How Data and Evidence Can (and Should!) Inform Scope of Practice

Erin Fraher, PhD, MPP; Julie Spero, MSPH; Shikira Thomas, MSPH; Evan Galloway, MPS; Heather Wilson, BA
Program on Health Workforce Research & Policy

NCIOM Legislative Health Policy Fellows
December 9, 2019

UNC | THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

This presentation in one slide

- My frame: objective, “data agitating” workforce researcher
- Scope of practice (SOP) battles are emerging with increased frequency
- Health professional regulation is state function—result is significant variation between states
- Strong stakeholder groups are involved in SOP battles, often focused on professional self-interest, not patients’ interests
- Lack of evidence about SOP changes makes evaluation difficult
- Health care is changing quickly, regulation needs to adapt
- The way forward for North Carolina is more evidence-based SOP and regulation

My lens on scope of practice (SOP)

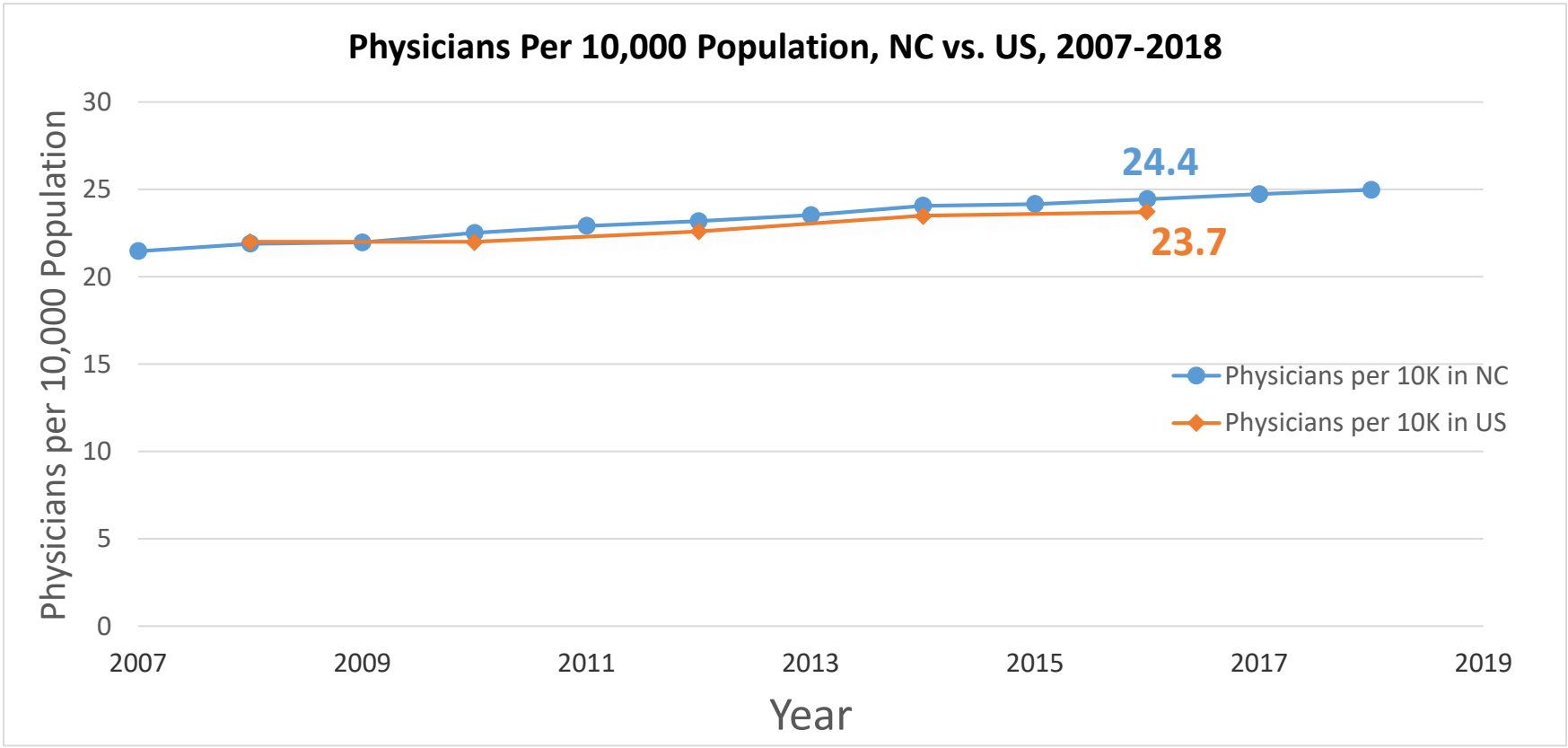
- First job was working for a regulatory body. Spurred my interest in health workforce policy
- I've been a health workforce researcher for more than 20 years. I've seen (and studied) lots of SOP debates
- Direct research program dedicated to providing timely, objective research to inform health workforce policy
- Based at Cecil G. Sheps Center for Health Services Research at UNC-CH. Focus is statewide and national
- My goal is to infuse data and evidence into what are often contentious turf wars
- I believe in patient-centered, not profession-centered, workforce planning

In NC (and other states) increasing number of SOP practice bills proposed

Driving forces include:

- Increasing involvement of corporate players who are putting significant pressure on hospitals and health systems to provide more patient-centered care at lower cost
- New payment models encouraging task shifting to lower cost health care workers
- New care delivery models encouraging team-based models of care and new roles for health care professionals
- Concerns about access to care due to workforce shortages and maldistribution of providers

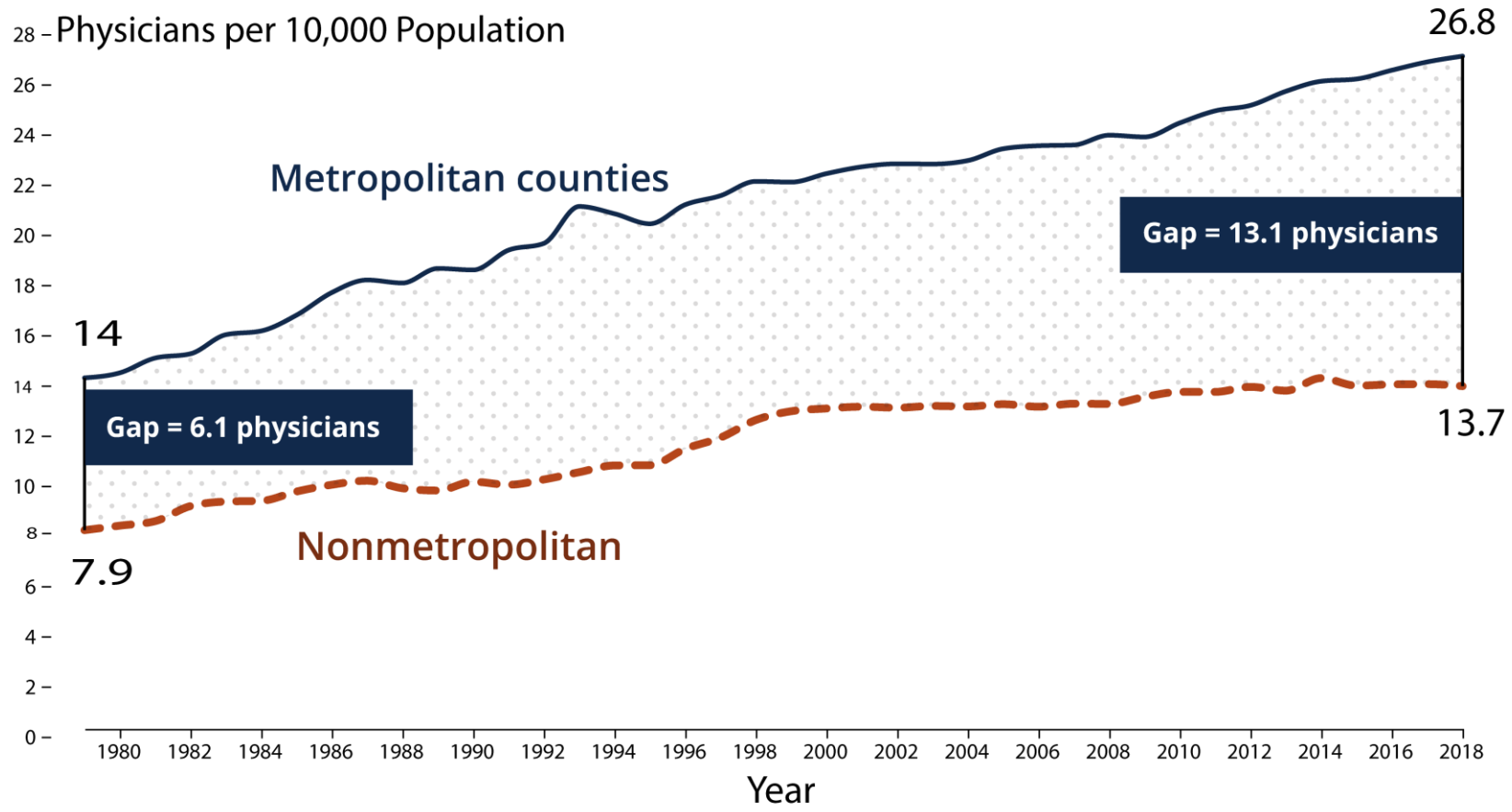
Fears of physician shortages create headlines, but we see steady increase in supply



Sources: North Carolina Health Professions Data System, 2007 to 2018, with data derived from the NC Medical Board; AAMC State Physician Workforce Data Book, years 2009, 2011, 2013, 2015, 2019, with data derived from the AMA Physician Masterfile; US Census Bureau; North Carolina Office of State Planning. North Carolina physician data include all licensed, active, physicians practicing in-state, inclusive of federally employed physicians and excluding residents-in-training. US data includes total physicians active in patient care, inclusive of federally employed physicians and excluding residents-in-training.

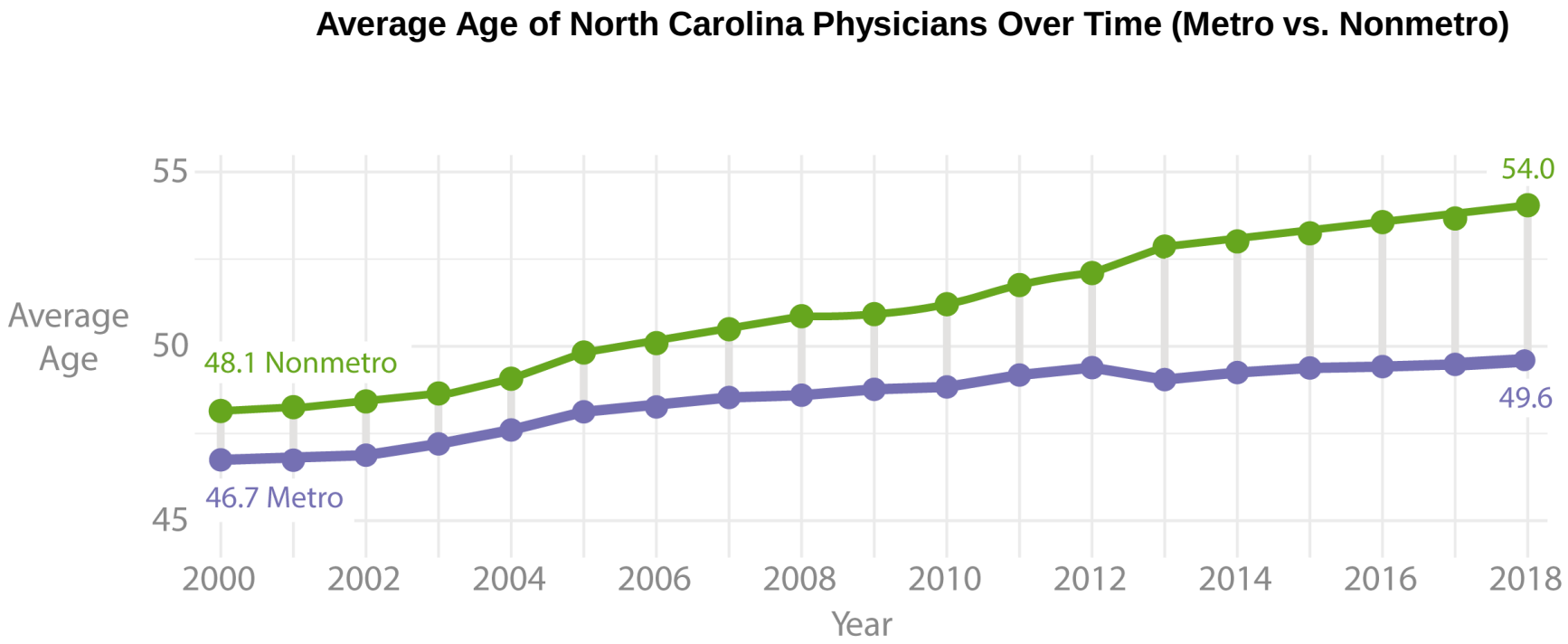
The real issue is maldistribution. Gap between shortage and non-shortage counties is growing

Physicians per 10,000 Population for Metropolitan and Nonmetropolitan Counties, North Carolina, 1979 - 2018



Notes: Data include active, licensed physicians in practice in North Carolina as of October 31 of each year who are not residents-in-training and are not employed by the Federal government. Physician data are derived from the North Carolina Medical Board. County estimates are based on primary practice location. Population census data and estimates are downloaded from the North Carolina Office of State Budget and Management via NC LINC and are based on US Census data.

And rural workforce is aging at faster pace than urban workforce

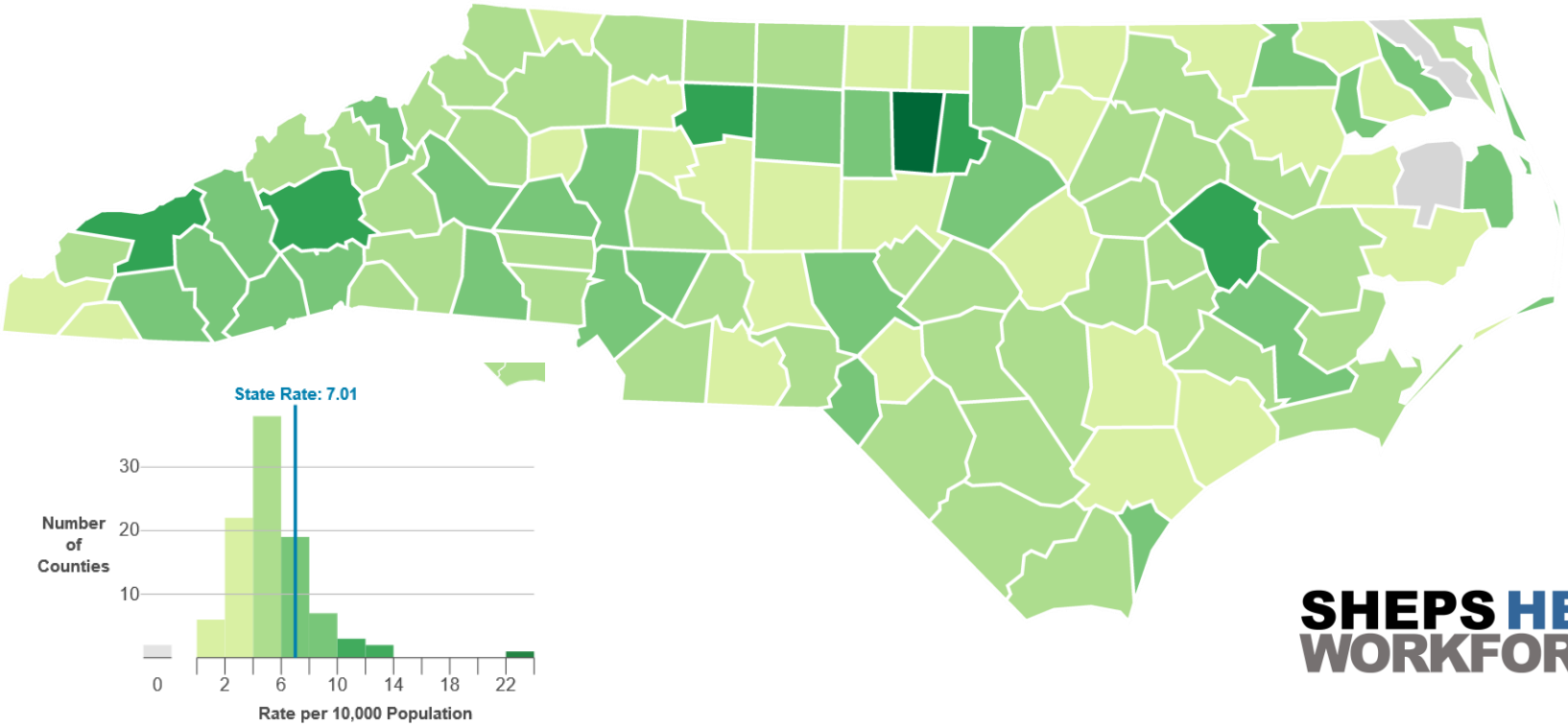


Notes: Data include active, licensed physicians in practice in North Carolina as of October 31 of each year who are not residents-in-training and are not employed by the Federal government. Physician data are derived from North Carolina Medical Board data. County status is based on the Metropolitan/Micropolitan delineation files published by the United States Office of Management and Budget. The county for each physician is the county of primary practice location. Age is calculated as of December 31 of each year.

SHEPS HEALTH WORKFORCE NC

20 NC counties have comparatively few primary care physicians; 2 counties have none

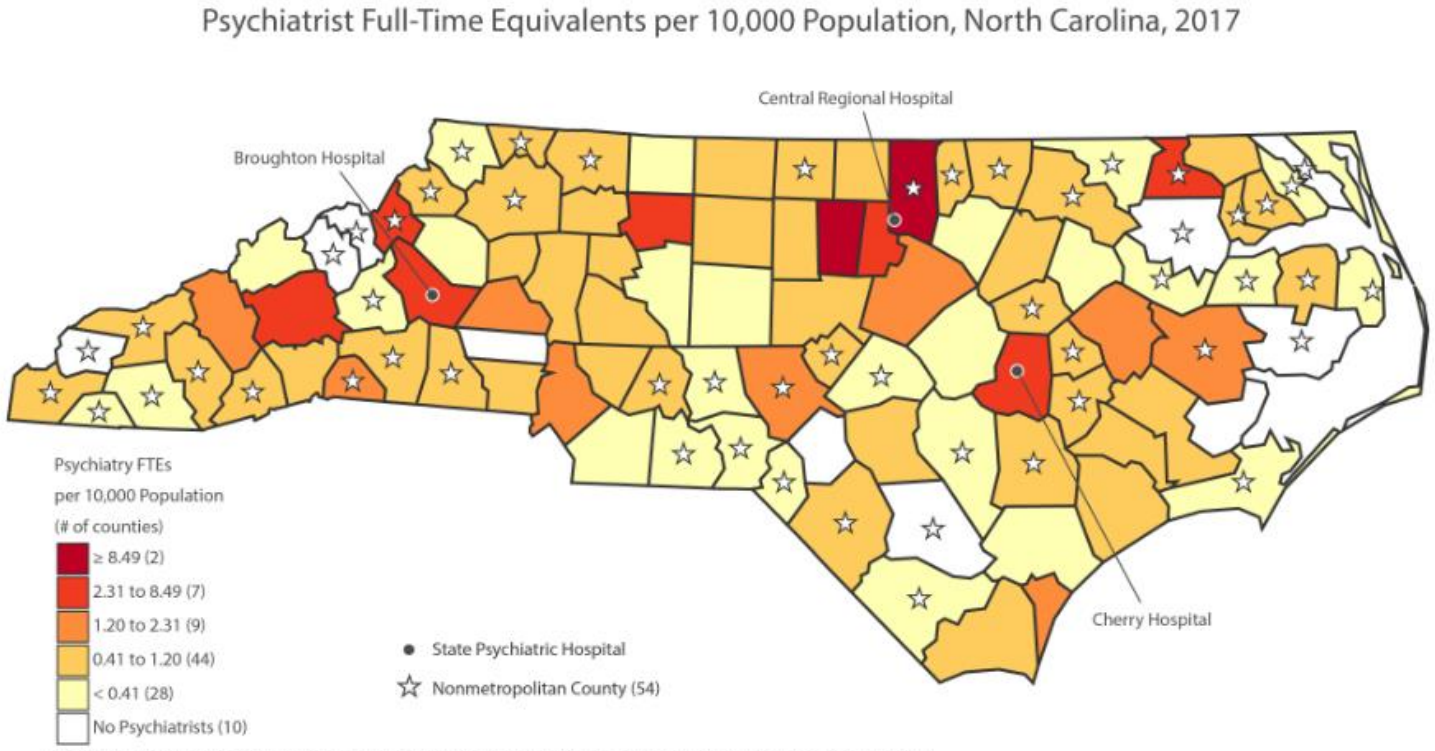
Physician - Primary Care per 10,000 Population North Carolina, 2018



SHEPS HEALTH WORKFORCE NC

Notes: Data include active, licensed physicians in practice in North Carolina as of October 31 of each year who are not residents-in-training and are not employed by the Federal government. Physician data are derived from the North Carolina Medical Board. County estimates are based on primary practice location. Population census data and estimates are downloaded from the North Carolina Office of State Budget and Management via NC LINC and are based on US Census data.
Source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created September 30, 2019 at https://nchealthworkforce.unc.edu/supply/.

10 counties in NC have no psychiatrist coverage



Notes: Data include active, licensed physicians in practice in North Carolina as of October 31 of each year who are not residents-in-training and are not employed by the Federal government. Physician data are derived from the North Carolina Medical Board. Population census data and estimates are downloaded from the North Carolina Office of State Budget and Management via NC LINC and are based on US Census data. Physicians with a primary area of practice of Psychiatry include the following: Child & Adolescent Psychiatry, Pediatrics - Psychiatry, Addiction Medicine, Addiction Psychiatry, Forensic Psychiatry, Geriatric Psychiatry, Hypnosis, Internal Medicine - Psychiatry, Psychiatry, Psychiatry - Family Practice, Psychoanalysis, Psychosomatic Medicine. Source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

SHEPS HEALTH WORKFORCE NC

UNC
THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

Closures of obstetric delivery units in rural NC have made state and national headlines

Eastern NC hospital nixes maternity services

Another Thing Disa
Rural America: Mat

A new study shows that more than half of
don't have hospitals with obstetric service
hit the hardest.

by **Adriana Gallardo** and **Nina Martin**, Sept. 5, 4:01 p.m. EDT

CITIZEN-TIMES
PART OF THE USA TODAY NETWORK

Search

HOME | LOCAL | SPORTS | ASHEVILLE SCENE | LIFESTYLE | VOICES & VIEWS | SUBSCRIBE | HOMES | USA TODAY | MORE

Pregnant women latest victims of rural health care shortage

559

Julie Ball, jball@citizen-times.com Published 1:26 p.m. ET May 11, 2017 | Updated 1:54 p.m. ET May 11, 2017

LETTER FROM NORTH CAROLINA

Rural Hospitals Are Dying and Pregnant Women Are Paying the Price

Heavily reliant on Medicaid dollars, small hospitals shut down maternity wards just to stay afloat.

By LISA RAB | October 03, 2017

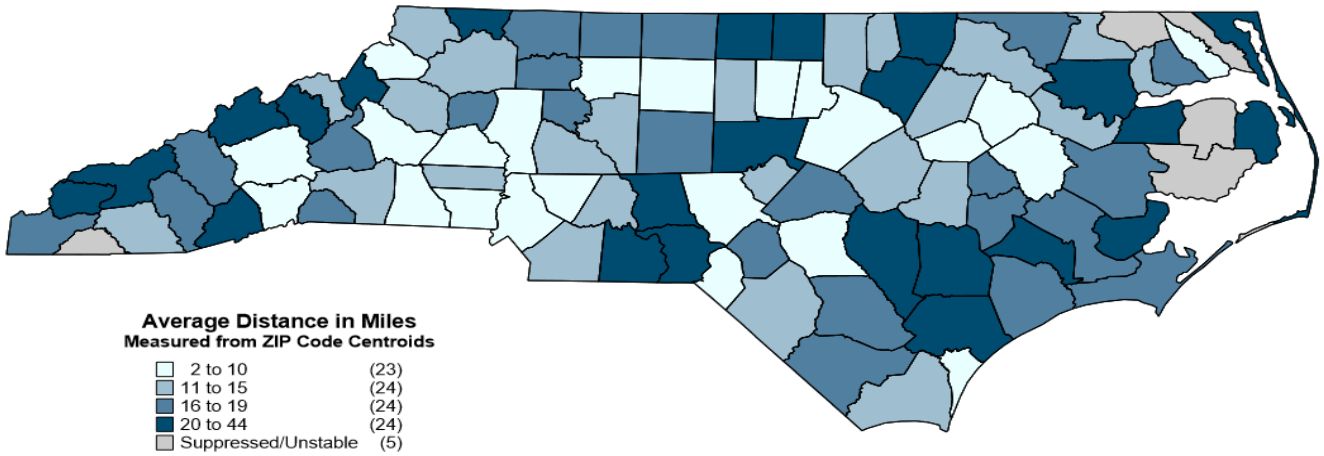
J. Scott Applewhite/AP Photo

BOONE, N.C.—Three years ago, Lucia Parker gave birth to her first child surrounded by people she loved. Her mother, sister, and husband were by her side at Blue Ridge Regional Hospital, and the nurses attending her were family friends. Each of them took turns massaging her back. They lifted her out of a

12 of the counties with the longest travel times lack maternity care providers and birth facilities; 2,383 (2%) births originated from these counties.

Average Distance to Care for Discharges for Childbirth
Miles from Residence to Hospital

Residents Discharged from North Carolina Hospitals: October 1, 2015 to September 30, 2016



Note: Inpatient DRG codes include 756, 766, 774, 775, 767, 768.
Information for counties with fewer than 50 discharges suppressed.
Source: Truven Health Analytics, an IBM Watson Health Company, Fiscal Year 2016.
Produced By: Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

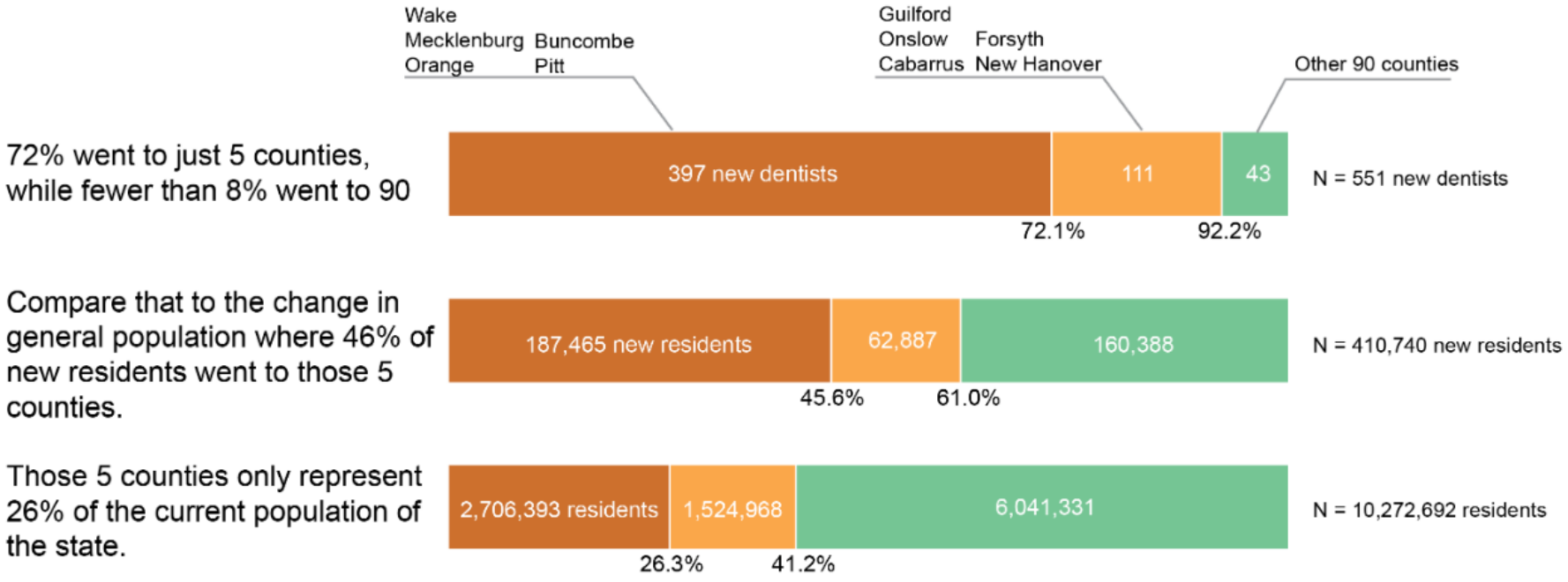
Positive news: NC has gained dentists per capita, although still below national average

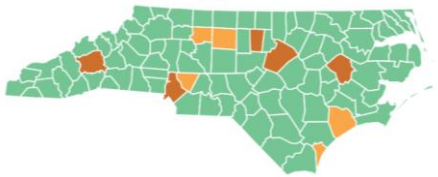
Dentists Working in Dentistry per 10,000 Population

	2001		2013		2017	
	Rank	Ratio	Rank	Ratio	Rank	Ratio
United States		**5.7**		**6.0**		**6.1**
North Carolina	**47**	4.2	**44**	4.8	**37**	5.1

Source: Supply of Dentists in the U.S.: 2001-2017 (XLSX - Published January 2018). American Dental Association, Health Policy Institute analysis of ADA masterfile. Downloaded 1/30/2018 from https://www.ada.org/en/science-research/health-policy-institute/data-center/supply-and-profile-of-dentists

NC added 551 new dentists between 2013 and 2017. Where did they go?

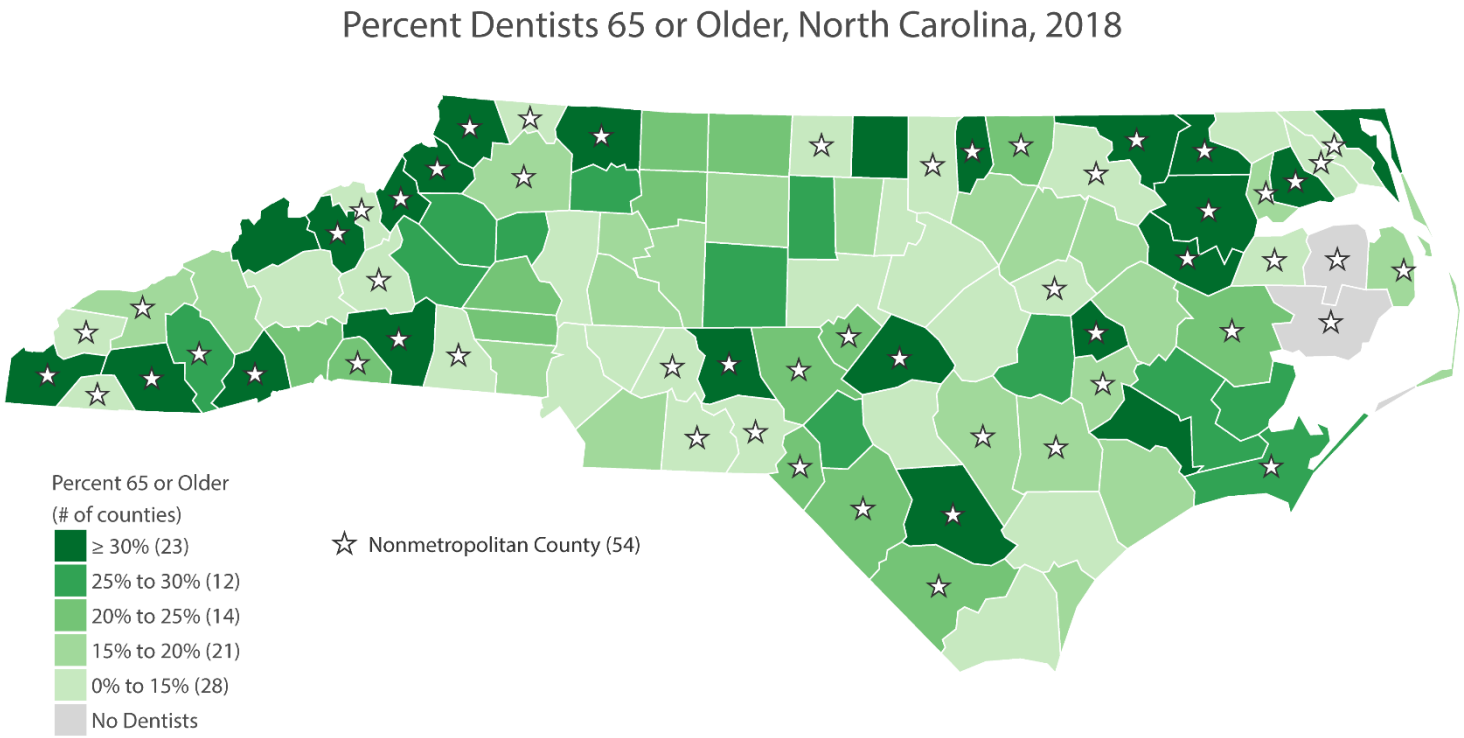




Notes: Data include active, licensed dentists in practice in North Carolina as of October 31 of each year. Dentist data are derived from the North Carolina State Board of Dental Examiners. Population census data and estimates are downloaded from the North Carolina Office of State Budget and Management via NC LINC and are based on US Census data.
Source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research,

SHEPS HEALTH WORKFORCE NC

In 23 counties, one-third of the dentist workforce is older than 65



Notes: Data include active, licensed dentists in practice in North Carolina as of October 31,2018. Data are derived from licensure data from the North Carolina State Board of Dental Examiners. County estimates are based on primary practice location.

SHEPS HEALTH WORKFORCE NC

"We try to see as many people as possible, but **the demand is overwhelming**"[1]

Missions of Mercy Clinics

- Portable dental clinics
- Provided services to 55,000 North Carolinians since 2003

Photo Credit: NC Dental Society

1. NC Dental Society NC Missions of Mercy Clinics Webpage. Accessed 30 Jan 2018 at: http://www.ncdental.org/member-center/getinvolved/nc-missions-of-mercy

A Quick Primer on Scope of Practice and Health Professional Regulation

What's the difference between licensure and certification?

Licensure

Recognizes competence to practice a given occupation of individual who completes required training and testing and is held accountable to practice within established standards of safety

Certification

Recognition (certification) by an authorized body that an individual, institution, or educational program has met predetermined requirements/standards

Both aim to protect public safety. What's the difference?

Licensure is required to practice, certification is voluntary.
Licensure confers a monopoly on who can enter profession, provide certain services (SOP) and get paid for it.

Definitions based on CLEAR (Council on Licensure, Enforcement & Regulation): http://www.clearhq.org/resources/glossary_general.pdf.

Regulation differs between states for same types of health care workers

- Education standards and licensure exams are mostly national, but licensure is state function
- State licensure boards determine requirements to enter practice and set boundaries on scope of services permitted
- Result = variation between states in:
  1. who is required to be licensed; and
  2. what services licensed health professionals can provide patients

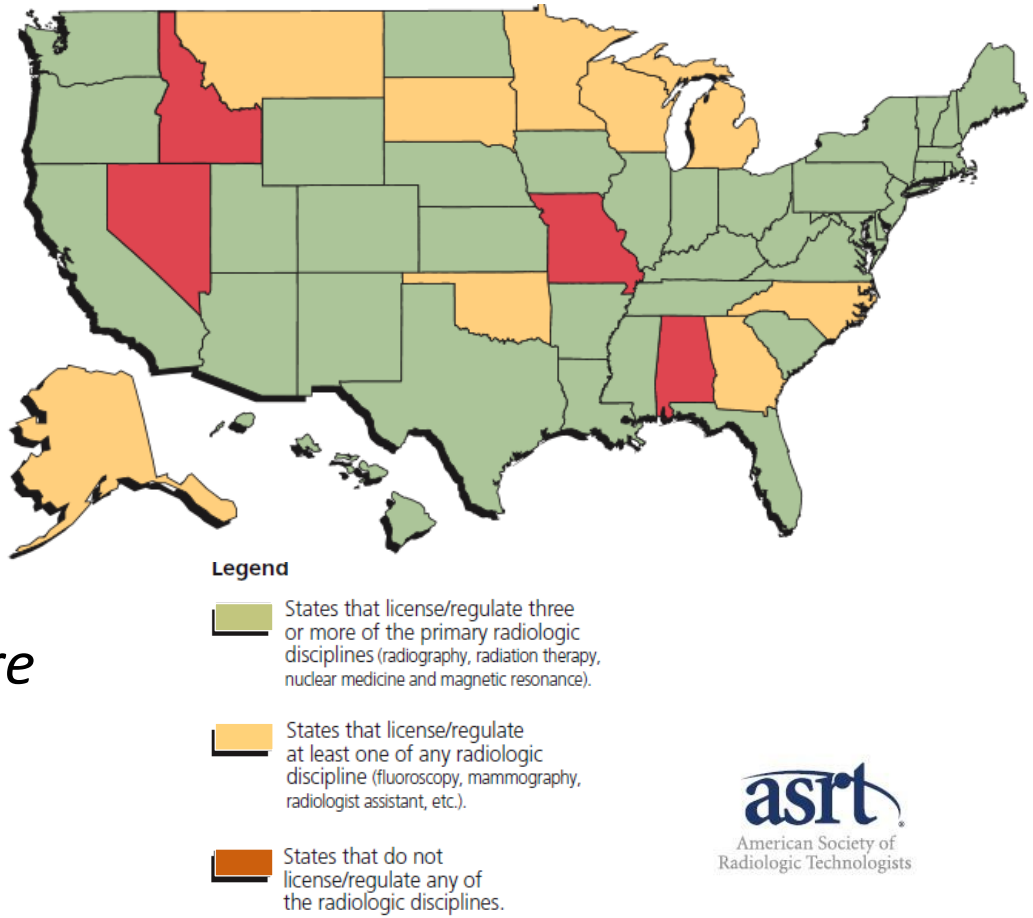
Example 1: Some states require radiologic technologists to be licensed, others do not

What they do:

RTs use various technologies (including radiation) to take pictures of a patient's body for radiologists, who interpret the images

Note: in North Carolina, hairdressers - but not RTs - are licensed

Radiology Technologist Licensure Environment, 2018



https://www.asrt.org/docs/default-source/govtrel/doesyourstateregulate.pdf?sfvrsn=2.

Example 2: Meanwhile Louisiana is only state where florists are licensed

- Louisiana previously required florists to make a floral arrangement that could be judged as part of licensing process. In 2010, legislature did away with that requirement. Now have to pass 40 question test

- Rationale cited is that without licensure “the profession would be denigrated…we are artists. It’s not an occupation”.

- Is this protecting the public or the profession?

Effort to end florist licensing in Louisiana nipped in the bud with Senate panel's rejection

BY ELIZABETH CRISP | ECRISP@THEADVOCATE.COM MAY 1, 2018 - 11:43 AM 2 min to read

2 of 2

Agriculture Commissioner Mike Strain and Rep. Julie Emerson, R-Carencro, discuss removing occupational licenses for florists during House Agriculture Committee on Thursday, March 29, 2018. In a close vote the committee sent House Bill 561 to the full House for consideration.

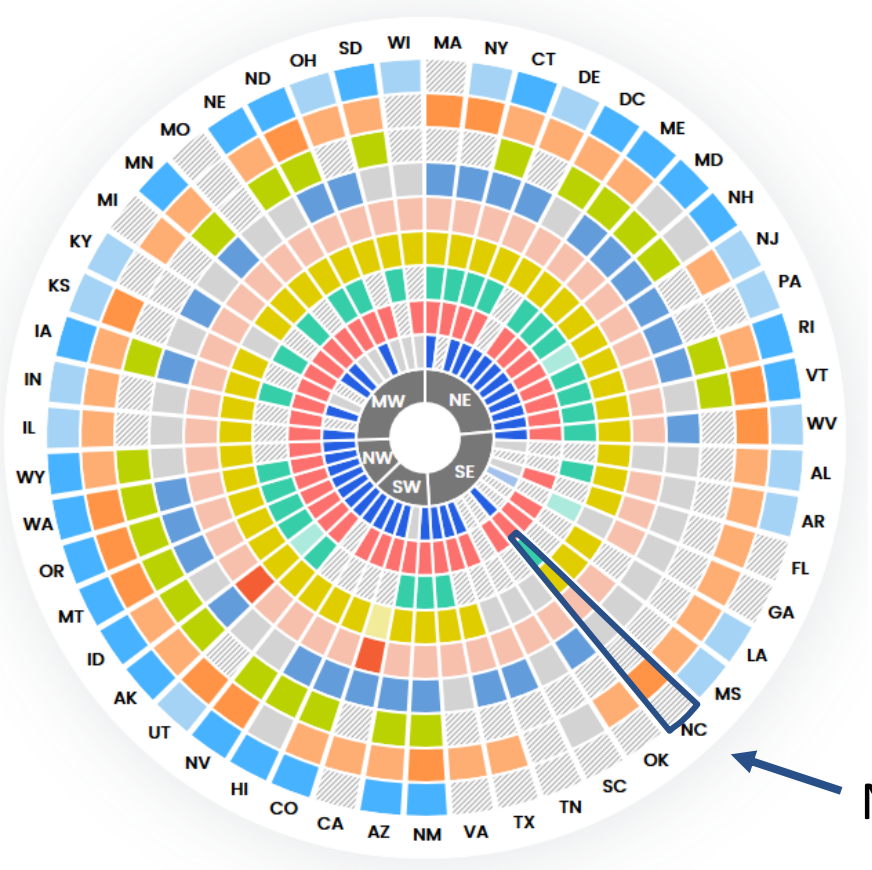
Buy Now

https://www.theadvocate.com/baton_rouge/news/politics/legislature/article_4058ed8e-4d59-11e8-aced-a3f61ef63b1c.html

Example 3: Nurse Practitioners are licensed in all states, but what they can do varies

- Significant variation exists in
  - prescriptive authority
  - whether physician supervision needed
  - whether NPs can order physical therapy, admit patients to hospitals, and sign workers' comp claims, death certificates, and handicap permits

In NC, NPs require physician supervision and are dually regulated by nursing and medical boards



NC

Color Key:

FULL

- Full, Reduced, or Restricted Practice
- Medical Staff Membership
- Autonomous Practice
- Primary Care Provider
- Independently Prescribe Schedule II Drugs
- Order Physical Therapy
- Sign Death Certificates
- Sign Disabled Person Placard Forms
- POLST/POST/MOLST/MOST/COLST

RESTRICTED

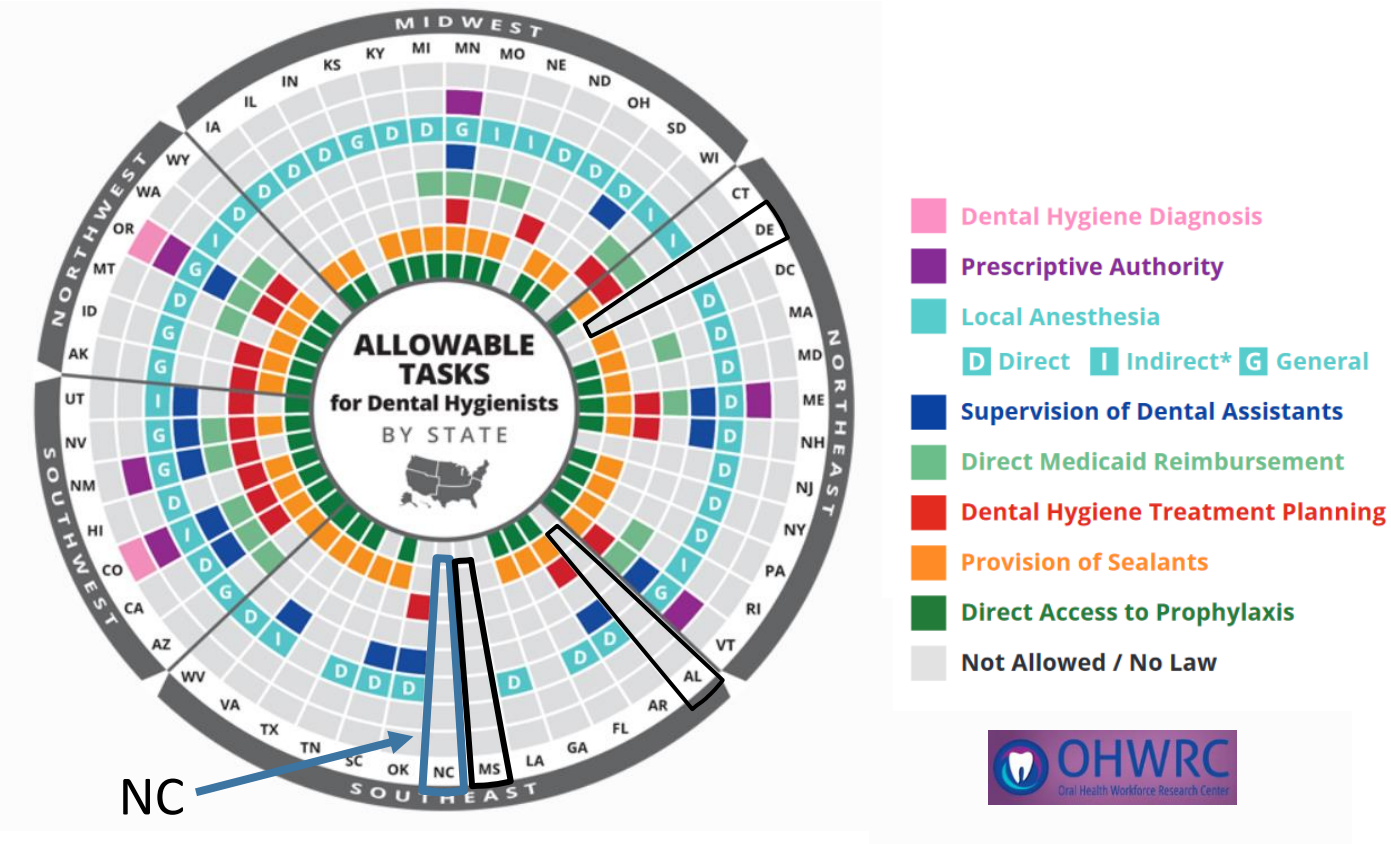
- No Law
- Not Allowed

https://www.bartonassociates.com/locum-tenens-resources/nurse-practitioner-scope-of-practice-laws/, Accessed 12/3/2019.

Scope of practice bills and laws in 2019-20 NC Legislative Session

- S143/H185 SAVE Act
  - Moves regulation of advanced practice nurses (APRNs—nurse practitioners, certified nurse-midwives, clinical nurse specialists and certified registered nurse anesthetists) to Board of Nursing, not joint regulation with Medical Board
  - Removes requirement for collaborative practice/supervisory agreements between APRNs and physicians
  - NC is only one of 12 states that requires supervising physicians for APRNs

Example 4: Compared to other states, NC has restrictive scope of practice for dental hygienists



http://www.oralhealthworkforce.org/resources/variation-in-dental-hygiene-scope-of-practice-by-state/, Accessed 12/3/2019.

Proposed rule change underway for public health dental hygienists

- Current NC law requires hygienists to be supervised by onsite dentist
- Exception: Public health hygienists practicing in schools, nursing homes, and federal, state, and local government-run clinics in underserved areas, but dentist must have previously examined the patient
- Prior examination requirement is bottleneck that restricts access to services for high-needs populations. A rule change supported by the NC Oral Health Collaborative and the NC Dental Society will replace the prior exam requirement with a standing order from a supervising dentist

What's the immediate impact of one small SOP rule change?

- The rule change (to be finalized 12/15/19) will allow public health hygienists with a dentist's standing order to provide preventive services to patients in:
  - Public school clinics
  - Nursing homes
  - Long-term care facilities
  - Government-run rural and community clinics
- The Duke Endowment and the BCBS Foundation are investing $35m in oral health services
  - Big part of investment is in school health clinics for high needs kids in NC, to be served by public health hygienists, after rule goes into effect
  - 10 school clinics are in implementation phase, 11 additional school clinics are in planning phase

Federal government has authority to restrict anti-competitive regulations and FTC has weighed in on rule change

FTC indicated in 11/15/2019 letter that it was supportive of the rule change but argued rule may still be too restrictive:

> "The Board's current regulatory requirement[…] ***decreases access to dental hygienists, without any apparent health and safety benefits***."

> "The [National] Institute of Medicine has likewise concluded that restrictive scope of practice and supervision laws and regulations governing dental hygienists ***are often unrelated to competence, education and training, or the safety of the services they provide***."

> "Although we support the Board's proposed rules […] we also ***urge the Board to consider less restrictive alternatives***" e.g. eliminating the standing order and allowing for direct access for public health hygienists

https://www.ftc.gov/policy/advocacy/advocacy-filings/2019/11/ftc-staff-comment-north-carolina-state-board-dental. Accessed 12/5/19.

The short version of the FTC's argument:

- Many low-income North Carolinians can't access preventive oral health care from hygienists due to regulatory restrictions
- There is a demonstrated need for oral health care in rural and underserved populations
- The data show that hygienists can provide this care. Evidence supporting concerns of decreased quality or safety is lacking
- Reducing the regulatory restrictions on hygienist SOP is likely to improve access to care, with no downside to patient health or safety

The Supreme Court has previously weighed in on North Carolina Dental Board regulation

- 2015 Supreme Court Case: *North Carolina State Board of Dental Examiners v. Federal Trade Commission*
  - Dental Board sent cease-and-desist letters sent to cosmetic teeth whitening clinics since not licensed to practice dentistry
  - FTC said anti-competitive because (per state law) 6 of 8 board members were dentists active in profession and had vested self-interest
- Court's decision has had national impact, with many lawsuits against state regulatory boards in other states and in professions outside health

Strong and often conflicting stakeholders involved in SOP battles

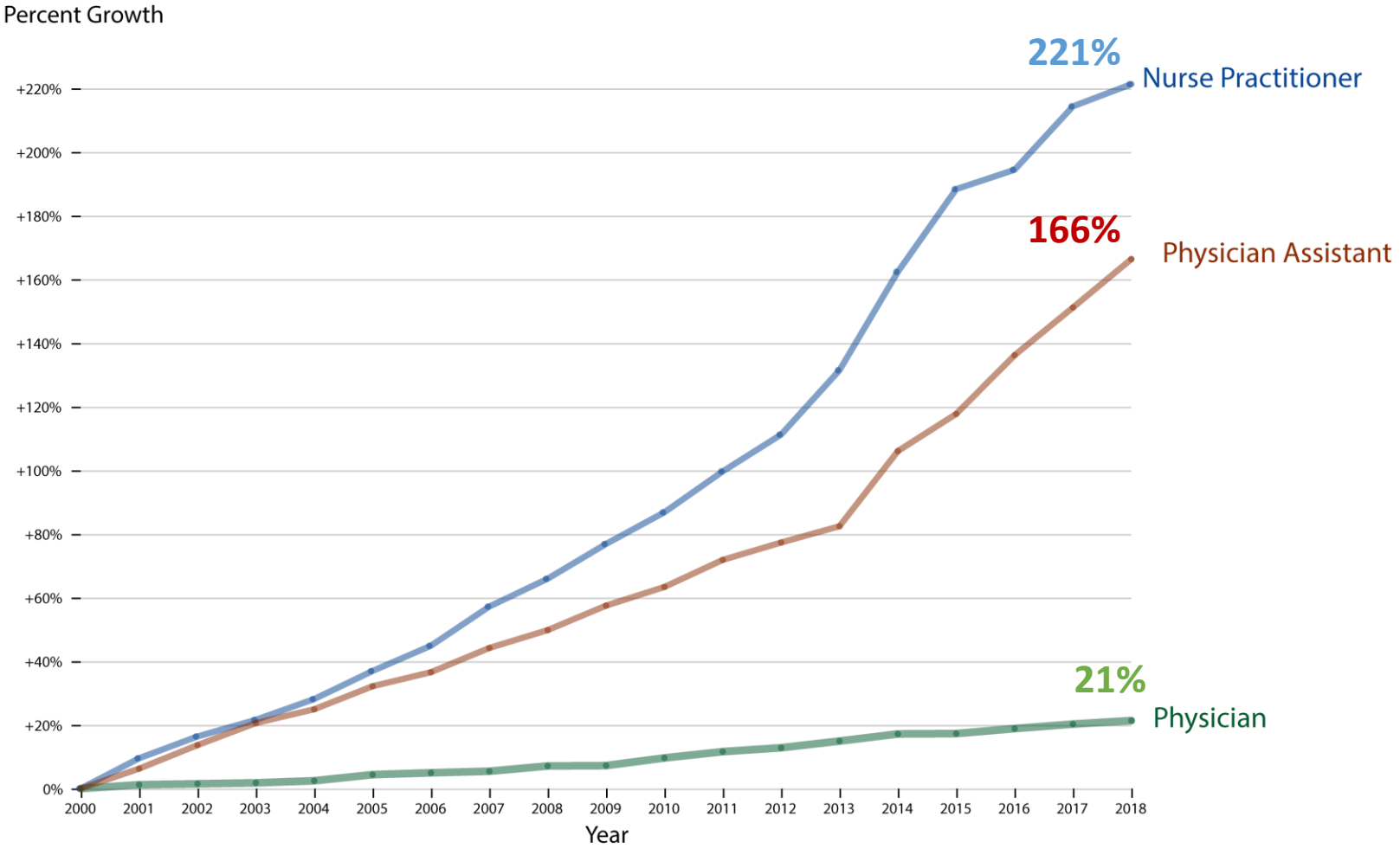
- Stakeholders include:
  practicing health professionals and their associations, licensure boards, employers, individuals wanting to enter profession, payers, legislators and state policy makers, patients/consumers
- Higher paid professionals (i.e. physicians and dentists) have more lobbying power than lower paid ones (nurses and hygienists)
- Often patient, family and community voice is lost among professional lobbyists

The role of licensure bodies as stakeholders: It's complicated

- Licensure bodies are self-regulating. Their mission is to protect public safety.
- Self-regulation was originally instituted at request of medical profession because the body of professional knowledge was unknown to average citizen, making external regulation difficult
- Licensure boards are expected to set standards and discipline members to protect public safety
- Yet, boards have relatively few public members. Tension exists between protecting public versus protecting the profession
- The ongoing tensions between nursing and medicine typify the struggle to balance self-regulation with professional self-interests

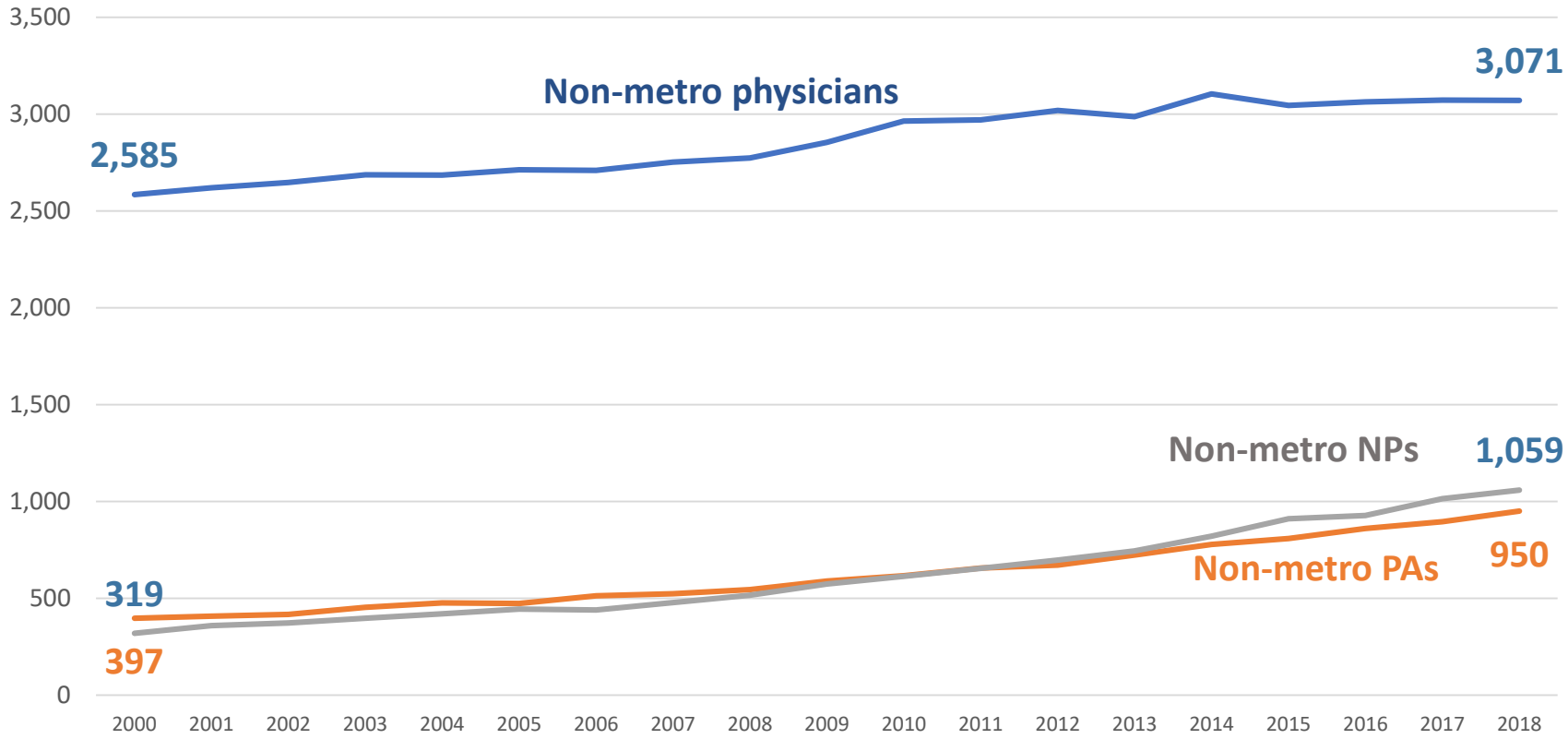
Let's look at the data: NC has seen rapid growth in Nurse Practitioner and Physician Assistant workforce

Cumulative Percentage Growth per 10,000 Population since 2000 for Nurse Practitioners, Physicians, Physician Assistants in North Carolina



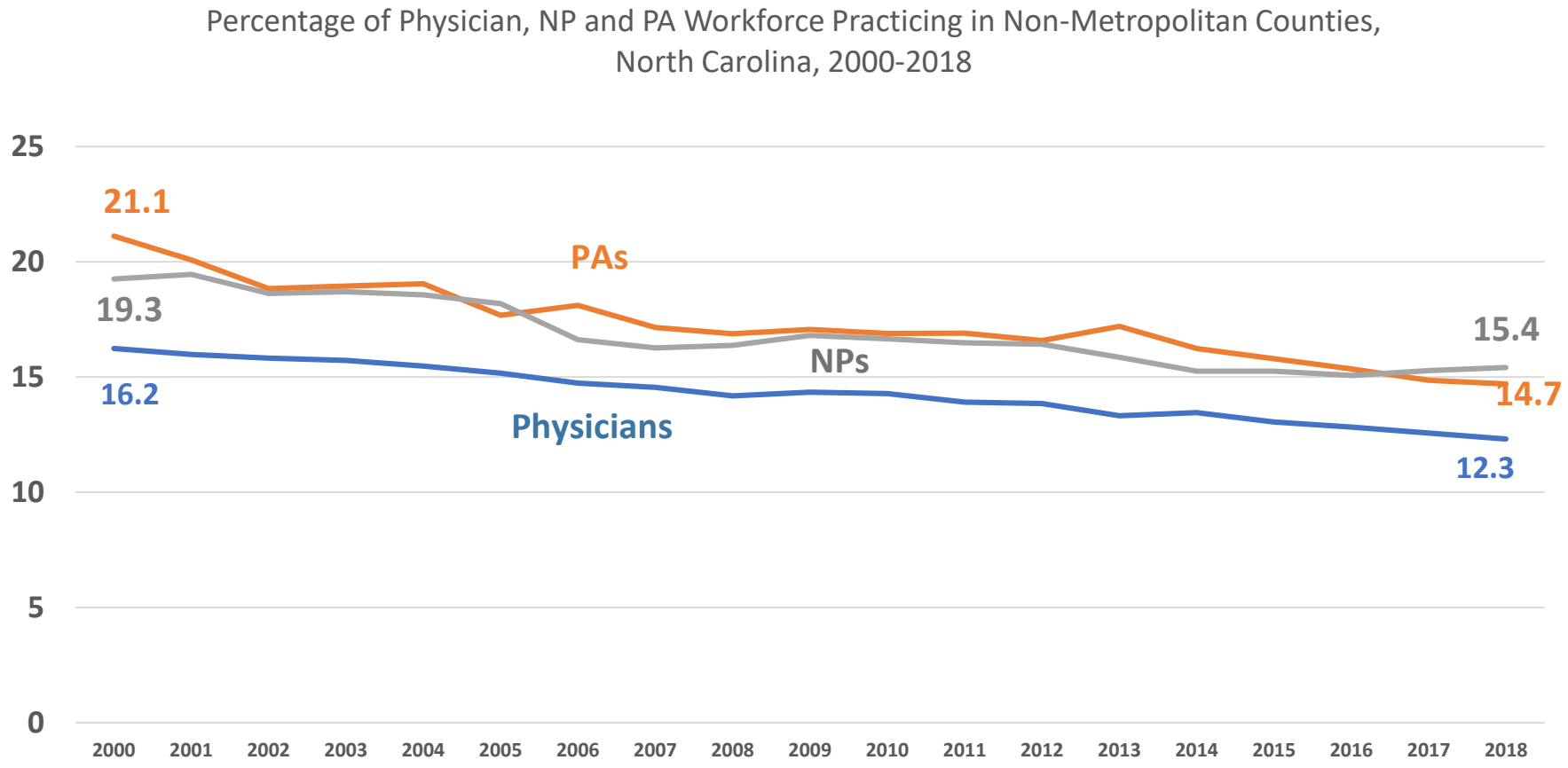
Many more physicians in non-metro counties compared to NPs and PAs but gap is narrowing

Numbers of Physicians, Nurse Practitioners and PAs in Non-Metropolitan Counties*, North Carolina, 2000-2018



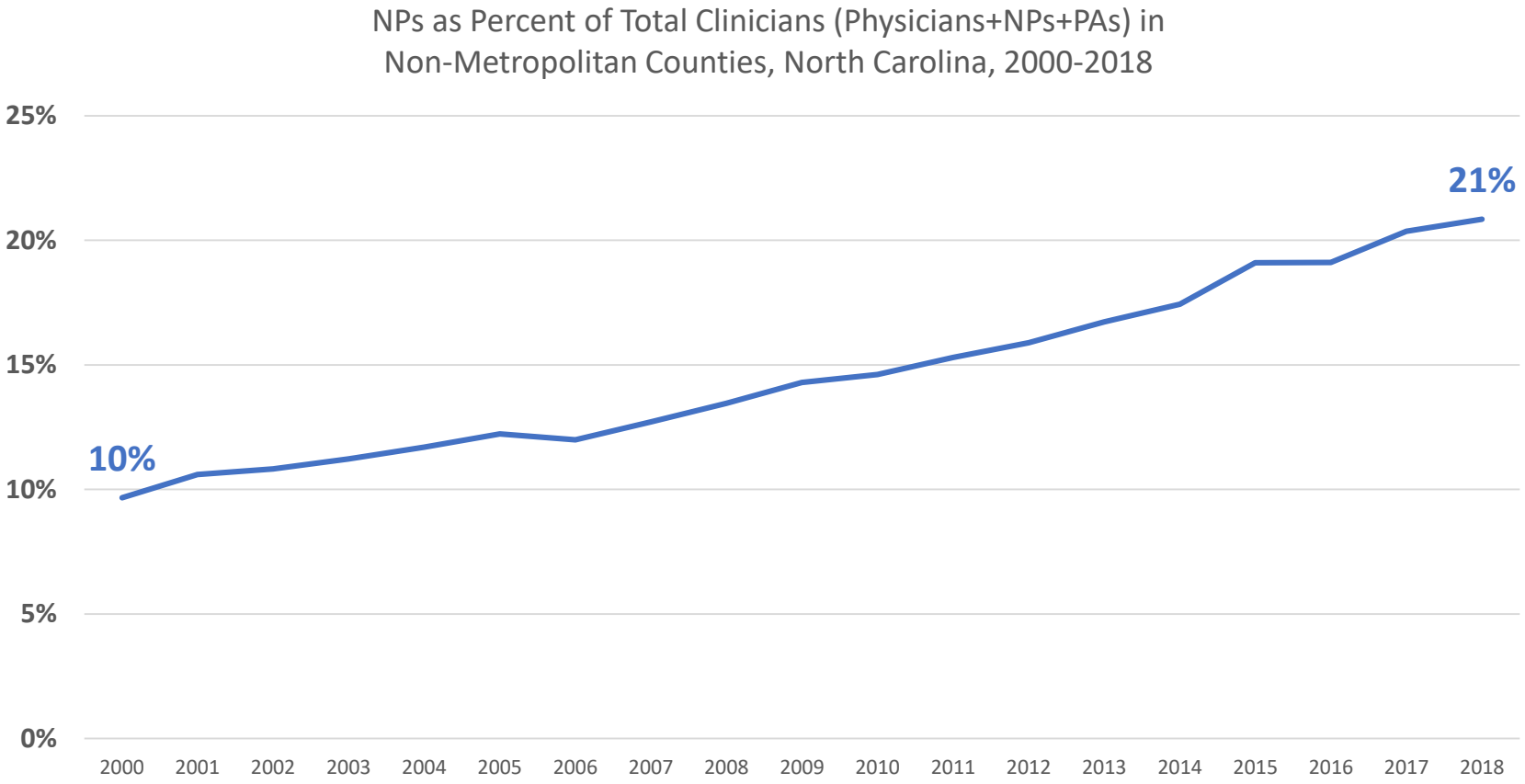
Notes: Data include active, licensed professionals in practice in North Carolina as of October 31 of each year. Data are derived from licensure data from each profession's licensing board. County estimates are based on primary practice location. Metro and nonmetro delineations are from the United States Office of Management and Budget and applied to Census data. According to the 2017 version of the delineation file, which is used for this analysis, North Carolina had 54 nonmetro (rural) counties.

Declining proportion of physician, NP and PA workforce practicing in non-metro counties



Notes: Data include active, licensed professionals in practice in North Carolina as of October 31 of each year. Data are derived from licensure data from each profession's licensing board. County estimates are based on primary practice location. Metro and nonmetro delineations are from the United States Office of Management and Budget and applied to Census data. According to the 2017 version of the delineation file, which is used for this analysis, North Carolina had 54 nonmetro (rural) counties.

Together, these trends mean that NPs make up increasing percentage of workforce in rural communities



Notes: Data include active, licensed professionals in practice in North Carolina as of October 31 of each year. Data are derived from licensure data from each profession's licensing board. County estimates are based on primary practice location. Metro and nonmetro delineations are from the United States Office of Management and Budget and applied to Census data. According to the 2017 version of the delineation file, which is used for this analysis, North Carolina had 54 nonmetro (rural) counties.

The Evidence: NPs increase access to care, particularly for rural and underserved patients

- NPs more likely to practice in counties with lower socioeconomic and health status[1]
- Narrowing gap between primary care NP and physician workforce supply in rural and low-income areas[2]
- Rural counties in "full practice" states have significantly more primary care NPs per capita compared to rural counties in states where NP scope of practice is "restricted" [3]
  (NC is a "restricted" state)
- States granting NPs greater SOP authority exhibit greater increase in the number and growth of NPs, greater care provision by NPs, and expanded health care utilization, especially among rural and vulnerable populations[4]

1. Davis MA, Anthopolos R, Tootoo J, Titler M, Bynum JPW, Shipman SA. Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *J Gen Intern Med*. 2018 Apr;33(4):412-414. doi: 10.1007/s11606-017-4287-4.
2. Xue Y, Smith JA, Spetz J. Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas 2010-2016. JAMA, 2019; 321(1): 102105
3. Graves JA, et al. Role of geography and nurse practitioner scope-of-practice in efforts to expand primary care system capacity. *Medical Care.* 2016;54(1):81-89

4. Xue Y, Ye Z, Brewer C, Spetz J . Impact of state nurse practitioner scope-of-practice regulation on health care delivery: Systematic review. *Nurs Outlook*. 2016 Jan-Feb;64(1):71-85. doi: 10.1016/j.outlook.2015.08.005. Epub 2015 Sep 9.

The relationship between SOP practice and NP supply is important in context of opioid epidemic

- In 2017, the *Comprehensive Addiction and Recovery Act* enabled NPs and PAs to obtain federal waivers to prescribe buprenorphine
- NPs and PAs must take 24 hours of training (physicians train for 8 hours)
- After training, NPs and PAs can prescribe buprenorphine for up to 30 patients in first year, 100 patients after that
- In NC, because of restrictive SOP, both NP and his/her supervising physician must be waivered for the NP to prescribe buprenorphine

In NC in 2018, nearly equal % of NPs and Physicians are waivered, fewer PAs

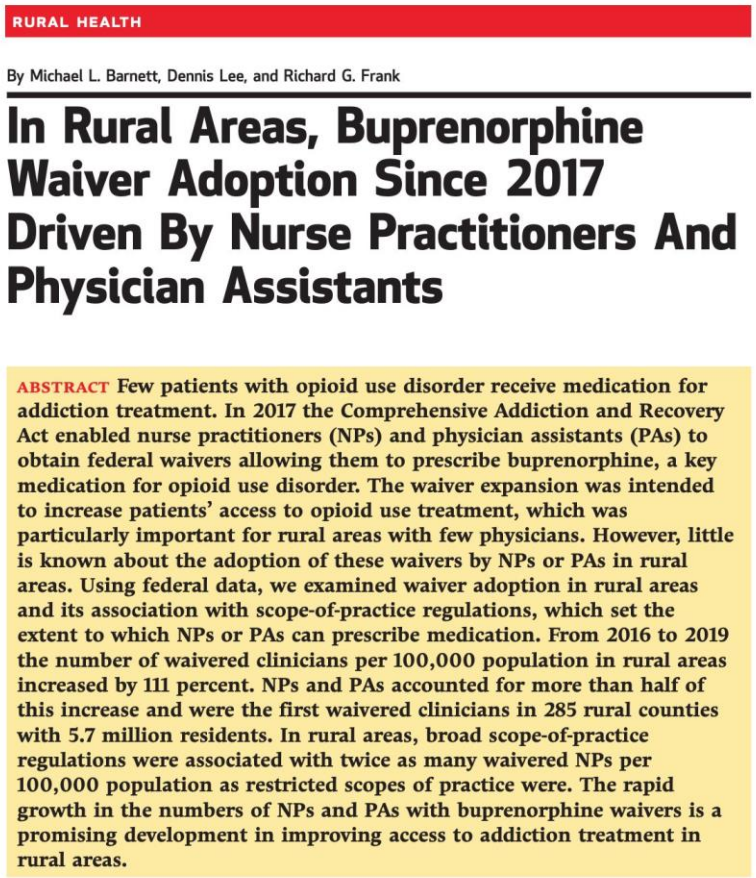
Provider Type	# of patients provider can prescribe for in a year (waiver limit)			Total waivered providers	Total active providers in NC	Waivered providers as % of active providers
	30	100	275			
Physician	770	229	155	1,154	24,934	4.6%
NP	238	49		287	6,868	4.2%
PA	101	28		129	6,463	2.0%
Totals	1,109	306	155	1,570	38,265	4.1%
Source: SAMHSA, Sheps Health Workforce NC						

Important notes:

1. Just because NP has waiver does not mean s/he is prescribing
2. We don't know if the NPs in these data are supervised by a waivered physician and therefore able to prescribe
3. 2019 *JAMA* study by Spetz and colleagues found more restrictive SOP states had lower percentage of NPs who were waivered

Spetz J, Toretsky C, Chapman S, Phoenix B, Tierney M. Nurse Practitioner and Physician Assistant Waivers to Prescribe Buprenorphine and State Scope of Practice Restrictions. JAMA 321(14): 1407-1408

States with less restrictive SOP have higher numbers, and growth, of waivered NPs and PAs, particularly in rural areas



RURAL HEALTH

By Michael L. Barnett, Dennis Lee, and Richard G. Frank

In Rural Areas, Buprenorphine Waiver Adoption Since 2017 Driven By Nurse Practitioners And Physician Assistants

ABSTRACT Few patients with opioid use disorder receive medication for addiction treatment. In 2017 the Comprehensive Addiction and Recovery Act enabled nurse practitioners (NPs) and physician assistants (PAs) to obtain federal waivers allowing them to prescribe buprenorphine, a key medication for opioid use disorder. The waiver expansion was intended to increase patients' access to opioid use treatment, which was particularly important for rural areas with few physicians. However, little is known about the adoption of these waivers by NPs or PAs in rural areas. Using federal data, we examined waiver adoption in rural areas and its association with scope-of-practice regulations, which set the extent to which NPs or PAs can prescribe medication. From 2016 to 2019 the number of waivered clinicians per 100,000 population in rural areas increased by 111 percent. NPs and PAs accounted for more than half of this increase and were the first waivered clinicians in 285 rural counties with 5.7 million residents. In rural areas, broad scope-of-practice regulations were associated with twice as many waivered NPs per 100,000 population as restricted scopes of practice were. The rapid growth in the numbers of NPs and PAs with buprenorphine waivers is a promising development in improving access to addiction treatment in rural areas.

- From 2016-2019 number of waivered providers in rural areas increased 111%
- NPs and PAs accounted for more than half of this increase
- Majority of new waivered providers in rural areas were NPs and PAs
- In rural areas, broad SOP associated with twice as many waivered NPs per 100K population than restrictive ones

Barnett ML, Lee D, Frank RG. In Rural Areas, Buprenorphine Waiver Adoption Since 2017 Driven By Nurse Practitioners and Physician Assistants. *Health Affairs* December 2019; 38(12): 2048-2056

In a system that is moving toward value, evidence is mounting that NPs provide value care

- Increased frequency of routine checkups and decreased emergency room use (Traczynski & Udalova, 2018)
- Medically underserved women living in states with laws that restrict NP full scope-of-practice are twofold more likely to be diagnosed with late-stage cervical cancer (Smith-Gargen, et al, 2018)
- Primary care NPs and primary care MDs order low-value back images at same rate (O'Reilly-Jacob et al 2019)

But why is the burden of proof one-sided?

State medical societies recognize lack of data on whether physicians provide higher quality care. Executives noted in 2012 report:

> "I don't think we can hold back scope of practice much longer without data. If there's no data, we're on thin ice."

> "The CRNAs have data [showing favorable outcomes], but we don't have any data showing that physician outcomes are better."

> "We don't have a strong policy argument [against allowing optometrists to prescribe oral medications] because we don't have any data showing that there's a problem in the other 46 states that *allow* prescriptions."

> "We just don't have the outcome data."

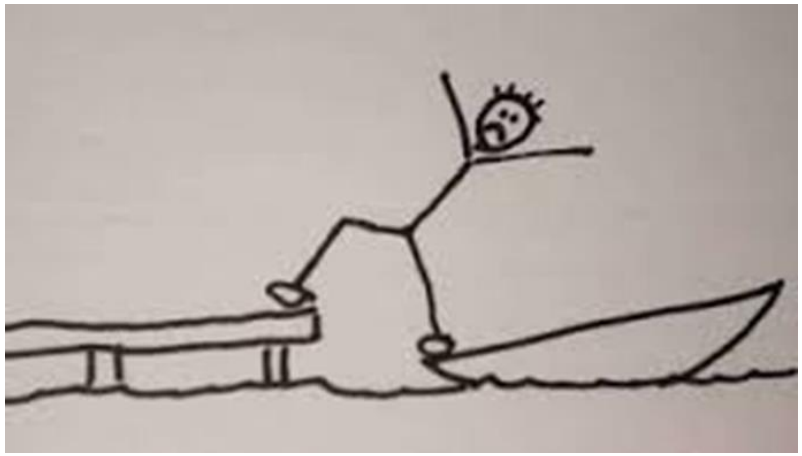
Source: Isaacs S, Jellinek P. Accept No Substitute: A Report on Scope of Practice. The Physicians Foundation. November 2012. https://physiciansfoundation.org/wp-content/uploads/2017/12/A_Report_on_Scope_of_Practice.pdf.

Variation in regulation between states is often not evidence-based

- Evidence is often not available to inform SOP decisions
- States sometimes look to other states as "policy laboratories" to determine:
  - Did change result in adverse patient outcomes?
  - Did SOP changes solve/have an effect on the problem at hand? Increase access? Decrease cost? Improve patient satisfaction?

Health care system is changing rapidly: Regulation needs to adapt

- New care delivery and payment models encourage new roles among existing health providers
- At same time, new roles are emerging –community health workers, care coordinators, community paramedics, etc.
- Technology and scientific advancements are changing roles and responsibilities



"The health profession regulation system in place today does not have the flexibility to support change"

Source: Dower C, Moore J, Langelier M. It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Aff* (Millwood). 2013 Nov;32(11).

Moving forward:
How do we get there from here?

Resources and tools for NC legislators that support evidence-based evaluation of SOP changes:

- Scope of Practice Evaluation Tool
- Demonstration project model
- Consider alternative policy levers instead of regulatory change

Resources and tools: Objective scope of practice evaluation frameworks

- Minnesota and Virginia have developed frameworks to help policy makers objectively evaluate scope of practice changes for regulated health professionals

- MN framework developed by professional associations, state licensing boards, legislators, MN Department of Health, Office of Rural Health, National Governors Association and National Council of State Legislatures

VA: Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions. https://www.dhp.virginia.gov/bhp/guidelines/75-2.doc

MN: Minnesota Office of Rural Health and Primary Care. Scope of Practice Tools. http://www.health.state.mn.us/divs/orhpc/scope.html

Key considerations for legislators evaluating SOP proposals

Public safety

- Describe, using evidence, how proposed change may improve or harm safety
- Is there research evidence that change might have risk?

Access

- Describe how unmet health care needs of population (including disparities) will be met by this proposal
- Does proposal encourage service to underserved populations?
- How does proposal contribute to evolving health care delivery and payment models?

Regulation and training required

Regulation

- What is proposed form of change (licensure, certification, etc.)
- Have other states adopted this regulatory change?
- Does proposed change in SOP overlap with other health professionals?

Education and supervision

- What training, education or experience will be required?
- Is education available?
- What is recommended level of supervision? Independent, collaborative, supervised?

Financial and workforce impacts

Reimbursement and Fiscal Impact to State

- How and by whom will expanded services be compensated?
- What costs will accrue to whom (patients, insurers, employers)
- Is reimbursement available in other states?
- What is the state fiscal impact of the change?

Workforce Impacts

- How many health professionals are expected to practice under the change? What is geographic distribution?
- How will change affect the overall supply of providers in relation to demand?

When data are lacking, one option is to allow demonstration projects to build evidence base

California Health Workforce Pilot Projects Program

- Allows organizations to test and evaluate proposed changes in licensure before decision is made by the Legislature. Demonstrations are used to:
  - evaluate changes to *existing* health professions' roles and regulation
  - evaluate *new/emerging* roles for health professions in new healthcare delivery models
- Demonstrations require evaluation, including cost effectiveness, access to care and implications for workforce development

Since 1972:

- **173 HWPP applications submitted**
- **123 approved**
- **77 resulted in legislative and/or regulatory change**

Regulations & Statutes

- California Codes Health and Safety Code Section 128125-128195 establishes HWPP. https://www.oshpd.ca.gov/documents/HWDD/HWPP/HMPPlegcode.pdf
- California Code of Regulations Section 92001-92702 provides definitions and criteria for administering HWPP. https://www.oshpd.ca.gov/documents/HWDD/HWPP/HMPPPregs.pdf

Sunset and Sunrise Reviews

Sunrise Review

- Before legislation enacted
- Clarifies impacts, costs, and benefits of licensing/professional regulation
- 14 states conduct these

Sunset Review

- Formal process to review regulatory agencies periodically to ensure effectiveness and necessity.
- 36 states conduct these. Ohio is the latest state to require sunset reviews of all regulatory agencies every 6 years

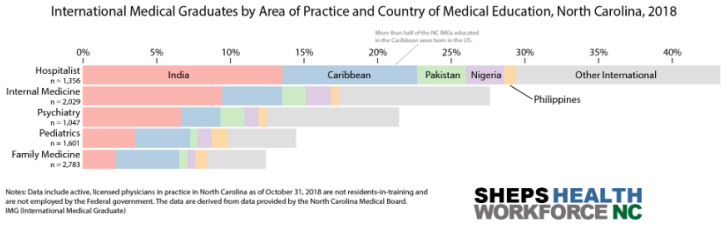
UNC
THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

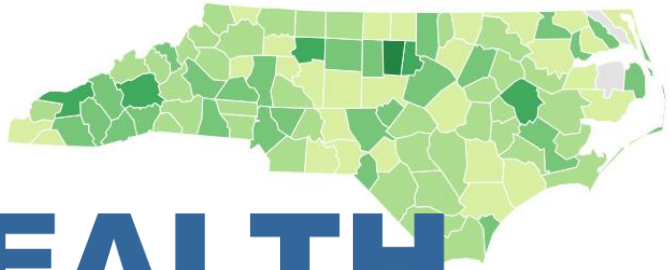
Hentze I. Improving occupational licensing with sunrise and sunset reviews. NCSL LegisBrief (vol. 26): July 2018. Accessed 12/5/19 from: http://www.ncsl.org/research/labor-and-employment/improving-occupational-licensing-with-sunrise-and-sunset-reviews.aspx

One final consideration, consider whether regulatory change is needed

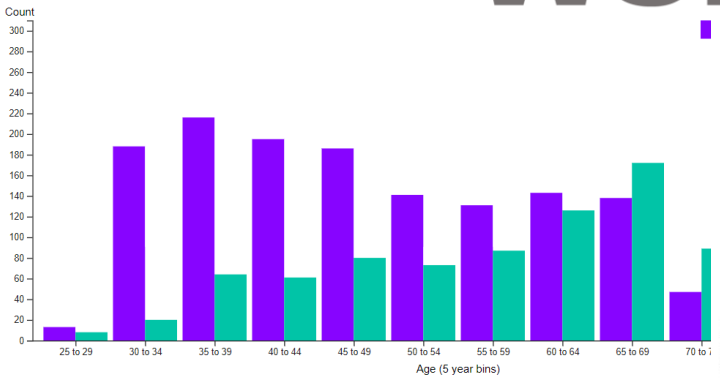
- Is regulatory change the best way to achieve underlying goal?
- Are there other ways to increase access to care, improve quality, and achiever greater efficiency?
- Consider multiple incentives to encourage practice in underserved areas
  - **Payment**: for example, increase Medicaid payment rates for dentists
  - **Support practice in rural communities**: for example, work with NC Office of Rural Health to better target loan repayment to needed communities
  - **Require outcomes data** for public funds spent on health professions training
  - Invest funding in **developing pipeline** of students from underserved communities
  - **Support career ladders** for health professionals in rural and underserved communities

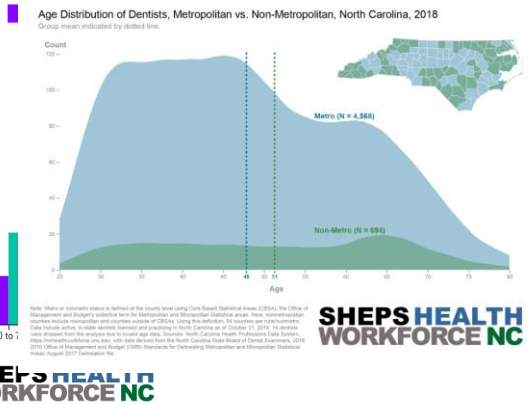
Check out our website for NC Health Workforce info, maps, and graphics!

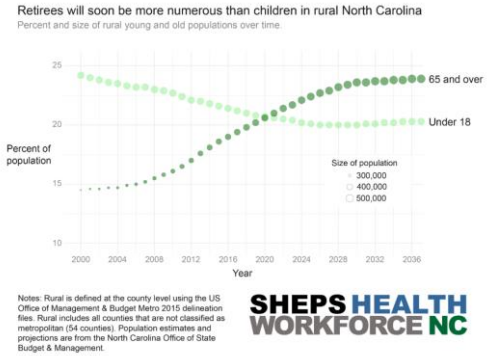




SHEPS HEALTH WORKFORCE NC







nchealthworkforce.unc.edu

Find us, Follow Us, Sign up For our Newsletter

UNC

THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

Program on Health Workforce Research & Policy

go.unc.edu/Workforce

@UNC_PHWRP

SHEPS HEALTH WORKFORCE NC

nchealthworkforce.unc.edu

@WorkforceNC

★ Sign up for our newsletter directly at go.unc.edu/WorkforceNewsletter

Contact Information

Erin Fraher, PhD

(919) 966-5012

erin_fraher@unc.edu

Director

Program on Health Workforce Research and Policy

Go.unc.edu/Workforce

nchealthworkforce.unc.edu

Citations: state resources

- California Health Workforce Pilot Projects Program: https://www.oshpd.ca.gov/HWDD/HWPP.html

  Regulations & Statutes

  - California Codes Health and Safety Code Section 128125-128195 establishes HWPP. https://www.oshpd.ca.gov/documents/HWDD/HWPP/HMPPlegcode.pdf
  - California Code of Regulations Section 92001-92702 provides definitions and criteria for administering HWPP. https://www.oshpd.ca.gov/documents/HWDD/HWPP/HMPPPregs.pdf
- Virginia Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions. https://www.dhp.virginia.gov/bhp/guidelines/75-2.doc
- Minnesota Office of Rural Health and Primary Care. Scope of Practice Tools. http://www.health.state.mn.us/divs/orhpc/scope.html
- CLEAR (Council on Licensure, Enforcement & Regulation): http://www.clearhq.org/resources/glossary_general.pdf
- Virginia Board of Health Professions. 2014. Review of Dental Hygienist Scope of Practice. https://www.dhp.virginia.gov/bhp/studies/DentalHygenistReview.pdf
- DeSanti SS, Farrel J, Feinstein RA. FTC Staff Letter to the Honorable Representative Jeanne Kirkton, Missouri House of Representatives, Concerning Missouri House Bill 1399 and the Regulation of Certified Registered Nurse Anesthetists. March 27, 2012. https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-representative-jeanne-kirkton-missouri-house-representatives-concerning/120327kirktonmissouriletter.pdf

Citations: scholarly articles and reports

- Astroth DB, Cross-Poline GN. Pilot Study of Six Colorado Dental Hygiene Independent Practices. *Journal of Dental Hygiene*. 1998;72(1):13-22.
- Freed JR, Perry DA, Kushman JE. Aspects of Quality of Dental Hygiene Care in Supervised and Unsupervised Practices. *Journal of Public Health Dentistry*. 1997;57(2):68-72.
- Graves JA, et al. Role of geography and nurse practitioner scope-of-practice in efforts to expand primary care system capacity. *Medical Care*. 2016;54(1):81-89.
- IOM (Institute of Medicine) and NRC (National Research Council). 2011. Improving access to oral health care for vulnerable and underserved populations. Washington, DC: The National Academies Press. https://www.nap.edu/catalog/13116/improving-access-to-oral-health-care-for-vulnerable-and-underserved-populations.
- Langelier M, Continelli T, Moore J, Baker B, Surdu S. Expanded Scopes of Practice for Dental Hygienists Associated with Improved Oral Health Outcomes for Adults. *Health Affairs.* 2016;35(12): 2207-2215.
- Martsolf G, Kandrack R. The Impact of Establishing a Full Scope of Practice for Nurse Practitioners in Michigan. Santa Monica, CA: RAND Corporation. 2016. https://www.rand.org/pubs/research_reports/RR1639.html.
- Olmstead JL, Rublee N, Zurkawski E, Kleber L. Public Health Dental Hygiene: An Option for Improved Quality of Care and Quality of Life. *Journal of Dental Hygiene.* 2013;87(5):299-308.
- Standley N. Antitrust and regulatory boards: where do we go from here? *J Nursing Regulation*. 2018;8(4).
- Xue Y, Ye Z, Brewer C, Spetz J. Impact of state nurse practitioner scope-of-practice regulation on health care delivery: Systematic review. *Nursing Outlook*. 2016;64(1):71-85.

Citations and additional resources

- Allowable Tasks for Dental Hygienists by State. Oral Health Workforce Research Center. http://www.oralhealthworkforce.org/resources/variation-in-dental-hygiene-scope-of-practice-by-state/.
- Interactive Nurse Practitioner (NP) Scope of Practice Law Guide. Barton Associates. https://www.bartonassociates.com/locum-tenens-resources/nurse-practitioner-scope-of-practice-laws/.
- Isaacs S, Jellinek P. Accept No Substitute: A Report on Scope of Practice. The Physicians Foundation. November 2012 https://physiciansfoundation.org/wp-content/uploads/2017/12/A_Report_on_Scope_of_Practice.pdf
- Langelier M. The Impact of Changing Workforce Models on Access to Oral Health Care Services. Health Workforce Technical Assistance Center Webinar to the OH 20/20/ Network. March 13, 2018. http://www.healthworkforceta.org/webinars/3419-2/
- LeGros, N, Robinson A. Retail Clinics — Coming Soon to a Store Near You. Health Lawyers News. September 2008, p. 32. http://www.healthlawyers.org/News/Connections/Archive/Documents/2008%20Analysis/hln0809_Analysis.pdf
- National Governors Association Center for Best Practices https://www.nga.org/cms/center/issues/health/health-care-workforce-redesign