

Promising Scope of Practice Models for the Health Professions

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Center for the Health Professions
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Table of Contents

I. Introduction.....	1
II. Select Comparisons of Scopes of Practice of Four Professions.....	1
A. Nurse practitioners (NPs) and independent practice.....	2
1. NPs in the United States.....	2
2. NPs in California must practice in collaboration with physicians...	2
3. NPs may practice independently in 11 states.....	3
B. Physical therapists (PTs) and the authorities to refer and diagnose.....	3
1. PTs in the United States.....	3
2. California.....	4
3. PTs in Illinois enjoy broader practice authorities.....	4
4. Laws and legislative activity in other states.....	5
C. Physician assistants (PAs) and the prescription of controlled substances..	5
1. PAs in the United States.....	5
2. PAs in California may prescribe controlled substances without prior patient-specific physician approval.....	5
3. Prescribing privileges of PAs employed by the Indian Health Service are facility-specific.....	6
a. IHS clinical privileges are facility and individual PA-specific.	6
b. IHS supervision requirements are flexible.....	7
4. PAs in the military may prescribe controlled substances.....	7
5. Most states allow PAs to prescribe controlled substances with varying levels of physician supervision.....	7
D. Paramedics and the administration of intravenous infusions.....	8
1. California.....	8
2. Paramedics in other states.....	9
3. Paramedics in the military are broadly permitted to administer intravenous infusion.....	9
III. Improving Scopes of Practice and How They Are Determined.....	10
A. Scope of practice review mechanisms.....	10
1. New Mexico’s scope of practice review commission.....	10
2. Iowa’s reviewing committee.....	11
3. Texas: pending bill to establish standard review process.....	11
4. Virginia: Board of Health Professions.....	11
5. Ontario: independent regulatory bodies.....	12
6. The military adjusts to changing needs by reclassifying personnel.....	13
7. Changes in Healthcare Professions’ Scope of Practice.....	13
B. Health boards with independent rule-making authority: a step towards eliminating conflicts of interest.....	13
1. Generally, DHs must be supervised by dentists.....	14
2. DHs are increasingly seeking authority to self-regulate.....	14
3. The California Committee on Dental Auxiliaries (COMDA) is a part of the Dental Board.....	15
4. DHs in Washington, Colorado, Iowa, and New Mexico have	

Promising Scope of Practice Models for the Health Professions

more expansive rule-making or practice authority.....	15
C. National Uniformity.....	16
1. Profession-specific Model Practice Acts.....	17
2. The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA).....	17
a. California’s UEVHPA bill.....	19
b. Other states efforts that do not mirror the UEVHPA.....	20
3. Nurse Licensure Compact.....	20
IV. Conclusion.....	20

I. Introduction

Legal scopes of practice for the health care professions establish which professionals may provide which health care services, in which settings, and under which guidelines or parameters. With few exceptions, determining scopes of practice is a state-based activity. State legislatures consider and pass the practice acts, which become state statute or code. State regulatory agencies, such as medical and other health professions' boards, implement the laws by writing and enforcing rules and regulations detailing the acts.

Due to the state-based nature of this process, the practice acts and subsequent rules and regulations vary from state to state for the different professions. Some of the variances are relatively minor; others are significant. Some professions are not recognized in all states. Some professions are permitted to provide considerably broad ranges of services in some states, but limited in others. Because legal scopes of practice can facilitate or hinder patients from seeing a particular type of health provider, the regulations have direct impacts on access to and cost of care. Quality of care may also be affected.

Exceptions to the state-based framework include institutions, such as the U.S. military, the Department of Veterans' Affairs, and Indian Health Service. Each of these institutions determines its own legal practice acts for the health professionals working onsite or within its jurisdiction. Although they sometimes make reference to state law, they are neither fully consistent with any of the state laws, nor with each other.

The purpose of this brief is to examine scope of practice issues within the context of improving access to care in California. First, out of the hundreds of differences in scopes of practice between California and other states, we will highlight a small sampling and compare the California scopes of practice of four occupations to more expansive scopes of practice in other states or institutions. Secondly, this brief will discuss efforts to improve scope of practice decision-making.

II. Select Comparisons of Scopes of Practice of Four Professions

Legal scopes of practice for the health professions exist in statutes enacted by the state legislature and in regulations developed and implemented by administrative agencies, such as health professions boards. Scopes of practice for many professions vary from state to state despite relatively standard education, training, and certification programs for many of the professions across the U.S.¹ This part compares select specific practice

¹ Sometimes, scopes of practice also vary within single states, as noted in the section below on paramedics in California. In some states, less direct physician supervision is permitted in alternative settings, where underserved patients may be treated by non-physicians. Yet, patients in settings like nursing homes, public health clinics, and rural areas are often more medically compromised than those who are capable of paying for private services. If patient safety was really the issue, these varying levels of supervision would not be permitted. "The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia, 2001," Center for Health Workforce Studies, University at Albany of the State University of New York and Health Research, Incorporated for the National Center for Health Workforce Analysis, Bureau of Health Professions, Health Resources and Services Administration, April 2004 ("HRSA 2004") pp. 49-50, <ftp://ftp.hrsa.gov/bhpr/workforce/dentalhygen.pdf>.

authorities of the following professions in California to more expansive authorities in other states or institutions:

Nurse Practitioners and independent practice
Physical Therapists and the authorities to refer and diagnose
Physician Assistants and the prescription of controlled substances
Paramedics and the administration of intravenous infusions

A. Nurse practitioners (NPs) and independent practice

1. NPs in the United States

Generally, NPs in the United States are registered nurses (RNs) who are prepared beyond initial nursing education in an NP program of at least three months. NPs must earn master's degrees in 24 states.² Some NPs have doctorates. State laws govern specific NP training requirements.

Although most states now require NPs to be nationally certified, NP scopes of practice vary widely among the states. For example, most states require NPs to practice in collaboration with a physician, but some states permit NPs to practice independently without physician involvement. Significant variation can also be found in NP authorities to diagnose, order tests, refer to other providers, and prescribe drugs and controlled substances.

2. NPs in California must practice in collaboration with physicians.

NPs in California do not have a legislatively-determined scope of practice beyond the state's RN scope. However, California NPs may exceed the RN scope of practice through individual "standardized procedures" that may include the authority to deliver care that would otherwise be considered medicine or independent practice.

Standardized procedures cover diagnoses, referrals, prescriptions, and procedures that involve penetration of tissue functions.³ Supervision of NPs performing medical functions is addressed in the standardized procedures, and may vary from one procedure to another.⁴ Standardized procedures must be developed collaboratively by the nursing, medical, and administrative departments of the institutions where they will be used.

As of late 2007, four bills to expand NP scopes of practice were pending in California. AB 1436 broadly seeks to authorize NPs to perform comprehensive health care services for which they are educationally prepared and competent to perform. SB 809 seeks to

² Carolyn Buppert, Nurse Practitioner's Business Practice and Legal Guide (Third Edition; Jones and Bartlett 2008), p. 5.

³ Linda Pearson, "The Pearson Report," *The American Journal for Nurse Practitioners* (February 2007), http://www.webnp.net/images/ajnp_feb07.pdf.

⁴ "The Certified Nurse Practitioner," Board of Registered Nursing, <http://www.rn.ca.gov/pdfs/regulations/npr-b-23.pdf>; Cal. Bus. & Prof. Code §2725.

remove the Medi-Cal Act physician supervision requirement for NPs practicing in long-term health care facilities. It also aims to improve access to primary care in underserved areas by allowing NPs to establish and run clinics. AB 1643 attempts to repeal the prohibition against a physician supervising more than four prescribing NPs at one time. SBX1 24A would require California NPs to be nationally certified.

3. NPs may practice independently in 11 states.

NPs are explicitly authorized to practice independently without physician oversight in 11 states: Alaska, Arizona, District of Columbia, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon, and Washington. In all of these states, the authority of NPs to practice independently includes the authority to prescribe drugs without physician involvement.

NPs in remaining states must practice under varying degrees of physician oversight. For example, stricter states, such as Oklahoma and Virginia, require NPs to practice under direct physician supervision. Most states, on the other hand, require NPs to “collaborate” with physicians.

States may also require ranging levels of physician involvement depending on geographical location (e.g., inner cities or rural areas), practice setting (e.g., nursing homes or hospitals), and service (e.g., diagnosing or writing prescriptions).⁵ For example, NPs in states with large rural, underserved populations tend to be entrusted to practice with minimal, or no, physician involvement. As another example, some states require only prescribing NPs to collaborate with a physician.⁶

B. Physical therapists (PTs) and the authorities to refer and diagnose

1. PTs in the United States

According to the Bureau of Labor Statistics, physical therapists (PTs) “provide services that help restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities of patients suffering from injuries or disease.”⁷ In 2004, PTs held approximately 155,000 jobs in the U.S. They are licensed in all states based on completion of an accredited PT program (all of which must lead to at least a master’s degree) and passage of a licensure exam. The scopes of practice of PTs vary across the states and include differences in whether PTs need a referral from another practitioner to see a patient, the range of practitioners that may make a referral to a PT, restrictions in

⁵ “Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety,” Federation of State Medical Boards (2005), http://www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf.

⁶ For more comprehensive information on NPs, *see* chart and discussion, “Overview of Nurse Practitioner Scopes of Practice in the United States,” UCSF Center for the Health Professions (Sept. 28, 2007).

⁷ “Physical Therapists,” U.S. Department of Labor, Bureau of Labor Statistics, <http://www.bls.gov/oco/pdf/ocos080.pdf>.

time before PTs can be directly accessed, treatments prohibited without a referral, and whether direct access to a PT might be allowed for specific diagnoses.⁸

2. California

To become licensed as a PT in California, one must possess a post-baccalaureate degree in physical therapy, pass the National Physical Therapy Examination (NPTE), and pass the California Law Examination (CLE).⁹ Once licensed, California PTs enjoy a comparatively broad scope of practice, and are not required to have a referral from a physician in order to provide treatment. However, although California PTs are authorized to perform physical therapy evaluations and treatment planning, they are not permitted to diagnose patients. Under California law, a disease or other physical condition cannot be treated without a diagnosis. Thus, PTs may not treat a patient without a prior diagnosis by a physician. In other words, a PT may practice without a physician's referral, provided that a physician diagnosis is first obtained.¹⁰ A pending California bill seeks to authorize PTs to initiate treatment of conditions within the PT's scope of practice.¹¹

3. PTs in Illinois enjoy broader practice authorities.

The nuances in PT scopes of practice among the states offer numerous examples of states that have "broader" scopes than California in some areas, but are more restrictive in other aspects of practice. For example, Illinois's PT scope of practice could be considered more expansive than California's. PTs in Illinois are not permitted to practice without prior referral. But the group of providers that may refer patients to PTs extends significantly beyond physicians. In Illinois, physicians, dentists, advanced practice nurses, physician assistants, and podiatrists may refer patients to PTs. Remarkably, in Illinois, oral referrals from these providers to PTs constitute sufficient authorization. Moreover, although PTs in Illinois are not permitted to diagnose patients, a diagnosis is not a prerequisite to administering physical therapy.¹²

A pending Illinois bill seeks to further expand the practice authorities of PTs. It proposes to allow PTs to treat ailments independent of a referral or diagnosis from a physician, dentist, advance practice nurse, physician assistant, or podiatrist.¹³

⁸ "Direct Access," Federation of State Boards of Physical Therapy, <http://www.fsbpt.org/publications/DirectAccess/>.

⁹ "About the Board," Physical Therapy Board of California, http://www.ptbc.ca.gov/about_us/about_board.shtml.

¹⁰ "Practice Issues," Physical Therapy Board of California, http://www.ptbc.ca.gov/laws_regs/practice.shtml; "Direct Access," Physical Therapy Board of California, http://www.ptbc.ca.gov/forms_pubs/direct_access.pdf (citing Cal. Bus. & Prof. Code §2620).

¹¹ CA AB 1444 (2007).

¹² "Physical therapy does not include determination of a differential diagnosis . . . [H]owever, the limitation on determining a differential diagnosis shall not in any manner limit a physical therapist from performing an evaluation." 225 Ill. Comp. Stat. 90/1.

¹³ IL SB 1626 (2007).

4. Laws and legislative activities in other states

Approximately 19 states provide patients with unlimited direct access to physical therapists. Another 31 have direct access to PTs, limited by ranging restrictions regarding time, treatment, or condition.¹⁴ Other states have, or are seeking, expanded scopes of practice for physical therapists. A pending Kansas bill seeks to identify instances where a PT may evaluate a patient without a physician referral.¹⁵ The New York legislature recently passed a bill expanding the authorized referring provider group to include midwives.¹⁶ PTs in Colorado may perform physical therapy on animals after obtaining veterinary medical clearance for the animal by a licensed veterinarian.¹⁷

C. Physician assistants (PAs) and the prescription of controlled substances

1. PAs in the United States

PA programs in the U.S. usually last at least two years. Admission requirements vary by program, but many require at least two years of college and some health care experience. All states require PA candidates to complete an accredited PA education program, and to pass a national exam open only to graduates of accredited programs.

PAs generally work under physician supervision, but specific laws and regulations vary by state. For example, in some states, PAs may be principal care providers in rural or inner city clinics, where a physician is present for only one or two days a week. The duties of PAs are determined by the supervising physician and by state law.¹⁸

PAs rank among the fastest growing occupations, as physicians and health care institutions increasingly utilize PAs to contain costs. A PA is formally trained to provide diagnostic, therapeutic, and preventive health care services, as delegated by a physician. Further, PAs may prescribe medications in 48 states and the District of Columbia.

2. PAs in California may prescribe controlled substances without prior patient-specific physician approval.

In October 2007, the California legislature passed Assembly Bill (AB) 3. Prior law prohibited a PA from issuing a drug order for Schedule II through Schedule V controlled substances without patient-specific advanced approval by a supervising physician. AB 3 authorizes a PA to issue a drug order for these classes of controlled substances without advanced approval by a supervising physician if the PA completes specified educational requirements and meets other requirements.

¹⁴ "Direct Access," Federation of State Boards of Physical Therapy, <http://www.fsbpt.org/publications/DirectAccess/>.

¹⁵ KS HB 2483 (2007).

¹⁶ NY AB 2139 (2007).

¹⁷ Col. Rev. Stats. 12-41-113(4).

¹⁸ "Physician Assistants," U.S. Department of Labor, Bureau of Labor Statistics, <http://www.bls.gov/oco/ocos081.htm>.

Despite the expansions, California PAs cannot prescribe independently. PAs must still be supervised, and the maximum number of PAs a physician may supervise at one time is limited to four. In addition, under AB 3, each supervising physician who delegates the authority to issue a drug order to a PA must first prepare general written formularies and protocols that specify all criteria for the use of a particular drug. Protocols for Schedule II controlled substances must address the diagnosis for which the Schedule II controlled substance may be issued. AB 3 does not affect federal requirements that PAs must register with the U.S. Drug Enforcement Administration to prescribe controlled substances.

3. Prescribing privileges of PAs employed by the Indian Health Service (IHS) are facility-specific.

Physicians assistants have worked in the IHS for over 30 years. Approximately 160 of the 58,000 PAs in the U.S. work in IHS federal, urban, and tribal health facilities. In Indian medicine, PAs play a significant role in relieving physician shortages in primary care.¹⁹ PAs employed by the IHS must be nationally certified, but the IHS does not require PAs to be licensed in the state in which they practice.²⁰ While grounded in the core requirement that a PA must be supervised by a physician, the IHS policy on PAs recognizes the value of PA practices tailored to individual capabilities and site-specific needs.

a. IHS clinical privileges are facility and individual PA-specific.

All PAs must have a supervising physician. Under the IHS PA practice policy, each facility must outline the scope of work for PAs employed at that facility. The granting of clinical privileges and the requisite degree of supervision are based on the individual PA's education, training, experience, and current competence. The supervising physician must meet with the PA in person on a periodic basis to discuss patient management. The frequency of these meetings is determined by local medical staff.²¹

Under IHS policy, prescribing privileges are granted based on the PA's education and clinical competencies. PAs may prescribe controlled substances if authorized by the facility. IHS PA policy notes that, although PAs employed by IHS need not be licensed by the state in which they are practicing, U.S. Drug Enforcement Agency regulations

¹⁹ "The PA Difference: Why Should IHS Federal/Tribal/Urban Clinics Hire Physician Assistants," Indian Health Service, U.S. Department of Health and Human Services, May 2, 2007 ("IHS 2007"), http://www.ihs.gov/NonMedicalPrograms/NC4/Documents/IHS_WhyHirePhysicianAssistants_allareas_2007.pdf.

²⁰ "Physician Assistants," Indian Health Service Circular No. 96-02 (1996), Indian Health Service, U.S. Department of Health and Human Services ("IHS Circular"), http://www.ihs.gov/PublicInfo/Publications/IHSManual/Circulars/CIRC96/Circ96_02/circ96_02.htm. Based on federal sovereignty and supremacy principles, a state may not require an IHS employee who provides health care in the state to be licensed in that state. PAs employed by tribal and urban clinics, on the other hand, must be licensed within the state in which they are employed. Tribes that contract with the IHS to provide health care are responsible for ensuring that all providers adhere to the statutory practice act of the state. IHS 2007, *supra*, note 19.

²¹ IHS Circular, *supra*, note 20.

require that the PA be authorized to prescribe controlled substances by the state in which he is licensed to practice.²²

b. IHS supervision requirements are flexible.

The IHS recognizes that its PAs are often required to practice in isolated settings where onsite physician consultation is not always available. The IHS PA practice policy thus allows PAs to practice at remote sites, or after hours without a supervising physician onsite, as long as voice telephone or two-way radio contact with an advising physician is available. The advising physician may either be the PA's supervising physician or a designated alternative.²³ Notably, accountability for physician supervision may be determined prospectively, by scheduling, or retrospectively, by chart review, as determined by the physician-PA team.²⁴

4. PAs in the military may prescribe controlled substances.

All PAs in the military must be certified by the National Commission on Certification of Physician Assistants (NCCPA). The certification process includes the passage of the NCCPA Physician Assistant National Certifying Examination.²⁵ In addition to national certification, PAs in the military must have a valid state license from any state to practice.²⁶

Military PAs are authorized to prescribe pharmaceuticals contained in the military treatment facility (MTF) formulary according to the guidance established by the local pharmacy and therapeutics committee. An open formulary is authorized. Prescription writing authorization for PAs must be approved by the MTF commander.

Military PAs are authorized to prescribe controlled substances in Schedules II through Schedules V. Further, when a PA is providing primary field medical support during a field training exercise or deployment, he may administer or prescribe any pharmaceutical stocked in the U.S. Army field medical kit, in addition to the pharmaceuticals authorized by the MTF commander.²⁷

5. Most states allow PAs to prescribe controlled substances with varying levels of physician supervision.

According to the American Academy of Physician Assistants four states currently do not allow PAs to prescribe controlled substances: Alabama, Florida, Kentucky, and Missouri. The remaining states authorize PAs to prescribe controlled substances to varying degrees. For example, Schedule II prescriptions by PAs in North Carolina and South Dakota are

²² Id.

²³ Id.

²⁴ IHS 2007, *supra*, note 19.

²⁵ AR 40-68, 7-16(b) (2004).

²⁶ AR 40-400, 10-2 (2006).

²⁷ Army Regs 68, 7-16.

limited to 30-day supplies. Other states, such as Colorado, Georgia, Kansas, and Mississippi, do not have similar restrictions.²⁸ The New York legislature recently passed a bill allowing PAs broader authority to prescribe controlled substances.²⁹

D. Paramedics and the administration of intravenous infusions

1. California

Paramedics are specially trained and licensed to render immediate medical care to the seriously ill or injured in the prehospital setting. They are typically employed by public safety agencies, such as fire departments, and by private ambulance companies. California paramedics work under the jurisdiction of the state's Emergency Medical Service (EMS) Authority, which implements regulations governing paramedic training, scope of practice, and licensure.

California has three levels of emergency providers: EMT-I (Basic), EMT-II (Intermediate), and EMT-P (Paramedic), with the paramedic having the highest level of training and corresponding practice authorities. Paramedics are trained and licensed in advanced life support (ALS) practices, which include the use of a laryngoscope, endotracheal and nasogastric intubation, and the administration of 21 drugs. The EMS Authority can approve the use of additional skills and the administration of additional medications upon request by a local EMS medical director.³⁰

California's scope of practice for paramedics is particularly challenging. Not only does it differ from other states (see below), but it also varies from county to county within the state. While the state EMS Authority is the governing agency, actual day-to-day emergency medical service operations are the responsibility of local county or multi-county EMS agencies. Notably, while paramedic licensure is valid statewide, paramedics must also be locally accredited in order to practice in any California county.³¹ Accreditation involves orientation to local protocols and training in any "local optional scope of practice" for the particular EMS agency jurisdiction. In addition to the state's basic scope of practice, paramedics may perform other procedures or administer other medications deemed appropriate by the medical director of the local EMS agency, and approved by the Director of the EMS Authority.³²

²⁸ "Information About PAs and the PA Profession," American Academy of Physician Assistants, <http://www.aapa.org/geninfo1.html>; "Where Physician Assistants Are Authorized To Prescribe," American Academy of Physician Assistants, <http://www.aapa.org/gandp/rxchart.html>.

²⁹ NY AB 8456 (2007).

³⁰ "California's Emergency Medical Services Personnel Programs 1999-2007," Emergency Medical Services Authority, http://www.emsa.ca.gov/aboutemsa/ems_prog.pdf; Cal. Code of Regs., tit. 22 §100139; "EMT Paramedic Licensure Frequently Asked Questions," Emergency Medical Services Authority, <http://www.emsa.ca.gov/Para/emtpfaq.pdf>.

³¹ EMTs, on the other hand, are certified and disciplined by local entities, which are designated by counties. A pending California bill provides for statewide standards and makes local EMS agencies jointly responsible for the implementation of statewide EMT-I and EMT-II licensure. CA SB 254 (2007).

³² Cal. Code of Regs., tit. 22 §100145(2)(A).

Evidently, local agencies may also constrict the basic practice authorities of paramedics. For example, under California's scope of practice, paramedics may monitor and adjust intravenous solutions containing potassium, equal to or less than 20 milliequivalents per liter.³³ However, the procedure is not permitted in Sacramento, San Mateo, Santa Clara, and Santa Cruz, although it is allowed in Marin, San Francisco, and Solano.³⁴

2. Paramedics in other states

The wide variability across the U.S. in laws and regulations affecting emergency practitioners, including paramedics, is what prompted the National Highway Traffic Safety Administration (NHTSA) study, which found that the "patchwork of EMS personnel certifications has created considerable problems, including but not limited to: public confusion; reciprocity challenges; limited professional mobility; and decreased efficiency due to duplication of efforts." NHTSA's efforts to develop a national EMS scope of practice model, discussed below in section III.C.1, would include intravenous infusion in the paramedic's scope of practice.³⁵

3. Paramedics in the military are broadly permitted to administer intravenous infusion.

The U.S. military's Special Operations Combat Medic (SOCM) is the closest military equivalent to the civilian paramedic. Although the training is not exactly equivalent, the training time is comparable and provides an example of what can be learned within a limited time frame. SOCMs in the three branches of the military (Air Force, Army, and Navy) provide patient assessment, teaching, emergency, and nursing care within the military treatment facility (MTF). They must maintain the skills of a nationally certified EMT-P, which includes competency in advanced cardiac life support.³⁶

SOCMs work relatively independently under specific protocols with a limited scope of practice, which may be enhanced during the complete absence of a medical officer. Assigned to special operations units, they complete unique advanced medical and military training to enhance their interoperability with other special operations soldiers.³⁷ SOCMs are broadly permitted to initiate, monitor, and discontinue intravenous infusion.³⁸

³³ Cal. Code of Regs., tit. 22 §100145(1)(L).

³⁴ "Paramedic Basic Scope of Practice," California Emergency Medical Services Authority, <http://www.emsa.ca.gov/Para/EMTSOP3.pdf>.

³⁵ US Department of Transportation, National Highway Traffic Safety Administration. National EMS Scope of Practice Model. February 2007. <http://www.emsa.ca.gov/EMSScopeofPractice.pdf>.

³⁶ "Career Management Field [CMF] 91, Clinical Baseline Competencies for Enlisted Medical Personnel Performing Direct Patient Care at the Military Treatment Facility," MEDCOM Reg. 40-50, United States Army Medical Command (2005) ("MEDCOM Reg. 40-50"), pp. 62, 65.

The SOCM is classified as the MOS 68W, ASI W1. (MOS stands for "military occupational specialty"; ASI stands for "additional skill identifier." In 2006, the 91W MOS was reclassified as 68W.) The SOCM is currently the most independent-duty enlisted medical personnel in the CMF 68 field.

"68W," Wikipedia, <http://en.wikipedia.org/wiki/68W>.

³⁷ "68W," Wikipedia, <http://en.wikipedia.org/wiki/68W>.

³⁸ MEDCOM Reg. 40-50, *supra*, note 36 at 63.

III. Improving Scopes of Practice and How They Are Determined

The next sections discuss efforts to address the differences in scopes of practice for given professions across the U.S. First, it elucidates the importance of implementing a single impartial mechanism to review all scope of practice expansion proposals in a state or institution. Secondly, to show the inherent conflict of allowing one professional board to govern members of a different profession, the brief discusses current efforts of dental hygiene boards to achieve independent rule-making authority in various states. The final section discusses efforts to address the lack of interstate scope of practice uniformity.

A. Scope of practice review mechanisms

Decision-making on scope of practice matters are largely left up to the political process and carried out by state legislatures.³⁹ Interest groups with strong lobbies play a significant role in shaping legislation.⁴⁰ Partly in response to frustration with this process and concern that technical and quality of care issues do not receive adequate attention, an increasing number of jurisdictions have established independent committees that utilize standard procedures to review proposals for scope of practice expansions. Committee reports are then transmitted to legislators, allowing them to make informed decisions based on the evidence. These jurisdictions recognize the need for fair, unambiguous, and transparent review processes.⁴¹

1. New Mexico's scope of practice review commission

New Mexico's law-makers recognize that every legislative session brings a request by a health profession to expand its scope of practice. Some legislators acknowledge that they are not qualified to make decisions on these confusing bills.

Therefore, 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 process to review the current scopes of practice of New Mexico's

³⁹ State practice acts are essential, but not sole, determinants of professional practice authorities. Case-by-case interpretations of practice acts are provided in the formal opinions and rules of courts, attorney generals, and licensing boards. These interpretations can affect actual practice landscapes of the states. For instance, a practice act with an apparently narrow scope of practice can be complemented by an attorney general's lenient application of the statutes.

⁴⁰ When powerful professional organizations do not succeed in advancing their interests through the political process, they sometimes turn to courts. For example, in 2006, the American Dental Association (ADA) and the Alaskan Dental Society sued the Alaska Native Tribal Health Consortium to prevent dental health aide therapists (DHATs) from providing dental services in the state's rural villages, where the rate of tooth decay in the region is among the nation's highest. The complaint provided no empirical evidence supporting the DHAT's alleged incompetence to render basic dental services to the Native population. In June 2007, a federal judge dismissed the case. Surprisingly, the ADA decided not to appeal. Instead, it committed to assist in the improvement of oral health care in rural Alaska.

⁴¹ In addition to the processes discussed below, the Minnesota Council of Health Boards follows detailed guidelines to objectively review proposals for expanded scopes of practice. The Minnesota Health Occupation Review Program, which authorizes the process, was created under state law in 2001 to provide legislators with relevant questions, upon their request. This model deserves further study.

health care professions. Its purpose is to provide legislators with objective information when evaluating proposed changes. HJM 71 and HM 88 realistically provide that some proposals are the result of changes already occurring in practice due to advances in technology and changes in societal health care demands.

2. Iowa's reviewing committee

Under the Iowa Code, 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.⁴²

3. Texas: pending bill to establish standard review process.

In 2005, Representative Dianne Delisi authored a bill to create the Health Professions Scope of Practice Review Commission. Its purpose was to establish a formal method for objectively evaluating proposed changes to health care scope of practice laws.⁴³ Although the bill was not passed in 2005, it was re-filed in 2007.⁴⁴ In addition to creating the Review Commission, HB 3950 would establish a formal method for objectively evaluating proposed changes to scopes of practice. The nine-member commission would include two representatives of the public and a representative of the Health, Law, and Policy Institute at the University of Houston. The bill explicitly requires that legislative analyses of commission reports be evidence-based.

Notice requirements for committee meetings would be similar to those of corporate boards of directors' meetings. For example, the bill articulates the requirements for establishing a quorum for purposes of voting. It also requires that meetings be open to the public. Further, H.B. 3950 requires that the Commission's analysis include a review of other states that have implemented similar scope of practice review mechanisms. An examination of subsequent impacts on access to care is also required.

4. Virginia: Board of Health Professions

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 five citizens (consumers), all appointed by the Governor.⁴⁵ Among its duties, the Board of Health Professions is

⁴² Iowa Code §147.28A (2005).

⁴³ HB 2706, 79(R) (2005), <http://www.capitol.state.tx.us/tlodocs/79R/billtext/pdf/HB027061.pdf>; Bill Analysis, <http://www.capitol.state.tx.us/tlodocs/79R/analysis/pdf/HB02706H.pdf>.

⁴⁴ HB 3950, 80(R) (2007), <http://www.capitol.state.tx.us/tlodocs/80R/billtext/pdf/HB039501.pdf>.

⁴⁵ Code of Virginia §54.1-2510.

responsible for evaluating and making recommendations on the need for and appropriate level of regulation for the health care professions.

At various times, the legislature has directed the Board to issue reports on scope of practice matters. For example, in 2000, the Board of Health Professions studied the appropriate level of regulation for Virginia's certified occupational therapy assistants (COTAs). The Board produced a report that included the results of: 1) a survey of all states that regulated occupational therapists or COTAs, showing aggregate numbers of complaints, disciplinary actions, and malpractice claims over a period of two years; 2) a survey of occupational therapists in the state, revealing supervision and delegation patterns for a variety of activities involving COTAs; and 3) a public hearing. Based on these findings, the legislature decided that no additional regulatory oversight was needed for COTAs at the time.⁴⁶

5. Ontario: independent regulatory bodies

The Regulated Health Professions Act of 1991 (RHPA) provides a common framework for the regulation of those who work in Ontario's 23 health professions and 21 "colleges" that regulate them. It was designed to introduce greater flexibility in health care delivery.⁴⁷

The Minister of Health is responsible for the administration of the RHPA. It has several powers over the councils of the regulatory colleges, including the power to require them to make, amend, and revoke regulations. In practice, Ministers have strongly relied on the commonality of interest that exists between the HPRAC and the colleges.⁴⁸

The HPRAC facilitates ongoing policy development, and reports to the Minister on quality assurance programs undertaken by the colleges.⁴⁹ Proposed regulations arrive before the HPRAC either by the Minister's direct referral, or by any other individual's referral through the Minister. A referral triggers a process of "consultation." The Minister must notify every college, and permit each college's council to submit arguments to the HPRAC within 45 days. The registrar of each college also must notify its members when a referral is made.⁵⁰

The Council is independent of both the Ministry and the colleges. It consists of five to seven individuals appointed by the Lieutenant Governor of the Council on the Minister's recommendation. Public employees, present and former members of any of the regulated

⁴⁶ "Study on the Appropriate Level of Regulation for Certified Occupational Therapy Assistants," Virginia Board of Health Professions (2000), pursuant to SJR 153.

⁴⁷ "Adjusting the Balance: A Review of the Regulated Health Professions Act," Health Professions Regulatory Advisory Council (2001), http://www.hprac.org/en/reports/resources/RHPA_Review_2001_Report.pdf.

⁴⁸ Linda S. Bohnen, *Regulated Health Professions Act: A Practical Guide*, Canada Law Book, Inc. (1994), pp. 11-12, citing RHPA §§1(1), 5.

⁴⁹ *Id.* at 12, citing RHPA §11.

⁵⁰ *Id.* at 13, citing RHPA §§5, 12, 13.

professions, and anyone who has ever served on the Council are not eligible for appointment.⁵¹

The Health Professions Board conducts registration hearings and complaint reviews. Like the HPRAC, the Board is independent of both the Minister and the colleges.⁵² Finally, the colleges are responsible for implementation of the RHPA.⁵³ A hallmark feature of the Act is that just under 50 percent of members of the colleges' governing boards are public appointees.⁵⁴

6. The military adjusts to changing needs by reclassifying personnel.

When the military realizes a need for new categories of health care personnel, it responds flexibly by implementing new, organized mechanisms to fill the need. For example, the Department of the Army issued a Notification of Future Change (NOFC) for Military Occupational Specialties 91B and 91C in September 1999. The NOFC established the start of the transition of 91Bs and 91Cs to 68Ws in October 2001. The transition period for active duty personnel ended in September 2007.⁵⁵ In six years, the military identified an area of need, created new occupations, implemented education and training requirements, and successfully facilitated the transition.

7. Changes in Healthcare Professions' Scope of Practice.

In 2006, six national health care regulatory organizations (in medicine, nursing, occupational therapy, pharmacy, physical therapy, and social work) collaborated to produce a landmark paper that outlines a rational approach to evaluating proposals to expand or revise practice acts. It recognizes that changes in scopes of practice are inherent in our current system, and urges regulators to allow for innovation in the use of all types of clinicians to meet consumer needs.⁵⁶

B. Health boards with independent rule-making authority: a step towards eliminating conflicts of interest

Some health boards have successfully convinced legislators that health board X, with professional and financial interests that inherently conflict with those of health board Y, should not be involved in shaping scope of practice laws governing practitioners Y.⁵⁷

⁵¹ Id. at 12-13, citing RHPA §§7(2), 8.

⁵² Id. at 14, citing RHPA Procedure Code §§18-23.

⁵³ Id., citing RHPA §2.

⁵⁴ "Adjusting the Balance: A Review of the Regulated Health Professions Act," *supra*, note 47.

⁵⁵ "Frequently Asked Questions/68W Questions," Department of Combat Medic Training, Army Medical Department, <http://www.cs.amedd.army.mil/68w/news/faqs.htm#question1>.

⁵⁶ "Changes in Healthcare Professions' Scopes of Practice: Legislative Considerations" (2006), <https://www.ncsbn.org/ScopeofPractice.pdf>.

⁵⁷ Inter-board collegiality is a crucial component of the rule-making process. Given the recent advances in health care technology, practice acts will constantly need to be revised to accommodate the utilization of new developments. Despite political realities, professional boards in some states understand that they must be willing to work together to reach consensus on scope of practice laws. For example, Washington state's NP scope of practice was successfully drafted after members of three health boards committed to

For example, a pending New Jersey bill seeks to establish the Health Care Professional Regulation Study Commission. One purpose of the study would be to evaluate whether the responsibility for the regulation of health care professionals should be transferred from the Board of Medical Examiners to other health boards or state agencies.⁵⁸ The following sections examine the rule-making authority of dental and dental hygiene boards over dental hygienists (DHs) in various states.

1. Generally, DHs must be supervised by dentists.

The role of DHs has greatly expanded since 2000. The profession is now licensed in every state and the District of Columbia.⁵⁹ As DHs have demonstrated their clinical ability to contribute to improved access to care, they have also been successful in expanding their legal scopes of practice in most states. DH roles, which were initially rooted strictly in preventive care, have slowly grown into a variety of basic restorative services. In some states, DHs are legally enabled to perform more extended functions, such as placing amalgam restorations and administering local anesthetics.⁶⁰

Most states, however, continue to require supervision by dentists at some level, depending on the task, the setting, and the patient being served. DHs are generally not permitted to have initial contact with patients exclusive of a dentist. States typically require that patients first be seen by a dentist before a DH provides any services.⁶¹

A 2004 study commissioned by the federal Health Resources and Services Administration suggests that expanding the professional practice environment of DHs improves oral health outcomes.⁶² The study found that greater autonomy for DHs would promote better access to basic preventive care in many geographic areas that cannot economically sustain the practice of a dentist, but could sustain the practice of a DH.⁶³

2. DHs are increasingly seeking authority to self-regulate.

States address DH practices most frequently in dental practice acts. The actual regulation of dental hygiene occurs almost universally through boards of dentistry or boards of dental examiners. Presently, very few states have created separate dental hygiene committees that are autonomous. Self-regulation is emerging as a particularly cogent issue for the DH profession.⁶⁴

finishing a collaborative outline within a set timeline. The North Carolina medical and pharmacy boards reached an agreement on prescriptive authority for pharmacists when one member of the medical board recognized the competence of pharmacists. There, various professional boards regularly get together for semi-social training programs.

⁵⁸ NJ A162 (2007).

⁵⁹ HRSA 2004, *supra*, note 1 at 19.

⁶⁰ *Id.* at 1-2.

⁶¹ *Id.* at 51.

⁶² *Id.*

⁶³ *Id.* at 12.

⁶⁴ *Id.* at 57 (citing “Educational Standards Position Paper,” American Dental Hygienists’ Association (ADHA), Chicago, IL (2001), p. 2, http://www.adha.org/profissues/education_standards.htm).

Although DHs are represented on many dental boards, the numbers of seats are minimal, and the effect on voting, when permitted, is small.⁶⁵ Even though several state hygienist groups have advocated the creation of independent dental hygiene boards, the profession has been mostly unsuccessful in lobbying efforts to attain self-regulation.⁶⁶

3. The California Committee on Dental Auxiliaries (COMDA) is a part of the Dental Board.

In 1964, the California legislature passed a Dental Auxiliary Act “to permit the full utilization of dental auxiliaries to meet the dental care needs of all the state’s citizens.” The 1964 act instructed the Board of Dental Examiners to regulate the precise functions that may be performed by each level of auxiliary, and the settings in which such functions could be performed.⁶⁷ DHs in California provide most services under general supervision.

Currently, as a part of the California Dental Board, COMDA administers the examination and licensing programs for the five classes of dental assistants and DHs in the state: 1) registered dental assistants; 2) registered dental assistants in extended functions; 3) registered dental hygienists; 4) registered dental hygienists in extended functions; and 5) registered dental hygienists in alternative practice.⁶⁸ COMDA includes three hygienists and three assistants.⁶⁹ The Dental Board has 14 members with one voting hygienist. It is under the Department of Consumer Affairs.⁷⁰

In September 2007, the governor vetoed SB 534, which would have created an independent Dental Hygiene Committee and extended the dental board’s sunset review date. SB 534 emerged after the Dental Board was cited in part for failing to properly deal with dental hygiene issues in a way that protected consumers in the state.⁷¹ In effect, the failure of SB 534 means the Dental Board will be “sunsetting,” or closed, in July 2008, when the board will become a bureau under the state Department of Consumer Affairs, unless other action is taken.

4. DHs in Washington, Colorado, Iowa, and New Mexico have more expansive rule-making or practice authority.

Washington is unique among states in that dentistry and dental hygiene are regulated under separate practice acts. Since the early 1980’s, DHs have been governed by a Dental Hygiene Advisory Committee composed of three DHs and one public member.⁷²

⁶⁵ Id. at 155.

⁶⁶ Id. at 156.

⁶⁷ Benjamin Shimberg, *Occupational Licensing: A Public Perspective*, Educational Testing Service (1980), pp. 89-90.

⁶⁸ Cal. Bus. & Prof. Code §1742; “Overview of COMDA,” Committee on Dental Auxiliaries, California Dental Board, <http://www.comda.ca.gov/overview.html>.

⁶⁹ Cal. Bus. & Prof. Code §1743.

⁷⁰ Cal. Bus. & Prof. Code §1601.1.

⁷¹ HRSA 2004, *supra*, note 1 at 156.

⁷² Rev. Code of Wash. 18.29.110.

Although the committee was originally established to supervise the examination and licensure of DHs, committee responsibilities have evolved to full regulation of hygienists in the state. The board functions independently of the dental commission.⁷³

DHs in Colorado are governed by the Board of Dental Examiners. The ten member board includes two voting DHs.⁷⁴ Importantly, however, Colorado law permits DHs to perform certain tasks without dentist supervision.⁷⁵ Moreover, the state permits the group practice of dental hygiene, making it possible for DHs to be self-employed.⁷⁶

DHs in Iowa are governed by the dental board. The nine-member board consists of two DHs.⁷⁷ In 1999, the legislature created a Dental Hygiene Committee within the state's Board of Dental Examiners. The committee is empowered to make rules for the practice of dental hygiene. The committee's recommendations must be passed unless a reasonable impediment can be demonstrated.⁷⁸

New Mexico's nine-member Board of Dental Health Care includes two DH members.⁷⁹ In 1994, the legislature established a nine-member Dental Hygienists Committee, which regulates the examination and licensure of DHs.⁸⁰ The committee also has the power to make mandatory recommendations regarding DH practices to the board. The board may decline to ratify the recommendations only under very specific circumstances.⁸¹

C. National Uniformity

Mandating that a practitioner licensed in one state be re-examined in a new state in order to transfer his practice to that state is an impediment to practice and thus negatively affects access to care. Additional restrictions on access, including variable scopes of practice among the states for a given profession, which indicate that at least some members of that profession are not practicing to the full extent of their education, training, and competence. One challenge facing the health care community is to develop more uniform standards for professional licensure, while retaining sufficient flexibility to meet the unique needs of each state.⁸² The following sections discuss efforts towards national uniformity.

⁷³ HRSA 2004, *supra*, note 1 at 57 (citing "Dental Hygiene Participation in Regulations," ADHA (September 2001)).

⁷⁴ Col. Rev. Stats. 12-35-104.

⁷⁵ Col. Rev. Stats. 12-35-124.

⁷⁶ *Id.*

⁷⁷ Iowa Code §147.14(4).

⁷⁸ Reasonable impediments may be found if the record does not support the ratification, a financial barrier makes it imprudent or impossible, or the recommendation is outside the jurisdiction of the board. Iowa Code §153.33A.

⁷⁹ N.M. Stats. 61-5A-8A.

⁸⁰ N.M. Stats. 61-5A-9.

⁸¹ N.M. Stats. 61-5A-10, 61-5A-11.

⁸² "National EMS Scope of Practice Model," The National Highway Traffic Safety Administration, U.S. Department of Transportation (2007), Introduction, <http://www.emsa.ca.gov/EMSScopeofPractice.pdf>.

1. Profession-specific Model Practice Acts

Some professions have moved toward nationally uniform scopes of practice by promoting model practice acts that are designed to be adopted by all of the states for a given profession. Often drafted by professional associations or federations of state boards, these models can be very helpful to legislatures considering establishing or expanding scopes of practice, in addition to alleviating the challenges of state variability. Such model practice acts have met with varying degrees of success. Some have been implemented by a majority of states, while others are less popular.

One of the latest efforts in this arena is the National Emergency Medical Services Scope of Practice Model, designed as a guide for states in developing their scope of practice legislation. One unique aspect of the EMS Scope of Practice Model is that it was prepared not by the EMS profession, but by the National Highway Traffic Safety Administration (NHTSA).

In 2005, the NHTSA identified 39 different licensure levels between the EMT and Paramedic professions. This patchwork of EMS personnel certifications has created considerable problems, including public confusion. The National EMS Scope of Practice Model defines four levels of EMS licensure: Emergency Medical Responder, Emergency Medical Technician, Advanced EMT, and Paramedic.⁸³

The model's drafters hope that the National EMS Scope of Practice Model will increase the consistency of the nomenclature and the competencies of EMS personnel nationwide, facilitate reciprocity, improve professional mobility, and enhance the name recognition and public understanding of EMS. Just published in February 2007, it remains to be seen how many states will act on the NHTSA's recommendations.

2. The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)

Prior to Hurricanes Katrina and Rita in 2005, many states had enacted emergency management laws that allow for emergency waiver of licensure standards to facilitate the interstate use of health practitioners. Within the public sector, 49 of 50 states had ratified the Emergency Management Assistance Compact (EMAC), which allowed for the deployment of health practitioners employed by state and local governments to other jurisdictions to provide emergency services without having to be licensed in the affected jurisdictions. EMAC does not apply to private sector employees. Today, all states have ratified the EMAC.⁸⁴

⁸³ "National EMS Scope of Practice Model," The National Highway Traffic Safety Administration, U.S. Department of Transportation (2007), Executive Summary, <http://www.emsa.ca.gov/EMSScopeofPractice.pdf>.

⁸⁴ "Prefatory Note," The Uniform Emergency Volunteer Health Practitioners Act, <http://www.uevhpa.org>.

Promising Scope of Practice Models for the Health Professions

The federal government allows its licensed health practitioners to respond to emergencies without compliance with state professional licensing requirements.⁸⁵ In addition, two federal systems were established to facilitate the use of private sector health practitioners in response to emergencies, especially those mobilized by charitable organizations. First, under the Public Health Services Act, local Medical Reserve Corps throughout the nation may recruit, train, and promote the deployment of practitioners in response to emergencies. Secondly, funding was provided to state governments by the Department of Health and Human Services to establish Emergency Systems for Advance Registration of Volunteer Health Professionals (generally referred to as “ESAR-VHP Programs”).⁸⁶

The National Conference of Commissioners on Uniform State Laws (NCCUSL) is a group of state-appointed lawyers that supports the federal system and facilitates the movement of individuals with rules that are consistent from state to state. The purpose of NCCUSL is to study and review state laws to determine which areas of law should be uniform.⁸⁷ The NCCUSL is perhaps best known for its development of the Uniform Commercial Code (UCC), which has been adopted by all 50 states to improve interstate commercial transactions.

The NCCUSL drafted the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) in an expedited manner in the months immediately following the Gulf Coast Hurricanes to implement efficient procedures to deploy public and private sector health practitioners in response to declared emergencies.⁸⁸ As of September 2007, the act has been enacted in Colorado, Kentucky, and Tennessee. It was introduced in Oregon, California, Pennsylvania, and the Virgin Islands this year. A Mississippi bill enacting the UEVHPA died in committee. A Maine bill was withdrawn.⁸⁹

The UEVHPA: 1) establishes a system for the use of volunteer health practitioners capable of functioning autonomously even when routine methods of communication are disrupted; 2) provides reasonable safeguards to assure that volunteer health practitioners are licensed; 3) allows states to regulate the scope of services provided by volunteer health practitioners to promote disaster recovery operations; 4) helps to protect volunteer health practitioners from civil liability; and 5) allows volunteer health practitioners who suffer injury or death while providing services pursuant to the act the option to elect workers’ compensation benefits from the host state if such coverage is not otherwise available.⁹⁰ Under the act, volunteers must be registered with public or private systems prior to deployment. All systems must be capable of determining that registrants are properly licensed and in good standing in their principal jurisdiction of practice, and communicating such information to host states.⁹¹

⁸⁵ Id. (citing 10 USCA §1094(d)(1)).

⁸⁶ Id.

⁸⁷ “States Work to Cut Red Tape for Emergency Care Providers,” CaliforniaHealthline, California HealthCare Foundation, Oct. 9, 2007 (citing “States Seek to Cut Disaster Red Tape,” USA Today (Hall), Oct. 8, 2007; National Conference of Commissioners on Uniform State Laws, <http://www.nccusl.org>).

⁸⁸ Id.

⁸⁹ “Bill Tracking,” The Uniform Emergency Volunteer Health Practitioners Act, <http://www.uevhp.org>.

⁹⁰ “Prefatory Note,” The Uniform Emergency Volunteer Health Practitioners Act, <http://www.uevhp.org>.

⁹¹ The Uniform Emergency Volunteer Health Practitioners Act §§3, 5, <http://www.uevhp.org>.

The act requires volunteers to limit their practice to activities for which they are licensed and qualified to perform. Volunteer health practitioners must also conform to the scopes of practice of host states. Moreover, host states may modify the activities of practitioners in response to emergency conditions. Specifically, the act vests authority over out-of-state volunteers in the licensing boards of host jurisdictions. It also requires the reporting of unprofessional conduct by host states to licensing jurisdictions, thus allowing licensing jurisdictions to impose sanctions on practitioners for misconduct. Licensing boards, however, are required to consider the unique exigent circumstances often created by emergencies and the limitations on communications that may occur.⁹²

a. California's UEVHPA bill

Under existing law, California's ESAR-VHP program (the California Medical Volunteer Site) is administered by the state EMS Authority. It currently allows nurses, doctors, pharmacists, and paramedics to register for volunteer service.⁹³ It does not permit other health professionals to register. It also does not address scope of practice issues.

Pending California Assembly Bill 64 proposes to enact the UEVHPA. It was passed by state Assembly in July 2007, and has moved to the Senate. Mirroring the UEVHPA, AB 64 requires volunteers in California to adhere to California scopes of practice. Moreover, volunteers may not practice outside of the scopes of their licensing states, even if a similarly licensed practitioner in California is permitted to provide additional services. AB 64 permits both the California EMS Authority and the licensing state to restrict the services that volunteers provide. It allows California licensing boards to impose administrative sanctions on an out-of-state practitioner for conduct in California. It also permits California boards to report the sanctions to the practitioner's licensing board.⁹⁴ Like the UEVHPA, AB 64 exempts registered volunteer health practitioners from unauthorized practice unless they have reason to know that similarly licensed practitioners in California are not permitted to provide the service.⁹⁵

⁹² The Uniform Emergency Volunteer Health Practitioners Act §§4, 6, <http://www.uevhpa.org>.

⁹³ Cal. Admin. Code tit. 22 §100144.

⁹⁴ The Uniform Emergency Volunteer Health Practitioners Act §8, <http://www.uevhpa.org>.

⁹⁵ Id.; CA AB 64 (2007), Assembly Committee on Appropriations, Hearing on May 9, 2007.

The list of supporters of AB 64 include: American Nurses Association of California, American Red Cross, Board of Registered Nursing, California Applicants' Attorneys Association, California Association of Physician Groups, California Dental Association, California Federation for Animal Legislation, California Nurses Association (co-sponsor), California Primary Care Association, California Professional Firefighters, California Society of Health-System Pharmacists, California State Conference of the NAACP (co-sponsor), Humane Society of the United States, Regional Council of Rural Counties, and United Animal Nations. Remarkably, no opposition was filed as of June 30, 2007.

A related bill is currently pending. Existing California law provides that certain health care providers rendering services at the request of a state or local official are immune from liability for injury except in cases of gross negligence or willful misconduct. AB 880 would additionally exempt a registered private business entity or nonprofit that provides volunteer services during any emergency from liability.

b. Other states efforts that do not mirror the UEVHPA

Recent efforts in various states attempt to address the issue of deploying emergency health care practitioners using mechanisms other than the UEVHPA. For example, in Missouri, prior law provided that only licensed, registered, or certified workers in Missouri were allowed to be deployed to emergencies in the state. Recently enacted HB 579 allows for the emergency deployment of any volunteer health care provider who is licensed, registered, or certified in Missouri, or any other state. Notably, during the period of emergency, HB 579 allows the governor to waive or suspend any law regarding the licensing or certification of professionals.

A pending bill in New York proposes to enact the State Emergency Health Powers Act, which allows the Public Health Authority to exercise certain emergency powers regarding the licensing and appointment of in-state and out-of-state personnel.⁹⁶ A pending South Carolina bill seeks to allow the Department of Health and Environmental Control to accept the volunteer services of out-of-state health care providers.⁹⁷

3. Nurse Licensure Compact

Yet another approach to addressing the challenges of non-uniformity has been pursued by the National Council of State Boards of Nursing, which developed the Nurse Licensure Compact. Relying on a mutual recognition model, the compact permits nurses who have one license and to practice in other states, while recognizing that the nurse is bound by the laws and regulations of the state in which she is practicing. Registered nurses in 21 signatory states of the compact thus have multi-state practice privileges. Similarly, the APRN Compact for NPs was developed in 2000.⁹⁸ Like the Nurse Licensure Compact recognizing RN and licensed practical nurse licenses, the APRN Compact offers states a mechanism for mutually recognizing APRN licenses. Although no date has been set for the implementation of the APRN Compact, Iowa, Texas, and Utah have passed laws to join the compact.⁹⁹

IV. Conclusion

This paper has highlighted a few specific cases out of countless examples of interstate variations in the legal scopes of practice for certain professions. Inefficiencies occur when health care practitioners are not utilized to their full capacity in terms of their education, training, and competence. These inefficiencies may manifest as higher costs, limited access to care, and concerns over quality and safety.

⁹⁶ NY SB 8729 (2007).

⁹⁷ SC HB 3852 (2007).

⁹⁸ “The Uniform APRN Licensure/Authority to Practice Requirements,” National Council of State Boards of Nursing, https://www.ncsbn.org/Uniform_Advanced_Practice_Registered_Nurse_Licensure_Authority_to_Practice_Requirements.pdf; “Participating States in the NLC,” National Council of State Boards of Nursing, <https://www.ncsbn.org/158.htm>.

⁹⁹ Id.

Promising Scope of Practice Models for the Health Professions

Efforts to address: 1) mismatches between scopes of practice and actual competence; and 2) the lack of uniformity among the states have been admirable in some cases, but of limited success to date. Some efforts are ongoing, and their impact is yet to be determined.

Further research efforts might explore the origination of these variations and the impact of these differences on access to care. There is no single, obvious explanation for the variations, which involve a multitude of actors and institutions making decisions without any set standard. Each stakeholder has his own goals, biases, and agendas, which change over time. For example, organized medicine's role in opposing expanded scopes of practice for all other professions has been significant.

Without evidence to the contrary, it would seem that uniform, broad scopes of practice would be optimal. Scope of practice laws that define practitioners as providers of general categories of services are preferable to those that define each separate task that a practitioner may provide to patients.¹⁰⁰

Our research on promising scope of practice models in other states and institutions has shown that more loosely defined regulations allow various provider groups to work together to provide services within a framework of basic competencies. Due to the recent exponential increase in new technology, travel, and means of communication, many groups of practitioners may competently provide new services, in addition those specifically enumerated in legislation. A scope of practice that permits some latitude is therefore most desirable.¹⁰¹

¹⁰⁰ HRSA 2004, *supra*, note 1 at 105.

¹⁰¹ *Id.*