



# News & Views

## Citizen Advocacy Center

Fourth Quarter, 2010 A Health Care Public Policy Forum Volume 22 Number 4

**SAVE THE DATES:** CAC's 2011 Annual Meeting will be in Washington, DC, on October 20 and 21, 2011.

CAC is now a membership organization and we invite your board to join. For information about the benefits that are available to our members, and for a membership enrollment form, please see pages 44 – 45 of this issue.

Although we encourage you to receive our newsletter by becoming a CAC member, you may still subscribe to our newsletter without becoming a member. Please see page 46 of this issue.

### PROCEEDINGS: CAC 2010 ANNUAL MEETING

This issue of CAC News & Views consists of proceedings from CAC's 2010 annual meeting. Although this is not a verbatim transcript of the speakers' remarks and the question and answer sessions, it is a faithful rendition of what occurred. Readers may wish to visit our Web site at [www.cacenter.org](http://www.cacenter.org) to view the PowerPoint slides that accompanied the speakers' oral presentations.

#### Scope of Practice, Continuing Competence, and Health Care Reform

#### INTRODUCTION

Scope of practice has been on CAC's radar screen for many years. We have addressed the subject at previous annual meetings and regularly report in CAC News & Views on the legislative initiatives taking place in various states and the turf battles that inevitably ensue. Depending on their content, scope of practice legislation and policy decisions can either foster or inhibit the reorganization of our healthcare system to improve access, quality and choice while reducing cost.

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Legislators are asked to write laws and resolve conflicts over scope. Licensing boards are often asked to write the rules and regulations that implement legislation. Educators are expected to prepare practitioners to practice within their scopes. Professional associations often advocate to either expand their scope or restrict the scope of other professions they feel are intruding on their turf. Consumer organizations, until now, have been quiet on this subject. It is esoteric and not well-understood, but we hope (as you will hear later this afternoon) that CAC will succeed in making the public and consumer organizations more aware of the implications of scope of practice for the care that they receive, and in getting them involved in influencing decisions about scope of practice changes.

Today, we will hear from speakers who represent a variety of professions whose education and training are changing in response to changes in technology and in demand. However, their scopes of practice are not necessarily keeping up.

We will hear from policy analysts and from people who work in the trenches. They will talk about the politics of scope of practice decision-making; structural considerations, such as shared jurisdiction among licensing boards; and the effects of scope of practice decisions on healthcare delivery and collaboration among the professions.

## **DAY ONE: SCOPE OF PRACTICE**

### **Keynote: The Process is Flawed and Needs to Be Reformed**

**Barbara Safriet, Public Member on the Federation of State Boards of Physical Therapy, former Associate Dean of Yale Law School, and frequent commentator on scope of practice**

I am pleased to be here to talk about scope of practice. It is an issue that is central to our regulatory framework and that should be of enormous concern, not just to the professionals who deliver care, but to the entire public.

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### **Citizen Advocacy Center**

1400 Sixteenth Street NW  
Suite #101

Washington, DC 20036

Phone: (202) 462-1174    Fax: (202) 354-5372

Email: [cac@cacenter.org](mailto:cac@cacenter.org)

Editor-in-Chief: Rebecca LeBuhn

Contributing Editor: David Swankin

Newsletter Layout and Subscription Manager: Steven Papier

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What is scope of practice, why is it broken, and why does the system for writing scope of practice laws need to be changed?

In a nutshell, scope of practice specifies the nature of patient services that a healthcare professional is permitted to provide, either independently on his or her own license, or under the supervision of another healthcare professional, or under the terms of a supervisory or collaborative practice agreement. It is the legal framework that defines who is authorized to provide – and often be paid for – what services, for whom, and under what circumstances.

This framework applies to all kinds of healthcare providers – clinical psychologists, podiatrists, optometrists, pharmacists, advanced practice nurses, physical therapists, chiropractors, dental hygienists, and so on. It is almost exclusively state-based, and takes the form of legislatively adopted practice acts and administratively developed rules and regulations applying to each and every kind of healthcare provider. If you multiply 51 times all the different kinds of licensed healthcare providers, there is likely to be almost infinite variation in what the law authorizes healthcare providers to do for patients.

Scope of practice is really an amalgamation of policy, politics, and law. In regard to policy, I believe that when government intrudes and imposes restrictions for our benefit, the policies should do the most good for the most number of people with the fewest restrictions possible.

When politics comes into play, that notion of policy is often torqued – sometimes beyond recognition. I think there is no clearer example of this than scope of practice laws for health care providers across the country.

### **Why does any of this matter?**

It is important because scope of practice affects the deployment and utilization of all kinds of healthcare providers in every kind of setting, addressing every kind of patient need.

And, scope of practice laws, both individually and collectively, have direct and significant ramifications for the three metrics we use to assess healthcare delivery: cost, quality and access. It is not tangentially related to these. It is directly related to these. Unnecessary restrictions on what a particular healthcare provider can do will affect at least access and cost, and may affect quality as well.

There are many examples of restrictions, which I think are unnecessary. In some states, for example, nurse practitioners who are authorized to prescribe drugs can only prescribe two weeks' worth of a medication. A physician may prescribe for thirty days, plus one, two, or three refills. If a nurse practitioner is considered competent enough to prescribe for two weeks, and the normal prescription pattern is for a month plus a refill or two before having to return to the prescriber, what is the point of the restriction? Surely, it is more expensive for the patient. It could also interfere with quality because having to come back every two weeks rather than every month or every three-months to get your scrip re-filled, might mean patients don't adhere to the medication pattern they are supposed to.

Similarly, when a scope of practice requirement says a practitioner may practice only pursuant to a collaborative practice agreement with a physician, what happens if the physician dies, retires, moves, or decides the other practitioner is a competitive threat to him or her and dissolves the agreement? The practitioner is unable to practice until s/he finds another physician who will agree to enter into such a collaborative arrangement. What happens to all the patients in the meantime? This is a common problem, especially in rural and under-served areas. When the collaborating physician leaves or otherwise terminates the relationship, the legal authority given to that practitioner evaporates – just because of the decision of one private individual.

In another example, unnecessary restrictions that mandate direct supervision or in-the-office supervision of dental hygienists mean that the dental hygienist does not have the authority to go to long-term care facilities or nursing homes or other facilities to do routine dental cleaning.

Other restrictions are more explicit. These include the vast array of physician-only laws. In many states, only a physician can sign the state authorization to obtain a disability license plate from the Department of Motor Vehicles. Or, only physicians can sign death certificates. In some states, only physicians can commit someone to a psychiatric facility for an assessment to determine whether the individual is a threat to him or herself or to others.

So, it matters enormously which providers are authorized to provide which services under which circumstances. The result of unnecessary restrictions is to constrain consumer choice among able providers.

**The next question is: What is the problem?**

The problem is enormous variation from state to state. It is a bizarre crazy quilt regulatory scheme, which fosters confusion and makes little sense. This variation is hard to comprehend, given that there are national standards for education and almost every licensed healthcare practitioner takes a national licensure examination. Specialty certification for healthcare practitioners is done on the national level. So, we have nationally uniform filters of education and examination, yet we have 51 different systems of regulation for healthcare providers.

Today's problems result in large part from the historical artifact of the broad, undifferentiated definition of the practice of medicine included in medical practice acts adopted about 100-120 years ago. Physicians got there first and they took everything. Many professions that are central to our healthcare delivery system today didn't even

exist then – e.g. physical therapy, nurse practitioners, nurse anesthetists, clinical psychologists, and so on.

Here is a definition of the practice of medicine from a typical medical practice act:

A person is practicing medicine if he does one or more of the following:

- Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain, or other condition physical or mental, real or imaginary, by any means or instrumentality;
- Administers or prescribes drugs or medicinal preparations to be used by any other person; or
- Severs or penetrates the tissues of human beings.

**What else is left?**

Some of my best friends while I was in law school who were medical students who pierced ears on the weekends. Only physicians or medical students could pierce ears because the process severs or penetrates the tissues of human beings. Never mind they don't teach ear piercing in medical school. Never mind that many cosmetic companies and jewelry manufacturers have courses specific to how to pierce ears.

Not that many years ago, a nurse or another provider, could not take blood pressure or start an IV line, unless it was pursuant to an order by a physician. Otherwise, it would be doing something that fell within the definition of the practice of medicine.

We have crafted ways around this without changing the laws. Nursing has the most experience with this. Instead of calling what nurses do to "diagnose," they call it to "assess." For example, if a nurse saw that a patient was dead, legally they could not say, "I think the patient is dead." That would be a diagnosis, which is the practice of medicine.

Instead, the nurse must say, “The patient appears dead.” That is a nursing assessment. This is only some of the silliness. But, the ramifications really are very serious for us as consumers of care.

The result of the all-encompassing medical practice act is that physicians were authorized by law to do any and everything, while all other healthcare providers, regardless of their increased skills and abilities, were legally authorized to do something only if ordered to, referred by, delegated to, and/or supervised by a physician.

As other professions’ education and skills increased and developed – just like medicine does – and new professions were created, they had to go to the legislature and/or administrative agencies to seek modification of their legal practice acts or legal authority to practice. In almost every instance, there was opposition, principally by organized medical groups because, as they said “You can’t do it because we do it and it is in the definition of medicine.” Well, everything is in the definition of the practice of medicine.

I have always found this to be an extraordinarily weak argument, but it continues to have salience today. This is what was proposed by Pennsylvania to the American Medical Association’s House of Delegates on October 29, 2010:

Resolved: that the AMA oppose any current or future federal or state health law legislation or act enabling regulations regarding any or all of the following provisions... (I will read just one)

Any state or federal provision which requires or permits any licensed or non-licensed non-physician practitioner to practice medicine independently without licensed medical supervision or a written collaborative agreement with a medical physician licensed in the same state.

Once again, everything is in the definition of medicine. Mowing your lawn is probably within the definition of medicine. This whole notion that everything is medicine and everything else requires legislative or administrative revisions is an enormous problem.

It is a problem because the process of seeking scope of practice revisions through the legislature and/or through licensing boards is, to put a fine legal label on it, a nightmare. It is costly. It is not hyperbole to say that each year, millions of dollars are spent on legislative battles over scope of practice in various states, and/or in administrative agency rulemakings.

It is extraordinarily contentious – and that’s an understatement. This contention leads to a reduction in the respect between and among professions. Often, providers work side-by-side very collaboratively, but when their professional associations duke it out in the legislature, things are said that are not easily forgotten. So, I think the residue from the nasty legislative battles has a corrosive effect on actual day-to-day practice.

There is little or no public participation in all of this. The public isn’t aware of what is going on.

Another problem with the process – one that is seldom talked about – is that it is not data-driven. There is lots of talk about evidence-based this and evidence-based that. (You have to have data to decide what kind of hamburger to order!) Typically the opposition to changes in scope of practice is not data-based. The opposition’s argument is, “This is medicine; it is ours; we’ve always done it; you can’t do it unless we tell you so.”

Ironically, the AMA report that led to the development of their Scope of Practice Partnership (SOPP), the goal of which is to oppose any scope of practice provision in any state for any provider, says the following:

While state laws have in specific instances allowed such independent practice of nurse practitioners and other non-physician providers, it continues to be uncommon. Further, there are no validated data in sufficient volume to conclude that there are inferior outcomes from the medical care provided by those non-physician health care professionals who do practice independently.

There is no data, but they went ahead to launch an SOPP in every state to oppose every opportunity to expand scope of practice legislation for other providers.

Data is also often lacking for the proponents of scope of practice changes. Why is that? Professionals can point to the expansion of their education and training and to the fact that they are taking certification and post-graduate courses that enable them to do certain things. But, if the law prohibits a profession from doing “X,” independently, how in the world is the profession going to get the evidence that its members can do “X” safely and independently without breaking the law? Some years ago, the Pew Health Professions Commission proposed pilot projects as a way to get around this Catch 22. Some have been launched in a few states.

In fact, the best data that is available comes from some of the more progressive states that have reduced restrictions on various kinds of healthcare providers. The evidence in these states confirms that professionals can perform safely and effectively on their own licenses.

The point remains that most of the scope of practice debates in the legislatures are not data-driven. They are politically-driven, money-driven, power-driven. Most important to me, the consumers and the public haven’t a clue they are even going on.

I want to highlight the ongoing significant effect of the notion – historically based – that everything legally is the practice of medicine. The Louisiana State Board of Medical Examiners has a policy on “Interventional

Pain Management Procedures.” It says that interventional pain management procedures, which have for years been performed by certified registered nurse anesthetists in Louisiana and many other states, constitute the practice of medicine and may only be performed in this state by a Louisiana-licensed physician. It cannot be delegated to someone else. That is pretty radical. Here is the most important thing for our purposes:

A non-physician may have education, training, and indeed expertise in such an area, but expertise cannot in and of itself supply authority under the law to practice medicine.

This is half right and half wrong. The half right part is that under our legal regime, ability often takes second or third place to the authority because of the all-encompassing definition of medical practice. You can’t do it until the legislature or a regulatory body says you are authorized to do it. The half wrong part is “supply authority under law to practice medicine.” I would argue that the administration of interventional pain management techniques is the practice of interventional pain management, not *physician-administered* interventional pain management. It doesn’t belong to physicians alone.

The problem is the attitude – codified in state law – that everything is medicine and no matter how capable you are, even if you have recognized expertise, you can’t do it unless the legislature says you can. Ability is explicitly irrelevant. Raw power and authority is the highest power. This has to change.

A better way of approaching scope of practice has been offered by an historic coalition of six groups of regulatory boards representing six different health professions that looked at scope of practice issues and processes collaboratively and came up with a unique document, entitled *Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations*. It is unique because it was

developed collaboratively by six different healthcare professions' regulatory board associations. It is unique because it is provider-neutral. It talks about the principles that should guide any assessment of scope of practice, regardless of the profession(s) involved. The overarching theme is that the ability to provide safe and effective care should guide legal authority.

The four central tenets are:

- Public protection, not professional self-interest should guide scope of practice decisions.
- Changes in scope of practice are inherent in our current healthcare system.
- Collaboration between healthcare providers should be the professional norm and not legally required for only one or two different professions.
- Overlap among professions is necessary. No one profession actually owns a skill or activity in and of itself.

Today you will hear others talk about better ways to approach scope of practice than our current system of fighting it out in the legislature where power, money and politics trump demonstrated data showing safe and effective practice. To bring the point home, let me recount an experience I had almost fifty years ago which will show you that scope of practice issues affect everyone.

When I was fourteen, I went to work on my first day as a candy-striper at my local hospital. It was a tiny town and I knew everyone who worked in the hospital and most of the patients. The nurse instructed me to help Mr. Turner, whom I knew. I was told to help him eat and then help him with a bath. I went to Mr. Turner's room. I knocked, but got no answer. I thought he

must be asleep. I said, "Mr. Turner, Mr. Turner, it's Barbara." No response. I went to the bed and touched Mr. Turner's arm. No response. I picked up his hand, which was cold and floppy. Mr. Turner is dead.

This was my first venture as a candy-striper. You can probably understand why I chose to go into law and not medicine.

I returned to the nursing station where they asked, "What are you doing back here so soon?" I said, "I'm not going to be giving Mr. Turner his breakfast or a bath because Mr. Turner is dead." The nurse said, "You can't say that!" I said, "What do you mean I can't say that?" She said "Only doctor can say he is dead." I said, "Well, doctor can say whatever he wants, but I'm here to tell you Mr. Turner is really dead."

I don't tell you that story to suggest in any way that I am a capable diagnostician or assessor, but rather to emphasize the continuing power and weight of legal definitions that were embedded in the immediate response of this registered nurse. It is a powerful force. My goal after thirty years of working on scope of practice issues is to see the day when demonstrated ability is the touchstone for our regulatory regime that governs who can provide what services for whom under what conditions. Not the historic artifact that everything in the universe is medicine and leaving it to power plays in the legislature.

Although it is almost always organized medicine opposing changes in scope of practice, the perniciousness of this has spread and other professions fight as well – "No, you can't do that, we do that." We need to get back to the notion that if a professional can demonstrate ability by education, examination, and other ways, authority should mimic that. It should not be left to the static status quo, which is nothing but the result of historic anomalies.

Thank you very much.

## **The Case for Changes in Scope of Practice in Five Healthcare Professions**

### **Henry Manasse, Executive Vice President and CEO of the American Society of Health-System Pharmacists**

Our organization represents about 36,000 pharmacists who practice in organized healthcare settings, largely hospitals and associated health systems. My perspectives will be a little bit more institutionally based, but I can speak generally to our profession.

Let's talk a little about the contemporary drug armamentarium. In this country, about 6,000 specific and distinct chemical entities are authorized for marketing. In addition to small-molecule drugs, there are biologicals, vaccines, and contrast media. All of this constitutes the broad array of chemical and biological agents that physicians have unlimited authority to prescribe.

In addition, there is "off-label" usage when physicians prescribe a drug for a purpose not approved and authorized by the Food and Drug Administration. In pediatrics, more than fifty-percent of prescribing is for off-label use because of the limited number of clinical studies in pediatrics.

The data shows that the second largest number of sentinel events in hospitals involving deaths or serious injury are related to prescribing. The Centers for Disease Control (CDC) just released a report showing a substantial upsurge in deaths associated with the use of prescription medicines, largely opioid analgesics and the combination of opioid analgesics and other prescription medicines.

We have also seen an increasing per-capita use of medicines. In 2009, we filled 3.9 billion prescriptions. A study done several years ago suggested that the cost of drug-related morbidity is estimated to be as much as \$289 billion. So, this is a significant public health issue.

Let's think about it in the context of pharmacy and pharmacists. Effective in 2000, the only accredited degree programs in pharmacy are at the doctoral level. About 70% of the students have prior degrees, which means eight years of education to earn a Pharm D. The entire four-year pharmacy curriculum is focused on drugs, biologicals, vaccines, and contrast media. In addition, the last year involves clinical rotation, so the students can see medications in use by the patient population.

The profession has spent the last several years considering not only current scope of practice laws, but also the safe and effective management of different patient populations. The medication therapy management needs of the elderly are different than those of teenagers, for example.

The pharmacy profession was successful in getting a provision in the healthcare reform legislation that provides for grants to study medication therapy management. Our literature is replete with evidence that suggests that when pharmacists are part of the teams, or when pharmacists manage drug therapy, there are better patient outcomes at a lower overall cost of care. A summary of the literature related to both clinical and economic outcomes has been published by Professor Marie Chisholm-Burns of the University of Arizona.

You will see in CAC's current newsletter that seven pharmacy organizations have challenged the AMA's Scope of Practice Partnership (SOPP) document related to pharmacy. My organization decided not to join the coalition, but to take a more aggressive approach. In our response to the AMA, we say the time has come to review whether it is good public policy to continue to allow the open-ended prescribing authority that physicians now have. In hospitals, we see that when pharmacists are not part of teams, there are serious safety issues associated with prescribing.



A good model has been established by the federal healthcare services. In the Veterans' Administration (VA), for example, pharmacists are privileged with authority to independently prescribe, to adjust doses, and to switch drugs when appropriate. Within the VA, there are differentiated pay levels tied to competence. Board certification, for example, would mean higher pay and a broader scope of practice. The Indian Health Service has done a terrific job for decades permitting pharmacists to provide primary care in many instances.

The lesson is that when a profession is not encumbered by state laws and state boards, it is possible to expand scopes of practice based on competence and the needs of patients.

**Gregory Moore, Immediate Past-President, West Virginia Board of Optometry**

In 2010, the professional association introduced legislation that would expand the scope of practice of optometry in West Virginia. What we ran into in the legislative battle is what I refer to as "intellectual bigotry." A bigot is defined as "a person who is obstinately and unreasonably wedded to a particular religious creed, opinion, or practice, a person blindly attached to an opinion, system or party, and bitterly intolerant of those who believe differently."

The bigotry we ran into comes from the fact that our educational system is based on a linear industrial model. The system was set up to educate people to do specific tasks, somewhat like a road lot in a manufacturing plant. What it doesn't do is allow talents to be nurtured and grow. Our healthcare regulatory system completely eliminates the nurturing of talent by enacting strict laws that limit what each individual can do.

When we tried to change the law in West Virginia, we ran into an intellectual bigotry that believes that because I'm a doctor of optometry and not a doctor of medicine, I must not be as smart as that guy and can never be trained to do what the doctor of

medicine can do. Somewhere in that linear mindset from kindergarten to the MD degree, I jumped off the bus and took a lesser course.

We need to educate the public and the legislators that human communities depend on a diversity of talents. We have a diversity of talents in healthcare – from the LPN up to the neurosurgeon. If we don't enable everyone to grow to the extent of his or her ability, we won't have the quality of healthcare that we want in this country. The way we get there is to enact laws that are not unnecessarily restrictive.

In 1976, West Virginia was the first state to allow optometrists to prescribe therapeutic topical medications. At that time, there were two ways to treat the eye: topical medications or major surgery. Optometrists don't want to be major surgeons. The 1976 law allowed optometrists to prescribe topical medications without any restrictions. Our law was the best law in the country for many years because in other states optometrists negotiated over a formulary.

In 1997, optometrists in West Virginia were authorized to prescribe oral medications, but we got stuck with a formulary. It took four years for the formulary to get through the rulemaking process and it was ridiculously restrictive. Formularies are just another way to restrict the practice of professionals who are not physicians.

The state Senate gave us therapeutic laser privileges. But, we knew we would never get this authority from the House. When it looked as if the Senate was going to give us laser authority, ophthalmologists ran full-page ads in the newspaper saying, "Your legislators are about to let non-physicians use laser knives to cut into people. This is wrong; you must call your legislator and stop this." The ads elicited no public response, but the West Virginia Optometric Association wrote to the West Virginia Academy of Ophthalmology saying since 1987 optometrists have been viewed by Medicare to be "physician-level" practitioners and threatening to sue for

slander if the ads continued. The ophthalmologists removed the “non-physician” terminology but kept running the ads. We persuaded the Senate to define an optometrist as an “optometric physician.” That generated more anger than laser authority did.

The ophthalmologists tried to take away our authority to treat glaucoma, even though since 1976, there has not been a single adverse event reported to the board of optometry, nor a single malpractice lawsuit against an optometrist for treating glaucoma in West Virginia. They cited one lawsuit in Palo Alto, California.

We persuaded the Senate to remove the formulary taken from the oral medication authority. In the House we agreed to keep the formulary so long as the Board of Optometry had control over it. We also were authorized to perform some procedures that are billable as surgical codes: pull an eyelash, remove foreign bodies, plug the tear drains. So, basically, we negated the surgical prohibition on optometry.

We gave up therapeutic lasers. I was the lead negotiator as the President of the Board of Optometry. I have a laser surgery center and three ophthalmologists who work with me. There were rumors that we gave up therapeutic lasers because I have a laser center. That’s ridiculous because I could make a lot more money doing the lasers myself.

To really change a law, you have to change the paradigm that says the MD is the pinnacle of educational success and anything less than that is because the individual couldn’t reach the highest level. It is harder to get into optometry school than it is to get into medical school.

At the beginning of our legislative session, I received emails saying, “You cannot permit these people to do this. They are not trained and educated in this field.” “What in their

training allows them to even think they could do this?” “If this is allowed, they would not be able to afford the proper equipment, so what is the point in allowing this?” “If this is allowed, people will go blind.” Surprisingly, these emails came from optometrists.

The pharmacists introduced a bill that would allow them to prescribe certain antibiotics, including topical antibiotics for the eye. Some of my fellow optometrists objected to this. My response was to say, “Don’t tell your legislators not to give pharmacists this authority. These are the same arguments ophthalmologists use against us and they do not carry weight, no matter where they are coming from.”

We have to stand strong against intellectual bigotry and professions that strive to expand their scopes of practice have to stand together. After our bill passed the newspaper published a letter to the editor from a physician who wrote, “We have long forgotten our Hippocratic Oath to serve the public to the best of our ability and to do no harm. We are enwrapped in greed.”

### **Angelina Barnes, Minnesota Board of Psychology**

I am the Executive Director of the Minnesota Board of Psychology and was an Assistant Attorney General providing legal services to several health-related licensing boards, including the Board of Social Work, Dentistry, Psychology and Nursing. My comments are entirely my own and do not represent the position of the Board of Psychology or any other Minnesota health-related licensing board.

In Minnesota, there are four mental-health-related boards: Psychology, Social Work, Behavioral Health and Therapy, and Marriage and Family Therapy. I will talk about an example from the Board of Psychology that illustrates specific ways in which scope of practice can be limiting and damaging to the profession. Then, I will discuss how the mental health professions in Minnesota

worked together to provide consumer services.

The Minnesota Board of Psychology regulates two different levels of practitioners: licensed psychologists and licensed psychological practitioners, who are the masters-level individuals who provide mental health or psychology services. The psychology license gives the doctoral-educated individuals the sole and exclusive independent practice of psychology.

Licensed psychological practitioners (LPPs) are prohibited from practicing independently. They must be supervised by a licensed psychologist, and they may practice only while employed by either a licensed psychologist or a health care or social services agency that employs or contracts with a licensed psychologist who shares clinical responsibility for the care provided by the LPP. This is very difficult to do because LPPs often are unable to find a healthcare or social services agency meeting the requirements. What LPPs ended up doing was hiring their own supervisors and paying out-of-pocket. This is a particular problem in rural areas where there is already a deficit in mental health services.

Another problem with being an LPP was the inability to get third-party reimbursement. They had gone to school, paid the licensing fees, passed the same exams as their licensed psychologist counterparts, but couldn't find work or provide services, except in a limited capacity. From a regulatory perspective, LPPs were undergoing disciplinary proceedings every time they overstepped the restrictions.

Ultimately, we opted to remedy the situation with statutory language that eliminated and abolished the LPPs. Only about 116 individuals had become LPPs, out of approximately 3700 licensees under the Board of Psychology. We have thirty-seven left. They are integrated into a conversion process whereby after two years of licensure and demonstrated supervised clinical practice, an

LPP can pay a fee and apply to be converted into a licensed psychologist.

We have had success in Minnesota with shared scope of practice among mental health professionals. I surveyed the mental health boards and examined the titles they have under their licensure. There are alcohol and drug counselors and technicians, licensed professional counselors, licensed clinical counselors, several varieties of licensed social workers, and so on. I then examined their scopes of practice. I was pleasantly surprised that core functions, such as screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, and client education overlap among the mental health professions. All of these practitioners range from bachelors-level to doctoral-level. What this says is that we are working more towards a competency-based model. We are not entirely there yet.

The Board of Psychology lists a licensee's competencies in his or her file and expects the licensee to stay within those competencies. We evaluate competencies when a complaint arises. We are building task forces to look at how to ensure greater competency, but now we have more than seven mental health practitioners providing services in overlapping areas. One of the big questions concerns prescription privileges. Our board has not taken a position on this, or on ADHD assessment.

Regulatory boards need to get educational material out to consumers who are currently unaware of the differences between mental health professions.

### **Dargan Ervin, Immediate Past-President, Federation of State Boards of Physical Therapy**

My first experience with scope of practice change was in the late 1990s when the South Carolina Board of Physical Therapy was doing the first major revision of its practice act since 1952. There had been major changes in practice during this time. One

proposed change would have allowed a consumer direct access to a physical therapist without a physician's prescription. An opponent of this change warned of "death in the streets." At that time, South Carolina was the 38<sup>th</sup> state to enact direct access. Death in the streets did not result.

Physical therapy is in discussion over scope every year with chiropractors, physiatrists and neurologists, athletic trainers, and massage therapists. Physical therapy is just as guilty as any group of approaching physicians seeking authority to do a little more and then exhibiting the same behavior physicians exhibit when other professions come to physical therapy wanting to enlarge their scopes to overlap with physical therapy. One of the challenges our profession needs to meet is to follow the Golden Rule. Treat other professions as your profession would like to be treated in relation to scope issues.

There are a lot of precedents in physical therapy for radical change in scope from what we typically see in our states. One is the military model. Sprains, strains and pains in the military system come first to a physical therapist. Physical therapists are in the primary care clinics in the military. They have the authority to order diagnostic tests, x-rays, and MRIs. They have authority to provide some level of medication. The objective is more about getting the job done than it is protecting income or protecting scope. Also, in Canada, some of the provincial jurisdictions are enacting scope changes that are very similar to the military model, making physical therapists an entry point for consumers.

Of the approximately 280 physical therapy educational programs, fewer than ten are not yet at the doctoral level. Those schools will be at the doctoral level within ten years or they won't be accredited. The American Physical Therapy Association has a large number of certified clinical specialists in such areas as neurophysiology, orthopedics, and

neurology. We are seeing growth in certifications every year.

National healthcare reform will create challenges related to access to care. We need to focus in the states on how to get the job done. I certainly will encourage physical therapists to follow the Golden Rule when dealing with other professions about scope of practice issues. We have the tools to confront the challenges positively, including the six-profession scope of practice document Barbara Safriet referred to and the precedents in jurisdictions that are a little bit more progressive.

### **Stacey Chappell, Manager of Government Affairs, American Dental Hygienists' Association**

The American Dental Hygienist' Association (ADHA) represents more than 150,000 dental hygienists. Dental hygienists serve as primary health care providers in partnership with dentists and dental assistants. They practice primarily in private settings, but also work in community health centers, school-based clinics, hospitals, prisons, nursing homes, and other non-traditional settings.

Growth in the dental hygiene profession and increasing consumer demand have prompted many states to enact laws permitting direct access to dental hygienists.

Dental hygienists provide primary care services, including teeth cleaning, prophylaxis, patient education, sealants, nutritional counseling, fluoride treatments, screenings, assessments and exams. In addition to these preventive services, states allow hygienists to provide therapeutic and restorative services. Many allow them to perform temporary restorations.

As the connection between oral health and overall health has become clearer, stakeholders outside dentistry have become engaged in oral health policy issues. The Pew Center on the States and the National Academy for State Health Policy released a

report revealing growing recognition that alternative providers can competently and safely deliver basic dental care. The Institute of Medicine has created an oral health initiative related to access to oral healthcare services. Legislation that reauthorized the children's health insurance program included a provision directing the GAO to study the feasibility and appropriateness of mid-level dental providers. The report is expected soon.

Throughout the past decade, policy changes have leveraged the dental hygiene workforce. Changes in state law are intended to maximize the potential of the dental hygiene workforce by allowing hygienists to perform all the services they are educated to deliver, enabling hygienists to practice in a number of settings, and loosening supervision requirements.

These changes allow dental hygienists to treat patients in settings outside the traditional private office, helping to overcome some of the barriers many under-served populations experience in accessing care. There has been a great deal of movement from direct supervision of dental hygienists to practice arrangements that encourage collaboration and cooperation with dentists and other medical providers.

One of these is direct access. The ADHA's concept of direct access is that hygienists be able to initiate care without the patient first being examined by a dentist, or without the dentist being present. Direct access takes many forms throughout the country. Some states call it public health supervision. Some have limited access permits. Some do collaborative practice.

Typically, direct access hygienists provide care in alternative settings, such as schools and nursing homes, or community health centers. Oregon recently passed a law that would allow hygienists to work in nurse practitioner and medical offices.

In 1995, only five states allowed direct access. Today, that number is 32 states and is growing almost every year. Fifteen of the direct access states allow hygienists to be reimbursed by Medicaid. This policy trend is intended to make care more accessible.

One of the other major trends is the development of new workforce models. ADHA has put forward a concept of a new provider: an advanced dental hygiene practitioner (ADHP). This concept builds on the strength and expertise of the dental hygiene workforce by further educating dental hygienists to build up their skill set. This is akin to the nurse practitioner concept. The ADHP is envisioned to be a masters-level practitioner who provides education, preventive, diagnostic, therapeutic, and minimally invasive restorative services to a wide range of patient populations.

In 2009, Minnesota passed legislation that established the first mid-level oral health practitioner in state statute. This was the culmination of two years of contentious debate between organized dentistry, hygiene and other stakeholders. The effort in Minnesota demonstrated the interest of third-party stakeholders in the development of new providers. The driving force was more than 50 organizations, including many citizens' groups. I don't know that it would have happened without outside stakeholders making themselves heard. The first class of graduates completes course work in May 2011.

**Questioner:** The Council on Credentialing in Pharmacy is looking at a framework for credentialing which ties in with scope of practice. The element I would like to explore with the panel is the concept of complexity of care. Have any members of the panel had experience in their professions with using complexity of care as the driver for scope of practice credentialing – putting the needs of the patient at the center of the framework

rather than starting with a provider competency model?

**Moore:** In 1976, West Virginia was the first state to have a therapeutic medication privileges. There are still people practicing in West Virginia who have never acquired the necessary skills, and cannot apply topical medications. New rules promulgated for an expanded scope will specify steps an optometrist must take through an accredited university or school of optometry to prove they have the clinical competence to provide the procedures. So, it is an individual choice whether to grow with the profession. You can't just legislate that someone is capable of doing something. There has to be proven clinical competence before they are permitted to do it.

**Questioner:** Speaking as a physician, I agree that competence is key, but I am concerned about bureaucratic oversight at a time of austerity, economic downturn and growing demand for healthcare services. I am worried that willy-nilly expansion of scope of practice will result in duplicative oversight.

Why don't people want to go to medical school? I've never before heard the argument that we should eliminate years of training because we can do the same with less. Medicine is very sensitive about branding so patients know who they are seeing and what service they will get. The term "doctor" has been diluted because it is used by many other professions.

**Moore:** One of the things you said strikes home with me. During our legislative debate, one of the ophthalmologists said, "Dr. Moore, if you wanted to be a real doctor, you should have gone to medical school." My response was, "You are correct, if I wanted to be a doctor, I could have gone to medical school. But, I wanted to be a real *eye* doctor, and the highest level of education attainable related to the eye is the Doctor of Optometry degree.

Physicians' laws allow them to do anything. Most physicians in their medical training

spend anywhere from one day to two weeks on the eye. Are you telling me that family practitioners have more skills and are able to do more things to the human eye than an optometrist who spends four years training specifically about the eye? Where you and I have a divergence of thinking is when you say a medical doctor is the be-all and end-all. There will have to be multiple ways that the public can obtain healthcare services in the future when more than 30 million more Americans have insurance. You restrict care and decrease quality and access with that kind of mindset.

## **Patient-Centered Scope of Practice Decisions**

**Lisa Summers, Senior Policy Fellow,  
American Nurses Association and  
Spokesperson for the Coalition for  
Patients' Rights**

What is at stake in this discussion?

Healthcare professionals who are not MDs or DOs offer necessary care, and often reach underserved populations. They offer quality health and wellness outcomes for patients and, in most cases, do so in a way that is more cost-effective, both for individual patients and for the healthcare system. This is something we are particularly aware of in the discussions of health system reform.

The Coalition for Patients' Rights (CPR) consists of more than thirty-five organizations representing a variety of licensed healthcare professionals. It was formed in 2006 to ensure that patients everywhere have direct access to the full scope of services offered by quality healthcare providers of their choice and the growing and increasingly diverse needs of the American healthcare system are met.

There are representatives of a number of our member organizations here today. Our members include the American Physical Therapy Association, the American Academy of Nurse Practitioners, the American Chiropractic Association, the Occupational

Therapists, the Foot and Ankle Surgeons, Practitioners of Oriental Medicine, nurse anesthetists, the American Psychological Association, the Speech Language Hearing Association, and others. This is a very diverse group of professionals.

We were motivated to form a coalition by the establishment of the AMA's Scope of Practice Partnership (SOPP). In CPR's view, this is not a "partnership" at all, but is a very divisive movement to restrict the valuable services that are provided by some healthcare professionals. It aims to limit the scope of practice of those healthcare professionals. If it is successful, the activities of the SOPP will limit patient access to safe and high quality care.

The SOPP consists of the American Medical Association, the American Osteopathic Association, forty-nine state medical associations, the District of Columbia's medical association, fourteen national medical specialty societies, and nineteen state osteopathic associations. *AMA News* wrote a couple of years ago about the SOPP, based on AMA House of Delegates directives of June 2006...

The Scope of Practice Partnership was charged with providing distinguishing qualifications among healthcare providers. In response to that charge, the SOPP has developed a series of modules that outline the training, licensure, and state regulation of ten non-physician provider groups. The SOPP has additional work groups and projects to research the clinical doctorate education template and to develop models to rapidly facilitate coalitions against unwarranted scope of practice expansions.

This is a very well organized and well-funded initiative on the part of the AMA.

The modules are directed at these professions: audiologists, dentists, naturopaths, nurse

anesthetists, nurse practitioners, optometrists, pharmacists, physical therapists, podiatrists, and psychologists. They are officially "draft" modules at this point. We are told that final publication is expected soon. They are already in use, however, by many state medical societies. Despite CPR's appeals to the AMA, we don't expect the AMA to withdraw or make significant changes in the modules.

The themes of these modules are safety and quality. Are we really questioning safety? Are we saying these providers are unsafe? Or, are we talking about safe with supervision? I suggest that in many cases, the debate is not about whether the healthcare provider in question can safely provide a service. The debate is whether that professional can "function" independently, or whether the patient can access those services without referral from a physician. Again, you have heard this both in Ms. Safriet's remarks and in the panel – examples include direct access to physical therapy, interventional pain management, and prescriptive authority.

What does this mean for patients? In the best circumstances, "sham" supervision (which is really what it is in many cases) creates delays in obtaining care, added expense to the system and the patient, duplication of services, and in too many cases it means the patient goes without the necessary care.

Here is an example involving the regulation of nurse practitioners in retail clinics. The National Academy of State Health Policy did an interesting analysis of state regulations and policies *vis a vis* the operation and licensure of clinics. The Academy found that the regulations vary according to the regions of the state. Generally, for a nurse practitioner to have prescribing authority, a physician must be at the clinic with the nurse practitioner 20% of the time. However, in medically underserved and rural areas, the rule is relaxed to one oversight visit every ten business days.

If my child has an earache and I decide to go to a retail clinic, do I ask myself whether this is one of the days when a physician is present at the clinic to provide oversight over the nurse practitioner who examines my child? I don't think patients think about this. I think they want to know whether there is someone there who can diagnose and treat otitis media. It's not that complicated. Patients also want to know whether, if there is something more complicated, the caregiver has the training, skills and education to refer the patient for the care they need.

I remember a discussion I had with a pediatrician in Tennessee about his work supervising the nurse practitioners in a nurse-managed health center. The regulation said he had to be physically present at the health center every thirty days. The rule doesn't tell him what he has to do while there. He could go in and read charts, or have a cup of coffee, or just walk in and walk out again. The rule doesn't say he has to treat patients, or supervise someone who is, it just says he has to be there. He told me that what is really silly about the rule is that he knows the nurse practitioners will call him if they have a problem – because they do. So the absurd requirement that he has to drive to the clinic and cross the threshold once every thirty days just wastes his time.

While we engage in scope of practice battles in the state legislatures, providers out there are caring for patients. In the course of their daily work, the physical therapist calls the orthopedic surgeon and the psychiatrist calls the marriage and family counselor and the nurse midwife calls the Pharm D. They all use one another's expertise to provide the best care they can for patients. I would like to see a study of the percentage of people out there caring for patients who really buy into the scope of practice battles being fought out in state houses. Many of us would just like to get on with caring for patients.

The American Nurses Association (ANA) did a survey of nurse practitioners related to legislation to allow them to certify for home health care. We asked them what it means when they cannot do this. One of the respondents wrote:

I frequently need home health services for IV steroid infusion to treat multiple sclerosis exacerbations. My inability to certify home health services results in no treatment for the patient. Therefore, if the patient cannot come to the clinic between 8:00 am and 4:00 pm on Monday through Friday, they do not receive the standard of care. This delay causes loss of brain tissue.

We are talking about high stakes for patients every day.

Independent practice refers to the ability and responsibility of a provider to utilize the knowledge, skills, judgment and authority to practice to the full extent of their education and licensure. Independent should not be interpreted to mean in a vacuum.

Independent practice is also not defined by the place of employment, the business model of the practice, or the method of reimbursement. CPR member professionals, like physicians, collaborate and consult with many other health care providers – often on a daily basis – requesting consultations and referring patients for specialized care. When we talk about independent, we mean the ability to do those things, to take the responsibility, to use the judgment and authority. It doesn't mean off willy-nilly, never talking to anyone else. It means without regulatory requirements for supervision or collaboration.

In talking with physicians about this, particularly physicians in leadership positions who have responsibility for large healthcare systems, I have become more and more sensitive to the fact that they are very tuned



into their responsibility for oversight and assuring quality of care. Sometimes those physicians get into the mode of thinking that somehow supervision ensures quality of care.

This may have made more sense in the systems that existed twenty or thirty years ago, but in today's incredibly complex systems, there are a whole host of quality assurance mechanisms that didn't exist a few decades ago. The idea of supervision to ensure quality is antiquated today.

I suggest that all healthcare professionals are expected and entitled to use their education and training to care for patients within their scopes of practice and fields of expertise. As care evolves, there are a number of mechanisms to ensure safe and competent practice. There are state laws and regulations, regulatory boards, professional standards, certification mechanisms, credentialing systems, institutional policies and quality assurance programs. All these things help protect the public and help ensure quality. Supervision does not need to be on this list because it doesn't work.

The CPR has been around for a couple of years and represents more than three million healthcare professions. Like all coalitions, we have developed some consensus documents and have coordinated some member efforts against state-level policy to limit scope of practice. We have built a Website. We maintain an online tool to identify, track and respond to coordinated campaigns to restrict patient access to coalition members across the country. We have developed communication materials to inform the media, lawmakers, policy makers, regulators, and the public about key patient care and access issues. We assemble our members in regular meetings to discuss activities and identify opportunities. Our goal is interdisciplinary care.

What frustrates me, particularly with the opportunities provided by a reformed healthcare system, is that the SOPP has (in the words of one of our members) placed the

AMA in an unproductive adversarial position to all other healthcare professionals. It is really draining valuable resources that could be marshaled for the true benefit of all the patients that we serve. As I have been saying for many years, there are enough sick people to go around. Now there are thirty-two million more covered lives to go around. I was hoping the AMA would realize it doesn't need to do this anymore. But, in fact, the AMA has become even more determined.

In conclusion, let me quote from our *View from the Frontlines*:

We believe that patients' interests are best served by a healthcare system in which many different types of qualified healthcare professionals are available, accessible, and work

**Questioner:** I am the consumer representative on the Wyoming Board of Nursing. One thing we discuss in addition to scope of practice is title protection. Our board can see the doctorate of nursing coming down the road. It occurs to me that while we discuss titles, public members and others should also be concerned with educating the public that the word "doctor" doesn't mean just physician.

**Summers:** I understand the issues associated with the doctor of nursing practice, but I'm aware title profession issues affect other professions.

I think it is important that every profession involved in caring for patients learns how to communicate with patients who they are and what they are prepared to do for that patient at that moment, whether it is in a hospital, a pharmacy, a community health center, and so on. There are such a large number of healthcare professions, and a growing number of them are being educated at the doctoral level. Patients, particularly younger patients, are capable of understanding the different roles of different healthcare professionals. It is incumbent on us to make clear who we are and what we do.

**Questioner:** I am the public member from the Tennessee Board of nursing. One of the things about scope of practice that you triggered in my mind when you talked about the nurse practitioner who said the patient couldn't get to the clinic Monday – Friday between 8:00 to 4:00 is the organization of when services are available. An example is public education. There has been the assumption that kids have to go to school for seven hours a day. But, young people's lives are now twenty-four hours a day.

**Summers:** What the nurse practitioner in my example was referring to was the need for this particular patient to have access to care in the evenings and on the weekends. That is what home healthcare services are all about.

One of the absurd ways that scope of practice battles play out is when organized medicine advocates rules or regulations that will limit the provision of services. Those of us who understand that patients need certain services recommend carving out an exception for rural areas, or some other group, and you end up with weird, irrational rules. We need to create systems that are flexible and will enable patients to obtain the care they need from the person who can provide it at the time they need the care.

**Questioner:** I am the national correspondent for the *New England Journal of Medicine*. I have a two-part question. First, have you observed any differences in the attitudes of physicians based on their age? Second, are there any state medical societies that you consider to be exemplars in terms of having more progressive attitudes toward scope of practice laws?

**Summers:** I can't point to a state where the medical society is more progressive on this subject. There are states where we have less difficulty than elsewhere, but I am not sure this relates to the state medical society.

In terms of age, there is absolutely a difference in attitude among younger medical professionals. I spent the bulk of my clinical

career in academic medicine because I wanted to train future consultants for midwives and I wanted physicians to learn something about normal labor and birth. I wanted to be a midwife. I wanted to attend women in labor and birth. I didn't want to be a surgeon. I didn't want to take care of sick people. That's why I didn't go to medical school. What I wanted to do working in schools of medicine was to teach physicians about normal labor and birth. They never would have learned this had there not been a midwife on their medical school faculty.

What I have seen over the years is that there are more and more physicians who have been educated with advanced practice nurses and who have come to respect their skills and abilities. I don't know if other professionals have had the same experience. There are a couple of well-known perinatal physicians who are unpopular in the OB/GYN world because they believe nurse midwives should provide well women care for the vast majority of women while perinatal physicians provide care for at-risk women. One of them relates that while he was in medical school, the chair of OB/GYN mandated that residents do their first ten births with midwives. The theory was to learn the normal first and then learn how to be a surgeon.

Let me ask you whether you have noticed a difference based on the age of physicians.

**Questioner:** There are certainly differences based on age in many aspects of medicine. I am not as familiar with scope of practice as I hope to be, but I have always been intrigued about why the whole scope of practice phenomenon – which I have mostly seen between the doctor and nurse, so I have been enlightened this morning to learn that it is universal – why it hasn't resonated more strongly at the national level, particularly with reform and presumably millions of newly insured patients and who is going to care for them. It hasn't penetrated that world and maybe that is one of the goals of your coalition.

**Summers:** My colleague who attends AMA meetings in an observer status related more than once that when scope of practice resolutions are discussed, younger physicians come to the microphone and say, “Come on, let’s get on with it and concentrate on building good interdisciplinary teams to take care of patients. Stop wasting our time and energy with this.”

**Questioner:** The latest figures on the number of physicians who are AMA members is about 17 percent of practicing doctors, so you have to wonder if there isn’t a tipping point out there somewhere.

**Questioner:** I am a public member of the New York medical board and of the Accreditation Council on Continuing Medical Education (ACCME). One of the things we have been talking about is the complexity of medical care today and the multiplicity of different specialist providers. We have also been talking about supervision among all the different groups. Couldn’t the electronic record be helpful in checking on what other providers are doing? It gives patients more power to figure out what is going on. It allows the pharmacist to make sure the patient is not getting medications from six different doctors. Wouldn’t the electronic record partly resolve some of these problems?

**Summers:** I think absolutely, yes. There is a concern about privacy issues, but when it is well done, what you hear from providers is that it allows everyone on the healthcare team to function better. One of the issues is who on the team gets access to what part of the record. In a way, it becomes a platform for members of the team to come together and see how many professionals are involved and see “the big picture.” Clearly, it is to the patient’s advantage to have an electronic record to take from one provider to another. It can help with care coordination and eliminate a lot of duplication of services that is inherent in the fragmented system we currently have.

## **Regulation of Advanced Practice Nurses: Is Shared Jurisdiction with the Medical Board a Good or a Bad Idea?**

**Polly Johnson, President and CEO of the Foundation for Nursing Excellence**

I retired two years ago from my position as executive director of the North Carolina Board of Nursing so I am feeling a little like an old soldier who didn’t die and was supposed to fade away, but has been pulled back to the same old battlefield that hasn’t changed much. I am listening to struggles that all professions are having with human behavior stuff. Recalling Maslow’s hierarchy, we have a conflict between self-actualization and survival. Those of us who believe that we are pretty far developed in our professional areas are dealing with survival issues. I think that is a sad statement about where we are.

The other things we struggle with are power, greed, and the old pecking order – the survival of the fittest. We are dealing with middle-aged feudalism issues. All of these things put together make it really tough to change the frameworks we are in. We are all in silos. How do we change the dynamic so we become needs-based? How do we get to a place where we make decisions based on a professional’s ability to provide the needed services?

Instead, we are struggling with who is regulating whom and who is allowed to do what. Who is playing in my sand box? The truth of the matter is that no sand box is self-contained – whether it’s a beach or a kid’s sand box in the back yard, sand spreads, doesn’t it? The whole issue of scope of practice creep – it’s nothing more than a sand box. How do we engage in public protection and not sand box protection?

I was asked to talk about the comparative value of shared versus sole jurisdiction. This is a little bit different than scope of practice.

It is related, but jurisdiction has to do with who is making the decisions within the scope of practice framework.

During my years at the board of nursing I was involved with shared regulation of nurse practitioners. We started regulating in 1972. So, we are talking about 40 years of regulation in this area versus a hundred to a hundred and fifty years of experience in medicine, nursing and pharmacy.

As we have heard before, we have a patchwork quilt in terms of the legal authority for scope of practice. I come from one of only four states where there is dual regulation by nursing and medical boards.

With solo regulation in forty-six states and D.C., we still have a hodge-podge of things going on. We have what is called collaboration required in 20 states, supervision required in three, and no physician collaboration or direct supervision in 24 states. We have 37 states that require some sort of shared supervision related to prescriptive authority.

In North Carolina, the law says that there is joint regulatory authority for “medical acts.” One of the struggles has been who defines and how do they define medical acts. It is a set up for disagreement. “Physician supervision” is the phrase in the law. We hear lots of different definitions of supervision versus collaboration.

When I think of collaboration, I think of an equal playing field where people come together and share their particular areas of expertise and skill and knowledge. When I think of supervision, I think of a linear, hierarchical framework.

Several years ago, we thought we were really moving forward with changing the law to collaboration and there was actually a decision made by the medical association in the state to take a resolution to the AMA to begin to use the term collaboration instead of supervision. But, when they got into the discussion, it became apparent that physicians

tended to define collaboration as supervision. It’s the old business of hierarchy that gets in our way again.

The other tricky business for us was that while we had a joint committee, it only had authority to recommend. So, any recommendation goes back to each board for its approval. There is the potential for a Mexican standoff.

Nurse practitioner preparation is entirely within the nursing framework, all standardized at the national level in terms of how one becomes a registered nurse, by whatever nationally accredited educational path. Certification is also national.

What is the comparative value of joint vs. solo jurisdiction?

Most health professions are regulated by a combination of public members and professionals from the same profession. So, one positive about solo jurisdiction is that it is done entirely within the nursing framework with a single professional perspective.

Nimbleness in handling regulatory issues is important. Yes, we are in bureaucracies and they limit what we can and can’t do. So dragging out public protection issues is a concern.

Solo jurisdiction makes individual licensee accountability clearer. Dual jurisdiction can muddy questions about who has supervised and who has actually provided the care.

Solo jurisdiction acknowledges overlapping scopes of practice. Many of us from different professions do similar things, from the perspective of our own preparation and training.

The down side of solo jurisdiction is that we operate in silos and tend to be involved in activities that we say are public protection, but are really self-serving turf protection.

What is the value of shared jurisdiction?

Two boards should broaden the perspective on regulation. As we focus more on how we

provide safety and quality as teams, and as we implement pay-for-performance, dual regulation may direct the focus to interdisciplinary teamwork in healthcare delivery.

Going back to 1995, the Pew Healthcare Commission Task Force on Healthcare Workforce Regulation recommended thinking about umbrella boards. I think that is a live issue still today. So, dual regulation may be a steppingstone toward focusing on the needs of the people we are serving and not the protection of any given profession's turf.

The downsides of dual regulation include blurred lines of accountability. Conflicts between turf protection and public protection. Dual jurisdiction is an inefficient system that requires a lot of work. Cultural differences often impede progress in changing regulatory processes. For example, the efforts nursing has made toward expanding regulatory options from single state based regulation to inter-state compacts are complicated if there are two boards in one state regulating the nursing profession. There can be terminology conflicts, as in the different interpretations of collaboration and supervision that I mentioned earlier. What is a medical act? What is medicine? Finally, dual jurisdiction can limit scope of practice in terms of a profession practicing to the limits of ability and educational preparation.

If you are a nurse, you are probably aware of the most recent Institute of Medicine Report on the future of nursing. It makes eight primary recommendations. Number one is "Remove scope of practice barriers.

Advanced practice registered nurses should be able to practice to the full extent of their education and training." Then it outlines a number of ways to achieve this.

There are a lot of regulations outside professional regulatory boards that impede practice to the full extent of one's training and skills. These include reimbursement systems, CMS, and others. So, the IOM recommended using what has been adopted as the model

rules and laws by a coalition of nursing organizations.

My answer to whether shared jurisdiction is a good or a bad idea is that it is an inefficient approach. There is no evidence that it provides better public protection.

We need changes in regulation, whether we are talking about shared jurisdiction or limited scope of practice. The changes may have to go through the political process and when you go to the legislature you leave logic at the doorstep. Emotion and power dominate. You can produce lots of data and evidence, but we live in a difficult political system. If we are going to provide care for thirty million additional lives and really focus on the needs of those patients, I think that will force changes in our regulatory framework.

**Questioner:** I am a public member of the Minnesota Board of Nursing where I was placed on the nurse practice committee while the committee was trying to clarify the difference in scope of practice for RNs and LPNs. I was astounded by the turf protection within a profession.

**Johnson:** Nursing has pointed the finger at medicine for a long time, believing they are the ones that are keeping the cap on our scopes of practice. But, bring along medication aides and how do nurses react? Respiratory therapists say nurses are encroaching on their turf. It goes on and on and I think this is really rather childish behavior we are all involved in. We can easily point the finger at others, but it is harder to look in the mirror ourselves.

**Questioner:** The Ontario model is very useful as a comparative frame of reference. I wonder if Barbara Safriet could tell us about it.

**Safriet:** The Ontario model involves an advisory committee comprised entirely of public members which takes recommendations from the various professions, analyses them, and then makes

its own recommendations on scope of practice, much in the way that is recommended in the document I referenced earlier. Some of the truly revolutionary aspects of the Ontario model are:

- It says explicitly that scopes of practice by necessity overlap.
- It inserts the public centrally in the process of assessing the evidence and data, based on substantial input from the profession and educators.
- It removes turf from the equation and asks: is this a needed service, will it serve the public and is there a basis for saying that these providers can do this safely and effectively.

## **Collaborative Practice Agreements: Politically Expedient, But Are They Rational?**

**Catherine Dower, Associate Director for Research, University of California San Francisco, Center for the Health Professions**

I am going to talk about collaborative practice agreements – what they are, how they work, what drives them, the pros and cons, some of the weaknesses, and options for how collaborative practice agreements might fit into healthcare delivery in the future.

Our research at the Center for the Health Professions at UCSF identified a number of elements in collaborative practice agreements – primarily in healthcare, but in other fields, as well. Some of the key elements relate to the providers, the legal aspects, the organizational aspects, operational aspects and the rationale behind them.

In terms of providers, the individuals involved in collaborative practice agreements may be just two providers or multiple providers who

agree to work collaboratively together. It can be providers of the same profession or providers of different professions.

In terms of the legal elements, some agreements are written; others are oral or handshake agreements. Sometimes there are licensing requirements or protocols mandated by law. Some agreements require supervision. Some require certain types of education or certification of the involved providers.

Organizational aspects include things such as the setting(s) where the parties to the agreement are permitted to practice. Some agreements apply to providers working in a single institution, such as an HMO or clinic. Other practice agreements apply across institutions. The institution might be owned by one or more of the people involved in the collaborative practice agreement or may be owned by an unrelated entity.

Operational elements include the number of caseloads and how they are divided between the practitioners. The arrangement may be simple or very complex. In some cases providers divide caseloads randomly; in other situations cases are divided according to the specialty, expertise, or level of experience one provider has compared to another one. Operational elements also include financing, such as salaries or reimbursement or some other arrangement. One provider may be paid via another one. There may also be malpractice insurance requirements.

Finally, the rationales and drivers behind collaborative practice agreements involve multiple layers and multiple elements that determine how a collaborative practice agreement plays out.

Collaborative practice agreements are not the same as supervision or delegation or collaboration. There is often confusion, even within a law, about how to distinguish between collaboration and supervision or between collaborative practice agreements and supervision. Sometimes supervision is an

element of a collaborative practice agreement, although this is not required. Delegation may also be an element of a collaborative practice agreement.

A collaborative practice agreement is a formal arrangement between two or more providers, whereas collaboration is something that is expected and anticipated among and between all practicing health care workers and other professionals.

Unfortunately, definitions vary tremendously from state to state. Some states spell out what they mean by collaboration and others don't. The only federal definition appears in Medicare's policy regarding nurse practitioners. Medicare says that:

Collaboration is a process in which a nurse practitioner works with one or more physicians to deliver healthcare services within the scope of the practitioner's expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by the law of the state in which the services are performed.

This specifies that medical direction and supervision are components of collaboration when nurse practitioners work with physicians. In the absence of a state law governing collaboration, Medicare says that:

Collaboration is a process in which a nurse practitioner has a relationship with one or more physicians to deliver healthcare services. Such collaboration is to be evidenced by nurse practitioners documenting the nurse practitioner's scope of practice and indicating the relationship that they have with physicians to deal with issues outside their scope of practice.

So, the burden is on the nurse practitioner to document how the collaborative relationship is set up.

There is a continuum rather than a bright line between various types of cooperative practice. At one extreme, direct supervision is the most restrictive form of two practitioners working together. In this case, one practitioner oversees, directly and in-person, the practice of another practitioner. General supervision is less restrictive because supervision need not be onsite and can be accomplished in a variety of ways, including chart review or telecommunications.

Next on the continuum are collaborative practice agreements, which allow for more independence. Neither practitioner needs to be supervised by the other, although supervision may be a component of the agreement.

Farther along on the continuum is independent practice. In healthcare, this term refers to the ability of a practitioner to see patients directly, without a referral from another practitioner.

At the end of the continuum is autonomous inter-professional practice, in which a practitioner can practice to the full extent of his or her scope independently and autonomously from all other practitioners. This applies to two professionals who practice without any legal or other requirement that they collaborate together. Nevertheless, they are expected to collaborate at some level so that they are referring patients to other practitioners for services that are outside their expertise and for quality care.

Collaborative practice agreements offer the potential for integrated inter-professional healthcare. Research over the years indicates that this is a good way to deliver care. Studies show that clinical outcomes and patient satisfaction are improved when there is good collaboration. However, collaborative practice agreements also have some downsides because they can exacerbate inter-professional tensions, particularly when they are required rather than being developed voluntarily by the professions themselves.

The title of my talk asks whether collaborative practice agreements rational. Do they make sense?

What we see in collaborative practice agreements across the country today is a complex patchwork. There are about 11 states where no physician involvement is required. About 10 states require physician involvement only for prescriptive authority. In about 7 states, physicians are required to both supervise and collaborate with nurse practitioners, although there is a lack of clarity in the definitions of these terms. Only about 3 states currently require direct or indirect supervision of nurse practitioners by physicians. In the remaining 20 or so states, collaboration is required by statute. This arrangement creates problems because nurse practitioners are not able to practice to the full extent of their competence because they are required to work with the physician, whereas physicians are not required to collaborate with anyone.

There is no discernable pattern to how these laws play out in the states. It is not a question of coastal versus inland states. It is not red versus blue states. It is not rural versus urban. It is a result of political decisions that are not based on evidence related to nurse practitioner competence. I mentioned that research suggests that collaboration is in the best interests of patients, but there is no solid evidence that collaborative practice agreements are better than anything else, and if they were, how they should be structured.

The California code says that a registered dental hygienist in alternative practice in underserved settings (those who have additional training and testing) shall provide to the dental board documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services. This is a political decision essentially requiring a collaborative practice agreement between a hygienist and a dentist. In practice, what has happened is that hygienists set up these agreements, but there

is no requirement on the part of the dentist to actually take referrals from the hygienist. This has created a problem for patients.

Another example comes from Australia, which recently passed legislation requiring collaboration agreements between nurses and physicians. The Australian Nursing Federation reacted by saying:

A legislative requirement for collaboration with medical practitioners is, quite frankly, offensive to nurses and midwives. Nurses and midwives are most often the linchpin in the collaborative process. They collaborate with a client or woman, their family, and a range of professionals including medical practitioners.

The statement goes on to say that while nurses and midwives are collaborative, they find that the mandated requirement is inappropriate and offensive. They are working to try to change the law because it does not serve the patients' interests.

The rationales and drivers behind collaborative practice agreements reveal why they might not be the best arrangement. Remember, there is a difference between the drivers of collaboration and the drivers of collaborative practice agreements.

The drivers of collaboration include things like access. In many cases, patient demand is exceeding provider supply so practitioners collaborate to improve patient access. Another driver is quality because collaboration among professionals with different expertise or specialties improves clinical outcomes and patient satisfaction. Another driver is efficiency and lowered cost.

In contrast, the drivers of mandated collaborative practice agreements are political compromises. When a legislature is considering an expanded scope of practice, it will hear both sides of the argument and often decide that a good compromise is to permit the expanded scope and require collaboration with the established profession. It sounds



good on its face and it is happening in many states for many professions. However, the choice of this compromise is not based on any evidence.

What might the future hold? Demographic shifts are one of the big drivers in healthcare. These include the ageing of the population, increased diversity, and a shift from treatment of acute conditions to management of chronic disease. Another driver is cost. In 2008, more than 16 percent of gross domestic product was devoted to health care compared to the European Union average of 11 percent. We are spending more for our health care and getting less for it. The majority of U.S. bankruptcies are due to medical bills.

Another driver in healthcare is technology. This includes everything from electronic health records to remote telephonic health services, which permit professionals to work collaboratively and provide care in areas where patients would otherwise not receive care. Use of technology will be enhanced by the passage of the high tech act of 2009, which put a significant amount of federal money into expanding telehealth services in this country.

Consumers are another driver. They are changing the face of how healthcare is accessed and delivered, whether it is the tech-savvy internet-using patient or patients with behavioral issues, such as smoking or obesity.

The market is another big driver. An example is retail clinics, of which there are more than 1,000 throughout the country. This is where nurse practitioners are the primary care providers, working collaboratively with physicians and medical assistants or other types of aides.

Finally, the big driver of this year is the federal affordable care act. A number of provisions will stimulate and support collaboration, including accountable care organizations to medical homes. There is still a lot to be explored and developed in both areas.

The big question is who is going to care for the additional 32 million people who will be covered under the federal legislation and how will those professionals work together. The key word is going to be creativity. In all the thousands of pages in the federal legislation and in all the state legislation, people are exploring new and creative ways to deliver healthcare. We will see experimentation and demonstration projects. To date there has been very little evidence showing how collaborative practice can and should work.

We know that between collaborating professionals there must be shared competence, shared accountability, mutual respect and trust, communication, autonomy, cooperation, and mutual support. These things are hard to legislate, so all practitioners will have to learn how to achieve these things and work in the best interests of patients, without necessarily legislation.

**Questioner:** What have you learned in your research about the amount (which is sometimes significant) that physicians are paid by nurse practitioners simply to sign collaborative practice agreements? I have found an unwillingness to talk about his practice, especially in small towns.

**Dower:** I don't have data related to this, and it is a question that cries out for research. I have heard about it anecdotally, but have not seen documentation about how widespread it is and how much it is costing. We need research into the scope of the problem, not details about specific individuals, which would raise ethical issues.

**Questioner:** I am the chair of the Pennsylvania Board of Nursing and the Chair of the National Council of State Boards of Nursing Committee that worked on the APRN Model Rules and Regulations. I have some questions about your diagram representing the continuum from direct supervision to autonomous inter-professional practice. In our model rules and regs, we were trying to support the notion that independent practice is

the highest order of independence. Could you give me an example of what you consider autonomous practice?

**Dower:** We don't want to make the terminology too complicated, but we were working across professions, so we were looking at dental hygienists, physical therapists, and other professions in addition to nursing. We found a trend in some professions to use the term "independent" to refer to the ability to see patients without a referral, and that is not necessarily full autonomous practice. I don't want to put too much emphasis on the words that we chose; the point is that there is a continuum and overlap between the various points on the continuum. Different professions use these terms differently and some of the distinctions are vague.

**Questioner:** My question is about the language of collaborative agreements. In the world of advanced practice nursing regulation, the term collaborative agreement refers to a formal regulatory arrangement between a nurse and a physician. Collaborative agreements tend to be prescriptive in ways that decrease access and increase cost, without any evidence to show that they enhance safety or quality of care. Some collaborative agreements have distance requirements or mandated ratios and some decrease the scope of practice. Some of the elements you suggest may be part of collaborative practice agreements speak more to a contract regarding payment, or some type of inter-professional or coordinated care arrangement that would be entered into voluntarily.

**Dower:** I definitely meant to refer to the whole universe of elements that could be part of collaborative practice agreements or arrangements, either legally mandated or voluntarily entered into, and either institutionally required or governmentally required. I agree with you that in many cases legally mandated collaborative practice agreements are an effort to restrict the scope

of practice of one profession, and while it sounds reasonable, they are a backdoor way to limit scope. Sometimes collaborative practice agreements are so vague that they can be interpreted to be permissive, or to be very restrictive, depending on the parties involved.

**Questioner:** I am with the American Academy of Nurse Practitioners. I think the word collaboration is used in so many venues that it has become very confusing. I want to point out in connection with your comments about Medicare definitions that Medicare is reimbursement law, not scope of practice law.

I also recommend that you consult the more up-to-date map of state requirements found in the IOM report.

### **CAC's New Scope of Practice Initiative**

**Becky LeBuhn Chair, CAC Board of Directors, David Swankin CAC President and CEO**

**LeBuhn:** The mission of CAC's scope of practice initiative is to provide independent, third party, economically disinterested input into processes and criteria for removing unjustified scope of practice restrictions.

Why does CAC consider this a priority and why have we become involved? You've already heard many of the reasons today. Healthcare reform is bringing more insured individuals into the marketplace. The aging of baby boomers will result in more demand for healthcare services. The primary care workforce is already over-taxed. For these reasons, it is imperative that practitioners be authorized to practice to the full extent of their training and skills.

It also means it is more important than ever to re-examine the process by which we make scope of practice decisions. Does it make sense for decisions to be made by legislators who probably aren't conversant with the issues and arguments and who are therefore susceptible to being influenced by lobbyists for one profession or another? Does it make

sense to be making scope of practice decisions fifty-one times over when any given profession's education and preparation doesn't vary from one legal jurisdiction to another?

CAC is not the only organization that advocates for scope of practice reform. Others include the Pew Health Professions Commission, the Institute of Medicine, the World Health Organization, the Association of Academic Health Centers, regulatory board associations, and many others. Still, we are the only consumer or public interest organization that has taken this on as a major priority.

An additional reason we consider this a priority is because there has been such push back by the AMA's Scope of Practice Partnership (SOPP) against virtually any change in the status quo. We believe this makes it all the more urgent that members of the public weigh in on scope of practice decision making at the state level.

**Swankin:** One of the things that struck us from the start is that "scope of practice" is an insider's term. It is a phrase and a concept little understood by the public. As Barbra Safriet says, we are talking about who can do what to whom under what conditions and in what circumstances. As we approach the public, we have to talk in language that people are likely to understand.

There was a public hearing in Washington State last year to explore expansions to the scope of practice of optometrists. Thirty-eight witnesses testified, 19 optometrists and 19 ophthalmologists. There were no surprises in their testimony. There was no public input. This same problem exists in licensing. The public rarely shows up at rulemaking hearings.

One of the reasons scope of practice disputes are turf battles is that only the affected professions become involved. One of the things we have to do is explain to the public why it is important to weigh in. CAC is

amassing examples that a majority of people can relate to.

Most active people recognize that at some time they may need the services of a physical therapist. They don't understand why it is necessary to have a doctor's referral to see a PT. When my mother was in a nursing home, she wanted two services. She wanted her hair done and her teeth cleaned. She could get her hair done, but wouldn't be able to get her teeth cleaned in too many places. People *get* that. Anyone who has needed medication adjusted knows that it is more convenient – and probably safer – to consult a pharmacist rather than make a doctor's appointment. We are looking for more examples that will help the public understand the issue.

In California, Consumers Union (CU) was able to involve some of its members in a rulemaking proceeding involving prescription package inserts. The legislature instructed the pharmacy board to develop implementing rules affecting, among other things, the size of the type and the availability of the inserts in multiple languages. The CU members had strong opinions about both these issues and, after some effort on the part of CU staffers, testified at hearings.

Occasionally, the public becomes involved spontaneously. Examples include unsafe products and TV advertising aimed at children. But, scope of practice is an arcane topic and needs to be translated into something that will resonate.

**LeBuhn:** In the process of attempting to mobilize the public, we have been fortunate to be able to work with other organizations, several of whom are represented in the room. These organizations include AARP, the Federation of State Boards of Physical Therapy and the National Council of State Boards of Nursing, each of which has given CAC much-appreciated financial support to help get the initiative off the ground. We are also working with the Coalition for Patient Rights, the American Nurses Association, and the Center for the Health Professions.

Other organizations we have touched base with and hope to collaborate with include the National Partnership for Women and Families, the Nurse Practitioner Association of DC, the California Health Workforce Alliance, the American Association of Critical Care Nurses, and the George Washington University Health Policy Forum. We hope these organizations can help us develop and perfect materials and also help inform the public, the media and legislators.

Our primary target audience is the public and we are in the process of developing materials that we think will inform them about scope of practice and what is at stake. Many of these materials will also be useful to advocacy organizations, legislatures, the media and other stakeholders.

All of the materials are on CAC's Web site, [www.cacenter.org](http://www.cacenter.org). They include a white paper that describes what the issues are and explains what various states have done to address scope of practice decision-making in something other than a turf-battle mode.

The Tool Kit is a more practical document intended for advocacy groups to use once they have decided to become involved. The Tool Kit covers the importance of scope of practice in terms of access, cost and quality, especially for rural and underserved populations. There is an overview of how scope issues affect specific professions. There is a chapter describing how the states have addressed scope. There is a catalogue of likely supporters and opponents of changes in scope or practice, advice about approaching the media and policy makers, a sample op-ed piece, and an appendix entitled, "Questions Consumers, Community Groups and Legislators Should Ask About Scope of Practice."

Several profession-specific scope of practice FAQ documents follow a standard format. They describe what the profession does, explain how it is regulated, discuss the more prominent scope of practice issues confronted by the profession, describe training, discuss

any evidence that the profession's scope can safely be expanded. The FAQ documents also list the states in which scope has been expanded and describes how the profession collaborates with other providers.

In addition, there is a generic FAQ document that addresses the reasons why consumers should become involved in scope of practice decision-making in their states. We hope this document will help pique the interest of individual consumers and advocacy groups and persuade them of the importance of becoming involved.

**Swankin:** This subject needs to be handled in the states in a non-partisan way. If this becomes associated with a particular political party or ideology, it could interfere with the chances of constructive change. We are fortunate that organizations on all points of the ideological spectrum have expressed support for the need to use healthcare professionals to the full extent of their training, abilities and experience.

These include the CATO Institute on the right and the Brookings Institution toward the left. As we write in one of our own publications:

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 healthcare professionals to practice to the full extent of their skills and training. One 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 Healthcare Workforce Gap: Reforming Federal Workforce Policies to Meet the Needs of the Twenty-first Century*, recommended this: "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." The report went

on to point out that, “maximizing health professional scope of practice is also a good way to decrease cost while maintaining and even improving quality of care.”

On the right side of the political spectrum, economic experts characterize scope of practice laws as ineffective government regulation that leads to market inefficiencies. The CATO Institute, in a 2008 policy analysis entitled, *Medical Licensing: An Obstacle to Affordable Quality Care*, said, “By almost all accounts, the quality of services consumers get from non-physician clinicians is at least on a par with what they would get from a physician offering the very same services. Dozens of peer reviewed studies compare outcomes in situations where patients are treated by a physician or 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.” They went on to say, “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.”

To reinforce the notion that bipartisan support is present, there is a report entitled *Crossing Our Lines: Working Together to Reform U.S. Health System* issued by the Leader’s Project at the Bi-partisan Policy Center. Three former Senate Majority Leaders, Howard Baker, Tom Daschle, and Bob Dole recommended,

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 professions.

A Sunset Review process is presently underway in Colorado dealing with direct entry midwives and other professions. The Department of Regulatory Affairs (DORA) studies the professions that are up for sunset review and prepares a report with recommendations prior to public hearings. Ultimately the decision rests with the legislature so the turf issues will always be there, but DORA’s involvement helps make it a deliberative process similar in some ways to the Ontario model.

A final CAC publication on our Web site is called *Building a Better Mousetrap*. In it, we sketch out a proposal that picks up where the Pew Health Professions Commission left off. The Pew Commission recommended that it doesn’t make any sense to make scope decisions 51 times. If a particular professional is qualified by experience and ability to perform certain tasks safely, that should be the deciding factor.

Some states are experimenting with innovative processes for approaching scope of practice decision-making. This may be where the action is for the foreseeable future and we encourage state-level experimentation. Our publication takes a longer view and recommends developing a prestigious national entity to make broad recommendations about scope of practice. The paper describes a possible structure for such a national mechanism. It wouldn’t remove power from the states, but would present a model for the states to consider and hopefully adopt.

CAC plans to convene a meeting next year to see if we can build a broadly based consensus in support of moving forward with this idea, recognizing that there is a shortage of funding available from either the federal or state governments.

**LeBuhn:** We consider the materials we are developing to be living documents that will evolve over time. We think the materials would be strengthened by the addition of real-life stories about successful outcomes when

patients receive care in team settings from non-physician healthcare providers. We are also interested in anecdotes that illustrate difficulties patients encounter accessing affordable quality care because of unnecessarily restrictive scope of practice laws and regulations.

**Questioner:** Have you considered addressing another side of this issue, which is individuals who work in healthcare without any regulation, licensure or other competence assessment? An example is pharmacy assistants or pharmacy technicians. Most states have no requirements for such individuals, but in most pharmacy operations, including hospitals, they are fixing intravenous mixtures, filling prescriptions, and accessing narcotics without any regulatory framework. When the profession has tried to resolve this, we get immense pushback, largely from the chain drug stores that fear they might have to pay more for help. Another concern is that as new technologies develop, there are no standards and is no regulation in too many areas.

**Swankin:** The problem you raise needs to be dealt with profession-by-profession. A determination needs to be made whether regulation is needed and what level is appropriate.

What are the options? One option is no regulation at all. States that have sunset requirements often look for the least restrictive types of regulation. There is a movement in many states to eliminate some licensing laws. Another option is registration so the state knows who is practicing. Other options include title protection and full licensure. The stricter the regulation, the more detailed the standards of practice.

**Comment:** I am a public member of the nursing board in Pennsylvania. I have experience working for a member of Congress and in the defense field. I want to offer a couple of ideas from a citizen's perspective.

I noted the comments by the speaker from West Virginia about using some portions of a legislative proposal as a bargaining chip that can be removed from a bill in exchange for something else. He also mentioned threatening to sue for slander. These are examples of hardball techniques that are typically reserved for the end game when the legislation is about to be voted on.

In the meantime, there is a huge education effort that is required. I really liked the first speaker's comments about basic principles: patient safety, demonstrated ability rather than authority as the touchstone for care, collaboration on a daily basis, and data-driven policies. This suggests to me that when you sit legislators down, don't even mention the term "scope of practice," but engage them in a conversation about patient safety, demonstrated ability, collaboration and data-driven policy. Talk about access to care, having to wait to see a doctor. Talk about the patients rather than the practitioners.

I really like the bipartisan dimension of this issue. Cultivate legislators who may want to be a hero on this topic.

**Comment:** Thank you for this meeting. It has been extremely helpful and I feel as though others in the audience agree there is a real hunger for information like this. I represent the Connecticut Association of Nurse Anesthetists. Two years ago the Connecticut legislature created a bi-partisan committee of review and investigation to come up with a better model for dealing with scope of practice. They researched for a year and interviewed MDs and non-MDs and experts and came back with a proposal modeled after SOPP – the contentious AMA-driven model where you begin by going to the medical practitioner whose scope you are encroaching on and then go from there. There was a huge blowup at a hearing attended by eight MDs, fifteen non-physician providers and no members of the public. Hard feelings ensued. When we got back to being able to talk to each other, several things became

evident. Number one: the legislators bought into the physician's idea that any change was an encroachment on their turf. When we finally got to a communication and dialogue stage, it was Barbara Safriet's work that we drew upon. Many of the things we have heard today will be helpful in the future.

I understand you are looking forward to developing a national model, but as you have said, many changes take place at the state level. It would be helpful if you could develop a model for the state level. Our legislators told us they accepted the AMA model because it was pre-packaged, because they didn't understand the power dynamics, and because it didn't cost any money. Many of the models on the non-physician side do cost money. They may require the creation of new boards, etc. The more we can engage in a creative way with a model that doesn't cost money and puts everyone equally in play, I think we are ready to look at it in Connecticut.

**Comment:** Healthcare delivery institutions are evolving. We are witnessing rapid growth in the number of physicians who are employed. We are seeing a consolidation of delivery organizations. These institutions employ many of the practitioners we are talking about and they establish the practice environment. We need to take that into consideration in deciding whom to bring to the table. If you were a legislator in the State of Michigan, for example, it would get your attention if someone from Henry Ford, which provides a large portion of Medicaid care in the state, tells you they want to manage their professional workforce more effectively and efficiently in order to reduce Medicaid costs.

## **DAY TWO: CONTINUING COMPETENCE**

### **INTRODUCTION**

Continuing competence is another longstanding priority for CAC. We have been

pleased to see recommendations from several prestigious Institute of Medicine committees that advocate more meaningful assessment and demonstration of current competence as a condition of re-licensure and recertification. One such recommendation reads:

All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care, as defined by the five competencies in this report, through direct measure of technical competence, patient assessment, evaluation of patient outcomes and other evidence-based assessment methods.

Other committees have critiqued reliance on mandatory continuing education and recommended significant changes in the way it is delivered. One report we will hear about later this morning is entitled, *Redesigning Continuing Education in the Health Professions*. Part of the justification for this report's recommendations reads:

Licensure and certification processes should reward successful demonstration of maintenance of competence. Additionally, certification should require a minimum standard of practice-based learning to promote the identification and solution of practice-based needs. Licensure should require demonstrated use of learning portfolios with documented needs assessment.

This is not just learning portfolios, but portfolios tailored to an individual's skills, practice and learning needs.

### **Keynote: The Future of Regulation**

**Mark Lane, Vice President of Professional Standards and Assessment, Federation of State Boards of Physical Therapy**

I'm not going to talk specifically about scope of practice or continued competence, but about regulation in general – what it is, where are we headed, and what can we do about it. Certainly, scope of practice and continuing

competence issues play a significant role in the future of regulation.

In order to understand where licensure is heading, we need to understand what licensure is. Here are some things licensure may be:

- **A public policy exercise of the state's police powers.** Is licensure designed to protect the public? Does it protect the public? Or, is it designed to do something entirely different? Is licensure a legalized monopoly to practice a profession? That certainly is an aspect of what licensure is.
- **A system of standards for entry into a profession.**
- **A system of standards for continued practice in the profession.** This raises questions about continued competence.
- **A system for removing impaired or incompetent providers from practice.** How do we identify whom to remove and decide how they should be removed?
- **A legal way to deter entry into a profession.** We may not like it, but licensure does deter entry.
- **A mechanism to protect licensees from competition.** We may not like it, but licensure does do that.
- **A means to gain access to third-party reimbursement.**
- **A means to establish and enhance the prestige of the profession.** We have many professions trying to obtain licensure for status reasons, even when there is no evidence of potential harm to the public.

- **A means to create a market for new academic disciplines.**

There are environmental factors that are influencing the future of regulation:

- **Limited access to healthcare is creating many problems.**
- **Decreasing state budgets which force distorted prioritization by regulators because there aren't the funds to discipline everyone who should be disciplined.**
- **Increasing deficits that force states to cut costs. One way to cut costs is to eliminate licensing boards.**
- **Economic recession, which is helping to drive regulation.**
- **The aging population.**
- **Technology, which changes the ways care is delivered.**
- **Professional associations, which promote their particular agendas and lobby the legislatures.**
- **The public.**
- **National healthcare reform.**

These and other environmental factors compete with each other and regulators are pulled in many different directions. Whoever wins the tug of war will direct the future of regulation.

David Montgomery of the Nebraska Department of Health made a comment I'd like to repeat here:

Our present professional regulatory system is a patchwork resulting from centuries of unsystematic legislation, band-aid fixes, and ad hoc changes. It is marginally effective, but also inefficient, needlessly expensive, inconsistent, and confusing to the public.



Do you agree? Is this true in your experience? If yes, we need to do something about the system. “The best way to predict the future is to invent it,” according to Alan Kay, one of the pioneers in computer science. It says we own the future. Our tendency as regulators is to sit back and let things happen to us, but we need to invent the future.

What does it mean to be an inventor? First, we have to change the way we regulate. If we want things to change positively, we can’t keep doing the things we have always done. If want things to get worse, we can sit back and let it happen.

If we are inventors as regulators, what qualities do we need to have?

- **Creativity.** Are we thinking outside the box?
- **Open-mindedness.**
- **Ability to listen.**
- **Willingness to change.**
- **Ability to learn from our mistakes.**
- **Proactivity, rather than reactivity.**
- **Perseverance.**
- **Willingness to question assumptions.**
- **Ability to buck the norm, to ask questions.**

We can all demonstrate these qualities of inventors. We can invent a regulatory future. Public members, licensee members and administrators alike need to stir the pot, to ask questions.

We have two choices. One is to continue on the current regulatory path, allowing things to happen to us. The alternative is to change the face of regulation and be inventors of the future.

What will happen if we stay on the current regulatory path?

- **Continuing scope of practice battles,** where it is the public who loses because decisions aren’t based on data. They are based on economics and politics and influence.
- **Reactive regulation.** Should we be regulating in reaction to events, creating a hodge-podge of laws that aren’t a cohesive guideline to good practice? Our system is currently complaint-based. This shouldn’t be the only determinant of good practice. Moreover, the complaint system waits until the harm has been done. Shouldn’t our approach be to promote good practice so we don’t have complaints coming in?
- **Discipline-based regulation.** Does punishment change behavior? Does it work in the public interest?
- **Unenforceable and ineffective regulations.** As an example, most jurisdictions have a supervision ratio for physical therapists vs. physical therapy assistants. The ratio varies from jurisdiction to jurisdiction. It doesn’t make sense. What if I am supervising two physical therapy assistants and I get sick or go on vacation? Does that mean the patients cannot get treatment? It’s all arbitrary and not based on any evidence. The real concern is whether the physical therapist is a good supervisor, not the ratio. Are our regulations really promoting good care and preventing harm, or are they arbitrary?
- **Little assurance of ongoing clinical competence.** We are at the tip of the iceberg in dealing

with continued competence. We are just moving from continuing education to thinking about competence. We are far from impacting and demonstrating competence and influencing patient care.

- **Protection and promotion of the profession.** I hear members of licensing boards and professional associations talk about the battles they are fighting with one or more groups. Why are we talking about battles? Shouldn't we be concerned about the patient and creating a system of regulation and service that is in the best interest of the patient? We need to change the dynamic.
- **Regulation based on assumptions vs. evidence.** Oftentimes our regulations inhibit good practice and may contribute to problems with access.
- **Restriction of mobility.**
- **Lack of collaboration between disciplines.**

What might happen if we do not change our regulatory path?

- **Scope of practice decisions would no longer be made by the professions.** The ideal would be an impartial commission that decides based on what would be best for the public.
- **Boards will be deemed ineffective and be eliminated.** They may be combined, stripped of authority, or nationalized.
- **Continued competence will be mandated and it won't necessarily be a good system.**

- **Licensure requirements will be reduced.**
- **There will be a mandated focus on outcomes.**
- **There will be stricter requirements for sunset review.**
- **There will be an increase in public members and fewer licensee members.**
- **There will be forced licensure compacts to improve mobility within the United States and globally.**
- **Elimination of licensure altogether** if we cannot justify what we are going.

What might happen if we change the face of regulation?

- Interdisciplinary scope of practice decisions.
- Proactive rather than reactive regulation.
- Just Culture, which recognizes that people make honest mistakes.
- Education and promotion of quality, as opposed to just trying to prevent bad care.
- Peer Review.
- Continuing Competence.
- Encourage good practice rather than simply punishing bad practice.

Effective regulation does not inhibit good practice. It is evidence-based. It involves collaboration between disciplines for the greater good. It is proactive. Regulators play an active role in promotion of quality and remediation. Effective continued competence measures are in place. Regulation is part of

the solution *vis a vis* access to quality healthcare.

How do we get there?

- **Collect the data.** We are doing a bad job now. We should have the capacity to do data analysis of our licensees to find out what the issues are.
- **Collaborate.** Professions and boards need to work together.
- **Change the framework** from a punitive reactive system to a prevention system.
- **Expand our perspective.**
- **Become inventors.**

Our choices are to continue on our current regulatory path, or to change the face of regulation. I suggest that we work together to do the latter. What leadership competencies would allow us to do this?

- External awareness
- Strategic thinking
- Innovation
- Entrepreneurship
- Leading transformation
- Leadership vs. management

Not everyone on a licensing board will have all these skills. That's why you are a team. Here is another quote from David Montgomery:

As part of healthcare reform, a major national conversation is needed over the effectiveness and efficiency of this system, including licensing, private certification, and enforcement. Such a conversation could lead to reforms that would streamline and modernize

licensing practices. At present, there is no sign that this will occur.

It is up to us to change the face of regulation. Invention involves creativity, open-mindedness, willingness to change, learning from our mistakes, being active rather than passive, and perseverance. These are the qualities you need to have on your board to be inventors of the future of regulation.

Is your board made up of inventors? Do your board meetings facilitate invention and the creation of a new future, or do they deal only with the agenda?

I challenge you to create an environment where you help create the future of regulation. We can work together to do that. As Margaret Wheatley wrote,

To be responsible inventors and discoverers, we need the courage to let go of the old world, to relinquish most of what we have cherished, to abandon our interpretations of what does and what does not work. We must see the world anew.

That is our challenge as we deal with scope of practice and continued competence. We need to get out of our comfort zones and start changing the regulatory future.

**Comment:** There is a provision in the healthcare reform bill saying if a professional gets recertified every two years, he or she is exempt from some data collection.

**Comment:** In my observation, one of the distinguishing characteristics of effective boards embedded in effective organizations is that there is time set aside for reflective discussion at every board meeting. They challenge the way they do business as a board and the way they do business as an organization. In other words, they exhibit and foster many of the characteristics you mentioned.

## **How Will the Institute of Medicine's Report "*Redesigning Continuing Education in the Health Professions*" Impact Health Professional Regulatory Boards?**

**Lucinda Maine, Executive Vice President and CEO, American Association of Colleges of Pharmacy**

The work of the IOM Committee on Planning a Continuing Health Care Professional Education Institute needs to be considered together with the work of three other entities. The first of these was research funded by the Macy Foundation. Two key priorities for the Macy Foundation are (1) inter-professional education and (2) maintaining practitioner competence to care for people throughout their professional lifespan. The Macy researchers concluded that the current reliance on continuing education (CE) is insufficient to achieve the second priority. They were particularly concerned about CE in medicine because of what they perceived as commercial biases in its design and delivery. That study group recommended the creation of the IOM committee on which I served and the Macy Foundation provided support.

The Macy Foundation also supported two other pieces of work. One was a study by the Association of American Medical Colleges and the Association of Colleges of Nursing that looked at CE and professional development in those two professions. The fourth piece of work was an economic analysis of the enterprise of CE and continuing professional development.

The IOM committee I served on was charged to review CE of healthcare professionals and to consider specifically a recommendation arising from the first analysis of nursing and medicine to create a national inter-professional continuing education institute to advance the science and the practice of CE.

The committee worked for approximately a year and involved three face-to-face meetings

of a very diverse panel. There were two public workshops, extensive literature reviews, and external review of the report and its recommendations.

The committee acknowledged the importance of CE across the lifespan to help professionals stay up-to-date. There was agreement that quality care of the future depends upon the functioning of inter-professional teams. Those teams are going to have different compositions based on practice site and patient needs, but that is the wave of the future. However, we now do uni-rather than multi-professional licensure and certification.

The committee agreed with many others that there are flaws in the way we are currently financing, regulating, conducting and evaluating CE. We agreed that current regulatory requirements are insufficient. There is room for conflicts of interest and bias in the financing CE, but a lot has been done to address this problem.

We talked about the research that is needed to move the enterprise forward. Even though we can draw on the literature on CE and the professions, and we know that the didactic learning method is not optimal for adult learners, we don't know a lot about what more effective models might be, especially for teams of practitioners. We are not currently anywhere near team-based learning at the point of care.

Self-assessment and selecting the right CE program is a very immature science.

The committee embraced continuing professional development as the philosophy and the practice underpinning a better system for keeping our professionals at the cutting edge of their clinical care abilities. The current system is too disaggregated and there is no leverage for change.

We evaluated different scenarios about what could create a better system. One alternative considered was to create a federal agency. Another was a purely private entity composed of professional associations. We considered a

coalition involving quality improvement organizations.

Ultimately, we recommended creating a public-private professional development institute that would bring all stakeholders together in support of a nationally coordinated system for professional development. We recommend some initial federal investment, but recognized the need to build a financial model that involves financial support from a variety of sources. The institute would have a board and a structure, but there would also be a variety of councils and ad hoc committees to do the work.

So, our first recommendation was that the Secretary of HHS should commission a planning committee to develop a plan for a public-private continuing professional development institute. This recommendation was made a couple of months before the passage of national healthcare reform, which calls for the creation of multiple offices, agencies and commissions. Our IOM recommendation is likely to take a back seat, but the National Health Workforce Commission called for in the Affordable Care Act could potentially address some of the recommendations in the IOM report.

The institute should help advance what we know about continuing professional development, help to guide and influence regulation across jurisdictions, and professions, address issues associated with financing CE and continuing professional development. The original Macy Foundation report recommending an institute documented the financing of medical CE, but there is little data for other professions. There is also a need for research into the science of CE and professional development.

The goals of the institute include creating a stronger scientific foundation for CE and continuing professional development. This means collecting and analyzing data, or creating a framework for other organizations to conduct data collection, analysis and measurement. Research is needed to identify

meaningful measures of practice performance and quality. Electronic health records may facilitate the meaningful measurement of quality in ways we haven't be able to do before.

The committee believed that the institute could help inform regulation nationally, even if regulation continues to be state-based. In pharmacy, there is already a National Association of Boards of Pharmacy and a model pharmacy practice act.

How would continuing professional development be funded? Perhaps employers and practitioners themselves will need to bear more of the expense. Responsibility should be shared by all of the stakeholders.

One of the principal rationales for a national public-private institute is that we are committed to changing the model of patient care to an inter-professional model. Educators have a responsibility to educate future clinicians to work effectively in teams. Early in 2011, pharmacy, medicine, nursing, dentistry and public health will release a set of core competencies for inter-professional education involving these disciplines.

It may be productive to host an annual symposium, perhaps with a partner such as CAC, to synthesize the learning across professionals and energize and advance the enterprise. This would benefit of licensing boards and certifying bodies by assembling a collection of best practices that accelerate learning and improve the delivery of education, the regulation of practice, and the delivery of patient care.

**Questioner:** I am a public member in the state of Pennsylvania. I am surprised you said there is little research into educational methods other than didactic. Looking at how people on the cutting edge are trained now, some of the techniques are simulation, partial-task training, human patient simulators, gaming, triage scenarios for trauma, virtual reality, joystick-controlled learning, smart phone applications that offer just-in-time

training, scenario-based cases, team ratings, video replay, cognitive task analysis, mentoring, and rotating skill stations.

**Maine:** We talked about everyone of those except the smart phone application, but not in any level of detail. The general consensus was that there is good evidence that there are a variety of different approaches. According to the Department of Education, blended learning appears to be the most effective – i.e., some didactic and some active learning via the tools you mention. Also, online learning appears to be more effective than the traditional model of sitting in a lecture hall and being lectured to. A complicating factor is that many entities that provide active learning are not approved by state regulatory boards so wouldn't satisfy regulatory requirements.

**Questioner:** There are continuing professional development activities underway within some specialty societies. This is the driver of continuing professional development within the medical professions. There has been a lot of attention paid to the various modalities of CE and other professional development and measurement activities that are part of maintenance of competence. This will undoubtedly be the primary way physicians will demonstrate to licensing authorities and others that they are maintaining their professional competence.

**Maine:** Maintenance of certification in medicine was on the table as an extremely important model. The problem is that only about three percent of pharmacists are board-certified, so we can't use maintenance of certification the way medicine is using it, and that is true in other disciplines also.

**Questioner:** Professional development must take place in the practice setting and not in a lecture hall. Mandatory CE is a big source of resort and cruise business in the US. Boards are asking people for contact hours, with little attention to the content of those hours. Did the committee address the role of

licensing boards as the demand structures to drive the desired change?

**Maine:** It was clearly understood that state mandates for CE units are the leading driver of practitioner behavior today. Most licensed professionals have those requirements. Nobody knows what would happen if they went away and nobody is recommending that the requirements and the regulatory oversight go away. But, we did talk about the probability that workplace learning is the most effective model.

**Questioner:** Please elaborate on the topic of funding by private sources, particularly with respect to pharmaceutical companies, which I think are pernicious when I see their ads on television. What circumstances would make it okay for pharmaceutical companies to be funding CE?

**Maine:** I agree. There is a difference between marketing activities, which are regulated by the FDA (including all the pernicious advertising on TV) and continuing education grant support. I administered CE earlier in my career and AACP offers CE credits at our annual meetings. I think the point made by the economist on the IOM committee was that there is absolutely potential for wrongdoing and ample evidence of it occurring, but if the accreditation framework for the providers of CE and the regulatory framework for the consumers of the CE have adequate safeguards, then wrongdoing shouldn't occur. The situation has improved and many providers have left the business. There has been some creative thinking, for example, finding ways to demonstrate that what is learned in CE is applied to patient care.

**Comment:** I am the current President of the National Board for the Certification of Hospice and Palliative Care Nurses and the President of the Alliance of Hospice and Palliative Nursing. My comment goes to the recommendation related to inter-professional models. We are very proud that the American

Academy of Hospice and Palliative Physicians and the Hospice and Palliative Nurses Association have a combined conference every year. The conference includes social workers, physicians, registered nurses, administrators, nursing assistants, and advanced practice nurses. They not only attend, they are also presenters. All the professions benefit from the presentations and the networking that goes on.

**Maine:** The Society of Critical Care Medicine is another organization that is moving in that same direction. We need to foster this kind of collaboration and to find ways to make the documentation of CE as inter-disciplinary and user-friendly as possible.

**Comment:** I am a public member of a medical board and a public member of the Accreditation Council for Continuing Medical Education (ACCME). As a sociologist, I am very skeptical about pharmaceutical companies and am suspicious of the research they fund. However, one of the things that ACCME has done is to require in its accreditation standards at least a symbolic separation between pharmaceutical company funding and what is actually taught in CE courses and the faculty who does the teaching. ACCME is also working with nursing organizations to permit both physicians and nurses to earn CE credit for some of the same courses. The proposed institute seems a great way to encourage more of this kind of collaboration.

**Comment:** I am with the Wyoming State Board of Nursing. We have been struggling with competence for initial licensure for entry-level nurses. We approve education programs and approve many online programs because of the rural nature of the state. Our requirement for practical clinical experience for initial licensure has provoked a lot of political pushback against online programs. We rely heavily on the National Council of State Boards of Nursing's research, which

shows that practical experience with a preceptor in an educational setting must supplement online learning.

## **Continuing Competence Initiatives by Licensing Board Associations**

### **Martin Crane, Immediate Past Chair, Federation of State Medical Boards Board of Directors**

The goal of the maintenance of licensure initiative at the Federation of State Medical Boards (FSMB) is to assure the continued competence of licensed physicians. This effort has moved forward in a deliberate and thoughtful fashion for about six or seven years.

Maintenance of licensure is a sea change in the licensure and license renewal process for physicians. It will mean that, as a condition of licensure renewal, physicians must demonstrate participation in a continuous professional development program of life-long learning that is objective, practice-relevant, and results in demonstrable practice improvement over time. It is the kind of change that the Institute of Medicine (IOM) has been recommending.

Why do it? Because state medical boards are mandated to protect the public and guarantee that licensed physicians are competent. It is implied authority in every medical practice act. For physicians, it is a commitment to their patients. For the public, it is an assurance that they have access to the highest quality care. I believe it will give the public confidence in a self-regulatory system and the medical profession. We are preparing to launch the initiative in a few states in the near future and expect full implementation in five to ten years.

Assuring that physicians maintain their competence throughout their careers is an absolute expectation by the public. Most surveys show that the public already believes that physicians are periodically evaluated for competence and quality of care.

The initial licensing process takes into account education, training, experience, examination, and other factors. The relicensure process to date has been mainly administrative. I agree with the previous speaker that mandatory continuing education leaves a lot to be desired, at least the continuing education system we have now.

There is definitely a cultural and paradigm shift underway in medicine and some other professions away from the reactive, complaint-driven approach to a proactive approach of prevention and improvement. This is not about finding bad apples. It is about making good practitioners better by encouraging continuing professional development.

We paid attention to the IOM reports (*To Err is Human, The Quality Chasm*, etc.), the Pew Commission recommendations, the patient safety and error reduction movements and recognized that the accountability of the regulatory system was being challenged. We did not want to be part of the problem and felt that we could change and be part of the solution.

We created a special committee, which included representatives of the public, the IOM and other stakeholders in addition to medicine. The core statement of this effort is that medical boards have an obligation to the public to ensure the ongoing competence of physicians seeking license renewal. This is the same as their obligation to assess people seeking initial licensure.

An important point about the recommendations coming from the committee is that current competence needs to be demonstrated within the scope of one's daily professional practice. We began with the core competencies of the Accreditation Council for Graduate Medical Education (ACGME), which encompass most of the practice of medicine and pay attention to system-based and team approaches to practice. This is a non-punitive, non-

burdensome system for physicians and does not create undue expectations by the public.

The guiding principle is lifelong learning to facilitate improvement in practice. State boards establish the requirements, but they don't have the resources and funding to do everything, so they will collaborate with other organizations, such as assessment certification organizations and third-party attestations, just as the CE process does now. The system should not compromise care nor create barriers to physician practice. It needs to balance transparency and privacy.

We created an advisory group in 2009 to look at the impact FSMB has on boards, on the public, on physicians, to review the FSMB's reports, to predict the challenges in the future, and to decide whether the maintenance of licensure initiative is a value-added endeavor. The advisory group represented regulators, licensees, legislators, assessment certification bodies, and the public. It endorsed the concept that licensees must participate in a professional development program based on the ACGME competencies.

There are three components to implementation: Objective self-assessment of knowledge and skills; performance improvement plans, measurement of the resulting improvements. Licensees may choose from several options to satisfy these three requirements.

One option is to maintain specialty certification, which itself requires continuing professional development and continuous practice improvement. About seventy percent of physicians are board-certified. That leaves at least thirty percent who cannot maintain their licenses through that route.

There are also physicians who are grandfathered by their specialty certification boards, which means they are exempt from maintenance of certification requirements. Depending on the specialty, anywhere from 29 – 40 percent of physicians are grandfathered. There are also physicians



who choose not to re-certify – 29 percent of generalists.

So, more than half physicians cannot participate in maintenance of certification as a surrogate for maintenance of licensure.

The system needs to be verifiable and satisfy the public that the profession means business. It needs to cover physicians who are in non-clinical roles because they may want to re-enter practice in the future.

In April, FSMB approved a framework for maintenance of licensure and a template for state board implementation. This will be exposed for public comment, submitted to the board in February and to the FSMB delegate assembly in April 2011.

The startup plan allows boards to build on programs they already have, so long as they are consistent with continuing professional development and lifelong learning, and do not rely exclusively on CE. We anticipate that the program will evolve with time. Self-assessment will drive educational opportunities and improvement plans will drive practice changes. We will start with a renewal cycle of 5-10 years

Challenges remain. One is that we are still developing programs like this in silos. We still don't fully know how we will deal with non-clinically active physicians.

We don't want to push out physicians who are at the end of their careers. Reciprocity and portability among states is important. Remediation programs must be created for those whose self-assessment identifies deficiencies.

FSMB is happy to share what we are doing as a model for other professions.

**William Rafferty, Immediate Past President, Association of Regulatory Boards of Optometry**

I am here on behalf of the Association of Regulatory Boards of Optometry (ARBO), but I am presenting as myself today because I

don't know whether my board would support everything I say.

Regulatory boards are charged with responsibility for ensuring the competence of licensees. Currently continuing education is the modality optometry uses. I think we all know that is insufficient.

ARBO formulated a plan based on common sense, which looks a lot like what the FSMB is doing. It is a work in progress. Our continuing education program (COPE) categorizes continuing education into subject areas and creates a framework states can use. It includes an accreditation process and a tracking system for every optometrist in the country. We also have a national mobility program providing a national uniform high standard for mobility. It has not been adopted by many states.

We have been working on competency since the 1960s, when we developed our CE system. Recently, we have had conferences on the topic. In 2009 we conducted a survey, which asked whether general board certification and continued competence are the same. Seventy-three percent of respondents said they are not the same. We asked whether there is a need for track education programs with post-assessment. Most respondents thought so. We asked them to name the highest priority for regulatory boards at this time. More than 50 percent said continued competence. This gave us the momentum to pass a resolution supporting the development of an improved system for demonstrating continued competency for the benefit of the public. In 2010, we presented the outline of our competency program to the membership. It was fairly well received.

Yesterday, our board considered increasing the number of CE hours and adding a test at the end. I said I thought that would be doing more of the same and expecting a different outcome. That approach would still not identify the practitioner's weaknesses and it

would not demonstrate the practitioner's competence to the public. I believe those are the two objectives we must try to accomplish. Hopefully, we will modify our approach in North Carolina.

People ask why bother to have a continuing competence program? Healthcare consumers have a right to expect their practitioner is competent. Our maintenance of licensure concept was not designed for third parties; it is designed to protect the public. However, we recognize that in some professions, competence will be demonstrated through certification and in others through licensure.

Our plan uses the competency, accreditation, and tracking programs I mentioned earlier. It involves self-assessment. It involves putting a framework around both continuing education and continuing professional development to address the results of self-assessment. It includes a post-assessment component to monitor what happens in step two and identify changes that affect practice performance. We want to see long-term changes in practice.

The self-assessment is computer-based. It can be self-or testing center-administered. It is not a test, but a self-assessment module. It directs education and remediation to an individual's weaknesses, not their strengths. Practitioners will be provided feedback about strengths and weaknesses.

The curriculum attempts to establish a dynamic, well-rounded, long-term learning process. Because optometry is a specialized area, it is possible to break down the learning process according to sections of the eye. There can be required areas and elective areas and general requirements related to ethics and medical errors, and so on.

Continuing professional development includes accredited and non-accredited learning activities, self-assessment programs, structural learning, degree programs, chart review, teaching, research, and so on. The post-assessment component is designed to

determine the effectiveness of the educational and professional development activities. We are thinking of a five-year framework for pre- and post-assessment.

This program could fit well in most states without statutory modifications. It is designed for boards that want to enhance their current programs. The program is feasible for ARBO because it builds on existing programs, such as the data tracking.

**Questioner:** Please talk a bit about the concepts of "legally defensible and psychometrically sound." These are often raised as stumbling blocks in the way of continued competence programs.

**Crane:** The American Board of Medical Specialties first called its program "maintenance of competence." Early on, they learned that they would not be indemnified if they gave someone a certificate of competence, so they changed the name to maintenance of certification. FSMB researched this and learned that we are indemnified and can use the word competence. The legal concerns you raise vary from jurisdiction to jurisdiction.

**Rafferty:** Our plan is to start small, with two or three states, to see what problems we run into. We are fortunate to have an exceptional psychometrically sound testing agency, which will be used for self-assessment and post-assessment, so it will be legally defensible.

**Questioner:** The Accreditation Council for Pharmacy Education accredits providers of continuing education. Quality improvement in CE is part of our strategic plan. Dr. Crane, you mentioned that non-clinically active physicians and physicians with inactive licenses will have to comply. Please explain how that will work.

You also referred to maintenance of competence programs in other countries, which have moved toward a continuing professional development model. In

pharmacy, most of these countries have a split register. They have different requirements for maintenance of licensure for pharmacists who are clinically active and those who are not. Please comment on this, given the objective of having a competency system that relates to what practitioners do on a daily basis.

**Crane:** There is a difference between having an active license and being an active physician. Anyone with an active license has to go through an administrative renewal process currently. Some of the licensees are not in clinical practice. They may be in administrative roles. There is a movement to create an administrative license, which would not authorize an individual to practice, but would enable him or her to be a medical director of an HMO or hospital.

Those with inactive licenses must now demonstrate something to a medical board in order to gain an active license. In the future, anyone who decides to re-enter practice will have to satisfy the maintenance of licensure requirements.

We were sure from the start that what we were talking about was an individual's current daily practice. We are now looking into the idea of "mapping a practice," as is currently done in hospitals. Most of medicine is now practiced outside hospitals.

**Questioner:** Do you have a system worked out for monitoring compliance with your program?

**Rafferty:** The program could be voluntary initially, but we are hoping state boards will adopt the program for re-licensure. In North Carolina, we monitor 100 percent of CE compliance currently, and could monitor a new program the same way.

**Crane:** Currently, medical boards randomly monitor CMEs. So, we don't really know much about compliance right now. We thought we would start with an attestation system because boards don't have the resources to monitor. Ultimately, in order to be credible, the system has to be verifiable. I am hoping that we will incentivize participation with changes in the reimbursement process.

\* \* \* \* \*

***SAVE THE DATES: CAC's 2011 Annual Meeting will be in Washington, DC, on October 20 and 21, 2011.***

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