IMPROVING PUBLIC POLICY FOR REGULATING MAINE'S HEALTH PROFESSIONALS

October 1997

A Report to the Governor and the Maine Legislature
prepared for
Medical Care Development, Inc.
Maine Health Professions Regulation Project

by

Judy C. Kany and Saskia D. Janes

Since 1966, Medical Care Development has worked with communities, consumers, and providers to improve health care for the people of Maine. This project, to identify ways that Maine's health professional licensing laws could be strengthened to coincide with changes in the health system, is consistent with our past accomplishments. MCD is prepared to work with all parties to facilitate the adoption of the recommendations in this report.

Medical Care Development, Inc.
11 Parkwood Drive
Augusta, Maine 04330

Tel: 207-622-7566
Fax: 207-622-3616

Project Staff:

Judy Kany, Project Director
Saskia Janes, Assistant Project Director
Lisa Rollins, Administrative Assistant

Copies of this report and the appendices may be obtained from:

Lisa Rollins
Medical Care Development, Inc.
11 Parkwood Drive
Augusta, Maine 04330

Report price: $10.00
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Executive Summary - 1997

The entire health care system has changed exponentially since the current regulatory system originated a century ago. This changing system has implications for the regulation of Maine's health practitioners. Although changes in Maine's regulatory laws have occurred over the years, they tended to be piecemeal, and a comprehensive review is in order (see Figure 2).

The goal of the project is to create a climate to produce a more understandable and accountable health professions licensing system that more thoroughly protects the public, provides better links between competency and licensing, and enables all health professionals to apply their skills, knowledge, and judgment at the level of their ability.

An occupational therapist works with a child with cerebral palsy in the public schools. This activity is helping her learn to hold her head and upper body, an important skill for all school based activities.

The policy development project was approached in a collaborative manner. The wide variety of people participating in the discussions, in varying degrees and at different times, included health practitioners, regulators, legislators, faculty, insurers, health care managers, and interested citizens. The discussions focused on the regulatory system and potential improvements in public policy. The approach both in the process and in the recommendations emphasized inclusiveness and attempted to stimulate cross-fertilization of ideas.

Medical Care Development's Health Professions Regulation project began looking at ways to improve Maine's regulatory system for health professionals in June 1993. The project director had recently finished serving in the Legislature after 18 years. In 1991-92 she served as the Senate Chair of a committee immersed in reform of Maine's Workers' Compensation System and the study of the feasibility of a statewide health insurance program. Among other recommendations, the Legislative Committee had called for a study and report to include the issue of the qualifications and full utilization of health care professionals and identifying the legal barriers to appropriate utilization. The project is an outgrowth of this work.

First, an Advisory Committee was formed followed by an introductory conference. Then, a Task Force began educational meetings and the work of developing recommendations to improve public policy for regulating health professionals.

In June 1995, the project offered to the Governor and the Legislature an initial report with recommendations for an improved, more coordinated regulatory system for Maine's health professionals. That report was a means of further stimulating dialogue for identifying potential regulatory improvements.

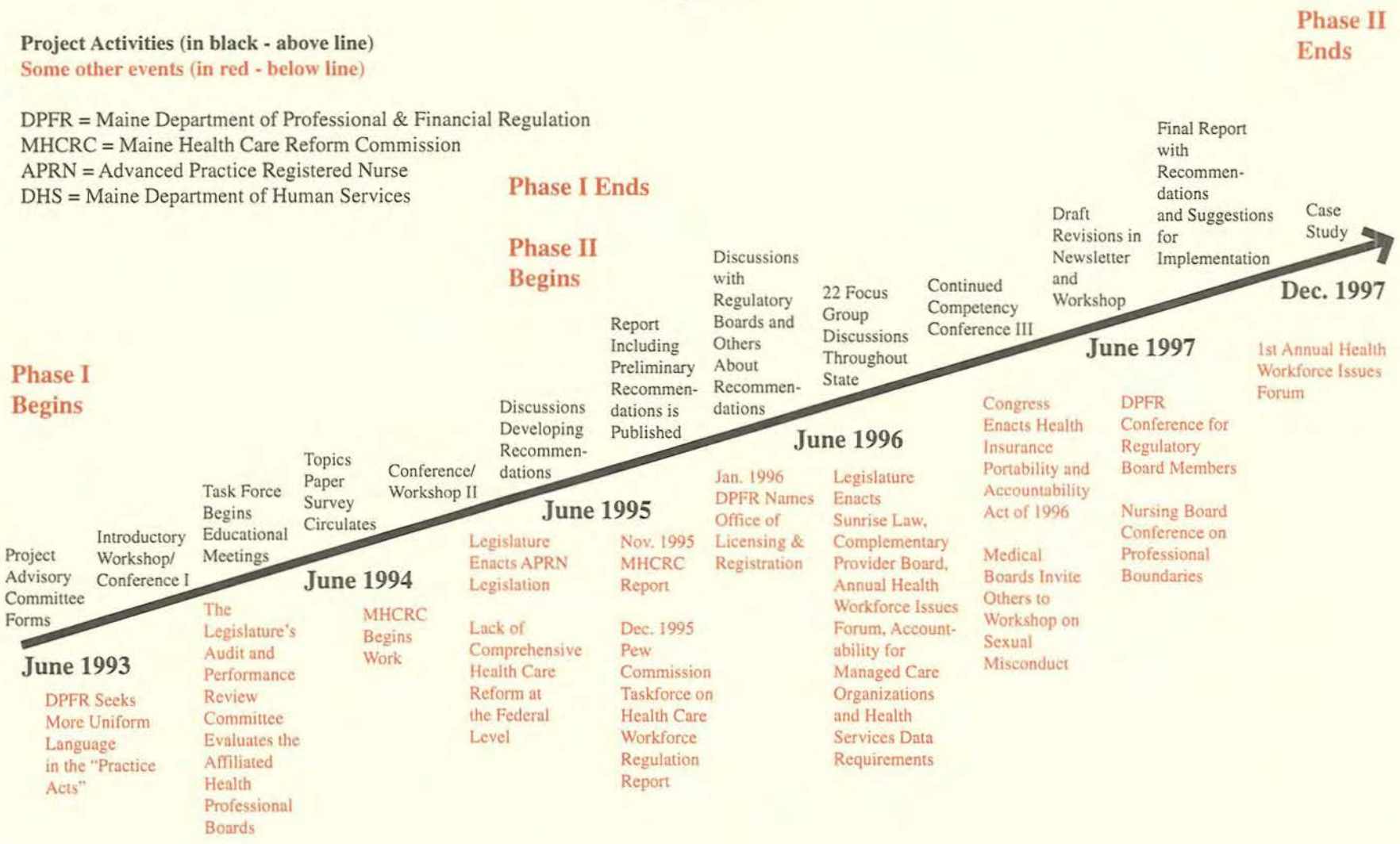
The 1995 recommendations generated much discussion—which included comments by those who do not fully agree that the state system that licenses individual health practitioners needs improvement along with those who believe that it is important to pursue improvements in the regulatory system.

What follows is a revision of the initial 1995 recommendations for improvements to the regulatory system. The full report identifies problems, describes the process for collecting information and input from Mainers, offers recommended solutions to the problems, and includes discussions about the issues and suggestions for implementing the recommendations.

The 1997 revised recommendations reflect the progression of dialogue resulting from additional input and information, focus group discussions, and recognition of the significant

Project Activities and Outside Events Build Upon Each Other in a Progression Toward Improved Public Policy for Regulating Maine's Health Professionals

Figure 1



improvements that have occurred in the regulatory system in the past two years. The 1997 revisions also reflect the changes in the overall health system environment during the past two years. Suggestions for implementation accompany the revised recommendations. The new recommendations are offered as guidance to policy makers. We envision regulators, practitioners, and consumers referring to them, too. It is hoped and expected that the recommendations will be a catalyst for change.

It is important to recognize the regulatory policy progress occurring in Maine, especially in the last two years. The Department of Professional and Financial Regulation's and the regulatory boards' conferences, the upcoming First Annual Health Workforce Issues Forum, and enactment by the Maine Legislature of new laws requiring the collection of important health services data and a sunrise law to assist policy makers in decisions about scopes of practice are indications of significant regulatory policy progress.

Yet more progress needs to be made. As this project ends, we have come to the conclusion that the recommendations summarized below, if adopted, will greatly improve the ability of today's regulatory system for health professionals to assist the health system's efforts to improve the health of Maine people.

- Protect the public by promoting continued competency assessments, furthering a relationship between competency and licensure.
- Assist the Legislature with its scope of practice decisions for practice acts by involving others with expertise in the discussion, in addition to those who view themselves as the immediate stakeholders.
- Assure coordination and regular communication among the regulatory boards and the professions. De-compartmentalize the professions and allow overlapping scopes of practice. Encourage availability of competent professionals. Coordinate the regulatory system with inter-related systems.
- Improve communication and understanding of competencies within the health system, including between professions.
- Standardize regulatory terms.
- Promote consumer understanding. Regulatory policymaking should encourage new patient/provider partnerships. Improve the accountability to the public of the regulatory system.
- Provide laws that are more uniform.

For problem statements, discussion of issues, recommendations for changes, and suggestions for implementation, see page 38.

These are the recommendations included in the project's final report.

ISSUE NUMBER 1: standardization of terms and uniform state credentialing forms, archives, and laws

Recommendation 1A: Regulatory terms in Maine's public law regulating health professionals should be standardized.

Recommendation 1B: The Department of Professional and Financial Regulation and the regulatory boards should streamline the credentialing process.

THE CHANGING REGULATORY SYSTEM

Figure 2

CURRENT REGULATION	EVOLVING REGULATION
Regulate solo practitioners	Continue to regulate individuals as solo practitioners, but recognize the changes in the organization of care
Standards only for entry to practice	Standards for entry to practice and continued competence
Little communication between boards and between health professions	Formal mechanism for assuring communication between boards and activation of inter-professional workgroups
Changes in law initiated by individual health profession	Changes in law recommended by the department's commissioner and a federation or inter-professional advisory group
"Scope of practice" turf battles end up in legislators' laps	Stakeholders along with impartial, knowledgeable health experts evaluate profession's competencies to provide certain health services and advise legislators

Recommendation 1C: The Department of Professional and Financial Regulation (DPFR) and regulatory boards in Maine should pursue public policy that would lead to uniform state laws and endorsement while assuring public protection and quality health services.

ISSUE NUMBER 2: professional competency, continued competency, and quality of care

Recommendation 2A: All involved with the health system should develop consensus about definitions of professional competence and quality of care.

Recommendation 2B: Competency standards should be reviewed periodically—for entry to practice and for resuming practice after a hiatus. In addition to assuring minimum quality at the beginning of a career, each health professional regulatory board should establish requirements for continued competency. Maine's regulatory boards need to develop competency policy and standards related to continued competency. There needs to be continuous feedback from educational programs, specialties, and practice environments about competencies. These, in turn, need to be incorporated into competency standards and assessments.

Recommendation 2C: Maine regulatory boards and health professionals should support the continued and expanded use of modern technology tools to enhance traditional competency assessment. Computers can provide benchmarks and immediate feedback.

Recommendation 2D: Maine should work with other states to develop uniform national entry-to-practice standards and national competency exams. Maine regulators should recognize the work of the federations or councils of state boards, inter-professional workgroups, and state and national professional associations in this public/private partnership effort.

Recommendation 2E: The health system should track the use of unlicensed assistive personnel as part of the development of an information base for use in comprehensive health planning. All involved with the health system should work together to develop consensus about appropriate roles for unlicensed assistive personnel.

ISSUE NUMBER 3: inter-professionalism

Recommendation 3A: Health profession practice acts should authorize practitioners to provide services to the fullest extent of their competencies. The scopes of practice should be continually modified and changed to reflect the actual competencies of health professionals. The law should continue to promote overlapping skills for the provision of health services while safeguarding the public from incompetent practitioners.

Recommendation 3B: Maine leaders of health care organizations and education programs should join Maine's regulators in exploring the opportunity provided by the 1996 law requiring the Commissioner of the Department of Human Services (DHS) to convene an annual health workforce issues forum to address current health professional issues in Maine.

Recommendation 3C: Maine leaders of health care organizations and education programs should join Maine's regulators in encouraging enhanced relationships among practitioners made possible by telecommunication and telemedicine and other modern technology.

Richard T. Chamberlin, MD, describes some of the collaborative statements issued in 1974-77 by the National Joint Practice Commission which he chaired.

ISSUE NUMBER 4: structure and performance of the regulatory system

Recommendation 4A: Regulatory policy should recognize changing practice settings, specialties, and organizational entities. However, "institutional licensure" should not replace the licensing of individual health professionals.

Recommendation 4B: A permanent and formalized expert advisory panel should be established for the purpose of advising on improvements in the regulatory system. Such a structure could be in the form of an advisory federation with representatives from the boards. The federation could help improve communication and coordination. The Commissioner of DPFR need not wait for legislative action to establish a federation of Maine's health professional regulatory boards to serve in an advisory capacity. The Commissioner should also establish a division of health professional regulation within the Department's Office of Licensing and Registration.

Recommendation 4C: State regulation of health professionals, wherever located in state government, should coordinate with other agencies and departments with responsibilities for health services and health policy.

Recommendation 4D: The Commissioner of DPFR should provide leadership recommending health profession regulatory policy to the Governor, the Legislature, and the people of Maine. They, in turn, should support the Department and its Office of Licensing and Registration in their efforts to improve the regulatory system, including communication.

Recommendation 4E: Membership on boards should include at least 30% public members to provide significant public representation. All regulatory boards should include educational leaders. DPFR should enhance the training for all regulatory board members so that they are fully aware of their responsibilities.

Recommendation 4F: There must be a stronger accountability component to the health professions regulatory system to make sure it responds to the needs of the public in an ever-changing environment. Accountability should include publicity and a periodic "policy" evaluation by the Legislature, not simply a programmatic review of the implementation of current law.

ISSUE NUMBER 5: professional conduct and ethics—complaints and discipline

Recommendation 5A: The Legislature should create a template and standardize the grounds for discipline for all health professions by statute, allowing the individual regulatory boards to define incompetence and unprofessional conduct by rule.

Recommendation 5B: The regulatory boards should communicate clearly and regularly about what is expected of practitioners and what conduct would be deemed unprofessional and subject to discipline. Ethics as it applies to health care professions should be periodically reviewed.

Recommendation 5C: Boards should evaluate categories of unprofessional conduct for which they receive complaints and attempt to address and prevent more such complaints through education, rules, and program development. Boards should consider educational programs and other methods to address recurrent problems.

Recommendation 5D: Boards should improve public access to information about the complaint processes for licensed and unlicensed personnel.

Recommendation 5E: Maine law should require disclosure of criminal convictions for unlicensed assistive personnel offering home care and assisted living services.

Recommendation 5F: Maine officials should advocate for national enforcement of the requirement that hospitals report disciplinary actions to the National Practitioner Data Bank. Maine officials should also advocate for complete reporting in data banks of federations of state regulatory boards if those are to be relied upon.

Recommendation 5G: The regulatory boards should shift focus from mostly punitive disciplinary record-keeping to include a broader picture of a career. Each health practitioner's descriptive portfolio or "profile" could include credentials, distinctions, specialty training and certifications by private organizations, and practice settings in addition to any final disciplinary actions or substantial malpractice settlements (allowing comment on consent decree or settlement by licensee).

ISSUE NUMBER 6: consumer information

Recommendation 6: State boards should promote consumer understanding about the competencies of health practitioners and about the regulatory system and make information accessible. Health professions educators should promote improved communication skills for practitioners. Regulatory policy-making should encourage new patient/provider partnerships.

ISSUE NUMBER 7: inter-related issues

Recommendation 7: Maine people should develop public policy in areas interacting with the regulation of health professionals and, when appropriate, advocate for changes in federal policy.

Introduction

Preliminary recommendations for improving the public policy regulating Maine's health professionals were issued by Medical Care Development's (MCD) Health Professions Regulation project in June 1995. Now, with input from a series of focus groups and meetings with health professionals and regulatory boards, final recommendations have been developed and are offered for an improved regulatory system for Maine, with suggestions for implementation. The following basic premises, recent health system changes, and guidelines for future direction were considered throughout the policy development process.

Basic Premises

- The most important principle underlying the regulatory system for health practitioners continues to be the need "to protect the public."

- State licensure of health professionals has traditionally focused on setting standards for entry into the profession and providing legal sanctions to discipline errant practitioners. Licensing laws do not generally include provisions to assure continuing competency.

- Maine's "practice acts" are public laws authorizing "scopes of practice," indicating which health care services can be delivered by each profession.

- Communication is key—within a profession and from the regulatory board to its licensees, between professions and between boards for inter-professional issues and understanding of competencies, and for the understanding of competencies by consumers, managers, and payers.

- New regulation and expansion of a scope of practice are generally initiated by the individual profession, rather than by a governor, legislator, or the public. The practice acts are usually developed independently of each other, rather than in collaboration with other professions delivering related services in the health system. (Osterweis, et al., 1996.) Expert advice—in addition to that from stakeholders—for legislative policy making about a health profession's competencies for a "scope of practice" has traditionally been lacking.

- Health professionals want to continue self-determination of the profession and to have a major role in the way the profession grows and evolves. Stakeholders want to be involved in studies of the complex issues surrounding determination of competencies and appropriate scopes of practice.

- While the roles of the national organizations of regulatory boards and national professional associations continue to expand to include national exams, model acts, credential archives, and continued competency assessment models, we expect licensure of individual practitioners to remain at the state level or, at the very least, we expect a strong state role in licensure.

- The tradition of public/private partnerships will likely continue in the growth, development, and regulation of the health professions.

The most important principle underlying the regulatory system for health practitioners continues to be the need to "protect the public."

Recent Health System Changes

Maine's overall health system has changed dramatically in the last two years. For example:

- Demographic data indicate that Maine's population continues to age, so that different and more health services are needed. The uninsured population is also growing.

- Managed care is growing rapidly in this rural state. Most insurance plans contain utilization review or other elements of managed care, and the state is making a major effort to move Temporary Assistance to Needy Families recipients (formerly the AFDC program) into managed care. Consumers are rapidly becoming acquainted with HMOs.

- Practice settings are changing. Medical care is shifting away from the traditional forms: a visit to the doctor or a hospital stay. Ambulatory and home care are becoming preferred, resulting in an oversupply of hospital beds. The mental health system is undergoing redesign to provide community services. Nurses are asked to manage out-of-hospital services and supervise unlicensed personnel. Toll-free telephone numbers link consumers with nurses who give advice on health problems. A new long-term care system is emerging.

Maine's overall health system has changed dramatically in the last two years.

- Fewer health practitioners are solo practitioners; more practice as part of teams. Hospitals are merging and forming integrated delivery systems. Insurers, hospitals, and physician organizations are joining to form new systems of managed care.

- There is a greater interest in public health issues, such as prevention of smoking. There is also more attention being directed at the health workforce—its education, distribution, and regulation—instead of focusing only on the financing and delivery of health care.

Guidelines For Future Direction

We suggest these guidelines for regulatory policy development for health professionals:

- Protecting the public should incorporate the concept that the health system performs effectively for the consumer.

- Every health professional should have the opportunity to practice at his or her level of training and qualifications. This will allow for optimal access to health care services. Maine needs to evaluate continually its regulatory laws to see if it can improve access to quality health services.

- Historically practitioners practiced in isolation. Now they often work within teams and as part of an organization. Although licensure must assure individual competency and set practice standards, it needs to recognize the organizational settings for care.

- It is essential that Maine improve communication within and about the regulatory system to help the public and health professionals understand which practitioners possess the competencies to provide particular health services on an individual basis or as members of a team.

- The licensure of the health professions should function as a regulatory system within the overall health system. The organizational structure for licensing boards should provide formal mechanisms for regular inter-professional dialogue to discuss shared regulatory policy issues, to reduce turf battles, and to provide expert advice to the Governor and Legislature.

- In addition to stakeholder advocacy, the Legislature needs unbiased expert advice about competencies that should be required for various scopes of practice. The Legislature also needs involvement of the stakeholders in studies it convenes to develop appropriate public policy about the complex issues surrounding the determination of appropriate scopes of practice.

In addition to stakeholder advocacy, the Legislature needs unbiased expert advice about competencies that should be required for various scopes of practice.

- There must be a stronger accountability component to the health professions regulatory system to make sure it responds to the needs of the public in an ever-changing environment to achieve the goals set forth above. Accountability should include publicity and a periodic policy evaluation by the Legislature, not simply a programmatic review of the implementation of current law.

- To develop sound policy for regulating health professionals, policymakers must recognize interaction with other systems, which also affect who may perform what services, where, and at what price. Inter-related areas include managed care, reimbursement, regulation of facilities and integrated health systems, and accreditation of educational programs.

- When more than one agency or department is involved in health policy, the state's strategic planning process needs to reflect measurable objectives jointly developed and coordinated strategies for achieving those objectives.

Background

Regulating Health Professionals in the U.S.

The U.S. health system's workforce is traditionally regulated by the states. Usually that regulation is in the form of licensure with an authorized "scope of practice" defined. (McLaughlin, 1994.) The Council on Licensure, Enforcement and Regulation (CLEAR), an affiliate organization of The Council of State Governments, introduces the topic of licensure to legislators in this way:

> Licensing is a process by which a government agency grants individuals permission to engage in a specified profession or occupation upon finding that individual applicants have attained the minimal degree of competency required to ensure that the public's health, safety and welfare will be reasonably protected. (Shimberg and Roederer, 1994.)

Barbara Crowley, MD, makes a young patient feel at ease.

Medical doctors were the first health professionals to be regulated in Maine: "On and after the first day of January, eighteen hundred and ninety-six, it shall be illegal for any person not duly registered by this board to practice medicine or surgery, or any branch thereof for gain or hire within this state." (Chapter 170, March 27, 1896.) Physicians were the first health profession to be licensed in all states, beginning with Virginia in 1884. Dentistry, pharmacy, nursing, optometry, and veterinary medicine followed, with a spurt of new professions licensed following World War II. (Morrison and Carter, 1992.)

Similarly to other states, Maine's Practice Acts were developed separately one by one. The same basic regulatory model remains in all 50 states, even with differing specific laws. The model consists of separate regulatory boards implementing the individual professions' practice acts that describe a scope of practice and entry to that state's licensure and disciplinary standards.

Ontario and other Canadian provinces recently developed a different model, effective January 1, 1994. In addition to entry and disciplinary standards, Ontario, beginning in January 1997, required all Ontario health professional colleges to have in place a quality assurance program that included continued competency assessments. The new Ontario model developed a listing of potentially hazardous procedures to be performed only by qualified practitioners called "controlled acts." Beginning in 1994, only designated professions were authorized to perform specific controlled acts.

Most of the other Canadian provinces are also involved in reforming their licensing systems. The states of Arizona, Colorado, Connecticut, Nebraska, Oregon, Vermont, Virginia, and Washington either are now involved in studying or have just made major changes in their health professional regulatory systems. For sources of further information about the Canadian provinces and other states, please see Appendix A.

States vary as to which health practitioners are licensed or regulated, the scope of practice granted, supervision requirements, and delegation of authority. Recent changes in Maine law allow independent practice for those Advanced Practice Registered Nurses (APRNs) who meet the state's requirements (1995) and the licensing of naturopaths (1996). There is wide

variation among the states on the regulation of these two professions, with APRNs gaining recognition and more authority in many states during the last few years.

Leadership in the development of public policy in the area of health professions licensure has not traditionally come from governors, commissioners, or legislators. The initiative and leadership in the development of the state laws for "practice acts" has traditionally come from each individual profession acting separately from the other professions, with few exceptions.

State regulation must be recognized as a key component of health care delivery. It simply cannot be examined in isolation from larger health care system quality, access, and cost issues. As an example, quality performance can be assessed at the beginning of a health professional's career—or later on—in general, in a specialty, or in a particular practice setting. For another example, exclusive statutory "scopes of practice" can affect access to health services and affect health care costs if they limit other competent professionals from offering those services. Health care systems may have to use overtrained and unduly expensive practitioners.

> Of the various regulatory options available to states, licensure imposes the most stringent requirements. Once a profession obtains licensure status, it is illegal for anyone who does not hold a valid license to practice that profession or occupation. In essence, when states have the power to grant licensure status to individuals, they also have the power to deny individuals the opportunity to earn a living in that profession if they fail to meet all of the initial, and continuing, licensure requirements. This is an impressive power that states possess and one that must be exercised judiciously. (Shimberg and Roederer, 1994.)

In essence, when states have the power to grant licensure status to individuals, they also have the power to deny individuals the opportunity to earn a living in that profession if they fail to meet all of the initial, and continuing, licensure requirements.

At the same time, systems separate from the licensure system for health professionals—reimbursement, malpractice law, and accreditation of educational programs, as examples—directly and indirectly affect the regulation of health professionals.

Regulatory Literature

In comparison to other public policy areas, the academic literature on the topic of health professional regulatory policy and history is surprisingly sparse and recent. Few universities, colleges, and "think tanks" can point to an expert in this field. Now that states are examining their roles in the health system and beginning to consider health professional licensure in that context, we expect political science and public policy programs to recognize the need for more expertise in this area.

Ben Shimberg was an early leader in developing academic literature in this field, beginning in the 1970s. He was formerly with Educational Testing Service of Princeton, New Jersey, and is currently the Board Chair for the Washington, DC, based Citizen Advocacy Center.

By the late 1980s, several sociologists focused their studies on the professions, occupational regulation, and consumer behavior. Donald Light of Princeton University, Louis Orzack of Rutgers University, and Richard Morrison, James W. Begun, and Ronald L. Lippincott of Virginia Commonwealth University are among them.

Carol Weissert of Michigan State University is a leader in this field among political scientists. Attorney Linda Bohnen of Toronto, Ontario, has written about the development of Ontario's

Background

new regulatory model. In 1994, Barbara Safriet of the Yale Law School faculty authored a definitive article on advanced practice nursing. Pam Brinegar, executive director of CLEAR, and David Swankin and Rebecca Cohen of the Citizen Advocacy Center have contributed to the regulatory literature. A recent Virginia study by the Eastern Virginia Medical School will also contribute to the field. (See the attached partial bibliography and Appendix A for sources of information about other states and provinces.)

The Pew Health Professions Commission, supported by The Pew Charitable Trusts and administered by the Center for the Health Professions at the University of California at San Francisco, recognized that health workforce reform must include regulatory reform. A Taskforce on Health Care Workforce Regulation was created in 1994. That Taskforce issued a report in December 1995 titled *Reforming Health Care Workforce Regulation, Policy Considerations for the 21st Century.* A second Taskforce was appointed in 1997 for further review of regulatory policy issues.

Origin of the Policy Development Project

Maine, like many other states, was working to improve its health care public policy when this project began June 1, 1993. Many incremental reforms had been implemented. They targeted access to health insurance, included some coverage for low income working uninsureds and guaranteed renewal, portability, and a move toward community rating in the individual and small group markets.

Maine reformed its workers' compensation system in 1991-92. A Maine Employers Mutual Insurance Company was established to take responsibility for the huge residual market and 24 hour coverage pilot project plans were authorized—combining health insurance and the medical portion of workers' compensation insurance. A Medical Liability Demonstration Act authorized practice parameters and guidelines as an affirmative defense for medical malpractice.

Many health care issues still needed to be addressed, including:

- increasing access to services in a rural state characterized by shortages and maldistribution of many types of personnel,
- finding more efficient ways to deliver services to the rural population,
- determining the best mixes of personnel and delivery settings to assure efficient and high quality services, and
- measuring the outcomes of services and determining the relationship between cost of care and health status.

"What public policy changes, costing very little in public or private funds, could be implemented at the state level in a state greatly impacted by a major recession, to help address some of these problems?"

In addition, issues surrounding communication, coordination, and cooperation also surfaced during Maine's reform of its broken workers' compensation system. Competition between health professions appeared sometimes to be more prevalent than cooperation. During that same period statewide comment was sought about the "feasibility of a statewide health insurance program." More was heard about lack of health workforce coordination, communication, and cooperation, and about unnecessary monopolies. We faced the following question: "What public policy changes, costing very little in public or private funds, could be implemented at the state level in a state greatly impacted by a major recession, to help address some of these problems?"

Background

The Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program, in its final report to the Legislature (December 1992), called for an examination of the allocation of health personnel in the delivery of health care in Maine. The Select Committee called for a study and report on "the issue of the qualifications and full utilization of health care professionals, identifying the legal barriers to appropriate utilization and the extent to which health policies determine health care policy, the degree to which health care professionals drive the system, and the effect of full and partial participation of health care professionals in health care programs funded by the public sector."

Public policy surrounding the regulation of the health professions was an area of health policy yet to receive a thorough public discussion. A policy development project involving all interested people, including the public, in the development of a new, coordinated health professions regulatory system seemed to be a reasonable undertaking.

This project began in June 1993 before the debate began about President Clinton's health care reform proposal. Also yet to come in Maine was the creation of the Maine Health Care Reform Commission, along with the beginning of a rapid change to managed care.

The following report describes the project's policy development process, including citizen involvement strategies, leading to the development of a series of recommendations and suggestions for implementing improvements in the regulatory system. The recommendations and suggestions for implementation are meant to serve as guidance to policy developers.

Paul Tessier, LCSW, Clinical Director for the Maine Children's Home confers with a client.

Calendar of Events for the Maine Health Professions Regulation Project

The following calendar summarizes project events which, together with meetings with Mainers, compose the history of project activities, personal contacts, and interaction with Maine people which led to the development of the recommendations offered as guidance to policy makers. (See Appendix B for additional activities.)

June 1993 - Phase I of Maine Health Professions Regulation Project begins.

Summer 1993. Project Advisory Committee formed.

September 17, 1993. Introductory conference. Topics included an overview of health professions regulation issues, a description of the Ontario regulatory model, panel description of Maine's regulatory system, small group discussions identifying issues to be addressed, and an update on federal health care reform proposals from U.S. Senator George Mitchell.

Colby College interns prepare the project's first newsletter.

Fall 1993. Open invitation extended to participate in a Task Force to develop recommendations for improving public policy for regulating health professionals and Task Force subcommittees on reimbursement issues and the regulation of practice.

November 18, 1993. Reimbursement Subcommittee Meeting. Managed care, integrated systems, Physician Payment Review Commission recommendations, Maine insurance laws, hospital credentialing and privileging were discussed.

November 23, 1993. Regulation of Practice Subcommittee Meeting. Perspectives on the "regulation of practice" from an internist, the executive director of the Maine Osteopathic Association, and the Chair of the Board of Registration in Medicine. Health professions education, accreditation, and a family nurse practitioner program were discussed.

December 14, 1993. Reimbursement Subcommittee Meeting. Maine Workers' Compensation Board reimbursement rules, Medicare policy, and Medicaid were discussed.

January 1994. Two interns from Colby College assist project.

January 11, 1994. Regulation of Practice Subcommittee Meeting. Topics included "scopes of practice" of 22 health professions in Maine law, brief descriptions of entry-to-practice standards, and practice settings.

January 18, 1994. Reimbursement Subcommittee Meeting. Facility licensure, Certified Nursing Assistants (CNAs), and long term care facilities were discussed.

February 1994-June 1995. Five newsletters issued.

February 11, 1994. Reimbursement Subcommittee Meeting. Medicaid and managed care, a nursing center, regulation of boarding homes and foster homes, family planning clinics, nursing, and home health services were discussed.

February 15, 1994. Regulation of Practice Subcommittee Meeting. Facility regulation and complaints about health professionals, CNAs, National Joint Practice Commission and concept of collaborative practice, acupuncture, massage therapy, podiatry, and a regional health agency were discussed.

April 12, 1994. Task Force Meeting. Changes that are occurring in the health system, Maine's Medical Liability Demonstration project, a hospital's quality improvement program, recommendations of the Physician Payment Review Commission, the future of health care in northern Maine, future of hospitals, networks, managed care, outcome measures in managed care organizations, managed care and mental health were discussed. In addition, small group discussions were held.

May 18, 1994. Reimbursement Subcommittee Meeting. Small hospitals, patient-focused care, EMS reimbursement issues, modular training, occupational therapy, mental health and managed care, and new Maine laws were discussed.

May 25, 1994. Regulation of Practice Subcommittee Meeting. Medicaid Quality Assurance Reform Initiative, mid-level practitioners project's survey, nurse practitioner legislation, and work redesign were discussed.

Summer 1994. Topics survey questionnaire circulated.

July 20, 1994. Task Force Meeting. Maryland Hospital Association's Quality Indicator Project, Health Plan Employer Data and Information Set (HEDIS 2.0), ambulatory care in rural Maine, primary care, mental health issues, and Medicare were discussed.

September 16, 1994. Workshop/conference II. Topics included health professions regulation projects in Colorado, Virginia, and Washington, public members of regulatory boards, Pew Health Professions Commission's work on health workforce reform, European professional regulation, patient/provider partnerships and new computer tools, and overview of topics survey responses. Small group discussions were held.

November 1, 1994. Task Force Meeting. CLEAR'94, naturopathy, health manpower issues, home care management services, and the Board of Licensure in Medicine's new rule governing physician assistants and physicians who supervise physician extenders were discussed.

December 1, 1994. Task Force Meeting. Topics included Personal Care Attendants' (PCAs) training, mental health and counseling services, and redesign and evolution of Maine's health care delivery system.

January 12, 1995. Task Force Meeting. CNAs and other unlicensed personnel were the topics of discussion.

February 15, 1995. Task Force Meeting. The topic was interdisciplinary training using computer conferencing as the main teaching and discourse tool. A discussion of Working Draft recommendations for a new, coordinated health professions regulatory system for Maine was also held.

Calendar of Events

March 30, 1995. Task Force Meeting. Discussion and demonstration of some of the ideas presented in Weed and Weed's 1994 Federal Bulletin article. (See bibliography.) Information technology, medical decision making, and the need for reform of credentialing were discussed along with the revised Working Draft.

April 6-May 18, 1995. Three small group discussions and two Task Force meetings. Discussion of fluid Working Draft.

June 6, 1995. Task Force Meeting. Final meeting regarding specific recommendations resulting from fluid Working Draft.

June 30, 1995. Issuance of *Toward a More Rational State Licensure System for Maine's Health Professionals*. Preliminary recommendations included.

July 1995 - Phase II of Project begins.

September 1995. Pamphlet issued containing recommendations of the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation.

November 1995-June 1997. Six newsletters issued.

December 1995. *Reforming Health Care Workforce Regulation, Policy Considerations for the 21st Century* issued as the Report of the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation.

February 1996. Commentary about the project titled "Start Making Sense: A Legislator Looks at Professional Licensure Reform," by State Senator Dale McCormick, in February 1996 issue of the Margaret Chase Smith Center for Public Policy's *Maine Policy Review*.

March 1996. *The U.S. Health Workforce, Power, Politics, and Policy,* published by the Association of Academic Health Centers; a textbook edited by Marian Osterweis, Christopher McLaughlin, Henry Manasse, Jr., and Cornelius Hopper, including an article titled "Developing Rational Health Professions Licensure" by Judy Kany, Project Director.

June-October 1996. Focus groups held in 22 locations throughout Maine, 21 in community hospitals. Two hundred and thirty participated, including health professionals, managers, legislators, regulators, faculty, and citizens-at-large.

November 22, 1996. Conference III. "Practicing for a Lifetime: Continuing Competency in the Health Professions," assuring and assessing continued competency conference. Topics: patient-oriented outcomes data management, "Through the Patient's Eyes," developing a quality assurance program, use of computerized simulations, and use of actors trained as standardized patients.

May 1997. Project contract with a former director of the Maine Legislature's Office of Policy and Legal Analysis to develop an independent case study of the project.

June 1997. "Draft Revised Recommendations for Improving the Public Policy for Regulating Maine's Health Professionals" included in newsletter.

June 24, 1997. Workshop on draft revised recommendations.

October 1997. Final Reports published. Pamphlets published.

December 1997. Case study completed.

December 31, 1997. Project formally ends.

January 1998. Final reports due for Phase II grants from The Pew Charitable Trusts and the Center for the Health Professions at the University of California at San Francisco—State Program Initiatives.

Two Maine health professionals communicate.

Involving Mainers in the Regulatory Policy Development Process

Phase I Process: June 1993-June 1995

From its beginning, the Maine Health Professions Regulation project stressed the need for involving major stakeholders and others interested in this issue. First the emphasis was on the collection of information about Maine's needs and the need to collaborate, discuss and educate about the importance of developing regulatory policy within the context of the health system as a whole. The initial goal was to involve the major stakeholders, legislators, and citizens-at-large in the development of a revised, improved, coordinated health professions regulatory system for Maine.

The project chose to try to change the political climate and mindset to meet its goals for long term improvements, instead of lobbying or writing specific legislation to change current laws which could be easily repealed during the next legislative session.

We intended to provide a two-year policy development project with these components: review of the current system, development of a shared information base, education, inter-professional collaboration, and public information. Examining existing Maine law and studying what was going on in other states were included in the process as we tried to approach consensus on what the public policy should be.

The project chose to try to change the political climate and mindset to meet its goals for long term improvements, instead of lobbying or writing specific legislation to change current laws which could be easily repealed during the next legislative session. We recognized that changing the tradition of isolation of the individual practice acts and integrating them into a more coordinated system would be difficult. It was recognized that each separate practice act had strong proponents. A change toward viewing the system as a whole would require viewing the practice acts' role within the health system. The mutual development of a shared information base for changing traditional views and developing new insights served as a key strategy. Dialogue was seen as an essential means of sharing information and changing attitudes.

A segmented approach to complex problems cannot mobilize the full range of resources required to address those problems and create recommendations for workable solutions. Effective, long-lasting change cannot be achieved without the participation of those directly involved. Therefore, this project adopted a collaborative strategy as a means to achieving the goal of inclusive participation by those affected by the health professions regulatory system. The project sought to be inclusive because of the traditional approach of separate development of regulation. The project sets the tone for an inclusive coordinated system by modeling that approach, including not only traditional stakeholders but others in a cross fertilization of ideas, not just in the process, but also in the recommendations.

Ongoing throughout the project was the continuous horizontal flow of new information, and recognition of new ways to facilitate discussion and consideration of new regulatory policy ideas. Consistent with the project's collaborative strategy, the project leaders/participants believed that the more informed the discussion, the more realistic the recommendations. The project developed a variety of communication strategies which included formal and informal channels for information exchange. The project used diverse methods in information gathering and dissemination in order to be very sure that all voices were heard and considered.

An Advisory Committee was developed, followed by an introductory conference, Task Force, focus groups, newsletters, presentations, conferences and subcommittees. In addition, the project sought input from a statewide audience and traveled to 22 sites to achieve this goal. The project was flexible, creative, and responsive to suggestions for new ways to reach out with information and to receive information from people through these strategies. The project's activities were not isolated events but were part of an overall strategy.

Sponsorship by a low-key not-for-profit research and development organization, Medical Care Development, enabled dialogue to take place in a non-confrontational setting away from the political spotlight. Although the process was anything but secretive, the press showed little interest in the project. Consequently, there have been little "grandstanding" or freezing of positions due to public utterances and no partisan political positions. The following chapter describes the communication strategy process during the first phase of the project.

The project's activities were not isolated events, but were part of an overall strategy.

Advisory Committee

The project began in June 1993 with the formation of an Advisory Committee of some of Maine's leading health policy experts. The members were all Mainers and include a former Superintendent of Maine's Bureau of Insurance, a Democratic and a Republican member of the Maine Legislature, the Executive Director of the Maine Medical Assessment Foundation, members of the Maine Health Care Reform Commission, the President of Medical Care Development, health policy consultants, a member of the Maine Health Care Finance Commission, the Executive Director of the National Academy for State Health Policy, the President of Health Commons Institute, and the Director of the Division of Medicaid Policy and Programs, Maine Department of Human Services.

The Advisory Committee provided credibility to the project from the start, provided advice to project staff throughout the duration of the project, and participates in conferences and other meetings.

Preliminary Research

In the summer of 1993, a review of Maine's "practice acts" and rules and other relevant laws was undertaken. Project staff next reviewed the extant academic literature on the topic of regulating health professionals. The extensive academic literature review has not been limited to regulation about health professions but was extended to research and commentary about health systems in the U.S. and elsewhere. (See bibliography for partial listing.)

Participants listen and take notes at a 1993 Reimbursement Subcommittee meeting.

Introductory Conference (September 1993)

About 250 health professionals and managers, faculty, legislators, insurers, state government employees, and citizens attended the September 1993 introductory conference, where Lisa Miller, MPH, described the supply and changing demands for health professionals in Maine. Featured was a panel review of Maine's present system of regulating health professionals. The conference included a discussion of health professions regulation—problems and prospects—by the director of the Virginia Board of Health Professions, an explanation of Ontario's new regulatory model scheduled to go into effect in January 1994, and an update on the federal health care proposal by U.S. Senator George Mitchell.

Small group sessions at the conference were clear about the purpose of regulation: protection of the public, quality, and access. They identified a wide array of issues to be addressed. Some of the major issues identified by the conference participants included education of health professionals, consumer choice and education, access and reimbursement/cost issues, improving Maine's database about health services and practitioners, and focusing more on outcomes and less on credentials. (See Appendix C for conference agendas.)

Task Force and Subcommittees

Small group sessions at the conference were clear about the purpose of regulation: protection of the public, quality, and access.

Participants at the conference were invited to join a Task Force to explore developing an improved, coordinated regulatory system. The goals of the Task Force and subcommittees were (1) to educate ourselves more about regulatory issues, (2) to develop a shared information base, and (3) to develop recommendations to improve the system. Initially, about 100 people signed up to participate. The Task Force mailing list eventually grew to over 400 names—many were participants and others simply monitored materials and events.

The Task Force and two subcommittees on (1) Reimbursement and (2) Regulation of Practice held frequent educational meetings that were summarized in the project's periodic newsletter. Education and accreditation, reimbursement, credentialing and privileging, liability, coordination, managed care, facility licensing and certification, quality improvement and assurance, practice settings, supervision and delegation and other regulatory issues were among the topics addressed by the Task Force and its subcommittees.

The charge of the Reimbursement Subcommittee chaired by Maine's Director of Medicaid Policy and Programs, Christine Zukas-Lessard, was to explore how reimbursement rules dictate scope of practice and the availability and cost of care. That subcommittee began to look at how reimbursement regulations affect who can be paid and, therefore, who can afford to practice what and where, as well as how the rules affect availability and cost of care.

The Regulation of Practice Subcommittee focused on scope of practice issues and regulatory structures. Because the health professionals wanted to learn about other professions, there were many discussions about the skills and training of different health professions.

As the subcommittee discussions began to overlap more and more, the project moved away from smaller subcommittee meetings to "meetings of the whole" or Task Force meetings. Among topics covered were scopes of practice, managed care, and credentialing, especially by managed care organizations. As a result, much discussion occurred about reimbursement issues, including the viewpoints of various health professionals.

Newsletter

In addition to conferences and meetings, project communication has been largely through a newsletter issued about three times a year. By January 1994 it was clear that the project needed a regular communication vehicle. Two Colby College seniors spent the month of January assisting the project and produced the first issue of our newsletter. The newsletter's mailing list now includes about 3,700 names. The newsletter includes information from the conferences and meetings, information about legislative documents and new laws, addresses for home pages on the world wide web, information about reports and other publications concerning regulatory issues, and reprinted materials. Phase I newsletter issues were distributed in February, June, and October 1994 and February and June 1995.

Issues "Topics Paper" Survey

In order to get a variety of views on problems with the existing regulatory process, we sent a Topics Paper (survey) to about 300 individuals during June 1994. The original draft of the survey contained open-ended questions. That draft was largely based on the issues that had been identified during the small group discussions at the end of our September 1993 introductory workshop/conference. After sending that draft around to respected advisers, including the project's Advisory Committee, we revised the form.

The survey was sent to the project's Task Force mailing list, consumer organizations, health profession boards, association officers, and health profession school faculties. Additional copies were requested when the Topics Paper's availability was made known through the June 1994 newsletter. The survey was quite long—and there were some comments about its length. Yet, in addition to answering the 100 questions using a standard Likert agree-or-disagree scale (Keenan, October 1993), people added additional narrative to their responses totaling 20 single-spaced pages. Some of the 90 respondents were agency directors, regulatory board members, faculty, and legislators; others were individual practitioners. (See Appendix D for a copy of the survey.)

An overview of the responses are not to be viewed as statistically significant, but instead, as an indication of where there is substantial agreement for the direction this project should move in the coming months while developing policy recommendations for a new, coordinated regulatory system for Maine health professionals.

Survey results were tabulated by a student at Mount Holyoke College. An overview of the responses was published in the project's October 1994 newsletter with the explanation that "The responses are not to be viewed as statistically significant, but instead, as an indication of where there is substantial agreement for the direction this project should move in the coming months while developing policy recommendations for a new, coordinated regulatory system for Maine health professionals." The survey was considered to be an inclusive process for identifying issues, not a scientific sampling of the opinions of the Maine populace.

An overview of the results from the survey was also reported at the project's September 1994 conference. (See Appendix E for Overview.) Substantial agreement about principles and most issues regarding the regulation of health professionals was reported by the respondents and led to these assertions:

1. The regulatory focus should be on the licensure of individual practitioners, instead of institutional licensure.
2. Overlapping skills between professions should be acknowledged and consumers should be able to choose among professions for those overlapping services.
3. We can expect the focus during the next few years to be on quality improvement, health status outcomes, and cost effectiveness, with cost effectiveness factoring in health status improvement and preventive measures along with consumer information about costs.
4. Supervision and delegation are going to continue to be troublesome areas as organizations change further. Another difficult area will be continued competency.
5. Health care and education need to be linked together more effectively—along with health workforce planning and the regulatory system.
6. There should be uniform state standards for entry to practice.
7. There must be more sharing and intermingling of ideas.

September 1994 Conference

In addition to the overview of the survey results, the second statewide conference/workshop included a description of the very different European professional regulation system by Louis Orzack, Ph.D.: "The principle put forth in Europe is that the qualifications of others can and should be mutually recognized."

Equally provocative were presentations by Richard Rockefeller, MD, and Deborah Deatrick, MPH, of the Health Commons Institute about computer tools for shared decision-making in medical practice. They emphasized patient involvement, keeping people healthy, and helping people understand and manage their ailments through use of computers. Charles Berger, MD, pointed out the regulatory significance: "Who can do *what* is hanging to a great degree with access to the computer. The credentialing system needs to reflect this. How are we going to license people who can function with these tools?"

Conference participants also heard about regulatory reform efforts in Colorado, Virginia, and Washington State. Again small group discussions were held.

"Who can do what is hanging to a great degree with access to the computer. The credentialing system needs to reflect this. How are we going to license people who can function with these tools?"

1995 - Developing Preliminary Recommendations for an Improved Regulatory System for Maine's Health Professionals

Following the educational and discussion opportunities at the two conferences and fourteen meetings of the Task Force and its two subcommittees, we began tackling the difficult task of formulating recommendations for change. In January 1995 the first in a series of draft recommendations was mailed to all those who had signed up for the Task Force mailing list. Discussions about the draft began in February at the first of eight meetings revising the recommendations. Those in attendance varied from meeting to meeting. The discussions were informal as understanding, clarity, and a near consensus were sought. No formal vote was taken approving the recommendations.

Next, the project issued very specific preliminary recommendations in a report titled *Toward a More Rational State Licensure System for Maine's Health Professionals,* addressed to the Governor of Maine and the Maine Legislature and dated June 30, 1995. The following paragraph introduced the basic premises:

> Licensing of health professionals should remain a principal means of protecting the public and providing accountability. Licensure is a privilege granted by the state but not a privilege which should be withheld inappropriately for the purpose of creating monopolies. Inclusive law, instead of creating exclusive monopolies and incorporating procedural protections, may be a more reasonable exercise of state powers under the U.S. Constitution. Any state license should be a legitimate credential assuring that a minimum standard has been met. Anyone involved in the health system should be able to "count on" such a license when attempting to identify competent practitioners to perform particular health services.

The following were listed as the major recommendations and were accompanied by statements of problems:

1. **Streamline and clarify the health professions regulatory laws. Promote understanding of the state's health professions regulatory system by participants and the public by making regulatory terms in the public sector distinct, transparent, and standardized. Lessen confusion by using transparent regulatory terms distinguishing government regulation from private sector regulatory activities. Use the term "licensure" for public regulation of the health professions. Reserve the term "certification" for the private sector.**

2. **Improve communication, coordination, and cooperation among the health professions and among the regulatory boards by establishing a federation of Maine's health professions regulatory boards. Assign responsibility for regulatory "system" policy development to the Commissioner of the Department overseeing most of the regulation of Maine's health professionals and to the proposed federation of regulatory boards.**

3. **Require demonstration of continuing competency to protect the public. This will improve health care services and help ensure quality during the change to managed care. Support the continued and expanded use of modern technology, especially modern information technology, to enhance traditional competencies and their assessment.**

4. **Acknowledge overlapping skills for the provision of health services and remove unnecessary monopolies for which there is no demonstrable benefit to the public. Allow access to more overlapping services from health professionals when the necessary competence to protect the public has been demonstrated.**

5. **Advocate the use of uniform terminology among the states and suggest uniform state standards. Uniform state standards would provide benchmarks for comparisons.**

The recommendations and the report, issued at the conclusion of Phase I, dated June 30, 1995, served as a catalyst for further discussion in Phase II of the project and the ultimate revision of the recommendations.

Jean Shaw, PT, helps a patient use a walker.

Phase II Process: July 1995-Fall 1997

Although the dialogue had begun, in mid-1995 it was clear that Maine people had not reached a consensus about appropriate policy for a new, coordinated, improved regulatory system. The project was extended to allow for discussion meetings with many of the regulatory boards, professional associations, and others in Maine and to pursue implementation, further evaluate health professions regulatory issues, and refine the recommendations. Phase II support came from The Pew Charitable Trusts and the Pew Health Professions Commission/ UCSF Center for the Health Professions. Phase II formally ends December 31, 1997. The Josiah Macy, Jr., Foundation provided support for the 1996 conference on continued competency assessment.

The grant application to The Pew Charitable Trusts called for building upon the project's work by:

- Overseeing a process allowing dialogue with health care practitioners, professional and civic organizations, and health care organizations about the rationale for the recommendations and likely changes that would result from their adoption. This process would provide opportunities for discussion, refinement, and consensus building for action on the recommendations. Are there better ways to meet the goals than in the recommendations?

- Working with Maine's relevant executive branch commissioners and regulatory boards on administrative measures that could be taken to implement the recommendations or reach mutual goals.

Involving Mainers in the Regulatory Policy Development Process

- Engaging Maine legislators in discussions about the possibilities for improving the regulatory system.
- Developing materials for distribution to other states detailing the substantive recommendations and the planning process used by Maine to work toward regulatory reform.

Following the issuance of the June 1995 recommendations, appointments were made with the regulatory boards, commissioners, and some professional associations for discussion of the report. After the September 1995 publication of a pamphlet outlining the recommendations of the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation, presentations and discussions often included those recommendations along with those of the Maine project. This project's Project Director served as one of eight members of the Pew Taskforce, and many of the issues, discussions, and recommendations were similar. The full report of the Pew Taskforce, titled *Reforming Health Care Workforce Regulation, Policy Considerations for the 21st Century,* was released in December 1995.

In November 1995 the Maine project received a response criticizing the project and its process from a Maine Provider Coalition consisting of 14 individuals. Each of the 12 organizations represented in the coalition was invited to have a dialogue about regulatory policy and the project's recommendations. In November 1996 coalition members invited MCD project staff for a discussion of its response. A second discussion meeting was also held. The coalition members were invited to a preview of revised recommendations in June 1997 for further dialogue and several of the group's suggested changes were incorporated into the final document.

Project newsletters were published during Phase II in November 1995, May and October 1996, and February, May, and June 1997.

Publications about this project during Phase II include a commentary in the February 1996 issue of the Margaret Chase Smith Center for Public Policy's *Maine Policy Review* titled "Start Making Sense: A Legislator Looks at Professional Licensure Reform," by State Senator Dale McCormick. *The U.S. Health Workforce, Power, Politics, and Policy*, published in March 1996 by the Association of Academic Health Centers and edited by Marian Osterweis, Christopher McLaughlin, Henry Manasse, Jr., and Cornelius Hopper, contained an article titled "Developing Rational Health Professions Licensure" by Judy Kany, Project Director.

Focus Group Discussions

Focus groups about regulatory policy issues were held in 22 locations throughout Maine from June through October 1996. All except one were held at community hospitals. Participants numbered about 230 and included an array of health professionals and managers, legislators, regulators including public members of regulatory boards, faculty, and citizens-at-large. (For a listing of the communities where focus groups were held, see Appendix B.)

The focus groups were designed to address two goals. The first goal was to learn more about what the target population had to say about health professions regulation in general and more specifically about issues identified by the project and included in the preliminary recommendations. The second goal was to encourage dialogue among health professionals in different occupations, legislators, and citizens across the state about the issues identified in the recommendations (through the focus group questions). The project chose the focus group method of

data collection because it allowed for the gathering of information as well as providing the opportunity to listen to and learn from professionals in different areas of the state. The information collected in these discussions was used as an indicator of issues and concerns and informed the project's continuing discussions about recommendations for health profession regulation system review. The basic focus group design was modified to meet these goals. The purpose of these groups was not to make absolute statements about opinions of the public, nor are they meant to represent the opinion of all health professionals. (For a description of the focus group protocol, see Appendix F.)

The following individual comments reflect some of the major varied responses to questions during the focus group component.

In response to — **How can we change our state licensure laws to make quality health services more available to rural Maine?**

Rural Sites - comments

- Medicaid and Medicare laws have not been changed to allow new nurse practitioner and physical therapist laws to work.
- Too much regulation may lead to limited access, especially in rural areas.
- Look at using unlicensed providers as appropriate in rural areas to provide access; otherwise often have to send people long distances for care.
- Physician extenders should be able to practice without supervision.
- Hospitals should be able to cross-train people in similar fields.
- Develop standards for certain clusters of responsibilities, instead of having separate licensing and fighting over turf.

Urban Sites - comments

- Nurse practitioner bill opened things up for nurses in advanced practice; four programs in the state but regulations are restrictive; would be better to open it up; saw bill as way to improve access without lowering standards.
- Practitioners don't want to live in rural Maine, so there is less access.
- Issue is not licensure but rather collegial support and economic incentive to live in Maine.
- Difference between what managed care chooses and the state's regulations; state should keep up with research that shows what is the best use of practitioners and the state isn't there yet.
- Nurse practitioners are willing to work in rural areas, but can't find a physician to supervise them for two years as required by law.
- Disabled populations are under-served because providers lack training (e.g., developmental disabilities training for a physical therapist); either have service from providers without background or have to travel 50-100 miles for trained provider care.
- Is it the implication that we need to reduce standards if we change our state licensure laws? It is difficult to live in rural Maine and that may be why people don't have access because practitioners don't want to live there.
- I saw the nurse practitioner bill as a means to improve access and not to lower standards. When the state went to Blue Select, I could no longer get my primary care from a nurse practitioner.
- There is so much regulation if you want to start a home health agency in a rural area, and that makes it difficult for small business.

Physicians have significant influence on other practitioners' practices regarding access; this is not recognized sufficiently when laws are changed.

Coastal Sites - comments

- Money is an issue due to high debt from dental school and cost of equipment; community could provide incentives, be supportive, provide housing, etc.; selling a lifestyle to practitioners.
- Physicians have significant influence on other practitioners' practices regarding access; this is not recognized sufficiently when laws are changed.
- Difficult to recruit physical therapists in rural Maine; don't know how much thought is put into the rule changes.
- Turnover is a problem in emergency medical services; need to design an educational program.
- Licensure board is for protection of the public; I don't think any board is trying to keep people out (from other states, countries); licenses are restrictive.
- Psychiatric treatment north of Portland is hard to find (Muskie Institute study).
- Maine Medical Assessment Foundation found that people of Maine had access to services equally, but it might take longer or they may have to travel further in rural areas; subspecialties don't have enough patients in rural areas.
- People on Medicaid do not have equal access in rural areas.
- Arguments for the social work law (passed in 1985) included improved access for people to more social workers instead of psychiatrists; access did improve.
- Optometrists broadened their prescriptive rights last session, broadening availability of some services.
- Advanced practice nurses can practice more and are more likely to do so in rural areas; this is an example of how a change allows for more liberalization of scopes of practice that will help rural areas.
- We are lining up practitioners more with physicians than we have before; in other words, wherever the physicians are, the practitioners will be, whether at clinic or hospital — Is this really going to solve the access problem that we thought we were improving with the new licensure laws?
- It will be interesting to see how many managed care companies allow nurse practitioners to practice independently.

Advanced practice nurses can practice more and are more likely to do so in rural areas; this is an example of how a change allows for more liberalization of scopes of practice that will help rural areas.

In response to — **Who should set scopes of practice?**

Rural Sites - comments

- Often reimbursement determines who can practice where.
- It is difficult to use mid-levels effectively because they can't always be paid for it.
- One of the inputs that could be built into an advisory federation, composed of representatives from the regulatory boards for health professionals, is an understanding of what those practitioners at the community level need to try to solve problems that are at hand.

Urban Sites - comments

- We have begun to open up things for nurses in advanced practice but we have a long way to go. We have four nurse practitioner programs in the state, but the regulations are pretty restrictive.
- It would be wonderful if the health care community would come together with a recommendation about setting scopes of practice, but they seem divided as a community.
- I think we need to empower the public. They believe the practitioner. They need to know who is coming into their homes.
- More is being handed to us practitioners at bedside so we need to make rapid changes in our education so we can perform as will be expected of us.
- There is agreement that there are certain medical procedures that only a medical specialist can do, others that other health professionals can do as well. The point of disagreement is where the boundaries are.

- The bottom line is what is best for the patient. In rehab, about half a dozen people get together and decide who can do what best to help that person get home.
- Why we have scopes of practice in its final form is to provide some degree of protection to the consuming public. There are also issues of access and cost. It also boils down to the individual's sense of responsibility for doing what they can do.

Coastal Sites - comments
- The market also drives access.
- Sometimes scopes are born out of need.
- It is the art of health care that makes a difference to the public. Educational programs are out of sync with what is going on.

In response to — **What is the relationship between licensure and quality?**

The public believes there is a relationship between licensure and quality.

Rural Sites - comments
- Pushing things now to the lowest common denominator—least amount of money for the same services. What isn't taken into consideration is training.
- Professions used to control the professions by internships and mentoring, which were ways of keeping down costs and keeping numbers out—economics. The number graduating into professions has proliferated without an analysis of appropriateness.

Urban Sites - comments
- Licensure doesn't ensure quality.
- As licensure doesn't guarantee quality, it does not guarantee competence.
- The public believes there is a relationship between licensure and quality.
- Continuing education isn't the whole answer. Should you be required to be competent in all physician practice areas, or just in pediatrics?
- What do you do to prepare people for licensure? Then what do you do to assure people will be interested in improving their practice as time goes on?
- There are some unique ways of assessing competencies, but mostly on an experimental basis. Most professions do not reassess the competency. The real professionals try to keep up in an ever-changing and difficult world.
- The general public can drive quality.
- Some of the public health goals are perhaps most important, but the dollars are not there.

Coastal Sites - comments
- Mechanisms in hospitals look at quality. It is harder to measure in the office setting.
- The public is becoming more aware of things. A patient was pleased because all three nurses were certified. There is a comfort level.
- This is one of the few states that doesn't have an organized public health system.
- Should the licensing board make the health workforce planning decisions?
- More education of consumers to ask the right questions.
- A federated board could talk about issues but not the supply of practitioners.
- Public policy in one practice act area affects others. Public policy in one area—let us say liability or reimbursement—can affect quality and other policy areas.
- Workforce planning should not be a role of the licensing boards.
- Legislation has not kept up with practice setting needs.
- In a hospital you have privileges. There is a disconnect between licensure and competency.

In response to — **How can we improve communication and cooperation between professions/boards?**

Rural Sites - comments

- We need to educate everyone. Competition is not a good thing in the health professions. There should be collaboration and working together.
- Regarding the advanced practice nurse issue, the boards should have taken a position on what was best for the public, rather than for the profession they regulate; they should be willing to take a position on public policy.
- I am inclined to move toward more centralization and do away with fragmentation, which is more costly.

Urban Sites - comments

- Get some of the boards together. One of the things you can do is get people trained to be able to work together in a team.
- Encourage talking and include the public.
- Encourage multidisciplinary approach, agree on goal.
- When relationships are stable people get to know each other's competencies; too much turnover can hurt quality.
- I understood other professions when we worked together as teams.
- The training process is the place to start this process.
- Often there are turf battles. In Michigan they are asking "What are your health goals for the community?" This removes turf and brings in key players for the discussion.
- There are so many nurses with different educational backgrounds and working in different practice settings that agreement is difficult.
- Public forums on professions to improve communication.
- We have put up a lot of barriers that are not acceptable to the buying public; they want you to do more than you described, e.g., cross training.
- There needs to be incentives from the state for the disciplines to be motivated to work together.
- One of the ways a profession can improve communication is to get clients involved.
- There is a lot of overlap among the professions. So it is not clear to the public or among professions themselves who does what. There are no clear-cut boundaries.

Coastal Sites - comments

Bringing people together around a common issue is a key way of improving communication.

- In a civilized society, although we value people's independence, there needs to be some sort of consumer protection and accountability. Health practitioners view licensure of other health professionals as a communication that the licensed individual met the credentialing standard. When a practitioner is not regulated by the state, licensed practitioners are reluctant to use his or her services.
- It is not a matter of social acceptability or reimbursement. It should be outcomes and truth. Cooperation and communication are kind of on the truth level.
- People seem more interested in cost than in outcomes. We health professionals do have an obligation to distribute information that proves our profession's effectiveness or disproves the other's. Cheapest is not necessarily best.
- The public has delegated all competency and quality issues to the state.
- The idea of increasing public members on the boards is interesting and would go a long way to promote the role of the consumer on boards.
- There is a new attitude that we are all in this together and that is what consumers are looking for.
- Bringing people together around a common issue is a key way of improving communication. We need to be clear about what it is we are going to talk about.

- As a provider, I don't know about other boards and am not sure about the competencies of other professions.
- It's a new world where people need to have broader training. Not a lot of relationship between educational training, licensing boards and practice setting.
- There is duplication of services. Better communication could identify duplication and remove it.
- Need to change the culture in the educational institution.
- Need to look at similarities between professions' training.
- Maybe some continuing education conferences could include more than one profession.

In response to — **How can we improve understanding by the public of what health care competencies an individual practitioner possesses?**

Rural Sites - comments

- Some sort of education that needs to be done about what a profession can do.
- Inform public by educating them.
- Public is apathetic about health system.
- The public is involved through the Legislature but we also have to educate the Legislature.
- Make process more public.
- The public's perception is based on whether or not you meet their needs.
- The public forms opinions by word of mouth.
- HMOs are telling people whom they have to see and that whole process has made the public more aware that they have options.

Deidre Finney Boylan, LCSW, provides professional and caring counseling services to a couple at Kennebec Valley Mental Health Center.

Urban Sites - comments

- One of the advantages of a managed care environment is that there is a primary care physician whose job it is to pull it all together.
- The public is often confused about their health care. How can we make it understandable to the patient.
- We have built a system that is too complex for some consumers to understand.
- Often the patient isn't part of the consultant process.
- The Medicaid managed care program is confusing to the public.
- Provide more public access to health screening and fairs.
- Bring health care to the people instead of to the industry. Health care without walls. Needs to be education about how you maneuver through the system.
- We need to look at the whole picture to maximize resources and maintain cost effective quality care.
- We are mandated by the Joint Commission to demonstrate how patients have been involved in their own goal-setting.
- Change the model so that the consumers be partners with practitioners.
- We need to develop a shared-decision-making model.
- Let consumers know how important their role is.
- We need to foster independence & empower them. Need a clearinghouse.
- When the public talks about access to medical care, it needs to address competencies and disciplinary records.

Coastal Sites - comments

- The professions have to develop understanding of each others' competencies first, then educate the public.
- There are navigators now hired to help consumers through the system.
- We should try and learn what the public wants; listen before we educate.

Project Conference III: Practicing for a Lifetime, Continued Competency in the Health Professions - November 1996

Assessing continued competency was regarded as a controversial recommendation in mid-1995. But views change. Unlike some other initial recommendations of the project, a recommendation for continued competency assessment found growing support in conversations held in Maine and at some national conferences.

An example of a changed view: a physician commented negatively about the project's recommendation for some kind of continued competency assessment after reviewing our initial draft of recommendations in early 1995. But in the October 2, 1995, issue of the *American Medical News,* he was quoted as saying "CME (continuing medical education) requirements are 'better than nothing, but if you're snoozing in the back of the room waiting to play golf, it doesn't mean much.' He says the Maine panel's recommendations for continued competency testing are on-target, even though they offer no specifics on mechanisms to be used."

CME (continuing medical education) requirements are 'better than nothing, but if you're snoozing in the back of the room waiting to play golf, it doesn't mean much.'

And he wasn't alone. There seemed to be a developing consensus that continued competency assessment was necessary. The question was how to do it well, easily, inexpensively, and appropriately. The November 1996 conference was an outgrowth of this discussion.

The conference was titled "Practicing for a Lifetime: Continuing Competency in the Health Professions." There were about 130 participants at the Lewiston conference. (See Appendix C for conference agenda.) Conference presentations included:

- ★ Pew: Next steps
- ★ Rising to the challenge: Can licensing move beyond continuing education?
- ★ Patient-oriented outcomes data management: What are the issues that arise and what are the appropriate responses?
- ★ Assuring quality for the public
- ★ Using data base management as a competency assessment tool
- ★ The dental boards' approach to continued competency
- ★ Through the Patient's Eyes
- ★ Use of computerized simulations (CST) to measure decision-making competency in the nursing management of client care
- ★ Assessing clinical competence of medical students using an actor trained to be a standardized patient

At least two national conferences for health professionals and consumers have also focused directly on continued competency assessment:

1. The Citizen Advocacy Center's conference "Continuing Professional Competence: Can We Assure It?" Washington, D.C., December 16-17, 1996.

2. The Interprofessional Workgroup on Health Professions Regulation "Continued Competency Summit: Assessing the Issues, Methods, and Realities for Health Care Professions," Chicago, Illinois, July 25-26, 1997.

Additional conferences and literature are now stressing closely related issues of outcomes and quality improvement in the practice setting.

Draft Revised Recommendations (June 1997)

The June 1997 newsletter contained "Draft Revised Recommendations for Improving the Public Policy for Regulating Maine's Health Professionals." The revisions were made after reviewing hundreds of pages of notes of comments by Mainers from the focus groups, meetings, phone calls, written responses, and conversations discussed above.

A workshop on the draft revised recommendations was held in Waterville, a central location, on June 24, 1997. Few people attended, but a discussion on regulatory policy included suggestions for further revisions. As a result, changes were made in the draft revised recommendations. Additions included definitions of professional competence and quality, a recognition of the importance of stakeholder advocacy in addition to unbiased expert advice, and recommendations concerning unlicensed personnel, the balancing act of confidentiality and informed consent, national data banks, and the focus of regulatory board efforts. See page 38 for the project's final recommendations.

David Swankin, President of the Citizen Advocacy Center, and Christine Gragnola, Program Manager for the States Initiatives Grant Program of the Center for the Health Professions at the University of California at San Francisco, were both presenters at the project's November 1996 conference.

The Context in Which Maine's Regulatory Policy Efforts are Taking Place

Lack of Comprehensive Health Care Reform at the Federal Level

When the project started in June 1993, the debate had not begun about President Clinton's comprehensive health care reform proposal. The President's Health Security Act contained several proposals for health workforce reform, including expansion of the role of mid-level practitioners. The Health Security Act also contained a recommendation calling for a federal override of restrictive state practice laws: "—No state may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals." (Title I, Subtitle B, Part 6, Sec. 1161.) That recommendation was a far cry from traditional state jurisdiction over occupational licensing.

Although the Health Security Act contained several health workforce proposals, including the override proposal, the financing and delivery of health care and the federal government's organizational role were the focus of the public debate.

In 1993-94 most states postponed enacting major health care reform, in anticipation of comprehensive reform at the federal level. The Clinton health care bill died at the end of 1994. The Kassebaum-Kennedy bill, enacted as the Health Insurance Portability and Accountability Act of 1996, contained some major reforms, especially about portability of insurance, and boosted electronic records, but was not considered comprehensive health care reform.

As a result of federal inaction, states began or renewed their efforts to examine health system reforms that could be made at the state level. Maine's and other states' traditional health system role includes serving as payer for state employees' health plans and Medicaid and being responsible for Medicaid policy, state hospitals for the mentally ill, workers' compensation laws, regulation of health insurance companies and managed care organizations, state university and technical college health professional educational programs, the regulation of health facilities and integrated health systems, and the licensing and regulation of health professionals.

Several states are evaluating or have recently reformed their licensing systems for health professionals as part of their efforts to improve their health systems. Arizona, Colorado, Connecticut, Kansas, Nebraska, Utah, Vermont, Virginia, Washington, and Wisconsin are among those states.

Managed Care

In addition and of importance, the state is a major payer in the market-driven system financing the state employees' health plan and part of the Medicaid program. Maine Medicaid is

moving toward managed care, starting with the Temporary Assistance to Needy Families Program, formerly the AFDC population.

In 1996 the Maine Legislature created the Health Plan Improvement Act which requires carriers offering managed care plans to:

1. provide an appeal procedure for denial of credentialing;
2. allow participating practitioners to advocate for medically appropriate care without fear of discipline; and
3. maintain a grievance procedure for enrollees.

Carriers were required to provide a description of the plan, including but not limited to coverage provisions and exclusions, procedures that could result in denial of coverage, whether provider contracts call for capitation or fee-for-service payments, and plan provisions for co-payments, renewal terms, and accessibility of services.

Managed care is bringing with it more cost awareness and what may be a paradigm shift from emphasis by a profession on protecting the patient to promoting positive, measurable outcomes on health status or quality of life. It is a struggle as we move from an acute care to a prevention and management model. There is greater emphasis on ambulatory care, primary care, and early intervention, and the use of mid-level practitioners. Is this reform or change? There is no question but that health care is more intensively managed. One way to protect the public from harm during this drastic change period is by informing and empowering consumers.

Sharon Marden Johnson is a registered massage therapist providing services in Maine.

Self Care and Complementary Medicine

Self care and complementary medicine are becoming mainstream. Mind/body medicine has proponents like Andrew Weil, MD, and Deepak Chopra, MD, who appear to be very much accepted in the national medical community and by the population at large.

Chiropractors are generally included in the definition of complementary or alternative medicine practitioners along with acupuncturists, naturopaths, homeopaths, and massage therapists. Chiropractors are generally included in insurance plans and are pursuing outcome studies for increased credibility. Acupuncturists now number about 50, compared to only eight when they were first licensed in Maine 11 years ago. Massage therapists are registered in Maine. Naturopaths became licensed in Maine in 1996 and share with acupuncturists a regulatory board called the Board of Complementary Providers.

The National Institutes of Health (NIH) now has an Office of Alternative Medicine. NIH is one of eight health agencies of the U.S. Public Health Service and is part of the U.S. Department of Health and Human Services. The Office of Alternative Medicine's mission is to identify and evaluate unconventional health care practices and support, coordinate and conduct research and research training on these practices and disseminate information. Seven broad categories of complementary and alternative medical practices have been classified:

- alternative systems of practice
- bioelectromagnetics applications
- diet/nutrition/lifestyle changes
- herbal medicine
- manual healing methods

- mind/body interventions
- pharmacological and biological treatments

Modern Technology Tools and Telemedicine

Computers, computerized medical records, and knowledge-coupling can dramatically change health services delivery. Computerized accounting records (with primary diagnosis) are used in most health services delivery settings. Yet computerized medical records are more slowly coming into use. A 1994 report estimated that only 1% of medical records were computerized. (Ornstein, 1994.) Once the records are computerized, we can expect computer programs that will provide instant feedback to diagnosis and treatment decisions.

Other major tools include magnetic resonance imaging (MRI) and laparoscopes.

The new technologies allow images to be sent across state lines and national borders. With telemedicine and the prospect of a practitioner in one state and a consumer in another, questions arise about inter-state and international regulation. The debates are beginning with varying views about appropriate public policy. Where should the practitioner be licensed? Disciplined? Should there be a separate or special license to practice telemedicine? If so, should it be a national license? Some of the alternative approaches to licensure for telemedicine include consulting exceptions, endorsement, mutual recognition, reciprocity, registration, and limited licensure. (U.S. Department of Commerce, 1997.)

Progress in Improving Maine's Health Professions Regulatory System

Administrative

There have been numerous positive changes in the state's administration of its occupational regulatory system. There was an administrative upgrade in the department associated with the regulatory boards effective January 1, 1996. A policy level manager now heads the new Office of Licensing and Registration, which has begun issuing a quarterly newsletter.

Licensing boards and professions are communicating more often and about policy issues. One example is the medical boards' sponsorship in the fall of 1996 of a workshop on sexual misconduct to which representatives from the other health boards were invited, followed by a new rule to make sexual boundaries for physicians more explicit.

In January 1997 the Department of Professional and Financial Regulation sponsored a board member conference titled "Protecting the Public: The Role of Professional and Occupational Licensing Boards in Maine." There were videotaped opening remarks from Governor Angus King and remarks from Commissioner S. Catherine Longley, followed by:

- a panel addressing the mission of regulatory licensing boards—public protection and board and association roles, board composition, and conflict of interest issues;

- a panel focusing on the nuts and bolts of the complaint process;

- a panel discussing "How is the System Working?";
- an ethical conduct workshop looking at ethical decision-making models.

The Maine State Board of Nursing held a conference in April titled "Professional Boundaries, the Nurse's Challenge," to which others were also invited. Professional boundaries, boundary crossings, boundary violations, and professional sexual misconduct were defined. In July the Department held a second conference, this one for health professional regulatory board members. Professional boundaries were again discussed.

The medical and optometry boards are distributing helpful informational pamphlets in their practice settings. Maine's allopathic medical board recently began issuing a newsletter, and the State Board of Nursing publishes final disciplinary actions in its newsletter. The Board of Podiatric Medicine, the Board of Social Worker Licensure, and the Board of Dental Examiners also issue a newsletter. In addition, the Maine Board of Pharmacy issues a newsletter in conjunction with the National Association of State Boards of Pharmacy.

Legislative

This project neither lobbies nor initiates legislation, because the ultimate goal is to create a climate where future policymakers will without hesitation improve the regulatory system and those decisions will be applauded or at least accepted by the stakeholders. Yet laws enacted in 1995-1997 are consistent with the project's preliminary recommendations.

In 1995 major change was enacted allowing Advanced Practice Registered Nurses to practice independently if they had practiced for two years under the supervision of a physician or if working in a facility in which a licensed physician serves as medical director.

In 1996 the following new laws were enacted:

- requiring an annual health workforce forum to be convened by the Commissioner of the Department of Human Services;
- calling for a state health plan to identify health care facility and human resource needs and resources available, and to make recommendations for addressing those needs on a statewide basis;
- approving of the development of a Maine Center for Public Health Practice, using a consortium of public and private organizations;
- creating a Maine Health Data Organization;
- establishing the Board of Complementary Health Care Providers to regulate the practice of naturopathic medicine and acupuncture;
- granting denturists, optometrists, and psychologists more authority;
- clarifying that nurses may provide coordination and oversight of patient care services provided by unlicensed health care assistive personnel;
- providing a sunrise review process for professional regulation.

The Context in Which Maine's Regulatory Policy Efforts are Taking Place

An Act to Revise the Sunrise Review Process for Occupational and Professional Regulation (P.L. Ch 686) provides that, after receiving legislation to regulate or substantially change the regulation of a profession, the legislative committee will informally review it and choose a method of sunrise review: (1) immediately hold a public hearing, (2) request that the Commissioner of the Department of Professional and Financial Regulation (DPFR) conduct an independent assessment, or (3) request that the Commissioner establish a technical committee to evaluate.

The commissioner may develop standardized questions designed to solicit information concerning the evaluation criteria. The preauthorization evaluation criteria are:

1. Data on group. A description of the professional or occupational group proposed for regulation or expansion of regulation, including the number of individuals or business entities that would be subject to regulation, the names and addresses of associations, organizations and other groups representing the practitioners and an estimate of the number of practitioners in each group;

2. Specialized skill. Whether practice of the profession or occupation proposed for regulation or expansion of regulation requires such a specialized skill that the public is not qualified to select a competent practitioner without assurances that minimum qualifications have been met;

3. Public health, safety, welfare. The nature and extent of potential harm to the public if the profession or occupation is not regulated, the extent to which there is a threat to the public's health, safety or welfare and production of evidence of potential harm, including a description of any complaints filed with state law enforcement authorities, courts, departmental agencies, other professional or occupational boards and professional and occupational associations that have been lodged against practitioners of the profession or occupation in this state within the past five years;

4. Voluntary and past regulatory efforts. A description of the voluntary efforts made by practitioners of the profession or occupation to protect the public through self-regulation, private certifications, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public;

5. Cost, benefit. The extent to which regulation or expansion of regulation of the profession or occupation will increase the cost of goods or services provided by practitioners and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers;

6. Service availability of regulation. The extent to which regulation or expansion of regulation of the profession or occupation would increase or decrease the availability of services to the public;

7. Existing laws and regulations. The extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from nonregulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners;

8. Method of regulation. Why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate;

9. Other states. A list of other states that regulate the profession or occupation, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on the profession or occupation in terms of a before-and-after analysis;

10. Previous efforts. The details of any previous efforts in this state to implement regulation of the profession or occupation;

11. Mandated benefits. Whether the profession or occupation plans to apply for mandated benefits;

12. Minimal competence. Whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are; and

13. Financial analysis. The method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonably financed by current or proposed licensees through dedicated revenue mechanisms.

Maine Health Care Reform Commission

The workforce forum, Maine Health Data Organization, Maine Center for Public Health Practice, and inclusion of health personnel resources and needs in the State Health Plan were outgrowths of the recommendations of the Maine Health Care Reform Commission. The Maine Health Care Reform Commission was established in mid-1994 to develop three models for health care delivery and financing reform, as well as to propose a health data collection system. The commission issued a final report in November 1995.

The three-member commission was appointed by the Governor, the President of the Maine Senate, and the Speaker of the House of Representatives. The director of this health professions regulation project served as chair of one of several subcommittees, the Advisory Committee on Accountability. Of interest to this project was the concern expressed by another subcommittee, the Advisory Committee on Governance/Administration. Its final report, dated February 16, 1995, said that some subcommittee members expressed concern about the lack of uniformity of professional licensing across the country and suggested that the Commission and Legislature may want to advocate for national professional licensing standards.

At one point the Commission was prepared to include in its proposals a recommendation from this project for an advisory federation of Maine's health profession regulatory boards. Because of objections, the Commission instead suggested that the recommendations of the Maine Health Professions Regulation Project, including its recommendation for a federation of licensing boards, be considered by the health care workforce forum. (Maine Health Care Reform Commission, 1995.)

Audiologist Anne Giroux tests the hearing of Luis Lopez at MaineGeneral Medical Center's Dr. F.T. Hill Center in Waterville.

Final Recommendations for Improving Maine's Health Professional Regulatory System

Statement of Problems, Discussion, and Public Policy Recommendations for the Licensing System and Suggestions for Implementation

Based on over four and a half years of effort, these are presented to the people of Maine and its governing bodies as guidance for achieving the goal of an improved regulatory system for health professionals, with the ultimate goal of improving the health system for and the health status of the people of Maine.

ISSUE NUMBER 1: Standardization of Terms and Uniform State Credentialing Forms, Archives, and Laws

Problems:

- Lack of communication is a serious problem because of the traditional separation between the professions and between their regulatory boards. The immense difficulty health care managers, payers, other practitioners, and consumers have in trying to understand a health care professional's skills is exacerbated by the lack of uniform state standards and laws. Lack of uniform state laws adds to the seriousness of the communication problem.

- The public does not understand the language that a profession is using and the professional's competencies. The regulatory literature traditionally refers to three levels of state regulation of the health professions: licensure, certification, and registration. When used in state law, the term "certification" can confuse as much as enlighten.

- We hear complaints about expensive and time-consuming duplication fulfilling paperwork credentialing requirements and providing validated credentials. Now that managed care organizations as well as hospitals require credentialing of physicians and other health professionals, duplicative applications and validation need to be replaced.

Discussion: Improving communication among health professions and their regulatory boards within a state and between states is a key goal. Health care practitioners and regulators need to know what practitioners or other health care fields can and cannot do, if they are to provide complete but non-duplicative patient care. Mainers need to be able to understand the language that a profession is using and the professional's competencies. This is especially important with an aging population needing health care services, telecommunication and telemedicine, more in-home care, more unlicensed care givers, and the voluntary nature of specialty certifications.

Final Recommendations for Improving Maine's Health Professional Regulatory System

Discussion in the 22 focus groups held throughout Maine in 1996 strongly supported standardizing definitions, uniform state laws, and endorsement. The focus groups also agreed that communication is a serious problem. Suggestions were made to remove residential requirements between states and link uniform standards to outcome work.

(a) Terminology

"Regulatory transparency" is a goal of European regulatory models: The goal is to have 99% of consumers understand a regulation when they read it. In this country the regulatory literature traditionally refers to three levels of regulation of the health professions: licensure, certification, and registration. Yet none of these words has a fixed, consistent meaning.

"Certification" is an especially confusing regulatory term. It is used in both the private sector and public sector (i.e., both without and with the official sanction of the state). It is applied to facilities, and to other entities, in addition to credentialing health professionals.

"Registered" also means a variety of things in Maine and in other states. For example, a "registered" nurse (RN) is licensed. A certified nursing assistant (CNA) is listed on a registry, but not licensed.

A couple of years ago, the Maine Legislature enacted some changes in state laws to provide more consistency in the language, but there are still large inconsistencies between the practice acts for different health professions. (See attached glossary of regulatory terms.)

An occupational therapist from Alpha One instructs a man with a spinal cord injury on how to use his new adapted van.

(b) Credentialing

Through our focus groups and in other discussions we have heard complaints from physicians about the expense and time-consuming duplication fulfilling paperwork credentialing requirements, now that managed care organizations in addition to hospitals require credentialing. To address this problem, the Maine Hospital Association, the Maine Medical Association, and the Maine Department of Professional and Financial Regulation have together worked on the development of a uniform application for credentialing Maine physicians. The Maine Board of Licensure in Medicine is accepting core credentials collected and submitted by the Federation Credentials Verification Service. This service was created in 1996 by the Federation of State Medical Boards to provide a centralized, uniform process for state medical boards and other entities to obtain a verified, primary source record of a physician's core credentials.

(c) Interstate standardization

It is also confusing when regulatory laws for one profession vary so from state to state, when the sole reason for the laws is to protect the public. One area of variance is the delegation of responsibilities within scopes of practice. For example, in Maine, nurses can only delegate to licensed nursing personnel—although they can supervise and oversee unlicensed assistive personnel—while in Colorado nurses can delegate to unlicensed personnel.

Many of the national health professional associations and organizations of state regulatory boards make available model practice acts. The National Council of State Boards of Nursing recently formed a task force to develop a regulatory concept incorporating characteristics of a multistate license. Agreeing that regulatory reform is necessary to meet the needs of a changing health care delivery environment, the task force answered the question, "Why?" with the following:

Final Recommendations for Improving Maine's Health Professional Regulatory System

1. New practice modalities and technology are raising questions regarding issues about compliance with state licensure laws.
2. Nursing practice is increasingly occurring across state lines.
3. Nurses are practicing in a variety of settings and using new technologies.
4. Expedient access to qualified nurses is needed and expected by consumers.
5. Expedient authorization to practice is expected by employers and nurses.
6. Having a nurse demonstrate the same licensure qualifications to multiple states for comparable authority to practice is cumbersome and is neither cost-effective nor efficient. Therefore, there is a question as to the effectiveness of the current regulatory system in meeting the mandate to protect the public in the changing health care delivery environment.

The International Certification Reciprocity Consortium on Alcohol and Other Drug Abuse is working toward uniform standards and uniform state laws. About 38 states have similar laws now, according to the Chair of the Maine Board. Various titles for the same practitioner are being changed across the country to be standardized to Alcohol Drug Counselor.

Recommendation 1A: Regulatory terms in Maine's public law regulating health professionals should be standardized.

To lessen confusion, we propose that Maine and its regulatory boards adopt these regulatory definitions suggested by the National Society of Professional Engineers:

1. "Licensure" is the process whereby a governmental authority, in accordance with state statute, determines the competency of individuals seeking to perform certain services. Through licensure, state governments grant individuals the authority to engage in an area of practice, generally to the exclusion of others, based on demonstrated education, experience, and examination. Licensees are required by law and code of ethics to faithfully discharge their responsibilities impartially and honestly. As a general rule, state governments possess the authority to discipline licensees who fail to comply with statutes and regulations and to take action against unlicensed individuals who practice within the scope of a licensed profession or occupation.

2. "Certification," unlike licensure (which is authorized by state statute), is the process whereby a profession or occupation voluntarily establishes competency standards for itself. Certification plays a helpful role in protecting the public, especially in cases where the state legislatures have not opted to regulate the profession or occupation through licensure. However, there are broad variations in this voluntary process. Some certification organizations require the completion of rigorous education, experience, and examination criteria. Others, unfortunately, do not. The private sector has established organizations to review and verify (accredit) the integrity of these certification programs. However, certification organizations are not required to submit their programs to such accreditation. Also, unlike licensing authorities, certification organizations lack the authority to limit incompetent or illegal practice.

3. "Registration" is the process by which an individual is listed as eligible to provide a regulated service. Not all registration processes require the demonstration of competency in that service... (Engineers, 1996.)

Other terms that are commonly used should also be identified and standardized.

Recommendation 1B: The Department of Professional and Financial Regulation (DPFR) and the regulatory boards should streamline the credentialing process.

The Department of Professional and Financial Regulation and Maine's regulatory boards should:

1. Streamline Maine's credentialing process.

2. Provide leadership in urging national organizations of health profession regulatory boards to provide for each profession
   (a) a national archive for a verified, primary source record for core credentials, and
   (b) uniform credentialing applications.
   (Such archives and applications could be modeled on those now used in the medical profession.)

Recommendation 1C: The Department of Professional and Financial Regulation (DPFR) and regulatory boards in Maine should pursue public policy that would lead to uniform state laws and endorsement while assuring public protection and quality health services.

DPFR and the regulatory boards should:

1. Authorize "endorsement," recognition of licenses issued in other jurisdictions, when the licensees meet the same standards as Maine applicants.

2. Pursue public policy that would lead to uniform state laws by working with other states while assuring public protection and quality health services.

3. Encourage the national organizations of other health professions to explore the topic of multi-state regulation. (The Council of the State Boards of Nursing is developing a prototype.)

John Koons, DMD, practices dentistry in Waterville.

ISSUE NUMBER 2: Professional Competency, Continued Competence, and Quality of Care

Problems:

- There has been little agreement on definitions of professional competence or quality of health care.

- Maine law does not generally assure remedial preparation or assessment for re-licensure of health practitioners who have not practiced for a long period. Nor do most boards currently address continued competence unless there is a complaint about a practitioner.

- The regulatory system has not adapted to the changing practice environment and different practice settings. Historically, health professionals practiced in isolation; now they often work as part of a team. Although organizational networks are rapidly being established, not all practitioners are associated with a network. Different practice settings offer different opportunities for measuring and assuring competency of practitioners.

- Assessing competence is difficult because outcome information is not yet readily available for many health services.

Final Recommendations for Improving Maine's Health Professional Regulatory System

- Appropriate roles for unlicensed assistive personnel have not been defined to the satisfaction of many health practitioners. Nor is use of unlicensed assistive personnel formally tracked.

Discussion: The most important principle underlying the regulatory system for health practitioners continues to be the need to "protect the public." Yet questions of access and cost effectiveness cannot be totally ignored by public policymakers as the quality questions of competency and continued competency of practitioners are reviewed.

Any state license for a health professional should be a legitimate credential that health care consumers and managers can "count on" when attempting to hire competent practitioners.

The Pew Health Professions Commission published its first report in 1991 titled *Healthy Practitioners: Practitioners for 2005*. The Commission suggested the following competencies practitioners should have to meet society's evolving health care needs:

Any state license for a health professional should be a legitimate credential that health care consumers and managers can "count on" when attempting to hire competent practitioners.

- Expand Access to Effective Care
- Provide Contemporary Clinical Care
- Ensure Cost-Effective and Appropriate Care
- Practice Prevention
- Involve Patients and Families in the Decision-Making Process
- Promote Healthy Lifestyles
- Assess and Use Technology Appropriately
- Improve the Health Care System
- Manage Information
- Understand the Role of the Physical Environment
- Provide Counseling on Ethical Issues
- Accommodate Expanded Accountability
- Participate in a Racially and Culturally Diverse Society
- Continue to Learn (Pew, 1991)

In addition, the College of Nurses of Ontario in its Quality Assurance Program states that Competence requires Knowledge + Skill + Judgment + Application, and is modified by Attitude and equals Quality Care/Service Outcomes. (Risk, 1996.)

Recognizing the importance of evaluating competency goals, the faculty of Maine's medical college, the University of New England College of Osteopathic Medicine, has approved a listing of expectations of its graduates, following an exhaustive process framing a set of competencies. (See Appendix G.)

Some of the questions about competency that arise are (a) "What is the issue regarding competency?" (b) "How do we determine competency?" (c) "Who decides?" and (d) "How do we regulate within various levels, specialties, and practice settings?"

(a) Continued competency

A national Inter-professional Workgroup consisting of 16 organizations from 15 health professions representing regulation or national certification of health professionals has defined professional competence in this way: "the application of knowledge and skills in interpersonal relations, decision making, and physical performance consistent with the professional's practice role and public health, welfare, and safety considerations. In many

professions, the requisites of competence change over time as various factors reshape the scope of practice and as the individual practitioner specializes." (Inter-professional Workgroup, 1996.)

"While probably insuring minimal competency upon entry into regulated practice, licensure—as currently practiced—provides no guarantee of continued competency, and there is no evidence that licensure is tied directly to positive outcomes." (Morrison, 1994.)

Discussions following issuance of the 1995 recommendations and in the focus groups indicated general agreement that continued competency needs to be addressed. The question is how to implement continued competency assessments, both for busy practitioners and for those who have taken a break from a profession and are returning to it.

In Maine, a health practitioner who has not practiced for many years, but who has continued to pay the relicensure fee, can usually re-enter practice without reexamination. Generally, laws do not require any continued competency assessment. Some boards require continuing education and see that as a means of assuring continued competency. Health professionals should be encouraged to avail themselves of it as part of an individual's own professional growth program. But unless there is an assessment accompanying the continuing education program, it cannot be considered a continued competency assessment.

"While probably insuring minimal competency upon entry into regulated practice, licensure—as currently practiced—provides no guarantee of continued competency, and there is no evidence that licensure is tied directly to positive outcomes." (Morrison, 1994.)

Egregious incompetencies are brought to the attention of the regulatory boards, which can discipline the offender or, through the courts, suspend or revoke the license.

(b) "How do we determine competency?"

Health care professionals feel strongly that they must have continuing input into changes in their profession. The professionals want to be and should be involved in the determination of standards for their profession. In the project's focus groups, participants mentioned frequently that measures of competency involve more than a sum of isolated tasks that are delegated. The project's focus group participants stated their preference for outcome based standards for determining competency.

New assessment tools are in the process of development. They include actors trained as standardized patients, used in Maine by the University of New England College of Osteopathic Medicine, computer simulations and knowledge couplers, interactive videos, and patient-oriented data management. The computer has the potential of providing immediate feedback to practitioners.

While pointing out that medicine has been a front-runner in evaluating practitioners' performance, M. Roy Schwarz, M.D., the American Medical Association's group vice president for scientific, educational and practice standards, was quoted in an article in the *American Medical News* saying, "Once you can truly profile performance off of preset standards, the issue will be if you're competent to perform this service, not whether you're an MD or a guardian angel." According to *AMNews,* Dr. Schwarz says competency testing is reasonable as long as it's not too burdensome on providers. Evolving computer technology should make it increasingly feasible. (Prager, 1995.)

Final Recommendations for Improving Maine's Health Professional Regulatory System

The State of Washington's Department of Health established a Task Force that recommended the following ways to address competence of its health professionals:

- Establish a performance based and measured health profession regulatory and education system.
- Develop a system where education curricula and regulatory requirements are developed collaboratively and are based on current and future needed competencies.
- Use assessment models developed in non-health and health-related professions as a guide to develop a system for assuring health professional competency.
- Develop a regulatory system that is not based primarily upon initial formal education in a particular field, but allows all competent persons to become credentialed.
- Develop examinations that more accurately reflect ability to perform in a competent manner.
- The department and the regulatory bodies should help promote meaningful outcomes research. (Washington, 1995.)

"Once you can truly profile performance off of preset standards, the issue will be if you're competent to perform this service, not whether you're an MD or a guardian angel."

(c) "Who decides?"

Objective expert advice for legislative policy-making about a health profession's competencies for a "scope of practice" has traditionally been lacking. Since it is expected that the Legislature will continue to make the final decision about a scope of practice actually enacted into law, those with expertise need to share that information objectively with the Legislature.

Validated and reliable mechanisms for assessing initial and continued competence of practitioners should continue to be developed by public and private sector credentialing entities as well as by the testing experts, according to the Interprofessional Workgroup. The Workgroup says that the health professions are working toward assuring continued competence, but are facing numerous barriers such as cost and specialization. It recommends that "requirements for licensure (continued or initial) not be based on any one assessment but be broad-based and include formal education, supervised clinical experience, and examinations." (Interprofessional Workgroup, 1996.)

The project's 1995 recommendations made it clear that the project did not support replacing individual licensure with licensure of the institution. The project's focus group participants agreed with that position, concerned about the potential conflict of interest between watching the financial statements and high quality services. They were interested in how managed care fits into the competency question and had questions about multi-skilling. Concern was also expressed over unlicensed personnel related to delegation and supervision issues. One comment: "What about schools where so many children are mainstreamed and needing medication? We can't expect nurses everywhere all the time."

The National Council of State Boards of Nursing pointed out the central role that educational programs play in the development of competence. "Some overlapping of scopes of practice currently exists between medicine, nursing, physical therapy, respiratory therapy, radiological technology, occupational therapy, counseling, etc. Educational programs need to prepare persons to be competent before the regulatory body can measure that competence and authorize practice in an expanded scope." (National Council of State Boards of Nursing, 1996.)

(d) "How do we regulate within various levels, specialties, and practice settings?"

Protecting the public should incorporate the concept that the health system performs effectively for the consumer. Historically, practitioners practiced in isolation. Now they work within a team. We need to license the individual still. But we need to assure the individual's competence as a member of the team.

Although an assessment does not necessarily accompany a physician specialty certification, the medical specialty boards are moving toward assessing at the time of recertification. The 1995 preliminary data from the Maine Physician Resource Inventory found that 57% of the respondents indicated they were Board certified, a significant decline from 68% in 1994.

What about those who are not Board certified? Physicians and other practitioners associated with hospitals generally are assessed periodically for their work within the hospital, but the hospital will not have data on them from their office practices. A 1993 Maine Medical Assessment Foundation analysis found 106 Maine family/general practitioners and general internists whose practices consisted of 40 or more outpatient claims and fewer than ten inpatient claims. (Keller, Soule, Schneiter, and Wennberg, 1996.) HMOs are doing some assessment of some physicians in their office settings. Although networks are being rapidly established, there will continue to be a gap in assessment for solo health practitioners.

Pharmacists and their practice settings are linked in their practice act. Other professions are interested in the concept of evaluating in the context of the environmental setting. The Ontario College of Nurses now includes in its profiles of individual licensees information about the practice setting. Practice setting can be defined by location, home care, hospital, prehospital, ambulatory, or, as Maine social workers do, by duties, clinical versus administrative.

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

To illustrate a varied practice, a podiatrist at one of the project's focus groups described his general practice in northern Maine: two days a week in nursing homes, one day at a mental health institute, some surgery, and more. He remembers starting out 19 years ago and the road to eventually getting hospital privileges. To meet his surgical organization's certification for surgery, he must now be re-tested every ten years.

Through our focus groups, Maine health professionals have made it clear that they prefer educational, not punitive, methods of assuring Maine health practitioners' competency. They would like to see appropriate remediation if deficiencies are identified. Monitoring is appropriate in some cases. Professionals appear to prefer regulation by peers. Peer review should be a means of assessment whenever feasible.

Before ending the discussion of competency issues, project staff believes it is necessary to repeat that communication between practitioners and consumers, between professions, and between regulatory boards is a serious problem in that there is a lack of understanding about a profession's competencies.

Recommendation 2A: All involved with the health system should develop consensus about definitions of professional competence and quality of care.

To aid dialogue, we propose that the Maine health system and its regulatory boards use the following definitions of professional competence and quality of care until a consensus is reached on better definitions:

Professional competence: "the application of knowledge and skills in interpersonal relations, decision making and physical performance consistent with the professional's practice role and public health, welfare and safety considerations." In many professions, the requisites of competence change over time as various factors reshape the scope of practice and as the individual practitioner specializes. (A national Interprofessional Workgroup consisting of 16 organizations representing regulation or national certification of health-care professionals has defined "professional competence" in this way. "Response of the Interprofessional Workgroup on Health Professions Regulation to *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*," November 1996.)

Quality, as defined by the Institute of Medicine (IOM): "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The IOM definition (of quality) suggests that (1) quality performance occurs on a continuum, theoretically ranging from unacceptable to excellent; (2) the focus is on services provided by the health care delivery system; (3) quality may be evaluated from the perspective of individuals or populations; (4) research evidence must be used to identify the services that improve health outcomes; and (5) in the absence of scientific evidence regarding effectiveness, professional consensus can be used to develop criteria. (Lohr, 1990 as noted in E. McGlynn, 1997.)

Quality, as defined by the Institute of Medicine (IOM): "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

The State Health Plan for Maine: 1997, published by the Department of Human Services' Bureau of Health, discusses the concept of quality:

> The concept of quality is an evolving one and is multidimensional. The domains of quality include: (1) efficacy or outcome of health care interventions; (2) the appropriateness of care based on professional consensus; and (3) patient satisfaction. Some current formulations also include measures of patient-defined outcomes and patient assessment of technical quality. However, there is less consensus in the field about including these domains in the measurement of quality.

Recommendation 2B: Competency standards should be reviewed periodically—for entry to practice and for resuming practice after a hiatus. In addition to assuring minimum quality at the beginning of a career, each health professional regulatory board should establish requirements for continued competency. Maine's regulatory boards need to develop competency policy and standards related to continued competency. There needs to be continuous feedback from educational programs and practice environments about competencies. These in turn need to be incorporated into competency standards and assessments.

Each regulatory board should:

1. Plan to set aside blocks of time to discuss competency policy and standards.

2. Provide for ongoing feedback about needed competencies from educational programs and practice environments.

3. Write rules setting forth minimum standards for competence and continued competency. The boards need to be granted a reasonable time period to develop these rules for the professions they regulate.

4. Evaluate whether periodic professional or network credentialing, peer review, or other assessing techniques may substitute for or supplant the need for continued competency assessment by the boards. Each professional should be required to demonstrate to the board that he or she is involved in a network or system that periodically assesses competence.

5. Require a competency assessment of any professional who has not practiced for a predetermined time frame.

6. Provide competency assessments that are outcome-oriented, to the degree that information is available, and tied to patients' health status.

7. Clarify supervision and delegation issues for practitioners who are licensed by different boards.

8. Encourage continuing education, but discourage its use as a substitute for assessing continued competency unless its validity for that purpose is confirmed.

9. When available, take advantage of national credential archive services and the use of standardized forms. In the absence of a national archive of credentials, a professional board should (a) require original transcripts and (b) validate credentials.

10. Require all licensees to have a formal relationship with one or more of the following: integrated network, school, hospital, health center or agency, personnel-enhancing technologies including computer tools, other practitioners, professional association, peer review or consultation, and monitoring.

Chiropractor Kevin Hagerty explains an x-ray to a patient.

Recommendation 2C: Maine regulatory boards and health professionals should support the continued and expanded use of modern technology tools to enhance traditional competency assessment.

Each regulatory board should consider a variety of options, such as the use of computer simulation for demonstrating competence and continued competence.

Each licensee should avail him/herself of computer programs designed to provide immediate feedback on diagnosis and treatment decisions and enlarge the licensee's memory capacity.

Recommendation 2D: Maine should work with other states to develop uniform national entry-to-practice standards and national competency exams. Maine regulators should recognize the work of the federations or councils of state boards, inter-professional workgroups, and state and national professional associations in this public/private partnership effort.

Maine leaders of health care delivery organizations and education programs for health professionals should join Maine's regulators in this effort.

The health professional associations should continue to play a major public/private partnership role in developing appropriate assessments for competency.

Recommendation 2E: The health system should track the use of unlicensed assistive personnel as part of the development of an information base for use in comprehensive health planning. All involved with the health system should work together to develop consensus about appropriate roles for unlicensed assistive personnel.

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The Department of Human Services (DHS) should track the use of unlicensed assistive personnel in the various practice settings, including hospitals, long term care and assisted living facilities, and home care.

DHS and the Department of Professional and Financial Services should encourage a dialogue and the development of a consensus about the roles and regulation of unlicensed assistive personnel.

ISSUE NUMBER 3: Inter-Professionalism

Problems:

- While the purpose of licensing the health professions is to protect the public from harm, the overall effect of exclusive scopes of practice can limit access to safe health services.
- Health professionals recognize that separatism among the health professions has resulted in sparse communication and understanding of others' skills by individual health professionals, health care managers, payers, and consumers.
- The licensure of the health professions occurs without formal mechanisms for regular inter-professional dialogue to discuss shared regulatory policy issues, to reduce turf battles, and to provide expert advice to the Governor and Legislature.
- Even with the 1996 law requiring an annual health work force issues forum, the current system offers too little opportunity for inter-professional discussion of regulatory changes that could improve health care and enhance public safety. Many important issues—pain management, better in-home care, preparation for a rabies outbreak, or caring for Maine's aging population, for example—require the attention of practitioners in more than one health profession.

Discussion: Licensure is a privilege granted by the state, but not a privilege that should be withheld inappropriately for the purpose of creating monopolies. Instead of exclusive monopolies, inclusive law where all who meet the competency test can perform the services, and including the incorporation of procedural protections, may be a more reasonable exercise of state powers under the U.S. Constitution. While the purpose of licensing the health professions is to protect the public from harm, the overall effect of exclusive scopes of practice can limit access to safe health services.

Begun and Lippincott's 1993 chart illustrates one example of possible overlapping skills and services. (See Appendix H.)

The National Commission on Allied Health presented its final report to Congress in 1995. It had this to say about inter-professionalism:

> Broad based collaboration (across allied health) would strengthen and benefit all stakeholders and expand understanding of both the issues and possible solutions...and is long overdue.
>
> The health provider community is not fully aware of the range of services that various allied health professionals provide or could provide. As a result, many opportunities for improving and coordinating patient services

Final Recommendations for Improving Maine's Health Professional Regulatory System

are missed. In general, health care communities and the individual professionals that constitute them could do a better job of communicating and sharing information across professions.

Professional associations, credentialing agencies, accrediting agencies, payers, consumer groups, and government should undertake efforts to reduce existing barriers to clinically effective and cost-efficient scopes of practice for those whose scope of training currently exceeds their scope of practice and for those who add new or multiple competencies in the future.

Some State licensure laws and scope of practice regulations are unnecessarily restrictive. They also tend to vary across states, which promotes a lack of practice pattern uniformity and decreases the ability of allied health professionals to move between states. Removal of such undue restrictions could:

- increase the availability of services to the community
- facilitate the development of innovative service delivery systems
- improve the availability of allied health professionals
- encourage role expansion
- decrease the cost of care.

Health professionals recognize that separatism among the health professions has resulted in sparse communication and understanding of others' skills by individual health professionals, health care managers, payers, and consumers. From our discussions in Maine we hear that health professionals want to learn about others' competencies.

States should convene a task force to develop model scope of practice laws and regulations. This task force should include representatives of all major stakeholders. The Council of State Governments should facilitate the development of a uniform national model.

State legislatures should examine and make necessary modifications to their State licensure laws to ensure that they do not restrict the clinical effectiveness, cost efficiency, or competent provision of care by allied health professionals.

State legislators should examine the composition of state licensing boards to increase significantly the representation of persons who are not members of the professions they oversee. The composition of the boards should be at least 50% consumers but should include members of the profession being regulated.

Currently, barriers to change include inflexible curricula, accreditation standards, licensure requirements, degree requirements, and disciplinary boundaries that prevent restructuring across the health professions. Removal of these barriers could enhance the ability of allied health educational institutions to respond rapidly to evolving work force needs.

Reduced compartmentalization of all health professions education and enhanced collaboration among programs, professional associations, and the health services industry could have positive impacts on the ability of the professions to meet evolving work force and educational demands. (National Commission on Allied Health, 1995.)

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Health professionals recognize that separatism among the health professions has resulted in sparse communication and understanding of others' skills by individual health professionals, health care managers, payers, and consumers. From our discussions in Maine we hear that health professionals want to learn about others' competencies. (See Appendix J for credential eligibility requirements for regulated Maine health professionals.)

In 1996, the Maine Legislature enacted into law a requirement that the Commissioner of the Department of Human Services call an annual health workforce issues forum. The forums will be an opportunity each year to discuss inter-professional issues that are in the forefront at that time. The new law follows:

> 22 MRSA 257 Effective January 1, 1997
>
> 257. Health workforce forum
>
> The department shall convene at least once annually a health workforce forum to discuss health workforce issues. The forum must include representatives of health professionals, licensing boards and health education programs. The forum shall:
>
> Inventory. Develop an inventory of present health workforce and educational programs; and
>
> Research. Develop research and analytical methods for understanding population-based health care needs on an ongoing basis.
>
> Through the forum, the department shall serve as a clearinghouse for information relating to health workforce issues. The department shall use the information gathered through the forum to develop its health policy and planning decisions authorized under this Title.

In an unprecedented development at the national level, an Interprofessional Workgroup on Health Professions Regulation, made up of representatives from 15 health professions, has "engaged in beneficial discussion about improvements in regulation stimulated and focused by the convergence of a number of factors..."

A Washington State Healthcare Workforce Project recommends developing interdisciplinary training models which allow providers to learn about each other's competencies and that include more effective distance learning and telecommunications options, to ensure that the health professional education and training system embodies the necessary core courses for health care workforce competency. (Washington State, 1995.)

In an unprecedented development at the national level, an Interprofessional Workgroup on Health Professions Regulation, made up of representatives from 15 health professions, has "engaged in beneficial discussion about improvements in regulation stimulated and focused by the convergence of a number of factors. The Pew Commission's Taskforce on Health Care Workforce Regulation, the sweeping changes in health care delivery systems, and the revolutionary uses of telecommunications technology for professional practice are some of these factors...The Interprofessional Workgroup offers itself as a resource to legislators, policy analysts, and other parties with interest in improving the regulation of the health care work force in this country." (Interprofessional Workgroup, 1996.)

Recommendation 3A: Health profession practice acts should authorize practitioners to provide services to the fullest extent of their competencies. The scopes of practice should be continually modified and changed to reflect the actual competencies of health professionals. The law should continue to promote overlapping skills for the provision of health services while safeguarding the public from incompetent practitioners.

The Legislature should enact practice acts that:

1. Allow monopolies to be inclusive—instead of exclusive—and acknowledge others' competencies and overlapping skills.

2. Are understandable to other professions and to the public.

The regulatory boards should develop public policy for delegation and supervision, consulting with national professional associations and federations of the professions' regulatory boards.

Recommendation 3B: Maine leaders of health care organizations and education programs should join Maine's regulators in exploring the opportunity provided by the 1996 law requiring the Commissioner of the Department of Human Services (DHS) to convene an annual health workforce issues forum to address current health professional issues in Maine.

The Commissioner of DHS should invite the Commissioner of the Department of Professional and Financial Regulation to join in the planning for the annual health workforce issues forum.

In addition to that which is required in the law, the Departments should include the following in the health workforce forum:

1. Plan for encouraging a variety of plans for effective working relationships among the professions.

2. Aid mutual understanding of scopes of practice and competencies to assist in the definition of areas where overlap is appropriate.

3. Foster inter-professional recognition.

4. Encourage the development of an inter-health-professions association.

5. Review "access" issues affected by regulation.

Shane Taylor and Steve Leach train in an ambulance with an infant mannequin.

Recommendation 3C: Maine leaders of health care organizations and education programs should join Maine's regulators in encouraging enhanced relationships among practitioners made possible by telecommunication and telemedicine and other modern technology.

ISSUE NUMBER 4: Structure and Performance of the Regulatory System

Problems:

- The traditional structure within state government for regulating health professionals has caused problems in two significant areas: it has hampered communication and coordination across the professions and among regulatory boards, and it has not supported legislative decision-making by providing objective, expert policy-making advice in addition to the expert advice from those who believe they are directly affected by a proposal. This has made the Maine legislature's job of understanding what competencies are needed for various scopes of practice difficult.

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- Historically, the health professions regulatory boards have not coordinated policy development with the Department of Human Services, the state's primary health policy agency.

- In Maine and other states, the public has not usually been involved in proposals to change the "practice acts." Nor have other health professions except those directly affected by the proposals. When two professions disagree, there have been unpleasant turf wars. Unbiased expert advice for legislative policy-making about a health profession's competencies for a "scope of practice" has traditionally been lacking.

- Although programmatic reviews of individual boards' adherence to implementation of the laws occurred under the old Sunset Act, there has been no periodic **policy** evaluation by the Legislature.

- Lack of communication and coordination between and among the health professions and their regulatory boards confuses consumers, payers, managers, and health practitioners themselves.

- Few health professionals fully understand the skills of other professions or individual practitioners, unless they work with them as team members in a system of care. The regulatory boards—even those administered by or affiliated with the same department—often have little communication with each other. Maine EMS, regulating important members of the health care team, is associated with a distant department. There needs to be much better communication among the professions and regulatory boards.

- An additional problem arises due to a vacuum created by the absence of designated statutory responsibility for developing regulatory system policy. The individual professions recommend regulatory policy for their own professions; regulatory policy affecting two or more professions or the entire health system is seldom addressed.

- When the regulatory boards are dominated by members of the profession being regulated, the perception can be that the boards are there to protect the profession more than the public.

- Regulatory board members—both professional and public members—have lacked technical support.

Discussion: Fortunately, major progress is now occurring in several of these areas. The current Commissioner of the Department of Professional and Financial Regulation (DPFR) has initiated a number of major improvements in the regulatory system, especially in the important area of communication. The Commissioner is assisted in this effort by the director of the Office of Licensure and Registration, established in 1996. The department directly administers most health professional regulatory boards and has some responsibilities regarding the five affiliated boards—dental, nursing, optometry, and two medical boards.

DPFR held its first major conference for regulatory members in January 1997 and a workshop for health professional board members in July. These conferences provide for learning opportunities and cross-fertilization of ideas. However, it is likely that even regularly scheduled conferences cannot replace a formalized mechanism for frequent inter-professional discussión and communication among the boards.

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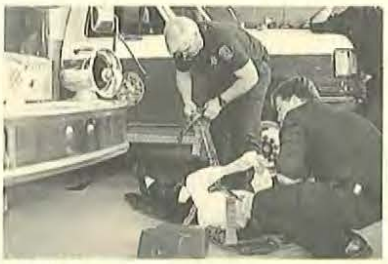
Maine's new 1996 Sunrise law is a giant leap forward, because it establishes a framework for the Commissioner of DPFR (or a task force appointed by him or her) to give advice to a legislative committee on a specific proposal for new regulation or an expanded scope of practice when a proposal is brought before a legislative committee.

It should be considered whether the Maine Department of Professional and Financial Regulation (DPFR) is the appropriate agency for the health professional regulatory boards, or if they would more appropriately reside in the state's major health agency, the Department of Human Services (DHS), where health care facilities and provider organizations are regulated. As previously mentioned, a law enacted in 1996 requires the Commissioner of DHS to hold an annual health workforce issues forum.

Wisconsin's health professional licensing boards are in a department similar to Maine's DPFR, but in their own separate "division." In Vermont, many of the boards are advisory to the Department. The 1995 Washington State Report suggestions included: (1) examine alternative structures for regulatory bodies, including the use of a regulatory oversight entity consisting of all public members or a composite body; and (2) have the boards and the department pursue those disciplinary cases related to quality of practice, and transfer all the others to another agency.

How many public members should serve on each board is an issue for consideration. There is now recognition that public members play an important role, that their membership be significant, and that they, like other board members, can serve the public best if they are provided intensive technical training and support.



Bob McMaster and Sean Goodwin train for an emergency.

The Interprofessional Workgroup believes that the addition of public members and greater diversity among practitioner members on boards have improved the accountability, credibility, and visibility of boards and further strengthened the process. It also strongly supports change for enhanced regulatory effectiveness, saying that a critical factor for facilitating changes in the regulatory system is the provision of personnel and technical and financial resources so that boards can respond to consumer needs promptly and thoroughly. It also believes consumers should have access to final disciplinary orders and information about the complaint process and that periodic self-evaluations of the effectiveness and efficiency of individual boards should be required. (Interprofessional Workgroup, 1996.)

Last year's focus group participants suggested including managers of health care facilities, other professionals, and faculty on the boards. They also offered these suggestions for Maine regulatory boards:

- Boards should survey for practice data at re-licensure. Others can analyze the information.
- Boards should be involved in long-term planning.
- Presentations to the boards from other professions would bring people together and help promote understanding across the professions.

Other suggestions included self-assessment by the regulatory boards of their performance, a Day of Discussion about regulatory policy, and having all boards issue newsletters and post information on the Internet.

During the project's 1996 focus groups, participants mostly said that they liked the idea of a federation of health professional regulatory boards, as long as it is advisory and not a centralized board with veto power. A few expressed reservations about any federation, seeing it as a first step toward centralization.

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A coordinating body could pro-actively address inter-professional issues, help inform regulatory policy decision-making by advising the executive and legislative branches, provide the vehicle for periodic programs, and maximize mutual understanding about the training and skills of the health professions.

Recommendation 4A: Regulatory policy should recognize changing practice settings and organizational entities. However, "institutional licensure" should not replace the licensing of individual health professionals.

Recommendation 4B: A permanent and formalized expert advisory panel should be established for the purpose of advising on improvements in the regulatory system. Such a structure could be in the form of an advisory federation with representatives from the boards. The federation could help improve communication and coordination. The Commissioner of DPFR need not wait for legislative action to establish a federation of Maine's health professional regulatory boards to serve in an advisory capacity. The Commissioner should also establish a division of health professional regulation within the Department's Office of Licensing and Registration.

The Commissioner should:

1. Establish a federation of Maine health professions regulatory boards to serve in an advisory capacity. A federation should be charged to address inter-professional issues including turf issues, help inform regulatory policy decision-making by advising the executive and legislative branches, provide the vehicle for periodic programs, and maximize mutual understanding about the training and skills of the health professions to address a lack of understanding about other professions' competencies.

2. Invite Maine EMS, although located in a different department and with responsibilities beyond the regulation of emergency medical personnel, to be included in the federation.

The Federation should:

1. Review proposals for future changes in regulatory law and advise the Commissioner, Governor, and Legislature.

2. Review and comment on boards' proposed rules.

3. Mediate disputes between health professions and boards.

4. Offer assistance to the Commissioner in providing for the Legislature a "sunrise" review of new professions seeking regulation or expanded scopes of practice.

5. Involve itself in long term planning for regulatory policy.

Recommendation 4C: State regulation of health professionals, wherever located in state government, should coordinate with other agencies and departments with responsibilities for health services and health policy.

The Commissioners of DHS and DPFR should:

1. Coordinate with the Health Data Organization an information system helpful for workforce planning for the health industry and for educational and public policy planning.

2. Connect the health information system with the regulatory system, using re-licensure or registration as an appropriate data-gathering survey opportunity for health services research—similar to the voluntary Physician Resource Inventory annually distributed through Maine's two physician regulatory boards. Any data evaluation costs to further public policy planning should be borne by the agency or organization using the data or by the general public, not by the health professional licensees.

Recommendation 4D: The Commissioner of DPFR should provide leadership recommending health profession regulatory policy to the Governor, Legislature, and the people of Maine. They, in turn, should support the Department and its Office of Licensing and Registration in their efforts to improve the regulatory system, including communication.

The Legislature should state in the law that the Commissioner of DPFR's responsibilities include recommending public policy for regulating the health professions to the Governor, Legislature, and the people of Maine.

The Department should:

1. Develop performance evaluation mechanisms and systems for regulatory boards to determine how well they are fulfilling their statutory role.

2. Encourage the regulatory boards whose professions offer similar or overlapping services to meet together on an ad hoc basis and communicate often. An example might be mental health professional regulatory boards meeting together periodically. Another potential example is rehabilitation therapists' regulatory boards.

3. Sponsor an annual Day of Discussion about regulatory policy.

4. Explain the public's role and solicit participation.

5. Make certain all licensees receive up-to-date laws, law changes, and rules pertaining to their licenses.

6. Continue to alert consumers, providers, and practitioners through a variety of methods, including pamphlets, the Internet, and newsletters, to the existence and responsibilities of the health professions regulatory units.
   (a) Require all boards to issue newsletters, allowing format options but requiring certain items be reported.
   (b) Continue the quarterly newsletter published by the Office of Licensure and Registration as a means of communication between professional boards and with the health industry, in addition to promoting public understanding.
   (c) Expand the information available at the Department's address on the Internet to include all boards' rules implementing the practice acts. Announce a reference to the Legislature's home page where all Maine statutes can be accessed, including Title 32 where practice acts for Maine's health professionals can be found. Encourage "on-line" communication via computers. Establish a computer bulletin board for all health professional board members and anyone else interested to discuss regulatory issues and functioning within the health system as a whole.

Robert Nutting practices pharmacy at True's Pharmacy in Oakland.

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7. Attempt to make the regulation of health professionals as paperless as possible. Assure confidentiality of identity regarding patient information. Assure confidentiality of practitioners' personal information unless that information relates to the trustworthiness or competence of a practitioner.

8. Encourage all health professional boards to become geographically sited at a single location.

9. Support the interdisciplinary Complementary Health Providers Board established in 1996.

Recommendation 4E: Membership on boards should include at least 30% public members to provide significant public representation. All regulatory boards should include educational leaders. DPFR should enhance the training for all regulatory board members so that they are fully aware of their responsibilities.

The Governor's staff should select members of licensure boards and the state's university and technical college system boards to ensure that they will take the time and effort to engage in regulatory policy discussion on a regular basis.

The Department should:

1. Develop training manuals and workshops for the health professional boards administered by the department and for the affiliated boards. Provide support and intensive training for all board members, including the public members.

2. Support involvement of public members in any organization like the Washington-based Citizen Advocacy Center and all members in organizations such as the Council on Licensure, Enforcement and Registration (CLEAR, an affiliate of the Council of State Governments), the Council of State Boards of Nursing, or the Federation of State Medical Boards.

Recommendation 4F: There must be a stronger accountability component to the health professions regulatory system to make sure it responds to the needs of the public in an ever-changing environment. Accountability should include publicity and a periodic "policy" evaluation by the Legislature, not simply a programmatic review of the implementation of current law.

Professional boundaries are still difficult issues for many health professionals.

ISSUE NUMBER 5: Professional Conduct and Ethics — Complaints and Discipline

Problems:

- It appears that what is acceptable professional conduct has not always been clear to practitioners or communicated to them. Major conduct issues in many of the health professions now focus on relationship boundaries, sexual misconduct, and substance abuse. Not too many years ago even major convictions were not seen as necessarily affecting the license of a physician, if the convictions resulted from activities outside of the medical practice. Professional boundaries are still difficult issues for many health professionals.

- Information on disciplinary actions is generally available only if one inquires, and not always then. Nationally, there is a problem with non-reporting to the National Practitioner Data Bank of disciplinary actions some hospitals have imposed on licensed practitioners. Consequently, when a practitioner moves to Maine from out-of-state, Maine regulatory boards, hospitals, and other potential employers or patients cannot be sure of getting complete information on prior misconduct. When federations of state regulatory boards are relied upon for disciplinary data about individual professionals, a similar need exists to ensure complete reporting.

- There is uneven treatment of health professions in the practice acts. Definitions of unprofessional or unethical conduct vary from profession to profession; an action that draws a severe penalty in one profession may be ignored in another.

- There is uneven treatment of complainants. One Maine health profession licensing board does not send the complainant the licensee's response to the complaint and allow the complainant to comment on the response, as the other health professional boards do.

- Sometimes the licensing boards seem only punitive or negative toward a licensee; not all boards use appropriate corrective and remedial measures.

- While a new Maine law will require disclosure of additional conviction information about Certified Nursing Assistants, other unlicensed assistive personnel, including Personal Care Attendants, are not required under the law to disclose such information.

Maine law says that final agency actions are public information. However, that information is generally only available if one inquires. The Maine State Nursing Board's newsletters contain a listing of final agency disciplinary actions. This board is the only health professional licensing board to publish such information.

Discussion: Maine's health professional boards and professional organizations are taking steps to address difficult regulatory policy issues involving ethics, professional boundaries, substance abuse **plus** misconduct and negligence. Some of the major efforts follow:

1. The Maine Department of Professional and Financial Regulation hosted a conference for its regulatory board members in January 1997 and included an Ethical Conduct Workshop: Models of Ethical Decision Making presented by Deborah Long, Ed.D. (See Appendix I.)

2. The Maine State Nursing Board held a conference discussing appropriate professional boundaries in April. Maine's medical boards recently developed a rule clarifying what constitutes sexual misconduct for their licensees and developed a communication plan to disseminate that information to their licensees and to the public.

3. Before that, in 1987, the Impaired Physicians Program administered by the Maine Medical Association was put in place, resulting in fewer substance abuse problems with practicing physicians. In 1997 Maine law was changed to allow dentists access to substance abuse assistance similar to that available to physicians.

There seems to be a growing recognition that complainants' involvement in the complaint process helps assure accountability.

Maine law says that final agency actions are public information. However, that information is generally only available if one inquires. The Maine State Nursing Board's newsletters contain a listing of final agency disciplinary actions. This board is the only health professional licensing board to publish such information.

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Some regulatory boards have expanded beyond a focus on punitive actions and now release a "profile" of a licensee to the public. Some profiles include a career plan as well as credentials and any disciplinary information. For example, Massachusetts now provides physician profiles and Ontario and the United Kingdom provide profiles of nurses.

Some participants in the project's 1996 focus groups suggested a template for the practice acts, especially a uniform disciplinary act. They also suggested that the regulatory boards need to establish policy for priorities for investigating complaints.

Recommendation 5A: The Legislature should create a template and standardize the grounds for discipline for all health professions by statute, allowing the individual regulatory boards to define incompetence and unprofessional conduct by rule.

The Legislature should enact one standardized licensure procedure and discipline act applicable to all health professions. The uniform law will state that both incompetency and unprofessional conduct will be subject to discipline. The individual regulatory boards shall define that incompetency and unprofessional conduct by rule. While Maine's Administrative Procedures Act largely assures uniform procedures, the Legislature should amend it to ease and speed process.

Recommendation 5B: The regulatory boards should communicate clearly and regularly about what is expected of practitioners and what conduct would be deemed unprofessional and subject to discipline. Ethical rules as they apply to health care professions should be periodically reviewed.

The regulatory boards should:

1. Develop definitions of professional boundaries and communicate those definitions to licensees and the public.

2. Encourage professional whistle blowing and criminalize retaliatory efforts.

3. Periodically review ethics as it applies to health care professions.

4. Inform health system participants, including managers and payers, about the "scopes of practice" associated with health professionals' licenses. To protect the public, clarify to whom one complains if an employer insists that a health professional perform services outside of that employee's "scope of practice."

5. Make the public aware of the complaint processes for the government regulator of the organization or facility and for the individual employer's health professions regulatory board.

6. Pursue discipline with the appropriate regulatory board for all licensed health professionals operating outside of their scopes of practice, unless the activity was legally delegated.

7. Establish a policy for prioritizing investigations of complaints.

The Attorney General should provide one assistant attorney general affiliated with all of the behavioral health boards. Any other assistant attorney general assigned to occupational boards should have a sub-specialty in health professional boards.

The courts should suspend a health professional's license during the pendency of an investigation for a criminal misdeed, if the licensee is alleged to have engaged in predatory sexual behavior toward patients within his or her practice.

Recommendation 5C: Boards should evaluate categories of unprofessional conduct for which they receive complaints and attempt to address and prevent more such complaints through education, rules, and program development. In addition to a profile, boards should consider educational programs and other methods to address recurrent problems.

Health professional associations and regulatory boards should follow the lead of the medical association and medical boards and provide assistance to impaired practitioners who are substance abusers seeking help prior to notifying the licensing board, if no harm is likely to occur to a consumer.

The regulatory boards should:

1. Periodically review complaints searching for categories where preventive measures appear feasible.

2. Use a professional, qualified investigator to investigate complaints. When the complaint is inter-professional, the two health professions regulatory boards need to investigate the complaint jointly.

3. Explore the use of non-punitive processes for improving practitioner outcomes while considering disciplinary measures.

Recommendation 5D: Boards should improve public access to information about the complaint processes for licensed and unlicensed personnel.

The regulatory boards should:

1. Allow the complainant to be involved in all steps of the complaint process. Send the licensee's response to a complaint to the complainant and allow comment on that response.

2. Allow voluntary treatment of health professionals for substance abuse or any other impairment to remain confidential. However, proven professional misconduct while impaired is not subject to the confidentiality provision.

3. Follow the lead of the Maine State Board of Nursing and publish final agency disciplinary actions.

Recommendation 5E: Maine law should require disclosure of criminal convictions for unlicensed assistive personnel offering home care and assisted living services.

The Maine Legislature should enact legislation requiring disclosure of criminal convictions for those unlicensed assistive personnel seeking work in home care and long-term care facilities.

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Recommendation 5F: Maine officials should advocate for national enforcement of the requirement that hospitals report disciplinary actions to the National Practitioner Data Bank. Maine officials should also advocate for complete reporting in data banks of federations of state regulatory boards if those data are to be relied upon.

All involved in regulating health professionals should advocate for enforcement of the requirement that hospitals report disciplinary actions to the National Practitioner Data Bank and that other states offer complete disciplinary action data to any federation of regulatory boards' data banks.

Recommendation 5G: The regulatory boards should shift focus from mostly punitive disciplinary record keeping to include a broader picture of a career. The descriptive portfolio or "profile" could include credentials, distinctions, specialty training and certifications by private organizations, and practice settings, in addition to any final disciplinary actions or substantial malpractice settlements (allowing comment on consent decree or settlement by licensee).

The regulatory boards should work with the professions to develop profiles for licensees to include credentials and other positive information, in addition to disciplinary actions.

ISSUE NUMBER 6: Consumer Information

Problems:

- The largest category of complaints to Maine's Board of Licensure in Medicine is in the sub-category of Unprofessional Conduct described as "communication." Although not traditionally considered part of a practice or a regulatory board's responsibility, health practitioners' communication with their consumer patients is an important competency problem.

- Generally, there is little communication and understanding about what competencies are possessed by practitioners in the health system. The lack of understanding applies to other practitioners, payers, and managers in addition to consumers.

- The public is not yet aware that it can access state laws regulating the health professions on the Internet.

Discussion: The dispensing of prescription medicines is one area in which communications failures are pervasive, costly, and potentially deadly. According to an article in the January 15, 1997, issue of *The Wall Street Journal*, "the unintentional misuse of medications...puts two million Americans in the hospital each year and sends another three million to their doctors. Hospitalizations alone cost an estimated $20 billion each year, according to Assistant Secretary of Health Phillip Less." *The Journal* quotes Food and Drug (FDA) Commissioner David Kessler as saying "There is more information on a box of Wheaties than on a bottle of prescription medicine these days. If we're really serious about having people take more responsibility for their health, they need this very basic information."

The federal government has a new initiative for communication with consumers by pharmacists. Now that pharmacists are starting to provide written information for patients about the impact of their medication, better health outcomes may prevail.

Maine is also clearly improving communication and consumer access to information about health professions, practitioners, and the regulatory boards. Yet more improvement needs to occur, as indicated in the above statements of problems concerning consumer information. Today, medical schools and other health profession educational programs give more attention to communication skills than in the past. Actors trained as standardized patients are used to teach and assess health professional students' communication skills. Printed information is made available to patients from their practitioners. Videotapes outlining treatment alternatives are becoming available. Health information is readily available on the Internet, including the U.S. Department of Health and Human Services' www. healthfinder.gov. Consumers are encouraged to assume greater responsibility for their health, and many want and expect more information so they can be an active partner in their health care.

Charles Burger, MD, an internist in Bangor, provides an example for informing and involving patients in a new patient/provider relationship. He and his staff, including a nurse practitioner who is experienced at using knowledge coupling programs on the computer, provide visualization and collaboration with patients on treatment decisions and a written record from the computer about those joint decisions.

Maine's medical and optometry boards offer pamphlets for their licensees' offices which provide information on standards as well as on how to file a complaint. The Department issued a new pamphlet this year describing "Who We Are, What We Do, How We Can Help You, and Who We Regulate." All occupational boards administered by the Department are listed.

Charles Burger, MD, is shown beside a central tool in his medical practice, the computer.

Maine State Government's home page on the Internet is www.state.me.us. Maine residents need to know that they can get a great deal of information here, including state laws regulating the health professions, the practice acts. In September the Maine Legislature posted the Maine statutes on the Internet, where they can be accessed at www.state.me.us/legis/homepage.htm#billlaw. The rules implementing the practice acts for occupational regulatory boards administered by the Department of Professional and Financial Regulation can be accessed on the state's home page through the Department and the Office of Licensing and Registration. The regulatory boards affiliated with, but not administered by, the Department are not yet posted, but have indicated they plan to create web sites. The affiliated boards include the two medical boards and those for nursing, optometry, and dentistry. However, the rules are all available separately through the Secretary of State's home page.

Recommendation 6: State boards should promote consumer understanding about the competencies of health practitioners and about the regulatory system and make information accessible. Health professions educators should promote improved communication skills for practitioners. Regulatory policy-making should encourage new patient/provider partnerships.

The Legislature, with assistance from the Department, should:

1. Make "practice acts" understandable to lay people.

2. Clearly link public education, information disclosure, informed consent, and public responsibility. Encourage a public understanding of the role of the practitioner as expert, consultant, and teacher.

3. Acknowledge overlapping skills and allow consumers an opportunity to choose practitioners or providers of service.

Final Recommendations for Improving Maine's Health Professional Regulatory System

4. Assign responsibility for disclosing to consumers, managers, and payers the criminal convictions of unlicensed assistive personnel seeking work in home care or long term care facilities.

The Department should:

1. Make information about the qualifications of regulated practitioners and laws and rules understandable. Frame statutes and rules so that language is transparent; consumers should be able to understand the law.

2. Make information about the qualifications of regulated practitioners and laws and rules easily accessible, including "profiles" or portfolios.

3. Promote consumer education, information, participation, and empowerment. There should be significant consumer involvement in the work of the regulatory boards, including membership on the boards.

4. Require each practice setting to distribute pamphlets describing generic and/or specific skills of practitioners employed, how to contact the Department's central office or the affiliated boards with complaints, and where regulatory laws are available.

The regulatory boards should:

1. Acknowledge the importance of communication as a competency for health practitioners.

2. Through the department, provide Internet access to the rules implementing the practice acts.

Provider organizations and the professions should:

1. Encourage new patient/provider partnerships through a variety of channels such as:
   (a) Patient's decision with advice from health professional expert
   (b) Shared patient/provider decision making
   (c) Computer tools
   (d) Outcomes information
   (e) Report cards
   (f) Emphasis on health education and self care

2. Encourage the availability of wrap-around medical and social services. Encourage interaction among the health professions.

3. Provide estimated price in advance of the delivery of health services, emergencies excepted.

4. Help practitioners enhance needed communication skills.

ISSUE NUMBER 7: Inter-Related Issues

Problems:

- The health system is extremely complex. Health policy areas need to be examined for simplification, standardization, and improvements aimed at better serving the health

needs of Maine's population. Reimbursement policies, accreditation of educational programs, and regulation of facilities are among the many public policy areas that interact very closely with the regulation of health professionals and need to improve to support the changes in Maine's health system.

Examples of a few of the problems that can arise from lack of coordination include:

- imperilment of quality if competency is assessed only at the beginning of a career and for a different practice setting
- confusion when it is unclear who can provide what services, where, and with how much supervision
- inconsistency when medications can be offered in a patient's home without supervision by a practitioner, but not in a nursing home with supervision
- "bad actors" can continue to practice if an employer trades reporting silence for a resignation
- cost escalation if a payer reimburses only the services of more expensive practitioners when other competent licensed practitioners could provide equal quality at less cost
- access to a qualified practitioner is denied if the law unreasonably prohibits him or her from practicing in a particular setting
- frustration and potential denial of access if a regulatory board's changed requirements go into effect before the educational programs are in place
- duplication of effort and expense if a practitioner is required to provide original credentials separately to a regulatory board, HMO, and hospital or other organization
- inefficiency if long distance transportation is required when a practitioner competent to provide the necessary services is close by

Discussion: Many systems interact with public policy for regulating health professionals and also affect who may perform what services, where, and at what price. Certainly outcomes research and some other issues are outside the responsibilities one can expect of a regulatory board. The important point is that all policy decisions should be made within the context of the total health system.

One of the most important interactions is between the regulatory system and the academic institutions. After all, the educational programs produce the practitioners. They have much influence over how and where the practitioners will serve—through design of the educational curriculum, choice of the clinical setting, and the tracking of students and graduates.

Recommendation 7: Develop public policy in areas interacting with the regulation of health professionals and, when appropriate, advocate for changes in federal policy.

The Legislature, Governor, and Commissioners of DHS and DPFR should develop and assess public policy in these areas:

1. Impact of managed care on quality and safety issues.

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2. Regulation of facilities, integrated systems, managed care organizations, insurance plans, and organizations.

3. Bureau of Insurance laws and rules.

4. Malpractice issues, including informed consent to perform procedures and to share data.

5. Health care delivery system data:
   (a) outcomes data;
   (b) workforce planning efforts;
   (c) confidentiality. Require informed consent to share information about patient with others. Periodically evaluate the balancing act for developing public policy for confidentiality and informed consent taking into consideration the impact upon public health problems, administrative burdens, and the developing right to privacy or control over information about oneself.

6. Reimbursement issues.

7. Coordination with other states about Medicare and Medicaid regulations, the Social Security Act, and the Employee Retirement Income Security Act of 1974 (ERISA).

8. Use of modern technology tools, including the revolutionary uses of telecommunications technology.

9. Use of unlicensed assistive personnel.

10. Accreditation of educational programs. Evaluate the role of specialized training. Coordinate with training. Involve university system and technical college system from the beginning.

11. Implications of NAFTA (North American Free Trade Agreement) and GATT (General Agreement on Tariffs and Trade) on competency issues. Work with other states to ease barriers to interstate mobility of health professionals.

Case Study

The Pew Charitable Trusts indicated that it wanted an independent case study of the project performed. It expressed interest in finding an individual who would be capable of developing a publishable case study for dissemination to national organizations. Martha Freeman, MS, JD, LCPC, agreed to develop a case study of the project. Freeman provides counseling, mediation, facilitation, and consultation and is the former director of the Maine Legislature's Office of Policy and Legal Analysis. Her proposal for a case study includes an assessment of the effectiveness of the project's process and substantive outcomes in relation to its stated goals and objectives.

In 1996-97 Maine nurse and paramedic, Patrick Cote, trained providers in Saudi Arabia in emergency medicine techniques.

Conclusion

The health system has changed dramatically since the first regulation of health professionals began in Maine a century ago. Recent changes seem especially rapid and are occurring because of longer life spans, new medical and communication technology, and attempts to address cost, access problems, and quality improvement with a focus on outcomes and prevention.

State laws authorizing scopes of practice and establishing supervision and practice setting requirements have a significant impact on the overall health system. Regulatory policy determines who can provide what health services where, to whom, and, in some instances, who is eligible for reimbursement.

As this project ends, we have come to the conclusion that the recommendations summarized below, if adopted, will greatly improve the ability of today's regulatory system for health professionals to assist the health system's efforts to improve the health of Maine people.

- Protect the public by promoting continued competency assessments, furthering a relationship between competency and licensure.
- Assist the Legislature with its scope of practice decisions for practice acts by involving others with expertise in the discussion, in addition to those who view themselves as the immediate stakeholders.
- Assure coordination and regular communication among the regulatory boards and the professions. De-compartmentalize the professions and allow overlapping scopes of practice. Encourage availability of competent professionals. Coordinate the regulatory system with inter-related systems.
- Improve communication and understanding of competencies within the health system, including between professions.
- Standardize regulatory terms.
- Promote public understanding. Regulatory policymaking should encourage new patient/provider partnerships. Improve the accountability to the public of the regulatory system.
- Provide laws that are more uniform.

It is important to recognize the regulatory policy progress occurring in Maine, especially in the last two years.

The Department of Professional and Financial Regulation's and the regulatory boards' efforts for improving the regulatory system are commendable. We believe the department's efforts and the work and recommendations of this project are complementary. In fact, many of our more significant recommendations were suggested by those affiliated in some way with the department.

Conclusion

We are pleased to see the Commissioners of the Departments of Human Services and Professional and Financial Regulation working closely together. We are looking forward to the First Annual Health Workforce Issues Forum and those that follow.

We applaud the Maine legislature's regulatory improvements—especially those enacted in 1996 following the work of the Maine Health Care Reform Commission. We urge Legislators to continue in that vein toward more system reform because, while progress is happening, more needs to occur as summarized in the recommendations above.

The project benefited greatly from a credible Advisory Committee and the willingness of so many Mainers to participate in some way in the discussions. We hope that Maine stakeholders and others can see that we "listened" and that the revised recommendations reflect their input. We hope that AARP leaders in Maine and other consumer organizations will join legislators and those employed in the health system in continuing to discuss these public policy issues and work for greater improvement in Maine's regulatory system for health professionals. The challenge is great, but the efforts will be worthwhile and the people of Maine will benefit.

Glossary of Regulatory Terms

Accreditation: "A conformity assessment process where an organization or agency uses experts in a particular field or interest or discipline to define standards of acceptable operation/performance for organizations and measure compliance with them." (Ham, Michale, *Fundamentals of Accreditation,* American Society of Association Executives, 1997.)

Certification, unlike licensure (which is authorized by state statute), is the process whereby a profession or occupation voluntarily establishes competency standards for itself. Certification plays a helpful role in protecting the public, especially in cases where the state legislatures have not opted to regulate the profession or occupation through licensure. However, there are broad variations in this voluntary process. Some certification organizations require the completion of rigorous education, experience, and examination criteria. Others, unfortunately, do not. The private sector has established organizations to review and verify (accredit) the integrity of these certification programs. However, certification organizations are not required to submit their programs to such accreditation. Also, unlike licensing authorities, certification organizations lack the authority to limit incompetent or illegal practice. (National Society of Professional Engineers, 1996.)

Credentialing: A generic term for licensure, certification, and registration. Can also be used as a term for a voluntary process under the auspices of private sector associations. (Shimberg and Roederer, 1994.)

Health care practitioner: Physicians and all others certified, registered or licensed in the healing arts, including, but not limited to, nurses, podiatrists, optometrists, chiropractors, physical therapists, dentists, psychologists and physicians' assistants. (24 M.R.S.A. 2502 sub. 1-A.)

Health care provider: Any hospital, clinic, nursing home or other facility in which skilled nursing care or medical services are prescribed by or performed under the general direction of persons licensed to practice medicine, dentistry, podiatry or surgery in this State and which is licensed or otherwise authorized by the laws of this State. (24 M.R.S.A. 2502 sub. 2.)

Licensure: The process whereby a governmental authority, in accordance with state statute, determines the competency of individuals seeking to perform certain services. Through licensure, state governments grant individuals the authority to engage in an area of practice, generally to the exclusion of others, based on demonstrated education, experience, and examination. Licensees are required by law and code of ethics to faithfully discharge their responsibilities impartially and honestly. As a general rule, state governments possess the authority to discipline licensees who fail to comply with statutes and regulations and to take action against unlicensed individuals who practice within the scope of a licensed profession or occupation. (National Society of Professional Engineers, 1996.)

Professional competence: The application of knowledge and skills in interpersonal relations, decision making and physical performance consistent with the professional's practice role and public health, welfare and safety considerations. In many professions, the requisites of competence change over time as various factors reshape the scope of practice and as the individual practitioner specializes. (Interprofessional Workgroup on Health Professions Regulation, 1996.)

Quality: The Institute of Medicine (IOM) has defined "quality" as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." (Lohr, 1990 as noted in E. McGlynn, 1997.)

The IOM definition (of quality) suggests that (1) quality performance occurs on a continuum, theoretically ranging from unacceptable to excellent; (2) the focus is on services provided by the health care delivery system; (3) quality may be evaluated from the perspective of individuals or populations; (4) research evidence must be used to identify the services that improve health outcomes; and (5) in the absence of scientific evidence regarding effectiveness, professional consensus can be used to develop criteria. (E. McGlynn, 1997.)

Registration: The process by which an individual is listed as eligible to provide a regulated service. Not all registration processes require the demonstration of competency in that service. (National Society of Professional Engineers, 1996).

Scope of Practice: The level of medical responsibility and/or health services a practitioner is legally authorized to offer to the public.

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- Representative Joseph Carleton, Maine House of Representatives
- Robert B. Keller, M.D., Executive Director, Maine Medical Assessment Foundation, and Chair, Maine Health Care Reform Commission
- John LaCasse, Eng. Sc.D., President, Medical Care Development
- Betsy Mahoney, Health Commons Institute
- Speaker Libby Mitchell, Maine House of Representatives
- Donald Nicoll, Public Policy Consultant
- Harvey Picker, Commissioner, Maine Health Care Finance Commission
- Trish Riley, Executive Director, National Academy for State Health Policy
- Richard Rockefeller, M.D., President, Health Commons Institute
- Neil Rolde, Maine Health Care Reform Commission, and Author
- Charlene Rydell, Program Officer, Milbank Memorial Fund
- Christine Zukas-Lessard, Director, Division of Medicaid Policy and Programs, Maine Department of Human Services

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Medical Care Development
Maine Health Professions Regulation Project
11 Parkwood Drive
Augusta, ME 04330
Phone: 207-622-7566
Fax: 207-622-3616