FINAL REPORT OF THE
BOARD OF HEALTH PROFESSIONS

# STUDY OF THE APPROPRIATE CRITERIA IN DETERMINING THE NEED FOR REGULATION OF ANY HEALTH CARE OCCUPATION OR PROFESSION

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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# COMMONWEALTH of VIRGINIA

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To: The Honorable George Allen
Governor of the Commonwealth of Virginia

The Members of the General Assembly of Virginia

It is my privilege to present the report constituting the response of the Board of Health Professions to the request contained in Chapter 532 of the 1996 Acts of the Assembly.

The report provides the findings and recommendations of the Board regarding the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession.

John W. Hasty

# FINAL REPORT OF THE BOARD OF HEALTH PROFESSIONS

## *Study of the Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupation or Profession*

## *In Response to § 54.1-2409.2 (1996)*

**The Board of Health Professions**
**Commonwealth of Virginia**

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Barbara A. Cebuhar, Chair
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William M. York, Jr.

We are especially indebted to the other members of the Board of Health Professions and its constituent Boards, and the employees of the Department of Health Professions. This report and its recommendations are the result of their dedication and commitment to this process, their hard work, and their wealth of knowledge and experience. Particular thanks go to John W. Hasty, R.Ph., Director of the Department of Health Professions, Robert A. Nebiker, Executive Director of the Board of Health Professions, Elizabeth A. Carter, Ph.D., Deputy Executive Director of the Board of Health Professions and Elaine J. Yeatts, Senior Regulatory Analyst of the Department of Health Professions. Carol S. Stamey of the Department also deserves special recognition for all her assistance in making certain that our meetings ran so smoothly.

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written comments to the Committee, for their suggestions on how to improve Virginia's process for regulating the health professions.

Finally, we thank Dr. C. Donald Combs, Robert J. Alpino, Dr. P. Preston Reynolds, and the entire Eastern Virginia Medical School study team and staff who assisted in the development and production of this document and the many study products produced over the last year.

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## EXECUTIVE SUMMARY

### Study of the Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupation or Profession

## AUTHORITY FOR THE STUDY

There is a growing sense that, although well-intentioned, health professions regulatory goals, structures, and mechanisms are increasingly out of synchronization with health care delivery processes. Moreover, as the pace of change in health care delivery accelerates in response to the new emphases on competition, health care outcomes, efficiency, and patient-focused care systems, the incongruence between the regulatory framework and the needs of the health care industry will be exacerbated. An urgent question facing policy makers and health professionals is: "How can health professions regulation achieve its primary objective of protecting the public from harm without unnecessarily restraining progress in health care delivery systems?"

Virginia is not immune to the rapid pace of change in health care and has been grappling recently with a variety of issues surrounding the regulation of health care professionals. Over the last several years the Board of Health Professions and the General Assembly have been faced with numerous requests from health professional associations interested in further regulation of their professions. In 1996, the issue of licensure of respiratory therapists in the Commonwealth was brought before the General Assembly. Respiratory therapists were certified, and obtaining licensure would have represented a greater degree of regulation for that professional group. The Virginia Hospital and Healthcare Association raised objections to the additional regulation of Virginia health professions based on "the premise that cross-training and cross-functioning of health care professions in their employment was desirable" and the fear that additional regulation of health care professions would preclude such workplace changes. The ensuing discussion of the respiratory therapy licensure issue resulted in a desire by the General Assembly to conduct a more wide-ranging study of the issue of health professions regulation in general and led to the study that produced this report. Over five years had passed since the current criteria used for regulation of health professions in Virginia were adopted. The Pew Health Professions Commission in 1995 had issued a widely circulated report on health care workforce regulation that initiated a national discussion of this issue. Thus, the timing was right for a review of health professions regulatory criteria utilized in Virginia. In its 1996 session, the Virginia General Assembly passed House Bill 1439, subsequently codified as Chapter 532 of the 1996 Acts of the Assembly, that amended the Code of Virginia section relating to the regulation of health professionals by the Board of Health Professions

(§ 54.1-2409.2). This new section of the Code of Virginia required the Board of Health Professions to study and prepare a report for submission to the Governor and the General Assembly by October 1, 1997 on the appropriate criteria to be used in determining the need for regulation of any health care occupation or profession. Six principles to guide the selection of appropriate criteria were included in the study legislation. The study charge was to produce findings and recommendations on the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession. A broad study was mandated by the legislation, to include an examination of the current health care delivery system, the current and changing nature of health care settings and the interaction of the regulation of health professionals with a number of other areas of regulation. The study was to include, but not be limited to, reviewing and analyzing the work of publicly and privately sponsored studies of reform of health workforce regulation in other states and nations. Finally, the study was to be conducted in cooperation with Virginia academic health centers with accredited professional degree programs.

## STUDY METHODOLOGY

To oversee the study process, the Board of Health Professions appointed a 5-member ad hoc Committee on Criteria. The Chair of the ad hoc Committee on Criteria was a public member of the Board of Health Professions. Other Boards/constituencies represented on the ad hoc Committee included the Boards of Medicine, Nursing and Social Work, while a second public member of the Board of Health Professions served on this Committee as well. To fulfill the General Assembly's legislative mandate to conduct the study in cooperation with Virginia's academic health centers, a Request for Proposals to conduct the study was issued to Virginia's three academic health centers. Proposals were received from a Virginia Commonwealth University/Medical College of Virginia study team and from an Eastern Virginia Medical School study team. The ad hoc Committee on Criteria selected the Eastern Virginia Medical School study team to conduct the study. The Eastern Virginia Medical School study team was subsequently awarded a complementary research grant from the Pew Center for the Health Professions to study the changing role of health professionals in integrated health care delivery systems.

Four key methodologies were used to conduct the study: a comprehensive review and analysis of the professional literature, site visits by the ad hoc Committee to integrated health care delivery systems in the Commonwealth, prepared testimony to the Committee by national and international experts in health professions regulation and health care, and broad provider, consumer, insurance and other organizations' participation in the study process.

## SPECIFIC ISSUES AND AREAS OF ANALYSIS

Among the issues addressed during the study process were those identified by the Pew Health Professions Commission in its 1995 study on reforming health care workforce regulation: standardizing regulatory terms, standardizing entry-to-practice requirements, removing barriers to the full use of competent health professionals, redesigning board structure and function, informing the public, collecting data on the health professions, assuring practitioner competence, reforming the professional disciplinary process, evaluating regulatory effectiveness and understanding the organizational context of health professions regulation.

## FINDINGS

Five key assumptions about the health care industry that undergird health professions regulation need to be modified if they are to continue to provide a solid conceptual framework for regulation.

1) The move to specialization in health care has slowed and generalism is moving to the fore. 2) Health care markets have changed from local, geographically-based markets to regional, national and even international markets with the advent of telehealth practice. 3) In the past, it was assumed that there was a slow depreciation of health professionals' knowledge and competence after they completed training. Now, a much more rapid depreciation of knowledge is assumed, thereby requiring provider verification of continued competence throughout their careers. 4) Previously, health care organizational structures were relatively small, local and tangible. Increasingly, health care organizations have merged, creating much larger organizations. 5) In the past, health care financing organizations interacted directly with health care providers. In the current health care environment, there are other entities such as health care delivery systems and utilization review organizations that mediate the health care financier--health care provider relationship.

The Ad hoc Committee on Criteria has determined specific findings in seven areas:

### *Appropriate Criteria to be Applied in Determining the Need for Regulation of Any Health Care Occupation or Profession*

Virginia has had criteria since 1983 for determining whether and at what level health care occupations or professions should be regulated. The criteria were last revised in 1991. In 1992, policies and procedures based on the criteria were adopted by the Board of Health Professions. The seven Virginia criteria are concerned with the following issues: 1) risk of harm to the consumer, 2) specialized skills and training, 3)

autonomous practice, 4) scope of practice, 5) economic impact, 6) alternatives to regulation, and 7) least restrictive regulation. Virginia is unique, as none of its surrounding states or localities utilize written criteria to determine the need for regulation.

Virginia's criteria for regulation have been consistently utilized and evenly applied in Board of Health Professions' regulatory studies and recommendations for regulation over the years since 1983. Virginia's use of written criteria, and policies and procedures based on these criteria, results in an orderly and fair process for applicant professions that desire to be regulated. Criterion #7, the newest regulatory criterion, adopted in 1991, emphasizes the importance of utilizing the least restrictive form of regulation possible, which is consistent with Virginia's history of a laissez-faire approach to regulating commerce. A regular sunrise/sunset review process by the Board of Health Professions prior to instituting and renewing regulation would be helpful in ensuring that the Commonwealth maintains appropriate levels of regulation. The evidentiary basis on which the criteria are applied could be strengthened and made more consistent. Finally, the existing seven criteria remain suitable and appropriate for determining the need for regulation of any health care occupation or profession in the Commonwealth.

***Promotion of Effective Health Outcomes and Protection of the Public from Harm***

Health outcomes analysis is still in its infancy, although the body of knowledge about effective medical treatments is growing rapidly. Most such analyses are based on specific disease states and treatment modalities and not on the care provided by individual practitioners. Thus, health outcomes analysis is not currently useful as a criterion for determining the need for regulation, although it may become more useful during the next decade.

***Accountability of Health Regulatory Bodies to the Public***

Virginia ranks above average in its utilization of public members on health regulatory boards such as the Board of Health Professions and its constituent boards. Increasing public and organizational participation in the Board of Health Professions' deliberations may improve its ability to mediate scope of practice disputes among the health professions. Several states provide for more, and for more accessible, public reporting of information on health professionals than Virginia provides. A Board of Health Professions with a stronger legislative charge to direct the individual professional boards may increase public accountability. Health professionals are increasingly accountable to employers, insurers and health care systems in addition to the health professions regulatory boards. There is a fragmentation of health regulatory responsibility in the Commonwealth among several health-related agencies.

*Promotion of Consumer Access to a Competent Health Care Provider Workforce*

Health care consumers desire more freedom of choice in their utilization of providers and therapies. Several health professional associations are seeking initial regulation or more restrictive regulation by the Board of Health Professions. There is currently no single primary database of health workforce practice-related information for Virginia. Continued provider competence is a major issue among the health professions, the public and a variety of regulatory and accrediting bodies today as there is widespread recognition that initial licensure to practice does not confer lifelong continued competence. Poor communication skills seem to be a major source of complaints regarding provider competence. There is no current consensus on how to measure and ensure such competence, although new testing instruments are under development. Continuing education requirements are losing favor as a means of ensuring continued competence.

*Encouragement of a Flexible, Rational, Cost-effective Health Care System that Allows Effective Working Relationships Among Health Care Providers*

Demonstration projects to evaluate new models of health professions' practice and regulation are currently not permissible in Virginia unless they fall clearly within existing scopes of practice. General Assembly action on health professions regulation prior to any study by the Board of Health Professions renders the regulatory process less professional than it might otherwise be. New technologies and emerging health professions are changing relationships among health care providers and are affecting existing scopes of practice of currently regulated professions.

*Facilitation of Professional and Geographic Mobility of Competent Providers*

Within Virginia itself, current regulations do not restrict mobility per se. Conflicting state regulatory laws can create problems for Virginia providers, patients and insurers, however, particularly in border regions of the Commonwealth. Resolution of interstate telehealth licensing issues may expand the availability of telehealth services in the Commonwealth.

*Minimization of Unreasonable or Anti-competitive Requirements that Produce No Demonstrable Benefit*

Several professions have commented during the study on particular regulatory requirements they deem unreasonable or anti-competitive in nature, but there is no consensus that the overall current regulatory framework is particularly unreasonable or anti-competitive.

## RECOMMENDATIONS

Based on the study analysis, the ad hoc Committee on Criteria has made sixteen recommendations in six areas to the full Board of Health Professions. A summary of each of the recommendations follows:

### *The Criteria*

1) The existing seven criteria remain appropriate for determining the need for regulation of any health care occupation or profession.

2) More evidence-based information, both quantitative and qualitative, should be factored into the regulatory process in the application of the criteria.

3) The criteria for determining the need for professional regulation should be codified in Title 54.1 of the Code of Virginia and strengthened by reference to §§ 54.1-100 and 54.1-311 A of the Code of Virginia. Further, the statutory mandate for this study in § 54.1-2409.2 of the Code of Virginia should be repealed.

### *Regulatory Mechanisms*

4) The Board of Health Professions, in consultation with the appropriate health regulatory board(s), should be required to review and to provide an opinion to the General Assembly prior to any change in the degree of regulation of health professions.

5) The Board of Health Professions should regularly review the appropriateness of statutes and regulations as they relate to the scopes of practice of all health professions.

### *Board of Health Professions Structure*

6) The number of public members on the Board of Health Professions is sufficient.

7) The Board of Health Professions should encourage the establishment of a process or an entity, or both, for the purpose of coordination and exchange among staff of state agencies and regulatory bodies that have responsibility for health care policy in the Commonwealth.

8) The Board of Health Professions should establish an advisory committee comprised of representatives of integrated health care delivery systems, health care payers and employer purchasers of health care services, and practitioners and other persons as may be necessary to advise the Board on matters relating to the regulation and delivery of health professions services in the Commonwealth.

***Flexible Regulation***

9) The Board of Health Professions should seek statutory authority to permit regulatory demonstration projects to be implemented with the advice and the consent of the appropriate health regulatory board(s).

***Monitoring Health Professional Practice***

10) The Department of Health Professions should establish a Virginia health workforce database that is financed by funds other than those derived from regulated professions.

11) The Board of Health Professions should regularly monitor, assess and report on emerging professions and technologies.

12) The Board of Health Professions should identify and study the training, means of identification and utilization of unlicensed assistive personnel in the delivery of health care and make appropriate recommendations.

13) The Board of Health Professions should monitor health care delivery systems and individual provider roles in these systems.

14) The Board of Health Professions should encourage its constituent boards to explore innovative strategies to monitor the continued competence of their practitioners, to include, but not be limited to, such areas as practitioners' communication, knowledge base development and diagnostic reasoning skills, and to report on their efforts on a regular basis.

***Geographic and Professional Mobility of Providers***

15) The Board of Health Professions should encourage consistency in the Virginia health professions regulatory scheme, including increasing the consistency of Virginia's entry-to-practice requirements for out-of-state providers among the health regulatory boards.

16) The Board of Health Professions should encourage a coordinated and consistent regulatory approach among its constituent boards with regard to interstate telehealth activities.

## CONCLUDING REMARKS

Virginia was the first colony to introduce regulation of health care professionals in colonial America. Since that time, Virginia has continued to be recognized by observers of occupational and professional regulation as a leader in the field. The Pew Health Professions Commission Report Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century, released in 1995, stimulated an extensive national discussion and review of health professions regulation. Virginia has responded to the Pew Commission's challenge by undertaking its own study, which was mandated by the 1996 General Assembly.

The health care industry has changed, and the assumptions about this industry that undergird the health professions regulatory system have been reviewed by the ad hoc Committee on Criteria. A thorough and wide-ranging study of Virginia's health regulatory system has been conducted in response to the General Assembly's mandate. The regulatory criteria utilized by the Virginia Board of Health Professions, and Virginia's entire health professions regulatory system, are generally appropriate. Sixteen recommendations have been offered by the ad hoc Committee on Criteria to improve the health professions regulatory system; recommendations that respond to the Pew Commission's challenge and that, if adopted, will maintain Virginia's tradition of leading the nation in innovative approaches to professional regulation.

The ad hoc Committee on Criteria recommends that a legislative forum be held to present the findings of the study to members of the Virginia General Assembly since several of the recommendations made in the report will require either statutory changes or further study.

# INTRODUCTION TO THE FINAL COMMITTEE REPORT

This report is the Final Committee Report of the ad hoc Committee on Criteria to the Board of Health Professions based on the Study of the Appropriate Criteria to be Applied in Determining the Need for Regulation of Any Health Care Occupation or Profession ("the study"). This Final Committee Report provides, in summary fashion, an overview of the entire study process and includes the findings and recommendations of the ad hoc Committee on Criteria to the Board of Health Professions. The findings and recommendations here draw heavily on the research presented in the Background Report on Health Professions Regulation, a much longer report that addresses the various legislatively mandated areas of regulation that were to be studied. The Background Report summarizes the major trends in the health care delivery system; in reimbursement for health care services; in accreditation of health professions educational programs; in the regulation of health care facilities, organizations and insurance companies; in public accessibility to health care and health care provider information; and in health workforce planning, among other areas. The Background Report is intended to provide supplementary background information and to provide a contextual framework for the findings and recommendations included in the Final Committee Report.

Another study resource available is the Supplemental Report on Health Professions Regulation which includes a complete record of meetings of the ad hoc Committee on Criteria, reports on the two site visits of the Committee to integrated health care delivery systems in the Commonwealth, reports of the two Committee sessions involving testimony from national health care industry consultants, summaries of public comments received during the study and the Committee's decision matrix on health professions regulatory issues.

Chapter 1 of the Final Committee Report provides background information on the authority for the study, the study title and the legislative charge to the ad hoc Committee. Chapter 2 discusses the methodology used in conducting the study. Chapter 3 highlights specific issues and areas of analysis. Chapter 4 outlines the findings of the ad hoc Committee in several specific areas. Chapter 5 contains sixteen recommendations by the ad hoc Committee on Criteria for improving the regulation of the health professions in Virginia. Finally, Chapter 6 offers concluding remarks concerning the study.

## CHAPTER 1.
## AUTHORITY FOR THE STUDY

### STUDY BACKGROUND

> *American health care is experiencing fundamental change. What was recently conceived as a set of policy changes for reform is now being lent the weight of institutional reality by the enormous power of the trillion dollar health care market. In five brief years the organizational, financial and legal frameworks of much of the U.S. health care industry have been transformed to emerging systems of integrated care that combine primary, specialty and hospital services. These systems attempt to manage the care delivered to enrolled populations in such a manner as to achieve some combination of cost reduction, enhanced patient and consumer satisfaction, and improvement of health care outcomes. Within another decade 80-90% of the insured population of the U.S. will receive its care through one of these systems.*
>
> -- Pew Health Professions Commission

Regulation of health care practitioners "grew up" in a fee-for-service, one-on-one health care environment in which individual consumers purchased health care services from individual practitioners. In turn, individual practitioners determined the use of services (e.g., diagnostic tests, hospitalization) for each client. With little public or private oversight over this system, health care services became technologically complex and service delivery became fragmented into ever-increasing specialization both within and across professions.[1],[2] The United States entered the last years of the twentieth century with a highly segmented, "high tech," and, above all, high cost health care system. In 1992, $838.5 billion (more than 14% of the gross domestic product) was spent on health care. Even at that level of expenditure, 35 to 37 million Americans were uninsured and the United States performed poorly in terms of standard public health measures (e.g., 19th worldwide in overall infant mortality rate).[3] Current estimates indicate that these figures in 1997 have increased to $1 trillion in spending, exceeding 15% of the gross domestic product.

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[1] In 1960, over half the physicians practicing in the U.S. were generalists. By 1992, generalists comprised 35% of the total, and only 13% of medical graduates selected residencies which would prepare them for practice in primary care. Additionally, there are over 200 recognized allied health professions.

[2] Third Report of the Pew Health professions Commission. *Critical challenges: Revitalizing the Health Professions for the 21st Century.* First Release; November, 1995: 13-18.

[3] Inglis AD and Kjervik DK. "Empowerment of Advanced practice Nurses: Regulation Reform Needed to Increase Access to Care". In Health Workforce Issues for the 21st Century. Edited by Paul F. Larson, et.al. Washington: Association of Academic Health Centers; 1994: 48-49.

Concern over costs has played a major role in driving rapid changes in the health care environment. What the end-stage of these changes will be is not known, although there is an emerging consensus on the major trends. In a recent high profile study by the Pew Health Professions Commission, a group of health care leaders projected that by the end of the century, the American health care system will be:

- more managed with better integration of services and financing,
- more accountable to those who purchase and use health services,
- more aware of and responsive to the needs of enrolled populations,
- able to use fewer resources more effectively,
- more innovative and diverse in how it provides for health,
- more inclusive in how it defines health,
- less focused on treatment and more concerned with education, prevention and care management,
- more oriented to improving the health of the entire population, and
- more reliant on outcomes data and evidence.

These changes will have a significant impact on health care practitioners. Some of the realities practitioners will have to confront include:

- closure of as many as half of the nation's hospitals and loss of perhaps 60% of hospital beds,
- massive expansion of primary care in ambulatory and community settings,
- a surplus of 100,000 to 150,000 physicians, as the demand for specialty care shrinks; a surplus of 200,000 to 300,000 nurses generated as hospitals close; a surplus of 40,000 pharmacists as the dispensing function for drugs is automated and centralized,
- consolidation of many of the over 200 allied health professions into multi-skilled professionals as hospitals and health systems re-design their service delivery programs,

- demands for public health professionals to meet the needs of the market driven health care system, and

- a fundamental alteration of the health professional schools and the ways in which they organize, structure and frame their programs of education, research and patient care.[4]

Given the dynamic health care environment, what competencies will health care workers need to meet population health care needs? The Pew Commission suggests that health care practitioners will need to be more aware of the health care environment, more oriented to primary, preventive and cost-effective care, and more able to deliver care in a coordinated manner.[5]

There is a growing sense that, although well intentioned, health professions regulatory goals, structures, and mechanisms are increasingly out of synchronization with health care delivery processes. Moreover, as the pace of change in health care delivery accelerates in response to the new emphases on competition, health care outcomes, efficiency, and patient-focused care systems, the incongruence between the regulatory framework and the needs of the health care industry will be exacerbated. Thus, an urgent question facing policy makers and health professionals is: "How can health professions regulation achieve its primary objective of protecting the public from harm without unnecessarily restraining progress in health care delivery systems?"

Virginia is not immune to the rapid pace of change in health care and has been grappling with a variety of issues surrounding the regulation of health care professionals. Over the last several years the Board of Health Professions and the General Assembly have been faced with numerous requests from health professional associations interested in further regulation of their professions. In 1996, the issue of licensure of respiratory therapists in the Commonwealth was brought before the General Assembly.[6] Respiratory therapists were certified, and obtaining licensure would have represented a greater degree of regulation for that professional group. The Virginia Hospital and Healthcare Association raised objections to the additional regulation of Virginia health professions based on "the premise that cross-training and cross-functioning of health care professions in their employment was desirable" and the fear that additional regulation of health care professions would preclude such workplace changes.[7] Over five years had passed since the current criteria used for regulation of health professions in Virginia were adopted. The Pew Health Professions Commission in 1995 had issued a widely circulated report on health care workforce

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[4] Third Report of the Pew Health Professions Commission. *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century*; 1995: 9-11.
[5] Ibid., 3-6.
[6] Letter from Robert A. Nebiker, Executive Director of the Virginia Board of Health Professions, dated August 2, 1996: 2.
[7] Ibid., 2-3.

regulation that initiated a national discussion of this issue. Thus, the timing was right for a review of health professions regulatory criteria used in Virginia.

## STUDY CHARGE AND TITLE

In its 1996 session, the Virginia General Assembly passed House Bill 1439, subsequently codified as Chapter 532 of the 1996 Acts of the Assembly, to amend the *Code of Virginia* section relating to regulation of health professionals by the Board of Health Professions (§ 54.1-2409.2, a copy of this section of the Code is attached as Appendix A).[8] This new section of the Code required the Board of Health Professions to study and prepare a report for submission to the Governor and the General Assembly by October 1, 1997 on the appropriate criteria to be used in determining the need for regulation of any health care occupation or profession.[9] The criteria were to address, at a minimum, the following principles:

1. Promotion of effective health outcomes and protection of the public from harm.

2. Accountability of health regulatory bodies to the public.

3. Promotion of consumer access to a competent health care provider workforce.

4. Encouragement of a flexible, rational, cost-effective health care system that allows effective working relationships among health care providers.

5. Facilitation of professional and geographic mobility of competent providers.

6. Minimization of unreasonable or anti-competitive requirements that produce no demonstrable benefit.

The study charge was for the Board of Health Professions to produce findings and recommendations on the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession. A broad study was mandated by the legislation--to include an examination of the current health care delivery system, the current and changing nature of health care settings and the interaction of the

[8] Initially, the legislation required that, until submission of the study report, no health regulatory board of the Board of Health Professions would be allowed to amend or promulgate any regulation which was more restrictive than it was on July 1, 1997. The Department of Health professions expressed concern that such a law would restrict and action which might be essential to protect the public from eminent danger, so the phrase was eliminated, but the legislation requiring the study report went forward, ultimately being codified as Chapter 532.
[9] The present criteria are found in Appendix B of this report. The term health occupation(s) and health profession(s) will be used interchangeably throughout this report.

regulation of health professionals with a number of other areas of regulation. These other areas of regulation specified in the legislation included the following:

1. Regulation of facilities, organizations and insurance plans
2. Health delivery system data
3. Reimbursement issues
4. Accreditation of education programs
5. Health workforce planning efforts

The study was to include, but not be limited to, reviewing and analyzing the work of publicly and privately sponsored studies of reform of health workforce regulation in other states and nations. Finally, the study was to be conducted in cooperation with Virginia academic health centers with accredited professional degree programs.

The study title was the "Study of the Appropriate Criteria to be Applied in Determining the Need for Regulation of Any Health Care Occupation or Profession".

## CHAPTER 2.
## STUDY METHODOLOGY

To oversee the study process, the Board of Health Professions appointed an ad hoc Committee on Criteria. The members of this five-person Committee included two of the Board's public members, one as Chair and the other as a member, and three additional members from the Boards of Medicine, Nursing and Social Work, respectively. Also working closely on the study with the ad hoc Committee on Criteria were the Director of the Department of Health Professions, the Executive Director and Deputy Executive Director of the Board of Health Professions and the Department's Senior Regulatory Analyst.

Chapter 532 of the Acts of the Assembly (1996) directed the Board of Health Professions to "cooperate with the state academic health science centers with accredited professional degree programs" in conducting its study. In response to this mandate, the Board initiated a Request for Proposal procurement process to select a contractor to undertake the study. Virginia's three academic health centers, the University of Virginia in Charlottesville, Virginia Commonwealth University/Medical College of Virginia in Richmond and Eastern Virginia Medical School in Norfolk, were invited to submit study proposals to the ad hoc Committee. Proposals were received from two offerors, an Eastern Virginia Medical School study team and a study team from Virginia Commonwealth University/Medical College of Virginia. The Board of Health Professions and its ad hoc Committee on Criteria contracted with the Eastern Virginia Medical School (EVMS) study team to perform the study, which included an overall policy review of the regulation of health professions and working with the Board and its ad hoc Committee on Criteria to develop specific recommendations with respect to Virginia's criteria for regulating health occupations and professions.

EVMS has substantial health workforce expertise among its faculty and staff and selected two of these individuals to serve on this project. Dr. C. Donald Combs served as study team leader and Principal Investigator for the study. He was assisted by Dr. P. Preston Reynolds, who served as Co-principal Investigator. Dr. Combs was responsible for overall direction of the study and for analysis of the regulatory policies of other states and nations. Dr. Reynolds focused more specifically on the issue of continued provider competence related to specialty board certification, licensure and national examination.

Dr. C. Donald Combs serves as Vice President for Planning and Program Development at EVMS. His responsibilities include strategic planning, governmental and community relations, and directing outreach programs such as the Eastern Virginia Area Health Education Center and the Eastern Virginia Regional Perinatal Coordinating Council. He holds faculty appointments as Clinical Professor of Family

and Community Medicine at EVMS and as Professor in the College of Business and Public Administration and Professor in the College of Health Sciences at Old Dominion University. His long-standing interest in health and human services management, health services research, organizational development, strategic planning and marketing is reflected in 80+ professional publications and conference presentations, 50+ consultancies with state and local agencies, non-profit services organizations and businesses, and $73+ million in external funding. In the international arena, Dr. Combs serves as a Senior Fellow of the Naval Postgraduate School and works with a number of countries concerning the development of health resource management programs. Most recently, he has developed programs for Bolivia, El Salvador and Uruguay.

Dr. Combs was awarded, subsequent to initiating the Board of Health Professions study, a complementary research grant from the Pew Center for the Health Professions to study the changing role of health professionals in integrated health care delivery systems.

Dr. P. Preston Reynolds currently serves as Vice Chair of the Department of Internal Medicine at EVMS, as Director of the Division of General Internal Medicine and as Associate Director of EVMS' Center for Generalist Medicine. Dr. Reynolds received her A.B. and Ph.D. in the fields of Health Policy, History of Medicine, Science, and Technology, as well as her M.D. degree, from Duke University. She graduated from Duke magna cum laude with honors in History, was elected to AOA, the medical school honor society, and received the Thomas Jefferson Award, voted by her peers and faculty for outstanding academics and leadership. Following the receipt of her M.D. degree, she completed a postdoctoral fellowship in History and a Robert Wood Johnson Clinical Scholar fellowship at the University of Pennsylvania. Dr. Reynolds completed her residency training at the Johns Hopkins Hospital from 1989 - 1992 in Internal Medicine. This training was followed by a Fellowship in General Internal Medicine at the Hospital of the University of Pennsylvania from 1992 - 1994. She joined the faculty there as an Assistant Professor of Medicine in the Department of Medicine. Dr. Reynolds is board certified by the American Board of Internal Medicine. She is a Fellow of the American College of Physicians and a member of national and international professional and scientific societies. She has been interested in health professions issues and has pursued them through the American College of Physicians, the Society of General Internal Medicine and other national organizations.

In setting out the terms of reference for the study, the Virginia General Assembly was clearly mindful of the tremendous changes in the health care industry and the health care delivery system that were discussed in Chapter 1 of this report. The General Assembly required that the study on the appropriate criteria for the regulation of any health care occupation or profession be performed "considering the current and changing nature of the settings in which health care occupations and professions are practiced." The General Assembly also recognized the important interplay between

health care workforce regulation and other areas of regulation. Thus, as directed by the General Assembly, the study had to examine, at a minimum, the impact on health care workforce regulation of the following other areas, each with their own unique set of regulations:

1. Regulation of facilities, organizations, and insurance plans;
2. Health delivery system data;
3. Reimbursement issues;
4. Accreditation of education programs; and
5. Health workforce planning efforts.

To assure that the study was grounded in a thorough understanding of the current and anticipated health care environment, the study team and the ad hoc Committee employed four methodologies. First, a comprehensive review and analysis of the professional and policy literature was conducted and documented. Second, the ad hoc Committee on Criteria and other members of the Board of Health Professions visited integrated health care delivery systems in the Commonwealth to experience first-hand the "current and changing nature of the settings in which health care occupations and professions are practiced." Third, outside experts on health professions regulation and health care from other states and provinces who have significant experience in reforming the regulation of the health care workforce provided prepared testimony to the ad hoc Committee on Criteria and other members of the Board of Health Professions. Fourth, a broad range of occupational, consumer, provider and other interest groups affected by the regulatory process was invited to attend public hearings, submit written testimony and comment on draft study products. The ad hoc Committee on Criteria believes that this multi-faceted approach has resulted in recommendations that are grounded in a solid understanding of Virginia's current health care industry and delivery systems and that are consistent with the forthcoming transformations in the health care sector.

The comprehensive review and analysis of the professional and policy literature resulted in a companion document to this report, as discussed in the Introduction, entitled the Background Report on Health Professions Regulation. A second written study product resulting from this extensive literature review and analysis is a comprehensive review of Virginia legislative activity on health professions regulation and the role that the Board of Health Professions played in this legislative activity for the years 1995-1997. Finally, a research grant from the Pew Center for the Health Professions was awarded to Dr. Combs subsequent to the initiation of the Board of Health Professions study on the research topic *Health Care Workforce Regulation and the Integrated Health Care Delivery System: Challenges and Opportunities*, that added further depth and context to the Board of Health Professions study.

The ad hoc Committee on Criteria and other members of the Board of Health Professions, along with the EVMS study team and staff of the Department of Health

Professions visited two integrated health care delivery systems in the Commonwealth to learn first-hand about the "current and changing nature of the settings in which health care occupations and professions are practiced."

On December 17, 1996, a site visit was made to Sentara Health System in Norfolk, Virginia. Sentara staff from a number of different departments, representing a wide variety of health professions, made presentations to attendees. A key subject of discussion was the "patient-focused" hospital system of care and the use of unlicensed assistive personnel, Sentara's Care Partners, in patient care settings. Mini-field trips incorporated into the site visit included visits to the Sentara Norfolk General Hospital Pharmacy, the Sentara Norfolk General Hospital Cardiac Services Unit, the Sentara Norfolk General Hospital Stroke Unit and the PACE (Program of All-Inclusive Care for the Elderly) program site.

On February 18, 1997, a site visit was made to Inova Health System in Falls Church, Virginia. Patient care redesign issues were a major focus of the site visit. Inova staff representing long-term care, home health care, pharmaceutical care, rehabilitation services and HIV services made presentations to attendees.

Because the study was to include a review of the work of publicly and privately sponsored studies of reform of health workforce regulation in other states and nations, the benefit of testimony of national and international experts in health professions regulation and health care was sought by the study team and the ad hoc Committee on Criteria.

At the January 21, 1997 meeting of the ad hoc Committee on Criteria in Richmond, prepared testimony was heard from the following experts:

Judy Kany, M.P.A.
Project Director
Maine Health Professions Regulation Project

Tim M. Henderson, M.S.P.H.
Director, Primary Care Resource Center
National Conference of State Legislatures

Linda S. Bohnen, B.A., LL.B.
Health Law Attorney
Toronto, Ontario, Canada

Ms. Kany testified about Maine's experience with reforming its health professions regulatory system. Mr. Henderson testified about health professions regulatory activities in selected states. Ms. Bohnen provided written information about

the experiences of the Province of Ontario, Canada in reforming its health professions regulatory system.

At the March 14, 1997 meeting of the ad hoc Committee on Criteria in Richmond, prepared testimony was heard from the following experts:

Ann Gill Taylor, R.N., Ed.D., FAAN
Director, Center for the Study
of Complementary and Alternative Therapies
University of Virginia School of Nursing

John M. Pietrzak
Chief Executive Officer
Unimed Management Services-San Jose, Inc.

Paul R. VanOstenberg, D.D.S., M.S.
Director, Department of Standards
Joint Commission on Accreditation
of Healthcare Organizations

Dr. Taylor testified about the increasing demand for complementary and alternative therapies and the emergence of new health professions and technologies that will require a response from health professions regulatory agencies. Mr. Pietrzak testified about the California experience with managed health care delivery and its implications for health care workforce regulation. Dr. VanOstenberg offered testimony on the position of the Joint Commission on Accreditation of Healthcare Organizations concerning state health professions regulation and on ensuring the continued competence of health professionals.

The ad hoc Committee has worked to ensure wide public participation in the study process. Comments on the study have been received from a broad cross-section of health care provider associations, consumer groups, insurance companies, and interested others.

At the outset of the study, a letter was sent to over 225 interested parties informing them of the study and seeking their input and advice regarding the study process.

A public hearing was held by the ad hoc Committee on Criteria to solicit oral testimony from interested parties. Written comments have been solicited from interested parties throughout the study process.

The Background Report on Health Professions Regulation, the companion background document to this report, was posted on the EVMS home page on the world wide web in late May to promote public access to the document for the purpose of receiving comments. The Supplemental Report on Health Professions Regulation, which includes a complete record of the minutes of ad hoc Committee on Criteria meetings, reports on the two site visits of the Committee to integrated health care delivery systems in the Commonwealth, reports of the two Committee sessions involving testimony from national and international health professions regulation and health care experts, summaries of public comments received during the study and the Committee's decision matrix on health professions regulatory issues, was also made available on the EVMS home page on the world wide web.

A second mass mailing was sent to over 225 interested parties in May, 1997 informing them of the progress of the study and of the availability of the Background Report on Health Professions Regulation. A third mass mailing was sent to over 225 interested parties in early July apprising addressees of the availability of the exposure draft of the Final Study Report on the world wide web and of opportunities to provide oral testimony to the Board of Health Professions on July 8, 1997 and to the ad hoc Committee on Criteria on July 21, 1997. Written commentary on the exposure draft of the Final Study Report was accepted through August 15, 1997.

## CHAPTER 3.
## SPECIFIC ISSUES AND AREAS OF ANALYSIS

The study was to include a review and analysis of the work of publicly and privately sponsored studies of reform of health workforce regulation in other states and nations. The most prominent of such studies was issued in December, 1995 by the Taskforce on Health Care Workforce Regulation of the Pew Health Professions Commission, and entitled Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century. The following 10 broad issue areas identified by the Pew Taskforce were among the issue areas addressed during the study process by the ad hoc Committee on Criteria:

Standardizing Regulatory Terms

Standardizing Entry-To-Practice Requirements

Removing Barriers to the Full Use of Competent Health Professionals

Redesigning Board Structure and Function

Informing the Public

Collecting Data on the Health Professions

Assuring Practitioner Competence

Reforming the Professional Disciplinary Process

Evaluating Regulatory Effectiveness

Understanding the Organizational Context of Health Professions Regulation

# CHAPTER 4.
# FINDINGS

## KEY ASSUMPTIONS UNDERGIRDING HEALTH PROFESSIONS REGULATION

Five key assumptions about the health care industry that undergird the current health professions regulatory system need to be modified if they are to continue to provide a solid conceptual framework for regulation.

Regulatory systems are built upon certain key assumptions that are based upon the regulatory entity's understanding of the industry, commodity, or occupation that is to be regulated. This understanding of the "world" to be regulated is the foundation of the regulatory system. If the world that is being regulated has undergone fundamental changes, the regulatory assumptions based upon this understanding may no longer be valid, calling into question the appropriateness of the entire regulatory system, including any criteria for regulation that may be a part of this regulatory system.

In light of the fundamental changes in the nature of health care over the last few years, it is appropriate to ask whether the assumptions drawn by health regulatory entities remain valid. The changes in the health care industry with respect to health care delivery may have occurred so quickly in the last few years so as to outpace the ability of the regulatory apparatus to effectively regulate the industry. If this is the case, the appropriateness and validity of the entire health professional regulatory system may be called into question. The five health care delivery issues outlined below provide a sense of the shifts that are occurring in health care that are impacting the effectiveness of health professions regulation.

### The Division of Labor

Since the days of Adam Smith, the concept of the "division of labor" has dominated the workplace, including the health care industry. The division of labor concept holds that the breakdown of labor into its components and their distribution among different persons, groups, or machines increases and maximizes production efficiency. The embracing of this concept by the health care industry has led to increasing specialization of health care labor and the development of the primary, secondary, tertiary and quaternary systems of health care with which we have all become familiar. Contributing to this increasing specialization has been the explosion in health care research, knowledge and therapeutic interventions over the last 50 years. The health care regulatory system has embraced this concept by using restrictive scopes of practice that both limit and protect professional practice. Yet, in the health-care industry today the demand for generalist practitioners exceeds that for specialists and there is tremendous interest and activity in the areas of multi-skilling and cross-training.

**The Concept of Geographic Health Care Market**

Until recently, the practice of medicine was often described as a "cottage industry."[10] Several regulatory factors contributed to this local market structure. Prohibitions on professional advertising forced a reliance on local, word-of-mouth advertising and participation in local organizations and other local activities as the means physicians had to appeal to their market. Also, in the past there were far fewer physicians and the industry was less competitive. Today, physicians and hospitals are part of competitive regional and national health care networks, professional advertising abounds--stretching the geographical limits of each practitioner's health care "market" to the geographical range of the advertising medium used--and practitioners are banding together in purchasing cooperatives and utilizing other cooperative means to limit costs and increase efficiency. Furthermore, the emergence of telehealth practice as a means of delivering health care services means that professionals and patients can be in different states, or even nations, during the care process, thus further stretching potential market size.

**The Notion of Competence**

Historically, professional and occupational competence in the health care field was something developed during one's initial training for practice. It was assumed that there was a slow depreciation of such competence over time, and regulatory systems reflected this assumption by the failure to require members of the health care workforce to demonstrate their continued competence throughout their careers. Over the last few years, however, there has developed a different assumption, one of professional and occupational competence not only depreciating after completion of training, but doing so in a rapid fashion. This has become known as the "continued competence issue" and is a major challenge facing the health care industry and health workforce regulators today.

**Health Care Organizational Structures**

Traditionally, health care organizations were small entities, solo practices, small group practices and community hospitals. Regulatory prohibitions against the "corporate practice" of health care professions contributed to the development of these smaller organizational structures. Over the years, as specialization in health care increased, larger health care organizations developed, such as large tertiary care teaching hospitals and academic health centers. As competition in the health care industry has heightened in recent years, the market has become increasingly characterized by larger and larger organizations. Private physician groups are being

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[10] A cottage industry is typically one whose labor force consisted of family units working at home with their own equipment. The extension of this analogy to medicine and hospitals was that thousands of solo practitioner or small group physicians and hospitals typically went about the practice of their professions, or providing services, for the most part independently of each other, in their own offices or facilities utilizing their own equipment. The health care "market" of each of these practitioners was typically the local geographic area in which they practiced, perhaps, for physicians, just the area within the range to make housecalls. They were village doctors, town doctors, neighborhood doctors and community hospitals. For the most part there was little competition among these practitioners and collegiality ruled.

purchased by large regional, national, and, in some cases, even global, health care groups known as integrated health care delivery systems. What are the consequences of this fundamental change in the nature of the health care organization for health workforce regulation? One consequence may be that whereas at one time a health care worker may have been locally credentialed and privileged, and, to some extent, may have been under the watchful eye of this local credentialing and privileging body--the medical staff office of a community hospital, for example--today it is just as likely that the credentialing office for that same hospital is based several hundred miles away in the corporate headquarters of that particular hospital's network. Another consequence, of course, is that professionals face review of their practice from several vantage points, each of which incorporates different measures of "good" practice.

**The Relation of Health Care Financing Mechanisms to Health Care Providers**

Under traditional health care financing arrangements, third-party payers made their payments for health care services rendered directly to health care providers in these small organizational entities as described above. Under these traditional fee-for-service arrangements there was a direct relationship between the services rendered by the provider and the payment received. Now, however, payments are just as likely to be made by organizations with the responsibility for purchasing health care services to organizations with the responsibility for providing health care services. This "disconnect" between the health care provider and the payment for their services rendered, most notably under managed care and fully capitated health care financing arrangements, has changed the incentives and the economics in the delivery of health care services.

***Appropriate Criteria to be Applied in Determining the Need For Regulation of any Health Care Occupation or Profession***

In the early 1980's the Department of Health Regulatory Boards engaged a private consulting firm to assist in establishing a systematic process for evaluating whether additional health occupations should be regulated. This consultation began in response to Joint Legislative Audit and Review Commission recommendations that the Department review state policy on the regulation of allied health occupations. A significant feature of the consultant's policy review was the proposal of six criteria to determine whether health occupations should be regulated. The consultant determined that "there needed to be improvements in what was essentially viewed as an 'ad hoc' approach to regulating the health professions " by the Commission of Health Regulatory Boards. The six criteria proposed by the consultant were adopted by the Commission of Health Regulatory Boards on October 4, 1983 for subsequent use in the Commission's evaluation of the need for a health professional group to be regulated. In October, 1991, the Board of Health Professions adopted a revised list of criteria, called the Criteria for Evaluating the Need for Regulation, that included the six criteria originally adopted in 1983 along with a seventh criterion on Least Restrictive Regulation. The seven criteria deal with the following areas (a complete list of the

criteria is attached as Appendix B): 1) risk of harm to the consumer, 2) specialized skills and training, 3) autonomous practice, 4) scope of practice, 5) economic impact, 6) alternatives to regulation, and 7) least restrictive regulation.

The Board of Health Professions and the Department of Health Professions incorporated the seven criteria into a 1992 policy document entitled "Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions". This document remains the Board and Department's official policy for evaluating the need to regulate and the degree of regulation to impose. These policies and procedures are utilized by the Board and Department in conjunction with § 54.1-100 of the *Code of Virginia*, which is the current version of the general occupational regulatory guidelines first adopted by the Commonwealth in 1974.

A review of selected Board of Health Professions studies on the regulation of health occupations and professions has demonstrated that the criteria first adopted in 1983 and revised in 1991 appear to have been consistently utilized and evenly applied.

The regular use and application of the existing criteria, along with the use of the policies and procedures based upon them, results in an orderly process for applicant professions and professional groups who desire to be regulated.

Criterion #7, Least Restrictive Regulation, emphasizes the importance of utilizing the least restrictive means of regulation possible should application of the criteria indicate that regulation is warranted. This is consistent with Virginia's historically laissez-faire approach to regulating commerce.

A survey of surrounding states and the District of Columbia has found that none of these governments utilize written criteria to determine the need for regulation of their health occupations or professions.

Under current Virginia statutes, the Virginia General Assembly is free to legislate regulation for health occupations and professions in lieu of and in spite of regulatory study of the issue at hand by the Board of Health Professions. A Board of Health Professions study is not required prior to the General Assembly imposing health occupational regulation nor is the General Assembly bound by any regulatory recommendations made by the Board of Health Professions. In addition, the Board of Health Professions does not engage in a regular review of the regulatory status of the health occupations and professions it currently regulates to determine if regulation continues to be warranted and if the level of regulation for the occupation or profession continues to be appropriate.

Criterion #7, Least Restrictive Regulation, was adopted in response to § 54.1-311 *Code of Virginia*, "Degrees of Regulation", which states "The Board shall regulate only to the degree necessary to fulfill the need for regulation and only upon approval

by the General Assembly". The Board referred to in this section of the Code, however, is the Board of Professional and Occupational Regulation (BPOR), the "sister" board to the Board of Health Professions, and § 54.1-311 is not directly applicable to the Board of Health Professions.

The ad hoc Committee on Criteria has determined that the existing seven criteria remain generally appropriate for determining the need to regulate any health care occupation or profession. Additional, evidentiary-based information utilized during the application for regulatory status process may increase the objectivity and consistency achieved when the criteria are applied.

***Promotion of Effective Health Outcomes and Protection of the Public From Harm***

The site visits of the ad hoc Committee on Criteria to the integrated health care delivery systems in the Commonwealth provided first-hand evidence that health outcomes analysis is still in its infancy at this time, although the body of knowledge about effective treatments is growing rapidly. Most such analyses are based on particular disease states and treatment modalities and not on the care provided by individual practitioners. For these reasons, health outcomes analysis is not currently useful as a criterion for determining the need for regulation, although it may become useful during the next decade.

***Accountability of Health Regulatory Bodies to the Public***

With 5 of 17 members of the Board of Health Professions, or 29%, being public members, Virginia is above average in its utilization of public members on its regulatory board.

In recent years there have been an increasing number of scope of practice disputes among the health professions as care delivery patterns change, as new health professions emerge and as health care technology advances. The Board of Health Professions has had to mediate these disputes. Increasing public or organizational participation in the Board of Health Professions' deliberations may improve its ability to mediate scope of practice disputes among the health professions.

Several states, notably Massachusetts, provide for more, and for more accessible, public reporting of information on health professionals than Virginia provides. In Massachusetts, for example, it is possible for state residents to dial-up information on their doctors--information that includes malpractice payouts, disciplinary records, and any criminal history. Also available is information on education, honors, awards, hospital affiliations, insurance plans and specialties. The recently implemented Board/Department of Health Professions world wide web site represents a positive step in this direction.

Current statutes empower the Board of Health Professions to "evaluate the need for coordination among the health regulatory boards" and to serve as a "forum for resolving conflicts among the health regulatory boards" (§ 54.1-2510 Code of Virginia). A Board of Health Professions with a stronger statutory charge to direct the individual health regulatory boards may increase the public accountability of the regulatory system.

With the move to managed systems of health care delivery and with health care providers finding themselves increasingly in the role of employees of health care systems rather than as sole proprietors of health care practices, professionals are increasingly being held accountable for their care delivery to employers, insurers, utilization reviewers, health care payers and health care systems in addition to the health professions regulatory boards through which they are regulated. At some point, there may be alternative methods with which to regulate these types of health care professionals through their affiliated organizations.

There is a fragmentation of health regulatory responsibility in the Commonwealth among several health-related agencies. For example, the Department of Health Professions regulates the health care workforce and selected health care entities, the Bureau of Insurance of the State Corporation Commission regulates health care insurers and managed care organizations, and the Virginia Department of Health regulates hospitals and nursing homes among other types of health care facilities/entities. Such fragmentation makes regulatory coordination difficult and can frustrate consumers seeking redress for complaints concerning aspects of the health care system.

***Promotion of Consumer Access to a Competent Health Care Provider Workforce***

The professional literature of the last few years has documented the strong demand from American health care consumers for the therapies provided by complementary health care providers. In public hearings and through public comments during our study we have identified a desire by Virginia health care consumers for more freedom of choice in their utilization of health care providers and therapies.

For varied reasons, several emerging and established health professions are seeking initial or more restrictive regulation for their professions from the Board of Health Professions. It is likely that the pace of such requests will increase in the future as greater use of technology is incorporated in the health care setting and as new systems of health care delivery challenge long-held scope of practice-based divisions of labor in the health care professions.

Although there has been statutory authority for the Department of Health Professions to collect practice profile information from licensees since 1994 (§ 54.1-2506.1 Code of Virginia) for health workforce planning purposes, there currently is no

single primary database of health workforce planning information for Virginia. Such a database may be useful for a variety of purposes.

Continued provider competence in the face of an ever-increasing health care knowledge base and rapidly changing technology has become a major issue among the health professions, the public and a variety of regulatory and accrediting bodies today as there is widespread recognition that initial licensure to practice does not confer lifelong continued competence. Poor communication skills seem to be a major source of complaints regarding provider competence. There is not yet a consensus on how to measure and ensure such competence, although new testing instruments are under development. Continuing education requirements are losing favor as a means of ensuring continued competence for several reasons, including a questioning of the relevance of courses taken by providers to meet such requirements.

***Encouragement of a Flexible, Rational, Cost-Effective Health Care System that Allows Effective Working Relationships Among Health Care Providers***

Several states allow regulatory demonstration projects that allow health care delivery organizations to redesign and evaluate health professions' work that would otherwise be precluded by law. This capacity provides for regulated innovation in the delivery of health care. Demonstration projects to evaluate new models of health professions practice and regulation are currently not permissible in Virginia unless they fall clearly within existing scopes of practice.

Virginia General Assembly action on health professions regulation prior to study of the regulatory issues involved by the Board of Health Professions renders the regulatory process less professional than it might otherwise be and can contribute to an inconsistent scheme of regulation.

New technologies and emerging health professions are changing relationships among providers and are affecting actual scopes of practice. At times, it appears that the Board of Health Professions has not considered the potential impact that such new technologies and emerging health professions will have on existing regulatory relationships until late in the regulatory process.

***Facilitation of Professional and Geographic Mobility of Competent Providers***

Within Virginia, the study uncovered no evidence that current Board of Health Professions regulations restrict mobility. There is, however, a lack of coordination of the policies of the individual health regulatory Boards concerning interstate mobility of providers that seek to enter practice in Virginia.

Conflicting state regulatory laws can create problems for providers, patients and insurers, particularly in the border regions of the Commonwealth.

There is a lack of coordination of the policies of the individual health regulatory boards concerning the use of telehealth practice technologies on an interstate basis.

The resolution of national telehealth practice licensing issues may expand the availability of telehealth services.

***Minimization of Unreasonable or Anti-Competitive Requirements That Produce No Demonstrable Benefit***

Several professional groups have commented on particular regulatory requirements that they deem to be unreasonable or anti-competitive in nature, but there is no consensus opinion that the current regulatory framework, including the use and application of the current criteria, is particularly unreasonable or anti-competitive.

# CHAPTER 5.
# RECOMMENDATIONS

Based on the study analysis, the ad hoc Committee on Criteria has made sixteen recommendations in six areas to the full Board of Health Professions. A summary of each of the recommendations follows:

***The Criteria***

1) The existing seven criteria remain appropriate for determining the need for regulation of any health care occupation or profession.

2) More evidence-based information, both quantitative and qualitative, should be factored into the regulatory process in the application of the criteria.

3) The criteria for determining the need for professional regulation should be codified in Title 54.1 of the Code of Virginia and strengthened by reference to §§ 54.1-100 and 54.1-311 A of the Code of Virginia. Further, the statutory mandate for this study in § 54.1-2409.2 of the Code of Virginia should be repealed.

***Regulatory Mechanisms***

4) The Board of Health Professions, in consultation with the appropriate health regulatory board(s), should be required to review and to provide an opinion to the General Assembly prior to any change in the degree of regulation of health professions.

5) The Board of Health Professions should regularly review the appropriateness of statutes and regulations as they relate to the scopes of practice of all health professions.

***Board of Health Professions Structure***

6) The number of public members on the Board of Health Professions is sufficient.

7) The Board of Health Professions should encourage the establishment of a process or an entity, or both, for the purpose of coordination and exchange among staff of state agencies and regulatory bodies that have responsibility for health care policy in the Commonwealth.

8) The Board of Health Professions should establish an advisory committee comprised of representatives of integrated health care delivery systems,

health care payers and employer purchasers [illegible] care [illegible]ices, and practitioners and other persons as may be necessary [illegible] advise the Board on matters relating to the regulation and delivery of health professions services in the Commonwealth.

### *Flexible Regulation*

9) The Board of Health Professions should seek statutory authority to permit regulatory demonstration projects to be implemented with the advice and the consent of the appropriate health regulatory board(s).

### *Monitoring Health Professional Practice*

10) The Department of Health Professions should establish a Virginia health workforce database that is financed by funds other than those derived from regulated professions.

11) The Board of Health Professions should regularly monitor, assess and report on emerging professions and technologies.

12) The Board of Health Professions should identify and study the training, means of identification and utilization of unlicensed assistive personnel in the delivery of health care and make appropriate recommendations.

13) The Board of Health Professions should monitor health care delivery systems and individual provider roles in these systems.

14) The Board of Health Professions should encourage its constituent boards to explore innovative strategies to monitor the continued competence of their practitioners, to include, but not be limited to, such areas as practitioners' communication, knowledge base development and diagnostic reasoning skills, and to report on their efforts on a regular basis.

### *Geographic and Professional Mobility of Providers*

15) The Board of Health Professions should encourage consistency in the Virginia health professions regulatory scheme, including increasing the consistency of Virginia's entry-to-practice requirements for out-of-state providers among the health regulatory boards.

16) The Board of Health Professions should encourage a coordinated and consistent regulatory approach among its constituent boards with regard to interstate telehealth activities.

# CHAPTER 6.
# CONCLUDING REMARKS

Virginia has a long history of being a leader in the field of occupational and professional regulation. The Pew Health Professions Commission report on health care workforce regulation issued in 1995 provoked a national discussion and review of health professions regulation. Because of both its own history of activity regarding health professions issues, and in response to the Pew Commission's work, Virginia has responded to the Pew Commission's challenge by undertaking its own study of the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession.

The health care industry has undergone far-reaching changes over the last few years and the assumptions about the health care industry that have undergirded the health professions regulatory system in the past are no longer valid. Changes to the health professions regulatory system are necessary to respond to the changes in the health care industry. A thorough and wide-ranging study of the health care industry and Virginia's health regulatory system has been conducted. The ad hoc Committee on Criteria has also thoroughly researched each area specified for attention by the Virginia General Assembly in Chapter 532 of the Acts of the Assembly (1996).

The ad hoc Committee on Criteria has concluded that Virginia's existing criteria and health regulatory system are generally appropriate, however, sixteen recommendations have been made to improve the system, changes that will maintain Virginia's progressive role in the field of professional regulation.

Because several of the recommendations made in this report will require statutory changes or require further study, we recommend that a legislative forum on health professions regulatory issues be held for members of the Virginia General Assembly after October 1, 1997.

# APPENDIX A
# STATUTE DIRECTING THE STUDY

**§ 54.1-2409.2. Board to set criteria for determining need for professional regulation.**

*The Board of Health Professions shall study and prepare a report for submission to the Governor and the General Assembly by October 1, 1997, containing its findings and recommendations on the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession. Such criteria shall address at a minimum the following principles:*

*1. Promotion of effective health outcomes and protection of the public from harm.*

*2. Accountability of health regulatory bodies to the public.*

*3. Promotion of consumers' access to a competent health care provider workforce.*

*4. Encouragement of a flexible, rational, cost-effective health care system that allows effective working relationships among health care providers.*

*5. Facilitation of professional and geographic mobility of competent providers.*

*6. Minimization of unreasonable or anti-competitive requirements that produce no demonstrable benefit.*

*The Board in its study shall analyze and frame its recommendations in the context of the total health care delivery system, considering the current and changing nature of the settings in which health care occupations and professions are practiced. It shall recognize in its recommendations the interaction of the regulation of health professionals with other areas of regulation including, but not limited to, the following:*

*1. Regulation of facilities, organizations, and insurance plans;*

*2. Health delivery system data;*

*3. Reimbursement issues;*

*4. Accreditation of education programs; and*

*5. Health workforce planning efforts.*
*The Board in its study shall review and analyze the work of publicly and privately nations. In conducting its study the Board shall cooperate with the state academic health science centers with accredited professional degree programs.*

# APPENDIX B

## CRITERIA FOR EVALUATING THE NEED FOR PROFESSIONAL REGULATION

Adopted October, 1991

**CRITERION ONE: RISK FOR HARM TO THE CONSUMER**

The unregulated practice of the health occupation will harm or endanger the public health. safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of the health services, or (d) from any combination of these factors.

**CRITERION TWO: SPECIALIZED SKILLS AND TRAINING**

The practice of the health occupation requires specialized education and training, and the public needs to have benefit by assurance of initial and continuing occupational competence.

**CRITERION THREE: AUTONOMOUS PRACTICE**

The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

**CRITERION FOUR: SCOPE OF PRACTICE**

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

**CRITERION FIVE: ECONOMIC IMPACT**

The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioners, and the cost of operation of regulatory boards and agencies.

**CRITERION SIX: ALTERNATIVES TO REGULATION**

There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

**CRITERION SEVEN: LEAST RESTRICTIVE REGULATION**

When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

## CRITERIA FOR DETERMINING WHETHER A HEALTH OCCUPATIONAL GROUP SHOULD BE REGULATED

Adopted October 4, 1983

**CRITERION 1:** The unregulated practice of an occupation will harm or endanger the health, safety and welfare of the public. The potential for harm is recognizable and not remote or dependent on tenuous argument.

**CRITERION 2:** The practice of an occupation requires a high degree of skill, knowledge and training, and the public requires assurances of initial and continuing occupational competence.

**CRITERION 3:** The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

**CRITERION 4:** The scope of practice of an occupation is distinguishable from other licensed and unlicensed occupations.

**CRITERION 5:** The economic impact on the public of regulating this occupational group is justified.

**CRITERION 6:** There are no adequate alternatives to regulation (i.e., licensure, statutory certification, or registration) that will protect the public.