organization to take an action in relation to a problem with a facility.

There are challenges in regulating both people and places, especially in the area of employer-employee relations. A consent order can stipulate restrictions on the number of hours an employee may work. We can stipulate that a pharmacist not work as a "floater," not work night shifts, or only work a certain number of hours per day. But, we cannot tell a facility that they have to reduce the hours that they commit employees to work. This is what I call a fine line distinction between regulatory authority and intrusion into established business practices. We are surveying workplace conditions for pharmacists to get data that might unveil some causes of medical errors.

I want to share some examples of cases where the pharmacy board has collaborated with other entities. In one case, we collaborated with the Maryland Office of Health Care Quality (OHCQ). In another, we collaborated with the Maryland Prison and Correctional System.

In the case of OHCQ, we had a pharmacy that serviced more than twenty long-term care facilities. The pharmacy bought several other establishments and combined operations under one facility. The new pharmacy was making mistakes in filling prescription orders from the nursing homes. As a result, many nursing homes were sanctioned by OCHQ. This resulted in complaints to our board from some of the nursing homes and from OCHQ. Our board investigated and documented about 1,800 medical errors. Fourteen hundred cases involved the wrong medications. There were 341 instances of the wrong drug delivered, or no drug delivered at all. Thirty-six cases involved wrong packaging. We wound up settling with the company. The board was satisfied that the errors made prior to and after the merger were corrected and would not recur. We also had at least one testimonial from a nursing home saying the problems with the new company were resolved. The maximum fine of $10,000 was imposed and the company made a $20,000 charitable contribution to organizations that serve the elderly. The company also has to submit quarterly quality assurance reports to the board for one year.

In the second example, there was a problem with prisoners being released who while in prison were on medication for behavior problems. They received prescriptions upon release, but they frequently went unfilled. The pharmacists could not give to released prisoners a short supply of medications to hold them over until they could connect with the appropriate social services systems outside of prison. We were approached by mental healthcare advocates and worked with them to bring about a change that allows for prisoners on discharge to receive a short supply of their medications.

Ditzler – The Funeral Consumers Alliance is the oldest and largest nonprofit watchdog organization protecting the rights and wallets of grieving consumers. Our responsibilities fall into two categories: We both educate and advocate. For more information, visit our Web site at http://www.mdfunerals.org. We publish newsletters, do price surveys, take phone calls, answer emails, and speak at seminars and meetings. Today, I will talk about our advocacy acting as a voice for consumers working with the funeral and cemetery industry and regulatory agencies and boards. Specifically, our collaboration with the Board of Morticians and Funeral Directors was in the area of legislation.

From my perspective, the problem facing consumer groups and regulators has three aspects: Consumer group frustration, regulatory staff resistance, and industry lobbyists who disregard the truth.

When we first attended a board meeting back in 2009, we were impressed that the board was willing to discipline funeral homes that didn't want to have their records audited. We were disappointed that nobody on the board could comment on legislation pending in the General Assembly; industry lobbyists led the discussion. I am pleased that this is no longer the case.

The board's staff members were accessible and answered our questions, although the staff leadership at that time was interested in avoiding controversy. That was the first time we met then-board inspector Ruth Ann Arty who we recognized was different than the other staff. During the next two years, I approached the president of the board and he did answer my questions. I told the board I wanted to do a couple of stories for our consumer newsletter. Ruth Ann admitted to me later that the board wasn't interested in cooperating with my consumer group, but she argued for openness and working with the public. The board was candid and cooperative. Ruth Ann was appointed the Executive Director of the board, which we considered significant because she was willing to be a catalyst and the board was willing to let her be one.

We were impressed and pleased that the board was willing to support a bill called the "Dignity Act" we felt needed to be introduced into the legislation.

A few years ago there was a series of articles about funeral homes owned by Service Corporation International that were holding bodies for burial at Arlington National Cemetery without properly refrigerating or embalming. It turned out that there weren't laws in Virginia and Maryland to address the situation. We asked the board of morticians to support the bill. They worked with us to strengthen the legislation.

I started regularly attending board meetings. This allowed me to build relationships with board members and staff. I was impressed that the president of the board was helpful and closed his meetings reminding attendees that the board's job was to protect the public and not to protect licensees.

We submitted comments on proposed regulations. The board actively supported legislation we sponsored even though it was opposed by the industry. With the board's help, the legislation ultimately passed.

My organization testified in favor of bills the Board of Morticians favored on the topics of insuring funeral directors' and morticians' competency, requiring mortuary transport services to be licensed, and a bill relating to family security trust fund. All those bills passed. Our working together really did make a difference and our support for the board's legislation gave the board credibility because we were the consumer group that saw value in what they were doing.

In 2013, we continued submitting comments on regulations. We offered another bill we wanted the board to introduce and support that would allow funeral home licensees to be held accountable if there were violations in their funeral homes. Believe it or not, they had the law written prior to this so that if there were a problem the owners could blame their employees and not take responsibility. The board was willing to introduce our bill; we supported the board's bills. This time the bills we supported increased requirements for apprentice sponsors and supervising morticians and provided immediate access to inspect prep rooms. We testified on bills the board of morticians opposed. Two of the three bills both we the board and my organization supported passed; two of the three we worked together to oppose were defeated. So, once again, our collaboration was having a positive effect.

The board was aware of a problem where sole proprietors of funeral homes were dying and the law was written so that the estates of sole owners who had been given prepayments by consumers could keep the consumers' money. The board convened a meeting of stakeholders, including trade associations and my group and others, to draft a bill to address this problem.

In 2014, my group proposed a bill to give the board authority to strengthen regulation of pre-need contacts. The board testified in favor of this bill and I testified in favor of three bills the board wanted and against a bill the board opposed, which would have allowed funeral homes to invest preneed payments in securities. Once again, we were successful working with the board to get consumer protection bills passed and consumer un-friendly bills defeated.

The board issued strong regulations in a number of areas during the time we were working with them. I believe that our collaboration has helped strengthen regulation for the state. We continue to work together and I anticipate we will continue to have success getting positive bills passed and hopefully defeating those that would not be best for the consumer.

However, the problems I mentioned at the beginning of my talk remains. Consumer groups are frustrated with unresponsive agencies and boards; regulatory staff may want to avoid doing anything controversial; and some companies and trade groups will adamantly oppose increasing regulation and will be deceitful when they testify.

Based on my organization's experience, these problems can be addressed in a number of ways. First, get to know the players, understand their perspectives, and understand the legislative and regulatory processes. It is not entirely "kumbaya" with the board of morticians. The board is prone to help funeral homes comply with regulations rather than punish them for violations. We wish the board would not be so lenient. It is the responsibility of groups like mine to seek common ground, to collaborate to achieve mutual success, and to not be intimidated by industry lobbyists.

What do I think board member and regulatory staff need to do? They need to listen to the consumer. We have established greater mutual respect as a result of the board's willingness to work with my organization. They need to listen to consumer complaints and requests for information and summary data. The board needs to be knowledgeable about problems and dedicated to making a difference. It should seek common ground with consumer groups, collaborate to achieve mutual success, and not be intimidated by industry lobbyists. The Board of Morticians and particularly Ruth Ann Arty have demonstrated that regulators need to get out from behind their desks and find out what is going on.

Question – Mr. St. Cyr, you said you can only regulate how many hours somebody works if they are under a disciplinary order. Many studies show that the more hours you work, the more likely you are to make mistakes. We have that problem in nursing where nurses moonlight after hours. My question is about pharmacy inspections. Are you inspections scheduled, or are they a surprise?

St. Cyr – Inspections are done annually or for-cause and they are not scheduled. We agree that working too many hours may contribute to medical errors. That is why we decided to conduct the survey that is underway. I think some state boards do place a limit on the number of permissible work hours.

Question – My social work board serves a number of families who are grieving loss. Many ask about the role of the medical examiner. Is there any oversight over the medical examiner's office?

Arty – The medical examiner is a governor appointee. The Board of Morticians works closely with the medical examiner's office. They have a big workload and big responsibility and they don't see families as often as we do. If families have a problem, call me and I can be a liaison with the medical examiner's office.

I want people to take away from Brian Ditzler's presentation that consumers make a difference. We have passed many bills and defeated others because we have had consumers by our side. It gives boards credibility when consumers show up and testify.

Question – Have you noticed any trends with your annual inspections of pharmacies?

St. Cyr – I don't know about recent stats. In 2011, there was a big spike in the number of establishment violations, such as professional misconduct violations, employing an unregistered pharmacy tech, or working with an expired license.

Question – Mr. Swankin, does CAC have a list of other consumer groups like Mr. Ditzler's organization that public members could access when legislation comes up in their states?

Swankin – CAC's mission is to service consumer members of regulatory boards. The best way to find consumer group support is to contact us when an issue or legislation comes up and we will give you what information we have or help find information for you.

Question – In the pharmacy case you described, what about the individual pharmacists? Were they investigated and were there disciplinary orders?

St. Cyr – The pharmacists in this case were not found to be culpable. The problems related to the merger of several pharmacies.

SESSION VI – COLLABORATION WITH LAW ENFORCEMENT AGENCIES

Moderator: Dave Swankin, President and CEO, CAC

Linda Bethman, Assistant Attorney General, Senior Counsel, Maryland Office of the Attorney General, Health Occupations Prosecution and Licensing Division

Basil Merenda, Deputy Attorney General, Pennsylvania Office of the Attorney General, Bureau of Consumer Protection

Michael Miller, Deputy Director, Licensure and Operations, State Medical Board of Ohio

Kathleen Privette, Manager of Regulatory Compliance, North Carolina Board of Nursing

Lilli Reitz, Executive Director, Ohio State Dental Board

Buddy Robshaw, Chief of Police, Cheverly Maryland, and Vice-Chair of the Natalie M. LaPrade Medical Marijuana Commission

Swankin – The call to the meeting describes this session this way: "It is not uncommon for the licensing boards and the criminal justice system to pursue civil or criminal action against the same licensee simultaneously. Relationships between these two enforcement institutions are sometimes unclear or strained. This session will focus on those states and programs that have developed positive working relationships with law enforcement agencies and will cover a variety of topics, including pill mills, medical marijuana, repeated sexual offenses, and chemically dependent practitioners in board treatment programs."

The image I have in mind is a two-way street where agencies with a common goal share information and resources. I hope what we can discuss is what information is and isn't shared, when it should be shared, and how such sharing helps each agency.

Basil, prior to working for the Pennsylvania Attorney General, you were the Commissioner of the umbrella agency over all the state's licensing boards. So you have seen this topic from both perspectives. When you were Commissioner, when did you expect your boards to send cases to the criminal justice system? What did the criminal justice system give to the boards?

Merenda – It was always a one-way street. We would give the criminal prosecutors everything they requested, but they would not coordinate with the licensing boards. It really annoyed me that the media questioned the actions of the Bureau of Professional and Occupational Affairs (BPOA) whenever a licensee was prosecuted for criminal conduct by law enforcement. But the boards were prohibited by due process considerations from knowing whether complaints were filed against these licensees, whether a professional conduct or a criminal complaint. At the same time, law enforcement would refuse to share investigative material with the boards. The board would learn about who was under investigation when the case was over, the indictment was handed out, or the individual filed a guilty plea. This made our boards look as if they were asleep at the switch.

I would like to see a more collaborative relationship – not with the board members who are the adjudicators – but with the board prosecutors. Now from my position as head of the Bureau of Consumer Protection in the Attorney General's Office, I assign agents and attorneys to serve as representatives of the AG on licensing boards. I have reached out to BPOA to develop a better cooperative relationship on consumer protection and licensure issues. This is something I have control over, but on the criminal side, it remains, unfortunately, a one-way street.

Swankin – On October 1, 2014, the Toronto Star reported about an Ontario doctor who had behaved inappropriately with more than ten female patients. The article pointed out that had the doctor been practicing in Alberta, the province's medical regulator would have been required to report it to the Minister of Justice and the Solicitor General. But, in Ontario, the decision to go to the police was at the discretion of the medical regulator. In Texas, Iowa and Nevada, state law requires medical board members, employees, and agents to report to police when such transgressions occur. What would happen in other states if a case like this were to come up?

Bethman – The Maryland Board of Pharmacy has discretion whether to report to law enforcement, but I don't believe there has been any issue. Because the pharmacy board deals with controlled substances, it has a very tight working relationship with the state division of drug control and is in regular contact with the federal Drug Enforcement Agency. Because there is an ongoing relationship, information flows both ways. In fact, because the board has inspection authority and can act quickly, law enforcement often wants the board to take the lead on a case. To the extent they can give the board and the Division of Drug Control information, they will do it. Once a grand jury indictment is handed down, the US Attorney becomes involved. There has never been an issue about information sharing, particularly when criminal discovery begins. We have had DEA agents testify at board hearings.

Outside the realm of pharmacy, some board statutes make every violation, no matter how small, a criminal misdemeanor. Local states attorneys are reluctant to take even what boards feel is egregious criminal conduct cases because it is out of their wheelhouse. So, I don't know how effective it would be to mandate reporting of all potentially criminal violations.

Reitz – As in most states, all prescribers are required to access Ohio's prescription drug monitoring program for information if they suspect a patient might be engaging in drug seeking behavior. I had the pleasure of handling the first case involving a professional who was criminally convicted for violating the laws regarding accessing that database of information. This

was a dentist who was stalking his ex-girlfriend and went into the prescription monitoring program database to get her new address and the addresses of her current boyfriend and lawyer. We worked with the pharmacy board that maintains the prescription drug monitoring program and the prosecutor's office in Cleveland. His DEA prescribing privileges are in jeopardy. We have all joined forces and have been cooperative.

Our hands were tied at the dental board for many years because we didn't have the legal authority to share confidential investigative information with anyone. We copied the state medical board's law and we now have that authority.

Swankin – Michael, the medical board has been criticized for not doing its share to close down pill mills, but this seems to have changed. How did you turn this around?

Miller – This has been an arduous battle. We have looked at other boards' regulations to see how we might share information with other boards and with law enforcement. We placed an investigator on every drug task force within the state and tasked them with educating other agencies about what kind of information the medical board can use and what kind of information the medical board can provide them. Some of us found good cases we could work together on and build relationships around. We have worked with regulatory boards, law enforcement, consumers, associations, the governor's office, and the attorney general's office. The boards of nursing, pharmacy, dentistry and optometry all adopted similar regulations on access to information in the prescription drug monitoring program. We did similar things with position statements and guidelines, one of which addresses when it is the licensee's duty to report criminal conduct to others. We try to take advantage of people and institutions that want to work together and build relationships to the fullest extent possible. For example, we received information from the bureau of workmen's compensation; we worked on cases with the attorney general's office.

Robshaw – I think the police traditionally think of cases that emanate from these boards as administrative crimes, even though statutes call for serious penalties. This is starting to change because it is increasingly difficult to get the US attorney to take a case unless it is gun-related. The State's Attorney also appears to take the view that clean crime doesn't warrant the attention that violent crime does.

As a policeman, I have learned that if I can't get what I want through the courts, I can go to regulatory boards to get at least some sense of justice that might not be available any other way. I think the police are less court-oriented and are looking for other alternatives to alleviate problems.

Swankin – You are also the vice-chair of the Medical Marijuana Commission charged with writing the implementing rules for the medical marijuana legislation. Tell us what you foresee happening with regard to licensing boards when the rules are issued.

Robshaw – I happen to have opposed the legalization of marijuana, but it didn't take long listening to other commissioners and prospective patients to change my point of view. Marijuana has a useful medicinal function. The problem I see is that boards are composed primarily of subject matter experts. This commission has no subject matter experts. Secondly, writing regulations is new to me and other commissioners. We haven't been shy about asking for advice.

Swankin – Kathleen, many boards have programs like North Carolina's for chemically dependent licensees. Please talk about the North Carolina Board of Nursing's program's relationship with law enforcement. In particular, how do you decide when to refer a case to law enforcement?

Privette – We do have nurses enter our program by way of law enforcement. Very often law enforcement shares information about our program with licensees. However, most do not come by way of law enforcement and in a few situations we report a new intake to law enforcement even though we are not required to do so. For example, if a nurse confesses to using impossibly large volumes of a substance we would report this to law enforcement. Another example is a case where there is evidence that a licensee has been stealing from an employer and selling and distributing from their home.

In the situations where law enforcement gives us a heads up about a nurse who may be engaging in fraudulent prescriptions, we check the individual's file and wait for law enforcement to act. At that point, we offer the licensee the opportunity for drug related rehab if they choose to participate. Many of these nurses decline initially but if there is a conviction they may change their minds.

When an individual in our monitoring program who is under criminal court supervised probation is non-compliant with the conditions of their order, we report to the probation officer. We do share information back and forth with the probation officer. We run parallel investigations with law enforcement. We make sure we don't preempt them in their investigation of the licensee. We feel we have a good working relationship.

A current case exemplifies our collaborative work with law enforcement. Last December we received a report from law enforcement that an RN who was in the last semester of her Nurse Practitioner program was using her mentor's name to obtain fraudulent prescriptions. Within a few weeks of calling the board, law enforcement made the arrest and soon after, the licensee called the board to obtain her nurse practitioner certification. We put her approval on hold to wait to see how the case progressed. In May she entered into a deferred prosecution agreement, which included an agreement to enter our board's drug monitoring program. Her nursing license was held in abeyance when she entered our program in June. In late July she was scheduled to meet with the monitoring coordinator who would work with her throughout her three to five years in the alternative program. The day the monitoring coordinator was to have met with her we received a complaint from her employer, a dermatology office and spa, saying that she was caught having sex with a Botox patient after hours. She was using supplies from the facility and they were consuming alcoholic beverages prior to the act. She was discovered because the facility was being painted and the owners suspected the painter was overcharging so they reviewed the internal cameras to see how long the painter was really there. The board rescinded the offer to admit her to the alternative program and reported her to the DA's office because she was in violation of her deferred prosecution agreement. The rest of the story is that the person with whom she was having sex on the treatment table in the dermatology office is a public official. She has a court date of November 8, 2014.

MEMBERSHIP INFORMATION

CAC is a not-for-profit, 501(c)(3) tax-exempt service organization founded to support public members serving on healthcare regulatory and oversight boards. Over the years, it has become apparent that our programs, publications, meetings, and services are of as much value to the boards themselves as they are to the public members. Therefore, **CAC** has decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our services.

We provide the following services to member boards:

1) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
2) A **substantial discount (currently $100.00)** for our annual meeting for **all** of your board members and **all** of your staff;
3) A **discount** for our other meetings for **all** of your board members and **all** of your staff;
4) A **$20.00 discount** for **CAC** webinars.
5) If requested, a **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;
6) **Discounted rates** for on-site training of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input on your board rule-making and other activities;
7) Assistance in identifying qualified individuals for service as public members.

We have set the annual membership fees as follows:

Individual Regulatory Board	$275.00
"Umbrella" Governmental Agency plus regulatory boards	$275.00 for the umbrella agency, plus $225.00 for each participating board
Non-Governmental organization	$375.00
Association of regulatory agencies or organizations	$450.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	$100.00

MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for 2015, please complete this form and mail or fax it to:

CAC

1400 16th Street NW ● Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 ● FAX: (202) 354-5372

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

Payment Options:

1) Mail us a check payable to **CAC** for the appropriate amount;
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card;
3) Provide us with a purchase order number so that we can bill you;

Purchase Order Number:

or

4) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature Date

Our Federal Identification Number is 52-1856543.

WE WANT YOU EITHER WAY!

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

NEWSLETTER SUBSCRIPTION FORM

Downloaded from our website: **Calendar year 2015 and back-issues for $240.00.**

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

Payment Options:

1) Mail us a check payable to **CAC** for the $240.00;
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card;
3) Provide us with a purchase order number so that we can bill you;

Purchase Order Number:

or

4) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature Date

Our Federal Identification Number is 52-1856543.