

# CONSIDERING THE FUTURE OF HEALTH CARE WORKFORCE REGULATION

*Responses from the field to the*

*Pew Health Professions Commission's December 1995 report*

## REFORMING HEALTH CARE WORKFORCE REGULATION

*Policy Considerations for the 21st Century*

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## BACKGROUND

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Established in the spring of 1989 by The Pew Charitable Trusts, the Pew Health Professions Commission is charged with assisting health professionals, workforce policy makers and educational institutions to respond to the challenges of the changing health care system. Recognizing that health care workforce reform must also include regulatory reform, the Pew Commission assembled a Taskforce on Health Care Workforce Regulation in the Summer of 1994 to identify and explore how regulation protects the public's health and to propose new approaches to health care workforce regulation to better serve the public's interest.

In exploring many important aspects of health care workforce regulation, the Taskforce identified ten specific issues for the focus of deliberations. These issues were identified as crucial elements of health professions regulation needed to serve the public's interest:

- Regulatory terms and language
- Entry-to-practice requirements
- Professional titles and scopes of practice
- Professional boards and their functions
- Information for the public about practitioners and regulation
- Collecting data on the health care workforce
- Assuring continuing professional competence
- Filing complaints against practitioners and the disciplinary system
- Evaluating regulatory effectiveness in protecting the public
- The various organizations and contexts impacting professional regulation.

In deliberating about these issues and setting forth ten recommendations for regulatory improvements, the Taskforce based its work on a set of principles and vision for health care workforce regulation that they believed would best serve the public's interest. The Taskforce believed that regulation of the health care workforce would best serve the public's interest by:

- Promoting effective health outcomes and protecting the public from harm;
- Holding regulatory bodies accountable to the public;
- Respecting consumers' rights to choose their health care providers from a range of safe options;
- Encouraging a flexible, rational, and cost-effective health care system that allows effective working relationships among health care providers; and
- Facilitating professional and geographic mobility of competent providers.

With these principles, the Taskforce's vision for state regulation of the health care workforce is one that is *S.A.F.E.*:

- *Standardized* where appropriate;
- *Accountable* to the public;
- *Flexible* to support optimal access to a safe and competent health care workforce; and
- *Effective* and *Efficient* in protecting and promoting the public's health, safety and welfare.

After 14 months of deliberations, the Taskforce released their findings and recommendations in a report entitled *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century* in December 1995. The report put forth ten recommendations for reform and offered policy options for state consideration under each recommendation as a way of stimulating debate and discussion on each of the issues. The ten recommendations made by the Taskforce are as follows:

**RECOMMENDATION 1** States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.

**RECOMMENDATION 2** States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.

**RECOMMENDATION 3** States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.

**RECOMMENDATION 4** States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.

**RECOMMENDATION 5** Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.

**RECOMMENDATION 6** Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.

**RECOMMENDATION 7** States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.

**RECOMMENDATION 8** States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.

**RECOMMENDATION 9** States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.

**RECOMMENDATION 10** States should understand the links, overlaps and conflicts between their health care workforce regulatory systems and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.

## A YEAR OF DEBATE AND DISCUSSION

The Commission, endorsing the Taskforce's vision, principles and the need for regulatory reform, invited ongoing discussion of the recommendations and policy options presented in the report. To date, some 9,000 copies of the report and 15,000 copies of the executive summary brochure have been disseminated. In addition, the Taskforce and its staff conducted a speakers' bureau presenting the report and its recommendations to key stakeholders across the country throughout 1996. This speakers' bureau worked to engage key constituents in debate and discussion about the issues and recommendations of the Taskforce as well as provided an opportunity to track feedback and responses from the professional, regulatory and other communities.

In 1996, 125 formal presentations were made to many diverse organizations, reaching more than 17,000 individuals. In addition to this active discussion, the Commission and Taskforce invited written responses to the report throughout the year. Responses were solicited from state legislators, regulators, the professions, consumers, and the health care community in general (*see Appendix I for the response solicitation that was mailed with each report*). Respondents were asked to react to the vision and principles set forth by the Taskforce, as well as the ten recommendations and policy options. In addition, respondents were asked to offer alternative suggestions for improvements, explore barriers and opportunities for reform, and highlight any activities to improve current regulation. In order to keep this process open and encourage continued discussions, these responses in their entirety were placed on the UCSF Center for the Health Professions website in early 1997 (<http://futurehealth.ucsf.edu>).

The Taskforce staff received 76 formal written responses (*a listing of the responding organizations is included in Appendix II*). In addition, 16 informal responses, such as phone calls, e-mail correspondence and letters were also tracked. Although these informal responses and the speakers' bureau responses were helpful throughout the year, this report focuses only on the formal responses submitted to the Taskforce.

Table I shows the distribution of formal respondents by group. Thirty-four responses, or 45 percent, were from the nursing community, including boards of nursing, and state and national nursing associations. Twenty responses, or 26 percent, were from individuals not representing a specific organization or profession, and 22 responses, or 29 percent, were from a variety of "other" stakeholders. The majority of the responses (59 percent) were representative of a single state, 36 percent having national representation, four percent representing an interstate organization or coalition, and one percent with an international affiliation (Thailand).

**TABLE I – Distribution of respondents**

Respondent	Number	Percentage
Nursing	34	45%
Individual	20	26%
Other	22	29%
- Physical Therapy	3	-
- Occupational Therapy	2	-
- Pharmacy	2	-
- State Regulatory Agency	2	-
- Interprofessional Groups	2	-
- Health Facility	2	-
- Education	1	-
- Acupuncture	1	-
- Dental	1	-
- Medicine	1	-
- Chiropractice	1	-
- Social Work	1	-
- Optometry	1	-
- Nuclear Medical Technology	1	-
- Health Related Organization	1	-
<b>Total</b>	<b>76</b>	<b>100%</b>

## REVIEWING THE RESPONSES FROM THE FIELD

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The Taskforce staff engaged an outside consultant (*see page 35 for biosketch*) to review and score each formal response report. A database was established to record the responses and to aid in the aggregated analysis. Although an outside reviewer was employed to analyze the individual responses, the subjective nature of the scoring process should be noted. The responses were analyzed and scored in the following manner as can be seen in Table II:

- The reviewer analyzed responses to each of the ten recommendations and its associated policy options for *level of concern*. A *high*, *medium* or *low* score was given based on the importance or value of the issue as indicated by the respondent. For example, a response that was supportive of a particular recommendation or policy option, but which did not view the overarching issue as important or pressing, would receive a *low level of concern* score.
- The responses were also rated for *level of support* for each of the ten recommendation areas. A judgment of either *support* or *challenge* was made based on whether the respondent generally supported or challenged each recommendation and its policy options. In some cases, respondents were supportive of the general recommendation but opposed to one or more specific policy options, or visa-versa. As a result, some responses were deemed *indeterminable* due to contrasting opinions or remarks made by respondents within one recommendation area. In some cases, specific recommendations or policy options were not addressed at all (N/A).
- Finally, a summary score was given to each issue based on the highest aggregate score received for *level of concern* and *level of support* for the recommendation.

## THE GENERAL TONE OF THE RESPONSES

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In general, the respondents were more supportive of the report's message than challenging of it, acknowledging that the regulatory system was cumbersome and could use improvement. Some respondents expressed only their general opinions about regulation, rather than focusing on the report's specific contents. Many respondents applauded the Taskforce and Commission for illuminating a controversial and complex issue and making it an important health policy topic.

Those who challenged the report, however, tended to voice their opinions more strongly and in greater depth. Specific comments focused on challenges to recommendations and policy options or to the Taskforce itself. Some respondents found the Taskforce to be naïve in many of its statements about the current state of regulation and felt affronted by the lack of recognition for their historical successes in regulating the professions and for recent work to improve the status quo. In addition, some found that

the Taskforce was not representative of their specific professional area. Many respondents felt that recommendations were laudable yet failed to provide adequate information on how to go about implementing and financing such reforms.

Roughly two-thirds of the respondents expressed a desire for outcome studies with which to judge the potential implications of the recommendations and policy options. Many respondents advocated for the education of the public regarding regulation of the health care workforce and any proposed reforms. Managed care was seen as either an impediment or a ready facilitator of some of the recommendations. About one-third of the respondents proposed a national approach to health care workforce regulation rather than a state orientation. Finally, the two most often articulated challenges to regulatory reform identified “institutional licensure” and the use of unlicensed assistive personnel as threats to public safety.

<i>... delivering nursing care in an increasingly corporatized and market-driven environment ...jeopardizes quality.</i>	Response scores indicate that the issues receiving the highest scores for level of concern were titles and scopes of practice, redesigning boards and their functions, and assuring continuing professional competence (see Table II on the following page). The lowest level of concern was found for issues regarding regulatory terms and language, and data collection. Data collection, regulatory effectiveness and the organizational contexts of health professions regulation were issues not addressed by many respondents.
<i>This environment is creating a deluge of anecdotal reports by nurses who fear for their ability to practice safely.</i> • <i>California Nurses Association</i>	Recommendations proposed to reform scopes of practice, professional boards and entry-to-practice requirements were the three most challenged by respondents. On the other hand, the recommendations proposed to assure continuing competency, reform the complaints and discipline process and standardize entry-to-practice requirements were strongly supported. Scores indicate the most support from respondents for recommendations to standardize regulatory terms, collect data, and evaluate regulatory effectiveness.

Table II also reveals that issues regarding scopes of practice and board structure and function received high scores for both high level of concern and challenge to the recommendation proposed for reform. The issue of assuring continuing competency also received the highest score for high level of concern and the respondents supported the proposed recommendation to reform existing policies.



**TABLE II – Respondents' Level of Concern and Support for Issues and Recommendations**

Issue	Summary Score	Level of Concern for the Issue Area (number of respondents)				Level of Support for Recommendation (number of respondents)			
		Low	Medium	High	N/A	Support	Challenge	Indeterminable	N/A
Standardizing regulatory terms	Low concern Support recommendation	<b>38</b>	14	7	17	<b>49</b>	4	6	17
Standardizing entry-to-practice	Low concern Support recommendation	<b>34</b>	18	11	13	<b>34</b>	<b>25</b>	4	13
Titles and scopes of practice	Medium concern Challenge recommendation	25	<b>29</b>	<b>13</b>	9	26	<b>29</b>	12	9
Redesigning board structure and functions	Medium concern Challenge recommendation	24	<b>25</b>	<b>12</b>	15	21	<b>36</b>	4	16
Information for consumers	Low concern Support recommendation	<b>32</b>	18	6	20	<b>33</b>	11	12	20
Data collection	Low concern Support recommendation	<b>35</b>	12	5	24	<b>38</b>	9	5	24
Assuring continuing competence	Low concern Support recommendation	<b>27</b>	24	<b>14</b>	11	<b>34</b>	18	13	11
Complaints and discipline	Low concern Support recommendation	<b>28</b>	21	5	22	<b>34</b>	6	13	21
Evaluating regulatory effectiveness	Low concern Support recommendation	<b>31</b>	14	3	28	<b>41</b>	5	2	28
Contexts of regulation	Low concern Support recommendation	<b>32</b>	16	1	27	<b>32</b>	7	10	27

Key: The **boxed** scores in the *Level of Concern for the Issue Area* column indicate the three issue areas for which respondents most often expressed *high* levels concern.

The **boxed** scores in the *Level of Support for Recommendation* column indicate the three recommendations which respondents most often supported and most often challenged.

The **bold** numbers in both columns indicate the highest total number of responses received. These scores correlate with the *Summary Score* column.

It is important to note that the reviewer's overall impression of the responses closely correlated to the aggregate scores as indicated in Table II with the exception of the following: for the issue regarding entry-to-practice requirements, the reviewer's impression was that the level of concern was medium as opposed to the low overall score due to the objections to specific policy options. These objections were in reaction to the possibility of lowest common denominator for baseline competency and alternative pathways to competency.

The reviewer's impression was that level of support for the recommendation to reform scopes of practice was indeterminable due to the high and nearly equivalent scores for both support and challenge. Responses to informing the public were perceived to be a high level of concern versus the low score as many alluded to the importance of informing the public when answering other recommendations or issue areas such as data collection and discipline. And finally, the reviewer's impression of concern for assuring continuing competency was a medium versus the low score received, due to the high level of support for policy change.

## RESPONDING TO THE PRINCIPLES

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**A**s stated in the Taskforce's report, the first undertaking was to articulate a set of principles upon which the health professions regulatory system should be based. The principles and vision set forth by the Taskforce became the foundation for each recommendation and policy option proposed.

*The principles are well founded,  
and the vision of the challenges that lie ahead  
are well articulated. Considering that a vision  
is a view or mind set of how the future should look,  
the Taskforce has set the groundwork for global  
and critical thinking on the issues and concerns  
confronting health care providers and society at large.*

•  
*American Nephrology Nurses Association*

In general, these principles and the vision were strongly supported, although sometimes viewed as generic or superficial. Of those respondents who commented on the principles and vision set forth by the Taskforce, the majority was supportive. Of the 71 percent responding, 35 responses were supportive, while 16 challenged one or more of the stated principles or vision for health care workforce regulation. Twenty-two of the 76 respondents, or 29 percent, failed to comment at all on the principles or vision. Response to each of the five principles was generally supportive, though mixed.

## Principles

Principle I - The Taskforce believes that regulation of the health care workforce will best serve the public's interest by **promoting effective health outcomes and protecting the public from harm.**

Principle II - The Taskforce believes that regulation of the health care workforce will best serve the public's interest by **holding regulatory bodies accountable to the public.**

Principle III - The Taskforce believes that regulation of the health care workforce will best serve the public's interest by **respecting consumers' rights to choose their health care providers from a range of safe options.**

Principle IV - The Taskforce believes that regulation of the health care workforce will best serve the public's interest by **encouraging a flexible, rational, and cost-effective health care system that allows effective working relationships among health care providers.**

Principle V - The Taskforce believes that regulation of the health care workforce will best serve the public's interest by **facilitating professional and geographic mobility of competent providers.**

I	Response Score	Number	Percentage
Support		27	36%
Challenge		6	8%
Indeterminable		2	3%
Not Addressed		41	53%

II	Response Score	Number	Percentage
Support		18	24%
Challenge		8	11%
Indeterminable		3	4%
Not Addressed		47	62%

III	Response Score	Number	Percentage
Support		16	21%
Challenge		3	4%
Indeterminable		7	9%
Not Addressed		50	66%

IV	Response Score	Number	Percentage
Support		16	21%
Challenge		9	12%
Indeterminable		2	3%
Not Addressed		49	64%

V	Response Score	Number	Percentage
Support		19	25%
Challenge		4	5%
Indeterminable		1	1%
Not Addressed		52	68%

## RESPONDING TO THE TEN ISSUES, RECOMMENDATIONS AND POLICY OPTIONS

The sections following this page will provide a summary of the general response to each of the issues, recommendations, and policy options. It will attempt to capture poignant suggestions, innovations, opportunities and actions presented by the respondents for each issue area as well as the major areas of concern or support. As with the previous section on the principles, the shaded portions of the text indicate that the language was drawn verbatim from the December 1995 report. Please see Table II above for scores regarding levels of concern and support for the ten recommendations. The tables that follow contain response scores for the policy options suggested for each recommendation.

## STANDARDIZING REGULATORY TERMS

*Adopting uniform health professions regulatory language for the public and the professions.*

### RECOMMENDATION 1

*States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses and the professions.*

This recommendation was strongly supported though concern for the issue was very low. Eighty-three percent of those addressing the issue agreed with the recommendation. However, 55 or 72 percent of respondents, scored low for level or concern or did not address the issue at all. In many cases, respondents did not address the policy options as well. Those responding to the policy options however, were generally supportive, with the most support garnered for standardizing the use of licensure, title protection and practice acts for public or state regulation.

Respondents identified costs, including time, personnel, and logistics, as the greatest barriers to achieving this recommendation. Also noted were “turf” issues and difficulty creating a standardized system that is also flexible within 50 unique states. Other issues cited included the difficulty of navigating the complex political systems in each of the state’s diverse legislatures, identifying leaders and resistance to change. The growth of managed care organizations, use of unlicensed assistive personnel and institutional licensure were also cited as barriers to achieving standardization. Many opportunities for improving current regulation were recognized by respondents. These opportunities included consumer participation in the reform process, outcomes studies, regulatory boards’ improved understanding of health care delivery settings, national guidelines, and benchmarks.

#### Policy Options for State Consideration:

1A. Use the term “licensure” for public or state regulation of health professions title protection and practice acts. Use standard language in health professions licensing statutes including reference to: title protection; practice acts; regulatory terms such as supervision and delegation; and enforcement and discipline processes and outcomes, including uniform definitions of classes of alleged offenses, and phases in and outcomes of the adjudication process.

1B. Reserve the term “certification” for voluntary private sector programs that attest to the competency of individual health professionals.

1A	Response Score	Number	Percentage
	Support	32	42%
	Challenge	2	3%
	Indeterminable	1	1%
	Not Addressed	41	54%

1B	Response Score	Number	Percentage
	Support	23	30%
	Challenge	2	3%
	Indeterminable	5	7%
	Not Addressed	46	61%

1c. Identify and convene a body to codify regulatory terms and language. States should consider models for standardizing and adopting terms such as those employed by the National Conference of State Legislatures, the National Governors' Association, or the Council on Licensure Enforcement and Regulation. This body should include representation from the regulated health professions, consumers, providers and payers of health care.

1c	Response Score	Number	Percentage
	Support	18	24%
	Challenge	3	4%
	Indeterminable	3	4%
	Not Addressed	54	71%

Respondents offered additional policy options which included studying other industries and countries such as the American computer industry and Ontario's health care regulatory system. Others suggested exploring whether the best approach to standardization is federal, national or state level reforms. Several respondents felt that standardization must be done at the national level, through governors' or legislative associations, specialty societies, professional associations, interdisciplinary collaborations, or the federal government. Respondents also commented that a national, collaborative body to codify terms should include a broad array of stakeholders including managed care organizations, payers, consumer groups, the public, and health care professionals.

There was considerable activity reported by respondents in this area. Nursing has been working in national or regional coalitions for many years, and also has national entry-to-practice exams. It was reported that Montana, Vermont and Texas boards of nursing are currently working together to standardize language while the National Council of State Boards of Nursing is working to develop a lexicon of disciplinary terms. The American Nurses Association has developed model regulations promoting standardization. Many other nursing sub-specialties also have national certification boards including perioperative and various advanced practice nurses.

There have also been efforts to standardize language regarding delegation of responsibilities to unlicensed assistive personnel. Position papers and models have been developed by the various nursing communities. Other standardization efforts include: the Model Telemedicine Act from the Federation of State Medical Boards; the National Association of Boards of Pharmacy's model practice act; the Federation of State Boards for Physical Therapy's model practice act; and national certification efforts of acupuncture and oriental medicine.

*This recommendation makes a better case for federal legislation than state legislation. A single law with common terms and implementation strategy is far more likely and efficient than the generational wait that would result while 50 states seek to enact common terms in this area.*

•  
*American Association of Neuroscience Nurses*

## STANDARDIZING ENTRY-TO-PRACTICE REQUIREMENTS

*Facilitating the physical and professional mobility of the health professions.*

### RECOMMENDATION 2

*States should standardize entry-to-practice requirements and limit them to competence assessments for health professions in order to facilitate the physical and professional mobility of the health professions.*

*Entry-to-practice requirements should be standardized based on defined curriculum, clinical education and minimum competence. There is concern that standardization could result in recommendations for lesser criteria than are currently in place. There is also concern that this recommendation ignores the individual state's right to protect the health, welfare and safety of its residents. The states may have differences of opinion in exercising their duty.*

•  
*Commonwealth of Massachusetts  
Division of Registration*

Respondents were largely supportive of this recommendation, though it was also challenged. The overall level of concern was medium-to-low, taking into account expressed concern for its policy options, especially adoption of lowest “common denominator” standards for entry-to-practice and minimum competency. Of the 83 percent of respondents who responded to this issue, 54 percent or 34 respondents, supported the recommendation overall, while 40 percent challenged it. Uniform entry-to-practice requirements and mutual recognition of licensure by endorsement received the highest support. The most challenged policy options were use of standard competency examinations to test minimum competence for entry-to-practice and use of alternative pathways in education. This option was seen as enforcing the use of the lowest level of competence for entry. Respondents feared this would backslide into inappropriate downward substitution between health personnel.

Institutional licensure and managed care organizations were most cited as barriers to standardization of entry-to-practice requirements. Opportunities cited for exploration of this recommendation included the need for outcomes data, recognition of formal professional education, streamlining endorsement processes for recognition of credentials, establishment of competency upon re-entry to a profession after an extended absence, and inclusion of a criminal record check in licensure processes.

### Policy Options for State Consideration:

2A. Adopt entry-to-practice standards which are uniform throughout the fifty states for each profession.

2B. Adopt mutual recognition of licensure by endorsement legislation, even without uniform entry-to-practice standards.

2C. Cooperate with the relevant private sector organizations and with other states to develop and use standard competency examinations to test minimum competence for entry-to-practice. In developing these standards, states should resist reliance on accreditation or examination standards which do not directly and demonstrably relate to the minimum knowledge and skills necessary for safe and contemporary practice.

2D. Recognize alternative pathways in education, previous experience, and combinations of these, to satisfy some entry-to-practice requirements for licensure.

2E. Eliminate entry-to-practice standards which are not based on the competence, skills, training or knowledge of the professional.

2A	Response Score	Number	Percentage
	Support	39	51%
	Challenge	15	20%
	Indeterminable	3	4%
	Not Addressed	19	25%

2B	Response Score	Number	Percentage
	Support	27	36%
	Challenge	16	21%
	Indeterminable	5	7%
	Not Addressed	28	37%

2C	Response Score	Number	Percentage
	Support	17	22%
	Challenge	25	33%
	Indeterminable	3	4%
	Not Addressed	31	41%

2D	Response Score	Number	Percentage
	Support	11	14%
	Challenge	19	25%
	Indeterminable	6	8%
	Not Addressed	40	53%

2E	Response Score	Number	Percentage
	Support	26	34%
	Challenge	15	20%
	Indeterminable	5	7%
	Not Addressed	30	39%

Some policy options suggested by respondents for implementation included adopting regional standards as a first step, using continuous quality improvement as a basis for ongoing improvement of standards, and using outcome measures to determine provider competency and consumer satisfaction. Accomplishments reported by respondents include the use of national entry exams for many professions such as registered nursing, licensed practical nursing, medicine, physical therapy, and pharmacy. In addition, recognition was sought for national certification programs already in place for advanced practice nursing and occupational therapy. Pharmacy reported the use of an Electronic Licensure Transfer Program (ELTP) in most states. Waivers are used for health care services provided to Olympic athletes, summer campers and low-income patients by out-of-state practitioners in Colorado, Maine, South Carolina and Texas. Professional associations, both nationally and interprofessionally, report working toward common standards for education, competency, ability and skill.



## REMOVING BARRIERS TO THE FULL USE OF COMPETENT HEALTH PROFESSIONALS

*Improving the public's access to a competent and effective health care workforce.*

### RECOMMENDATION 3

*States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the fullest extent of their current knowledge, training, experience and skills.*

*It's appropriate that expanding and changing scopes of practice should occur slowly to assure that appropriate education, training and oversight are part of that evolution. ...Who will be responsible for establishing standards for practitioners' expanded scopes of practice? ...There are no current valid measures for assessing judgment. ...Assessment, evaluation and judgement are critical components that cannot be delegated. Protecting the public from less than quality health care by encouraging too much responsibility in the hands of those less than completely trained must be avoided.*

•

*Federation of State Medical Boards*

This recommendation received one of the highest scores for level of concern and was also one of the most challenged. Though the majority of respondents scored “medium” for level of concern, it also received the second highest score for “high” level of concern. This recommendation was also one of the most difficult to score as comments often supported the recommendation but challenged the policy options in a contradictory manner. As a result, support for the recommendation was perceived as “indeterminable” by the reviewer. Actual scores indicate nearly equivalent scores for both challenge and support of the recommendation. Of the 88 percent responding, 43 percent or 29 respondents, challenged it and 39 percent or 26 respondents supported it. Twelve respondents, or 18 percent of those addressing this issue, were scored as indeterminable. Eliminating exclusive scopes of practice elicited the highest response rate and most controversy. Exactly two-thirds of respondents addressed this policy option scoring 44 percent supportive, 35 percent challenge and 21 percent indeterminable. The majority of respondents failed to address the policy options regarding title protection and expansion of individual scopes of practice, however those responding were largely supportive.

Respondents identified the increasing use of unlicensed assistive personnel, institutional licensing and managed care organizations as barriers to implementation. Respondents also suggested that turf battles, special interest groups, politics, and governmental reimbursement policies also act as barriers. Some opportunities however were also identified including the need for standardized regulation and limitation of scopes of practice for unlicensed assistive personnel, as well as clarification and standardization



of delegation and supervision issues. Respondents called for outcome studies to support expansion of scopes of practice, standardization of training and education for overlapping scopes of practice, and specific and targeted education of the public. And finally, respondents identified the need for periodic review and revisions for practice acts in order to purge exclusionary language.

### Policy Options for State Consideration:

3A. Eliminate exclusive scopes of practice which unnecessarily restrict other professions from providing competent, effective and accessible care. States should ensure that the training, testing and regulating of health care professionals allow different professions to provide the same services when competence – based on knowledge, training, experience and skills – has been demonstrated.

3A	Response Score	Number	Percentage
	Support	25	33%
	Challenge	20	26%
	Indeterminable	12	16%
	Not Addressed	19	25%

3B. Grant title protection without accompanying scope of practice acts to some professions. This would be appropriate for professions (e.g. massage therapy) which provide services that are not especially risky to consumers. Consumers will benefit from the assurance that the titled professional has met the state's minimum standards for initial and continuing competence.

3B	Response Score	Number	Percentage
	Support	12	16%
	Challenge	9	12%
	Indeterminable	4	5%
	Not Addressed	51	67%

3C. Allow individual professions from one profession to expand their scopes of practice with an additional service or level of service found in one or more other professional practice acts, through a combination of training, experience and successful demonstration of competency in that skill or service level.

3C	Response Score	Number	Percentage
	Support	23	30%
	Challenge	11	15%
	Indeterminable	3	4%
	Not Addressed	39	51%

Additional policy options were suggested including regionally defined scopes of practice, replicating what works for others, and piloting a program modeled after Ontario's eleven controlled acts. Many respondents also acknowledge and accept that scopes of practice do overlap. However, the increasing use of unlicensed assistive personnel was a strong concern.

## REDESIGNING BOARD STRUCTURE AND FUNCTION

*Responding to the changing expectations of the public and the health care delivery system.*

### RECOMMENDATION 4

*States should design health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.*

*There is an increased  
danger/threat to the safety  
of the public if decisions made  
by a board of established  
professionals can be amended  
or rejected by an oversight board  
largely consisting of members  
who have no knowledge of  
the profession or of what  
constitutes safe (nursing) practice.*

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*Missouri State Board of Nursing*

Though scoring low to medium for level of concern, this recommendation also received one of the three highest scores for high level of concern. It also was the most challenged issue area. The challenges can be mostly attributed to strong opposition to the formation of oversight boards and/or merged boards. Thirty-six, or 60 percent of the 60 respondents who addressed this issue challenged it, while 21, or 35 percent of those responding supported it. Most policy options to establish an oversight board or merged boards around related health service areas were strongly challenged. However, respondents support adequately staffed and financed boards.

Barriers identified to this recommendation include lack of sufficient funding to educate the public, the complexity and size of the current health care system, and turf battles among professional groups. Opportunities were seen to educate the public as well as professionals regarding the regulatory system. The need for recruitment, training and support for board members – including public members – and the need for boards to be independent and free from politics were also seen as potential opportunities for this issue area.

#### Policy Options for State Consideration:

4A. Establish an interdisciplinary oversight board which has a majority of public members. The mission of this board should be to coordinate health professions regulation to meet an explicit state health policy agenda and provide oversight to ensure that the public's best interests are served. This board should have the authority to approve, amend or reject decisions made by individual boards.

4A	Response Score	Number	Percentage
	Support	13	17%
	Challenge	32	42%
	Indeterminable	5	7%
	Not Addressed	26	34%

4B. Consolidate the structure and function of boards around related health professional or health service areas. These consolidated boards should be dedicated to consumer protection and quality assurance. Such consolidated boards, for example, might be medical/nursing care, vision health care, oral health care, rehabilitation, mental health care or health technologies.

4B	Response Score	Number	Percentage
	Support	11	14%
	Challenge	24	32%
	Indeterminable	3	4%
	Not Addressed	39	51%

4C. Develop board membership profiles that include significant, meaningful and effective public representation to improve board credibility and accountability. States should evaluate the board member appointment process to ensure that all appointments are fair and accountable to the public. All board members should be carefully recruited, well trained and supported.

4C	Response Score	Number	Percentage
	Support	6	8%
	Challenge	5	7%
	Indeterminable	2	3%
	Not Addressed	63	83%

4D. Staff and finance all boards and regulatory committees so that they can perform their missions effectively and efficiently. Support should include funding for appropriate technological needs.

4D	Response Score	Number	Percentage
	Support	24	32%
	Challenge	3	4%
	Indeterminable	5	7%
	Not Addressed	44	58%

4E. Compose boards with representatives of the state's urban, rural, ethnic and cultural communities.

4E	Response Score	Number	Percentage
	Support	10	13%
	Challenge	15	20%
	Indeterminable	3	4%
	Not Addressed	48	63%

Boards should also include representatives from the health care delivery system.

Other policy options include term limits for board members, inclusion of large purchasing organizations and insurance companies on boards, having an “expert” committee of boards with consumer representation, voluntary state-level interprofessional workgroups, development of independent health professions information organizations, and implementation of pilot studies for oversight boards. Action in this area include interdisciplinary board meetings in Texas and Minnesota and the development of the Interprofessional Workgroup on Health Professions Regulation – a group of 15 different health professions – that has been meeting to discuss regulatory issues since November 1995.

## INFORMING THE PUBLIC

*Providing practitioner information to improve board accountability  
and to assist the public in making informed decisions about practitioners*

### RECOMMENDATION 5

*Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.*

This recommendation scored a low level of concern and was strongly supported by respondents. Though there was a significant percentage of respondents failing to address the issue altogether (26 percent), the need to inform the public was raised in responses to a number of other recommendations. For this reason, the reviewer felt the level of concern for this recommendation was high. Policy options for this recommendation were also not addressed to a large degree. Those responding, however, were mostly supportive.

Barriers to achieving this recommendation as identified by respondents included increased costs, time and effort for already taxed regulatory boards. One respondent remarked that as the public becomes more educated, complaints will increase and therefore costs will increase. Other barriers were identified such as state professional associations and state laws which hamper sharing of information. One opportunity identified was the need to evaluate or assess the public's knowledge of regulation and to provide necessary information, consumer guidelines and education. Other ideas included providing profiles on health care practitioners, institutions and health systems, and the expansion of the National Practitioner Data Bank to include all regulated health care professionals.

#### Policy Options for State Consideration:

5A. Collect information about health professionals and make that information accessible and understandable to the public unless the law forbids disclosure or there is a compelling public policy reason that mandates confidentiality. The burden in disclosure decisions rests with those seeking to restrict access to information. The "compelling" criteria which prevents disclosure should be publicly available and specifically explained when an individual request is denied.

5B. Develop individual profiles for regulated health care professionals who deal directly with consumers. These profiles should include legally disclosable information about demographics, education, practice, employment, disciplinary actions, criminal convictions, and malpractice judgements.

5A	Response Score	Number	Percentage
	Support	23	30%
	Challenge	11	14%
	Indeterminable	7	9%
	Not Addressed	35	46%

5B	Response Score	Number	Percentage
	Support	16	21%
	Challenge	6	8%
	Indeterminable	1	1%
	Not Addressed	53	70%

Other policy options were suggested by the respondents in order to better inform the public. These include allowing managed care organizations to profile the professions through their panel selection process. This would require that the professions provide their profiles to boards and the public. Panels would then provide score cards and/or report cards on individual practitioners. Other respondents suggested that state interdisciplinary boards be available to inform the public as demanded on various practitioners. Respondents also identified the need to use the public's trust as a benchmarking tool, and to make legal reforms. Many respondents however, felt that they had done a good job of informing the public already. The American Nurses Association has a Nursing Care Report Card. Moreover, the Association of Operating Room Nurses has a consumer education campaign, and the many boards of nursing provide newsletters with pertinent practitioner information.

*We therefore urge...the reform and expansion of the National Practitioner Data Bank (NPDB) to include all regulated professionals. The NPDB should be accessible to the public, and the states should be required to be pro-active in informing the public about where and how credentialing and disciplinary information can be obtained and how complaints can be filed.*

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*Wisconsin Occupational Therapy Association*

## COLLECTING DATA ON THE HEALTH PROFESSIONS

*Supporting planning for an effective health care workforce.*

### RECOMMENDATION 6

*Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.*

This recommendation was one of the least addressed issues by all respondents and scored very low for level of concern. Of the 68 percent responding, over three-quarters were supportive of the recommendation, 17 percent challenged it, and ten percent were indeterminable. In addition, the two policy options were not addressed to a large degree, however those responding were supportive. Barriers most cited by respondents included the costs of data collection, idiosyncrasies in state laws that impede data sharing, lack of outcome studies, and resistance to change. Opportunities for further exploration include the need for boards to have access to workforce supply and demand data, the need for all stakeholders to share data, the need for a centralized agency for systematic data collection, the inclusion of unlicensed assistive personnel in planning, and the regulation of health care administrators.

#### Policy Options for State Consideration:

6A. Use regulatory mechanisms to collect a workforce data set to facilitate timely and informed workforce policy development. Regulatory agencies would not have the responsibility to analyze the data that they collect but, respecting disclosure and confidentiality laws, would share it with other public and private agencies.

6B. Work collaboratively with other public and private agencies that use such data for health policy planning to identify a standard health personnel data set which is comparable, compatible and accessible.

6A	Response Score	Number	Percentage
	Support	26	34%
	Challenge	11	14%
	Indeterminable	1	1%
	Not Addressed	38	50%

6B	Response Score	Number	Percentage
	Support	16	21%
	Challenge	5	7%
	Indeterminable	1	1%
	Not Addressed	54	71%

Suggested policy options provided by the respondents include looking to managed care organizations for financing data collection efforts, or even letting managed care organizations collect the data themselves. Others suggested that a national database is needed with a 50-state caucus, including consumer advocate organizations, to develop database standards. Nurses have been collecting data on the workforce and have a “Nurse Information System” in development. National associations for pharmacy and physical therapy also reported workforce studies in progress.

## ASSURING PRACTITIONER COMPETENCE

*Assessing the continuing competence of health care practitioners*

### RECOMMENDATION 7

*States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.*

*Accountability for competence in a given practice setting should rest with the professional, and the responsibility of the regulatory body should be limited to monitoring competence on a periodic basis. Assuring competence is different from ensuring competence, and both vary markedly from guaranteeing competence.*

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*American Nephrology Nurses Association*

This recommendation received the highest score for high level of concern and one of the highest scores for level of support. Most respondents did address this issue, with only 14 percent failing to comment. Of the 86 percent responding, 52 percent were supportive of the overall recommendation, 28 percent challenged it and 20 percent of responses were indeterminable due to support for some or part of the recommendation and opposition to one or more policy options.

Respondents challenged the policy option requiring all regulated health professions to periodically demonstrate competence fearing that it is not necessary and too costly to require of all practitioners. Also challenged was the suggestion to cooperate with other states to develop minimum competence testing as respondents felt this would result in the use of the lowest common denominator for minimum competence in all states.

Identified barriers to reform include the complexity of the evolving health care environment and the vast differences in various practices. These differences make standard “testing” for competence difficult as areas of expertise may not fit into standardized testing. Furthermore, though respondents generally agreed that some form of continued competency assurance was important, they struggled with how to “test” for competence and who is responsible for competency assurance. Some suggest that professional responsibility includes self-education and continued competency, others turn to employers, and others feel it is the regulatory board’s responsibility.

Other respondents noted the lack of sufficient resources and political quagmires as barriers to continued competency assurance. Opportunities identified were many, including the need to evaluate the efficacy of current continuing medical education and empirical validation or outcomes studies for relevancy of competency testing. Respondents expressed the importance of collaborative efforts between boards, educators and the health care professions, as well as the need for testing to be based on research-based practice protocols. Others saw the opportunity to look to Canada and the Ontario models of self-assessment and professional portfolios.



### Policy Options for State Consideration:

7A. Require the regulated health professionals to periodically demonstrate competence through appropriate testing mechanisms.

7A1. Competence assessment testing could be: “triggered” by a variety of markers, including for example, the number of disciplinary actions, lack of specialty or private certification, length of time in solo practice, number of procedures performed, or other state-determined indicators; and random or targeted peer reviews for practitioners.

7B. Cooperate with the relevant private sector organizations and with other states to develop and use standard continuing competency examinations to test minimum competence for continuing practice.

7C. Support the expanded use of modern technological tools to enhance traditional competencies and their assessment.

7A	Response Score	Number	Percentage
	Support	16	21%
	Challenge	17	22%
	Indeterminable	4	5%
	Not Addressed	39	51%

7A1	Response Score	Number	Percentage
	Support	8	11%
	Challenge	8	11%
	Indeterminable	0	0%
	Not Addressed	60	79%

7B	Response Score	Number	Percentage
	Support	14	18%
	Challenge	14	18%
	Indeterminable	1	1%
	Not Addressed	47	62%

7C	Response Score	Number	Percentage
	Support	25	33%
	Challenge	4	5%
	Indeterminable	1	1%
	Not Addressed	46	61%

Respondents had a number of suggestions for assuring continuing competency of health professions as well. Many suggested that current continuing education (CE) and peer review programs are working to ensure that practitioners are competent throughout their careers. To improve upon these programs, respondents suggested CE programs should be specified, standardized and stricter, with exit testing. Other safeguards could include more proactive programs and testing, and practical demonstrations of competence. Others suggested state-mandated peer assessment programs, interprofessional peer reviews, and proactive fellowship programs throughout health care practitioners’ careers to ensure continuing competence. One respondent suggested using the number of procedures performed as an indicator or trigger for competency testing. Still others suggested that managed care organizations are responsible for continued competency of their practitioners and that they should be held legally responsible for proactively ensuring the competence of their staff.

Nurses, in particular the National Council of State Boards of Nursing (NCSBN), has identified three possible competency standards including: 1) entry-level; 2) generalist core; and 3) focused area. The NCSBN has also been developing a clinical simulation testing model for entry and continuing competency, and is working to facilitate the Interprofessional Workgroup on Health Professions Regulation (IWHPR). This group of 15 different health care professions has been



conducting research into various competency assurance models of the various professional groups around the country and held a conference in the summer of 1997 to determine best approaches and next steps. The National Board for Certification in Occupational Therapy is working on a self-appraisal guide to measuring competency. Pharmacy is working on competency assessment programs, and the National Board of Medical Examiners and the Federation of State Medical Boards have developed an assessment project and quality evaluation committee.

*Professional competence may be defined as the application of knowledge and skills in interpersonal relations, decision making and physical performance consistent with the professional's practice role and public health, welfare and safety considerations.*

*In many professions, the requisites of competence change over time as various factors reshape the scope of practice and as the individual practitioner specializes.*

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*Interprofessional Workgroup  
on Health Professions Regulation*

## REFORMING THE PROFESSIONAL DISCIPLINARY PROCESS

*Protecting and promoting the public's health in an accountable, timely and fair manner.*

### RECOMMENDATION 8

*States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.*

This recommendation was strongly supported by respondents but scored low to medium for level of concern. Of the 70 percent responding to this issue, 64 percent were supportive, 11 percent challenged it, and 25 percent were indeterminable. Though the majority did not address the policy options, those who did supported the establishment of a uniform complaints and discipline process for all health professions and public access to final disciplinary information. The most challenged policy option, though also equally supported, was the establishment of an authoritative body to oversee all complaints and discipline processes within a state. Respondents were concerned about confidentiality issues, legal impediments and costs. Other barriers cited included health care politics, self-interest of the professions, political appointments, and legislative inaction.

Opportunities seen for this issue area included public relations activities for health professions boards, the need to strengthen linkages and relationships between state boards and professional certification/disciplinary bodies, the need to interface with the legal system, and to work with data-rich managed care organizations (MCO). Other potential areas for exploration include prioritization of disciplinary processes, discipline of institutions and corporations, and empowerment of professional boards' disciplinary measures.

#### Policy Options for State Consideration:

##### 8A – Detection

8A1. Establish an authoritative body, or assign such responsibility to an existing body, which would oversee the complaints, resolution and discipline processes for all professions to ensure that boards are acting uniformly, equitably and in the interest of public protection.

8A2. Establish uniform complaints and discipline processes for all regulated health professions to ensure that all investigations of complaints are handled in an objective, prioritized, and timely manner. The concerned parties should be informed of the progress of the complaint and investigation on a regular basis.

8A1 Response Score	Number	Percentage
Support	12	16%
Challenge	12	16%
Indeterminable	3	4%
Not Addressed	49	64%

8A2 Response Score	Number	Percentage
Support	26	34%
Challenge	3	4%
Indeterminable	1	1%
Not Addressed	46	61%

8A3. Make public access to the complaints and discipline process simple and clear. Information about filing a complaint, the standards by which complaints are judged, investigation procedures, discipline and appeals should be explained in a manner that is simple and clear.

8A3 Response Score	Number	Percentage
Support	20	26%
Challenge	3	4%
Indeterminable	4	5%
Not Addressed	49	64%

## 8B. Resolution

8B1. Employ resolution processes that are best suited to the parties and dispute, including alternative dispute resolution methods.

8B1 Response Score	Number	Percentage
Support	13	17%
Challenge	1	1%
Indeterminable	0	0%
Not Addressed	62	82%

8B2. Discipline practitioners using the best available tools including rehabilitation, targeted education, settlement and punitive actions.

8B2 Response Score	Number	Percentage
Support	16	21%
Challenge	1	1%
Indeterminable	0	0%
Not Addressed	59	78%

## 8C. Disclosure

8C1. Ensure that the outcomes of complaints and resolution of investigations are available and understandable to the parties involved, and to the public where appropriate, unless the law forbids disclosure or there is a compelling public policy reason that mandates confidentiality.

8C1 Response Score	Number	Percentage
Support	3	4%
Challenge	1	1%
Indeterminable	2	3%
Not Addressed	70	92%

The burden in disclosure decisions rests with those seeking to restrict access to information. The “compelling” criteria which prevents disclosure should be publicly available and specifically explained when an individual request is denied.

There were also a few alternative policy options suggested by the respondents to improve upon the current complaints and discipline systems. Respondents suggested the following: that boards conduct proactive professional audits, and/or random credential verification; that practitioners be fined if found to fall below benchmarks; that targeted education is augmented with psychiatric evaluation and management; and that an independent national body be convened to handle all complaints uniformly. Others focused on the role of MCOs, lawyers or the complainant suggesting that there be regulation of malpractice insurance premiums and attorney fees, incorporating risk management with quality management in MCOs, and having complainants sign a legally binding form vouching validity of the complaint with civil/criminal consequences for frivolous cases.

There was not significant activity reported in this area. Respondents citing action included the American Occupational Therapy Association, which publishes final disciplinary actions in its “OT Week”, the National Council of State Boards of Nursing’s disciplinary databank, the American Association of Dental Examiners’ clearinghouse of board actions, and the National Association of Boards of Pharmacy’s taskforce on standardizing disciplinary terms.

## EVALUATING REGULATORY EFFECTIVENESS

*Ensuring that health professions regulation protects and promotes the public's health.*

### RECOMMENDATION 9

*States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies in order to best protect and promote the public's health.*

Recommendation nine was the least-addressed issue with only 63 percent responding. Of that 63 percent however, respondents were overwhelmingly supportive scoring one of the highest levels of support. Eighty-five percent of those responding supported the recommendation, ten percent challenged it and four percent were indeterminable. The level of concern for this issue scored very low however with 65 percent of those responding scoring low and 29 percent scoring medium for level of concern. Most respondents did not address the policy options suggesting specific criteria for sunset or internal evaluations. Support was strong, however, for some general type of external or internal assessment. Barriers identified to achieving this recommendation include the political and limited nature of sunset reviews and the bureaucratic nature of external reviews. Many respondents cited the opportunity to conduct outcome studies for regulatory effectiveness, the need for apolitical evaluations, and the exploration of mechanisms to deal with boards found lacking in performance.

#### Policy Options for State Consideration:

9A. Regulatory bodies and processes should be subject to periodic external (e.g. sunset type according to agreed upon objective standards) and internal (e.g. self-evaluation assessment based on set criteria) evaluation.

Criteria for evaluation might include:

9A1. Timelines of adjudication process

9A2. Public perception of and satisfaction with regulatory processes and accountability;

9A	Response Score	Number	Percentage
	Support	22	29%
	Challenge	6	8%
	Indeterminable	1	1%
	Not Addressed	47	62%

9A1	Response Score	Number	Percentage
	Support	6	8%
	Challenge	0	0%
	Indeterminable	0	0%
	Not Addressed	70	92%

9A2	Response Score	Number	Percentage
	Support	0	0%
	Challenge	0	0%
	Indeterminable	0	0%
	Not Addressed	76	100%

9A3. Effectiveness of boards at meeting their mission and objectives.

9A3 Response Score	Number	Percentage
Support	1	1%
Challenge	1	1%
Indeterminable	0	0%
Not Addressed	74	97%

Some policy options for achieving evaluation were also offered by respondents. Suggestions include instituting time-limited periods of self-assessments for regulatory bodies, asking managed care organizations to establish outcome measures, having an oversight interdisciplinary review board with public members and/or a separate citizens review board, and having the state Attorney General oversee board assessments. There was very little activity reported in this area, probably due to the low response rate. The Federation of State Medical Boards however, reported that they have developed a self-assessment instrument and are working on uniform evaluation criteria and outcomes.

## UNDERSTANDING THE ORGANIZATIONAL CONTEXT OF HEALTH PROFESSIONS REGULATION

*Developing effective partnerships between state, federal and private regulatory systems to streamline health professions regulation.*

### RECOMMENDATION 10

*States should understand the links, overlaps and conflicts between their health care workforce regulatory system and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.*

This recommendation was also one of the least addressed issue areas with 27 of 76 respondents failing to address it. Of the 64 percent who did answer to this recommendation, 65 percent were supportive, 14 percent challenged it, and 20 percent of responses were indeterminable. Response rates for the various policy options were also extremely low, averaging only about a nine percent response rate. The most challenged policy option, however, was the relationship between state regulation and professional associations. Respondents felt that professional associations are not only appropriate, but the best entity to determine professional standards, educational requirements and scopes of practice as only they have the appropriate understanding and knowledge of the intricacies of the profession. Barriers identified include limited access through reimbursement policies, institutional licensure and Federal preemption. Respondents identified the need to include all stakeholders equally in improvement efforts. Education and telecommunications were also identified as an area of opportunity in evaluating regulatory effectiveness.

#### Policy Options for State Consideration:

10. Study the interplay between their health professions regulatory system and the system listed below in order to evaluate where links should be forged or broken, where redundancies could be streamlined or removed, where conflicts exist and can be resolved, and where gaps demand attention:

10A. Reimbursement

10B. Accreditation

10C. Professional associations

10A Response Score	Number	Percentage
Support	4	5%
Challenge	5	7%
Indeterminable	1	1%
Not Addressed	66	87%

10B Response Score	Number	Percentage
Support	5	7%
Challenge	6	8%
Indeterminable	1	1%
Not Addressed	64	84%

10C Response Score	Number	Percentage
Support	2	3%
Challenge	11	14%
Indeterminable	0	0%
Not Addressed	63	83%

10D. Legal system (civil and criminal)

10E. Testing

10F. Facility regulation

10G. Federal government

Respondents also suggested other policy options such as the need to reform reimbursement strategies providing equal reimbursement for equal procedures regardless of provider, periodic review of the entire health care system, funding for health professions students, and the establishment of an ombudsman for health care quality concerns. Respondents also cautioned that corporate interests should not be equated with public interests, and that professional associations are the best suited to champion reform processes. There was no significant activity reported in this area.

10D Response Score	Number	Percentage
Support	3	4%
Challenge	2	3%
Indeterminable	0	0%
Not Addressed	71	93%

10E Response Score	Number	Percentage
Support	2	3%
Challenge	2	3%
Indeterminable	0	0%
Not Addressed	72	95%

10F Response Score	Number	Percentage
Support	4	5%
Challenge	1	1%
Indeterminable	0	0%
Not Addressed	71	93%

10G Response Score	Number	Percentage
Support	2	3%
Challenge	1	1%
Indeterminable	0	0%
Not Addressed	73	96%

## GRANT-MAKING ACTIVITIES TO IMPROVE REGULATION

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In an effort to support continued discussions and explorations of health professions regulation and the recommendations of the Taskforce, the States Initiatives Grant Program to Reform Health Care Workforce Regulation at the Center for the Health Professions, University of California San Francisco, offered modest grants to organizations, coalitions and individuals pursuing improved health professions regulation. Grant projects are working to improve the management of the health care workforce by attempting to improve health professions regulation, and highlighting models or innovative efforts in this improvement. Fourteen grant programs were funded, focusing on three specific areas: 1) debate and discussion of health care workforce regulation and the need for improvement; 2) planning for regulatory reform; and 3) research into health care workforce regulation and its reform (*see Appendix III for current list of Grantees*). The activities and outcomes of these grant programs are intended to inform the deliberations of the Pew Commission and its Taskforce on Health Care Workforce Regulation and the writing of a second report on regulatory reform scheduled for publication in the Fall of 1998.

Debate and Discussion grants included funding for six organizations to convene summit meetings or conferences on current and future workforce regulation. The Interprofessional Workgroup on Health Professions Regulation (IWHPR) was funded to explore and evaluate models of continuing competency assessments. The national conference was held July 25-26, 1997 in Chicago exploring models of assessing continued competency and addressing the theoretical framework and practical implications tied to the role of regulation. In preparation for the conference, IWHPR conducted extensive research on professional activities around assuring competence. The National Council of State Boards of Nursing (NCSBN) was funded to convene a conference examining issues of multi-state licensure held on June 2-6, 1997 in Arlington, Virginia. Participants explored and evaluated the needs of consumers, nurses, and health care delivery systems, as well as the impact and implications of state-level regulatory processes. The NCSBN is developing models and recommendations that will be analyzed for implementation feasibility, political realities and cost implications. The National Conference of State Legislatures was funded to conduct seminars in Connecticut and Kansas in conjunction with the Intergovernmental Health Policy Project's Forum for State Health Policy Leadership. The seminars provided a forum for state lawmakers and officials to understand and debate cutting edge regulatory structures, processes and issues.

The Maricopa County Community College District was funded to convene a summit meeting for 400 Arizona stakeholders in the proposed Health Care Integrated Education System (HCIES). The summit meeting was held on April 4, 1997 in Phoenix, Arizona resulting in a Taskforce on Workforce Regulation. This Taskforce is focusing on the impacts of implementation of the HCIES and development of recommendations for regulatory changes as necessary. The American Academy of Nursing received a grant to hold a summit meeting, held May 1-3, 1997 in Miami, Florida. At this meeting, nursing organizations worked toward consensus on regulation for the future discussing a number of policy options including: scopes of practice; articulation of education and practice; regulatory systems; continuing competence; delegation/accountability; and roles and



responsibilities of professional associations and licensure bodies. And finally, The National Black Nurses Foundation was awarded a grant to convene a meeting on February 2, 1997 in Washington, DC. Participants discussed the recommendations set forth in the Taskforce's report and worked toward consensus regarding licensure, regulations and models of care.

Planning grants funded four organizations to study current regulatory structures, models and systems and to promote necessary regulatory reform efforts. The Colorado Health Professions Panel (CHPP) was funded with the objective to purchase the systems hardware and write the systems software to implement the Colorado Health Professions Workforce Information bill (HB-1904). This bill would have required a set of workforce related questions to be asked of all licensed health professionals upon license renewal. The system was to serve as a model for other states. In February 1997, the bill failed to pass through the Colorado House Appropriations Committee and consequently, the grant agreement was concluded. The CHPP submitted a follow-up proposal, to fund the collection of data throughout the state based on a public-private partnership between the Department of Regulatory Affairs, the University of Colorado and the CHPP. This effort was funded in September 1997.

The State College of Optometry, State University of New York was funded to study the practice of optometry within a number of health plans in different states including Washington, Massachusetts, Pennsylvania, Wisconsin and Minnesota. The goal of the project is to promote discussions and convene a conference examining eye care practitioners' clinical practice patterns in the five jurisdictions, having different optometric scope of practice laws. The study hopes to determine whether practice patterns differ as a result of state law or competency, and if there are differences in the cost and quality of care in relation to the use of therapeutic prescriptive authority among optometrists within the various jurisdictions. The Nebraska Nurses Association and Nebraska Board of Nursing was funded to jointly evaluate Nebraska's current nursing regulatory system in relation to the Pew recommendations in an effort to streamline regulatory processes for all levels of providers of nursing care. The project is focusing on issues of unlicensed assistive personnel including competency, discipline and standards for entry, continued competency, and consumer education. And finally, the National Citizens' Coalition for Nursing Home Reform (NCCNHR) was funded to build a consensus of support for specific legislative and administrative changes that would remove unnecessary barriers to the full use of competent health care professionals and other caregivers, using the nursing home as a laboratory. In collaboration with the Citizen Advocacy Center, NCCNHR held a consensus conference June 25, 1997 in Washington, DC reaching consensus on a number of broad areas including issues of accountability; initial hiring and credentialing; ongoing training and maintenance of skills; competency evaluations; delegation and supervision; and ongoing oversight and discipline.

Research funding was provided to four organizations to conduct studies of regulatory issues and changes in a number of different areas. Projects include funding for the Maricopa County Community College District to study the cost implications, political realities and feasibility of regulatory reform in Arizona's Health Care Integrated Education System. In addition, Eastern Virginia Medical School will study the current and projected roles and work responsibilities of

health professionals within Virginia's three integrated health care delivery systems. And the Council on Licensure, Enforcement and Regulation was funded to research and explore telepractice and its relationship to health care workforce regulation in an effort to determine what best serves the needs of consumers, and develop tools to help legislators meet these needs. And finally, at Michigan State University, funding was provided for Carol S. Weissert, Ph.D. to conduct research on state medical boards as potential or actual agents of change in health professions regulation.

In addition, of particular note is the work being done in Maine to illuminate and improve health professions regulation. This project seeks to improve Maine's health professions regulatory system by involving all Mainers in a discussion about developing appropriate regulatory public policy. Specific preliminary recommendations were offered to the Governor and Legislature in a June 30, 1996 report and refinements to the recommendations are being formed. The final report was released in October 1997.

## NEXT STEPS

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The Pew Health Professions Commission has been empanelled for the third phase of its work and will focus on two specific areas: graduate medical education and health care workforce regulation. Consequently, the Commission has convened the second Taskforce on Health Care Workforce Regulation which consists of four Commissioners and four additional experts (*for a complete list of Commission & Taskforce members, see the Center's web site at <http://futurehealth.ucsf.edu>*). The second Taskforce has endorsed the principles as set forth in the first report, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, as a starting point for the next phase of its work. In addition, the second Taskforce will focus its continued efforts on consumer protection, particularly within the current environment of managed care and high technology. The report of this second Taskforce is scheduled for publication in the Fall of 1998.

## APPENDIX I *Response Solicitation Letter*

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Guidelines for Responding to

### *Reforming Health Care Workforce Regulation: Policy Consideration for the 21st Century*

#### **Response questions to be answered and information to be provided (page limits in parentheses):**

- Title page with name of organization, authors of response, address, phone, fax, and date;
- Summary bullet points that review general responses to the entire report and key issues for regulatory reform from your constituency's vantage (one page);
- Response to the report's *principles* and *vision* for health care workforce regulation (two pages);
- For each of the ten issues (or those to which you wish to respond), address the *issue* and broad *recommendation* for reform (one page for each issue/recommendation); address the *policy options for consideration* and if desired, make proposals for other policy options which would accomplish the recommendation and meet the stated *principles* (two pages for each issue/recommendation);
- Address in general the barriers and opportunities for the implementation of regulatory reform (three pages).

#### **Format for responses**

- 11 point font, 1 inch margins, 1 1/2 line spacing. Response *must not exceed* 36 pages.
- Submit one original with two hard copies and one copy in MicroSoft Word 3.0 on a 3.5 inch disk.

#### **Deadline for submission**

- December 6, 1996

### *Outside Reviewer of the Responses to the Report*

#### **Elizabeth Stone, MD**

Dr. Elizabeth Stone received her medical degree from Northwestern University in 1967. Dr. Stone is board certified in Plastic and Reconstructive Surgery and has a private solo practice in Portland, Oregon. Since 1992, Dr. Stone has served as an Institutional Review Board Investigator for Providence Portland Medical Center. She has also served the past three years as medical consultant for Blue Cross Blue Shield of Oregon. Dr. Stone is currently studying for her masters degree in Public Health at Portland State University.

## APPENDIX II *Organizations Formally Responding to The Report*

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- |  |   |   |
|--|---|---|
| • Acupuncture Association of Colorado                          | • BBK & Associates  | • North Dakota Nurses Association                                     |
| • American Association of Colleges of Nursing                  | • California Board of Registered Nursing (endorsement of NCSBN)     | • Northwest Organization of Nurse Executives                          |
| • American Association of Colleges of Pharmacy                 | • California Nurses Association                                     | • Nurses of Pennsylvania  |
| • American Association of Community Colleges                   | • Colorado Federation of Nursing Organizations                      | • Nursing Association of Counties of Long Island, Inc.                |
| • American Association of Dental Examiners                     | • Colorado Nurses Association                                       | • Nursing Community Pew Commission Report Analysis Work Group         |
| • American Association of Neuroscience Nurses                  | • Commonwealth of Massachusetts Division of Registration            | • Ohio Nurses Association   |
| • American Association of Nurse Anesthetists                   | • Federation of State Boards of Physical Therapy                    | • Ohio Organization of Practical Nurse Educators                      |
| • American Association of Occupational Health Nurses, Inc.     | • Federation of State Medical Boards                                | • Oncology Nursing Society  |
| • American College of Nurse-Midwives                           | • Illinois Directors of Associate Degree Nursing Programs           | • Opticians Association of America                                    |
| • American Nephrology Nurses Association                       | • Interprofessional Workgroup on Health Professions Regulation      | • Pennsylvania Physical Therapy Association (endorsement of APTA)     |
| • American Nurses Association                                  | • Maine Board of Nursing (endorsement of NCSBN)                     | • Sentara Health System   |
| • American Nurses Association – California                     | • Maine Provider Coalition  | • Society of Nuclear Medicine – Technologist Section                  |
| • American Occupational Therapy Association, Inc.              | • Missouri State Board of Nursing                                   | • South Carolina Board of Nursing                                     |
| • American Organization of Nurse Executives                    | • National Association of Boards of Pharmacy                        | • The Rial Rehabilitation Facility                                    |
| • American Physical Therapy Association (APTA)                 | • National Association of Orthopaedic Nurses (endorsement of NFSNO) | • The Washington State Nursing Care Quality Assurance Commission      |
| • Association of Operating Room Nurses                         | • National College of Chiropractic                                  | • Wisconsin Health Professions and Occupations Regulatory Authorities |
| • Association of Operating Room Nurses – Massachusetts Chapter | • National Council of State Boards of Nursing (NCSBN)               | • Wisconsin Occupational Therapy Association                          |
| • Association of State and Territorial Directors in Nursing    | • National Federation for Specialty Nursing Organizations (NFSNO)   | • Yale University School of Nursing                                   |
|  | • National Federation of Societies for Clinical Social Work         |   |
|  | • North Carolina Nurses Association                                 |   |

*(20 individuals also responded)*

### **APPENDIX III** *Grantee Contact List - States Initiatives Program to Reform Health Care Workforce Regulation*

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#### *Debate and Discussion Grant Award Winners*

##### **American Academy of Nursing:**

##### **Coalition on Nursing Futures and Regulation**

Janet Heinrich, DrPH, RN, FAAN

Director, American Academy of Nursing

600 Maryland Avenue, SW, Suite 100W

Washington, DC 20024-2571

Phone: 202/651-7239

Fax: 202/554-2641

Website: <http://www.nursingworld.org/aan/index.htm>

Email: [jheinrich@ana.org](mailto:jheinrich@ana.org)

##### **Interprofessional Workgroup on Health Professions Regulation (coalition of 15 different health care professions): Creative Partnering To Build the Conceptual Framework for Continued Competency Initiatives**

Randy Lindner

Executive Director, National Association of Boards of Examiners for Nursing Home Administrators

808 17th Street, NW, Suite 200

Washington, DC 20006-3910

Phone: 202/223-9750

Fax: 202/223-9569

Email: [NAB.WDC@WORLDNET.ATT.NET](mailto:NAB.WDC@WORLDNET.ATT.NET)

Website: <http://www.ncsbn.org/iwhpr.html>

##### **National Black Nurses Foundation: NBNF Summit II - Healthcare Workforce Regulation**

C. Alicia Georges

President, National Black Nurses Foundation

1511 K Street, NW, Suite 415

Washington, DC 20005

Phone: 718/960-8799

Fax: 718/960-8488

Email: none listed

##### **National Conference of State Legislatures:**

##### **Improving State Legislators' Capacity to Debate Issues Affecting the Licensure and Regulation of Health Care Professionals**

Tim Henderson, MSPH

Program Manager, National Conference of State Legislatures

444 North Capitol Street, NW, Suite 515

Washington, DC 20001

Phone: 202/624-3573

Fax: 202/737-1069

Email: none listed

##### **Maricopa County Community College District: The Maricopa/Arizona Dialogue: Impact and Implications of Workforce Regulation on Plans for the Health Care Educational Integrated System**

Mary F. Briden

Director, Transfer Education and Special Projects

Maricopa County Community College District

2411 West 14th Street

Tempe, AZ 85281-6941

Phone: 602/731-8124

Email: [briden.mary@al.dist.maricopa.edu](mailto:briden.mary@al.dist.maricopa.edu)

##### **National Council of State Boards of Nursing: Development of a Model Regulation which Incorporates the Characteristics of a Multistate License**

Jennifer Bosma, RN, Ph.D.

Executive Director

676 No. St. Clair, Suite 550

Chicago, IL 60304

Phone: 312/787-6555

Fax: 312/787-6898

Email: [jbosma@ncsbn.org](mailto:jbosma@ncsbn.org)

### **APPENDIX III** *Grantee Contact List (continued)*

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#### *Planning Grant Award Winners*

**State College of Optometry - State University  
of New York: Effect of Patient Care Within a  
Health Plan Operating in Multiple Jurisdictions**

Dr. Mort Soroka  
Director, State College of Optometry  
– State University of New York  
100 East 24th Street  
New York, NY 10010  
Phone: 212/780-5024  
Fax: 212/780-5009  
Email: none listed

**Nebraska Nurses Association/Nebraska Board  
of Nursing: Nebraska Nurses Regulatory  
Reform Proposal**

Ann Oertwich, RN, MSN  
Executive Director, Nebraska Nurses Association  
1430 South Street, Suite 202  
Lincoln, NE 68502  
Phone: 412/475-3859  
Fax: 402/475-3961  
Email: none listed

**Colorado Health Professions Panel:  
Implementation of a Licensure  
Based Workforce Data System**

Benjamin Cordova, EdD  
Executive Director  
Colorado Health Professions Panel, Inc.  
225 E. 16th Avenue, Suite 1050  
Denver, CO 80203-1614  
Phone: 303/832-1109  
Fax: 303/832-1538  
Email: COHPPAN@ix.netcom.com

**National Citizens' Coalition for Nursing Home  
Reform: Regulatory Change to Remove Barriers  
to the Full Use of Competent Health Care  
Professionals in Nursing Homes**

Sarah Burger  
National Citizens' Coalition for Nursing Home Reform  
1424 16th Street, NW, Suite 202  
Washington, DC 20036-2211  
Phone: 202/332-2275  
Fax: 202/332-2949  
Email: none listed

#### *Research Grant Award Winners*

**Maricopa County Community College District:  
Arizona: Planning for Regulatory Changes Which  
Support the Proposed Health Care Integrated  
Education System**

See above grant - debate and discussion

**Eastern Virginia Medical School: Health Care  
Workforce Regulation and the Integrated Health Care  
Delivery Systems: Challenges and Opportunities**

C. Donald Combs, PhD  
Vice President for Planning and Program Development  
Eastern Virginia Medical School  
PO Box 1980  
Norfolk, VA 23501-1980  
Phone: 757/446-6090  
Fax: 757/446-6087  
Email: combs@planning.evms.edu

### **APPENDIX III** *Grantee Contact List (continued)*

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#### **Council on Licensure Enforcement and Regulation:**

##### **Telepractice, Licensing and the Common Good**

Pam Brinegar

Executive Director

Council on Licensure Enforcement and Regulation

404 Lafayette Avenue, Suite 100

Lexington, KY 40507

Phone: 606/269-1901

Fax: 606/231-1943 Website: <http://www.clearhq.org/>

Email: [pambr@uky.campus.mci.net](mailto:pambr@uky.campus.mci.net)

#### **Michigan State University - Carol S. Weissert:**

##### **State Medical Boards as Change Agents in**

##### **Health Professions Regulation**

Carol S. Weissert, PhD

Associate Professor of Political Science

Michigan State University

East Lansing, MI 48824

Phone: 313/747-6367

Fax: 517/432-1091

Email: [weissert@pilot.msu.edu](mailto:weissert@pilot.msu.edu)

#### **Medical Care Development (MCD) - Maine Health**

##### **Professions Regulatory Reform Project**

Judy Kany, MPA

Senior Consultant Medical Care Development, Inc.

11 Parkwood Drive

Augusta, ME 04330

Phone: 800/535-1030

Fax: 207/622-3616

Email: [jkany@mcd.org](mailto:jkany@mcd.org)