# News & Views

## Citizen Advocacy Center

**Fourth Quarter, 2013 - A Health Care Public Policy Forum - Volume 25 Number 4**


## *Save the Dates!*

***Our 2014 annual meeting will be held on October 23 – 24, 2014, in Baltimore, Maryland.*** *More information will be at http://www.cacenter.org/cac/meetings as we get closer to the meeting.*

***CAC is now a membership organization*** *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership and on pages 50 – 51 of this newsletter.*

*Although we encourage you to receive our newsletter by becoming a CAC member,* ***you may still subscribe to our newsletter without becoming a member.*** *More information is at http://www.cacenter.org/view/newsletter and on pages 52 of this newsletter.*

# 2013 Annual Meeting Proceedings

## Regulation's Impact on Access to Safe and Affordable Care

**Co-sponsored by the Citizen Advocacy Center and the Washington State Department of Health, October 29 and 30, 2013, Seattle, Washington**

***Editorial Note: The following proceedings are not a verbatim transcript, but are a faithful account of the remarks made by the presenters. Visit CAC's Website to see the speakers' PowerPoint slides: http://www.cacenter.org/cac/meetings***

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# Welcome

## David Swankin, President and CEO, Citizen Advocacy Center (CAC)

The title of this year's meeting is "Regulation's Impact on Access to Safe and Affordable Care." The topic is especially timely because the implementation of the Affordable Care Act (ACA) will provide millions more Americans with healthcare insurance and therefore increase the demand for qualified caregivers.

This is the third time we have partnered with the Washington State Department of Health in hosting our annual meeting. It is clear that the notion of public input into the oversight system matters from the top down in Washington State. I especially want to thank Lisa Hodgson and Susan Chamberlain for their invaluable help.

Thirteen different types of licensing boards are represented at this meeting. They come from 20 states; there are 30 public members. There are a large number of CEOs and senior staff members and representatives of licensing board associations. There are at least six people representing national certification organizations and at least five representing professional associations. There are also representatives from hospitals, health plans, and community colleges.

## Martin Mueller, Assistant Secretary, Washington State Department of Health

The Department of Health is honored to co-host the 26th Citizen Advocacy Center Annual Meeting. In addition to echoing appreciation to Department of Health (DOH) staff for helping to make this meeting happen, I want to acknowledge the DOH members who are on the faculty: Renee Fullerton, Blake Maresh, Mindy Schaffner, and Sam Watson, as well as John Wiesman and Lori Jinkins, who will speak tomorrow.

I want to thank CAC for its support of thousands of public members serving healthcare regulatory boards and governing bodies as they go about representing the interests of consumers and patients. This is really important work. The training

and networking opportunities this annual meeting provides keeps all of us informed and helps achieve our regulatory mission. The theme of this meeting, Regulation's Impact on Safe and Affordable Care," is especially relevant in today's climate.

We process close to 300 professional applications every day. We deal with 9,000 complaints a year. We inspect and regulate thousands of medical and community facilities, 20,000 phone calls a month and many more emails. Health Systems Quality Assurance is the primary government contact for health professionals, health facilities, the public, and emergency management services. We work closely with health systems to maintain and strengthen urban and rural systems to ensure access to safe, affordable, quality health care and emergency services. Now, we are assisting military personnel transition to civilian life and careers.

Today's Keynote speaker, John Wiesman, was appointed Secretary of Health in April. He brings more than 22 years of local public health experience to this job. He has a MA in public health and chronic disease epidemiology from Yale University and doctorate in public health leadership from the University of North Carolina. John is a leader and a systems thinker who keeps our public health mission at the forefront.




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# Keynote Address

**John Wiesman, Secretary, Washington State Department of Health**

We are all concerned about public safety and serving those of you who do the regulatory work on boards and commissions. Washington State has about 6.9 million people, nearly 400,000 of whom are licensed or credentialed healthcare providers. We oversee 83 healthcare professions. As Secretary of Health, my name goes on every license. It is a huge responsibility. When patients see a license with the Secretary of Health's signature, they expect that the healthcare provider is qualified, has the knowledge to do the job, and will take good care of them. If there is a problem, the buck stops with me and with each of you on our oversight boards and commissions. I am sure you feel the same sense of responsibility. Your decisions help shape the professions and in turn affect every patient the healthcare providers see, including your friends, families, neighbors, and the Governor who appointed you.

Those of you who are public members play an important role in keeping professions connected to the communities they serve. I know being part of a board or commission is the type of work the public only notices if something goes wrong. You are a public servant and it can be thankless work, but you play an incredibly important role in the health of people in your communities. I want to thank you for everything you do in that vein.

Public health and healthcare must work together as one system in order to have the greatest impact on the communities we serve. We all have a lot of work to do. In August, Bloomberg ranked countries based on the efficiency of their healthcare systems. The rankings considered life expectancy, relative per capita cost of healthcare, and absolute per capita costs. The US ranked 46th out of 48 countries.

I am sure you have heard the saying, "health is wealth." Unfortunately, it doesn't work that way – or the other way around -- when you are talking about countries. We are one of the wealthiest nations in the world and we spend more on healthcare than just about anyone. But, when it comes to life expectancy, infant mortality, and other measures of a country's health, we are way down on the list, behind countries that spend much less per person on healthcare than we do. This has to change. I am hopeful that healthcare reform will be part of the answer.

Right now, the public focus is on getting people signed up for insurance, but there are also some important prevention pieces in the Affordable Care Act (ACA), and rightly so. Our health is influenced by our lifestyles, our genetics, and the environment. Unfortunately, when it comes to health spending, about 95% of every health dollar goes for healthcare rather than prevention, and that is clearly not working for us.

In Washington State, we are investing ACA money in working with communities on policies and actions to create safer routes to schools, better places to walk, and more access to healthy foods. Here is just one example. We worked with a school district on the Washington coast to eliminate processed foods from their breakfast and lunch menus. Now the chefs are preparing fresh food and fruits and vegetables for kids every day. Changes like these can mean healthier communities and give people a better chance to live longer and healthier lives. Together, public health efforts, health insurance and health care will help our communities and people at every income level to be healthier.

I'm sure it's no surprise that healthcare reform is a volatile subject with a lot of politics around it. Some states, like mine, are squarely behind healthcare reform and the ACA. Others have passed laws preventing state employees from working on it, or even promoting it. I am sure there are folks on all sides of this issue in the room today. On top of that, the Web sites have really gotten off on the wrong foot, making even supporters unhappy.

As a public health person, I certainly know that insurance is not the only answer, but getting more people insured is a step in the right direction. It is not just more people enrolled, but more people enrolled in policies with better benefits, no bans on pre-existing conditions, no lifetime limits and a better menu of prevention and care services. During the first two weeks, more than 35,000 people in Washington have enrolled in healthcare coverage and another 56,000 have completed online applications that are awaiting payment in December. We are proud of that. While it has been rocky and may

be for a while nationally, more people are going to have access to healthcare and prevention services, and that has to be good.

As more people are insured, protecting patient safety is one way we can have a direct impact on the health of people in our communities and in our states. But, that's not the only way. With more people covered, access to care may become an even larger issue than it is today. Your role in professional development, setting and overseeing practice standards, and investigating and disciplining providers will be more important than ever. Healthcare reform is impacting your professions and every healthcare professional you license.

As a country, we have a lot to do to improve health. But, the good news is that there are some tangible health ways we can make a big difference to healthcare providers, health systems and public health if we set our sights on common goals and work together. Here are some examples. Nine percent of new moms in Washington State smoked during their pregnancy. That adds up to almost 8,000 new babies every year that may have health problems today or down the road because their mom smoked. Healthcare and public health need to put their heads together and figure out the best ways to help these moms and bring the numbers down. Our goal should be zero pregnant moms smoking, which means we have a long way to go. People will live longer and there is clear evidence of a real return on investment when we help people quit smoking. Far too many pregnant women are getting little or no prenatal care, so those babies face a tough road even before they are born.

Diabetes is ravaging our communities, setting individuals up for even worse health problems, such as heart disease, as they grow older, and putting more financial pressures on our healthcare system. More than 8% of the people in our country have diabetes. We know the primary reason for those rising numbers is poor diet, unhealthy weights and not enough physical activity. It is not enough to tell people to exercise more and eat better. If it were that easy, we wouldn't have this problem. We need to work together to make the healthy choice the easy choice and the less expensive choice.

I visited a local health department recently that is working with corner stores to provide more fruits and vegetables. People want to eat healthy. We need to make it lot easier for them to do it. Far too many of our kids are overweight and obese. In some age groups, the rate is 25% or more. If we can't do something about it, this generation may be the first generation that doesn't live as long as their parents. These are complex health issues that require complex solutions that we all have to contribute to.

I assume most of you are familiar with the Triple Aim: 1) contributing to population health, 2) improving the patient experience of care, and 3) reducing the cost of healthcare. I see licensed health professions, boards and commissions like yours, state associations, and other healthcare agencies as our partners in achieving the Triple Aim.

Historically, it seemed important to draw the distinction between medical care and public health so that public health wasn't swallowed up by medical care, where 95% of our health dollars go. Candidly, drawing this distinct line hasn't served public health very well. Public health struggles to get the most basic funding. Meanwhile, our nation spends most of its healthcare dollars on care and we don't have much to show for it. That is unacceptable and unproductive.

I believe that the best way to narrow the divide between governmental public health and medical care is to fully embrace healthcare reform. That is one of my priorities as the Secretary. One of my key objectives is to engage with and influence healthcare professionals, hospitals, and health plans as they work together to treat patients one at a time while re-emphasizing preventative care. We are bringing together healthcare, public health and human services agencies in working to rid ourselves of the silos and barriers between us. Healthcare reform offers us the opportunity to re-think how the healthcare system provides care.

Prevention is the cornerstone of improving the health of our population. We promote healthy choices, better eating, active living styles, immunizations and screenings to find chronic disease at early stages. Prevention includes your work to ensure patient safety by finding and correcting substandard care that puts patients in jeopardy and their health at risk. That's an example of where patient safety and prevention overlap.

There are many ways that healthcare professionals have a direct impact on the decisions their patients make. Time and time again, surveys show that healthcare providers are among the most trusted professionals. The work of boards and commissions is key to public trust in the healthcare system. People are more likely to quit smoking if they get information and encouragement from their healthcare provider. We have held focus groups here in Washington State about whooping cough and flu shots and people tell us they are most likely to get vaccinated if their healthcare provider recommends it.

Our agency's prevention and community health division is working with healthcare professionals to make patient-centered medical homes a reality and improve management of chronic health conditions, such as heart disease and diabetes. We are also working with several partners to establish standard community health worker training. Community health workers help sort out what a person needs, what community resources are available, when to go to a health plan, and how to get appropriate treatment and care. Training community health workers is a fairly new initiative and it is a good example of a technique that bridges public health and medical care.

We must find similar initiatives that expand access to care, which is a key part of the Triple Aim. One example involves your work. We have got to find ways to increase the number of healthcare professionals in our state. One way may be to facilitate the transition of veterans with medical training to civilian life as healthcare professionals. Similarly, we need to find ways to help foreign graduates qualify for licensure. One of the topics at your conference is the scope of practice limitations. How do we make sure they are reasonable and allow people to practice at the highest level of their licensure?

Access to quality care is a vital part of reducing healthcare costs. This is directly connected to your work in quality assurance. High quality, effective care early can prevent hospital-acquired infections and other downstream treatment needs that drive up the cost of healthcare. It is a big job that requires teamwork among all stakeholders. Together, we can ensure that public health delivers on its part of healthcare reform. Our commitment to teamwork within the healthcare system is so vital to realizing the Triple Aim so people in our communities have a better patient experience, and better health, at an affordable cost. It won't be easy, but I am confident we can get there.

**Question:** As a member of a dental board, I am concerned about access to dental care. In our state, a 12-year old boy died from a dental infection. We are also concerned about an aging population. If older people aren't able to masticate, they are not getting proper nutrition.

**Wiesman:** We need to integrate dental care with medical care. When students have tooth pain, they can't focus on their academics. When people seeking jobs have poor teeth, the first impression at an interview isn't good. In Washington State, we have added adult dental back into our Medicaid program, in response to advocacy from the public. We need advocates who will stand up and talk about the impact of poor dental health. We also have a program called Access to Baby and Childhood Dentistry (ABCD), which helps Medicaid families get access to dentists and navigate getting care.

**Question:** Could you say a little more about initiatives in Washington State related to your comment about healthcare professionals practicing to the highest level of their licensure?

**Wiesman:** As we look at health reform and moving more toward a team based approach, we need to look at how - in medical homes, for example – we can enable a team to work together. The curriculum at schools that train healthcare professionals needs to shift to team-based training.

Another piece is looking at how to enable community health workers to do some of the tasks that are now done by practitioners who could be practicing at a higher level.

These are some of the ways we are looking at this in Washington.

**Question:** I am currently a public member on a pharmacy board. I am intrigued by your comment about finding a pathway for medical personnel trained in the military and foreign graduates to work in healthcare delivery. What are some of the things being done in Washington State, particularly in regard to foreign graduates?

**Wiesman:** Our boards and commissions are taking a look at requirements and equivalencies. Legislation proposed during the last session failed to pass. This may be one of those areas where it doesn't make sense for all fifty states to act separately

**Comment:** I am a member of the Washington State Medical Quality Commission, which proposed legislation last year to change the requirements for foreign medical graduates. We feel there is a need to find a way for qualified foreign medical graduates to become licensed more easily. This would require legislative action in this state.

**Question:** I am a public member of a board in Washington State and I want to know if I would have the blessing of the Department of Health if I personally reached across boards and commissions to other public members. I believe that could be a framework for getting some things done.

**Wiesman:** I would welcome that.

**Comment:** I am liaison from the Secretary of Health to the licensing boards in my state. We have had legislation permitting expedited licensure of military and spouses. Most of the military has already been licensed in their profession. The exception is the medical corpsmen, navy corpsmen, and medics. Montgomery College in Maryland has developed a program for Navy Corpsmen to do a quick bridge into the RN program. It seems to be

working and other community colleges are willing to follow suit. Our shock trauma group will be training military medics to qualify for licensure in the state.

# How Unjustified Scope of Practice Restrictions Limit Access to Care

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

Scopes of practice are the state practice acts and regulations that define which professionals may provide which services to which consumers in which settings. For example, Washington State's medical practice act says a person is practicing medicine if he or she 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, or administers or prescribes drugs or medicinal preparations, severs or penetrates tissues, or says in writing that he is a doctor of medicine." This short but all-inclusive scope of practice for medicine is typical statutory language – except perhaps for the "real or imaginary" piece. What about other professions? In contrast to the succinct scope for medicine, just the summary of the scope of practice for medical assistants in the California Code is four pages long. The actual practice act contains many more pages specifying what medical assistants may or may not do.

Access to care is affected by many variables, such as population growth, demographic shifts, language diversity, aging of the population, and shifts in disease burdens to chronic as opposed to acute conditions. Access is also affected by changes within professions, provider practice patterns, and the Affordable Care Act (ACA). The ACA will result in an estimated 30 million newly insured individuals, and increase of about 10%.

Healthcare professions constitute a large segment of our workforce. Primary care keeps growing. The increase in the number of primary care physicians per 100,000 people between 1995 and 2005 was 12%, compared with 5% for other physician specialties. Primary care physicians increased 1.1% per year per capita. That means that every year the number of primary care physicians grew a little faster than general population.

The headlines tell us that fewer U.S. medical graduates go into primary care. But, that decrease was more than outweighed by the increase in the number of doctors of osteopathy and foreign medical graduates who choose primary care. Moreover, the number of nurse practitioners (NP) grew 9.4 % per year per capita during this time period and NPs and Physician Assistants (PA) grew 3.9 % per year per capita.

So, the universe of primary care providers is growing. It is the distribution of these professionals that is the problem. For example, in California in 2008, the highest ratios of physicians to population were in the urban and suburban areas. There were shortages in the rural areas. And in urban areas, some neighborhoods have an abundance of primary care providers while others have shortages.

Is there an access problem? Do we need to build more medical schools? Kaiser advertises that is hires only the top 10% of graduates. If that is so, maybe there isn't a shortage.

Surveys show that Medicare patients have no difficulty finding physicians. So, it depends where you are and what type of care you are seeking whether there is an access problem.

Looking at the intersection between scope of practice and access, there are five variables: geography, competence, innovation, teamwork, and availability. In terms of geography, part of the problem is that scope of practice laws are state-based and politically driven, resulting in great variability from state to state and a disconnect between competence and practice authority. The result is that some professionals practice at the top of their competence, training, and education in one jurisdiction but not another.

Nurse practitioners exemplify this conundrum. For example, in some states they can practice autonomously, in others NPs must be supervised by or collaborate with physicians. There is no clear definition or agreement about what supervision and collaboration mean. The regulation of dental hygienists and many other professions also varies from state to state because of scope of practice decisions based on political compromises rather than on the evidence. If they were based on evidence, there would be more consistency. A few states have adopted evidence-based scopes, but most have not.

In terms of competence, we know that practice acts prohibit many professions from practicing at the top of their competence. Professions such as dental hygienists, dental therapists, dental assistants, medical assistants, emergency medical technicians, optometrists, pharmacists, acupuncturists, naturopaths – the list goes on and on --could all play a greater role in the provision of care, but state laws often prohibit them from doing so.

In terms of innovation, there are experiments and pilot studies attempting to realize the Triple Aim (population health, lower costs and improved patient experience). There is growing pressure on safety net providers. New finance and delivery models may reduce costs while improving access and quality of care. Scope of practice laws can obstruct such innovations, but there is hope that new models, such as patient-centered medical homes and Accountable Care Organizations, will stimulate changes in scopes of practice.

Teamwork is another area where we see scope and access intersect. Exclusive scopes of practice, I believe, exacerbate inter-professional tensions. People are educated in silos so they don't learn how to work together. Exclusive scopes of practice maintain those silos. Professional associations that encourage students to become involved in policy work sometimes ask them to go to the state capitals to weigh in against other professions. If students are taught to think of other professions as the opposition, it is more difficult to get them to work with other professions in effective teams. I've testified or been an expert witness in many legislative battles, which can become really nasty. These battles are costly and time consuming and I don't believe they serve patients, the professions, or the public at large.

In terms of availability, it has been proven that restrictive regulations limit availability and productivity. Economists have no vested interest in scope battles; they just look at the numbers and their findings are more objective. A paper by Traczynski and Udalova, economists from the University of Wisconsin and University of Hawaii, entitled "Nurse Practitioner Independence, Healthcare Utilization, and Health Outcomes," (see http://www.lafollette.wisc.edu/research/health_economics/Traczynski.pdf) shows that the 17 states that authorize NPs to practice and prescribe without physician supervision have

increased healthcare utilization of between 16 and 35%. They also saw improved care quality and reductions in inappropriate emergency room use in those states. These improvements were primarily due to eliminating physician and NP supervision time (about 10% of their time). There were no dramatic shifts in where and how these professionals were practicing, except that doing away with supervision requirements based on old political compromises freed up NPs and MDs both to spend more of their time providing patient care. There were lower indirect costs, such as better appointment availability and lower patient travel costs. So, significant increases in care utilization and quality and reductions in inappropriate emergency room use was due to the reduction in supervision and administrative time.

We know that legal scopes of practice can limit access by reinforcing geographic maldistribution of healthcare professionals, underutilizing our workforce (whose training is partially subsidized by taxpayer dollars), exacerbating inter-professional tensions, and incurring unnecessary oversight and administrative costs. While it is necessary to correct and improve scope of practice regulations, we also have to create better training opportunities, adopt incentives for providers to practice in underserved areas (such as expand loan repayment programs), utilize telehealth more creatively, and improve data collection.

Back in 1996, the Pew Health Professions Commission concluded that scope of practice restrictions interfere with access, quality and cost and recommended moving toward national standards. The Commission pointed out significant overlap in practice among the health professions. There is a core practice for each profession, but at the edges, they overlap because different professions do learn to do similar things. Since then, we have demonstrated that dental hygienists can whiten teeth just as well as dentists can. We know that a number of different professions can draw blood. We know that we can have overlapping scopes at the edges.

There is a terrific inter-disciplinary report on the National Council of State Boards of Nursing website advising legislators how to consider scope of practice changes. (Please see https://www.ncsbn.org/ScopeofPractice_09.pdf). The Institute of Medicine has recommended removing scope of practice barriers for Advanced Practice Registered Nurses. (Please see http://iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx). I was delighted to learn that Mark Twain weighed in on this subject in the 19th century when medical doctors tried to push out doctors of osteopathy. Twain testified in New York State that if osteopaths have the training, they should be permitted to practice.

Between January 2011 and December 2012, almost 2,000 bills introduced in state legislatures would have expanded scopes of practice for one or another profession. Twenty percent of those bills passed. So, there is a lot of activity and many good resources to use.

We can have scopes of practice that are more evidence based and more consistent across the country. The professions need to play a role, and so does the public. So, particularly those of you who are public members need to weigh in and challenge the way things have been done in the past. The norm should be a scope of practice system that assumes overlapping scopes among and between the professions.

In conclusion, regulation definitely affects access. We can't keep approaching regulation and healthcare delivery the way we have for the last hundred years. We have to develop more flexible systems. Exclusive scopes of practice just don't work anymore as we aim for more integrated, team-based, patient-centered care. Public members should be communicating across boards; boards should be aware of what other boards are doing and should work collaboratively toward more integrated systems.

Be creative. If a practice act is coming up for review, challenge the old ways of thinking; consider the evidence; contact your networks on other boards in your state and in other jurisdictions. Some states have been very creative and innovative in their approach to scope of practice regulation and those are the models to use. Finally, be accountable for the decisions you make. Being accountable for outcomes is a powerful theme of the ACA and a number of the reforms being adopted in the states. Professionals need to be accountable for outcomes and regulators need to be accountable for their decisions, which affect healthcare professionals and the care they provide.

**Question:** I am a public member of a board of nursing. Some of the cases we review have to do with scope of practice. Our law limits our ability to look systemically. Nurses coming in from different states have to learn the different requirements in my state. How do nurses stay current?

**Dower:** I think it is important to offer CE courses on scope of practice. I think many practitioners are unfamiliar with the details of their own scope of practice, let alone that of other professions. This is particularly important for nurses who often have tasks delegated to them, and who in turn delegate and supervise other caregivers. As people move from state to state, they are challenging some of the variations that don't make sense.

**Question:** Have you followed the experience in Ontario which licenses "acts" as opposed to licensing individuals? Is it completely unrealistic to think a concept like that might take hold here?

**Dower:** Ontario has legislation that regulates about a dozen risky acts, such a surgery, severing tissue, diagnosing, and other critical aspects of health care. Rather than giving one profession an exclusive scope of practice to do one or another act, each profession is granted authority to do one or more things from the list of acts. The result is that multiple professions each have some or several acts from the list. This has reduced scope of practice battles. It is probably a more efficient and less costly way of regulating. Some professions still try to position themselves to have authority to perform more acts from the list, but the process is less adversarial.

One key feature is that the board that reviews scope of practice changes is made up entirely of laypeople – non-healthcare professionals. These people review evidence, call in experts for advice, and make decisions. The result is a more uniform approach from profession to profession. Recommendations from this group are sent to the Minister of Health for his or her approval. I don't see anything like the Ontario system being adopted in this country any time soon, even though it is a great model.

**Question:** The National Committee for the Certification of Physician Assistants has a new outreach initiative linking oral health with overall health. Some of our practitioners go into underserved areas and perform dental exams. This lightly steps on other

professions' scopes of practice, but it is working well – perhaps because there is no real money involved. Have there been studies that look at the role of remuneration and reimbursement on workforce allocation?

**Dower:** As far as I know, there have been very few studies. We do know that loan repayment programs work to get practitioners to underserved areas, but usually for the short term. A better solution may be to encourage people who come from rural and underserved areas to seek professional training and return to their home regions to practice.

A few early studies of the role of financial gain and scope of practice showed a correlation between regulation and higher prices. (This may be the only field where the regulated population requests regulation because regulation has the effect of increasing their revenue.) More recent studies have found that physician salaries are not negatively affected by expanding the scope of practice of NPs.

**Comment:** I think when we communicate about scope of practice, we should be clear that the goal is to have professionals practice to the full extent of their education and training rather than "expanding" their scope. People are doing what they are educated to do and not expanding the scope of the profession.

**Dower:** That is a good point.

**Question:** I appreciate and agree with your comments, but the tension I worry about is between the primary care model and fragmented, episodic care. For example, my pharmacy board has been looking at collaborative practice arrangements where pharmacists provide a variety of primary care services. This seems justifiable and good to me, but it isn't consistent with the traditional business model of primary care.

**Dower:** All I can say is that the tension you refer to will help push us forward. Business incentives are encouraging us to change to more team-based, cost-effective models that produce better outcomes for the patient. Accountable Care Organizations and Medical Homes can improve care and efficiency. Both impact the scope of practice of the professionals involved.

**Comment:** I am a nursing education advisor for a board of nursing. Nursing practice is fairly broad and it is often individuals themselves who limit their scopes of practice. Our board has a scope of practice decision tree, which takes into account the practice act, an individual's education, professional organizational standards, and so on. The decision tree also asks what a reasonable and prudent nurse would do and whether the nurse willing to bear ultimate responsibility for his or her action.

**Question:** Please discuss the interplay between scope of practice laws and universal insurance coverage.

**Dower:** The quick answer is that public and private insurance plans require providers to have an unencumbered license in order to be paid for services. So reimbursement and payment policies are tied to scope of practice decisions. Insurance companies are seeking cost-effectiveness, so they are looking at malpractice rates, safety records, and so on. So insurance decisions are often more evidence based than political decisions are. The shift toward team based care and reimbursement for outcomes is a major change from the fee for service model we have lived with for many decades. We don't yet know how a team

should be compensated. Should it be a bundled payment for the condition or a per capita payment?

# Improving Access in Underserved Communities

**Lisa Thiemann, Chief Credentialing Officer, National Board for Certification and Recertification for Nurse Anesthetists (NBCRNA)**

Nurse anesthetists have been providing anesthesia for well over 150 years. According to an ANA practice profile survey conducted in 2012, they provide 34 million anesthetics. They practice in every setting across the country, from trauma centers to community hospitals to office-based practices. They practice in every state. Nurse anesthetists are the primary providers of anesthesia in rural areas, and in some states are the sole providers in 100% of rural hospitals.

The authorization to practice has been codified in nurse practice acts and rules and regulations. The requirement for certification and recertification has been codified as well. Although nurse anesthetists have been practicing for over 150 years, the first certifying exam was administered in 1945. Entry into practice requires successful performance on the national certification examination administered by the NBCRNA. The NBCRNA and its predecessors have been responsible for administering and maintaining the CRNA credential.

States have come to recognize the importance of certification for healthcare professionals. According to a 2013 Harris poll conducted on behalf of the NBCRNA and the CAC, large majorities of Americans want their healthcare professionals to be required to keep up with developments in their professional fields and want their skills assessed by independent bodies, such as the NBCRNA, as one example.

The Harris poll showed that 91% of U.S. adults believe it is very important for healthcare professionals to pass an exam that measures professional knowledge; 89% believe it is important or very important that healthcare professionals refresh their knowledge and learn the latest scientific evidence. Eight-five percent believe it is important than an independent body evaluate the skills and knowledge to certify them as being competent; 85% believe it is important that healthcare professionals should not be excused from lifelong learning.

With this in mind, the NBCRNA is developing innovative programs to ensure competency and continued competency. Nurse anesthetists have a longstanding history of providing quality, safe and effective care. Many studies have demonstrated this quality of care. Most recently, a 2010 study conducted by Dulisse and Cromwell and published in Health Affairs found that patient outcomes are no different when care is delivered by a solo nurse anesthetist, a solo anesthesiologist, or by a CRNA who is supervised by an anesthesiologist. (Please see http://content.healthaffairs.org/content/29/8/1469.abstract?sid=df519c15-8059-445e-981d-f4782b4f1ec5). The authors further found that removal of the Center for Medicare and Medicaid physician supervision requirement does not negatively impact outcomes for patients. A similar study in 2008 by Needleman and Minnick found that hospitals that use only CRNAs or a combination of CRNAs and anesthesiologists do not have poorer maternal outcomes compared to anesthesiologist-only hospitals. (Please see

http://www.ncbi.nlm.nih.gov/pubmed/19178582). This becomes important in the context of access to care in rural settings and making sure we have competent providers to deliver care to this population.

It has long been held that nurse anesthetists may play a significant role in reducing healthcare costs. According to a 2010 study by Hogan, et.al. that examined the total cost to deliver required anesthesia services across anesthesia delivery models found that solo nurse anesthesia care is the most cost-effective model. (Please see http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf). The authors further found that nurse anesthesia independent practice is the only model that is likely to result in positive net revenue in areas with low demand, such as rural areas. Independent practice means working with an operating practitioner, such as a surgeon or dentist. That other practitioner does not supervise the nurse anesthetist, nor does an anesthesiologist.

It is important to examine practitioner distribution and its influence on access to care. In 2004, Fallacaro, et.al studied the comparative distribution of nurse anesthetists and anesthesiologists. (Please see http://www.aana.com/newsandjournal/documents/9-14.pdf). They found that nurse anesthetists are more likely than anesthesiologists to reside in non-metropolitan areas. Further, they found that 43 counties in the U.S. did not have either a nurse anesthetist or an anesthesiologist present. Ninety-seven percent of those counties were non-metropolitan. Patients in these areas are unable to access anesthesiology services.

When we see differences in reimbursement, we see differences in scope of practice and differences in distribution. A 2007 General Accounting Office study found that nurse anesthetists are the predominant providers in areas with greater numbers of Medicare beneficiaries and where the gap between Medicare and private pay is less. Anesthesiologists were more likely to predominate where there are relatively fewer Medicare beneficiaries and private pay is relatively higher.

A real life example of the effect of scope of practice restrictions involves provision of pain care. According to the 2011 Institute of Medicine paper, Relieving Pain in America, an estimated 100 million Americans suffer from chronic pain. The estimated cost to society and individuals is in excess of $600 billion annually.

In response to this need, the NBCRNA is introducing a non-surgical pain management certification so we can make sure that competent providers are available in rural America to deliver pain care. We have conducted a professional practice analysis of this subspecialty area. We developed a taskforce to determine the certification requirements and are in the process of developing a non-surgical pain management examination. We have an estimated program launch of about 18 months. Our hope is that we will be able to position nurse anesthetists to care for chronic pain patients so they don't have to travel long distances. This is one example of how certifying bodies are responding to the needs of the American population. NBCRNA will continue to monitor healthcare trends and ensure that competent providers are in the workforce.

**Renee Jensen, CEO, Summit Pacific Medical Center**

I am here to tell you a story about rural healthcare. In February, we opened a brand new hospital called Summit Pacific Medical Center. In this difficult economic time, why

would we think about building a new hospital? Hospital is really a misnomer. We provide about 85% outpatient services. So, most of what we do is meet the primary care needs of the community.

The cities of McCleary and Alma are located in Grace Harbor County. Eighty percent of Washington State's population lives along the I-5 corridor. The remaining 75% of the State's geographic area is rural. We serve a rural population of about 15,000. Our former hospital was located at the edge of our hospital district in a residential area with no bus service. There were two larger hospitals within about a 40-minute drive, but the rural culture is not conducive to driving those distances for care. So, when rural residents show up at the emergency room, they are very sick.

Most of our patients are Medicare, Medicaid or uninsured. The old facility had about 10,000 square feet. Too much of that space was taken up by paper charts. There was one shower in the entire facility. The whole hospital, including the emergency room and patient rooms had carpet.

In preparation to build a new hospital, we formed a community advisory committee. The communities of McCleary and Alma argued over the location of the facility, so we had to rely on statistics, which showed that Alma has a larger population.

We chose a 22-acre site. We developed guiding principles based on the culture and needs of this rural community. The facility is strategically located in the center of the site, which leaves room for expansion around the entire building. No utilities were located in the areas where expansion is likely to take place.

We wanted an atmosphere devoted to healthcare rather than sick care. One of our guiding principles was to use nature. So, we chose a décor that brings nature in. We introduced electronic medical records. We included meeting rooms, which are open to community groups for their use. We invite the community to come in and share meals. At the request of the community, we will be reintroducing fishing contests in the ponds on the property. Our landscaping includes a healing garden adjacent to the hospital.

We operate a rural health clinic, which provides basic primary care. Physicians are leaving rural communities because they can't afford to provide care to Medicare, Medicaid and uninsured patients. So, we employ our primary care providers to enable them to afford to stay and practice.

Finally, everyone involved in the construction project and now the operation of the hospital has passion.

**Sam Watson, Washington State Department of Health, Community Health Services**

I want to make some comments about ways to think about the complexity of healthcare delivery and workforce distribution. I will talk about complexity by focusing on bottlenecks, systems, turbulence and laminaries.

A bottleneck is a constraint that does not allow a system to perform. To illustrate, you may have the best server in the world and beautiful network of terminals at the other end, but if you have wiring that only allows you to deliver a fraction of the capacity, you have wasted your investment. Constraints come in many ways. Some are evident; some are not. Constraints can be procedural, structural and functional.

It is possible to have all the right equipment but be unable to manage it because of the complexity of the system. Every system is a bathtub. It has an input and outflow and stopper to control volume. In healthcare, it isn't just a matter of water in and water out. Use dialysis as an example. What is the right level of infrastructure? How do you calculate probable outcomes? It is about calibration. The system of healthcare has hundreds of thousands of variables. How do you calibrate such a system?

Now I want to talk about turbulence. The speed of change is such that it is unpredictable. There are changes in behavior, in direction. By the time you figure out what to do, your response may be irrelevant. This makes the system more difficult to understand and calibrate.

How do we resolve a problem that is laminar at the beginning but is turbulent at the end? It may be more like surfing than navigation.

**Renee Fullerton, Washington State Department of Health, Community Health Services**

What do we mean by "rural?" There are many definitions, but at the Department of Health we frequently use the rural–urban-commuting area code. This shows daily travel patterns. The I-5 corridor is urban and the rest of the state is rural.

What do we mean by "shortage?" We don't count providers; we evaluate health disparities. Rural populations tend to be poorer, older and sicker than the population as a whole. In any given rural area, there may be a disproportionate number of obese people.

How do we track this? We track health professional shortage areas, using a methodology developed by the federal government that shows the relative degrees across the entire country. Tracking these statistics is required in order to access federal workforce programs, such as the National Health Service Corps, Medicare Incentive Payments, and the Federally Qualified Health Center Program.

In Washington State, 75% of the highest need areas are rural areas. We see something similar in access to primary care dental and mental health. The problem is more complicated than just supply and demand. While we see huge disparities in access to dental care, we are having difficulty finding new jobs for dentists. We hope there will be more employment opportunities when Medicaid restores adult dental care. There is a similar high level of need for mental health services, but this is not quite as rural-focused.

The ACA is going to bring a huge change on many different levels – workforce, payers, and so on. We are not sure how it will play out and what role regulation will play. Our Office of Financial Management did a survey last year to see whether the state will be able to meet the demand created by Medicaid expansion. When you compare urban and rural, the disparities show up again. King County has an oversupply. But, rural areas in the western part of the state have only 23% of the capacity needed to meet Medicaid population needs.

Our Department of State is doing direct recruitment for rural areas, taking advantage of federal loan repayment programs and sponsoring international medical school graduates to practice in underserved areas. There are also some regulatory initiatives, such as legislation to ease the pathway for foreign medical graduates wishing to obtain licensure by modifying the requirement that they first complete a residency program.

We also look at small levers where we might be able to make some changes. For example, we have a small program that provides malpractice insurance to volunteer and retired medical providers as an incentive for them to work in free clinics. Under this program, we pay for licensure for retirees and require different CE. We are hoping to do something similar with dentistry.

# Facilitating Access to Mental Health Services – Collaboration among the Professions

**Mary Jo Monahan, CEO, Association of Social Work Boards**

Our objective today is to look at aspects of the ACA related to behavioral healthcare. Then, we will look at the benefits of professional regulation and the challenges and barriers presented by professional regulation. Finally, we will talk about collaborative strategies being pursued in some of the states.

The ACA emphasizes increased support for primary care, training for healthcare providers, incentives for serving the underserved, and also encouragement for new ways to practice. Collaboration is the most important value we will be demonstrating as we embark on new ways to practice. The federal government foresees that the ACA will encourage social workers to demonstrate leadership in team-based inter-professional care. Also, mental healthcare has to be patient-driven, client-centered, and community based. The service locations will be healthcare centers, school-based clinics, home visits, and maternal and child healthcare. This is a different way of providing services. In social work, we say, "Start where the client is." We focus on the client in the context of their families and the community.

Some current projects sponsored by the federal Healthcare Resources and Services Administration (HRSA) are HRSA Community Health Centers, where behavioral healthcare is being delivered, and the National Health Services Corps, which combines mental and behavioral healthcare. Twenty-eight percent of the Corps' field strength is made up of social workers, psychologists, licensed professional counselors, marriage and family therapists, and psychiatric nurse specialists. Fourteen-hundred of the 8,000 clinicians practicing in the Health Services Corps served in rural sites in the past year. That's not nearly enough. More caregivers are providing services in homes and in at-risk communities.

The Mental and Behavioral Health Education and Training Grant program was awarded $9.8 million from the Affordable Care Act's Prevention and Public Health Fund. This money will be used to arrange for cross-disciplinary learning experiences among mental healthcare professionals. Funding has also been made available to the Center for Integrated Health Solutions, which is run by the National Council for Community Behavioral Healthcare. HRSA is partnering with the White House Forum on Military Credentialing and Licensing in an effort to fast track our returning veterans' ability to earn certifications and licenses.

The ACA is finally here. The Implementation is going to be important. It is a privilege to be a social worker and be able to help people get the care that has been needed for so long. Many of the goals of the ACA are the same values and goals shared by social work and psychology.

**Kate Zacher-Pate, Executive Director, Minnesota Board of Social Work**

Regulation and licensure can either help or hinder access to services and collaboration across professions. The most important three goals and duties of a regulatory agency are first, to set standards and ensure that professionals in the workforce are competent, accountable, ethical, and professional. Secondly, licensing should provide an independent process to which consumers of services have access to resolve problems related to substandard delivery of services. Third, an important role of regulatory agencies is to provide data to practitioners and to the public. We can do that by making presentations and posting information on our websites. We can try to promote a more educated consumer base.

**Angelina Barnes, Executive Director, Minnesota Board of Psychology**

Regulation also creates barriers. One example involves professional mobility. Some of our licensees are Master's level practitioners and others are doctoral level. The standard in most states is doctoral level. As geographic borders disappear, it is important for regulation to be consistent. We need states to collaborate, across jurisdictions and across professions.

In addition to mobility, we need to look at educational standards. In addition to recognizing different educational levels, regulations may specify that training will not be recognized unless it occurs at accredited institutions. Other barriers include cost, language and cultural diversity, transportation, and access to care.

**Timothy Cahn, Vice-Chair, Washington State Department of Health, Board of Psychology**

First, let me say that I don't think any regulatory board could do its job well without the participation of public members. They bring a certain insight and perspective that is extremely important in our decision-making.

What are the real barriers to mental health access? We may need a lot of collaboration to overcome them. The first is money. Washington State is 48th out of 50 states in funding for mental health. But, the biggest barrier is stigma in the heads of the people we need to serve. It is very difficult for individuals to access mental health services because they think having a mental illness is their fault.

Two things my board is focusing on are telehealth and portability.

**Stephen DeMers, CEO, Association of State and Provincial Psychology Boards**

We are the national association of psychology boards in the United States and Canada and both Angelina and Tim represent two jurisdictions that are very active in the association. I'd like to pick up on a couple of things that have already been mentioned. I want to echo what Mary Jane Monahan said about collaboration. We have parallel associations that could be at war, but we are not.

I also want to talk about what Kay referred to as barriers and challenges. We talked about scope of practice this morning. Some of you may be aware that certain groups of psychologists have been advocating for prescriptive authority. Their arguments are that 1) there aren't enough psychiatrists in underserved areas, and 2) most psychoactive medications are prescribed by general practitioners who often consult with the mental

health provider working with that client to find out what scrip to write. So, some psychologists, mostly in the American Psychological Association, advocate seeking prescriptive authority and building a training program to support that. Naturally, the medical community has risen up to say that psychology is encroaching on medicine's scope of practice.

Here is the age-old dilemma. Everyone acknowledges limited access to care, but can't agree on the appropriate training to prescribe. So, here are psychology and psychiatry going to war in various states over bills that would give prescriptive authority. While the psychologists are fighting psychiatrists, along come behavior analysts asking legislators for an insurance mandate and authority to offer services related to autism. Psychology rises up to say, "No, that's our scope of practice." Meanwhile, there are people who are not getting services and access to care.

I am not here to argue for prescriptive authority for psychologists or against behavioral analysts. I just want to point out that these turf battles are the problem. As Tim said, it is about the dollars. I was trained as a school psychologist. I watched the Clintons try to pass healthcare reform, which would have established school-based health clinics with a mental health component. Now, the Affordable Care Act includes a significant portion for school-based health clinics. Where better can you deliver mental health services to kids and their families than public schools? However, the ACA won't fund school psychologists to participate in school-based clinics because they are not licensed; they are only certified by the Department of Education. These are people who are working in the schools; they know the kids and families. But HRSA would rather fund outside individuals to run these programs.

My point is that we make our own turf battles. There is plenty of work for everyone. We don't need to push aside the behavior analysts or school psychologists. The psychiatrists don't need to push aside psychologists. We can get better mental healthcare and we need to work collaboratively to break down barriers.

**Zacher-Pate:** Before we talk about developing innovative models, I need to mention two additional challenges in regulation. One is licensing exemptions. There are some practice settings in which social workers are not mandated by law to be licensed. That means there is not the same oversight and enforcement of standards. Consumers in these settings do not have equal protections. In Minnesota we have tried to eliminate licensing exemptions.

Another barrier is the pervasive sentiment in favor of deregulation. In Minnesota, all of our regulated healthcare professions just went through a rigorous sunset review. Each board had to prove its case in terms of outcomes, effectiveness, efficiency, and the need for regulation to ensure public safety.

**Monahan:** I have been with ASWB for ten months. Prior to that, I served on a regulatory board in Florida. Now, all states regulate clinical social workers. There is a lot more to social work. The ACA contains incentives to encourage mental healthcare in the community. Many social workers practicing in those communities have Bachelor's or Master's degrees (e.g., child protection and case workers) and are well trained to deliver services and to work collaboratively with whatever mental health professional is available. By not licensing social work at levels other than clinical, we are not doing the

best job of protecting some of our most vulnerable populations. This is a loophole that needs to be looked at so the ACA can truly be implemented in a community-wide manner.

**Cahn:** Psychologists working in exempt-status settings are probably better off surrendering their licenses because then no one can complain about them. The system itself needs transformation. Before they go on television, the "Dr. Phils" of the world surrender their licenses because they are giving advice on the airwaves, which is completely unprofessional to do.

In the State of Washington, it is extraordinarily difficult to commit someone against his or her will. We need to have some sort of safety net for people who have severe mental illnesses, but can't be committed to receive treatment. We need changes in the law so we can help the folks who really need help.

**Monahan:** Every year, the social workers, the mental health counselors, and marriage and family therapists would approach the Florida legislature to ask for separate licenses. Psychologists have their own board, so each other group wanted its own board. Every year, the legislators would refuse. Finally, all three professions approached the legislature with a request for an omnibus bill creating a collaborative board covering all three.

**DeMers:** I'd like to mention some other good things that are occurring. We have talked about disparities in workforce distribution. ASPPB will be partnering with HRSA in the collection of workforce data in psychology. The American Psychological Association didn't have this data, but we have a database of all licensed psychologists and can use the occasion of licensure renewal to keep tabs on the constantly changing environment. I think the loan forgiveness and clinic dollars will follow the data showing where psychologists are practicing for how many hours and in what settings.

The other exciting thing is telepsychology where we have worked collaboratively with the American Psychological Association. I believe psychology is well suited to the medium. There is no doubt that technology can enhance access to care, reach people who are home bound or aren't willing to overcome the stigma issues associated with seeking mental healthcare. Still, there are limits to carrying on a comprehensive psychotherapeutic relationship with someone one never meets. So, we collaborated with the American Psychological Association to jointly develop telepsychology guidelines.

The piece we haven't yet resolved is inter-jurisdictional practice. What happens when someone is licensed in Virginia and wants to work with a patient in the State of Washington? We are working on creating what we are calling an e-passport, which is an ASPPB sanctioned credential that will authorize licensees to practice in another jurisdiction. To qualify, there will be educational requirements and a disciplinary status review. We are also talking about international mobility, but that is a work in progress.

**Zacher-Pate:** In Minnesota, we are doing some things that are consistent with the spirit of the ACA and collaboration and could be used by other professions besides the mental health disciplines. We are finally creating a positive culture of supervision and case consultation. The Board of Social Work finally passed legislation saying that other mental health professionals can provide 25% of the supervised hours necessary to earn a full license. In addition, there is now full reimbursement for a professional in training to conduct a diagnostic assessment under Medicaid and medical assistance. In other words,

a graduate level licensed social worker trying to accrue the required supervised practice hours to obtain an independent clinical license may be reimbursed at a full dollar. This will help grow the profession. It enhances and promotes the culture of supervision and case consultation. It also mitigates the disincentive for mental health organizations to hire people who require supervision. In our last legislative session, mental health clinical care consultation was finally put into statute as its own reimbursable service.

Finally, one of the programs of the Governor's 2007 mental health initiative was to provide cultural and ethnic minority infrastructure grants to help grow mental health professionals from diverse communities and across disciplines, including psychology, social work, licensed professional counselors, and marriage and family therapy. In a 30-month grant cycle, there were 59 therapists from communities of color who were supervised to the point of being able to get licensed as mental health professionals. The 59 providers were working in three agencies that developed evidence-based practice models and 350 children and families who were either uninsured or underinsured were served by these individuals. These numbers may seem small, but they demonstrate positive outcomes from leveraging resources and collaborating. The licensing boards worked with the 59 grantees.

**Cahn:** There are no MDs on this panel. We do have a long way to go to establish collaborative sets where people feel safe to participate. Hopefully one of our goals is to be more inclusive throughout the professions.

**Comment:** The state of Maryland is part of the HRSA workforce study. The nursing board already collects that data at licensure renewal, so it is possible to do it. Our psychology board was willing to take behavioral analysts on as psychology associates, but they wanted their own board and will probably be thrown in with professional counselors, marriage and family therapists, also drug and addiction therapists. Also, in Maryland we are in the process of totally integrating our behavioral health system to include all of the disciplines. It should make it a lot easier to deal with the ACA and new mental health initiatives.

**Question:** Currently, states authorize individuals to practice within their state and state laws provide for discipline and licensure. How is it that an association of licensing boards would be able to issue an e-passport that would allow practice within states that are governed by their own practice acts?

**Barnes:** An e-passport is not a license. It is a contractual agreement between jurisdictions. It's not a compact or a reciprocity agreement, but it is a contract between the jurisdiction sending a psychologist through telemeans and the receiving jurisdiction that agrees to accept the e-passport. Practitioners are still obligated to follow the respective laws of both jurisdictions, which could be tricky if there is a conflict of laws. The legal authority to enter into the contract is the certificate of professional qualification, (CPQ), which comes from ASPPB. A jurisdiction essentially says that those who hold an ASPPB CPQ meet our licensure requirements.

**DeMers:** That is why some people refer to this as a legal fiction. Licensing laws were written assuming the provider and client are in the same jurisdiction, but that isn't the way practice is evolving. My message to our member jurisdictions is that we understand their commitment to protection of their own citizens, but we need to consider what is

happening in the federal government, where bills are regularly introduced to eliminate state-based licensing. I would rather live under a system we ourselves develop rather than have the federal government enable inter-jurisdictional practice through a federal license. The e-passport system will have to be approved by state legislatures.

**Barnes:** One of the critical aspects of the e-passport plan is that jurisdictions agree to cooperate in the complaint investigation process with other jurisdictions that are e-passport holders.

**Comment:** The Federation of State Medical Boards is considering an interstate compact for medicine. While there are certainly a number of threats to state-based licensure at the federal level, we try not to dwell on that because there are many reasons for us to move in this direction anyway. The FSMB has come to appreciate the numerous benefits, including telemedicine and improved access, especially in rural and underserved areas. I think we will see more professions working on this in years to come.

**DeMers:** The FSMB has been helpful to ASPPB because you have been working on credentials banking and portability for a long time. When I talk with legislators, I promote access to care. The reason we are involved in regulation is that we know there are bad actors out there. I want to increase access to good practitioners. There needs to be an enforcement piece built or we will be creating a pathway for undesirable as well as desirable practitioners.

I am proud that ASPPB has been working on getting beyond CE with licensure renewal and introducing ongoing assessment of competence. The public assumes a license means the practitioner is competent and that regulators are assessing competence all the time. That's why they support regulation.

# Keynote Introduction

**Lisa Hodgson, Executive Director, Office of Health Professions and Facilities, Health Systems Quality Assurance, Washington State Department of Health**

It is my honor and privilege to introduce today's keynote speaker, Laurie Jinkins. Laurie is a legislator, an attorney and a public health advocate with a long record of public service and community involvement. Laurie has been engaged in education, government improvement, community leadership, and human rights issues for many years. Throughout her career, she has focused on supporting working families, building vibrant communities, and standing up for those who are less fortunate.

Elected to the Washington State House of Representatives in 2010, Laurie represents the 27th District in Pierce County. Her legislative priorities include improving our schools and healthcare, helping working families, and transforming Washington State's revenue structure. Laurie also serves as the Director of Organizational Development at the Pierce County Health Department.

Before her public health work at the local level, we were honored to have Laurie serve in several executive positions between 1995 and 2008 at the Washington State Department of Health. Her positions included Assistant Secretary of Health, Chief Administrator and Executive Director. She focused on developing the State's health budget, with a strong emphasis on accountability and efficient programs. Earlier in her career, Laurie worked in the Office of the Attorney General as an Assistant Attorney General.

Laurie's active community involvement over the years includes work in the following organizations: Fair Housing of Washington, Greater Tacoma Community Foundation, Tacoma Rotary, Tacoma Community College, Tacoma Pierce County American Leadership Forum, Approve Referendum 71, Tacoma Community House, Seattle University School of Law, Tacoma Charter Review Committee, African American Museum, Tacoma Pierce County YWCA, and Tacoma Hate Crimes Task Force. As you can see, Laurie has been very involved in our community.

A native mid-Westerner, Laurie earned her Bachelors and Masters Degrees from the University of Wisconsin, Madison, and later a JD from Seattle University of Law. Laurie has also completed executive studies at Harvard University Kennedy School of Government. Laurie lives in Tacoma with her wife, Laura Wolfe, and their 13-year old son.

# Keynote Address

**Laurie Jinkins, Vice-Chair, Health Care and Wellness Committee, Washington State House of Representatives**

The last time I attended a CAC meeting here in Seattle, I was an Assistant Director at the Department of Health. It's great to be back at a CAC meeting and to represent a different perspective. This conference always has a great mix of people from different states, professions, and job titles. That's one of the great things about it.

I think there are two key things about healthcare that legislators around the country are looking at: quality and cost. One of the most important things we have to do is break down some myths.

One myth is that more care equals better outcomes. Actually the data proves the opposite. Another myth is that regulation is always bad; it creates red tape; it hurts free markets. If we got rid of it we'd all be better off. Another myth is that mandates are inherently bad, so we if got rid of them, we would have inexpensive healthcare.

We see the regulation myth debunked in the financial markets. Most economists agree that unless you have basic rules for ensuring fair play in a marketplace of any type, the market will drive itself into very contorted forms that actually hurt people. They either create monopolies or emphasize profits over outcomes. A lot of the regulation of the healthcare industry is intended to prevent something like this from happening.

Almost everyone who enters a healthcare field is motivated to care for people. But that's not what the system is designed for. When you put caring people in a system where profit is the motivation, regulation is necessary to provide incentives for better behavior.

Healthcare is different from other markets because consumers can't refuse to pay providers when service unsatisfactory. The consequences of bad outcomes are more serious in healthcare than they are in other marketplaces (e.g., car repair). Because the risks are bigger, we cannot allow for a completely free, unregulated market in healthcare. One of our challenges is to incentivize the right kinds of behaviors in healthcare. This is why I have developed my theory that every solution comes with a new problem.

Washington State has tried to achieve quality of care and affordability at the same time. For example, the number of elective Caesarian sections being done in the state used to be

outrageous. More than 50% of the births in Washington State are paid for with Medicaid dollars, so the state was paying for many of the elective Caesarian sections. The legislature didn't turn to regulation to address this problem, but provided data to providers and hospitals. Hospitals began comparing their performance to generally recognized standards and we have seen the number of elective C-sections decrease. This saves money and also encourages the right standard of care. Washington State has a health technology assessment group that looks objectively at new technologies and decides whether they should be reimbursed through Medicaid. If we let the free market make these decisions, we wouldn't realize the economies nor achieve the same quality of care. It is incumbent on state governments to be sure they are using scarce healthcare dollars wisely.

Prior to the ACA, uninsured people paid more for healthcare than anyone else. The way prices are set in healthcare institutions, particularly hospitals, is not related to reality. The charge assessed for a particular procedure – the "charge master charge" – is not based on cost. Somewhere between the charge master charge and the actual cost are the varying rates negotiated with different insurers. If you are insured, your insurance company will pay the negotiated rate. The only people who are charged the charge master rate are the uninsured because they don't have anyone negotiating for them. The number one cause of bankruptcy in the U.S. is medical bills.

The ACA has a lot to do with quality of care. I believe that a focus on quality will have an effect on cost because it means paying for outcomes rather than for services provided. This solution will no doubt bring with it other problems. Regulators can help legislators anticipate problems today's solutions may create. A lot about legislating is making value judgments about which problems would be better to have. So legislators need to be enlightened about regulation, among other things, so we can make wise choices.

Regulators spend a lot of time on scope of practice issues. No legislator likes working on those issues because someone always wants to murder you. I believe that most states, especially those that have created an insurance exchanges, have big concerns about access to care. In Washington State, we want every healthcare provider to practice at the maximum of his or her skill level. I think more and more we will see scopes expanding.

You have a panel later today on degree creep. I talk with other legislators who have serious questions about whether requiring higher education levels for licensure is just another way to increase income or restrict entry into practice. There are a lot of skeptics about that. I think there are also skeptics about the growing number of professions seeking regulation.

**Question:** I am a legislative liaison for a board of nursing. Please tell this audience who is most effective bringing board related issues to the attention of a legislator. Would it be someone in your precinct or someone in the profession who would get your attention, your respect, and your agreement to take action?

**Jinkins:** My experience is that the person most influential with most legislators is a constituent they know and respect. Our legislature has a non-partisan staff we can ask to objectively assess issues. Legislators appreciate full disclosure and being given as complete and rounded a presentation as possible. The best lobbyists can articulate the other side's argument as well as they can articulate their own.

**Question:** Can you talk a little more about how you would like scope of practice issues to be presented to the legislature? What kind of information would you like to have in order to make a decision about changes in scope of practice?

**Jinkins:** My number one preference would be to have the parties involved work it out amongst themselves and come to us with a plan. My experience is that scope of practice advocacy usually cast in terms of patient safety and professional training. I believe that legislators think it is all about the money. I think the legislators are right. Patient safety may be a consideration, but I think those arguments often are a subterfuge for who is going to make money. I think it is better to be candid about that, or at least acknowledge the financial dimension.

Even when it is difficult to get to a solution, legislators want to feel that everyone is engaged in a good faith effort to work it out. My experience is that everyone who brings a scope of practice bill forward eventually gets it enacted, but rarely in one year. Those professions that perceive they are having a piece of their scope of practice carved out have to calculate how long they are willing to fight. At a certain point, they will jeopardize their credibility with legislators if they don't show a good faith effort to move forward.

**Comment:** I am a former nurse legislator who experienced turf battles over scope of practice. I would say that legislators want the people who come to see them to be thoroughly prepared, to be able to tell the legislator what is being taught at school, what is being done in other states, what malpractice records reveal. Professions seeking scope of practice changes need to talk to other stakeholders and bring them on board.

**Jinkins:** I agree. Most legislators don't have expertise in the technical details involved in scope of practice. That is why we tend to rely on experts. Finally, when you propose legislation, it should address a real problem, not a theoretical problem.

# Where Do Licensees Work and What Services Do They Provide?

### Blake Maresh, Executive Director, Washington State Department of Health, Board of Osteopathic Medicine and Surgery

I am responsible for numerous of Washington State's Boards and Commissions, but today I am speaking as a member of the board of directors of the Federation of State Medical Boards. I am here to talk about the creation of a uniform national minimum data set for physicians.

What is motivating us to create this minimum data set? First, the ACA could result in as many as 30 million newly insured people by 2019. In addition, we are expecting the population to increase by 60 million by 2030. The population is aging; 19,000 people turn 65 every day, and this demographic will be 20% of the population by 2030.

The American Association of Medical Colleges (AAMC) estimates we will face a shortage of up to 90,000 physicians by 2020 and 130,000 by 2025. I agree with Catherine Dower's comments yesterday that we need a more nuanced discussion about these predictions, but there are two takeaway points. First, we are going to have more Americans, more insured Americans, and more older Americans taxing our healthcare

system, while at the same time we may end up having fewer physicians than we need, and they may not be in the specialties or the geographic areas where we need them to be.

Why do these data really matter? In my view, the data reflect key milestones and decision points that physicians face from the time they choose to become physicians to the time they leave practice. Those decisions and milestones affect how people access the healthcare system – what providers they see, when they see them, how they see them, where they see them. So, the data are important to figuring out how we enhance access to care, especially in rural and underserved areas.

The decision to enter medical school is an important decision. So are decisions about where to go to school, what specialty to pursue, whether to enter solo practice, a large multi-specialty clinic, a hospital, or an accountable care organization. Will medical school graduates decide to practice in a rural or urban setting? Will they participate in continuing professional development in the areas where they practice? Will they be mobile? How long they stay in practice? Will they leave and return to practice and do they help meet an access need?

These data are vital for policymakers, licensing boards, and professional associations because we are making decisions based on what we think physicians are going to do and the better the information we have, the better decisions we will make. The minimum data set provides opportunities for research as well.

Let me talk about three key actors. The first is the National Center for Health Workforce Analysis, which is part of the Health Resources and Services Administration (HRSA). The National Center is promoting a national database and is working with FSMB. The FSMB House of Delegates passed a resolution in 2011 to promote the creation of a national demographic and practice data set for physicians, a data collection tool, and a repository for the information.

Pursuant to the 2011 resolution, the Federation looked at health workforce literature, other organizational initiatives, and the workforce information already being collected by the states, either at licensure or renewal. Of the 69 state licensing boards, 59 responded and of those, 37% are collecting some workforce data. Sixty-eight percent collect information at renewal. Fifty-four percent collect voluntary information; 19% collect mandatory information; 16% collect some combination of the two. States collect demographic information, such as race and ethnicity. There is an attempt to capture practice and workplace information, such as areas of specialization, hours worked per week, and location of practice.

Based on the research and survey results, the Federation proposed a minimum data set. The Federation already collects data on licensure status, date of birth, medical school, continuing professional development, and specialty board certification. When boards put continuing professional development requirements in place, they will report maintenance of licensure data. New data to be collected includes type of clinical setting in which physicians practice, the number of work hours per week, specialties, and demographic diversity.

The Federation concluded from its research that license renewal is the most opportune time to gather this information. Because so many boards require either annual or biennial renewal, it will give us the opportunity to see what physicians are doing and to trend out

into the future. The Federation thinks it is important that the data questions be a mandatory part of the renewal process and be standardized across states. The data will be aggregated as part of the Physician Data Center, which was created in 2004. It already holds licensure data on 1.7 million physicians nationally.

**Kathleen Haley, Executive Director, Oregon Medical Board**

I have three comments on the workforce data survey. First, it really needs to be mandatory for licensees to complete this survey. The Oregon Medical Board has been doing surveys since the mid-2000's. We started with just a few questions. In 2009, the legislature set up a policy and research group to develop questions for ten licensing boards. With the ten boards and the mandatory questions, which are asked at the two-year renewal time, we now have data on 21 healthcare professions and 100,000 professionals. In 2011, they added three more boards, but didn't make responding mandatory for them. The return on the survey was a lot smaller.

My second comment is that the questions have to be reasonable and useful. Researchers can think of millions of questions. Our licensees' time is valuable and they get lots of surveys. So, let's make the questions reasonable. We use the data set recommended by the Federation. We added one question related to access. We began the survey because it was important to gather this data for emergency preparedness. Now, the impetus is access to healthcare, particularly in the rural areas. Although it is subjective, we ask, "What are your practice plans for the next two years?"

My final comment is that we need to understand the limitations of our data and to be able to tell a story relative to it. For example, between 2010 and 2012 the number of physicians practicing in Oregon declined by 2% according to the research data. Two things happened, which I think impacted this statistic, which the researchers wouldn't know, but we know as holders of the data. For one thing, we changed the status of one of our licenses and we mandated that CME be practice-relevant. Some physicians left rather than take mandatory CME. If you just look at the numbers without telling your story, I doubt you are helping access or emergency preparedness.

**Lori Scheidt, Executive Director, Missouri Board of Nursing**

It is estimated that there will be 500,000 more people insured in Missouri at the end of this year. We rely on data from the Missouri Economic Research and Information Center and the Missouri Health Professions Registry, which is a voluntary tool maintained by the Department of Health. This year, we tied to that database when RNs renewed, but sadly, only 28% of RNs responded to the survey. Our board has discussed making the survey mandatory. The bottom line question is, "Would you really deny someone a license because they didn't enter demographic information?" We would like to provide incentives for providing the information without making it mandatory.

The Missouri Hospital Association collects data on turnover and vacancy rates, but that is only for hospitals, so we have huge gaps in our data. This is a problem for policy makers. On the national level, we used to rely on the HRSA survey, which was discontinued because of lack of funding.

In 2013, the National Council of State Boards of Nursing published its survey of RN workforce. The National Council works with the Forum of State Nursing Workforce Centers on this survey. This Forum is present in 34 states. We would like to have a

workforce center in Missouri, but legislative and financial hurdles haven't been overcome. There was a recent controversy in our state about where data is going, so it is a sensitive subject at the moment.

We will have a new software system within the next two years that will allow us to collect more information about where nurses are practicing. We know where they live, but we don't know where they work or whether they have multiple positions. The Nurse Licensure Compact creates another challenge in that we have individuals practicing in Missouri who are licensed in another state, so we don't have basic information about those individuals.

The National Council of State Boards of Nursing is developing a licensure system in which the Missouri board will participate. This will be helpful to us because it is a way to collect this information. Nurses will be able to provide the information at renewal time and when they change their address or when they interact with the board of nursing for another reason. We renew every two years and a lot can happen in that time period. It would be nice to know why nurses retire or become inactive.

Using the limited information we have, we produce maps showing the average age and count of nurses in each county of RNs, LPNs, and advanced practice nurses. We also try to give information about the kind of actions our board takes, what kind of complaints we receive, and the main causes of complaints.

Nursing constitutes the single largest healthcare profession in the state of Missouri and the healthcare system is changing. Policymakers need reliable data on the healthcare and nursing workforce supply and demand to make changes that will advance healthcare and improve our economic environment and quality of life. But, we first must understand and carefully plan and implement strategies to fill the need and prevent a major healthcare crisis.

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

Critical care nursing began with the special care units during the polio epidemic. Now, we think there are more than 500,000 critical care nurses in the United States. Where do we get that data? We used to get it from the HRSA survey, but that has been discontinued. So we really don't know how many critical care nurses there are in the U.S., but we have about 100,000 members in our association and our certification organization has more than 80,000 certificants. We certify registered nurses, advanced practice nurses, nurse practitioners, and clinical nurse specialists. Our exams are used by state boards of nursing to license advanced practice nurses. Some boards of nursing use our exams to assess continuing competence.

We know how many certified nurses reside in the various states from the demographic information they provide on their annual renewals. We collect data about patient needs and the nurses' work environments. We collect demographic data on membership applications and membership renewal. We collect demographic data when they apply for certification exams and renew their certification. Sometimes we send out focused surveys.

As other speakers have said, we do not require nurses to supply us with this information. We do know there are a certain percentage of new graduates who say they go to work in

critical care areas. We get this information from the National Council's job analysis studies. They survey a percentage of newly licensed nurses and ask where they started working. Based on these numbers, we know there are a large percentage of nurses who start to work in critical care, but we don't know whether they continue to work there.

We collect data about patients as part of our job analysis for our exams. We ask what types of patients are nurses caring for, what are their needs, what kind of skills and competencies are needed to take care of these patients. We share this information with the professional association so they can prepare orientation and education programs and continued competency resources. We also collect information on the work environment and develop advocacy and educational resources for nurses to promote healthy work environments.

There is a lot of additional data we would like to have. We don't require social security numbers, so we don't have any way to distinguish one Suzy Jones from another Suzy Jones. We do have reasons to deny or revoke certification and one of those is a restriction placed on a license. Certificants are supposed to tell us when their license has been disciplined. Sometimes we find out from other sources. Sometimes we don't find out until after patients have been harmed. We would love to have access to the disciplinary database. States publish lists of people they discipline, but we don't know whether it is our Suzy Jones.

We have challenges with data collection. There is a critical care continuum. Critical care can be delivered in many settings. There are more than 400 long-term acute care hospitals. Who are the nurses there? What are their competencies? Are they really qualified to take care of critical care patients?

**Question:** What are some concrete examples of instances where data collection has made a significant difference to policy making?

**Maresh:** My counterpart in Wyoming says that to provide access to care, one needs to know more than how many physicians there are in a state. One needs to know about location, practice patterns, and so on. I have heard that 91% of the counties in New Mexico are federally underserved areas. We need to know what specialists are and are not practicing in those areas where there aren't enough healthcare providers.

**Haley:** In Oregon, there is a rural health tax credit. Data informs whether we should institute or continue that rural health tax credit.

**Comment:** I work with physician assistants. We collect demographic data each time our physician assistants enter our Web portal. It is not mandatory, but we don't emphasize that point. PAs who haven't completed the data are steered to the questions by a popup. We have about 80% participation.

**Question:** How does the data reflect how many hours per week professionals work?

**Maresh:** That is the kind of information we are seeking. We know who has a license, but we don't yet know whether they are working 60 hours a week or 10 hours a week. The physician population is aging. Will a sizeable number of them start to work part time? It is important to know that to predict practitioner shortages.

**Haley:** In Oregon, we can tell how many hours are worked and how many are in direct patient care. Seventy percent of physicians in Oregon work thirty or more hours a week in direct patient care.

**Question:** Can you comment on attempts to collect data in dentistry, where there may be more problems with access to care?

**Maresh:** One of the hats I wear is director for the Dental Commission. Ideally, the federal government would like to have uniform workforce data for as many professions as possible. It would be valuable to have this data for dental professions.

**Question:** Increasingly, physicians are specializing to a degree that the specialty designation doesn't really represent the scope of their practice. Specialization is almost a restriction of scope and limit on physician availability. Is this trend being taken into consideration in data collection?

**Maresh:** Medicine is getting to a point where people are specializing on parts of the body. I don't know how we will ferret that out.

**Hartigan:** In nursing, in some states you may be recognized as an advanced practice registered nurse; in others you might be recognized as a nurse practitioner; in others you might be recognized as an adult, pediatric, of family specialist, and so on. It all depends on how the practice act is written.

**Scheidt:** In Missouri, we are interested in knowing whether a practitioner accepts new patients and whether he or she accepts Medicare and Medicaid reimbursement. We are finding these are key access questions.

# Promoting Access to Good End of Life Care

**Kathryn Tucker, Director of Legal Affairs and Advocacy, Compassion and Choices**

Compassion and Choices is the nation's oldest and largest organization advocating on behalf of terminally ill patients to protect and expand their rights. The reality is that most of the time death comes slowly through terminal illness. Sometimes patients find themselves trapped in a dying process they find unbearable. We advocate for dying patients being empowered to choose how they approach death in a manner consistent with their values and beliefs. Many of us consider how we die to be an important reflection of how we have lived.

Patients approaching end of life through terminal illness have a lot of choices, but they may not always have information about those choices. Law and medicine in all states respect the rights of patients to either refuse or direct the withdrawal of life-prolonging treatment, such as cardiac devices, feeding tubes, ventilators, resuscitative events, medication, and so on.

It is now the standard of care to provide excellent palliative care, so that there is no suffering. Failure either to respect the patient's choice or to provide appropriate palliation is out of bounds. Most of you have occasion to see complaints about the adequacy of care. Please have your antennae out for complaints that may not be familiar, but should be very closely examined. Were the patient's wishes ignored? Corrective action should be taken. Was appropriate palliative care provided? If it wasn't, corrective action is warranted.

Aggressive pain and symptom management is a choice patients are entitled to make. The Oregon board has been in the forefront of correcting clinicians who fail to adequately treat pain. California eventually began to correct physicians who fail to treat pain adequately. Routine assessment and charting of pain is now standard of care. Failure to do that is actionable.

Patients may choose palliative sedation. This is the intervention for those patients who don't get relief even with excellent, modern, state-of-the-art symptom management. Those who have intractable pain are entitled to be informed about and choose palliative sedation, also known as terminal sedation, also known as sedation to unconsciousness. This is where the patient invites the provider to administer through an IV medication that induces total unconsciousness, so the patient is not aware of pain or other distressing symptoms. Food and fluid are withheld until death arrives.

This intervention is embraced as a matter of federal constitutional law as a result of a pair of cases I took to the U. S. Supreme Court in 1997, known as Glucksberg v Washington and Quill v New York. This right has been widely embraced in medicine and both literature and clinical practice guidelines recognize the import of the Supreme Court decisions.

The sad thing is there was a recent study documenting the fraction of physicians who refuse, for reasons of personal moral or religious belief, to tell patients about this choice. A clinician who does not want to provide this choice does not have to do so, but does have a duty to refer a patient to a clinician who is willing to do so. We have an interesting test case pending in California where a patient dying of pancreatic cancer and enrolled in hospice still had intractable suffering, but was never told about palliative sedation. Her mother, who was the caregiver, said the way she knew her daughter died was that the screaming stopped. That patient should have been told about palliative sedation, but never was, so the case is testing whether failure to inform about this option is outside standard of care. The case is known as Hargett v Vitas.

Patients in all 50 states, whether or not they are terminally ill, may choose to voluntary stop eating and drinking (known as VSED). This is a choice that will require attentive palliative support. When patients make this choice, they have the right to have their providers do what they can to keep them comfortable. Failure to do so is outside standard of care. We do hear about cases where patients' wishes are obstructed, such as the case where an elderly couple was evicted from their expensive assisted living facility when they both chose VSED. It is important to take action against providers who make such decisions.

A choice we advocate for at Compassion and Choices, which may be controversial, is the choice for aid in dying. This is the practice where a physician writes a prescription for a mentally competent terminally ill patient who finds him or herself in unbearable suffering and wants to ingest medication to achieve a peaceful death. We do not call this assisted suicide because that term is pejorative and incendiary. Seventy percent of Americans support the concept of aid in dying. The law and policy regarding this choice is evolving. The U.S. Supreme Court declined to find a federal constitutional right, but reserved the right to do so in the future. For now, the Court respects the right for the states to grapple with this issue.

Shortly after these decisions, the Oregon Death with Dignity Act was passed in 1994 by ballot initiative. It permits the practice of aid in dying. It closely regulates and monitors the practice. The law became effective in 1998 and there is a rich body of demographic data about who makes this choice and why.

The State of Washington enacted a ballot initiative almost identical to Oregon's in 2008. The Vermont legislature enacted a very different statute in 2013. Montana respects the practice as a result of a decision by the state supreme court in Baxter v Montana. The court recognized three bright lines – the patient must be mentally competent and terminally ill, and the physician role is limited to writing a prescription for medication that the patient can self-administer to achieve a peaceful death. Oregon and Washington require an elaborate set of procedures that must be followed for a patient to qualify, for a physician to prescribe, and for the collection and reporting of data. In Montana, the matter is left to professional practice standards. In Hawaii, there is a broad base of state law that empowers patients with end of life autonomy, so a patient should be able to choose aid in dying there under professional practice standards.

A few states have chosen to enact statutory prohibitions. These statutes say it is a crime for a physician to write a prescription for a dying patient for medication the patient takes to precipitate death. Nevertheless, the practice of aid in dying is gaining support within the medical community. This is somewhat a product of the data coming from Oregon, which documents no harm, but rather an improvement in end of life care.

The Oregon data shows that very few patients make this choice. Contrary to early fears, the practice has not been forced on minority populations, or on disadvantaged uneducated populations. In fact, the people who typically choose this are more highly educated. Fears that making the choice available would drive hospices out of business or deprive patients of good hospice care have not proven true. Nearly all the patients who opt for aid in dying are in hospice care. Most of the patients are dying of cancer or ALS and they are virtually all insured.

The good news is that change is accelerating to permit wider patient choice. I find the Vermont statute very interesting. It is a hybrid. From 2013-2016, it follows the Oregon model. This is because a faction of the legislature wanted to follow a proven model. Another faction in the legislature considered the Oregon model an intrusion into the practice of medicine. The compromise was to follow the Oregon model for three years and then move to a model that leaves a safe harbor for clinicians, but without all the many mandates and regulations, so that professional practice standards govern the practice. This is important because it normalized the practice within the practice of medicine.

There may be another lesson from the experience in Montana. The Baxter decision provided protection from criminal prosecution. But, will the Montana medical board punish doctors who provide aid in dying? The board conducted a very professional examination of the Baxter case and issued a position statement, which normalized the practice. However, Montanans against Assisted Suicide went to war with the medical board and demanded they retract the position statement. The position statement had been issued after a public comment period, so the board said no. Montanans against Assisted Suicide filed suit asking the court to force the nullification of the board position. That litigation became so burdensome that the lawyers representing the board caved in and

rescinded all of its policy statements. We don't know whether the board will readopt or give up on policy statements.

If aid in dying is governed by best practices or standard of care, this may mean that when a complaint about the practice comes before a board, the appropriate thing will be to evaluate whether the care is within standard of care. If the answer is yes, there are no grounds for discipline. I think it is timely for clinical practice guidelines to emerge for this practice that will help both clinicians and reviewing authorities understand the standard of care.

An interesting case pending in New Mexico is Morris v New Mexico in which the court is being asked whether a law prohibiting physicians from participating in assisted suicide has anything to do with a physician writing a prescription for a mentally competent terminally ill patient who wants to achieve a peaceful death. We argue that a patient's choice of a peaceful death is not suicide and that a clinician providing that compassionate option has nothing to do with assisting a suicide. The mental health community has been in the forefront of saying these choices are very different. This case may impact other states with similar statutes.

I predict we will see an expansion of choices available to dying patients. We will start to see clinical practice guidelines promulgated for aid in dying and more normalization of the practice within end of life care. Boards have an important role in end of life care. When patients' choices are ignored or thwarted, that is actionable. If unwanted treatment is imposed, the provider should be subject to disciplined. Inadequate pain and symptom management calls for corrective action. On the flip side, licensees need to feel safe from disciplinary action when they respect patient wishes, refrain from providing treatment that has been refused, and do provide good pain and symptom management and palliative sedation and/or aid in dying if that is permissible in that jurisdiction.

**Kathleen Haley, Executive Director, Oregon Medical Board**

Oregonians got to vote on this matter twice. Where we are today is a different place than where we started twenty years ago. The vote on the first initiative was 51-49% in favor. The medical school center for ethics convened a group in 1995 to talk about it. The members spanned the spectrum. We shared information, looked at standards, developed educational resources, networked and talked with hospice people. We also went to the Netherlands, even before it was legal there. We developed a guidebook that is online at the Oregon Health Sciences University Center for Ethics website.

What is the role of regulatory boards? Kathryn has given us some ideas about philosophy and ways to handle different cases. In Oregon, we looked at information from the health division regarding complaints about those practitioners who are not following the guidelines and the specifics of the statute. Our role is to examine those cases and also to be a resource for practicing physicians. The board's staff medical director consults with licensees.

While in the midst of legal wrangling over the initiative, we got a complaint about a physician caring for a woman who had a stroke and was in the emergency room. We ended up disciplining the physician because he hastened the patient's death. He didn't do it himself. The ER nurse was calling him and she and the patient's daughter were pushing to move the death along. As a result, he was following what the nurse told him to do. The

doctor was reprimanded, suspended for a period of time, and charged the costs. At the same time, Oregon was the first state to discipline a physician for under-treatment of end of life pain, which was also revolutionary at the time. Making these decisions set some parameters for practitioners in the field. It tells them what the board is thinking about these critical issues.

We have mandatory reporting in our state. The guidebook lists the kinds of things the board would discipline for. In the implementation phase, no disciplinary actions have been taken. We have had 24 complaints in the last 11 years. Four of those cases resulted in letters of concern. Maybe the physician didn't follow the minute specifics of the statute, which doesn't warrant discipline, but does warrant a letter of concern to remind them of the statutory requirements.

Board members are generally supportive of physicians who are doing this work in the community. We could argue over whether the statute is too specific or whether the safeguards are important.

Our role is to decide cases and also provide resources. Even in those cases that don't result in a letter of concern, we provide physicians with resources. We have undergone a revolution in thinking about this issue in the last 20 years, and I think we have important roles as regulatory boards and I am happy to be a resource for any of you who are stepping into this important issue of our day.

**Question:** Is there a definition of terminally ill that is used nationwide?

**Tucker:** Every state has a statutory definition. They vary widely. Some states use a quantum of time, commonly six to twelve months of life expectancy. Other states say something vague, such as "death within a reasonable period of time." There is a federal definition for hospice eligibility. That is six months or less life expectancy.

**Comment:** Speaking as a hospice medical director, I think it is a tragedy in this country that between 30 and 40% of patients never even get offered hospice. There are also facility barriers, particularly dementia facilities that are caring for people with a terminal illness and insist on calling 911 at the time of death. They say it is their corporate policy to not allow a natural death in their facility.

**Tucker:** If you hear of any case where a patient directive has been disregarded, you can always contact us at Compassion and Choices. That facility should be held accountable. Sometimes accountability can be achieved through tort litigation with a significant financial judgment; that often changes behavior. It can be accomplished by regulatory action by licensing authorities or certifiers, such as the Joint Commission. We typically advise terminally ill patients to update their advance directives. Until cases are brought forward and corrective action results, there won't be a change in behavior.

We are concerned not only about patient wishes being ignored and unwanted treatment imposed. That treatment, which may evolve into extended care at an expensive facility, is billed to the federal government for Medicare reimbursement. If you ever see a case where reimbursement is sought for treatment against the patient's wishes, please bring me the case and I will file it as a federal false claims act case.

**Question:** Are there residency requirements in the states where aid in dying is permitted?

**Tucker:** Yes, there are residency requirements in Vermont, Oregon, and Washington State, but these are not a big obstacle. Besides, few people want to move away from familiar places and people when they are dying.

**Question:** In acute and critical care, we find futile care to be very depressing and we support advance directives. With the uproar about "death panels," have you seen some pushback against your efforts?

**Tucker:** About the "death panel" issue, an Oregon legislator proposed a bill in Congress that would have established federal reimbursement for comprehensive end of life counseling. Those of us who work in the field know that patients are inadequately informed about end of life care options. The idea that there would be reimbursement for those important conversations should have been universally embraced because when reimbursement happens, the conversation is more likely to take place. Unfortunately, the bill went nowhere. It was folded into the ACA, but it blew up into the "death panel" thing. Virtually everyone from the medical, health policy, and patient advocacy communities has come forward to say these conversations need to take place. So, I think the bill will be reintroduced. Many states have enacted comprehensive end of life counseling bills.

**Question:** What would you say to a regulatory board that would want to be ahead of the curve?

**Tucker:** The emergence of a consensus in the medical community for end of life choices is influential with lawmakers, so when a bill comes up in your legislature, introduce the statement from the American Public Health Association. You may be on a board that wants to step forth boldly and announce its intention to review a complaint about a provider who violates a patient's end of life wishes just as it would any other complaint. You could adopt a policy that favors discipline when a clinician fails to inform patients about end of life choices.

# Who Gains from "Degree Creep" – The Public or the Profession?

**Moderator:**

**Paul Grace, President and CEO, National Board for Certification in Occupational Therapy**

**Panelists:**

**Angelina Barnes, Executive Director, Minnesota Board of Psychology**

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

**Bill Hatherill, CEO, Federation of State Boards of Physical Therapy**

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

**Sarah Matthews, Nurse Practitioner, Group Health Cooperative**

**Mindy Schaffner, Nursing Consultant, Washington State Department of Health, Nursing Quality Assurance Commission**

**Jill Wakefield, Chancellor, Seattle Community Colleges**

**Grace:** The panelists are speaking on behalf of themselves, and not necessarily their organizations

Grady, what evidence do physician assistants (PA) use to justify the decision to raise the required degree from Baccalaureate to Masters?

**Barnhill:** The evidence was that the needed education could be accomplished in the time required for a Bachelor's degree. The first PAs were medics from the Vietnam War who were trained at Duke University. Over time, education programs were devoting more and more hours and it was felt unfair to the students.

The second reason, which may be less politically correct to talk about, was that nurse practitioners had a Master's degree requirement, so we had to have on. That was part of the story, too, in all frankness.

A few programs that were grandfathered in still award Associate degrees. There are no plans for an entry level Doctorate.

**Grace:** Lucinda, what evidence did your organization rely upon?

**Maine:** Pharmacy used to require a five-year Baccalaureate degree, but even at the five-year level, the number of credits to degree had become too high. The body of evidence that medication use was not safe as currently managed was what the profession relied upon in making the final decision to go to the Doctor of Pharmacy degree. The Institute of Medicine helped us convince others outside the profession that that was true.

**Grace:** Jill, is there evidence that shows better patient outcomes as a result of degree creep?

**Wakefield:** Not that I have found. Community college presidents are required to have a doctorate. I asked why. Is there some knowledge you need to be a successful president? Ask any college president what their degree is in, and you will find it could be any field. I am not aware of any evidence showing a relationship between the degree and a person's effectiveness.

**Grace:** Mindy, how do you feel about that?

**Schaffner:** I think there is a lot of evidence to support advanced degrees in nursing. I found 149 studies comparing an Associate degree to a Baccalaureate. They did not find differences in the skills, but they found a difference in the thinking process with Baccalaureate. More recently, studies have looked at patient outcomes. The difference with Baccalaureate degree holders involved critical thinking, leadership, communication, inter-disciplinary negotiation, and relationships. Most of the studies have been done in acute care settings, which have hugely changed. The ratio of beds to specialty care is now one to one, so we need very qualified people at the bedside. The ACA is shifting focus to community-based settings. Baccalaureate prepared nurses train for the community setting, so they understand epidemiology.

**Grace:** Do you foresee changes that will limit the scope of Associate degree nurses?

**Schaffner:** I do not. But, we already have three levels of Registered Nurses. There are three-year diploma schools, primarily affiliated with a hospital or college. An Associate degree is a two-year degree, but because more courses are now required is takes almost four years to complete an Associate degree.

**Grace:** Sarah, will degree creep affect the supply of nurse practitioners, and how will this gap be filled?

**Matthews:** There is clearly going to be a greater demand for healthcare as 30 million more Americans acquire coverage, and nurse practitioners are available to provide primary care. There is a trend for nurse practitioner programs to go from a Master's to a clinical Doctorate, which requires one more year of schooling. But, there is support for helping people begin practice by taking their boards after their second year of school and continuing their education with courses focusing on leadership, improving systems, quality of care.

**Grace:** Bill, what evidence should regulatory entities look at when a profession proposes changing the entry level, particularly given that the regulators have a responsibility to look out for the public interest?

**Hatherill:** The move toward a Doctor of Physical Therapy or a post-graduate degree got started before the Federation was in a position to analyze and comment on it. So, I don't think we are a good example. Regulatory associations that recognize accrediting bodies have an opportunity to evaluate whether there is evidence for post-Baccalaureate degrees.

**Grace:** Lucinda, how does public input factor into these decisions?

**Maine:** In pharmacy, the accrediting body was created when the American Pharmacists' Association, the American Association of Colleges of Pharmacy, and the National Association of Boards of Pharmacy decided about 75 years ago that pharmacy needed an independent quality assurance agency for academic programs. We each send representatives to the board of directors of the independent accrediting body. So, the regulatory boards were at the table when the accrediting agency embarked on a standards revision and concluded there should be a single degree and it should be at the Doctoral rather than Baccalaureate level.

**Grace:** Angelina, what is psychology doing? Is there a difference between what the PhD and clinical Doctorate offer?

**Barnes:** For many years, Minnesota had both Master's and Doctoral level practitioners. In the Doctoral, we had PsyD and a PhD, with the latter focusing on clinical and the former less so. We went through a controversial period where we transitioned our Master's level individuals into the same level of licensure as a licensed psychologist. Currently half of our licensed psychologists are Masters and half are Doctoral. It is difficult to find differences in levels of practice. From the licensing board's perspective, what I think is important is education, training and experience. You will find our Master's level practitioners practicing in different specialties and meeting different needs than some of our Doctoral individuals. But, they still have difficulty finding employment. Some employers elect not to hire Master's level practitioners based on reimbursement rates. We find that employers sometimes prefer to hire social workers or other mental

health practitioners given that it is more affordable. The rest of the field of psychology has a Doctoral degree as its terminal degree. Whether a degree program is accredited is also a battle within psychology. Minnesota licenses graduates from both accredited and non-accredited institutions. We do an intense educational review, looking a syllabi, textbooks, and data from programs that are not accredited by the professional association.

**Grace:** Jill, you are president of a community college that offers Associate degrees in various allied health disciplines, how do you react to the assertion that there is evidence to support requiring advanced degrees in a particular practice area?

**Wakefield:** First of all, thank goodness this ends with a Doctorate because I'm sure if there were a post-Doctoral degrees, we would be forcing people up to earn them. My gut feeling is that we keep pushing and pushing "just because."

What really worries me is that the Associate Nursing degree serves a good purpose. If you don't come from a privileged background, earning an Associate degree is the way you will enter a profession. We need to help these people enter professional careers rather than erect more barriers. I am concerned about making a higher degree the entry- level requirement.

**Schaffner:** I think fewer barriers exist today. Here in Washington State, universities and community colleges are partnering to offer multi-level training. Also, many schools offer hybrid courses, with an online component.

**Barnhill:** As I listen to this, I wonder whether we have credential creep instead of education creep. If I understand correctly, there are three sub-groups of RNs, but this is not designated as part of the credential. Registered dieticians encounter a problem because graduates from didactic programs have difficulty finding the internships that are required to become an RD. Dietician organizations are considering a different kind of credential for those who cannot find an internship. I wonder if that would help in some of the underserved areas.

**Hatherill:** All of the professions are addressing concerns about mobility, particularly in light of the ACA. In physical therapy, we have largely created a moat around this country because internationally educated physical therapists are not at the doctoral level. PTs in other countries often have broader scopes of practice than we have in the United States – prescriptive authority in the UK, manual therapy in Australia – yet therapists who come here cannot get licensed in the states, sometimes because they didn't take enough general education courses. The world is getting smaller, but we are erecting barriers to international mobility.

**Grace:** Lucinda, what is the tie-in between a profession's desire to expand its scope and changes in eligibility and educational requirements? If it is good for the profession, is it good for the public?

**Maine:** I think our professions look at it differently. We took drugs for granted for a long time. If the FDA said they were safe and a physician prescribed them, why would a patient need anyone else's help? But the data showed drug-related problems and people being hospitalized because drug therapy was not effectively managed. That changed the conversation from drug distribution to the need to prepare professionals who have the knowledge, skills, and ability to help prescribers and patients safely and effectively use

medications. This was the public protection rationale for changing the definition of what pharmacists are supposed to contribute to society.

**Grace:** In my state, pharmacists give flu shots, take blood pressure and prescribe medication. Who authorized this change and was the public involved in the process?

**Maine:** Pharmacy-based immunization started in here Seattle. The CDC looked at the evidence that the public could not get immunized on nights and weekends. The adult immunization rates were very low. It was shown that when pharmacists were involved in immunizations, more immunizations were given by everyone, including physicians, public health clinics, and pharmacies. It has nothing to do with academic degree. It has to do with license because about 50% of pharmacists in America have BA degrees and a license to practice.

**Grace:** Bill, do you see an expansion of physical therapy's scope when the DPT comes online completely?

**Hatherill:** I'm sure that's envisioned by the professional association. I would anticipate the profession wants to expand its scope of practice. I remember listening to someone speak at the University of Minnesota in the 70's about the significance of continuing competence. We still don't have standard mechanisms in place to assess ongoing competence of professionals. Yet, in a relatively short time period, we were able to move people from Baccalaureate degrees to Doctorates in physical therapy. What pressures brought about the change in degree requirements that don't seem to add urgency to ongoing competence? Is this really the right emphasis?

**Grace:** Sarah, when nursing goes to an entry-level doctorate, will the public be confused about the role of nurse practitioners who currently aren't required to have a doctorate?

**Matthews:** I think it doesn't make a big difference to the public. We aren't trying to say that a Master's prepared nurse practitioner is not a great practitioner. There has been a lot of debate about calling nurse practitioners doctors. All the nurse practitioners I know identify themselves proudly by that title. Doctor is a term that applies to many professions other than physicians. We have tried to start educating the public about what the Doctorate offers in terms of leadership and communication skills, greater ability to focus on quality improvement and team functioning and to take a leadership role. The IOM report, The Future of Nursing, advocated that nurse practitioners become partners with physicians and help to redesign healthcare. This is the message we try to convey to our patients.

**Grace:** In psychology, do you see a day when there will be Doctoral entry exclusively?

**Barnes:** That is the push. The Association of State and Provincial Psychology Boards is encouraging consistency and Doctoral only. One reason is for mobility. Minnesota's Masters' level psychologists struggle for mobility. While I appreciate the desirability of consistency, I still think the Master's level psychologists are meeting a need. We have 3,700 Master's level psychologists and we still don't have enough to meet rural needs and serve all the citizens of Minnesota.

**Grace:** Grady, do you anticipate any shortages as a result of moving toward a Doctoral requirement?

**Barnhill:** There was concern when we moved toward a Doctoral level that we might be eliminating the community college Associate level track. This has come to pass. There are only about four such programs remaining. Those that survived established a partnership with a university that can award a degree program. We don't have data, but think there is some loss of access for those who want to get into the profession. We don't know what this has done to access to care in underserved communities. We have had success with a grant program for those who agree to practice in an underserved area and with recruitment from programs that reach out to people from those communities and provide incentives to study.

**Grace:** Lucinda, will patient outcomes improve as we push degrees to higher levels?

**Maine:** There is evidence that morbidity and mortality decrease when a clinical pharmacist is present in the care delivery model. This is harder to prove in the ambulatory and chronic disease management sphere. But, the evidence is reasonably strong that care improves when pharmacists shift their role to a patient care practice rather than a simple distributive practice.

**Grace:** Jill, what is your experience at the college level? Do your graduates report better outcomes?

**Wakefield:** I don't have that kind of data. What worries me is the assumption that a Doctorate automatically means you are better than someone with a Bachelor's degree. There are levels of colleges, too. We must look at competencies. Does it need to be a degree? Is it enough to have a certification? There are other ways besides degrees to demonstrate knowledge. We talk about leadership and critical thinking. Why don't we embed these skills into every class that is taught, whether at a community college or a university? Start with what a practitioner needs to know and work back. Then I think degree creep wouldn't be the discussion.

**Schaffner:** In nursing, the essential competencies are taught for an Associate degree. We spell out different competencies for Baccalaureate nurses. Faculty members base the curriculum on those competencies. When we evaluate a curriculum, we look at student outcomes.

**Grace:** Are those Baccalaureate competencies focused on direct patient care, or general education?

**Schaffner:** They tend to be in three areas: public health (working in community health systems, epidemiology), research (evidence-based practice and evaluative skills), and leadership (negotiation, interdisciplinary team building, communications, care case management).

**Grace:** Lucinda, do you anticipate a change in the eligibility requirements for pharmacy technicians to an Associate or Baccalaureate level? If so, would scope change as well?

**Maine:** Pharmacy education has ignored technician education for as long as technicians have existed. But, my organization has begun to look at what the relationship should be between pharmacy schools and pharmacy technician programs. The majority of pharmacy technicians are prepared on the job. Since 1994, there has been a national certification that does not require any threshold of education other than high school graduation or GED. The Pharmacy Technician Certification Board, which awards the

credential, has been engaged in strategic planning in response to requests from the profession for a better prepared cadre of pharmacy technicians who can accept more responsibility for oversight of drug distribution management while the pharmacist redirects time and attention to direct patient care. But, they have not yet established a degree parameter. They will probably see that a higher level of preparation is needed for relatively independent technician practice.

**Grace:** Bill, do you envision any change in scope or eligibility for physical therapy assistants?

**Hatherill:** It seems like a real possibility. As people move toward the doctorate, their assistants who are now trained at the associate level would move to a baccalaureate program. We are trying to cut the cost of healthcare, but students are paying a lot more money for more education and they will make less money in the long run. So we have to find ways to be more efficient about using other individuals to provide some of the care and PTAs could fill an important role. Also technology will replace some practitioners in the interest of cost reduction.

**Grace:** Grady, you mentioned earlier today that one of the reasons for the Master's requirement was that nurse practitioners are at the Master's level. You also have credentials in anesthesiology and other fields where nurses also practice.

**Barnhill:** We have a lot of political challenges in our organization because of specialties. We use the term "certificates of added qualification" because there is a group that believes specialization will infringe on practitioner mobility. In addition, the examination all PAs must pass every six years to maintain their certification is a general test, which upsets PAs who have settled into more narrow specialties.

I foresee a migration from knowledge-based to competency-based certification. Increasingly, the Joint Commission and employers care more about what practitioners can do as opposed to what they know. Hopefully, we will soon have certification and recertification systems more geared toward competencies.

**Grace:** Sarah, will we see costs go up because people have advanced degrees?

**Matthews:** There is a lot of debate about nurse practitioner reimbursement, which is 85% of physicians' reimbursement. Yet, I think nurse practitioners are committed to containing costs.

Assuring competence is a big issue for all professions. In addition to seeing patients, I am responsible for education and competency assurance of nursing and provider staff throughout our organization. We are constantly challenged with determining whether practitioners really know what they are doing. How do we know after we train someone that they learn and maintain that skill? All the energy we spend on this potentially means more staff and more cost.

**Grace:** Angelina, do you think that this wouldn't be as much of an issue if we had more public representation on licensing boards? If the board is there to protect the public, why are only one or two public members?

**Barnes:** I believe there is a lot of merit in having more public members rather than professional members on boards. We struggle continuously to remind board members that they serve the public interest and need to make a public-oriented decision. We have

three public members on an eleven-member board and when we vote on a controversial issue, nine times out of ten, the split is public member vs. professional member. I encourage more public members at every opportunity.

**Maine:** I haven't observed licensing boards in action very much, but I have a bias that they tend to be guild-like. Therefore, it would be beneficial for there to be a more even balance of the public's versus the profession's perspective.

**Barnes:** We have experienced difficulty getting public members. We want some diversity in our public membership, but a straight consumer perspective is very beneficial to the boards.

**Comment:** I have watched both degree creep and credential creep. We haven't emphasized competence, or even defined it. The public is totally absent in these decisions. I have watched in physical therapy, in pharmacy, in nursing, in audiology, in you name it. Here is the pathway. It starts with the educators. There is no public among educators. Then it goes to the professional association. Almost no professional association has public members in its governing body. It then goes to the accreditors, where there are few if any public members. Then it comes to the licensing board. So the first time we have a real governmental actor is when it is already done. The public's voice is missing.

The private conversations go this way: "Others did it." "We are going to do it because it will led to independent practice and probably increase our scope of practice." "It will increase our status." "It will make us equal partners at the table with physicians." "It will give us the title, 'doctor,' which is status." "It will increase our income."

Those are the real reasons. We have lost sight of competence. We emphasize degrees and hours and knowledge. The biggest problem with healthcare today is the application of knowledge. Degree creep doesn't assure competence in applying knowledge; in the guise of public protection, it harms the public because it costs more and reduces access. I think it is demeaning to the public when we try to over-protect. When somebody says they want to protect me, it is usually to advance their agenda more than mine.

**Comment:** I would have liked to have heard more about collaboration and support for nurses who want to progress in their education. I think there is enough evidence that patient care demands a higher level of education. We have more people wanting to be nurses than there are seats in the classroom. I think students need to be prepared to do the work when they get to the clinical environment. There are systems around us that affect the quality of patient care and professionals need to know how to handle that.

**Wakefield:** Our commitment is to give students a pathway to go wherever they want to go.

**Comment:** In the airlines, the system demands competence. We don't have that in healthcare. If we did, there wouldn't be so much emphasis on educational degrees.

**Comment:** The University of Maryland Dental School may be closing its Bachelor level dental hygiene program because of the cost and lack of interest. I have been telling students to please get their Bachelor degree because there are things in a dental office that can hurt one. One injury and they won't be doing dental hygiene any more. Having a Bachelor's degree can open up teaching and other opportunities. There is tension between

our dental board and the professional association. Some people say the professional association grooms people to get on the board so they can advocate for better pay for associate level dental hygienists.

**Question:** I am the public member of a pharmacy board. There has been a lot of discussion of looking for proof of competence. As a consumer, I would like to skip a highly duplicative infrastructure and have professions figure out cross-professions what the competence is.

My other question is, if everybody works at the highest level, how will the other levels be allowed to do more, without fighting tooth and nail? What about supervision of techs?

**Barnes:** The Association of State and Provincial Psychology Boards has a committee that identified core competencies needed to be a psychologist. They did research, conducted a survey and published a white paper on the subject. They are also developing programming that could potentially be offered to re-test hands-on clinical performance. ASPPB looked at some of the US Army technology-based solutions for determining competence. That can simulate patient experience, such as PTSD, from facial expression, demeanor, and conversation. Graduate students can interact with this artificial "person," who then reacts to the therapy given.

**Maine:** For five years, medicine, nursing, dentistry, pharmacy and public health educators have been working to develop a competency map for students in all the healthcare professions to improve their ability to collaborate. A parallel conversation has begun among accrediting bodies in the same professions, which all include inter-professional and team based care in their competencies for accreditation. The Tri-regulatory council just this week agreed to look at inter-professional learning. So the professions are looking at the overlapping competencies to see whether education can be made more efficient and appreciate what characteristics professions hold in common. I can't tell you why we can't measure competencies after 50 years of talking about it.

**Barnhill:** The study we are doing on competency is looking at areas of practice as well as core competencies. The tension between core competency and specialty is present for most professions.

**Comment:** The complaints we see at my medical board almost all arise because of the way physicians communicate with patients. This has nothing to do with the degree and level of training a practitioner has. Another observation is that I found myself training people who had higher levels of education than I did, but who hadn't learned clinical skills. People continue to learn after academic training if they have someone who mentors them in the right way. My concern is that our system of mentoring and training is deficient.

# Business Restrictions, Anti-Trust, and Access to Care

**Barbara Safriet, Visiting Professor of Health Law and Policy, Lewis and Clark Law School**

I will speak about business restrictions, anti-trust and access to care, using as an exemplar the North Carolina Board of Dental Examiners' teeth whitening case. I think a punchier title for this talk would have been, "The Case that Scared All Licensing Boards to Death." In this case, the Federal Trade Commission found that a state licensing board was

not entitled to state action immunity or free from liability for anti-competitive purposes. My view is that good boards that adhere to their legislative mandate and use the procedures set out in law have nothing to worry about.

Suits have been filed in other states related to teeth whitening. Is it the practice of dentistry, or is it the unauthorized, unlicensed practice of dentistry and hence illegal? There are four different kinds of teeth whitening. All involve the application of a form of hydrogen peroxide or carbonide peroxide, which triggers a chemical reaction that whitens the teeth. The procedure can be performed in a dentist's office, using a high concentration of peroxide and a light source. This option is typically quicker and more expensive. Or, dentists can provide a take-home tray and a whitening gel of a lesser concentration. The third form of teeth whitening uses over-the-counter strips containing a much less concentrated form of peroxide.

Finally, there are mall kiosks where a non-dentist sells customers a kit containing an even lower concentration of peroxide in a gel or strips. The customer applies the material and an LED light is shined on it. The non-dentist almost never touches the client.

Dentists began offering teeth whitening services in North Carolina in the 1990's. In 2003, non-dentists began offering teeth whitening services. The North Carolina dental board began receiving complaints from dentists and dental hygienists. In 2006, the board began issuing cease and desist orders to the non-dentists providing these services. The non-dental teeth whiteners complained to the Federal Trade Commission saying the dental board was engaging in anti-competitive behavior. The FTC found that the actions by the board were anti-competitive and that the board was not entitled to state action immunity from anti-trust laws. The case was appealed to the Fourth Circuit in Richmond, VA, which ruled unanimously in favor of the FTC's decision.

The North Carolina Dental Practice Act says "it shall be unlawful for an individual to practice dentistry in North Carolina without a current license to practice dentistry by the board." Under the dental practice act, a person "shall be deemed to be practicing dentistry if that person removes stains, accretions or deposits from the human teeth." My assumption is that any time you use a toothpick, you are practicing dentistry, but it won't be a violation of the law if you do it for free.

The North Carolina dental statute doesn't expressly address the question of teeth whitening, or under what circumstances a non-dentist may engage in teeth whitening. So the law was and is unclear. In contrast, a study group of the Ohio Board of Dental Examiners looked at this specific question and decided teeth whitening is not the practice of dentistry.

Who are the actors in the North Carolina case? There are six licensed dentists, one licensed hygienist and one public member on the North Carolina board. The six dentists are selected by the dental association – not by the governor, nor by the legislature, nor by the department of health. Plus, in the dental board's proceedings, the public member and the dental hygienist are excluded from any disciplinary matters. The other actors in this case are the Federal Trade Commission, which enforces anti-competitive behavior statutes, and the Fourth Circuit Court.

The board issued forty-two cease and desist letters to non-dentists charging them with practicing illegally and ordering them to stop. They also sent at least six letters

threatening and discouraging non-dentists who were considering opening teeth whitening businesses saying they could not do it unless they were directly supervised by a physician. They also mailed 11 letters to owners of retail malls, who had nothing to do with dentistry or teeth whitening, telling them that they should not rent space to individuals engaging in teeth whitening services because it would be deemed to be harboring illegal activities on their property. Several of the salons and spas lost their leases. There is evidence in the record that on more than one occasion, one board member sent cease and desist letters within minutes or hours of receiving notice of a complaint and with no investigation whatsoever. The FTC and the Fourth Circuit found these actions illegal under the Sherman Anti-Trust and FTC Acts, laws that are intended to encourage competition.

Everything boards do is anti-competitive. Licensing, by definition, is anti-competitive. Boards select a category of people who meet certain qualifications of competence and allow the, and only them, to do certain things. People who are not licensed, no matter how skilled and competent they may be, cannot do those things. It is inherently anti-competitive. That is not necessarily a bad thing, but how do you square licensing with anti-trust law?

There has to be an exception for anti-competitive action taken on the official authority of the government. Licensing is one of those exceptions – if it is done correctly. There has to be an exception to validate and give board members immunity for what they do. This exception is called the state action doctrine, because the state is immune from federal anti-trust actions and state agencies are also, if they are operating pursuant to a specific provision which is meant to displace competition, such as a licensing law.

Why was the North Carolina Board not protected by state action immunity? First the FTC Administrative Law Judge, then the FTC itself, and then the Fourth Circuit found that in North Carolina, the dental board was not entitled to state action immunity because they were acting as private parties. This was because a state entity composed of participants in the regulated market, who are chosen by and accountable to their fellow market participants, are private actors.

We still can give immunity to private actors, but only if two requirements are met. One is that they are acting pursuant to a specific directive to displace competition. The second is that they are actively supervised by the state. The FTC and Fourth Circuit said the North Carolina dental board wasn't a governmental actor; it was a private actor because it was appointed not by non-governmental officials, but by a very interested professional association composed entirely of competitors. Secondly, there was no active supervision by the state. So, the court found here that they were not entitled to state action immunity from anti-trust action.

The court said, "At the end of the day, this case is about a state board run by private actors in the marketplace taking action outside of the procedures mandated by state law to expel competitors from the market." They deemed them to be private actors, not state actors, because of their appointment. There was a specific intent by North Carolina, like any licensing statute, to displace competition. But, one of the major safeguards we have as citizens was lacking because there was no governmental oversight of the appointment. Other safeguards we have when we entrust these blatantly anti-competitive powers to licensing boards are procedural safeguards. This board didn't follow through on many of

them. They sent letters to totally uninvolved third parties, some of which were not authorized by statute, board rule, or past practice. They didn't send things to the District Attorney's office for prosecution. We have procedures set up to guard against self-dealing and self-interest, but they didn't follow those procedures.

There were lots of alternatives the board could have chosen. They could have petitioned a state court for an injunction. They could have investigated the non-dental providers for suspected violations of the dental practice act before sending the cease and desist letters. They could have clarified their statute or their rules and regulations. They could have referred matters to the District Attorney for prosecution. They could have communicated to the non-dentists their belief that they thought this fell within the definition of dentistry and offered to talk.

The takeaway messages to avoid FTC scrutiny for anti-trust are these:

First, know your law.

Second, do away with giving private entities appointment power for governmental bodies. In most states, the delegation of the selection of licensing board members to private entities would be unconstitutional. No matter where it occurs, it is bad practice.

Third, follow authorized procedures for pursuing people you have good reason to believe might be violating your statute.

Fourth, be sure you are a state actor and not a private actor. Does the state exercise supervisory authority over the board?

This case got a lot of attention and many amicus briefs were filed. Frankly, there was a lot of misinformation. People read the decision to mean that all state boards are private actors and not state actors because they have professionals on them. That wasn't the reason. The reasons had to do with who appointed the professionals and what procedures they followed. There is a lot in the record to demonstrate that the actions taken by the board, whether intentional or not, were taken more in response to threats to the financial stability of dental practices than to protect dental health and public safety.

So, if you are a good board, appointed by the right people, and you follow procedures, you shouldn't have to worry about the Federation Trade Commission. However, people are watching far more closely than they have before. There are now other cases on the teeth whitening issue. One is in Alabama, where the board passed a statute saying bleaching of human teeth by non-dentists is illegal and instructing the public in the use of any bleaching product is illegal. The board persuaded the legislature to enact this statute on the strength of 97 complaints over a course of 6 years. Four were from consumers who had relatively minor complications. Ninety-three complaints were from dentists and dental hygienists. Not one Alabama dental school offers required clinical training for teeth whitening. Consumers in Alabama can buy these products over the counter, take them home and use them with no supervision, and it is perfectly legal because the products are regulated as a cosmetic by the FDA. However, if a consumer sits in a comfortable chair in a salon in a mall and pays someone to tell him or her how to self-administer the products, somehow it is a threat to their health.

Over-regulation is under threat, and it's about time. Women who do hair braiding and charge a fee are considered a threat to the public health because they are operating

without a cosmetology license. Hair braiding, especially African American style hair braiding, is not taught in cosmetology or barber school. But, in many states, the cosmetology association and the board of cosmetology or barbering brought action charging that hair braiders were practicing cosmetology without a license and must stop. These are some of the very few cases where courts rule that an economic regulation fails constitutional muster because the only standard required is that there be a conceivable reasonable basis for the regulation. Not that it was really the reason, but could we conceive of a reason for it? In these hair braiding cases and floral arranging cases, and interior design cases, the courts have said there is no reasonable public health or safety basis for this. All it is doing is protecting the cosmetology schools, because you have to go to cosmetology school for 2,000 hours at an average cost of $30,000, where they don't teach hair braiding, for you to be able to do hair braiding. The courts have finally begun to say enough is enough. Licensure has a place. Reasonable restrictions for demonstrable health and safety have a place. But, when it is so unreasonable that we can't even conceive of a legitimate reason, we are going to strike it down.

I'll close by summarizing one of my favorite cases, which the U.S. Supreme Court just declined to review. It is the Benedictine monk coffin case. The monks make and sell coffins to the public. They received a cease and desist letter from the funeral board in Louisiana charging them with practicing funereal science without a license. The Fifth Circuit decided that the Benedictine monks making elegant pine boxes and selling them to the public did not violate the funeral practice statute.

The back-story is that the Benedictine Monk's coffins cost about $1,000. The coffins sold by licensed funeral directors cost $5,000 or more. The court found no rational relationship between the public health and restricting intra-state casket sales to funeral directors. Louisiana does not even require a casket to be buried. It does not impose any requirements for their construction or design. It does not require a casket to be sealed before burial. It does not require licensed funeral directors to have any special expertise in caskets.

What all this leads us to conclude, says the court, is that there is no rational relationship between public health and safety and limiting intra-state sales of caskets to funeral establishments,

The great deference due state economic regulation does not demand judicial blindness to the history of the challenged rule or the context of its adoption. Nor, does it require courts to accept nonsensical explanations for regulations. The deference we owe to principles of federalism and our judicial roles require us to say these things. The principle we protect from the hand of the state today protects an equally vital core principle. The taking of wealth and handing it to others when it comes not as economic protectionism in service of the public good, but as an economic protection of the rule makers' pockets is not acceptable.

Courts and plaintiffs are increasingly looking at the rationality of a restriction. Your goal as licensing boards, and as attorneys advising them, is first to regulate in the public's interest – not in the profession's interest. I think licensing boards can advance both the publics' and the profession's interest if that is in service of the public. More in the past two years than in the 30+ years I have taught law, I am seeing the public challenging many regulations. You shouldn't fear the teeth whitening case in North Carolina. You

shouldn't fear regulation in the public interest. Have really good reasons for the restrictions.

**Question:** Could you imagine a situation where a medical board is taken to task for a restraint of trade reason for restricting the scopes of practice of other clinicians?

**Safriet:** If we lived in a rational world where legal principles were applied consistently, yes. And, I do think the day is coming. Unnecessary restrictions on practice are becoming increasingly obvious. That combined with the need for authorizing professionals to do what they are competent to do is the only way for licensing to go. It has become apparent that many actions by state legislatures and especially medical boards are neither based on evidence of harm to the public nor increased quality as a result of restrictions. The only rationale is to restrict the application of other competent providers' knowledge to patients. It is coming, but it will be a multi-faceted approach.

**Question:** Is the CAC making an effort to get consumers involved on boards?

**Safriet:** I am on the CAC board. The reason I participate is that this is the only national organization I know that has as its goal promoting public input into the regulatory process. This is not for a particular cohort, like AARP, or the Sierra Club, but across the board. It is the long unheard voice.

**Swankin:** CAC's mission includes "advocating for a significant number of public members." That is a quantitative statement. As Ben Shimberg used to say, putting just any old consumer on a board is tokenism that doesn't really change the dynamics of a board. There has been a movement – perhaps most prevalent in medicine – to have significant participation by public members. Texas, for example, has 6 public members, I believe, on an 18-member board.

For better or worse, it is a political process. In most states, governors appoint board members. Sometimes thought is given to who would be a good board member, but for the most part appointment is a political. Most statutes define public members using negative qualifiers. A public member cannot be a member of the profession, or related to someone who is, and so on. If there were positive qualifications in the statutes, it would raise awareness of what it means to be a public member. We are hopeful the situation will improve, but it will take time.

**Question:** I am a geriatric nurse practitioner. It is not a state law that limits my practice as much as a federal register statement that says only physicians can order home health and perform the exam necessary to admit people into nursing homes and certify people for CMS. Nurse practitioners cannot be reimbursed for these kinds of services. We have battled this for years. We can admit to hospitals, write orders in nursing homes, assess in ambulatory care settings and hospitals, but we can only do histories to admit someone into a nursing home. How does the FTC address this anti-trust thing?

**Safriet:** It is going to be extraordinarily unlikely that a federal agency such as the FTC will successfully sue another federal agency, The Centers for Medicare and Medicaid Services. Nothing prohibits you, as a nurse practitioner, from writing an order to admit someone into a long- term care facility or hospice. The question is, can you get paid? Scope of practice has three elements. Can (are you able?), May (are you authorized) and Pay (can you be reimbursed?). So, it is not your scope of practice that precludes you, it is

that reimbursement. It is inextricably linked to scope of practice, but there is huge movement underway toward removing those restrictions.

**Question:** Many of our boards are dealing with healthcare practitioners who are advertising on Groupon and offering services at a discounted price. The legal issue is whether this constitutes cost splitting.

**Safriet:** You would have to look at state law to determine this. Federal payment policies may not be exactly applicable, but the principles might apply. You could control advertising on Groupon only if it constituted unprofessional conduct. If the advertising is truthful about a legal process, you can't inhibit it. But the question as to whether fee splitting is unprofessional conduct or illegal depends on state law.

**Question:** Do you have any current information about "incident-to" billing rules so nurses can track their outcomes?

**Safriet:** This is another example of how pay is tied to scope of practice. Under some federal reimbursement policies, if a nurse practitioner, for example, provides care independently in one of the 17 states where they can do so, they will be paid 85% of the physician's fee schedule. However, if the same nurse practitioner does the same thing in a physician's practice and "incident to" the physician's services, the physician will be paid 100% of the physician's fee schedule and then, one hopes, pay the nurse practitioner something. Many people argue this has very pernicious effects, one of which is that it masks who is providing the care and what they are doing. In today's world, if you can't count it, it does not exist. So, for quality comparison purposes, it makes invisible or impossible to gather, information on who is doing what, how often, with what results, and the rest. It is only one of many ways where practitioners, especially nurses, are invisible in the data, which are ultimately used for pay, among other things. People keep trying to change this, but we still have the sustainable growth ratio issue for payment of physicians, which we haven't figured out.

**Question:** In the "incident-to" situation, if something were to go wrong with the delivery of a service, who would be subject to sanction?

**Safriet:** Potentially both practitioners. But, here's the real problem: If I were an attorney, I would sue the nurse practitioner and the supervising physician because that gives me four pockets, not two. If the physician is getting higher pay, it is ostensibly for some role in supervision. Another problem is billing fraud. If you are billing incident to a physician's services, the physician must first see a patient and issue a diagnosis. The nurse practitioner can treat subsequently, but only for that diagnosis identified by the physician in the first visit. So, if you have a nurse practitioner working and billing incident to a physician's practice and I arrive with a broken arm, the physician is likely to set my arm. If I come back the next week complaining about the cast and say, by the way, I have pink eye. The nurse practitioner offers to look at the pink eye. If there is billing for that, it is illegal because the nurse practitioner is treating an additional condition, not the broken arm. Now, is that ridiculous, or what? It is a trap for both physicians and nurse practitioners. So, there could be liability, not for malpractice, but for fraud for not complying with the specifics of the law.

# MEMBERSHIP INFORMATION

**CAC offers memberships to state health professional licensing boards and other organizations and individuals interested in our work. We invite your agency to become a CAC member, and request that you put this invitation on your board agenda at the earliest possible date.**

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

We provide the following services to boards that become members:

1) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
2) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
3) A $20.00 discount for CAC webinars.
4) If requested, a **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;
5) **Discounted rates** for **CAC's on-site training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;
6) Assistance in **identifying qualified individuals** for service as public members.

We have set the annual membership fees as follows:

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

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