

REFORMING SCOPES OF PRACTICE

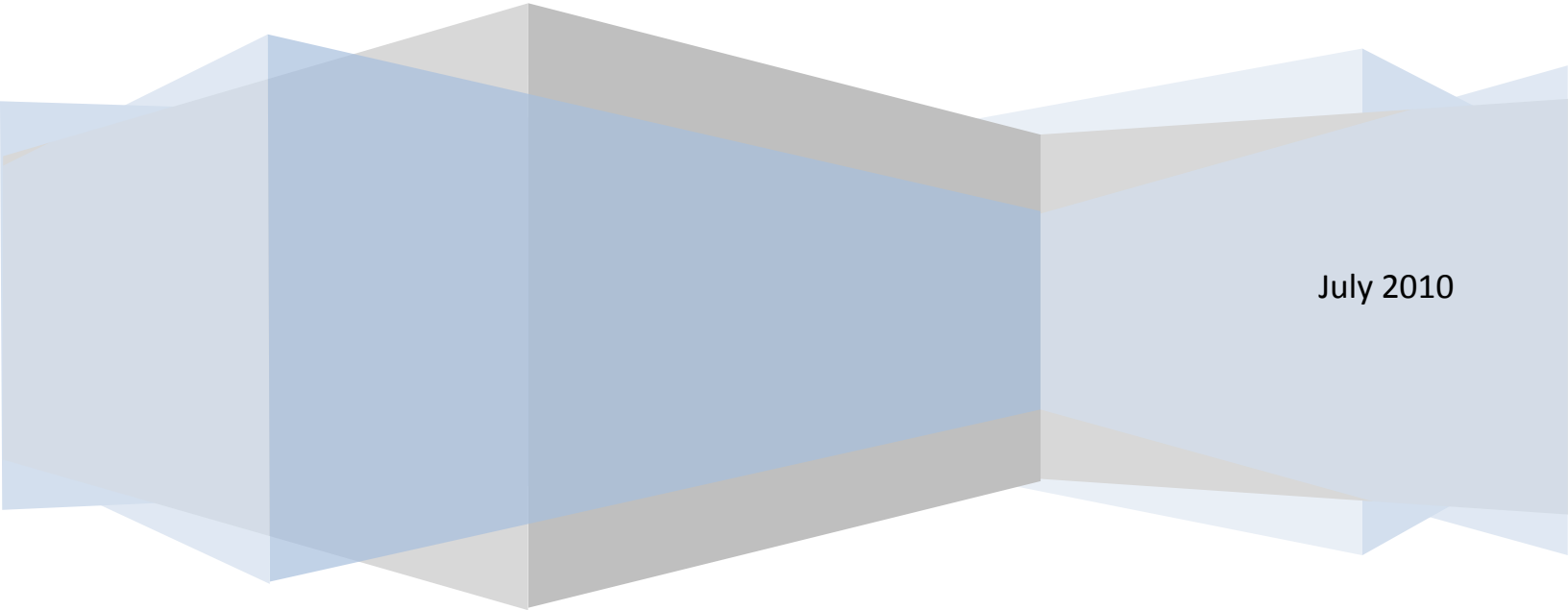
A WHITE PAPER

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Abstract.....	1
Reforming Scope of Practice.....	2
Introduction	2
The Challenges.....	3
Most States Are Approaching Healthcare Reform and Scope of Practice in a Piecemeal Fashion	5
Case Study: Pennsylvania.....	6
How Did This Happen in Pennsylvania?.....	8
The Evidence Base for Expanded Scopes.....	9
Developing Evidence in the Future.....	12
Implementation	14
Standards and Criteria for Deciding Scope of Practice Issues	14
Institutional Mechanisms for Deciding Scope of Practice Expansions	15
Conclusion.....	18
Next Steps	18

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ABSTRACT

Many aspects of healthcare reform can be accomplished at the federal level through the Patient Protection and Affordable Care Act, but there are at least two elements (scope of practice and continuing competence) that must be addressed by the states, because the legal authority resides in state-based health professional licensing laws. Depending on how they are written and implemented, scope of practice laws can either limit or promote access to care, thereby affecting the quality and cost of services. Proposed or recently enacted scope of practice expansions demonstrate that disputes can occur anywhere, and involve just about any health care profession. In ten states that currently have legislative activities addressing healthcare quality improvement, only Pennsylvania has made scope of practice reforms an essential element of its program. Those who support expanded scopes of practice recognize how difficult it is to provide evidence to demonstrate that quality and safety will not be diminished when scopes of practice are expanded. There are very few institutional mechanisms to address and resolve scope of practice disputes in the states. Consumer advocacy groups will need to make their support known if changes in scopes of practice similar to those in Pennsylvania are to be repeated in multiple other states.

REFORMING SCOPE OF PRACTICE

Introduction

The Obama administration and the interest groups that worked to enact the Patient Protection and Affordable Care Act are hopeful that it will help salvage the country's broken healthcare system, provide more consumer-friendly insurance coverage for all or some of the nearly fifty million Americans who are currently uninsured, and reduce the rate of increase in healthcare costs, if not the total amount expended.

Many aspects of healthcare reform, including insurance coverage, portability, and mandates, are being addressed at the federal level. Nonetheless, there are at least two elements (scope of practice and continuing competence) that must be addressed by the states because the legal authority resides in state-based health professional licensing laws. Although stronger continuing competence requirements at the state level could significantly enhance healthcare quality, that aspect of reform is beyond the scope of this paper.¹ Here, we concentrate on scope of practice regulations, which directly impact the composition and productivity of the healthcare workforce. Depending on how they are written and implemented, scope of practice laws can either limit or promote access to care, thereby affecting the quality and cost of services.

By covering a significant number of the currently uninsured, federal health care reform will increase demand for healthcare services and thereby compound already worrisome shortages of healthcare personnel, especially among primary care physicians and nurses practicing in all settings. Paradoxically, having an overtaxed healthcare workforce is an incentive for policymakers to take a fresh look at the subject of this paper: the scope of practice regulations that specify which services various healthcare professions are permitted to provide to whom in what settings. It is increasingly recognized that scope of practice restrictions often prevent professionals other than physicians from practicing to the full extent of their training and skills.

In testimony before the House Committee on Energy and Commerce Subcommittee on Health, James R. Bean, MD, President, American Association of Neurological Surgeons put it this way:

To the degree that the clinical care workforce as a whole needs more providers to address the changing needs of the population, a strong strategy of support for nurse practitioners and physician assistants should be adopted. The increased use of PAs and NPs should not be limited to the primary care section. Both professions have demonstrated excellent functionality as team members in all aspects of medical practice... Nurse practitioners and physician assistants are trained more quickly, at less expense than physicians, cost less in practice, and are not, on their own, drivers of ancillary clinical tests and services. Moreover, they represent a highly flexible workforce – an important asset generally lacking in the physician workforce... NPs and PAs provide a well-proven quality, clinical workforce that can interdigitate with all aspects of physician practice and whose pipeline can be turned up or down as needed to assist in addressing emerging or changing clinical needs.²

¹ Swankin, D., LeBuhn, R., Morrison, R., *Implementing Continuing Competence Requirements for Health Care Practitioners*, AARP Public Policy Institute, #2006 – 2016, July 2006.

² Bean, James R., MD, Testimony before the House Committee on Energy and Commerce Subcommittee on Health, March 14, 2006.

Further, changing scope of practice laws represents an important way to control long-term health care costs. The Engelberg Center for Health Care Reform, at Brookings Institution in the report, *Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth*, among its recommendations, points out the need to:

Create incentives for states to amend the scope of practice laws to allow for greater use of nurse practitioners, pharmacists, physician assistants, and community health workers.³

While it might make sense to address scope of practice on a national level,⁴ the authors of this paper chose to accept the existing legal framework and concede the difficulty of cracking the ingrained tradition of state-level professional regulation. Scope of practice reform is more likely to get attention at the state level than it is to find its way into an already complex and contentious federal healthcare reform initiative. So, the premise of this paper is that states should be encouraged to experiment with new approaches to scope of practice as part of healthcare reform. From this experimentation, there may emerge a model so compelling that it eventually will be widely adopted as a best practice.

This paper explores three aspects of the relationship between scope of practice reform and healthcare reform more broadly:

- The contribution of scope of practice reform to access, affordability and quality of care;
- The case for consumer involvement and leadership in reforming state scope of practice laws and their implementation by state licensing boards;
- Alternative institutional methods for making scope of practice decisions.

The Challenges

The productivity of the U.S. healthcare system is constrained by an inability to make full and appropriate use of its professional workforce. Artificial scope of practice restrictions prevent healthcare professionals from performing the full range of skills for which they have been trained, limit consumer access to care and choice of providers, and inflate the cost of healthcare. These problems are greatest in times, as now, of workforce shortages, and they especially impact already underserved rural areas. Two looming developments will only compound healthcare workforce challenges. These are the aging of the Baby Boomers (including many physicians and nurses of that generation, whose retirement will compound workforce shortages) and the surge in the number of insured Americans as a result of healthcare reform.

State licensing laws define the permissible scope of practice for the healthcare professions. The stated purpose is to ensure consumers that healthcare workers conduct their practices in areas for which they are properly trained. However, as a number of prestigious groups have reported, scope of practice

³ Engelberg Center for Health Care Reform, Brookings Institution, *Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth*, August 2009.

⁴ Students of professional regulation, including the Pew Health Professions Commission and the Center for the Health Professions at the University of California, San Francisco, and workforce advocates, including the Association of Academic Health Centers, argue that it is inefficient and irrational to have state legislatures define health professional scopes of practice fifty times over. These experts would like to see the creation of a national body to establish scope of practice guidelines. To do so, they argue, would correct the crazy-quilt situation where nurses, to cite one example, who share an identical education encounter different scope of practice parameters in different states. National scope of practice standards, they point out also would eliminate the unjustifiable state-by-state differences in access and choice available to consumers of healthcare services. Why, for example, should consumers in some states, but not others, be entitled to make an appointment directly with a physical therapist?

laws too often protect the economic interests of healthcare professionals by unnecessarily restricting other professions from providing competent, affordable, and accessible care. The first practice acts were written at a time when there were only a few healthcare professions. Now, there may be as many as 30 different practice acts in any given state, a totally different environment, yet still governed by the old regulations.

Nearly fifteen years ago in 1995, the Pew Health Professions Commission's *Report of the Task Force on Health Care Workforce Regulation* proposed changes in scope of practice regulation in its publication, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*. Recognizing that advances in technology and workforce innovations have blurred traditional boundaries between professional scopes of practice, the task force called for increased regulatory flexibility. They wrote:

The varying objectives and levels of specificity found in different professions' scopes of practice are more than frustrating; they have encouraged a system that treats practice acts as rewards for the professions rather than as rational mechanisms for cost-effective, high quality and accessible service delivery by competent practitioners.⁵

The task force proposed some policy options to advance the following recommendation, which is just as relevant today as it was in 1995:

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.⁶

More recently, in February 2007 six associations⁷ representing licensing boards and a certification body in a variety of professions published a document intended to guide state legislators and regulatory bodies in their decisions related to scope of practice. In the section entitled, "Assumptions Related to Scope of Practice," the authors elaborate on what they believe to be five ground rules about scope of practice legislation:

- The purpose of regulation – public protection – should have top priority in scope of practice decisions, rather than professional self-interest.
- Changes in scope of practice are inherent in our current healthcare system.
- Collaboration between healthcare providers should be the professional norm.
- Overlap among professions is necessary.
- Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service.⁸

In May 2009, the National Council of State Boards of Nursing urged the Obama administration and Congressional authors of healthcare reform legislation to consider several policy priorities, including maximizing the use of all licensed healthcare providers by supporting overlapping scopes of practice:

⁵ *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, Report of the Taskforce on Health Care Workforce Regulation, December, 1995, p. 10.

⁶ Taskforce, p. 9.

⁷ Association of Social Work Boards (ASWB), Federation of State Boards of Physical Therapy (FSBPT), Federation of State Medical Boards (FSMB), National Board for Certification in Occupational Therapy (NBCOT), National Council of State Boards of Nursing (NCSBN), and National Association of Boards of Pharmacy (NABP).

⁸ *Changes in Healthcare Professions' Scope of Practice: Legislative Considerations*, 2007, pp 8 – 10.

As scopes of practice evolve, they should be supported, provided care can be delivered in a safe, effective and efficient manner. For example, advanced practice registered nurses (APRNs) can safely and effectively deliver primary care, anesthesia and midwifery services.⁹

A few classic scope of practice debates demonstrate that restrictive scopes can unjustifiably prevent some healthcare professionals from using their full range of skills and limit consumers' choice and access to affordable care. One has to do with whether dental hygienists should be permitted to practice independently so that they might, for example, visit long term care facilities to clean residents' teeth without a dentist being physically present. Similarly, many states wrestle with whether advanced practice nurses need direct supervision by physicians and, if so, how much. Further, regulatory and business practice restrictions relating to optometry and opticianry interfere with consumer access to affordable eye care services, typically less costly than those offered by ophthalmologists. The battle between physicians and podiatrists over whether a foot ends above or below the ankle would be laughable, if it did not represent a highly questionable limitation on practice.

Other recently proposed or enacted scope of practice expansions in the states demonstrate that disputes over scopes of practice can occur anywhere and involve just about any profession. For example, Utah's medical association recently opposed an effort to add direct-entry midwives to the list of professions overseen by the Division of Occupation and Professional Licensing; the Board of Examiners for Registered Nurses in West Virginia threatened to revoke the licenses of school nurses who prescribed or dispensed any type of medication without a doctor's order; West Virginia speech therapists were angry with the Board of Education for permitting speech/language *assistants* to treat public school children if no speech/language *therapists* were available; and doctors and advanced practice nurses in Florida have battled over whether a physician must be present when a nurse anesthetist administers anesthesia, whether advanced practice nurses can prescribe controlled pain medications, and whether new patients must be seen by a dermatologist or may be seen by an advanced practice nurse.

Traditionally, competing claims to a scope of practice have been characterized as "turf battles" over control, prestige, and the all-important right to receive direct reimbursement from third party payers. Few state level policy makers have begun to see scope of practice as a tool to promote the goals of healthcare reform: improved access, quality care and lowered costs. The most notable exception to be discussed in detail below is Pennsylvania where Governor Ed Rendell linked scope of practice changes to healthcare reform in general.

Most States Are Approaching Healthcare Reform and Scope of Practice in a Piecemeal Fashion

Several states (MA, ME, VT, CA, IL, HI, WI, NM, CO, AK, MN, PA and others) have enacted healthcare reform legislation in recent years, focusing primarily on reining in costs and expanding insurance coverage. The State Coverage Initiatives (SCI) program sponsored by the Robert Wood Johnson Foundation and administered by Academy Health observed that:

Finding ways to expand coverage to the uninsured continued to dominate state policy agendas in 2008. The year saw a multitude of state efforts aimed at developing, legislating, and implementing reforms. While forecasters projected that 2009 would bring renewed energy to

⁹ NCSBN *Weighs in on Health Care Reform*, NCSBN Press Release, May 13, 2009.

many states' coverage efforts, the nation's serious economic ills are causing an about-face such that state officials are now concerned whether progress by states can continue to be made.¹⁰

States have undertaken a variety of worthwhile initiatives, including such things as increased Medicaid spending, and other measures to expand insurance coverage and access to care; advancements in health information technology infrastructure, evidence-based care, and other delivery improvements; and promoting wellness and illness prevention.

Public/private partnerships are operating in at least ten states with the goal of improving healthcare quality, expanding access and containing costs. A summary of the activities underway in the ten states (CO, KS, ME, MA, MN, OR, PA, RI, VT, and WA) confirms that only in Pennsylvania is scope of practice reform a central part of healthcare quality improvement efforts. Quality Improvement Partnership accomplishments in the other nine states include infrastructure development, public reporting of quality indicators, experimentation with the medical home concept, adoption of payment efficiencies, data gathering to support evidence-based treatment decisions, chronic care disease management, and nosocomial infection control.¹¹

Largely unrelated to healthcare reform, legislative initiatives in a variety of states have sought scope of practice expansions for various non-physician professions. There is nothing new or unusual about these initiatives, a number of which are described later in this paper. State legislatures have been fielding requests for scope of practice changes for decades. Medical societies, dental societies, and other interests who feel threatened by another profession's scope expansion typically push back.

Case Study: Pennsylvania

"Prescription for Pennsylvania" was announced by the Governor in 2007 and almost completely enacted by the legislature as of 2009. The goals of the scope of practice plank of the Prescription are to relieve shortages of primary care providers; ensure access to cost-effective healthcare for citizens of all racial, ethnic, and language backgrounds; improve access to healthcare services in evenings and weekends; and, increase the diversity of the healthcare workforce. These goals are reflected in legislation intended to remove unnecessary restrictions that prevent licensed healthcare providers – including nurses, advanced nurse practitioners, and physician assistants, social workers, midwives, pharmacists and dental hygienists – from practicing to the fullest extent of their education and training.

The original legislation introduced in 2007 was an omnibus bill (HB 700) calling for comprehensive healthcare reform. It included provisions related to access to insurance and insurance rates, charitable care institutions, price transparency at drug stores, hospitals and outpatient clinics, the use of health information technology, patient safety, the creation of a Center for Health Careers and a Health Careers Leadership Council, health professional education and training, as well as scope of practice expansions for a variety of professions. Shortly after it was introduced, HB 700 was broken up into more manageable pieces with the scope of practice issues separated out by profession:

¹⁰ *State of the States: Charting a Course Preparing for the Future, Learning from the Past*, January 2009, p. 6.

¹¹ National Academy for State Health Policy, *State Partnerships to Improve Quality: Models and Practices from Leading States*, June 2009, pp. 27 – 28.

Profession	Additional Scope
Physician Assistants	Under supervision, authorized to order physical, respiratory, occupational, dietetic therapy and medical equipment; authorized to perform defined patient assessments.
Respiratory Care Practitioners	New specialty authorized to provide direct respiratory care to patients referred by doctors, advanced registered nurse practitioners, and physician assistants.
Advanced Registered Nurse Practitioners	Under a collaborative practice agreement, authorized to perform the same services as physician assistants and to order home health or hospice care.
Physical Therapists	Practice redefined to include evaluation, examination and testing to diagnose and establish a treatment plan; practice in schools and home health settings with indirect supervision.
Public Health Dental Hygiene Practitioners	New specialty authorized to independently perform educational, preventive, therapeutic, and intra-oral procedures.

The scope expansions contained in the legislation are very specific. For example, amendments to the medical practice act (HB 1804) and the osteopathic medical practice act (HB 2088) grant physician assistants who are “acting within the supervision and direction of the supervising physician” authority to order durable medical equipment, physical therapy, respiratory therapy, occupational therapy, and dietician services. It also authorizes physician assistants to perform disability assessments, issue homebound school certifications and perform and sign initial assessments of methadone treatment evaluations. HB 1804 also creates the specialty “respiratory care practitioner” authorized to “implement direct respiratory care to an individual being treated by either a licensed medical doctor or a licensed doctor of osteopathic medicine upon referral by a physician, certified registered nurse practitioner or physician assistant.”

HB 1253 expands the scope of practice of advanced practice registered nurses working under a collaborative practice agreement with a physician to perform much the same services as physician assistants and also order home health and hospice care. Part of the motive for expanding the scope for nurse practitioners was to legitimize walk-in clinics which were proliferating in Pennsylvania as well as other states and which are often managed and staffed by nurse practitioners. (In the case of physician assistants and advanced practice registered nurses, it must be kept in mind that hospital and nursing home bylaws also impact the ability of advanced practice registered nurses and physician assistants, notwithstanding the contents of collaborative practice agreements.)

Another law (HB 1255) establishes licensure for nurse midwives within the medical practice act permitting them to practice under a collaborative agreement with a physician. Nurse midwives with the required preparation are authorized to “prescribe, dispense, order and administer drugs, including legend drugs...” HB 1199 redefines the practice of physical therapy to include evaluation, examination and testing patients to determine a diagnosis, prognosis and plan of treatment, performance of tests and measurements as an aid in diagnosis, use of therapeutic exercises and rehabilitative procedures. It also permits qualified physical therapy assistants to treat patients with only indirect supervision in certain care settings, such as schools and home health settings. Other bills provide for licensure for social workers (HB 1693), massage therapists (HB 2499), and perfusionists (HB 500 and HB 501).

SB 455 amended the dental practice act to create a specialty called “Public Health Dental Hygiene Practitioner.” These individuals are defined as licensed dental hygienists “who may perform

educational, preventive, therapeutic, and intra-oral procedures which the hygienist is educated to perform ... without the authorization, assignment or examination of a dentist.” Under the legislation, these services may be performed in certain specified settings, including schools, correctional facilities, personal care homes, adult daily living centers, and so on. The act permits public health dental hygiene practitioners to perform unsupervised radiological procedures in any setting.

Some demographic examples suggest why and how these scope of practice changes are likely to profoundly improve Pennsylvanians’ access to care.

- Pennsylvania’s 3,195 Nurse Anesthetists, 6,637 Advanced Practice Registered Nurses, and more than 5,000 physician assistants will have an expanded scope of practice, resulting in patients getting more personalized attention and freeing physicians to concentrate on more challenging therapies;
- Community and retail clinics staffed by Advanced Practice Registered Nurses are likely to become more abundant, with particular impact in rural areas where nearly three and a half million Pennsylvanians reside;
- Pennsylvania’s 8,111 dental hygienists will be permitted to provide services to the more than 89,000 residents in Pennsylvania’s 724 nursing homes;
- Pennsylvania’s 334 nurse midwives will be permitted to provide a broader range of services to patients, including those who live in rural areas.

How Did This Happen in Pennsylvania?

Members of the Rendell administration who shepherded the Prescription for Pennsylvania bills through the legislature¹² describe the circumstance as a “perfect storm.” The Governor’s first Executive Order at the beginning of his second term in January 2007 created an Office of Health Care Reform. Key actors in the administration and in the legislature were sympathetic to the idea of creating a climate where healthcare professionals could perform to the full extent of their education and training. Not only did they see this as a step toward alleviating growing workforce shortages (especially among primary care physicians) and improving access to care among underserved demographics in the state, many of them (including the Governor) have had positive experiences receiving care from practitioners other than physicians, such as Advanced Practice Registered Nurses and physician assistants.

They perceived that many scope of practice limitations have no basis in clinical evidence but are based on the profit motive of those in a position to impose the limitations. They looked to other states where professions such as advanced practice nurses, physician assistants and dental hygienists had more expansive scopes of practice than existed in Pennsylvania at the time and found no evidence of a decline in the quality of care in those jurisdictions. In addition, they were aware of research at the University of Pennsylvania and elsewhere showing that higher nurse staffing ratios are related to elevated quality of care.

Interest groups, whose counterparts have generally opposed scope of practice changes in other states over the years, including the state medical society, were willing to negotiate on this aspect of Prescription for Pennsylvania in order to position themselves to bargain on other aspects, notably insurance reform. One staffer’s assessment is that the scope of practice legislation made it through

¹² In-person interviews conducted in the spring of 2009 with Basil Merenda, Commissioner, Pennsylvania Bureau of Professional and Occupational Affairs; Donna Cooper, Secretary, Governors Office of Policy and Planning; Barbara Holland, Deputy General Counsel, Governor’s Office of Healthcare Reform; and Larry Clark, Legislative Director for the Governor’s Office of Health Care Reform.

the legislature because the Governor originally put forth his plan as a single bill addressing cost, quality and access all at once. The scope of practice elements attracted less attention than other hot-button issues, so they “slipped through” with less opposition. This staffer also credits the skill and determination of the leaders of the legislature’s professional licensing committees.

One reason the scope of practice expansions were palatable to the medical society and other possible opponents was the decision to link scope expansions to collaborative practice agreements calling for some level of supervision or delegation by one profession over another. These collaborative practice agreements are to be negotiated case by case between the affected professionals.

Writing collaborative practice agreements into the legislation also helped defuse an argument commonly advanced by professions who believe their exclusive claim on particular acts will be encroached by expanding another profession’s scope of practice. This argument is that expanding another’s scope will expose patients to unsafe care by inadequately trained practitioners. This is a difficult case to make when the expanded scope is authorized only in the context of a collaborative practice agreement. Supporters of Prescription for Pennsylvania countered that, “I’m sure my physician would never enter into a collaborative practice agreement with someone who would expose me to substandard care.” The bottom line is that including collaborative practice agreements was necessary to pass the legislation.

The elephant in the room during the legislation-related negotiations was the question of direct reimbursement to the professions enjoying expanded scope. Reimbursement was not addressed in the Prescription for Pennsylvania bills. It is noteworthy that Advanced Practice Registered Nurses were awarded direct Medicaid reimbursement prior to their scope of practice expansion. A major wrinkle inhibiting direct reimbursement to allied health professions in Pennsylvania, we were told, is an insurance regulation in the state which permits health plans to determine which professionals are “primary care providers” and therefore eligible for direct reimbursement.

The Evidence Base for Expanded Scopes

The Rendell administration didn’t find it necessary to produce new evidence that what they were proposing would be safe. Nor do they intend to invest in research to evaluate the impact of the scope of practice changes that have been enacted. Their attitude is that the absence of problems in other states which had already liberalized scopes of practice for many professions is sufficient evidence. Moreover, they are confident that professional associations will speak up if patient safety problems emerge.

The authors of this paper agree that it is a red herring to demand research or documentation to justify the safety of expanding a scope of practice to the full extent of a professional’s training and skills. Of course there is value in studying outcomes after a scope of practice has been expanded. Experience shows that the only way to generate data showing the safety and efficacy of scope of practice expansions is to make the leap and expand scope. A demand for data in advance in the absence of evidence from real life practice amounts to a nearly impenetrable barrier to scope expansions and improved access to care.

Those who support expanded scopes of practice recognize how difficult it is to provide evidence to demonstrate that quality will not be diminished when scopes of practice are expanded. This is because until an expanded scope is legally authorized, delivery of those services would violate the existing practice act. Despite these difficulties, there is a growing body of evidence that non-physician, mid-level health professionals are capable of providing a level of care comparable in terms of patient safety to care provided by physicians within the same field. Determinations regarding patient safety should

be made for each profession individually, based on the qualifications and training of its members, and currently there is not much evidence available for many professions. Nevertheless, the preponderance of evidence that is currently available indicates that mid-level health professionals provide a quality of care that is equal to or better than their physician counterparts. In February 2008, Gov. Ritter of Colorado issued an executive order commissioning a Scopes of Care Advisory Committee to investigate the level of care provided by physician assistants, advanced practice nurses and dental hygienists. In December 2008, the Scopes of Care Advisory Committee released, *Collaborative Scopes of Care: Final Report on Findings*, which includes the most systematic and comprehensive review of evidence from literature on the subject, to date. The committee found that evidence shows that physician assistants (PAs) provide a level of care comparable to physicians in terms of quality, with no difference in patient satisfaction, and PAs are more likely to work in rural and health professional shortage areas and provide care to vulnerable populations. With regard to advanced practice nurses, the committee found that nurse practitioners (NPs) provide a “comparable level of care” to that of physicians and that certified registered nurse anesthetists (CRNAs) and nurse midwives have “equivalent quality of care” when compared with physicians. Moreover, patient satisfaction with NPs was found to be, “consistently and significantly higher.” With respect to dental hygienists, both studies reviewed by the committee found that dental hygienists provide care that is at minimum equivalent and at times better than the care provided by dentists, including better patient follow-up.¹³

One non-physician profession where there is a particularly solid and growing body of evidence that scope of practice expansions can be accomplished without jeopardizing, patient safety, and in fact can enhance the quality of care provided, is advanced practice registered nursing. This profession has increased its scope incrementally over decades and steadily accumulated a base of evidence during that time.

Research comparing the quality of care provided by advanced practice registered nurses with the quality of care provided by physicians dates back as far as the late 1970s, in part because the United States Congress Office of Technology Assessment (OTA) chose to evaluate nursing performance and outcomes for many of the same reasons this interests us today. For example, case Study #16, “*The Costs and Effectiveness of Nurse Practitioners*,” published by OTA in 1981¹⁴ attributes the interest in “physician extenders” to that era’s physician shortage.

Advanced practice nursing continues to be a growth profession. Data on the American Academy of Nurse Practitioners’ Website (www.aanp.org) show more than 125,000 advanced practice nurses practicing in 2009, 8,000 of whom were newly prepared in 2008. As to the setting where they practice, 39% have hospital privileges and 13% practice in long term care settings. Twenty percent practice in rural or frontier areas and 66% practice in at least one primary care site while 31% practice in at least one non-primary care site, such as inpatient, emergency, surgical or specialty practice. In terms of quality of care, AANP reports that only 1.4% of the more than 125,000 advanced practice nurses have been named as a primary defendant in a malpractice case.

In 2002 the British Medical Journal published a “Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors.”¹⁵ The authors reviewed 11 randomized controlled trials and 23 prospective observational studies to determine whether nurse practitioners can provide care at first point of contact equivalent to doctors in a primary care setting.

¹³ Colorado Health Institute. *Collaborative Scopes of Care: Final Report of Finding*. Prepared for SOC Advisory Committee. December 30, 2008.

¹⁴ <http://www.princeton.edu/~ota/disk3/1981/8131/813103.pdf>.

¹⁵ Horrocks, S., et al., BMJ 2002;324:819 – 823, <http://bmj.com>.

The authors found no differences in health status or in prescriptions, but patients were more satisfied with care provided by nurse practitioners. The nurse practitioners provided longer consultations and made more investigations than did doctors. The conclusion was that “Increasing availability of nurse practitioners in primary care is likely to lead to high levels of patient satisfaction and high quality care.”

A literature review of 4,253 articles published in *The Cochrane Database of Systematic Reviews* in 2009¹⁶ reached a similar, although more guarded, conclusion:

The findings suggest that appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients. However, this conclusion should be viewed with caution given that only one study was powered to assess equivalence of care, many studies had methodological limitations, and patient follow-up was generally 12 months or less.

While doctor-nurse substitution has the potential to reduce doctors’ workload and direct healthcare costs, achieving such reductions depends on the particular context of care. Doctors’ workload may remain unchanged either because nurses are deployed to meet previously unmet patient need or because nurses generate demand for care where previously there was none. Savings in cost depend on the magnitude of the salary differential between doctors and nurses, and may be offset by the lower productivity of nurses compared to doctors.

Another view of the performance of advanced practice nurses can be found in the Pearson Report¹⁷, which analyzes data from the National Practitioner Data Bank (NPDB) and the Health Integrity and Protection Data Bank (HIPDB). These agencies compile data related to malpractice suits, adverse actions, licensure actions, civil judgments and criminal action reports against nurse practitioners, doctors of osteopathy and medical doctors. For the 2009 report, Pearson added up the accumulated actions against NPs, DOs, and MDs during the previous 18 years and the absolute number of practitioners in each profession and then calculated ratios. Pearson’s objective is to compare the safety of the care provided by advanced practice nurses relative to the care provided by the other professions:

Overall national occurrence ratios, obtained by dividing the total number of each group of providers by the total number of accumulated malpractice and adverse actions in the NPDB against that group of providers, were 1 in 173 for NPs, 1 in 4 for DOs, and 1 in 4 for MDs. Overall national occurrence ratios, obtained by dividing the total number of each group of providers by the total number of accumulated adverse action reports, civil judgments, and criminal conviction reports in the HIPDB against that group of providers, were 1 in 226 for NPs, 1 in 13 for DOs, and 1 in 23 for MDs.¹⁸

The authors of another study entitled, “Does the Employment of Physician Assistants and Nurse Practitioners Increase Liability,” found:

There were no observations or trends to suggest that PAs and APNs increase liability. If anything, they may decrease the rate of reporting malpractice and adverse events. From a policy

¹⁶ *The Cochrane Database of Systematic Reviews*, 2009, Issue 3, <http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001271/frame.html>.

¹⁷ Pearson, L., (2009). The Pearson Report, *The American Journal for Nurse Practitioners*, 13:2.9., http://webnp.net/downloads/pearson_report09/ajnp_pearson09.pdf.

¹⁸ Pearson, p 9.

standpoint, it appears that the incorporation of PAs and APNs into American society has been a safe and beneficial undertaking, at least when compared to doctors.¹⁹

A RAND Corporation study funded by the California Healthcare Foundation and published in the September 1, 2009, *Annals of Internal Medicine*²⁰ compared the quality and cost of care at retail clinics and in doctors' offices, urgent care centers or emergency departments. The significance of the study for this paper is that retail clinics are staffed primarily by advanced practice registered nurses, whereas the other settings are staffed primarily by doctors. The researchers found that the cost of care for three common illnesses at retail clinics (\$110.00) was notably less than the cost of care at other settings (physicians' offices \$166.00, urgent care centers \$156.00, and emergency departments \$570.00). Significantly, the quality of care and the delivery of preventive care at retail clinics were comparable to the care delivered at the other settings for the three illnesses.

Among advanced practice specialties, nurse anesthetists have gained the right to independent practice in several states, helped by Medicare reimbursement regulations. Anesthesiologists have been slow to concede, however, causing nurse anesthetists to accumulate evidence to prove that their safety record is just as good as the anesthesiologists'. Nurse anesthetists administer approximately 65% of the anesthesia in the U.S. annually and they are the sole providers of anesthesia in 85% of rural hospitals.²¹ A review of more than 400,000 Medicare cases in 22 states involving a variety of conditions and illnesses yielded important findings about the quality of anesthesia care:

- Mortality rates were similar for CRNAs and anesthesiologists working individually.
- There was no statistically significant difference in the mortality rate for CRNAs and anesthesiologists working together versus CRNAs or anesthesiologists working independently.
- There was no statistically significant difference in the mortality rate for hospitals without anesthesiologists versus hospitals where anesthesiologists provided or directed anesthesia care.²²

These illustrative studies of actual experience with independent or expanded practice confirm that the way to generate data to establish or refute the safety and efficacy of expanding scopes of practice is to permit that practice to occur and monitor the resulting outcomes. Pennsylvania went ahead and expanded the scopes of several professions without feeling the need to produce evidence of safety and efficacy.

Developing Evidence in the Future

As this section shows, there already is substantial evidence demonstrating the ability of advanced practice registered nurses to practice safely and with high quality outcomes after scope of practice restrictions were removed. Unfortunately, there is no comparable body of evidence to demonstrate conclusively that expanding scope of practice rules and regulations for other health professionals will have the same positive results regarding safety and quality. Nevertheless, every time states expand the scope of practice for non-physician professions (e.g., authorizing independent practice for dental hygienists in California or oral health practitioners in Minnesota, legalizing disease management by

¹⁹ Hooker, Robert S., PhD, PA, Nicholson, Jeffrey G., PhD., Lee Tuan, MD, Dr. PH, *Journal of Medical Licensure and Discipline*, Federation of State Medical Boards, Vol. 95, Number 2, 2009.

²⁰ Mehrotra, A., et al., "Comparing Costs and Quality of Care at Retail Clinics With That of Other Medical Settings for 3 Common Illnesses", *Annals of Internal Medicine*, vol. 151, issue 5, September 1, 2009, pp. 321 – 328, <http://www.annals.org/current.shtml>.

²¹ Pine, M., et al., "Surgical Mortality and Type of Anesthesia Provider," *AANA Journal*, 2003, 71:109 – 116.

²² <http://www.aana.com/Resources>.

pharmacists or permitting independent practice by physician assistants in several states) opportunities are created for accumulating evidence based on actual practice.

Some state legislatures may prefer to take the more cautious route of authorizing demonstration projects in order to generate data to support more permanent expansions and to spread experimentation to other jurisdictions. As an example, the Health Workforce Pilot Projects Program of the California Healthcare Workforce Development Division provides the legal framework for pilot projects under which healthcare organizations demonstrate, test, and evaluate new or expanded roles for healthcare professionals.

In 1998, the National Consumer Voice for Quality Long Term Care (then known as the National Citizens' Coalition for Nursing Home Reform, or NCCNHR), conducted a workshop to explore regulatory changes that would remove unnecessary barriers to the full use of competent healthcare professionals in nursing homes. The workshop was conducted jointly by NCCNHR and CAC, with financial support from the Pew Health Professions Commission. The workshop proceedings were entitled "Removing Barriers / Improving Care."²³

The workshop endorsed the idea of demonstration projects when it said:

Licensing boards should have authority to grant waivers in order to allow demonstration projects to test adaptations in scopes of practice. Boards should publish criteria for evaluating and approving the demonstration projects. The criteria must be based on assuring resident protection during the demonstration in part by requiring informed consent from the patient, during the demonstration period, including sound evaluation components, input by consumers and the public and their advocates who represent residents, and demonstrations of competence by any individual who will be assigned additional responsibilities during the demonstration period. Demonstration projects will require the cooperation of other licensing authorities and third party payers for reimbursement purposes when people are performing tasks they could not be performing legally but for the demonstration.²⁴

²³ The report is not online. It is available in hard copy from CAC.

²⁴ Removing Barriers / Improving Care, op. cit., p. 11.

IMPLEMENTATION

There is no consensus about the best institutional mechanism(s) for addressing and resolving scope of practice decisions. Nor is there a consensus among the professions as to the appropriate role of physicians in resolving scope of practice disputes. Because of the “turf battle” mentality that currently characterizes most scope of practice disputes, choosing the right mechanism(s) for resolving scope disputes is just as important as addressing the substance of the dispute.

In this section, we examine implementation issues. The primary opposition to scope of practice expansions can be expected to come from the medical establishment.

Seeing allied health professions become bolder about seeking expanded scopes, and concerned about the expansion of healthcare delivery by non-physicians in non-traditional settings such as retail stores, the American Medical Association is fighting back. In 2006, the AMA joined other national specialty organizations to create a Scope of Practice Partnership (SOPP) for the purpose of tamping down scope of practice legislation in the states. All fifty state medical associations have since joined the SOPP.

The AMA resolution (#814, June 2006) leading to the creation of the SOPP promised that the AMA and its partners would “study the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes and peer review of the limited licensure healthcare providers, and limited independent practitioners, as identified by the Scope of Practice Partnership...”

Follow-up resolutions passed by the Delegate Assembly in November 2006 upped the ante. Resolution 902 calls for medical boards to oversee the “medical scope of practice activities by mid-level practitioners.” The resolution states that it is AMA policy that “state medical boards shall have full authority to regulate the practice of medicine by all persons within a state, notwithstanding claims to the contrary by boards of nursing, mid-level practitioners or other entities.”

Resolution 904 asserts that “Diagnosis of disease and diagnostic interpretation of tests constitutes the practice of medicine to be performed under the supervision of licensed physicians.” This supervisory authority is apparently meant to apply to all non-physician personnel, including laboratory personnel and PhD scientists who employ new laboratory technologies.

The AMA policies are designed to protect the interests of physicians, not to benefit the public, and therefore they are not appropriate to use in designing a review process for proposed expansions of scopes of practice. The process that should be utilized in making determinations needs to be unbiased, comprehensive and focused on the interests of consumers and the public.

Standards and Criteria for Deciding Scope of Practice Issues

In 1991, in Ontario, Canada, the legislature enacted the Regulated Health Professions Act (RHPA) which provides precisely the type of common framework for the regulation of health professions that is objective, thorough and focuses on public benefit. A Health Professions Regulatory Advisory Council (HPRAC) was established, independent of the Ministry of Health and the several “colleges” that regulate the different health professions. HPRAC consists of 5 to 7 individuals appointed by the Lieutenant Governor of the Council on the Minister’s recommendation. Over the years, the HPRAC has been requested to advice on a number of professions’ scopes of practice, including:

- The scope of practice of registered nurses in the extended class;
- Regulations concerning non-physician professions who prescribe and/or use drugs in the course of their practice;
- Framework and process for changes to drug regulations for non-physician prescribers
- The regulation of diagnostic sonographers;
- The regulation of dental assistants;
- The regulation of paramedics and emergency medical attendants;
- The regulation of chiropody and podiatry; and
- The use of therapeutic pharmaceutical agents (TPAs) in optometry.

HPRAC's procedures incorporate many of the standards identified earlier in this section. For example, in their advisory report on allowing optometrists to use therapeutic pharmaceutical agents (TPAs), they collected evidence on:

- 1) Consumer needs;
- 2) Practices in other jurisdictions worldwide;
- 3) The views of interested professions;
- 4) The risk of harm from optometrists using TPAs;
- 5) The effect on quality of care from optometrists using TPAs;
- 6) Optometrists' clinical education and training;
- 7) The effect on access to appropriate care;
- 8) The benefits/costs to the public and the profession from optometrists using TPAs;
- 9) The types of drugs that should be permitted, for which diseases (if optometrists were permitted to use TPAs), and;
- 10) The conditions that should be placed on the use of TPAs by optometrists (if they were permitted to use TPAs).

Institutional Mechanisms for Deciding Scope of Practice Expansions

Historically, most scope of practice decisions have been the province of state legislatures. Over the past 20 years, the Citizen Advocacy Center (CAC) has reported on hundreds of state legislative proposals addressing scope of practice expansions.²⁵ It is not yet a common practice for states to establish mechanisms that would be charged with conducting fair, expeditious, expert and objective appraisals of the need for and impact of any requests for expansion of the scope of practice for any health profession.

The NCCNHR / CAC project cited earlier looked at scope of practice issues in the nursing home setting, and assessed the level of consensus among major stakeholders in favor of regulatory experimentation and change designed to remove unnecessary barriers to the full use of competent healthcare professionals and other caregivers. The workshop's sponsoring organizations said:

Because many different professionals and paraprofessionals practice, delegate, and supervise in nursing homes, the work situation is analogous to emerging managed care settings. Further, accumulated experience with the nursing home environment makes this an ideal testing ground

²⁵ As reported in many issues of the Citizen Advocacy Center's quarterly newsletter, CAC News & Views.

for identifying unnecessary barriers to safe, quality care and for devising the regulatory and systemic changes that can produce a more rational allocation of personnel both here and in managed care and other healthcare settings.

Recommendation 3 called for the establishment of scope of practice mechanisms in the several states to resolve disputes related to the delivery of services in a nursing home setting, reading in part:

The Governor or the legislature shall establish a scope of practice dispute resolution board. The board shall consist of the chief executive officer of each professional and occupational licensing board in the healthcare field, plus an equal number plus one of the public members. The Governor shall appoint one of the public members to be chair of the board...

The board may entertain petitions to resolve scope of practice disputes that might impact on the ability of a particular profession or occupation to deliver services in a nursing home setting. Petitions may be filed with the board by an affected health licensing board, by a professional association representing the affected profession, by a patient advocate, or by any other interested party...

The board will accept the petition if it finds that the petitioner has demonstrated the existence of a scope of practice disagreement which, if not resolved, will prohibit licensees in one profession or occupation from delivering certain healthcare services in a nursing home setting. The board must find that one or more licensed professions is seeking to expand its scope of practice in order to accept a petition to resolve a pending dispute.

The board will promulgate rules and regulations setting forth the procedures it will follow in resolving scope of practice disputes. The board may use alternative dispute resolution mechanisms if it so chooses.

The burden of proof for an expanded scope of practice will rest with the party or parties supporting or requesting the expansion. The party or parties shall meet their burden of proof by demonstrating that:

- By training and education, the members of the profession or occupation seeking the expanded scope can safely perform the new tasks or services, and can exercise the judgment necessary to assure safe, quality care; and,
- The board shall approve an expanded scope of practice if it finds that the burden of proof has been met by the party or parties seeking expansion, and if it finds that, as a result of the expanded scope of practice, the quality of care will be maintained or improved, taking into account the perspective of the recipient of the care.²⁶

Nine years later, in 2007, the Center for the Health Professions at the University of California, San Francisco, issued a report, "Promising Scope of Practice Models for the Health Professions." Section III of that report describes scope of practice review mechanisms in New Mexico, Iowa, Virginia, Minnesota, and Ontario (Canada). A brief summary of the mechanisms in these five jurisdictions follows:

New Mexico

In 2007, the legislature passed House Joint Memorial 71 and House Memorial 88, requesting the Interim Legislative Health and Human Services Committee to establish an unbiased and fair review

²⁶ IBIO, pp 6 – 8.

process to review the current scopes of practice of New Mexico's healthcare professions. Its purpose is to provide legislators with objective information when evaluating proposed changes.

Iowa

Under the Iowa Code (Section 147-28A, 2005), a reviewing committee (limited to five members: one member representing the profession seeking a change in scope of practice; one member of the health profession directly impacted by, or opposed to, the proposed change; one impartial health professional, who is not affected by the proposed change; and two impartial members of the general public) reviews a proposed scope of practice change and makes a report to the Department of Public Health. Based on the committee's reports the Department of Public Health, in turn, advises the general assembly on whether the proposal poses a significant new danger, and whether it will benefit the public.²⁷

Virginia

Virginia's 13 health regulatory boards are responsible for promulgating the regulations that govern the health professionals. The Board of Health Professions consists of 18 members, one from each of the 13 regulatory boards, and 5 citizens (consumers), all appointed by the Governor (Code of Virginia, Section 54.1 – 2510). Among its duties, the Board of Health Professions is responsible for evaluating and making recommendations on the need for and appropriate level of regulation for the healthcare professions.

Minnesota

Each of the 16 independent health licensing boards consists of members appointed by the Governor. The principal staff person for each board is the Executive Director.

In 2001, the legislature created the Council of Health Boards. The Council consists of one board member from each board, and the Executive Directors. The Council meets periodically to discuss issues and concerns affecting all boards. The Council is required to statutorily review emerging issues relating to health occupation regulation, such as proposals to regulate new health occupations. The council was given formal direction when legislation, Minn. Stat. 214.025, was enacted on July 1, 2001. The health-related licensing boards may establish a council of health boards consisting of representatives of the health-related licensing boards and the emergency medical services regulatory board. When reviewing legislation or legislative proposals relating to the regulation of health occupations, the council shall include the commissioner of health or a designee.

²⁷ By Catherine Dower, JD, Sharon Christian, JD, and Edward O'Neil, PhD, MPA, FAAN, available on the Center for the Health Professions website: <http://www.futurehealth.ucsf.edu>.

CONCLUSION

Next Steps

For better or for worse, state legislatures will likely continue to be the venue where scope of practice disputes will be addressed and resolved. While consumer advocacy organizations should push for states to adopt impartial mechanisms such as those described in this report, the reality is that at least in the short run, advocacy organizations need to be prepared to weigh in on proposed scope of practice legislation, issue by issue, as bills are introduced in state legislatures. Efforts by consumer advocacy organizations will be enormously helpful in bringing a broader, public interest perspective before state legislatures (and before health professional licensing boards engaged in rule making to implement scope of practice expansions). The involvement of consumer advocacy organizations in scope of practice decisions is necessary to counterbalance the heretofore unchallenged raw political power enjoyed by the affected professions and their associations.

The convergence of several forces makes it opportune to change the dynamics as states address professional scopes of practice. These include:

First, the nation's attention is on healthcare reform at both the federal and state levels. There is a general consensus that meaningful healthcare reform will improve access, control or reduce cost, and maintain or improve quality and safety. Scope of practice reform would contribute to the realization of each of these goals.

Second, those who analyze the U.S. healthcare system have begun to question not only its fairness in terms of coverage and access, but also its quality, once thought to be unmatched in the world. The well-respected Commonwealth Fund recently compared healthcare in six industrial countries and ranked the U.S. next to last on most measures, including quality of care and access. This study may turn out to be seminal – as was the Institute of Medicine's Errors report nearly a decade ago. What it shows, among other things, is that the current scope of practice paradigm is not providing all Americans with quality care. It follows that evidence-based expansions in the scopes of practice of various specialized professions could well elevate quality while expanding access to care. Scope of practice reform would reduce the "silo effect" and promote team practice, one of the basic characteristics of quality care, according to the Institute of Medicine.

Healthcare cost concerns are driving the establishment of walk-in clinics staffed by advanced practice nurses in pharmacies, chain stores, and neighborhoods in many parts of the country. This development has been controversial, largely because physicians question the quality of the care unsupervised nurses will provide. Many believe that such objections miss the point because the availability of convenient, affordable healthcare – preventative and therapeutic – through commercial or community clinics promises significant public health rewards.

Researchers Mary Takach and Kathy Witgett wrote that:

Licensing health facilities and practitioners gives states the ability to monitor patient safety and healthcare quality. Most states exempt retail clinics from facility licensure and rely instead on practitioner licensure by the applicable state board for oversight. Massachusetts' system of licensing retail clinics separately distinguishes retail clinics from private physician offices and from other healthcare facilities. This allows the state nuanced regulation of retail clinics without regulating other healthcare practitioners. It has allowed Massachusetts to regulate retail clinics to promote medical homes by requiring them to connect better to primary care providers.

As states require increased oversight of healthcare practitioners, they will increase the retail clinics' operating costs and may dissuade some clinic chains from doing business in the state. Physician groups argue that physician supervision of nurse practitioners is necessary to maintain quality and ensure patient safety. Others see it differently: retail clinics use evidence-based guidelines that deliver appropriate services and ensure that nurse practitioners are operating well within their scope of care.²⁸

In an Internet report, MSNBC reporter Alex Johnson wrote:

There is no evidence to back up doctors' warnings that low-cost retail health clinics in hundreds of pharmacies and other stores across the country could expose customers to substandard medical care, researchers said this week...

The clinics which operate under names like MinuteClinic, TakeCare and MediMinute, have become increasingly popular as convenient options for Americans seeking routine care without the expense of visits to doctors' offices or hospital emergency departments.

More than 1,200 such clinics now dot the country since the first ones opened in pharmacies under the QuickMedX name (now MinuteClinic) in 2000, according to the Convenient Care Association, the industry's trade group...

Some physicians' groups, such as the American Academy of Pediatrics and the American Academy of Family Physicians, have raised concerns about potential conflicts of interest and the quality of care at retail clinics, where immunizations and treatment for routine illnesses like middle ear infections and sore throats are generally offered by nurse practitioners rather than doctors.

But the new research, the first large-scale study of the care provided in U.S. retail clinics, found "no difference in the quality offered to patients visiting retail clinics, physician offices and urgent care centers." For some services, retail clinics even did slightly better than hospital emergency rooms, said the researchers, who published their findings in two papers this week in the *Annals of Internal Medicine*.²⁹

The number of such venues is growing. Regardless of whether one supports this trend, what is needed is a sound approach to scope of practice so that clinics are staffed by people with the necessary skills and competencies, and that clinic management has the flexibility to deploy personnel and organize care delivery efficiently and appropriately.

The challenge is to focus the attention of state legislatures on scope of practice reform as something that would benefit their constituents and as a promising steppingstone on the way to achieving the goals of healthcare reform. To start with, legislators need to view proposals to modify scopes of practice as something more than turf battles between professional groups. Scope of practice needs to be viewed in consumer protection terms. Patients benefit when professions are authorized to practice to the full extent of their training and skills. The benefits include improved access to care, probable financial savings, and no reduction in safety and quality. Indeed, quality and safety may actually improve when, for example, more highly trained professionals are freed up to concentrate on more challenging tasks, or when patients receive more time and counseling from members of a healthcare team.

²⁸ National Academy for State Health Policy, *Analysis of State Regulations and Policies Governing the Operation and Licensure of Retail Clinics*, February 2009, p. 19.

²⁹ Johnson, Alex, *Study: Retail health clinics as good as doc office*, MSNBC, Sept 4, 2009.

Who is in the best position to re-cast scope of practice as an important ingredient in healthcare reform and a consumer protection issue? The answer is consumers and their advocacy groups. Thus far, they have been absent from scope of practice decision-making.

We have learned from the healthcare reform debates at the federal level that when consumers weigh in, they can have a major impact on shaping the policy options considered by legislators. At the state level, consumer opinion has helped make medical homes a fashionable concept. If scopes of practice reforms similar to those enacted in Pennsylvania are to be adopted in other states, consumer advocacy groups will need to take an active role in ensuring that the public's views are heard in these policy debates.