
PRACTITIONER REMEDIATION AND ENHANCEMENT PARTNERSHIP (PREP):



IMPROVING PATIENT SAFETY AND HEALTHCARE QUALITY
April 2002



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For more information on the Practitioner Remediation and Enhancement Partnership (PREP), we invite you to visit the program web site at www.4patientsafety.net.

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EXECUTIVE SUMMARY

This report is in four (4) parts: an explanation of the nature and significance of PREP; a section describing the benefits to stakeholders from their participation in the program; an update of the status of the thirteen PREP pilots; and a conclusion which airs some of lessons learned thus far and raises several as yet unanswered questions.

PART I - The Practitioner Remediation and Enhancement Partnership (PREP) is a pilot project conceived and administered by the Citizen Advocacy Center (CAC) in cooperation with Administrators in Medicine (AIM) and the National Council of State Boards of Nursing (NCSBN). It is funded through a contract with the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

PREP is a framework within which state medical, nursing and eventually other health professional licensing boards work with hospitals and other health care organizations to identify, remediate and monitor health care practitioners with knowledge and skill deficiencies that cause concern but do not rise to the level of precipitating disciplinary action. Working together in PREP's non-punitive environment, health care organizations and licensing boards can identify and correct individual practitioners' clinical deficiencies and may also discover systemic issues that jeopardize patient safety.

PREP earned the endorsement of Dr. Lucian Leape, one of the better-known members of the Institute of Medicine (IOM) Committee that produced the "Errors" report, and one of the leaders of the "system safety movement." In correspondence with CAC, Dr. Leape wrote:

...I strongly support what you are setting out to do. I think it is a great idea, clearly needed, for the reasons you outline, and it has immense potential to significantly improve both the boards' and the hospitals' processes. Clearly, we need much more collaboration to move ahead in safety, and where more importantly than here? I don't see safety failures overall as a dichotomy: either as systems problems or as performance problems. Performance problems are systems problems, too. We have totally inadequate systems for identifying potentially unsafe practitioners before (emphasis crucial) they cause harm.

Through the PREP pilots, we hope to learn several things:

- Can a program designed to enhance the skills of health care practitioners also lead to the identification and correction of institutional system safety weaknesses?
- Can a licensing board be both a disciplinary body when discipline is called for, and also a proactive force for quality improvement in situations where discipline is not the appropriate answer to a quality problem?
- Will health care practitioners accept confidential, non-punitive interventions developed by hospitals and licensing boards, with the practitioners' participation, to enhance their skills and knowledge and improve the quality of their patient care?
- What types of remedial interventions are most effective and affordable? What steps will lead to a proliferation of high quality, cost-effective remediation resources?

PART II – The public stands to benefit from the PREP program in several ways. While consumers are asked to accept that the assessment and improvement of a PREP-eligible practitioner's performance will not

become public information, patients will benefit from the resulting betterment in the safety and quality of care. Marginal providers are more likely to be identified before harm occurs and medical errors will likely decrease in frequency. It is important to remember that the PREP program is not a substitute for an effective discipline program; rather it is an additional tool for licensing boards that allow boards to enter areas in which they previously were not involved.

Why would hospitals and other health care organizations allow state licensing boards to participate in "employment" or "peer review" decisions currently viewed as private? The answer is that health care organizations stand to gain substantial benefits from the PREP program. These include having access to a "turn key" patient safety program, with a proven support network, that will enable the facility to meet new Joint Commission (JCAHO) and emerging state licensing requirements for patient safety and/quality improvement activities.

One might expect some practitioners to view the PREP program as "another way to get in trouble with the licensing board." However, experience has shown that practitioners are likely to appreciate the ways in which PREP protects their interests. PREP is voluntary, collaborative, and non-threatening. Practitioners participate in the design of their remediation plans, which may well impart significant, career enhancing skill development.

Licensing boards also have much to gain from the PREP program. This program is a win-win for both of the boards' constituencies – the public and the profession. This is so because PREP gives the boards a proactive role in the systems safety arena without interfering at all with the boards' powers and responsibilities when discipline is called for.

PART III – Thirteen (13) state boards presently participate in PREP. These are:

BOARDS OF MEDICINE	BOARDS OF NURSING
(1) California	(1) Colorado
(2) Minnesota	(2) Maryland
(3) Missouri	(3) Nebraska
(4) North Carolina	(4) North Carolina
(5) Oregon	(5) Oregon
(6) Rhode Island	(6) South Carolina
	(7) West Virginia (LPN)

PREP programs are operational in three (3) states: North Carolina (Board of Nursing), West Virginia (LPN Board), and California (Medical Board of California).

PART IV – Several lessons have been learned during the first year of the PREP program, but many questions still need to be answered. We have learned that:

- There is a powerful relationship between PREP and system safety activity.
- Even when committed to developing a PREP program, boards may be hampered because of staff and resource issues.
- In the pilot phase, success is more likely when the board invites the participation of individual health care organizations it has reason to believe will be receptive.

- Signing a Memorandum of Understanding (MOU) is only a first step. Boards need to be creative and persistent to generate a flow of referrals back and forth between the board and a participating institution.
- Success depends on a change of perception on the part of both boards and health care institutions so that they view each other as partners for quality improvement rather than “policeman” and “guilty party.”
- The parameters of a PREP program can be flexible, so long as the core ingredients are present (i.e., there is a clear demarcation between PREP cases and cases that belong on the disciplinary track). Each state must start where it can and adapt the PREP concepts to local realities.
- Ultimately, it will be desirable to give PREP programs a statutory basis in their respective states.

At least a dozen additional questions and issues have arisen during PREP's first year. These are enumerated at the conclusion of the report.

PART I *∞* INTRODUCTION

What Is PREP?

The Practitioner Remediation and Enhancement Partnership (PREP) is a pilot project conceived and administered by the Citizen Advocacy Center (CAC) in cooperation with Administrators and Medicine (AIM) and the National Council of State Boards of Nursing (NCSBN). It is funded through a contract with the Health Resources and Services Administration (HRSA), an agency within the U.S. Department of Health and Human Services.

PREP is a framework within which state medical, nursing, eventually other health professional licensing boards work with hospitals and other health care organizations to identify, remediate and monitor health care practitioners with deficiencies that cause concern but do not rise to the level of precipitating disciplinary action. Working together in PREP's non-punitive environment, health care organizations and licensing boards can identify and correct individual practitioners' clinical deficiencies and may also discover systemic issues that jeopardize patient safety.

The Significance Of The PREP And Its Potential Input On Reducing Medical Errors And Furthering Patient Safety

The Executive Director of the Medical Board of California, Mr. Ron Joseph, cogently described the significant role PREP can play in reducing medical errors and furthering patient safety. He wrote the following to his board when California decided to join PREP:

The role of regulation in this environment has historically been a reactive one, responding to events in which there has been a violation of the Medical Practice Act, often with attendant patient harm. Frequently, during the course of its long involvement with the quality of health care services provided to patients by its licensees, the Medical Board of California has raised the issue of how it can move beyond simple reliance on continuing medical education and disciplinary action after a problem has occurred and take a role in preventing behaviors which may result in future problems.

One of the areas where the Medical Board has had long-standing involvement is in the area of peer review and the subsequent reports of Medical Executive Committees when a physician's staff privileges have been restricted for a period of time. In discussions with various hospitals it has been stated that there are often times when the peer review process results in a finding that does not warrant suspension or severe restriction of privileges, but does suggest that the subject physician would benefit from additional education, training or proctoring to enhance his or her skills. It is the recognition of this potential which has led to a recently issued proposal by the Citizen Advocacy Center...(which) would establish a pilot project designed to encourage greater collaboration between hospitals and medical regulatory boards. The basis for this proposal is the recognition that medical boards can, and should, be participants in finding proactive measures designed to forestall medical error. In such situations, the current law requires that if these measures, undertaken to enhance the physician's skills, were to extend to 30 days, then a report would need to be filed with the Medical Board. It is reasonable to assume that this system serves to dissuade the involved parties from reaching agreement to adopt these measures in marginal cases. If this is the case, then an opportunity to provide the community with a better-trained, safer physician may be lost.

Dr. Lucian Leape, a moving force behind the Institute of Medicine's (IOM) "Errors" report and the "safety movement" has endorsed the PREP program. He wrote as follows:

Thank you for the invitation to participate in the PREP program.... First, let me say that I strongly support what you are setting out to do. I think it is a great idea, clearly needed, for the reasons you outline, and that it has immense potential to significantly improve both the boards' and the hospitals' processes. Clearly, we need much more collaboration to move ahead in safety, and where more importantly than here?

I don't see safety failures overall as a dichotomy: either as systems problems or as performance problems. Performance problems are systems problems, too. We have totally inadequate systems for identifying potentially unsafe practitioners before (emphasis crucial) they cause harm. Once they have hurt someone, there is no question that actions have to be taken and reports need to be made to the Board.... However, if we in hospitals are doing our job, it would rarely get that far. Lack of effective methods of identifying and dealing with marginal performers is one of the most important "latent errors" or "systems failures" we have in health care - every bit as important as the other ones we talk about, such as long hours, excessive work loads, and paper prescriptions!

Hospitals need to develop much better mechanisms for identifying problem practitioners before they harm patients. There need to be internal standards, effective monitoring, and early intervention - at levels lower than "actions." I hope you will address this issue, for boards need to put pressure on hospitals to do this as well as to collaborate with them, as in the PREP plans.

PREP won high praise from the immediate past president of the Federation of State Medical Boards (FSMB), Dr. George Barrett, who wrote in the Federation's Journal:

Hospitals at times identify but fail to report physicians whose problems do not rise to the level of suspension or restriction, instead suggesting they would benefit from additional education, training or proctoring. This has created an environment that fails to protect the public. Under (PREP), hospitals would agree to inform licensing boards of every intervention to upgrade skills and knowledge, and boards would agree to inform hospitals when a physician with a problem is brought to the attention of the board....This non-punitive program can provide a market for focused educational opportunities as well as assessment programs. In turn, this will create the infrastructure

for ongoing assessment and education. Furthermore, it makes CAC and licensing boards proactive in decreasing errors in medicine.

The PREP program has been endorsed by the National Council of State Boards of Nursing (NCSBN) and Administrators in Medicine (AIM). It has also been favorably recognized by the American Society for Healthcare Risk Management (ASHRM). The program is advised by a broadly based committee that includes representatives of health care, consumer, patient safety, accreditation, licensure, and other interested organizations.

Program Objectives

PREP pilot projects institutionalize information sharing between hospitals and licensing boards when one or the other of these entities identifies a practitioner whose performance is below an acceptable standard of quality and recommends remedial actions, such as targeted education or mentoring. Most states already have statutes that require hospitals to report to licensing boards when they take an adverse action that results in termination or significant restrictions on practice privileges. PREP will not affect these mandatory reporting requirements. Rather it is designed to trigger communication among hospitals, licensing boards, and those practitioners who (1) have some clinical skills or knowledge deficiencies, (2) have not to this point caused patient harm or committed acts that would subject them to a licensing action, and (3) who could benefit from an appropriate educational intervention.

HRSA, CAC, and the pilot project states share a belief that patients, hospitals, licensing boards and practitioners will all benefit from improved communication and collaboration and from a change in the culture that has discouraged boards and health care organizations from working together on a case by case basis with practitioners to improve the quality of care.

Through the PREP pilots, we hope to learn several things:

- Can a program designed to enhance the skills of health care practitioners also lead to the identification and correction institutional system safety weaknesses?
- Can a licensing board be both a disciplinary body when discipline is called for, and also a proactive force for quality improvement in situations where discipline is not the appropriate answer to a quality problem?
- Will health care practitioners accept confidential, non-punitive interventions proposed by hospitals and licensing boards to enhance their skills and knowledge and improve the quality of their patient care?
- What types of remedial interventions are most effective and affordable? What steps will lead to a proliferation of high quality, cost-effective remediation resources?

Pathways for Entering the PREP Program

PREP is an effort to intervene early to reduce the risk of patient harm and avoid the need for punitive action. There are two pathways by which a practitioner can enter the PREP program. In one pathway, a hospital identifies a practitioner in need of improvement and then enlists the involvement of the applicable licensing board, on a non-public basis, in the development of educational interventions designed to upgrade the practitioner's competence. An alternative pathway is when a licensing board is first to identify a practitioner whom it feels needs to upgrade knowledge and skills, but whose practice is not such that a disciplinary action is warranted. Once again, the board and the hospital that employs or privileges that individual work together,

in a non-public environment, to develop and implement an appropriate remedial intervention. Whichever pathway is taken, the practitioner agrees to participate in the enhancement program voluntarily.

PART II WHO BENEFITS FROM PREP?

PREP encourages the early identification of deficient practitioners through collaboration between hospitals and licensing boards. Identification is followed by assessment of both individual provider and system issues. Assessment permits the players to design appropriate remedial action to prepare the practitioners to return to safe practice, and to rectify systems safety issues that are revealed during the PREP process.

PREP asks the public, health care organizations, practitioners, and licensing boards to become a piece of the patient safety mosaic. Each stakeholder group stands to benefit from improved practitioner performance, improved patient safety, and improved relationships between licensing boards and health care organizations.

Benefits to the Public

The public stands to benefit from the PREP program in several ways. While consumers are asked to accept that the assessment and improvement of a PREP-eligible practitioner's performance will not become public information, patients will benefit from the resulting betterment in the safety and quality of care.

The competence of individual practitioners can be expected to improve, as can the quality of health care provided to individual patients. Marginal providers are more likely to be identified before harm occurs and medical errors can be expected to decrease in frequency. The decline in medical errors may be hastened as individuals who are "systems" experts take a seat at the PREP table, as recommended by the PREP advisory committee.

PREP offers provider institutions another pathway for identifying and correcting systems safety problems in their institutions. In addition, peer review will become more accountable as licensing boards participate in hospital quality improvement and safety initiatives. It is important to remember that the PREP program is not a substitute for an effective discipline program; rather it is an additional tool for licensing boards that allow boards to enter areas in which they previously were not involved

Benefits to Health Care Organizations

Why would hospitals and other health care organizations allow state licensing boards to participate in "employment" or "peer review" decisions currently viewed as private? The answer is that health care organizations stand to gain substantial benefits from the PREP program. These include having access to a "turn key" patient safety program, with a proven support network, that will enable the facility to meet new Joint Commission (JCAHO) and emerging state licensing requirements for patient safety and/quality improvement activities.

PREP can help facilities reduce turnover and retain practitioners, an especially important consideration given current shortages in many health professions. In the PREP program, assessment of incidents involving individual practitioners becomes a means for identifying both practitioner deficiencies and also systems issues that might otherwise go unnoticed. Especially with the addition of a "systems" person at the table, the PREP program enables better identification of individual versus system problems and fosters an appreciation of the interrelationships between the two. In this way, the program uses resources wisely and is, therefore, an efficient risk management and quality improvement tool. The PREP program promotes a culture conducive to disclosing safety problems within facilities. Finally, the PREP program enriches the relationship between

facilities and licensing boards by fostering cooperation and trust in pursuit of patient safety, much as licensing board programs for chemically dependent health care practitioners have done.

Benefits to Practitioners

One might expect some practitioners to view the PREP program as “another way to get in trouble with the licensing board.” However, experience has shown that practitioners are likely to appreciate the ways in which PREP protects their interests. PREP is voluntary, collaborative, and non-threatening. Practitioners participate in the design of their remediation plans, which may well impart significant, career enhancing skill development.

The practitioner's perspective on the problem and the solution is an essential ingredient. It gives the program a "professionalism" in the sense that the professional has input into his or her own competence assessment and competence improvement plan. PREP is a framework within which the licensing board, the health care organization, and the practitioner work together in a non-disciplinary, non-public setting. In fact, practitioners may come to view PREP as a welcome contribution to meaningful continuing competence assessment and assurance. The PREP process in a framework within which environmental factors - system safety issues - can be taken into account and addressed along with the knowledge and skill enhancement of individual practitioners.

Benefits to Licensing Boards

Licensing boards have much to gain from the PREP program. This program is a win-win for both of the boards' constituencies – the public and the profession. This is so because PREP gives the boards a proactive role in the systems safety arena without interfering at all with the boards' powers and responsibilities when discipline is called for.

Boards cannot undertake PREP without rededicating themselves to ensuring the effectiveness of their disciplinary programs, because PREP is not a substitute for discipline when the practice act has been violated. PREP programs have explicit guidelines for distinguishing between those practitioners who are eligible for PREP and those who belong in the disciplinary track.

PREP should result in the boards receiving improved information from health care organizations, not only information about PREP-eligible situations, but also information about transgressions that call for formal investigation which could to disciplinary action. Boards often comment that health care organizations are their most valuable sources of information about quality of care concerns, and by improving communication and trust, PREP will hopefully result in health care organizations being more willing to alert the boards in a timely manner about instances of substandard practice where discipline, rather than non-public remediation, is the appropriate course of action.

PREP offers licensing boards a non-disciplinary, non-punitive means to prevent errors before they happen, to monitor practitioners' progress toward fulfilling remediation goals, and to help ensure the continuing competence of the workforce. Until now, this quality maintenance role has been thought to belong to health care organizations. Boards need to become involved because, unlike health care organizations, licensing boards retain jurisdiction over practitioners whether or not they complete a remediation or skills enhancement plan, and whether or not the resign from one facility and seek employment elsewhere. The public depends on licensing boards to have complete, useful, timely information about practitioner performance. PREP's formula for two-way information exchange and trusting collaboration between boards and facilities will help boards fulfill that public duty.

PART III  STATE-BY-STATE SUMMARY OF PROGRESS BY STATE BOARDS PARTICIPATING IN PREP

As of January 31, 2002, the following boards have voted to participate in PREP:

BOARDS OF MEDICINE	BOARDS OF NURSING
(1) California	(1) Colorado
(2) Minnesota	(2) Maryland
(3) Missouri	(3) Nebraska
(4) North Carolina	(4) North Carolina
(5) Oregon	(5) Oregon
(6) Rhode Island	(6) South Carolina
	(7) West Virginia (LPN)

PREP programs are operational in three (3) states: North Carolina (Board of Nursing), West Virginia, (Board of Examiners for Licensed Practical Nurses), and California (Medical Board of California).

State-by-State Summary: Boards of Medicine

Medical Board of California – In early December, 2001, the Kaiser Permanente System, Cedars Sinai, and Scripps agreed to sign MOUs with the Medical Board of California. At the beginning of 2002, the California Medical Board's PREP pilot was the third to move beyond the planning stage and become operational. California is the first state to give PREP a legislative mandate in the form of a law enacted in October 2001 directing the medical board to establish "a Citizen Advocacy Center type PREP program."

Commenting on the potential significance of the program, then Board President Ira Lubell, MD observed in the board's April 2001 ACTION REPORT that, "This could be a substantial project, since 2/3 of the over 10,000 complaints about physicians received by the Board in FY 1999-00 dealt with alleged negligence or incompetence."

Minnesota Board of Medical Examiners – Minnesota continues discussions with a few large hospitals/systems in search of partners for its PREP pilot. In addition, a special board committee adopted a 3-part resolution to:

- Ask the Federation of State Medical Boards to draft model legislation addressing medical board involvement in system safety matters,
- Inform legislators and their staff about PREP and other patient/system safety initiatives, and
- Begin to develop an outreach program for health care providers.

The lead story by board President Scott Tongen, MD in the Minnesota Board of Medical Examiners fall 2001 newsletter, *UPDATE*, discusses Minnesota's participation in PREP. In the article, entitled "Reducing Medical Errors, Increasing Patient Safety," Dr. Tongen compares PREP to the board's program for chemically dependent practitioners. He writes:

Essentially, this proposal is a competency analogue to an Impaired Physicians' Program, such as the Minnesota's Health Professionals Services Program. Under both Prep and HPSP, a

practitioner has an opportunity to remediate a problem which threatens their ability to practice with skill and safety in complete confidence, so long as the practitioner is cooperative and successful. The objective of both the Prep program and HPSP is to address problems which require remediation in confidence at as early a point as possible, and with as little disruption to the practitioners as possible. The result is the reduction of errors due to impairment or competency, and improved patient care. Institutions participating in Prep-model partnership have the advantage of having their own internal peer review programs strengthened and enhanced.

Physicians participating in such a partnership have the advantage of being able to address any skill and knowledge deficits in a confidential, non-punitive, non-disciplinary program. The public has the advantage of having potential patient safety issues stemming from practitioner competence identified and addressed at a much earlier point, before patient harm has occurred.

Missouri Board of Registration in the Healing Arts – Missouri's PREP program is moving gradually forward. Representatives of the board met with representatives of the Missouri Association of Osteopathic Physicians and Surgeons, the Missouri State Medical Association and the Missouri Hospital Association and learned that the associations are working with the Department of Health and the Medicare Quality Improvement Organization to review current programs and consider implementing new programs to identify practitioners who need additional education/training. The association representatives offered to share information with the board and the board agreed to review it to determine how existing programs might fit in with the board's plans and expectations.

North Carolina Medical Board – The North Carolina Medical Board plans to launch its PREP program in cooperation with the same hospitals presently participating the North Carolina Board of Nursing's PREP program (see below.) The board is optimistic that its program will be operational early in 2002.

Oregon Board of Medical Examiners – The Oregon Board of Medical Examiners plans to launch PREP with 3 or 4 participating hospitals and hospital systems representing a mix of size and geography. In January 2002, the board of directors of the Kaiser Permanente affiliate in Oregon agreed to participate in PREP for at least a year. The board is in active negotiation with at least two other hospitals/health systems.

Rhode Island Board of Medical Licensure and Discipline – The Rhode Island board is optimistic that its PREP program will be operational in early 2002. Board and CAC representatives met with two hospital systems late in 2001 and so far one of these, Kent Hospital, has agreed to participate in the program.

State-by-State Summary: Boards of Nursing

Colorado Board of Nursing – The board decided to begin its PREP program in long-term care facilities, many of which have enthusiastically embraced the concept. Hospitals have taken a more go-slow attitude thus far, although hospital risk managers have shown a keen interest in exploring the program.

Maryland Board of Nursing – Maryland is a state where the Board of Nursing first approached the state association rather than selecting a few hospitals with which the board has good working relations. As a consequence, the board has devoted time getting acquainted and earning the trust of individuals with whom it had not previously worked closely. While this is likely to pay dividends in the long run, it has prolonged the planning stage of the pilot. Individual hospitals have expressed an interest in participating in the PREP pilot and pressure from the state to do something about patient safety and medical error reduction may give a boost to the board's organizational efforts.

Nebraska Health and Human Services System, Department of Regulation and Licensure, Nursing Section – Before it could approach health care organizations with the PREP concept, the board had to overcome the concerns of attorneys for the Department of Regulation that PREP might be inconsistent with Nebraska's open records laws. Not wanting to abandon the program, the board voted to develop PREP as part of its continuing competence and quality assurance initiatives, and not as an "alternative to discipline" program. This approach takes the PREP outside the concerns raised by the attorneys. Implementation of the program was put on hold when the staff person assigned to the program left the board, but interest in moving PREP forward remains very high, according to the board.

North Carolina Board of Nursing – On June 1, 2001, the North Carolina Board of Nursing's PREP program was the first to become operational. Nine cases have since been referred for participation in the PREP program. All nine cases have originated a participating hospital, not at the board of nursing. BON staff considers that to be an indication of the trust the hospitals already invest in the board.

The seven participating hospitals are:

- New Hanover Regional Medical Center-Wilmington, NC
- Pitt County Memorial Hospital-Greenville, NC
- Forsyth Medical Center-Winston-Salem, NC
- Catawba Memorial Hospital-Hickory, NC
- Rowan Regional Medical Center-Salisbury, NC
- Carolinas Medical Center-Charlotte, NC
- Mission-St. Joseph's Health System-Asheville, NC

Oregon State Board of Nursing – Interest remains high, but progress has been slow because the board's resources were stretched thin during the legislature's session.

South Carolina State Board of Nursing – The Board has approached eleven health care organizations to participate in PREP and expects to execute MOUs with at least four of them in early 2002. The MOU is a hybrid that borrows from both the North Carolina and West Virginia programs. The State's Departments of Mental Health and Corrections, both of which employ nurses, have already agreed to participate in PREP. The board is considering expanding its PREP program to long term care facilities in the future.

West Virginia Board of Examiners for Licensed Practical Nurses – To date, three hospitals in West Virginia have agreed to participate in the LPN board's PREP program. Two are mid-sized and employ a significant number of LPN's; the other is a smaller rural facility. The board signed and MOU with these facilities, and the program became operational in July, 2001. The board has drafted licensee and facility intake forms to use in the initial determination of whether an LPN is eligible for PREP. So far there are no referrals to report. The LPN Board also has sent MOUs to two long-term care facilities for their signature and anticipates that others also will sign on.

PART IV ∞ WHAT WE HAVE LEARNED AND OPEN QUESTIONS

In most of the participating states, the first year of this demonstration project was devoted to locating willing hospitals to participate in the program and to doing the necessary spade work to make PREP programs operational in 2002. A few important lessons are already apparent:

There is a powerful relationship between PREP and system safety activity. As we learned from the first cases referred to the North Carolina Board of Nursing, assessment of individual practitioner weaknesses can lead to the identification of system issues that could impact patient safety. PREP makes it clear that

comprehensive assessments of individual practitioner competence can lead to a better understanding of the complex and often interrelated causes of medical errors, whether they originate with the system, the individual, or both. PREP promotes a sharing of information in a non-disciplinary environment, focusing on the need for remediation. To ensure that PREP cases are always scrutinized for opportunities to make safety based system changes, PREP's project advisory committee has suggested that it would be beneficial to have a "fourth person" at the table, along with the practitioner, the licensing board, and the health care facility. That fourth person should have the authority to effect system changes at the target institution.

Even when committed to developing a PREP program, boards may be hampered because of staff and resource issues. Several committed boards have delayed the implementation of a PREP pilot because of insufficient staff and or financial resources to allocate to the project. Examples include the boards of nursing in Oregon and Nebraska and the board of medicine in Rhode Island where the staff members who would be responsible for getting pilot in motion have been unavoidably occupied with other activities critical to the board's mission, such as attending to the demands of a legislature in session.

In terms of selecting or grooming staff to manage a PREP program, it is apparent that there will be a need to hire quality improvement-oriented individuals or to reorient present staff to a quality improvement rather than an investigative mind set. The Executive Director of the North Carolina Board of Nursing believes the perspective, personality, and style of the PREP staff director had a great deal to do with the speed with which that board was able to get the PREP program in operation and with the willingness of participating hospitals to begin immediately to refer cases.

In the pilot phase, success is more likely when the board invites the participation of individual health care organizations it has reason to believe will be receptive. This is a demonstration project and not every hospital can be expected to want to participate. Similarly, most of the participating licensing boards chose to "start small" with a few selected hospitals. The boards that approached individual hospitals which they had reason to believe would be interested in participating have either signed MOUs or made progress in that direction. Some boards report that their state hospital associations enthusiastically support the PREP concept. In other states, this has not been the case.

Signing an MOU is only a first step. Boards need to be creative and persistent to generate a flow of referrals back and forth between the board and a participating institution. Along with the enthusiastic support of the board and its executive director, the persistence, qualifications, and skills of the program coordinator appear from our pilots to have a great impact on the future success of the program.

Success depends on a change of perception on the part of both boards and health care institutions so that they view each other as partners for quality improvement rather than "policeman" and "guilty party." We hypothesize that even after an MOU has been signed, health care organizations may be slow to actually refer cases to the PREP programs. Participating boards will need to stay in regular contact with participating hospitals to develop the trust relationship PREP requires. Some boards may find that at the outset, more cases originate at the board than at the participating hospitals (although that has not been the case at the North Carolina Board of Nursing). Some boards may wish to get the ball rolling by initiating the case referral process rather than waiting for the hospitals to do so. In other words, rather than writing a "letter of concern," or taking some other non-disciplinary action, boards could bring cases involving knowledge or skill concerns to the attention of the institution where the practitioner works or enjoys privileges and invite the institution to help develop and monitor a remediation plan, paving the way for that institution to eventually join PREP.

The parameters of a PREP program can be flexible, so long as the core ingredients are present (i.e., there is a clear demarcation between PREP cases and cases that belong on the disciplinary track.)

Each state must start where it can and adapt the PREP concepts to local realities. Several states have adapted the parameters of the PREP program to accommodate local factors (political, legal, or otherwise) For example, the Colorado Board of Nursing chose to begin its PREP pilot in cooperation with long term care facilities (which were receptive) rather than hospitals (most of which have chosen to wait and see). Confronted with questions about the confidentiality aspect of PREP from their lawyers the Nebraska Board of Nursing decided to develop its PREP pilot as a continuing competence initiative to finesse the dilemma created by the state's open records law. The California Medical Board cast its PREP pilot in juxtaposition to the state's mandatory reporting statute to emphasize the distinction between PREP and the disciplinary program.

Ultimately, it will be desirable to give PREP programs a statutory basis in their respective states.

There are at least three reasons to anticipate that legislation will be required to put PREP on a permanent statutory footing. One is to obtain appropriations to support the program, or otherwise develop financial support. A second is to clarify the relationship (or lack of relationship) between PREP and the board's disciplinary responsibilities. A third is to establish a legal basis for the confidentiality aspect of PREP and clarify that it does not amount to concealing from the public what would otherwise be a disciplinary case.

Continuing Questions and Issues

A number of critical questions and issues that have arisen and will need to be addressed as PREP programs move from the "setup" to the operational stage. Among them are these:

- What initiatives or techniques are most effective in starting a flow of case referrals from health care institutions to the boards?
- How will the "fourth person" fit into the PREP formula? Who should the "fourth person" be? A risk manager? Some other person in the health care institution who has the authority to make change happen? A person from outside the hospital, such as a JCAHO or Health Department official?
- What is the best approach to convince health care institutions to welcome the licensing board's involvement in system changes? How can PREP mesh with risk management and quality improvement programs in health care organizations?
- Would self-referral by individual practitioners be viable under a PREP program?
- What staff qualifications and staffing configurations work best?
- How can PREP be applied beyond the hospital setting (e.g., in long-term care facilities, office practice, throughout managed care networks)?
- Is PREP applicable to all health care professions?
- How can PREP mesh with JCAHO standards?
- What is the best way to go about developing guidelines for uniform or consistent assessment techniques and remediation strategies? How can PREP programs be sure the remediation fits the assessment in an individual case, or fixes the problem(s) when system issues are present?
- What are the most appropriate means for measuring the effectiveness of individual remediation plans in improving the skills and knowledge of the practitioner?

- Can PREP learn from and work with continuing competence programs being established by many voluntary credentialing bodies? What information and resources can be shared in connection with needs assessment methods and techniques as well as remedial education?
- What are the most appropriate means for measuring the impact of PREP on patient safety (in both micro and macro terms)?