

Why Consumers Need to be Involved in Scope of Practice Reform

Points to Consider

Are you aware that 1 in 5 Americans is affected by shortages of primary care providers?

According to the federal government, 65 million people live in “health provider shortage areas.” In other words, 1 in 5 Americans finds it difficult if not impossible to see a doctor for preventative care, treatment of minor health problems, and even treatment of serious illness. Some residents in rural areas have to drive over 100 miles to see a doctor. Those who are unable to obtain primary care may develop more serious illnesses and seek treatment in hospital emergency rooms, which results in longer waiting times for other patients and higher health care costs for all of us. Federal health care reform will bring insurance to millions more Americans and thus increase demand for services. To meet this demand, it will be necessary to use the entire health care workforce more efficiently and effectively.

Do you know that many health care providers are trained and willing to help meet this need, if only they were permitted to do so?

Aside from physicians and dentists, many other health care providers are ready to step up and meet the growing demand for medical care. Based on 2008 estimates, there are 158,348 nurse practitioners, 34,821 nurse anesthetists, 18,492 nurse midwives, 74,800 physician assistants, 185,500 physical therapists, 152,000 psychologists, 49,100 chiropractors, 34,800 optometrists, 174,100 dental hygienists, 269,900 pharmacists, 104,500 occupational therapists, 105,900 respiratory therapists, 12,200 podiatrists, and 119,300 speech-language pathologists, just to mention a few of the professions in the “non-physician” health care workforce. There is a total of 1,308,261 professionals in just these fourteen specialties, greater than the total number of doctors and dentists, which was only 803,300 (661,400 physicians and surgeons, 141,900 dentists) in 2008. Many of these 1+ million professionals are prepared to undertake greater responsibilities to help meet the access needs of many Americans who will require medical care over the next few years, if allowed to do so by state policymakers.

Why are we not relying more on “non-physician” professionals to give patients more options and provide more types of services, especially given the shortage of primary care physicians?

Health care professionals are regulated by the states in which they practice. State legislatures determine the requirements one must meet to be licensed to practice a particular health care profession and the rules one must follow when providing patient care. These laws are known as “Practice Acts.” These acts are enforced by licensing boards, which are made up of members of the regulated profession(s), and representatives of the public. Licensing board members are

typically appointed by the state governor. In addition to enforcing the practice act, licensing boards adopt rules and policies that spell out in more concrete terms the meaning of the practice act and other legislation enacted to govern the professions.

One important piece of legislation that health professional licensing boards are empowered to implement through rulemaking is Scope of Practice (SoP) laws that govern which professions can do what to whom, in what settings and under what circumstances. Originally these rules were designed to protect the public (so optometrists don't provide physical therapy, for example), but they have become outdated and are often unnecessarily restrictive, given changes in the education and training of non-physician providers and changes in thinking about the most sensible ways to deploy the health care workforce. Each health profession has a financial interest in how scope of practice laws are written both for their own profession and for professions considered competitors. As a result health professions invest heavily into lobbying state legislatures to make decisions favorable to them, and the state legislatures often make decisions based on which profession has the most effective lobbyists, rather than what is most consistent with the best interests of health care consumers.

Why would SoP laws prevent health professionals from being able to provide services that they are qualified to provide?

As professions evolve and adopt new techniques and technologies education, training, and licensure requirements change accordingly. But SoP laws in many states have not kept up. For example, pharmacy practice has expanded to include much more than dispensing medications. Many pharmacists are currently trained in "disease management" of chronic conditions such as diabetes and heart conditions and other services, such as administering vaccines. Pharmacists also are skilled in recognizing the potential for unwanted adverse interactions between a patient's medications. Moreover, state and federal regulations require pharmacists to counsel patients on how to properly take medications and answer questions. State SoP laws either permit or restrict the ability of pharmacists to practice to the full extent of their training. That is, some states allow pharmacists to engage in disease management or administer flu shots and other states do not. Some states allow pharmacists to prescribe medications; others do not.

Another example involves dental hygiene. Some state SoP laws permit licensed dental hygienists to go to long-term care facilities to clean residents' teeth. Some states permit dental hygienists to practice independently in public dental clinics. However, most state SoP laws do not allow dental hygienists to practice outside of a dental office where the supervising dentist is physically present. It is hard to explain why dental hygienists are qualified to deliver services independently in one state but not another. It is also hard to understand why dental hygienists are permitted in some states to practice independently in a public clinic, but not in a long-term care facility, an outpatient center, or a retail mall.

Has having to get a referral from a primary care physician ever interfered with your ability to get timely and affordable care from a specialist?

Some states require patients to get a referral from a primary care physician (or occasionally another primary care provider) prior to seeing another health care provider, such as a physical therapist (PT). Getting the referral can involve expense, inconvenience, and potentially harmful delay in receiving needed therapy. Obtaining a referral can be especially difficult for residents of rural areas where primary care practitioners are in short supply.

For example, if you were to strain your arm playing tennis, wouldn't you want the option to go to a physical therapist as soon as possible to get help regaining full use of that arm? In some states you would first have to schedule an appointment with a primary care physician to obtain a referral for physical therapy. You may have to wait days or weeks until the doctor can see you, and the delay could impact your chances of a successful and speedy recovery. You would likely need to take time off from work to attend the appointment. At the doctor's office, you may have to fill out paperwork, go through a number of physical and lab tests, and make co-pays or other out of pocket payments your insurance doesn't cover. Also, the referring physician (or other primary care provider), while earning income from the office visit, incurs a cost in terms of time that could be spent with more needy patients. Thus, having to obtain a referral may not only burden patients needing physical therapy, but also may limit access to care for all consumers in the state.

What is the difference between Direct Supervision, Collaborative Practice Agreements, and Independent Practice?

State laws define several relationships between physicians and dentists and other health care providers. The most restrictive is *direct supervision*. Direct supervision requires that a physician (or dentist) be physically present to oversee the services being provided by a non-physician health care professional, such as a physician assistant (or dental hygienist). *Indirect supervision* is somewhat less restrictive in that it requires a physician (or dentist) be present in the building, but not necessarily in the room where the non-physician health care professional is providing services.

General supervision or *collaborative practice agreements* do not require the physician (or dentist) to be in the same building or even in the same city as the health care professional providing services to patients. Under these arrangements, the supervising professional signs an agreement with the supervised health care provider to monitor, review and/or advise (depending on specific legal requirements) on the care provided by the supervised professional and concur with or challenge the chosen course of treatment for specific patients. These arrangements also sometimes specify which services the supervised practitioner is allowed to provide or the medications he or she is allowed to prescribe. Sometimes these arrangements

are called independent practices because the physician (or dentist) is not present when services are provided and the non-physician provider makes most day-to-day decisions about patient care. The least restrictive regulatory arrangement for health care professionals is *autonomous independent practice*. Unlike general supervision or collaborative practice agreements, autonomous independent practice does not involve any oversight over or confirmation of decisions made by the non-physician who makes all diagnostic assessments and treatment recommendations based on his or her own judgment.

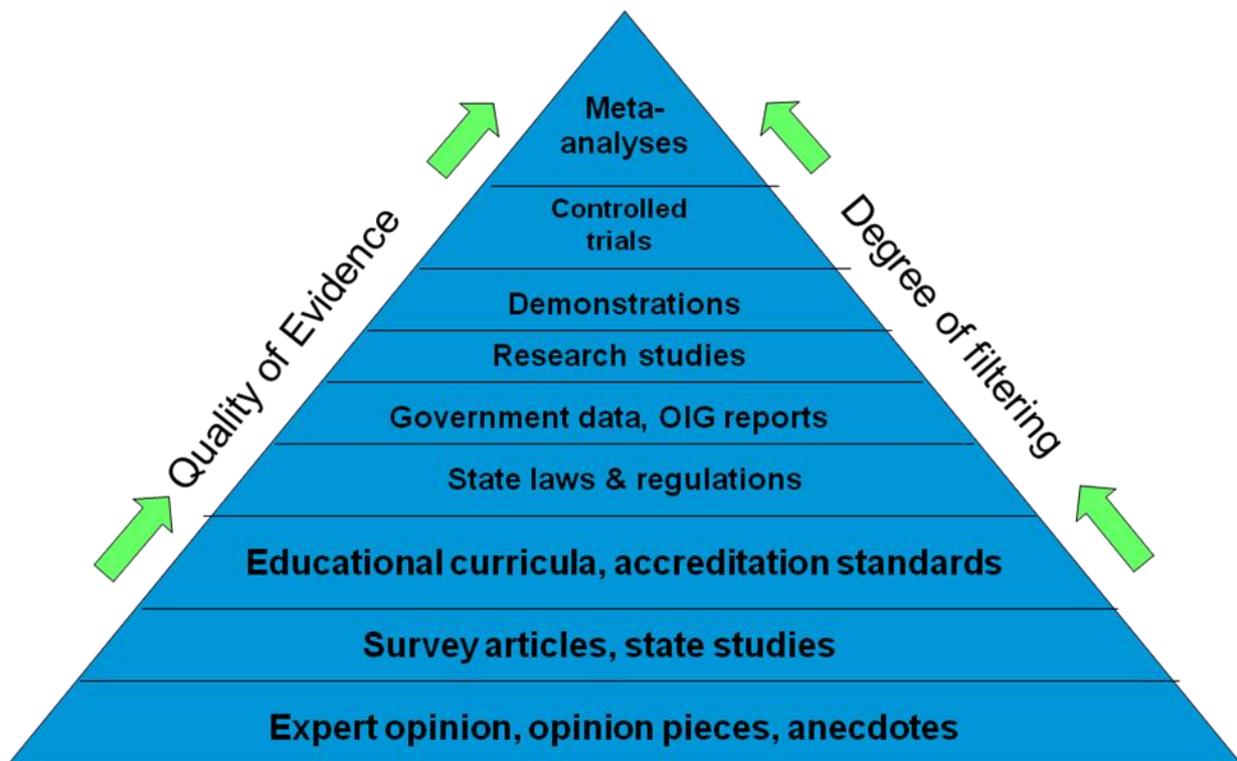
How do these different requirements affect the care available to you?

Unjustified scope of practice restrictions that prevent non-physician providers from practicing to the full extent of their training and skills interfere with patient access to quality affordable health care services. When advanced practice nurses, physician assistants, physical therapists, pharmacists, psychologists, and other non-physician professionals are prevented from practicing to their full capacity by unnecessary restrictions on their scope of practice, or unnecessarily burdensome supervision requirements, patients and their insurers incur unnecessary costs. This one of the reasons we have seen such a growth in retail clinics because they address both access and cost concerns.

What does it mean for scope of practice decisions to be *evidence-based*?

In many of CAC's publications, as well as other literature on this subject, you will encounter references to evidence and recommendations that scope of practice decisions be *evidence-based*. This notion is based on the principle that scope of practice decisions should be made based on the demonstrated ability of various health care professions to deliver services safely and effectively and that some professions will have overlapping scopes of practice. The opposing concept holds that if one health care profession can deliver a certain service or category of services, then no other profession can deliver the same services. The concept of "exclusive scopes" is concerned with economic and political benefits for one profession over another, rather than with what is in the best interest of consumers.

In evaluating whether a profession has demonstrated the ability to perform a certain service or type of services there is a variety of different types of evidence that policymakers can consider, including research studies, government reports, expert opinion, surveys, and laws and regulations in other states, among others. Some of these types of evidence are stronger than others. Catherine Dower of the Center for the Health Professions at the University of California, San Francisco has developed an *Evidence Pyramid* to help guide consumers and decision-makers in evaluating the different types of evidence available for different professions:



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Currently, many professions are unable to point to a significant body of evidence from the civilian health care system in the US that would fall within the top levels of the *Evidence Pyramid*, primarily because researchers cannot study the safety and efficacy of practices that are currently illegal under state scope of practice laws and regulations. However, there is top-level evidence pertinent to a number of professions that comes from overseas and federal health programs, including the VA, the Military Health System, and the Indian Health Service. Also, some professions, such as advanced practice nurses and dental hygienists, can cite significant amounts of high-quality evidence from the states where these professionals have been allowed to practice independently.

Will reforming SoP laws improve access to care by resulting in a more efficient use of the healthcare workforce?

Reforming scope of practice laws and regulations is the essential first step toward empowering non-physician health care providers and improving consumer access to care. Once scope of practice laws have been modified to enable professionals to practice to the full extent of their training and to allow new models of care to emerge, it will be necessary to address other barriers in the way of professional empowerment and consumer access to care. These include reimbursement policies, insurance practices and regulations, organizational policies, and educational opportunities, among others.

What can you do to ensure that quality, affordable health care is available from non-physician providers in your state?

First, familiarize yourself with the situation in your state. Find out what services SoP provisions in your state's Practice Acts allow and don't allow non-physician professionals to provide and under what circumstances. Find out about SoP bills pending in your state legislature or rule making proceedings scheduled by health professional licensing boards.

Do some research to help you evaluate whether the SoP restrictions in existing law or in pending legislation or regulation appear to be reasonably justified. Resources you may want to consult include publications available on CAC's Web site (www.cacenter.org). These publications include *Reforming Scopes of Practice: A White Paper*, *Reforming Scopes of Practice: Empowering Non-Physician Providers To Meet The Health Care Needs Of Consumers And Communities – A Toolkit* (for advocates and decision-makers), and FAQs relevant to specific professions. Check the Web sites of professional organizations for different health professions to see what they say about the issues, and go to your local library to search for additional information about the content and impact of SoP laws.

If you conclude that the SoP laws or regulations in your state may be too restrictive, ask your elected officials and appointed regulators to explain the reasoning behind the restrictions. Ask whether they took into consideration the impact of the restrictions on your and other consumers' access to and choice of care. Ask if they considered the experience with the quality of care in other states where there are less restrictive scopes of practice for the profession under consideration.

Make your position known at legislative hearings and rule-making proceedings. If you belong to a consumer or citizen organization encourage its members to get involved. Discuss the subject with friends, family members, and colleagues. Make them aware of the impact scope of practice laws have on the access to care in your community.

Help raise the awareness of other consumers in your state. Try to find people who have received good care from a nurse practitioner, a physician assistant, a physical therapist, a dental hygienist, a psychologist, a podiatrist, a clinical social worker, an optometrist, a chiropractor, a nurse anesthetist, a nurse midwife, an occupational therapist or any other non-physician provider send their stories in to your local newspaper, TV news network, or a blog dealing with health care issues in your state. Also, you can write op-ed pieces for your local newspaper and post comments on blogs.

This publication was produced by Citizen Advocacy Center (CAC). For questions, comments and further information please contact CAC at davidswankin@cacenter.org.