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ANALYSIS & COMMENTARY

It Is Time To Restructure Health Professions Scope-Of-Practice Regulations To Remove Barriers To Care

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ABSTRACT Regulation and licensure of health professionals—nurses, physicians, pharmacists, and others—currently falls to the states. State laws and regulations define legal scopes of practice for these practitioners. Concern is growing that this system cannot support workforce innovations needed for an evolving health care system or for successful implementation of the Affordable Care Act. Existing state-based laws and regulations limit the effective and efficient use of the health workforce by creating mismatches between professional competence and legal scope-of-practice laws and by perpetuating a lack of uniformity in these laws and regulations across states. State laws limit needed overlap in scopes of practice among professions that often share some tasks and responsibilities, and the process for changing the laws is slow and adversarial. We highlight reforms needed to strengthen health professions regulation, including aligning scopes of practice with professional competence for each profession in all states; assuring the regulatory flexibility needed to recognize emerging and overlapping roles for health professionals; increasing the input of consumers; basing decisions on the best available evidence and allowing demonstration programs; and establishing a national clearinghouse for scope-of-practice information.

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The implementation of the Affordable Care Act (ACA) is transforming the health care delivery system in the United States. With the ACA's new emphasis on improving population health, providers face increasing pressure to expand access to cost-effective, high-quality health care. The workforce innovations needed to implement ACA programs require an adaptable regulatory system capable of evolving with the health care environment. The health professions regulation system in place today does not have the flexibility to support change.

With the ACA's expansion of access to health

care services, there is increasing interest in scope of practice—that is, what services may be provided by which health professions under what conditions. Scope-of-practice laws limit the bounds of professional practice for many providers. According to the Scope of Practice Legislation Tracking Database, established by the National Conference of State Legislatures, nearly 1,800 practice act–related bills were proposed in the United States between January 2011 and December 2012; of these, almost 350, or 20 percent, were adopted.¹ The Institute of Medicine, National Governors Association, and major consumer groups are now weighing in on scope-of-

practice issues, with reports and policy positions highlighting scope-of-practice laws' impact on health care access, quality, and cost and advocating for updating these laws.²⁻⁴ For example, the National Governors Association specifically outlined how states could expand access to care by easing scope-of-practice restrictions and modifying reimbursement policies for nurse practitioners, enabling them to play a greater role in meeting increased primary care demand.³

What Is Scope Of Practice?

The term *scope of practice* generally describes what type of services a member of a health profession can provide. However, it is important to distinguish between professional scope of practice and legal scope of practice.

Professional scope of practice, often referred to as professional competence, is a profession's description of the services that its members are trained and competent to perform. Professional competence evolves over time as health professions integrate new developments into the clinical practice, expanding the body of knowledge and skills for that profession.

Legal scope of practice refers to state laws and regulations that define the services that may and may not be provided by members of each profession. The regulation of health professions in the United States falls to the states, and state-specific practice acts are key to this regulatory responsibility. Practice acts—for example, the Medical Practice Act of Oregon or the Florida Nurse Practice Act—are passed by state legislatures to grant professionals the authority to provide care to patients such as diagnosing disease, treating illness, or prescribing medications, which would otherwise be against the law. These acts and their associated regulations also delineate qualifying education and training, licensure, supervision, and disciplinary processes.

Although legal scope of practice and professional competence are closely related, the amount of overlap varies by profession and by state. For example, dental hygienists are trained and competent to administer local anesthesia, but legal scopes of practice in some states do not allow dental hygienists to provide this service.

The Affordable Care Act And Team-Based Care

The ACA creates some specific scope-of-practice challenges and opportunities for the health professions. Its provisions aim to enroll an estimated thirty million Americans in health insurance beginning in 2014, which would greatly increase

demand for health care services. As the new insurance exchanges are launched, a prevailing concern among health care providers and payers is that the current supply of health care workers may be insufficient to meet the anticipated demand for health services.

Increasing supply is an obvious strategy to meet the higher demand. However, expanding educational programs to train new professionals is a costly endeavor, and for some professions, such as medicine, the time it takes to train a new professional is too long to meet immediate needs. An alternative approach is to make better use of the existing health workforce through legal scopes of practice that are based on professional competence.

The ACA supports innovative ways to organize and deliver care. One example is the demonstration grants available for accountable care organizations and patient-centered medical homes. An element central to these two models is the use of multidisciplinary teams that can improve patient outcomes and promote the optimal use of health resources.⁵ Team configurations are based on the needs of the patient population and the practice size and type. Primary care teams, for example, can include physicians, nurse practitioners, physician assistants, registered nurses, social workers, dietitians, licensed practical nurses, medical assistants, or community health workers.⁶

Effective care involves a team's shared responsibility for a patient, including some role overlap. For example, to draw blood for testing, a care team might rely on its registered nurse, phlebotomist, or medical assistant—all of whom have this skill. Legal scopes of practice often inhibit the multidisciplinary collaboration and role overlap seen in these new models.⁷ Current laws may either prohibit the person from providing the service he or she was trained to perform or contain outdated supervision rules that are neither practical nor necessary. An example is a requirement in sections 2069–71 of the California Business and Professions Code that doctors and selected other professions—but not registered nurses—may supervise California medical assistants.

Broader Issues With Health Professions Regulation

Beyond the immediate ACA implications, the current US approach to health professions regulation limits the best use of the health workforce. Problems include mismatches between professional competence and state-specific legal scopes of practice for some health professions, lack of uniformity in legal scopes of practice across states for some health professions, limit-

Changes to legal scope of practice require legislative and regulatory action, which is frequently slow, adversarial, and costly.

ed flexibility to support overlapping scopes of practice across health professions, and the slow and often adversarial process for changing state-specific scopes of practice.

The concept of enabling all health professionals to practice at their full level of competence is vital to the success of innovations driven by the ACA. Advances in health science and research often result in new approaches to diagnosis and treatment. Health professions education programs routinely modify their curricula to integrate new information and teach new skills. The development of increasingly capable technology has allowed additional health professionals to provide more complex services. For example, automated laboratory equipment now permits technicians and assistants to safely and accurately conduct much of the testing that was previously reserved for higher-level laboratory professionals, such as clinical laboratory technologists. However, state laws that fail to acknowledge these changes in professional competence limit health professionals' practice relative to their knowledge and skills.

Another issue with the current health professions regulation system is state-to-state practice variation for some health professions. For example, nurse practitioners' ability to safely diagnose, treat, and prescribe—services that were traditionally reserved for physicians—has been well documented in the research literature.⁸ However, only one-third of the states have granted nurse practitioners full authority to provide such services, while the majority of states place limits on their practice.²

Examples of state-to-state variation in legal scopes of practice are prevalent. Optometrists in Oklahoma and Kentucky are authorized to provide some laser surgical treatments to patients, while optometrists in other states are not permitted to provide any type of laser sur-

gery.⁹ Clinical psychologists in New Mexico and Louisiana have authority to write prescriptions, but no other states allow clinical psychologists to prescribe medication.¹⁰

In some instances, health professionals are recognized in certain states but not in others. For example, dental therapists are licensed to practice in Minnesota but are not recognized in neighboring North Dakota. Such variation is especially problematic for health service systems that are multistate or that use out-of-state telemedicine providers in service delivery.¹¹

State-to-state scope-of-practice variation does provide research opportunities and policy laboratories. Researchers have found that states with the least restrictive scope of practice for nurse practitioners experienced the largest increase in the number of patients seen by nurse practitioners in primary care practices during recent years.¹² Another study found that the frequency of routine checkups increased and quality of health care improved in states that allow nurse practitioners to practice more autonomously.¹³

Overlapping scopes of practice would be more common if there were greater recognition that people from different health professions can be educated to safely perform some of the same tasks. Achieving greater scope-of-practice overlap is sometimes challenging when it involves delegation of tasks. For example, physicians and registered nurses, among others, may share legal responsibility for the services provided by other health workers whom they supervise.¹⁴ Lack of clarity and consistency in regulations about delegation and liability adversely affects efforts to increase scope overlap, including, for example, home health aides administering medication and medical assistants giving flu shots.¹⁵

Changes to legal scope of practice require legislative and regulatory action, which is frequently slow, adversarial, and costly. The process often becomes a turf war between groups with unequal resources. Incumbent professions with more resources for advocacy can overpower emerging professions with more modest means. This scenario routinely occurs in state legislatures, despite clear evidence of the safety and quality of services provided by the emerging profession. These adversarial processes can also contribute to animosity between professionals who are ultimately expected to work together, regardless of the outcome of proposed legislation.¹⁶ Alaska's use of dental therapists to help address high oral disease rates and insufficient numbers of dentists prompted the American Dental Association—which represents dentists—to file an ultimately unsuccessful lawsuit against the state and tribal governments.¹⁷ When mem-

1,800

Practice acts

Between January 2011 and December 2012, nearly 1,800 practice act-related bills were proposed in the United States. Of these, almost 350 were adopted.

bers of one profession see members of another as the opposition, team-based practice models are harder to implement.

These issues stem from the challenges of fitting today's health professional practice into an outdated regulatory scheme, which typically authorizes one profession to provide a specified list of services while simultaneously prohibiting all other professions from providing those services. This approach inhibits efforts under way to use team-based models of care effectively by enabling overlapping scopes of practice.

Policy Reforms To Strengthen Scope-Of-Practice Decision Making

The success of efforts to transform the health care delivery system and improve population health requires a workforce that is capable of adapting to new roles and responsibilities in emerging service delivery models. As noted by the Institute of Medicine,¹⁸ the health professions regulatory environment must foster innovation in organizational arrangements, staffing, and work relationships to achieve these goals.

The following recommendations relate to both the process and the content of scope-of-practice decision making. Together they could enhance states' efforts to support the development of the workforce needed to provide high-quality, cost-effective health care.

Many of these recommendations are not new. There have been long-standing concerns with the regulation of health professions in the United States, with numerous calls for reforms to the system.^{19–22} Consequently, these proposed recommendations reflect the thinking of many experts who have studied the system and have identified reforms that are most likely to improve the effectiveness of scope-of-practice decision making. The pace of health system reform under the ACA adds a sense of urgency to the need for regulatory reform today. Without regulatory reform, the United States may not have the workforce—in terms of numbers or competence—needed to transform care.

ALIGN SCOPES OF PRACTICE WITH PROFESSIONAL COMPETENCE States could improve access to health services and lower costs of care by adopting standard scope-of-practice laws based on professional competence.^{23–25} As an example, growing demand for primary care providers points to an immediate need for nurse practitioners, physician assistants, and nurse midwives to practice to the full extent of their professional competence. Yet some state scope-of-practice laws limit how these professionals can practice. Revising those laws to remove practice barriers would unlock the potential of

these providers. The resulting harmonization of such profession-specific scopes of practice across all states could increase access to primary care services, facilitate geographic mobility of health professionals, and ease burdens on providers whose service delivery systems cross state borders or who provide telehealth services.

Many professions, including physical and occupational therapy, pharmacy, and social work, have developed “model” practice acts that are either exemplary existing state practice acts or ideal practice acts based on professional competence. States could use model acts as guides to align practice authority with competence. They could adopt such models on their own or be encouraged to do so through federal action.²⁶

ADOPT REGULATORY FLEXIBILITY TO ACCOMMODATE NEW ROLES The political nature of legal scopes of practice—which include practice acts passed by state legislatures and regulations developed by state regulatory boards and agencies—prohibits easy updating that can reflect professional advancements. However, the health care system is undergoing transformation, and many of the factors that drive change require more efficient ways to deliver needed services.^{23–25,27} Health professions education and training are also evolving, incorporating advancements in the delivery of health services. There is a need to develop new ideas and regulations around scope of practice to support the ongoing changes and ensure that the system in place around scope of practice is flexible enough to accommodate the new models of delivering care and the new roles for all providers on the team.

RECOGNIZE AND ACCOMMODATE OVERLAPPING SCOPES OF PRACTICE Few professions can claim exclusive ownership of any set of health care services. As the use of multidisciplinary teams in primary care service delivery increases, it is critical to recognize the value of overlapping professional competencies to the effective and efficient functioning of professional teams. Unfortunately, the state-based health professions regulatory system is profession specific, making it ill suited to support overlapping scopes of practice.^{23–25,27}

An innovative approach to health professions regulation is the model in place in Ontario, Canada, since 1993. Ontario's Regulated Health Professions Act uses a framework to regulate “controlled acts”—that is, actions of health professionals with the potential to do harm—instead of to regulate profession-specific tasks. The framework includes provisions for delegation and professional liability. This flexible approach to regulation has resulted in increased scope overlap across health professions.⁷

INCREASE PUBLIC ENGAGEMENT Perhaps one

Compelling evidence of the positive impacts of expansions in scope of practice can be found in states that have already permitted them.

of the biggest criticisms of the current health professions regulation system is that it is less focused on public protection and more focused on professional self-interest.^{23–25,27} One way to address this concern is to increase the participation of consumers in health professions regulation generally and scope-of-practice decision making specifically.

Although it is not uncommon for consumers to be included in the membership of health professions boards, their numbers are typically quite small. The Ontario model for health professions regulation requires that the body of reviewers that makes recommendations regarding new or revised scopes of practice be made up entirely of members of the public—that is, people who are not health professionals. This approach, which has now spread to several other Canadian provinces, ensures opportunities to present the public perspective on issues of cost, quality, and access to care that can inform regulatory decision making.²⁸

USE BEST AVAILABLE EVIDENCE Some states require in-depth policy analyses when practice act legislation is under consideration. These analyses can include evidence of professional competence; assessment of gaps between supply of health care professionals and demand for care; and research about potential alternatives, anticipated costs, and benefits to the public.²⁹ For example, Washington State is conducting analyses of proposed scope-of-practice changes or clarifications for licensed midwives, chiropractors, and diabetes educators.³⁰

It can be challenging to furnish proof of competence in a new skill or for a new category of worker in a state where it is not legally recognized. However, evidence may be available from other states that previously supported the scope modification or recognized a new category of worker.

CONSIDER DEMONSTRATION PROGRAMS Creating opportunities to test new approaches to health service delivery in time-limited pilot projects is crucial to a better understanding of the safe and effective use of the health workforce.²⁵ Rigorous evaluations of these projects' outcomes are essential to informing decision making in the sponsoring state and in other states.

California's Health Workforce Pilot Projects program has been operating since the mid-1970s, providing short-term waivers to existing scope-of-practice laws for testing expanded scopes in a controlled way, with a required evaluation. The majority of the more than 170 projects that were approved and completed have had positive impacts on state practice laws and regulations.³¹ The projects have resulted in expanding the legal authority of emergency medical technicians to offer lifesaving or life-sustaining care in ambulances, recognizing nurse midwives, and updating the Dental Practice Act.

ESTABLISH A NATIONAL CLEARINGHOUSE In 1998 the Pew Health Professions Commission recommended establishing a national policy advisory body to research, develop, and publish national scopes of practice and monitor continuing competency standards.²⁵ The need to establish a national clearinghouse that provides broad access to up-to-date and reliable information and relevant research about emerging health professions and scope-of-practice expansions is even more critical today. There is no single place to find this information. The clearinghouse could be a valuable resource to states and could inform their decision making.

Compelling evidence of the positive impacts of expansions in scope of practice on quality, cost, and access can be found in states that have already permitted them. Despite this evidence, state legislatures have failed at times to update scope-of-practice laws. Recently, a bill to remove outdated physician supervision requirements for nurse practitioners in California failed.³² Broader access through a clearinghouse to relevant national- or state-level research and information could exert pressure on legislators to take appropriate action.

Conclusion

The success of ACA initiatives that expand access to health care services requires a workforce capable of working efficiently and effectively in team-based models of care. The state-based system for health professions regulation as it operates today is not well suited to supporting the necessary transformation of the workforce. Policy reforms are urgently needed to transform

scope-of-practice laws and regulations into flexible instruments that can enhance health and health practice in the twenty-first century. The reforms include greater consistency between legal scopes of practice and professional competence for all health professionals across all

states, more consumer input into decision making, increased regulatory flexibility to support scope-of-practice changes, and broader access to relevant research and information to support reformation of scope-of-practice policy. ■

NOTES

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