

REFORMING SCOPES OF PRACTICE

EMPOWERING NON-PHYSICIAN PROVIDERS TO MEET THE HEALTH CARE NEEDS OF
CONSUMERS AND COMMUNITIES

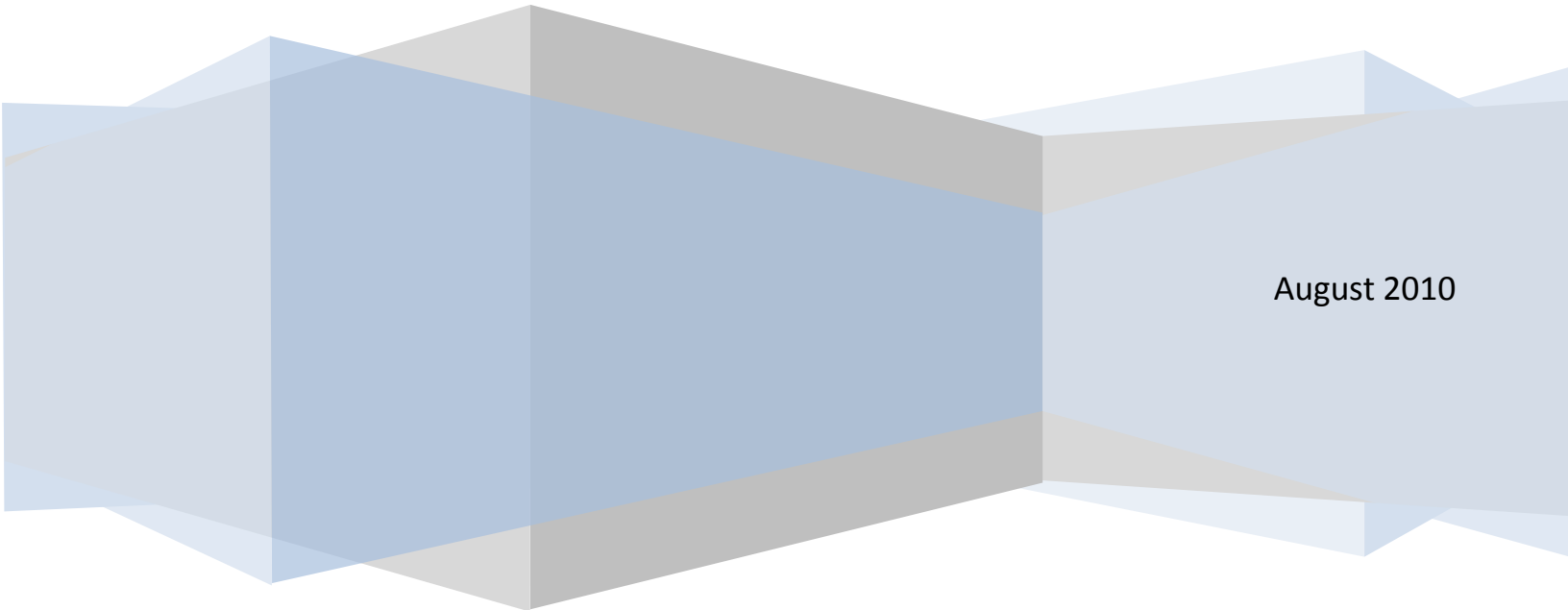
A TOOL KIT

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INTRODUCTION

Passage of the federal Patient Protection and Affordable Care Act in March 2010 is a significant step toward the goal of access to quality health care for every American. Still, there is at least one potential impediment to access to care that must be addressed by the states because the legal authority to define health professional scopes of practice resides in state-based health professional licensing laws. This tool kit explores in depth the role of state-level scope of practice regulations in enabling non-physician providers¹ to be a meaningful part of the response to a growing demand for health care services. Depending on how they are written and implemented, scope of practice laws either limit or promote access to care, thereby affecting the quality and cost of services for millions of consumers.

When it is fully implemented, the federal legislation will provide affordable health insurance to a significant number of the currently uninsured. The ultimate success of this important and historic achievement will depend in large part on the ability of the health care system to handle increased demand for services by as many as 32 million newly insured. This is a worrisome area because of already significant shortages of many types of health care personnel, including primary care physicians, pharmacists, and nurses. In fact, workforce shortages are an incentive for policymakers to take a fresh look at the scope of practice regulations that specify which services various health care professions are permitted to provide, to whom, and in what settings. It is increasingly recognized that scope of practice restrictions often prevent professionals other than physicians from practicing to the full extent of their training and skills, and consequently limit consumer access to important services.

WHO SHOULD USE THIS TOOL KIT?

The toolkit is designed primarily for consumer and community groups, but will also be useful for legislators and their staffs, the National Conference of State Legislatures, regulatory boards, media representatives, foundations and anyone interested in researching, advocating, or gaining a broader understanding of scope of practice issues and their role in the US health care system.

¹ We are aware that some health care practitioners who hold a credential other than an MD dislike being identified by such phrases as “allied health providers,” “mid-level practitioners,” or “non-physicians.” We believe that this sensitivity is partly fallout from many scope of practice “turf battles” fought in state legislatures which have left the impression that such identifying phrases are demeaning. However, we needed to decide on a succinct identifier to use in this tool kit to refer to the many valuable health care practitioners who are not physicians. So, in the hope that we do not offend, but with apologies if we do, we have chosen to use the term “non-physicians.”

WHAT IS INCLUDED IN THE TOOL KIT?

- Why Scope of Practice Issues are Important (including access, quality and cost aspects)
- Implications for Rural Health Access and Underserved Populations
- Overview of Scope of Practice Issues across Different Professions
- Current Approaches to Scope of Practice Changes and Why They Do Not Benefit Consumers
- Experiences of Pennsylvania, Colorado and Other States in Dealing with Scope of Practice issues
- Stakeholders
- Deploying Consumer and Community Groups to Empower Non-Physician Health Providers and Optimize Scope of Practice Policies
- Conclusion
- Appendix A: Op-Ed Pieces
- Appendix B: Questions for Consumers, Community Groups and Legislators to Ask About Scope of Practice

WHY SCOPE OF PRACTICE ISSUES ARE IMPORTANT

Access to Care

The health care workforce plays a major but sometimes under-appreciated role in our system's ability to deliver high quality economical health care. Current health care workforce shortages will be exacerbated when more Americans are able to purchase health care insurance. Already, millions of Americans live in designated Health Professional Shortage Areas (HPSAs).² It behooves policy makers at all levels of government to strive toward more efficient utilization of the health care workforce to deliver care when and where it is needed. Scope of practice regulation is central to this endeavor.

State licensure laws theoretically give physicians an unlimited scope of practice – having a license entitles a doctor to provide any medical service from treating sore throats to brain surgery. In fact, most physicians practice within the confines of the specialties for which they are trained. The threat of a malpractice lawsuit regulates the marketplace and a diligent licensing board probably would discipline a doctor for practicing outside his or her specialty. But the point is that all other health care practitioners – the non-physicians – practice within

² Statistics from the Department of Health and Human Services underscore the enormity of the problem. As of September 30, 2009, there were 6,204 primary care HPSAs with 65 million people living in them. It would take 16,643 practitioners to meet their need for primary care providers (a population to practitioner ratio of 2,000:1). There were 4,230 dental HPSAs with 49 million people living in them. It would take 9,642 practitioners to meet their need for dental providers (a population to practitioner ratio of 3,000:1). There were 3,291 mental health HPSAs with 80 million people living in them. It would take 5,338 practitioners to meet their need mental health providers (a population to practitioner ratio of 10,000:1). Health Resources and Services Administration (HRSA), (2009). Shortage Designation: HPSAs, MUAs, and MUPs. Available at <http://bhpr.hrsa.gov/shortage/index.htm>.

strictly defined limits – their scopes of practice – which are, in effect, carved out from the physicians’ all-encompassing scope.³ For each non-physician profession, state legislatures decide what its licensees can and cannot do, and under what circumstances.^{4,5}

Non-physician health professions are dynamic and evolving. In keeping with the health care needs of the population, many non-physician professions encourage their members to learn new skills and techniques and some have ratcheted up education and training requirements to attain licensure or certification. The result is that many practitioners are now capable of providing new services, or the same services under a new set of conditions. However, outdated scope of practice restrictions in many states do not always allow these professionals to practice to the fullest extent of their qualifications. Further, physicians, dentists and some other health professionals believe they must unite in opposition to any attempt “to encroach on their turf” and lobby state legislators to stop any changes to the status quo. This “turf battle” mentality results in politically focused decision-making that marginalizes if not discounts the greater public interest and consumers’ need for access to quality care.

In its report *Out of Order, Out of Time: The State of the Nation’s Health Workforce*, the Association of Academic Health Centers (AAHC) contends that health care workforce shortages – and the policies that permit them to occur – urgently need attention. AAHC points out that, among a number of health care workforce policy problems, scope of practice laws and regulations often do not reflect the educational achievements of non-physician practitioners and state legislatures often make decisions based on professional turf conflicts, without sufficient expertise or assistance from independent review committees. Further, AAHC states:

There is a lack of uniformity in scopes of practice around the country where issues such as identifying practice boundaries between professions tax state legislators, especially with pressure to expand scopes of practice in some professions. Further, professional boundaries may serve to limit the interaction amongst health professions at a time when team care is suggested as important way to meet public needs.⁶

An Institute of Medicine report issued in 2008, *Retooling for an Aging America: Building the Health Care Workforce*, speaks to scope of practice reform as a means to enhance health care workforce productivity in ways that will especially benefit older Americans. The authors write that:

Efficiency can be further improved by ensuring that health care personnel are used in a way that makes the most of their capabilities. Expanding the scope of practice or responsibility for providers has the potential to increase the overall productivity of the workforce and at the same time promote retention by providing greater opportunities for specialization (e.g., through career lattices) and professional advancement. Specifically, this would involve a cascading of responsibilities, giving additional duties to personnel with more limited training in order to increase the amount of time that more highly trained personnel have to carry out the work that they alone are able to perform. While the necessary regulatory changes would likely be controversial in some cases, the potential shortfall in workforce supply requires an urgent response. This response will most likely have to involve expansions in the scope of practice at all levels, while at the same time ensuring that these changes are consistent with high-quality care.⁷

³ For more information on ten major non-physician clinical professions and their scopes of practice across states see Copper, R., Henderson, T., and Dietrich G., (1998). Roles of Non-Physician Clinicians as Autonomous Providers of Patient Care. *JAMA* 280 (9), 795-802.

⁴ For more information on scope of practice laws see CAC (2010), *Reforming Scope of Practice*. Available at <http://www.cacenter.org/publications>

⁵ For more extensive discussion of the historical context of scope of practice regulations see Safriet, B. J., (2002). Closing the gap between can and may in health care providers’ scopes of practice: A primer for policy makers. *Yale Journal on Regulation* 19 (2), 301-334.

⁶ Association of Academic Health Centers, (2008). *Out of Order, Out of Time: The State of the Nation’s Health Workforce*. Available at <http://www.aahcdc.org/policy/outoforderoutoftime.php>.

⁷ Institute of Medicine, (2008). *Retooling for an Aging America: Building the Health Care Workforce*, p. 77. Available at http://www.nap.edu/catalog.php?record_id=12089.

The World Health Organization (WHO) has also weighed in on the need for scope of practice expansions to address worldwide health care workforce shortages. WHO makes the following recommendations for changes in the regulatory environment that would facilitate task shifting, a term used by WHO to refer to the concept of redistributing tasks among health care professionals' teams to improve access to care:

Countries should assess and then consider using existing regulatory approaches (laws and proclamations, rules and regulations, policies and guidelines) where possible, or undertake revisions as necessary, to enable cadres of health workers to practice according to an extended scope of practice and to allow the creation of new cadres within the health workforce.

[and]

Countries should consider adopting a fast-track strategy to produce essential revisions to their regulatory approaches (laws and proclamations, rules and regulations, policies and guidelines) where necessary. Countries could also simultaneously pursue long-term reform that can support task shifting on a sustainable basis within a comprehensive and nationally endorsed regulatory framework.⁸

COST OF CARE

In addition to workforce shortages, sensible scope of practice policies could also help slow down the growth in health care costs. In its report, *Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth*, the Engelberg Center for Health Care Reform at the Brookings Institution points out the need to “create incentives for states to amend the scope of practice laws to allow for greater use of nurse practitioners, pharmacists, physician assistants, and community health workers.”⁹

Also, the RAND Corporation study conducted for the Massachusetts Division of Health Care Finance and Policy, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, found that more widespread use of Nurse Practitioners (NPs) and Physician Assistants (PAs), through expanded scopes of practice for the two professions, could result in \$4.2 to \$8.4 billion in savings for the Commonwealth.¹⁰

As the economic theory holds, increasing the supply of a service decreases the price of that service. Thereby, increasing the supply of primary care providers with broad scopes of practice will decrease the cost of primary care. Also, permitting nurse practitioners, physician assistants, or other professionals to practice independently, with direct reimbursement, saves the expense of compensating a physician for his or her supervision. Advocates for expanded scopes of practice are in no way supporting “lower pay for equal work.” Nor, as we are about to see, are they envisioning a two-tiered system in which patients treated by non-physician practitioners receive second-class care.

QUALITY OF CARE

The third important public policy dimension of scope of practice expansions is quality of care. Arguing against expansions, the medical establishment often cites quality of care and patient safety as reasons why non-

⁸ World Health Organization (WHO), (2008). *Task shifting: Rational Redistribution of Tasks Among Health workforce Teams: Global Recommendations and Guidelines*. Available at <http://www.who.int/healthsystems/TTR-TaskShifting.pdf>.

⁹ Engelberg Center for Health Care Reform, Brookings Institution, (2009, August). *Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth*. Available at http://www.brookings.edu/reports/2009/0901_btc.aspx.

¹⁰ Eibner, C. E., Hussey, P. S., Ridgely, M.S., and McGlynn, E. A., (2009, August). *Controlling Health Care Spending in Massachusetts: An Analysis of Options*. RAND Corporation. Available at http://www.rand.org/pubs/technical_reports/TR733/.

physician health professionals should not be allowed to provide expanded levels of care. The AMA and their allies regularly assert that physicians experience more rigorous and more numerous years of education and must meet more demanding professional development requirements than do other health care professions. If the only measuring rod were who has attended school the longest, physicians would always be the practitioners who have to do everything, even though more education is not necessarily synonymous with superior quality. Physicians attend school longer than other health care practitioners in part because of their all-inclusive scope of practice. Non-physician practitioners concentrate their training on more limited, specialized skills and procedures and may well acquire expertise in their fields that is better honed than any given physician's skills in the same specialty. Moreover, it is legitimate to ask what it is about attending medical school that qualifies an MD to judge the quality of another profession's educational preparation.

Consider, for example, the relationship between physicians and pharmacists. Physicians and the other professionals whose scope includes prescribing medications are thought in some circles to be more knowledgeable and highly skilled in medication therapy than pharmacists, who are thought in some circles to be closer to technicians. In fact, pharmacists' schooling involves many more hours of training in medications than does a physician's education and there is evidence that a sizeable percentage of physicians depend on pharmacists for guidance about drug-drug interactions (and perhaps other prescribing matters). Researchers at the University of Arizona and the Arizona Center for Education and Research on Therapeutics surveyed 12,500 prescribers with a history of prescribing drugs known to have potential drug-drug interactions (DDIs). The respondents correctly identified fewer than half of the drug pairs with potentially dangerous DDIs. Asked what sources of information they rely on in actual practice to identify DDIs, about two-thirds of respondents said they rely on pharmacists for this information.¹¹

Consider also the relationship between physicians and nurse anesthetists. Some jurisdictions require nurse anesthetists – a non-physician specialty with documented records of quality and patient safety comparable to that of anesthesiologists – to be supervised by a physician. This supervision requirement can be satisfied by *any* physician, regardless of specialty; the supervisor does not have to be an anesthesiologist. Such a requirement is hard to justify on patient safety grounds because a podiatrist or family practitioner, for example, is unlikely to know as much about anesthesiology as does the nurse anesthetist who is being supervised.

Further, evidence that more rigorous education does not necessarily equal quality care is available in the Pearson Report. Pearson (2009) examined malpractice and adverse actions for nurse practitioners compared with MDs and DOs. The occurrence ratios for malpractice and adverse actions in 2008 were 1 in 173 for nurse practitioners, compared with 1 in 4 for MDs and 1 in 4 for DOs.¹² Thus, the quality of care is at some level an empirical question that can be answered through research. However, legislators face a Catch 22. While their scope of practice decisions should ideally be evidence-based, there is rarely a body of evidence available for professions other than advanced practice nurses, physician assistants, and dental hygienists because the professions that seek expanded scopes of practice are not allowed under their current scopes to perform the functions they wish to add. Therefore, it is often impossible to gather evidence regarding quality of care, because the activity that needs to be researched does not fall within legal boundaries of practice. One solution to the evidence dilemma could be to conduct demonstration programs, with sufficient funding to generate independent evaluation of their findings.

Those studies that have been conducted (mostly involving nurse practitioners, physician assistants, and dental hygienists) have generally found that the non-physician providers offer comparable quality of care to that of physician providers. For example, research by Mundinger et al. (2000) found that the care provided by independently practicing nurse practitioners produced patient outcomes comparable to those resulting from care provided by primary care physicians.¹³ A systematic review of randomized controlled trials and prospective observational studies, Horrocks, Anderson and Salisbury (2002), also finds that the care provided by nurse practitioners results in similar health outcomes and potentially higher patient satisfaction compared with the

¹¹ *Drug Safety*, 31 (6), pp. 525-536, 2008.

¹² Pearson, L. J., (2009, February). The Pearson Report. *American Journal for Nurse Practitioners*, 13(2).

¹³ Mundinger, M. O., Kane, R. L., Lenz, E. R., et al., (2000). Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians. *JAMA*, 283(1) 59-68.

care provided by primary care physicians.¹⁴ A more recent study, Mehrotra et al. (2009), examined costs and quality of care provided at retail clinics, which are usually staffed by nurse practitioners, compared with care at physician offices, urgent care centers and emergency departments for three commonly treated illnesses (otitis media, urinary tract infection and pharyngitis). The results, based on claims data from a major health plan in Minnesota, show that retail clinics provide similar quality of care, at substantially lower costs, for fourteen quality of care indicators, compared with other care settings.¹⁵

Also, a literature review by Laurant et al. (2009) analyzing studies of non-physician providers (advanced practice nurses, physician assistants and pharmacists) substituting for or supplementing physicians' care found that such providers usually maintain or improve the quality of care and patients outcomes. The evidence regarding impact on health care costs is mixed, depending on context and nature of non-physician provider's role revision.¹⁶ The *Collaborative Scopes of Care Advisory Committee: Final Report on the Findings*, commissioned by Gov. Ritter of Colorado and released in December of 2008, presents the most extensive review of evidence from literature on care provided by the physician assistants, advanced practice nurses, and dental hygienists. While there are many gaps in current research, the general inference from the review is that these mid-level health professionals provide care of equivalent or similar quality to their physician and dentist counterparts. Moreover, the review also finds that physician assistants, advanced practice nurses and dental hygienists provide care with equal or greater patient satisfaction, and have the potential to increase access to care in a cost-effective way. The *Collaborative Scopes of Care Advisory Committee: Final Report on the Findings* covers the majority of studies conducted on the quality of care provided by the aforementioned health professionals and is one of the best sources of evidence available on quality and efficacy of care provided by non-physician health care professionals.¹⁷

Absent empirical evidence showing that non-physicians provide equal quality of care, advocates for changes in scopes of practice may be able to point to the experience in other jurisdictions in the U.S. and overseas where the profession in question has enjoyed an expanded scope of practice. If there has been no increase in patient or co-worker complaints, discipline by licensing boards, or malpractice activity after expanding the profession's scope, this in itself is evidence of the absence of problems.

Another approach is to examine the academic training and practical experience required of the profession seeking a change in scope. If training and clinical experience justify expanding a profession's scope, there is little reason to expect the result would be reduced quality of care.

IMPLICATIONS FOR RURAL HEALTH ACCESS AND UNDERSERVED POPULATIONS

Nowhere is there a more pressing need for a sensible approach to scope of practice regulation than in rural communities. The National Advisory Committee on Rural Health and Human Services (NACRHHS) describes the rural health care workforce situation in this way:

Rural communities face many challenges in acquiring and maintaining an adequate supply of health and human services workers; the majority of rural areas do not currently have a sufficient workforce to meet their populations' needs. Primary care physicians are much less likely to work in rural counties than in urban counties. More than one-third of rural residents live in a federally designated Health Professional

¹⁴ Horrocks, S., Anderson, E., and Salisbury, C., (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *BMJ*, 324 819-823.

¹⁵ Mehrotra, A., Hangsheng, L., Adams, J., Wang, M., Lave, J., Thygeson, N., et al., (2009). Comparing Costs and Quality of Care at Retail Clinics with that of other Medical Settings for 3 Common Illnesses. *Annals of Internal Medicine*, 151(5), 321-W.109.

¹⁶ Laurant, M., Harmsen, M., Wollersheim, H., Groll, R., Faber, M., and Sibbald, B., (2009, December). The Impact of Non-physician Clinicians. *Medical Care Research and Review*, 66(6) Suppl, 36S-89S.

¹⁷ Scopes of Care Advisory Committee, (2008, December). *Collaborative Scopes of Care Advisory Committee: Final report of findings*. Denver, CO: Prepared by Colorado Health Institute.

Shortage Area (HPSA) and more rural than urban counties are designated as a mental health HPSA or dental HPSA.¹⁸

In addition NACRHHS (2009) also points out:

The lack of an adequate workforce is magnified in rural areas because the elderly population is growing more rapidly in rural than in urban areas. With an influx of baby boomers retiring to rural areas, rural America is experiencing a disproportionately large and growing elderly population—a population that often needs more health care and human services, which places a greater demand on the workforce. Compounding this problem is an out-migration of talented youth from some rural areas in search of broader educational and job opportunities. In the face of expected workforce shortages, maintaining a qualified workforce that can adequately meet the needs of the community poses some challenges for many rural areas.¹⁹

The WWAMI Rural Health Research Center (2009) policy brief, *The Crisis in Rural Primary Care*, points out that there are fewer primary care physicians in rural areas (55 per 100,000) as compared to urban areas (72 per 100,000) and that primary care physicians in rural areas are older compared to their colleagues in urban areas. In addition, and most relevant for scope of practice policy considerations, WWAMI Rural Health Research Center points out that rural communities rely more heavily on non-physician providers, nurse practitioners and physician assistants, with 46% of providers at rural federally-qualified community health centers being non-physicians.

In many states, artificial scope of practice restrictions prevent these and other non-physician providers in rural areas from practicing to the full extent of their qualifications and training. As a result residents of rural areas do not have access to services they would be able to receive if scope of practice restrictions were appropriately revised. Further, the variability in scope of practice laws among states encourages allied health professionals to move to states with the least restrictive scope of practice laws for their professions, sometimes resulting in out-migration of these providers from rural areas where they are needed the most. Hartley, et al. (2002) study, *State Licensure Laws and the Mental Health Professions: Implications for the Rural Mental Health Workforce* provides an example of how restrictive scope of practice laws and reimbursement policies can have an impact on the health care workforce and therefore the availability of services in rural areas. The following statement by Hartley et al. (2002) regarding mental health care providers is indicative:

Scopes of practice for these professions are thought to have an effect on access to mental health services due to the fact that third party payers often base their decisions about whom they will reimburse for mental health services on these laws. If a specific type of provider is not being reimbursed by Medicare, or by another major insurer, providers of that type cannot practice independently. While such providers may be able to provide services in an institutional setting under the supervision of a provider who is reimbursable, such as a psychiatrist or psychologist, many rural areas do not have such settings. In fact, many rural areas have neither psychiatrists nor psychologists.²⁰

Not only do the challenges of rural areas demonstrate the importance of setting scope of practice policies appropriately, they also present special considerations that legislators and regulators need to take into account when making decisions regarding scope of practice laws and regulations.

In addition to rural areas, non-physician providers serve in non-traditional settings and constitute an important source of care for populations underserved by conventional medicine. In this context, non-physician health

¹⁸ NACRHHS, (2009, April). *The 2009 Report to Secretary: Rural Health and Human Services Issues*. Available at http://ruralhealth.hrsa.gov/reports/2009_NAC.pdf (has been moved/removed by HRSA)

¹⁹ WWAMI Rural Health Research Center, (2009, April). *The Crisis in Rural Primary Care*. University of Washington. Available at http://depts.washington.edu/uwrhrc/uploads/Rural_Primary_Care_PB_2009.pdf

²⁰ Hartley, D., Ziller, E. C., Lambert, D., Loux, S. L., and Bird, D.C., (2002, October) *State Licensure Laws and the Mental Health Professions: Implications for the Rural Mental Health Workforce, Working Paper #29*. Maine Rural Health Research Center, Edmund S. Muskie School of Public Service, University of Southern Maine. Available at <http://www.annapoliscoalition.org/pages/images/wp29.pdf>.

professionals represent an important way to help address racial and ethnic inequalities in health care. One such non-traditional setting is the federally sponsored community health center. Another such setting, which has been experiencing growth in recent years, is the retail clinic, often located at a retail store or pharmacy, and often staffed by nurse practitioners and physician assistants, sometimes with support from pharmacists. Mehrotra et al. (2008) compared patient visits to primary care physicians with visits to emergency departments and retail clinics. They found that retail clinics are serving a population different from that seen by primary care physicians in terms of age, reason(s) for visit, and having a regular primary care physician.²¹

Moreover, Mehrotra et al., (2008) suggest that retail clinics are demonstrating a potential for becoming safety-net providers and alleviating some burden from emergency departments.³¹ For one thing, non-physician providers are more likely than physicians and dentists to come from the populations and communities they serve. Therefore, greater utilization of non-physician practitioners provides additional benefits to members of underserved communities.

First, non-physician providers are better able to provide culturally competent care. Individuals are much more likely to seek care from and develop trusting relationships with providers who share their culture, especially members of previously disenfranchised populations. So, there are benefits in terms of both access (people from underserved communities are more likely to go to non-physician providers) and quality, due to better understanding and communications between patients and providers. Cohen, Gabriel and Terrell (2002) in the *Health Affairs* article, *The Case for Diversity in the Health Care Workforce* point out four benefits of having a more diversified health care workforce: (1) culturally competent workforce, (2) access for underserved populations, (3) broadened research agenda, and (4) diversity in related policy and administrative workforces. The authors go on to argue that disparities in pre-college education need to be addressed, and affirmative action programs in medical education need to promote diversity in the health care workforce.²² However, reforming K – 12 education to remove disparities is a challenging endeavor that will not happen overnight, and affirmative action programs have only limited impact because they do not address the social and cultural factors that cause underrepresented minority groups not to apply to medical schools. Hence, if policy makers want a practical solution to diversifying health care workforce, empowering non-physician providers through appropriate licensing and scope of practice laws and adequate reimbursement and support for proper educational programs may be the best means to accomplish that goal.

The second benefit is tied less to health care than to overall economic development of underserved communities. Because becoming a non-physician provider involves less education, lower startup costs, and fewer barriers to entry, it represents a viable career opportunity for members of the underserved communities. Thus, in addition to health care, non-physician providers offer important economic benefits for underprivileged communities.

In sum, both underserved populations and those living rural areas stand to benefit from improved access to non-physician health care providers with more extensive scopes of practice. These factors need to be factored into cost-benefit analyses of individual scope of practice policies.

OVERVIEW OF SCOPE OF PRACTICE ISSUES ACROSS PROFESSIONS

Many health care professions are involved in scope of practice disputes in one or more states. There are significant inconsistencies in the way the states have handled these conflicts. The following examples illustrate some typical scope of practice controversies and the issues they involve:

²¹ Mehrotra, A., Wang, M., Lave, J., Adams, J., and McGlynn, E., (2008). Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison Of Patients' Visits. *Health Affairs*, 27(5).

²² Cohen, J. J., Gabriel, B. A., Terrell, C., (2002). The Case for Diversity in the Health Care Workforce. *Health Affairs*, 21(5).

- **Nurse Practitioners (NPs).** Issue(s): independent practice, level of supervision, collaborative agreements and prescriptive authority. For detailed information on NPs scope of practice across 50 states see The Pearson Report.²³

There are two primary areas of debate between NPs and Primary Care physicians. First, should nurse practitioners practice independently, with no formal association with physicians? Since collaboration between healthcare providers is a professional norm, should collaboration agreements between NPs and physicians be formalized, delineating how NPs will consult and refer more complex cases? Or do NPs require physician supervision in order to practice, and if so, can physicians supervise NPs remotely, providing advice and consultation without actually being in the building? Second, should NP prescribing authority be restricted? Although NPs prescribe medications in all 50 states and DC, two states do not allow NPs to prescribe controlled substances, which are drugs such as morphine that may be abused. Several states limit NP prescribing authority to categories of controlled substances with less potential for abuse. States may also limit the quantity or time frame of NP controlled substances prescriptions, such as a 72 hour supply. Since NPs who prescribe controlled substances must register with the Drug Enforcement Administration (DEA) and must follow DEA regulations, are additional prescribing limits for NPs necessary?

- **Physical Therapists (PTs).** Issue(s): referral requirements. See Promising Scope of Practice Models for the Health Professions section II B for information regarding referral and diagnosis issues surrounding physical therapy in different states. The primary dilemma with regard to physical therapists is whether patients should be allowed to go directly to a physical therapist for treatment, or whether they should be required to see a primary care provider to get a referral prior to being able to receive physical therapy.
- **Physician Assistants (PAs).** Issue(s): prescriptive authority and degree of supervision. See Promising Scope of Practice Models for the Health Professions section II C for more information regarding physician assistants' authority to prescribe certain medications without specific physician approval.²⁴ Policy makers need to resolve whether a physician needs to be present in the building to supervise PAs or whether PAs may provide care in the community under a general supervisory agreement but without a physician being present. In connection with prescriptive authority, should PAs be allowed to prescribe medication only with a physician present in the room? In the building? Providing approval or consultations remotely? Should PAs be permitted to renew prescriptions for medications originally prescribed by a physician?

²³ Pearson, L. J., (2009, February). The Pearson Report. *American Journal for Nurse Practitioners*, 13(2).

²⁴ Dower, C., Christian, S., and O'Neil, E., (2007). *Promising Scope of Practice Models for the Health Professions*. San Francisco, California: Center for Health Professions, University of California. Available at http://futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=Promising_Scope_of_Practice_Models_for_the_Health_Professions., 27(5).

- **Dental Hygienists.** Issue(s): independent practice, level of supervision, and permitted procedures. For more information on potential benefits of dental hygienists independent practice, see *The U.S. Oral Health Workforce in the Coming Decade: Workshop Summary*.²⁵ Oral health is increasingly recognized as a critical aspect of overall wellbeing. Inadequate preventive oral care can lead to serious problems. In light of this, should dental hygienists be allowed to practice in community health centers, nursing homes and malls without a dentist present? Should they be allowed to open their own offices and provide care without a dentist's direct supervision? Should dental hygienists be limited to cleaning teeth? Should they be allowed to give whitening treatment? What about filling simple cavities? Should they be required to undergo additional education to offer services beyond teeth cleaning?
- **Psychologists.** Issue(s): prescriptive authority. For more information on psychologists' initiative(s) to gain prescriptive privileges see *In Pursuit of Prescription Privileges*.²⁶ If psychologists are allowed to prescribe medication, what types of medication? Unlimited prescriptive authority is not under consideration. However, there is considerable debate over where the line lies between medication for mental conditions and medication for other maladies. There is also concern about the possibility of interactions between drugs prescribed for mental health reasons with medications prescribed for physical conditions.
- **Podiatrists.** Issue(s): treatment of lower leg conditions and utilization of diagnostic tests. For additional information on issues in podiatry scope of practice see *Unlocking the Door to a National Scope of Practice*.²⁷ The debate between podiatrists and physicians is all about where the foot ends and the leg begins. Physicians claim that podiatrists are only qualified to treat conditions below the ankle. Podiatrists, on the other hand, strongly believe they are qualified to treat ailments that affect any part of lower leg and foot. A separate issue that has recently become a source of contention is the use of diagnostic imaging. Should podiatrists be allowed to use imaging technology, such as X-rays and MRIs to make a diagnosis or should they be required to refer patients to radiologists for this purpose?
- **Optometrists.** Issue(s): surgical procedures, prescriptive authority. For a discussion of issues involved in optometry scope of practice see *Optometry Scope of Practice Sunrise Review*, a report by the Washington State Department reviewing a request by optometrists in that state for expanded scope of practice.²⁸ Issues associated with optometrists' scope of practice generally revolve around the nature of surgical procedures optometrists can safely be allowed to perform, including laser and other forms of surgery. Another question

²⁵ Harris, T., (2009, August). *The U.S. Oral Health Workforce in the Coming Decade: Workshop Summary*. Institute of Medicine (IOM). Available at http://www.nap.edu/catalog.php?record_id=12669

²⁶ Cullen E. A., and Newman, R., American Psychological Association, (1997, April). *In Pursuit of Prescription Privileges. Professional Psychology: Research and Practice*, 28(2), 101-106.

²⁷ Hall, J., (2003, April). *Unlocking the Door to a National Scope of Practice. Podiatry Today* 16(4), 12. Available at <http://www.podiatrytoday.com/article/1395>.

²⁸ Washington State Department of Health, (2009, December). *Optometry Scope of Practice Sunrise Review*. Available at <http://www.doh.wa.gov/hsqa/sunrise/CurrentReviews/Optomety/Default.htm>.

is whether optometrists should be allowed to prescribe medications and, if so, which medications and for what conditions.

- **Nurse Anesthetists.** Issue(s): Independent provision of care. For information on services provided by nurse anesthetists as sole providers in rural areas see Rural Nurse Anesthesia Practice: A Pilot Study.²⁹ The main issue with nurse anesthetists is whether they should be allowed to deliver anesthesia, independent of supervision by an anesthesiologist or other physician. This is an especially contentious debate at rural hospitals, which are often unable to recruit anesthesiologists.
- **Chiropractors.** Issue(s): types of procedures allowed to be performed outside of spinal manipulation.³⁰ The main debate about chiropractic scope of practice is whether chiropractors should be restricted to manipulation of the spine or be allowed to treat muscles, and other bones and joints.
- **Clinical Pharmacists.** Issue(s): degree of involvement in direct patient care and administration of vaccines (with recent epidemics, such as H1N1 demonstrating benefits of the expanded scope and encouraging further changes in the statutes by other states). For an overview of scopes of practice and types of practice in pharmacy see Scope of Contemporary Pharmacy Practice: Roles, Responsibilities, and Functions of Pharmacists and Pharmacy Technicians.³¹ For a study of the impact of allowing pharmacists to deliver vaccines on vaccination rates see The Role of Pharmacists in Influenza Vaccinations.³² Should pharmacists be allowed to independently provide vaccines? Second, under what conditions and under what level of supervision should pharmacists be allowed to provide disease management, including giving patients clinical advice?
- **Certified Nurse Midwives and Certified Professional Midwives.** Issue(s): types of practices allowed/overlapping scopes. For a history of how the role of nurse midwives expanded to its current scope see The Evolving Scope of Nurse-Midwifery Practice in the United States.³³ The main debate between certified nurse midwives certified professional midwives and obstetricians is over who should be allowed to deliver babies and under what conditions. Should this privilege be reserved for clinically trained OBGYNs? Or, should certified nurse midwives (CNMs) or certified lay midwives be permitted to perform home-births, especially in underserved communities?

²⁹ For more information on services provided by nurse anesthetists in rural areas see: Seibert, E., Alexander, J., and Lupien, A., (2004). Rural Nurse Anesthesia Practice: A Pilot Study. *AANA Journal*, 72(3), 181-190.

³⁰ For an example of issues involved in chiropractic scope of practice see Washington State Department of Health, (2003, January). *Chiropractic Scope of Practice Sunrise Review*. Available from Washington State Department of Health.

³¹ Council on Credentialing in Pharmacy, (2009, February). *Scope of Contemporary Pharmacy Practice: Roles, Responsibilities, and Functions of Pharmacists and Pharmacy Technicians* (A Resource Paper of the Council on Credentialing in Pharmacy). Available at http://www.pharmacycredentialing.org/ccp/Contemporary_Pharmacy_Practice.pdf.

³² Steyer, T. E., Ragucci, K. R., Pearson W. S., and Mainous, A. G., III., (2003, August). The Role of Pharmacists in Influenza Vaccinations. *Vaccine* 22 (2004), 1001-1006.

³³ Stone, S. E., (2000, December). The Evolving Scope of Nurse-Midwifery Practice in the United States. *Journal of Midwifery and Women's Health* 45(6), 522-531.

There are a number of newly emerging professions whose scope of practice has not yet been well defined. In dental care alone, the professions of dental therapist, dental assistant, and advanced practice dental hygienist have arisen in response to the needs of underserved populations.³⁴ As pharmacists' scope of practice changes, the pharmacy technician profession is taking on some of the responsibilities previously confined to pharmacists.³⁵

In addition to regulatory restrictions, non-physician health professionals live with reimbursement policies employed by both public and private payers that limit the extent to which they are able to practice to the full extent of their professional abilities. Except to the extent that many scope of practice disputes have their roots in a battle over who is going to be paid for providing health care services, the complicated problem of reimbursement is not addressed in this tool kit. The first step is to change laws and regulations to remove unjustifiable scope of practice restrictions. Once this is accomplished, it will be imperative to make reimbursement policies consistent with the new paradigm.

CURRENT APPROACHES TO SCOPE OF PRACTICE CHANGES AND WHY THEY DO NOT BENEFIT CONSUMERS

Despite their significant impact on the cost of and access to quality care, scope of practice matters are still decided state-by-state, profession-by-profession, and case-by-case. Dower, Christian and O'Neil at USCF Center for Health Professions describe the state-based process this way:

With few exceptions, determining scopes of practice is a state-based activity. State legislatures consider and pass the practice acts, which become state statute or code. State regulatory agencies, such as medical and other health professions' boards, implement the laws by writing and enforcing rules and regulations detailing the acts.

Further Dower, Christian and O'Neil (2007) point out:

Scopes of practice for many professions vary from state to state despite relatively standard education, training, and certification programs for many of the professions across the U.S.³⁶

The Pew Health Professions Commissions described the fragmented nature of scope of practice regulations for non-physician providers this way:

The lack of uniformity in laws and regulations among the states limits effective professional practice and mobility, confuses the public, and presents barriers to integrated delivery systems and the use of telemedicine and other emerging health technologies. The standardization of entry-to-practice requirements limited to competence assessments for health professions would facilitate the physical and professional mobility of the health professions and improve the accessibility of health care services.³⁷

³⁴ Edelstein, B. L. *Training New Dental Health Providers in the U.S.* Columbia University and Children's Dental Health Project. Available at http://www.cdhp.org/resource/training_new_dental_health_providers_us.

³⁵ For more information on role of pharmacy technicians see: Council on Credentialing in Pharmacy, (2009, February). *Scope of Contemporary Pharmacy Practice: Roles, Responsibilities, and Functions of Pharmacists and Pharmacy Technicians* (A Resource Paper of the Council on Credentialing in Pharmacy). Available at http://www.pharmacycredentialing.org/ccp/Contemporary_Pharmacy_Practice.pdf.

³⁶ Dower, C., Christian, S., and O'Neil, E., (2007). *Promising Scope of Practice Models for the Health Professions*. San Francisco, California: Center for Health Professions, University of California. Available at http://futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=Promising_Scope_of_Practice_Models_for_the_Health_Professions.

³⁷ Pew Health Profession Commission, (1995, December). *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. USCF Center for the Health Professions. Available at <http://www.soundrock.com/sop/pdf/Reforming%20Health%20Care%20Workforce%20Regulation.pdf>.

The report by a six-professional group led by the National Council of State Board of Nursing (NCSBN), *Changes in Health Care Professions' Scope of Practice: Legislative Considerations*, describes the process by which scope of practice decisions are made in most states this way:

Proposed changes to a healthcare professions' scope of practice often elicit strongly worded comments from several professional interest groups. Typically, these debates are perceived as turf battles between two or more professions, with the common refrain of "this is part of my practice so it can't be part of yours." Often lost among the competing arguments and assertions are the most important issues of whether this proposed change will better protect the public and enhance consumers' access to competent healthcare services.³⁸

Such a system is hardly equipped to effectively address the fundamental challenges of access, quality and cost. State governments end up choosing sides in professional 'turf' disputes instead of making decisions based on the public interest, with appropriate analysis of clinical and economic ramifications. Contrast this with the straightforward, problem-solving approach described in a recent *Telemedicine Business Week* article, American Gastroenterological Association (2010). The authors of this article point out the need for intensive airway training for nurse anesthetists administering Propofol due to risk of airway modifications (AMs) associated with the procedure.³⁹ This is a refreshing common sense, evidence-based approach to patient safety where one profession respectfully recommends a solution to a potential safety issue without seeking to limit scope of another profession and the other profession respectfully considers the recommendation.

EXPERIENCES OF PENNSYLVANIA, COLORADO AND OTHER STATES IN DEALING WITH SCOPE OF PRACTICE ISSUES

Pennsylvania

While most states address scope of practice issues legislation profession-by-profession and issue-by-issue, a number of states have addressed scope of practice in a more comprehensive way and/or developed a more structured and less political approach to dealing with scope of practice issues. "Prescription for Pennsylvania" was announced by the Governor Ed Rendell in 2007 and was almost completely enacted by the legislature as of 2009. The goals of the scope of practice plank in Rendell's "Prescription" are to relieve shortages of primary care providers; ensure access to cost-effective healthcare for citizens of all racial, ethnic, and language backgrounds; improve access to healthcare services in evenings and weekends; and, increase the diversity of the healthcare workforce. These goals are reflected in legislation intended to remove unnecessary restrictions that prevent licensed healthcare providers – including nurses, advanced nurse practitioners, physician assistants, social workers, midwives, pharmacists and dental hygienists – from practicing to the fullest extent of their education and training. According to an analysis by the Minnesota Department of Health, Pennsylvania's comprehensive health care reform initiative accomplished the following things:

- Lifts limitations on how many NPs and PAs a physician may supervise under a collaborative or written agreement at a time;
- Prohibits unreasonable restrictions in collaborative or written agreements;

³⁸ Association of Social Work Boards (ASWB), Federation of State Board of Physical Therapy (FSBPT), Federation of State Medical Boards (FSMB), National Board for Certification in Occupational Therapy (NBCOT), National Council of State Boards of Nursing, Inc. (NCSBN), and National Association of Boards of Pharmacy (NABP), (2007, February). *Changes in Healthcare Professions' Scope of Practice: Legislative Considerations*. Available at <https://www.ncsbn.org/ScopeofPractice.pdf>.

³⁹ Cruz, A. J., (2010, March). Adverse events rate is low when Propofol is administered by trained professional. American Gastroenterological Association. Available at <http://www.medicalnewstoday.com/articles/181223.php>.

- Requires the establishment of a complaint review and mediation process by the state to resolve continuing barriers to non-physician practice;
- Gives NPs additional authority to order various types of services and equipment and to perform and sign various types of evaluations and assessments. NPs may now order home care, hospice care, and durable medical equipment, make physical therapy and dietician referrals, perform and sign the initial assessment of methadone treatment evaluations, perform disability assessments, and issue home schooling certificates;
- Gives nurse midwives prescriptive authority;
- Establishes the “Independent Hygiene Practitioner” as an identified provider who can perform the functions of a dental hygienist at specified sites without the supervision of a dentist;
- Expands the places where pharmacists are permitted to manage drug therapy;
- Gives nurse anesthetists greater autonomy to practice in collaboration with, not under the supervision of, an anesthesiologist;
- Requires insurers to include in all provider networks: NPs, PAs, clinical nurse specialists working in primary care, nurse midwives, and the following types of practices if geographically available — urgent care, convenient care, nurse managed care, and federally qualified health centers; and
- Requires insurers to provide financial incentives for primary care providers to offer extended evening and weekend hours, which permit patients to “walk in” or receive a same-day appointment.⁴⁰

The legislation also creates the specialty “respiratory care practitioner” authorized to “implement direct respiratory care to an individual being treated by either a licensed medical doctor or a licensed doctor of osteopathic medicine upon referral by a physician, certified registered nurse practitioner or physician assistant.”

The original legislation introduced in 2007 was an omnibus bill (HB 700) calling for comprehensive healthcare reform. It included provisions related to access to insurance and insurance rates, charitable care institutions, price transparency at drug stores, hospitals and outpatient clinics, the use of health information technology, patient safety, the creation of a Center for Health Careers and a Health Careers Leadership Council, health professional education and training, as well as scope of practice expansions for a variety of professions. Shortly after it was introduced, HB 700 was broken up into more manageable pieces with the scope of practice issues separated out by profession.

Some demographic examples suggest why and how these scope of practice changes are likely to profoundly improve Pennsylvanians’ access to care.

Pennsylvania’s 3,195 Nurse Anesthetists, 6,637 Advanced Practice Registered Nurses, and more than 5,000 physician assistants will have an expanded scope of practice, resulting in patients getting more personalized attention and freeing physicians to concentrate on more challenging therapies;

Community and retail clinics staffed by Advanced Practice Registered Nurses are likely to become more abundant, with particular impact in rural areas where nearly three and a half million Pennsylvanians reside;

⁴⁰ Office of Rural Health and Primary Care, Minnesota Department of Health, (2007, December). *Expanding Scope of Practice to Allow work at the Top of a License*. Available at <http://www.health.state.mn.us/divs/hpsc/hep/transform/dec10documents/expandscopeofpractice.pdf>.

Pennsylvania's 8,111 dental hygienists will be permitted to provide services to the more than 89,000 residents in Pennsylvania's 724 nursing homes;

Pennsylvania's 334 nurse midwives will be permitted to provide a broader range of services to patients, including those who live in rural areas.

Members of the Rendell administration who shepherded the Prescription for Pennsylvania bills through the legislature⁴¹ describe the legislative environment at the time as a "perfect storm." The Governor's first Executive Order at the beginning of his second term in January 2007 created an Office of Health Care Reform. Key actors in the administration and in the legislature were sympathetic to the idea of creating a climate where healthcare professionals could perform to the full extent of their education and training. Not only did they see this as a step toward alleviating growing workforce shortages (especially among primary care physicians) and improving access to care among underserved demographics in the state, many of them (including the Governor) have had positive experiences receiving care from practitioners other than physicians, such as Advanced Practice Registered Nurses and physician assistants.

They perceived that many scope of practice limitations have no basis in clinical evidence but are based on the profit motive of those in a position to impose the limitations. They looked to other states where professions such as advanced practice nurses, physician assistants and dental hygienists had more expansive scopes of practice than existed in Pennsylvania at the time and found no evidence of a decline in the quality of care in those jurisdictions. In addition, they were aware of research at the University of Pennsylvania and elsewhere showing that higher nurse staffing ratios are related to elevated quality of care.

Interest groups, whose counterparts have generally opposed scope of practice changes in other states over the years, including the state medical society, were willing to negotiate on this aspect of Prescription for Pennsylvania in order to position themselves to bargain on other aspects, notably insurance reform. One staffer's assessment is that the scope of practice legislation made it through the legislature because the Governor originally put forth his plan as a single bill addressing cost, quality and access all at once. The scope of practice elements attracted less attention than other hot-button issues, so they "slipped through" with less opposition. This staffer also credits the skill and determination of the leaders of the legislature's professional licensing committees.

One reason the scope of practice expansions were palatable to the medical society and other possible opponents was the decision to link scope expansions to collaborative practice agreements calling for some level of supervision or delegation by one profession over another. These collaborative practice agreements are to be negotiated case-by-case between the affected professionals.

Writing collaborative practice agreements into the legislation also helped defuse an argument commonly advanced by professions who believe their exclusive claim on particular acts will be encroached by expanding another profession's scope of practice. This argument is that expanding another's scope will expose patients to unsafe care by inadequately trained practitioners. This is a difficult case to make when the expanded scope is authorized only in the context of a collaborative practice agreement. Supporters of Prescription for Pennsylvania countered that, "I'm sure my physician would never enter into a collaborative practice agreement with someone who would expose me to substandard care." The bottom line is that including collaborative practice agreements was politically necessary to pass the legislation.

The elephant in the room during the legislation-related negotiations was the question of direct reimbursement to the professions enjoying expanded scope. Reimbursement was not addressed in the Prescription for Pennsylvania bills. It is noteworthy that Advanced Practice Registered Nurses were awarded direct Medicaid reimbursement prior to their scope of practice expansion. A major wrinkle inhibiting direct reimbursement to allied health professions in Pennsylvania, we were told, is an insurance regulation in the commonwealth which

⁴¹ In-person interviews conducted in the spring of 2009 with Basil Merenda, Commissioner, Pennsylvania Bureau of Professional and Occupational Affairs; Donna Cooper, Secretary, Governors Office of Policy and Planning; Barbara Holland, Deputy General Counsel, Governor's Office of Healthcare Reform; and Larry Clark, Legislative Director for the Governor's Office of Health Care Reform.

permits health plans to determine which professionals are “primary care providers” and therefore eligible for direct reimbursement.⁴²

Colorado

In February of 2008 Colorado Governor Bill Ritter, following the recommendation of the Blue Ribbon Commission on Health Care Reform, commissioned a Collaborative Scopes of Care Advisory Committee (SCO Advisory Committee) to study potential ways to limit the barriers to utilization of non-physician health providers, such as physician assistants, advanced nurse practitioners, dental hygienists and others, to the full extent of their training and licensure. One goal was to achieve better access to care for Colorado’s rural communities.^{43,44} The Scopes of Care Advisory Committee, with assistance from Colorado Health Institute, reviewed the evidence with respect to quality, safety, cost-effectiveness and efficacy of utilizing advanced practice nurses, physician assistants, and dental hygienists, with particular focus on providing primary care for underserved populations. The SOC Advisory Committee also explored models and settings of care that demonstrate the potential to improve access to quality care by using non-physician health care providers. The SOC Advisory Committee also reviewed evidence with regard to independent practice by certified registered nurse anesthetists. In its report, *Collaborative Scopes of Care Advisory Committee: Final Report of Findings*, the SOP Advisory Committee reviewed patterns or processes of care by non-physician professionals, such as referral and prescription patterns. It also identified specific barriers to practice, and made recommendations for more effective use of non-physician health care professionals.

For example, with respect to dental hygienists, the SOC Advisory Committee concludes that one potential barrier is the fact that some payers in the state do not pay directly for dental hygiene services provided within the authorized scope of practice. The Advisory Committee recommends a review and evaluation of alternative reimbursement policies that could increase utilization of dental hygienists in locations experiencing problems with access to oral health care services.

Similarly, the SOC Advisory Committee found that the unwillingness of primary care physicians to enter into collaborative agreements with advanced practice nurses for prescriptive authority is a potential barrier to practice. The committee recommends considering changes in advanced practice nursing scope of practice laws to allow more flexibility in collaborative agreement requirements and also exploring policies that would promote interdisciplinary team-based care.

The SOC Advisory Committee makes a number of general recommendations aimed at improving access through better utilization of non-physician health professionals. These recommendations include:

- determining the feasibility of training new oral health providers such as dental therapists, advanced dental hygiene practitioners, and community dental health coordinators;

⁴² Citizen Advocacy Center, *Reforming Scope of Practice*, (2010). Available at <http://www.cacenter.org/publications>.

⁴³ Blue Ribbon Commission for Health Care Reform, (2008, January). *Final Report to the Colorado General Assembly*. (Recommendation 7 pertains to scope of practice study). <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application2Fpdf&blobheadername1=Content-Disposition&blobheadername2=MDT-Type&blobheadervalue1=inline;+filename%3D609%2F559%2FCommission+Final+Report-Narrative.pdf&blobheadervalue2=abinary;+charset%3DUTF-8&blobkey=id&blobtable=MungoBlobs&blobwhere=1191379296057&ssbinary=true>

⁴⁴ Scopes of Care Advisory Committee, (2008, December). *Collaborative Scopes of Care Advisory Committee: Final Report of Findings*. Denver, CO: Prepared by Colorado Health Institute. Available at http://www.coloradotrust.org/attachments/0000/9371/CollaborativeScopesCare_final_report.pdf.

- considering changes to reimbursement policies requiring state-sponsored programs to offer direct reimbursement to advanced practice nurses and dental hygienists for services provided within their authorized scopes of practice;
- collection of additional data for policy monitoring, and authorization of demonstration projects in rural areas of Colorado;
- utilizing high quality standards from clinical and health services research to establish a more specific evidence base for future policy decisions with respect to scope of practice and effective utilization of non-physician primary health care providers.⁴⁵

The SOC Advisory Committee report helped to establish an evidence base and a sensible conceptual basis for scope of practice policies in Colorado from that point forward. It is a good example of the type of work that needs to be done to establish a more sensible, effective, and evidence-based approach to consideration of scope of practice policies.

While Pennsylvania and Colorado are the most notable examples of broad-level changes to scope of practice policies, a number of other states have also taken significant steps toward adopting a progressive approach to health care workforce policy. In 2007, the Center for the Health Professions at the University of California, San Francisco, issued a report, "Promising Scope of Practice Models for the Health Professions." Section III of that report describes scope of practice review mechanisms in New Mexico, Iowa, Virginia, and Minnesota. A brief summary of the mechanisms in these four jurisdictions follows:

New Mexico

In 2007, the legislature passed House Joint Memorial 71 and House Memorial 88, requesting the Interim Legislative Health and Human Services Committee to establish an unbiased and fair review process to review the current scopes of practice of New Mexico's healthcare professions. Its purpose is to provide legislators with objective information when evaluating proposed changes.

Iowa

Under the Iowa Code (Section 147-28A, 2005), a reviewing committee (limited to five members: one member representing the profession seeking a change in scope of practice; one member of the health profession directly impacted by, or opposed to, the proposed change; one impartial health professional, who is not affected by the proposed change; and two impartial members of the general public) reviews a proposed scope of practice change and makes a report to the Department of Public Health. Based on the committee's reports the Department of Public Health, in turn, advises the general assembly on whether the proposal poses a significant new danger, and whether it will benefit the public.⁴⁶

Virginia

Virginia's 13 health regulatory boards are responsible for promulgating the regulations that govern the health professionals. The Board of Health Professions consists of 18 members, one from each of the 13

⁴⁵ Scopes of Care Advisory Committee, (2008, December). *Collaborative Scopes of Care Advisory Committee: Final report of findings*. Denver, CO: Prepared by Colorado Health Institute (see above for access source). Available at: http://www.coloradotrust.org/attachments/0000/9371/CollaborativeScopesCare_final_report.pdf.

⁴⁶ Christian, S., Dower, C., and O'Neil E., Center for Health Professions, University of California, (2007). *Promising Scope of Practice Models for the Health Professions*. Available at http://futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=Promising_Scope_of_Practice_Models_for_the_Health_Professions.

regulatory boards, and 5 citizens (consumers), all appointed by the Governor (Code of Virginia, Section 54.1 – 2510). Among its duties, the Board of Health Professions is responsible for evaluating and making recommendations on the need for and appropriate level of regulation for the healthcare professions.

Minnesota

Each of the 16 independent health licensing boards consists of members appointed by the Governor. The principal staff person for each board is the Executive Director.

In 2001, the legislature created the Council of Health Boards. The Council consists of one board member from each board, and the Executive Directors. The Council meets periodically to discuss issues and concerns affecting all boards. The Council is required to statutorily review emerging issues relating to health occupation regulation, such as proposals to regulate new health occupations. The council was given formal direction when legislation, Minn. Stat. 214.025, was enacted on July 1, 2001. The health-related licensing boards may establish a council of health boards consisting of representatives of the health-related licensing boards and the emergency medical services regulatory board. When reviewing legislation or legislative proposals relating to the regulation of health occupations, the council shall include the commissioner of health or a designee.

In addition to its unique structural approach to dealing with certain aspects of scope of practice policy, Minnesota has also experimented with some unorthodox non-physician health care professionals. The Office of Rural Health & Primary Care (2007) describes the following provider models in its report, *Expanding Scope of Practice to Allow Work at the Top of a License*:

- Dental Hygienists Minnesota's collaborative agreement law allows dental hygienists with additional training to provide care at remote sites without a dentist present. (MDH's 2006 – 07 dental workforce survey found very small numbers of hygienists working under collaborative agreements. Of some 2,000 actively practicing hygienists, less than a dozen said they were practicing under a collaborative agreement.)
- Working under collaborative agreements regulated by the Board of Dentistry, the Minnesota Head Start Association secured federal approval in 2006 to use hygienists to meet Head Start dental care requirements that include screenings, cleaning, dental care education, and referrals to dentists for more advanced care.

Proposed models under consideration in Minnesota:

- The American Dental Association is sponsoring "community dental health worker" pilots in a half dozen states. Minnesota was not selected because we already have the collaborative agreement process in place.
- The Minnesota Association of Community Dentistry is proposing to create an occupation called "advanced oral practitioner." These professionals could practice independently, somewhat like a nurse practitioner does.
- Community Health Workers acting as patient advocates help patients apply for and connect with needed services. Following legislative action, DHS has sought federal Medicaid waivers to reimburse them. Minnesota is leading development of a new entry-level occupation of community health workers. The Health Education Industry Partnership developed the curriculum, which is now offered in a half dozen community colleges around the state. CHWs are not medical practitioners, but rather outreach workers who can guide

people into the proper health care channel. CHW certification does not require a college degree, but requires completion of approved training.

- Community Paramedic EMS leaders from Minnesota and elsewhere are supporting MNSCU development of a curriculum to span Community Health Workers, EMS and additional responsibilities. The role will be called the Community Paramedic or Community Health Care Specialist. Functions may include basic prevention and chronic disease management, basic oral health, mental health screening, immunizations, etc.
- Psychiatric Nurse Practitioners may get their education at St. Scholastica and are able to prescribe medications. There is further talk about psychologists' ability to prescribe in Minnesota.
- Pharmacist Medication Therapy Management, allowed under current scope, has potential for integration into primary care, improved outcomes, and reduced costs. Pharmacists Association is considering seeking expanded authority for pharmacists to administer vaccines. (Note: in 2007, 40 states allowed collaborative drug therapy management agreements.)⁴⁷

More recently, Minnesota has followed through on the proposal to establish an "advanced oral practitioner" specialty. With the support of a coalition of consumer advocates, dental hygienists, hospitals, health plans and other interested parties, and over the opposition of the ADA, legislation was enacted and regulations promulgated in 2009 to create two new dental health professions: dental therapist and advanced dental therapist.^{48,49}

California

Another state that has experimented with innovative ways of approaching scope of practice policy making is California. As Catherine Dower and Sharon Christian (2009) describe, in 1972 California established a Health Workforce Pilot Project (HWPP), which allows for a temporary waiver of legal requirements associated with certain types of practice restrictions and educational requirements in order to test out new and/or expanded roles and new training programs for health care professionals. The demonstrations approved under this project usually last one to three years, after which Office of Statewide Health Planning and Development (OSHPD), which administers the project, prepares final evaluation reports. These reports may be shared with the California state legislature to inform the legislative process. Dower and Christian (2009) list the following elements of the final evaluation reports:

- New health skills taught or the extent to which existing skills have been reallocated;
- Implications of the project for existing licensure laws, with suggestions for changes in the law where appropriate;

⁴⁷ Office of Rural Health and Primary Care, Minnesota Department of Health, (2007, December). *Expanding Scope of Practice to Allow work at the Top of a License*. Available at <http://www.health.state.mn.us/divs/hpsc/hep/transform/dec10documents/expandscopeofpractice.pdf>.

⁴⁸ For more information on legislative developments that led to creation of two new oral health providers in Minnesota see: American Dental Hygienists Association, (2009). *The History of Introducing a New Provider in Minnesota*. Available at http://www.adha.org/downloads/MN_Mid-Level_History_and_Timeline.pdf.

⁴⁹ For more information on the training requirements and specific authorizations for dental therapists and advanced dental therapists in Minnesota see Edelstein, B. L., (2009, December). *Training New Dental Health Providers in the U.S.* Columbia University and Children's Dental Health Project prepare for W. K. Kellogg Foundation. Available at http://www.cdhp.org/resource/training_new_dental_health_providers_us.

- Implications of the project for health services curricula and health care delivery systems;
- Teaching methods used in the project;
- Quality of care and degree of patient acceptance;
- Extent that those who acquire the new skills could find employment in the health care system, assuming laws were changed to accommodate them; and
- Cost of care provided in the project; the like cost of such care if performed by trainees after the conclusion of the project, and the cost of the same care delivered by current providers.⁵⁰

West Virginia

In February 2010, SB 528 proposing the creation of a Commission on the Scope of Practice in Health Care Delivery to advise the legislature on scope of practice issues was introduced in West Virginia's state legislature. The bill states the following reasons for the creation of the commission:

- (1) [The] scope of practice issue for health care delivery is a complex and often contentious process. Factors such as fluctuations in the health care workforce and specific health specialties, geographic and economic disparities in access to health care services, economic incentives for health care professionals and consumer demand influence the decision-making regarding the scope of practice across all health care disciplines.
- (2) Health care is a dynamic industry and is constantly evolving. Consequently, changes in the scope of practice are inherent in the health care system. Practitioners do not work in isolation. Collaboration between disciplines is crucial as most professions share some skills or procedures with other professions. The evolution of abilities of each health care discipline should, therefore, be reflected in scope of practice modifications.
- (3) The regulation of health care professions is designed to protect the public and enhance consumer access to competent health care. Changes to the scope of practice need to be considered with that in mind. However, changes to the scope of practice should recognize the established history of the practice scope within the profession, recognition of the education and training received by a particular health care discipline, evidence supporting the need for a change to the scope of practice and the appropriate regulatory environment.
- (4) It is necessary to seek advice from within the health care industry when making informed decisions regarding the scope of practice of health care professions due to the complexities in examining

⁵⁰ Dower, C. and Christian, S., Center for Health Professions, University of California, San Francisco, (2009). *Improving Access to Health Care in California: Testing New Roles for Providers*. California Health Care Foundation. Available at: <http://www.chcf.org/publications/2009/12/improving-access-to-health-care-in-california-testing-new-roles-for-providers>.

scope of practice issues. The Legislature needs solid expert guidance on issues such as education levels, skills training, adequate evidence supporting a modification and sufficient regulation.⁵¹

To be sure, the effectiveness of a commission approach depends on its implementation. Critical variables include sufficient funding to do a proper job. A commission's objectivity and credibility will depend upon who gets appointed to the commission and who staffs it.

STAKEHOLDERS

A number of organizations and interest groups have a stake in the way scope of practice decisions are made and in the fate of specific proposals for changes in the scope of one or more professions. Some of these stakeholders can be expected to support efforts to institute a more objective, empirical process for making scope decisions. Some are likely to look favorably on changes in scope that enable non-physician practitioners to practice to the full extent of their training and skills. Some can be expected to oppose specific proposals for a change in another profession's scope when they perceive a threat to their own status or income. Members of the American Medical Association-sponsored Scope of Practice Partnership aggressively oppose any legislation that would expand the scope of practice of non-physician practitioners. The following pages identify potential opponents and supporters, beginning with likely opponents.

OPPONENTS

Physicians and some other health professions, lead by the AMA and its Scope of Practice Partnership, represent the most powerful and best organized resistance to expanding the scopes of practice of non-physician health providers. As non-physician professions become bolder about seeking expanded scopes, the AMA is fighting back. In 2006, the AMA joined other national specialty organizations to create the Scope of Practice Partnership (SOPP) for the purpose of tamping down scope of practice legislation in the states. All fifty state medical associations have since joined the SOPP.

The AMA resolution (#814, June 2006) leading to the creation of the SOPP promised that the AMA and its partners would "study the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes and peer review of the limited licensure healthcare providers, and limited independent practitioners, as identified by the Scope of Practice Partnership..."

Follow-up resolutions passed by the Delegate Assembly in November 2006 upped the ante. Resolution 902 calls for medical boards to oversee the "medical scope of practice activities by non-physician practitioners." The resolution states that it is AMA policy that "state medical boards shall have full authority to regulate the practice of medicine by all persons within a state, notwithstanding claims to the contrary by boards of nursing, non-physician practitioners or other entities."

Resolution 904 asserts that, "Diagnosis of disease and diagnostic interpretation of tests constitutes the practice of medicine to be performed under the supervision of licensed physicians." This supervisory authority is apparently meant to apply to all non-physician personnel, including laboratory personnel and PhD scientists who employ new laboratory technologies.

The SOPP's 50-state legislative strategy includes preparing "modules" describing the training and skills of various non-physician professions for use in lobbying against scope changes. The SOPP also plans to introduce legislation in state legislatures along the line of the West Virginia bill mentioned earlier. The legislation appears benign

⁵¹ West Virginia Senate Bill No. 528. Available at http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=SB528%20intr.htm&yr=2010&sesstype=RS&i=528.

because it would establish a commission to review scope change proposals. However, coming from an entity with the stated goal of stopping scope changes for non-physician professions, one has to closely examine proposals such as these and, if enacted, work to be sure their implementation doesn't result in commissions dominated by organized medicine.

The stated rationale for these proposals and assertions by the AMA and their allies is to protect public safety and assure the highest quality competent care. However, one must recognize underlying economic motives behind these efforts to maintain the barriers to entry inherent in statutes that restrict the 'practice of medicine' to physicians, dentists, ophthalmologists, psychiatrists, and other "senior" health care professions. Determining what constitutes safe, competent, quality care needs to be based on evidence from unbiased research or clinical experience, not arguments presented as "facts" by one of the interested parties.

Members of and associations representing professions, whose scope is being "encroached" upon are another probable source of opposition to scope expansion legislation. These professions usually have the statutory right to provide services that another profession wants to be allowed to provide. These professions usually have some economic stake in remaining the sole or primary providers of all services within their scope of practice. These professions are not limited to medical doctors, but include the midlevel health practitioners as well, depending on specific legislation considered. For example physical therapists may be concerned about an expansion in chiropractors' scope of practice that may create competition within their sphere of practice, or even restrict their current scope of practice.⁵² This, of course, works both ways as chiropractors can be expected to oppose legislation that would expand physical therapy's scope of practice into areas overlapping chiropractic's scope. Protection of "professional turf" is usually the role these professions and their representatives play in scope of practice policy proceedings.

SUPPORTERS

National associations of non-physician health professions are in general interested in professional advancement through scope of practice expansions for their members. They usually have specific position statements or guidelines, stating what they believe the scope of practice for a particular profession is or should be. For example, the American Association for Respiratory Care identifies specific diagnostic and therapeutic activities in its *Respiratory Care Scope of Practice* position statement.⁵³ The position statement of the American Academy of Nurse Practitioners, *Scope of Practice for Nurse Practitioner* describes *Professional Role, Education, Accountability and Responsibility* of nurse practitioners.⁵⁴ Position statements and association guidelines are usually a good source to get a sense of national consensus for how a given health profession sees itself. The American Physical Therapy Association offers a directory of state practice acts on its Website, and the association hosted an International Summit on Direct Access and Advanced Scope of Practice in Physical Therapy.⁵⁵

The **state associations of allied health professions** will usually be the organizations most immediate supporters of expanded scope legislation under consideration in their states. They are a good source of information about current legislative developments related to their professions, and have good information on training, education, and demographics of members of their professions.

⁵² For example of types of concerns expressed by physical therapists in connection with chiropractors' scope of practice expansion see: Washington State Department of Health, (2003, January). *Chiropractic Scope of Practice Sunrise Review: Information Summary and Recommendations*. Available at <http://www.doh.wa.gov/hsga/sunrise/Documents/Chiro.pdf>.

⁵³ American Association for Respiratory Care, (2007). *Respiratory Care Scope of Practice*. Available at http://www.aarc.org/resources/position_statements/dop.html.

⁵⁴ American Academy of Nurse Practitioners, (2007). *Scope of Practice for Nurse Practitioners*. Available at http://www.aanp.org/NR/rdonlyres/FCA07860-3DA1-46F9-80E6-E93A0972FB0D/0/Scope_of_Practice.pdf.

⁵⁵ American Physical Therapy Association (APTA), (2009). *Directory of State Practice Acts and International Direct Access Summit Highlights*. Available at <http://www.apta.org>.

The **Coalition for Patients' Rights** (CPR) was founded in early 2006 under the leadership of the American Nurses Association to counteract the lobbying efforts of the AMA and its Scope of Practice Partnership (SOPP). CPR is made up of more than 35 member organizations representing non-physician providers that support expanded scopes of practice for professional reasons and to help improve access to care.^{56,57}

Licensing boards play various roles *vis a vis* scope of practice, depending on the specific profession and state. Typically, boards are given authority to enact rules and regulations to implement legislation governing the scope of practice for the profession they regulate. Sometimes boards are mandated to enforce the content of statutes in cooperation with another executive agency. Should they choose to do so, licensing boards are in a position to educate legislators about relevant scope of practice considerations.

In 2006, six professional regulatory board associations under the leadership of the National Council of State Board of Nursing (NCSBN) published a paper, *Changes in Health Care Professions' Scope of Practice: Legislative Considerations* designed to provide guidance to state legislators for handling scope of practice in a more reasonable, public interest-oriented way. The paper points out:

Healthcare education and practice have developed in such a way that most professions today share some skills or procedures with other professions. It is no longer reasonable to expect each profession to have a completely unique scope of practice, exclusive of all others. We believe that scope of practice changes should reflect the evolution of abilities of each healthcare discipline, and we therefore have attempted to develop a rational and useful way to make decisions when considering practice act changes.⁵⁸

Policy groups on both the left and the right side of the political spectrum have endorsed the idea of relaxing unjustifiable scope of practice restrictions to give greater flexibility to health care professionals to practice to the full extent of their skills and training. On the left side of the political spectrum, policy experts believe that expanded scopes for health care professionals will lead to increased access to affordable, quality care. The Center for American Progress, in *Closing the Health Care Workforce Gap: Reforming Federal Health Care Workforce Policies to Meet Needs of the 21st Century*, recommends:

⁵⁶ Lindeke, L. L., and Thomas, K. K., (2010, March). The SOPP and the Coalition for Patients' Rights: Implications of Continuing Interprofessional Tension for PNs. *Journal of Pediatric Health Care* 24(1); 65-65. Available at [http://www.journals.elsevierhealth.com/periodicals/ymph/article/S0891-5245\(09\)00244-2/abstract](http://www.journals.elsevierhealth.com/periodicals/ymph/article/S0891-5245(09)00244-2/abstract).

⁵⁷ Members of the coalition include: American Academy of Nurse Practitioners, American Association for Marriage and Family Therapy, American Association of Colleges of Nursing, American Association of Critical-Care Nurses, American Association of Naturopathic Physicians, American Association of Nurse Anesthetists, American Association of Acupuncture and Oriental Medicine, American Association of Occupational Health Nurses, American Chiropractic Association, American College of Nurse-Midwives, American College of Nurse Practitioners, American Nephrology Nurses Association, American Nurses Association, American Occupational Therapy Association, American Physical Therapy Association, American Psychological Association, American Psychiatric Nurses Association, American Speech-Language Hearing Association, Association of Nurses in AIDS Care, Association of Perioperative Registered Nurses, Association of Rehabilitation Nurses, Association of Schools of Allied Association of Women's Health, Obstetric and Neonatal Nurses, California Optometric Association, Emergency Nurses Association, Hospice and Palliative Nurses Association, Integrated Health Policy Consortium, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, National Association of Pediatric Nurse Practitioners, National Council of State Board of Nursing, National League for Nursing, National Nursing Centers Consortium, National Organization of Nurse Practitioners Faculties, Oncology Nursing Society, Preventive Cardiovascular Nurses Association, and Wound Ostomy and Continence Nurses Society For more information on Coalition for Patients' Rights see Coalition for Patients' Rights website: <http://www.patientsrightscoalition.org>.

⁵⁸ Association of Social Work Boards (ASWB), Federation of State Board of Physical Therapy (FSBPT), Federation of State Medical Boards (FSMB), National Board for Certification in Occupational Therapy (NBCOT), National Council of State Boards of Nursing, Inc. (NCSBN), and National Association of Boards of Pharmacy (NABP), (2007, February). *Changes in healthcare professions' scope of practice: Legislative considerations*. Available at <https://www.ncsbn.org/ScopeofPractice.pdf>.

Given the current and growing shortage of health professionals, it is important to encourage the use of the nation's entire health workforce to the full extent of their education and training.⁵⁹

The report goes on to point out that maximizing health professionals' scope of practice is also a good way to decrease costs, while maintaining or even improving quality of care.

On the right of the political spectrum, economic experts characterize scope of practice laws as ineffective government regulations that lead to market inefficiencies. The Cato Institute, in 2008 policy analysis publication, *Medical Licensing: An Obstacle to Affordable, Quality Care*, points out:

By almost all accounts, the quality of services consumers get from non-physician clinicians is at least on par with what they would get from a physician performing the same services. Dozens of peer-reviewed studies compare outcomes in situations where patients are treated by a physician, a physician assistant, or an advanced practice nurse. Outcomes appear similar—an important factor, considering that non-physician clinicians can provide many services at much lower cost...

[and]

Despite the progress made in incorporating non-physician clinicians, licensing and scope of practice rules still restrict providers' ability to employ medical professionals to their full competence.⁶⁰

Reinforcing bipartisan support for maximizing the scopes of practice is a proposal for health care reform, *Crossing Our Lines: Working Together to Reform U.S. Health System*, issued by the Leader's Project at the Bipartisan Policy Center. Three former Senate majority leaders, Senator Howard Baker, Senator Tom Daschle and Senator Bob Dole recommend:

In conjunction with making meaningful quality-of-care and outcome measures more widely available, provide incentives for states to amend scope-of-practice laws that discourage use of advanced practice nurses, pharmacists and other allied health professionals.⁶¹

Retail Clinics employ primarily nurse practitioners who treat a variety of common health conditions at pharmacies or retail stores for a set price and without appointment. The retail clinic business model, lead by The Minute Clinic, with support from retailers like CVS, Walgreens and Wal-Mart, has been experiencing significant growth in recent years. Since the retail clinics' business model is tied to having qualified non-physician providers with sufficient scope of practice to meet the needs of their patients, retail clinics have a direct interest in promoting scope of practice laws which permit a strong non-physician health care workforce.

Health Care Administrators and Hospital Systems rely on qualified non-physician health providers with appropriately extensive scopes of practice to deliver quality, cost-effective services, especially in locations with physician shortages. Further, hospital systems that operate across state lines would prefer to have consistent personnel policies and to be able to move clinical staff from state to state as necessary to meet their organizational goals.

Rural Health Advocates have a unique appreciation for the contributions of non-physician providers. Nowhere are the access problems due to health care workforce shortages as great as in rural areas. In many rural communities, non-physicians are the only available providers, making these communities dependent on policies and delivery models that allow non-physician practitioners to provide full the range of services they are qualified to deliver.

⁵⁹ Derksen, D. J., and Whelan, E. M., (2009, December). *Closing the Health Care Workforce Gap: Reforming Federal Health Care Workforce Policies to Meet Needs of the 21st Century*. Center for American Progress. Available at http://www.americanprogress.org/issues/2010/01/health_workforce.html.

⁶⁰ Svorny, S., (2008, September). *Medical Licensing: An Obstacle to Affordable, Quality Care*. Cato Institute. Policy Analysis No. 621. Available at http://www.cato.org/pub_display.php?pub_id=9640.

⁶¹ Baker, H., Daschle, T., and Dole, B., (2009, June). *Crossing Our Lines: Working Together to Reform U.S. Health System*. The Leader's Project, Bipartisan Policy Center. Available at <http://www.bipartisanpolicy.org/projects/leaders-project>.

Flexible delegation and supervision requirements or collaborative practice agreements are essential in regions of the country where physicians, dentists, and other supervisory providers are in short supply. Telemedicine may turn out to be a valuable tool in this regard.

Insurance Companies and Third-Party Payers are concerned with the cost of services. Short-term cost considerations sometimes result in insurance companies refusing to pay for various services provided by non-physician providers. However, considerable research and expert opinion show that relying to a greater extent on non-physician providers is more cost-effective and will result in greater savings than trying to support an increasing number of physicians to meet growing demand for primary care. Non-physician health providers are far less likely to over-utilize expensive technological procedures, and they also offer important preventive and primary care, avoiding costly hospitalization or other expensive care. It is important to educate third-party payers about the long-term cost benefits of supporting non-physician health providers.

Pharmaceutical Companies spend significant capital encouraging physicians to prescribe their products to patients. The greater the number and variety of health care professionals who have prescriptive privileges in a given state, the more providers are able to make pharmaceutical products available to the end consumers. Pharmaceutical companies have not been prominent players in legislative activities related to scope of practice, but these companies possess considerable lobbying resources that could be mobilized in support of scope of practice reforms.

Employers want to offer their employees quality health care at a reasonable cost. Human resources (HR) research demonstrates that a significant portion of employer health care costs result from absenteeism and lost productivity.⁶² Based on this research, more employers are starting to recognize the benefits of providing easily accessible preventive and primary health care services to their employees. In fact, some employers hire non-physician provider(s) to provide services on-site to employees.

Like some other stakeholders, many employers may need to be educated about the connection between policies that empower non-physician providers and health care cost savings and employee productivity. There are, however, at least two groups that have organized around large employers' broad interests in health care. The Leapfrog Group, founded in 1998, uses the collective purchasing power of large employers to promote quality of care and efficiency in care delivery.⁶³ Another major group representing employers' interests in health care is the National Business Coalition on Health (NBCH). NBCH is a membership organization of local and regional coalitions composed of mid to large size employers who, as health care purchasers, campaign for a safe, high-quality and efficient health care system.⁶⁴ Not only is NBCH a good national resource for accessing employers interested in influencing health care, the local and regional coalitions may be interested in becoming engaged in scope of practice advocacy at the state level.

Of course, the most important stakeholders are **consumers**, as described in the following section.

DEPLOYING CONSUMER AND COMMUNITY GROUPS TO EMPOWER NON-PHYSICIAN HEALTH PROVIDERS AND OPTIMIZE SCOPE OF PRACTICE POLICIES

Adding the Consumer Voice to the Discussion

Until now, the consumer voice has been missing from the discussion. Consumer advocacy and community groups want the people in their communities to have access to quality affordable health care. While many of these groups may not currently be aware of the contribution non-physician providers can make toward that goal,

⁶² Goetzl, R. Z., Guindon, A. M., Turshen, I. J., and Ozminkowski, R. J., (2001). Health and Productivity Management: Establishing Key Performance Measures, Benchmarks and Best Practices. *Journal of Occupational and Environmental Medicine* 43; 10-17.

⁶³ For more information on The Leapfrog Group see their website: <http://www.leapfroggroup.org>.

⁶⁴ For more information on The National Business Coalition on Health see their website: <http://www.nbch.org>.

once presented with the relevant information they could become some of the most ardent supporters of systemic changes to empower non-physician providers. These groups can bring the consumer perspective to scope of practice deliberations, moving the discussion beyond inter-professional ‘turf battles’ and toward the more general public interest.

Legislators need to know that consumers are aware of the stakes and favor optimal use of the healthcare workforce. Consumers and consumer advocates may not be able to weigh in on the technical merits of each and every argument about educational preparation and clinical skills. But, consumers and their advocates can make it clear that they expect legislators to render scope of practice decisions that make good public policy sense and that give equal, if not greater weight to the health care needs of their constituents than to the self-interest of the affected professions.

In a typical year there could be as many as 150 – 300 scope of practice bills introduced in state legislatures across the country (see the AMA’s state-by-state listing by for 2009).⁶⁵ Many of these bills involve attempts by various health professions to expand their scope of practice, and some involve attempts by one or more health care professions to constrict the scope of another. Sometimes the requested changes in scope are backed up by evidence; often they are not.

Consumer advocates could have an impact if they submit comments and testify at scope of practice hearings, letting legislators know how scope of practice restrictions and proposed changes will impact the public’s ability to access affordable, safe care. It is often the case that groups can have more impact than individuals, so consumer advocates can seek support from other stakeholder groups, such as employers, delivery systems, and others that share the consumers’ interest in the efficient and effective deployment of the healthcare workforce.

Evaluating legislative proposals in terms of which profession benefits and which profession loses out misses the point. It is not the responsibility of state legislatures to referee between different health professions, but rather it is to enact policies that will be most beneficial to the citizens of their state. This means that legislators should analyze any proposed changes in the context of the health care delivery system, taking into account the impact of scope changes on access, quality and cost, the very real challenges many people face when seeking health care, and the economic efficiencies of a workforce policy that permits non-physician health care professionals to practice to the full extent of their training and skills.

Asking the right questions can help change the conversation from one about professional rivalries to one about the public interest. *Changes in Health Care Professions’ Scope of Practice: Legislative Considerations* poses many of the questions legislators should ask in order to hone in on the public interest. The guidelines used in Ontario, Canada by the Health Professions Regulatory Advisory Council (HPRAC) – the all-public member entity that makes decisions about scope of practice changes – also raise the issues from the public interest perspective.⁶⁶

GETTING PUBLICITY

Scope of practice policymaking has been based on professional turf battles in part because the issues and the process go unnoticed outside of the affected professions. Raising public awareness is a critical first step toward reforming the way scopes of practice decisions are made. The media can be an ally. Where policy analysis, expert recommendations, and professional jargon do not awaken public opinion, personal interest stories may. Reporters will be interested in interviewing consumers who have had problems accessing primary care and consumers who have had positive experiences obtaining care from various non-physician providers. The focus needs to be on the primary care services a wide variety of skilled practitioners can provide in an era of growing demand.

⁶⁵ American Medical Association (AMA), (2009). *Scope of Practice Campaign: Trends for 2009 State Legislative/Regulatory Sessions (By State)*. Available at

<http://www.oacns.org/imported%20files/news/Scope%20of%20Practice%20Campaign%20by%20State.pdf>.

⁶⁶ For more information on HPRAC and their review process for scope of practice regulations revisions proposals see their website: <http://www.hprac.org>.

It can help to write op-ed pieces or letters-to-the-editor that talk about how non-physician providers help to meet your community's health care needs. (See Appendix A for a sample op-ed piece.) Another option is to put non-physician providers and their patients in touch with the press so they can relate tell their health care stories.

It is important to get media coverage when scope of practice or health care access bills are under consideration by the legislature. Reporters should be delighted to include a consumers' perspective in their coverage.

COMMUNICATING WITH STATE LEGISLATORS AND DECISION MAKERS

A public discussion of healthcare workforce policy, including scope of practice, will be instructive not only for the general public, but also for legislators and regulators who will be making and enforcing policy decisions but who may not be fully informed about the issues and their implications. They may focus in on scope of practice from time to time, but their familiarity with the issues typically comes from lobbying for or against changes in scope by the affected professions.

The enactment of healthcare reform at the federal level presents a good opportunity to approach elected officials and regulators to ask them about what actions are under consideration to address shortages of providers. The information in this toolkit will be helpful to educate them about the potential of empowering non-physician providers to respond to the needs of consumers and underserved communities. (See Appendix B for *Questions Consumers, Community Groups and Legislators Should Ask About Scope of Practice.*)

Legislators with a history of advocacy related to access to care, rural healthcare needs, and inequities in health care delivery are likely to be especially interested in how policies that empower qualified non-physician providers would contribute to address these challenges.

Finally, real-life patient stories, which are important in engaging the press, are also important in communicating the need for change to the legislators. While the state legislators will have a better grasp of the policy concepts and implications involved than the general public, it is the personal stories from their constituents that will move them to act and give them the necessary political reassurance to balance against pressure from professional groups.

CONCLUSION

Universal access to quality, affordable health care is an important and challenging public policy goal. Health insurance coverage issue will be expanded as a result of national health care reform legislation. But, newly covered individuals won't be able to access care if there are inadequate numbers of primary care providers available to see them.

While increased financing for training programs, student loans and incentives to practice in underserved areas are all important, the primary focus should first be on changing outmoded and unjustified policies that prevent full utilization of the available workforce. Scope of practice policy is one major area that presents an opportunity for expanding access to care, without incurring new costs. However, because this area of policymaking has been so dominated by professional interests, the needs of citizens and consumers have been kept out of the debate. So, if we are serious about empowering our health care workforce to meet the increasing needs of the population, we need to bring the public interest into this important policy area and move away from the ineffective "turf battle" process. While change will not be easy, persistence can pay off.

APPENDIX A: EXAMPLE OF AN OP-ED PIECE

Op-ed pieces placed in a newspaper, a blog, a community newsletter, a radio broadcast, or some other media outlet are very important for raising public awareness of scope of practice issues. This appendix contains a sample op-ed piece which users of this toolkit might find helpful as they develop their own op-ed pieces with content relevant to their states. Much of the data presented in the toolkit related to such things as the difficulty of accessing care in rural areas, or the quality of care provided by non-physician professionals would be appropriate to include in op-ed pieces or letters to the editor.

Example

Federal health care reform legislation will make affordable health insurance available to millions of currently uninsured Americans. This will increase the demand for health care services at a time when the delivery system is already overtaxed because of personnel shortages in many primary health care professions. While the experts debate about the right combination of incentives and investments to educate more physicians, there is something else our state legislators can do to help ensure access to appropriately trained primary care professionals to meet our citizens' health care needs.

In many communities in our state non-physician providers, including nurse practitioners, physician assistants, dental hygienists, optometrists, chiropractors, and other allied health professionals, play a critical role in providing preventive and primary care. Sometimes these health professionals are the only providers available within a hundred mile radius, and they form the backbone of our rural health infrastructure.

However, outdated legal regulations in our state prevent many non-physician providers from caring for patients to the full extent of their education and training. These "scope of practice" regulations dictate what services each health care profession is and not allowed to perform, and under what circumstances. While the original rationale for these laws was to protect us from incompetent care, they have not kept up with the evolution in education and training of health professionals and the growing needs of our communities. Too often, scope of practice changes are politically charged "turf battles" between two or more health professions, each seeking financial and political gain. In the meantime, thousands of people in our state are unable to get the care they need.

Increasing numbers of senior citizens with chronic health problems, for example, present new challenges for the delivery system. Experience shows that pharmacists can safely manage chronic conditions, such as diabetes and cardiac conditions, more conveniently and less expensively for patients than repeated visits to a physician's office. In another example, why shouldn't dental hygienists be permitted to go to long-term care facilities to provide basic services to residents who are unable to leave the facility?

Scope of practice changes do not have to engender "turf battles." Decisions about the extent of permissible professional practice should be based on an analysis of healthcare professionals' training and skills, the quality of care they provide, and the public's need for access to quality affordable care. In fact, a number of states including Pennsylvania, Minnesota, California and New Mexico have already begun to move in this direction. The active involvement and concentrated efforts of the citizens of this state can encourage the legislature to change the way scope of practice is handled. Let your elected officials know that the needs of citizens of this state are not subordinate to any professional or political interests.

APPENDIX B:

Questions Consumers, Community Groups and Legislators Should Ask about Scope of Practice

It is often a challenge for legislators to dissect lobbyists' arguments and reach conclusions about scope of practice changes that are in the best interests of the public. This appendix recommends questions to ask witnesses and to discuss with colleagues to probe the impact on the public of proposed scope of practice changes. Consumers and community groups should ask the same questions when deciding whether to support any particular legislative or regulatory proposal.

Access

Would the proposed change meet an unmet need for services?

What is the magnitude and significance of the unmet need? Would the services in question have a major impact on public health, or are they 'luxury' services for a minority of the population?

Would the proposed change increase or decrease access to services? What would be the magnitude of the change?

How long would it take for the change in the availability of services to take effect? Does the change require training of a new workforce? Does it require additional training for the current workforce?

Based on unbiased national, state or disinterested third party data, is there a workforce shortage in one or more of the affected professions? What is the evidence regarding distribution of services (e.g., does one profession tend to practice more in rural and underserved areas than the other)? Would the proposed change in the law affect/improve the distribution of services?

Do access-to-care difficulties in rural and underserved areas warrant adjustments or exceptions in requirements under the new regulations?

Safety

Can the profession seeking the change in scope safely deliver the services in question under the conditions specified in the proposed regulation?

What is the evidence from other states or jurisdictions that this profession can safely deliver the services? Have there been pilots, demonstrations or research studies of the ability of the profession in question to safely deliver the proposed services under the proposed conditions? What are the results of this research?

Could a demonstration project be tried in this state without compromising public safety?

Could any patient safety concerns be addressed through additional education and training?

Could patient safety be protected by requiring that the proposed services be delivered under collaboration agreements or indirect or general supervision?

Quality

What mechanisms, both current and proposed, promote high standards and encourage quality improvement for the delivery of proposed services?

What mechanisms, both current and proposed, would require professionals delivering the proposed services to demonstrate their continuing competence?

Are there specialty certifications, rankings and/or reporting of quality indicators that would help patients make better decisions regarding a professionals' qualifications to deliver quality services?

Cost

How will the proposed legislation affect the cost of care borne by patients and taxpayers? Will the proposed model offer more affordable options to people currently unable to afford the services in question? Will it bring down costs for public programs, such as Medicare, Medicaid, and new state based exchanges?

Will the increased competition in the market help to bring down prices in the long term, or is it likely to result in a 'technological arms race,' characterized by overuse of services?

Should cost considerations be addressed through scope of practice regulations or reimbursement policies?

Community Development

Will the proposed model result in new job opportunities among under-privileged populations and in underserved communities?

Will the proposed model promote better education and/or stimulate economic development in underserved communities?

Patient Involvement and Cultural Compatibility

Will the proposed change help patients become better informed and/or more actively involved in managing their health?

Will the proposed change help contribute to integration of services, and improve coordination of care for the patients?

Will the proposed change help narrow the cultural gap and promote better communication between patients and providers?