# IMPROVING PUBLIC POLICY FOR REGULATING MAINE'S HEALTH PROFESSIONALS

*October 1997*

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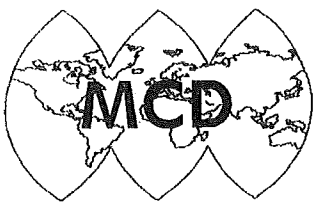
# APPENDICES

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.

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Report price: $10.00
Appendices price: $7.00

# *Table of Contents*

# APPENDIX A

## Sources of Information about Regulatory Changes in States and Canadian Provinces

# SOURCES OF INFORMATION ABOUT REGULATORY CHANGES IN STATES AND CANADIAN PROVINCES

- **Citizens Advocacy Center**: David Swankin and Rebecca Cohen, Citizens Advocacy Center, 1424 Sixteenth St., NW, Suite 105, Washington, DC 20036 Tel. 202/462-1174
- **Council on Licensure, Enforcement and Regulation** (CLEAR): Pam Brinegar, 403 Marquis Ave., Suite 100, Lexington, KY 40502 Tel 606/269-1289 Fax 606/231-1943
- **Interprofessional Workgroup on Health Professions Regulation**: Jennifer Bosma, Executive Director, National Council of State Boards of Nursing, 676 North St. Claire, Suite 550, Chicago, IL 60611-2921 Tel. 312/787-6555
- **National Conference of State Legislatures**, Intergovernmental Health Policy Project, Tim Henderson and Marla Rothouse, 444 North Capitol Street, NW, Suite 515, Washington, DC 20002 Tel 202/624-3578 or 202/624-3573
- **National Governors Association**: Tracey M. Orloff, National Governors Association, Health Policy Studies Division, Hall of the States, 444 North Capitol Street, Washington, DC 20001-1512 Tel. 202/624-7820
- **UCSF Center for the Health Professions/Pew Health Professions Commission Taskforce on Health Care Workforce Regulation**: Len Finocchio and Catherine Dower, Center for the Health Professions, University of California at San Francisco, 1388 Sutter Street, Suite 805, San Francisco, CA 94109 Tel. 415/476-8181 Fax 415/476-4113

- **Arizona**: Carla Smith, Troy Groll, or Lisa Eddy, Office of Auditor General, State of Arizona, 2910 N. 44th St., Suite 410, Phoenix, AZ 85018 Tel. 602/553-0333
- **Colorado**: Bruce Douglas, Director, Division of Registrations, Department of Regulatory Agencies, 1560 Broadway, Suite 1300, Denver, CO 80202 Tel. 303/894-7690
- **Connecticut**: John Kasprak, JD, Senior Attorney, Connecticut General Assembly, Office of Legislative Research, Legislative Office Building, Hartford, CT 06106 Tel. 860/240-8400
- **Maine**: Anne Head, Director, Office of Licensing and Registration, 35 State House Station, Augusta, ME 04333 Tel. 207/624-8633
- **Nebraska**: Helen Meeks, Director, Bureau of Examining Boards, Nebraska Department of Health, P.O. Box 95007, Lincoln, NE 68509 Tel. 402/471-2115
- **Utah**: Gar Ellison, Health Policy Commission, 288 North 1460 West, Box 141100, Salt Lake City, UT 84114-1100 Tel 801/538-6983
- **Vermont**: Claudia Bristow, Legislative Council, 115 State Street, Montpelier, VT 05633 Tel. 802/828-2231
- **Virginia**: Don Combs, Ph.D., Office of the Vice President for Planning and Program Development, Eastern Virginia Medical School, P.O. Box 1980, Norfolk, VA 23501-1980 Tel. 757/446-8910
- **Washington State**: Stephen Boruchowitz, Health Services Development, Department of Health Licensing and Certification, 1112 SE Quince Street, P.O. Box 47850, Olympia, WA 98504-7850 Tel. 360/753-0719
- **Wisconsin**: Thomas Neumann, Administrative Officer, State of Wisconsin, Department of Regulation and Licensing, 1400 East Washington Ave., P.O. Box 8935, Madison, WI 53708 Tel. 608/267-2357

- **Alberta**: Dona Carlson and Dennis Gartner, Professions and Occupations Services, Advisory Committee on Restricted Activities, Alberta Labour, 8th floor, 10808 - 99 Avenue, Edmonton, AB, Canada T5K 0G5 Tel. 403/427-2655 or 403/427-8256
- **British Columbia**: Sherry Campbell and Verna Magee Shepherd, School of Health Sciences, Allied Health Project, British Columbia Institute of Technology, SW3, Room 3735, 3700 Willingdon Ave., Burnaby, BC, Canada V5G 3H2 Tel. 604/451-7129
- **Manitoba**: Law Reform Commission, 12th Floor, Woodsworth Building, 405 Broadway, Winnipeg, MB, Canada R3C 3L6 Tel. 204/945-2896 Fax 2044/948-2184
- **New Brunswick**: Bonny Hoyt-Hallett and Janet Cameron, Department of Health and Community Services, 520 King Street, Carleton Place-7th floor, P.O. Box 5100, Fredericton, NB, Canada E3B 5G8 Tel. 506/453-2793
- **Ontario**: Alan Burrows, Director, Ministry of Health, Professional Relations Branch, 5700 Yonge Street - 3rd Floor, North York ON, Canada M2M 4K5 Tel. 416/327-8894 Fax 416/327-8897
- **Quebec**: Andre Contant, Direction de la recherche, Office des professions du Quebec, Complexe de la place Jacques-Cartier, 320, rue Saint-Joseph Est, 1er etage, Quebec, Canada GIK 8G5

# APPENDIX B

## Calendar of Events for Project Activities

# CALENDAR OF EVENTS FOR PROJECT ACTIVITIES

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

**Summer 1993. Project Advisory Committee formed.**

**September 17, 1993. Project's introductory conference, Lewiston. Topics included an overview of health professions regulation issues, a description of the Ontario regulatory model, a 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.**

Fall 1993. Open invitation extended to participate in a Task Force to develop recommendations for improving public policy for regulating health professionals and in 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 family nurse practitioner program were discussed.

December 1, 1993. Maine Respiratory Therapy Association Annual Meeting, Central Maine Medical Center, Lewiston.

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.

February 18, 1994. Presentation: "Health Reform and Regulation of Health Professions" sponsored by School of Social Work, University of New England, Biddeford.

March 25, 1994. Organization of Nurse Executives, Alfred's Restaurant, Augusta.

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, discussion of nurse practitioner legislation, and work redesign were discussed.

June 1994-January 1997. Project director is member of Pew Health Professions Commission Taskforce on Health Care Workforce Regulation.

**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. Project workshop/conference II, Lewiston. 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, overview of topics survey responses. Small group discussions were also held.**

September 28-October 1, 1994. Panel presentations at CLEAR conference/annual meeting, Boston.

October 27, 1994. Maine Health Care Reform Commission meeting focuses on health professions.

November 1, 1994. Task Force Meeting. Report on CLEAR '94, naturopathy, observations on 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.

November 4, 1994. Grand Rounds for mental health professions, Bangor Mental Health Institute.

November 30, 1994-February 16, 1995. Project director chairs Advisory Committee on Accountability for the Maine Health Care Reform Commission.

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

December 2-4, 1994. Presentation to the National Conference of State Legislatures' Western Roundtable on Health Professions, Scottsdale, Arizona.

December 10-11, 1994. Citizen Advocacy Center's roundtable discussion, Washington, D.C.

December 13, 1994. Project presentation to Maine Health Care Reform Commission.

January 11, 1995. Legislative conference sponsored by the Maine Rural Health Association: "Health Care in a Rural State," State House, Augusta.

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.

February 21, 1995. Presentation of Advisory Committee on Accountability's report to the Maine Health Care Reform Commission.

March 16, 1995. Meeting with Organization of Maine Nurse Executives Board, Augusta.

March 30, 1995. Task Force Meeting. Discussion and demonstration of some of the ideas presented in Weed and Weed's 1994 Federal Bulletin article. 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.

April 11, 1995. Maine Pharmacy Board, Gardiner.

May 3, 1995. Presentation to the Association of Academic Health Centers, Washington, D.C.

May 5, 1995. Discussion with Maine Hospital Association Practice Council, Augusta.

May 19, 1995. American Speech Language Association conference: "The Changing Face of Health Professions Regulation in Maine: A Prediction for the Nation?," Ogunquit, Maine.

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

June 9, 1995. Presentation about project at the American Dental Hygienists Association annual meeting, Chicago, Illinois.

June 26-27, 1995. CLEAR conference with the Kentucky Board of Nursing. Two panel presentations on Maine's project, Louisville, Kentucky.

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

**July 1995. Phase II of Project begins.**

July 10-27, 1995. Individual meetings with Commissioners of the Department of Human Services, Labor, and Professional and Financial Regulation to give them project report.

August 15, 1995. Meeting with Governor about project and to deliver report.

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

September 6-9, 1995. CLEAR conference. Participation in two panels, San Antonio, Texas.

September 11, 1995. Maine Speech Language Hearing Association Board, Gardiner.

September 15, 1995. Maine Affiliate of the National Association of Social Workers Board, Augusta.

September 28, 1995. Maine Chiropractic Board, Gardiner.

October 4, 1995. Maine Veterinary Association Board, Gardiner.

October 11, 1995. Maine Physical Therapy Board, Gardiner.

October 12, 1995. Maine Rural Health Association annual meeting/conference. Panel, Orono.

October 18, 1995. Medical Technologists of New England, Portland.

October 19, 1995. Maine State Nursing Board, Augusta.

October 26, 1995. Eastern Maine Medical Center Grand Rounds, Bangor.

November 9, 1995. Citizen Advocacy Center annual meeting/conference. Panel, San Diego.

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.

December 8, 1995. Maine Hospital Association Practice Council, Augusta.

January 10, 1996. Maine Rural Health Association health conference for legislators, Augusta.

January 12, 1996. Maine State Dental Board, Augusta.

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

February 14, 1996. (1) Coastal Health Educators Council, Damariscotta. (2) Maine Board of Licensure in Medicine, Augusta.

February 15, 1996. AFL-CIO Department for Professional Employees, Committee on Health Occupations Workshop on Licensing and Credentialing, Washington, D.C.

February 16, 1996. Maine Board of Osteopathic Medicine, Augusta.

February 19-20, 1996. CLEAR and North Carolina Board of Nursing conference. Panel, Charlotte, North Carolina.

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

March 4, 1996. Advocates for Oral Health, Augusta (Public health dental hygienists).

March 5, 1996. Board of Examiners of Psychologists, Gardiner.

March 15, 1996. Maine Psychology Association Board, Colby College, Waterville.

March 18, 1996. American Dietetic Association conference. Presentation. Washington, D.C.

March 20, 1996. (1) Maine Nursing Home Administrators Licensing Board, Gardiner (2) Maine Board of Veterinary Medicine, Gardiner.

March 21, 1996. Maine Radiologic Technology Board of Examiners, Gardiner.

April 5, 1996. Maine Board of Alcohol and Drug Counselors, Gardiner.

April 10, 1996. Maine Board of Podiatric Medicine, Gardiner.

April 22, 1996. Maine Board of Speech Pathology and Audiology, Gardiner.

April 27, 1996. Maine Physical Therapy Association, Eastern Maine Medical Center, Bangor.

May 4, 1996. Maine Acupuncturists Association, Augusta.

May 9, 1996. Maine Society of Radiologic Technologists, Sunday River Ski Resort, Newry.

May 10, 1996. Maine Dental Association Board, Manchester.

May 16, 1996. Coalition of Maine Nursing Organizations, Augusta.

May 17, 1996. Public policy course for students in Master's in Nursing program, Husson College, Bangor.

May 22, 1996 New Hampshire Board of Nursing's Discussion Day. Presentation, Manchester, New Hampshire.

June 7, 1996. Maine Acupuncturist Board, Gardiner.

**June-October 1996. Focus groups about regulatory policy issues held in 22 locations throughout Maine. All except one were held at community hospitals. The communities included Augusta, Bangor, Belfast, Biddeford, Brunswick, Calais, Damariscotta, Ellsworth, Farmington, Lewiston, Machias, Norway, Portland, Presque Isle, Rockport, Rumford, Skowhegan, Waterville, and York. 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.**

August 9, 1996. Maine Board of Social Workers, Augusta.

August 12, 1996. National Academy for State Health Policy annual conference. Panel, Minneapolis, Minnesota.

September 11, 1996. Presentation, University of Maine monthly lunch time issues series, Orono.

September 26, 1996. (1) Continuing Health Educators Partnership, Veterans Administration Center and Hospital, Togus. (2) Board of Licensure in Medicine's seminar on sexual conduct, Augusta.

October 2, 1996. Maine Public Health Association annual meeting/conference. Panel, Augusta Civic Center, Augusta.

October 25, 1996. Bangor Psychiatric Grand Rounds. "Can We Improve Our Public Policy for Regulating Health Professionals?" Acadia Hospital, Bangor.

November 6, 1996. Meeting with Maine Provider Coalition, Maine Dental Association, Manchester.

November 14, 1996. Maine Board of Osteopathic Medicine, Augusta.

**November 22, 1996. Project conference III, Lewiston. "Practicing for a Lifetime: Continuing Competency in the Health Professions," assuring and assessing continued competency conference. Topics included patient-oriented outcomes data management, "Through the Patient's Eyes," developing a quality assurance program, use of computerized simulations and an actor trained as a standardized patient to measure competence.**

December 9, 1996. Meeting with Maine Provider Coalition, Maine Dental Association, Manchester.

December 11, 1996. National Conference of State Legislatures' workshop for the Connecticut Legislature's Public Health Committee. Presentation, Hartford, Connecticut.

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

January 9, 1997. Maine Board of Osteopathic Medicine, Augusta.

January 20-21, 1997. Eastern Virginia Medical School's workshop for Virginia's Board of Health Professions. Presentation, Richmond, Virginia.

January 22, 1997. Maine Legislature's Business and Economic Development Committee. Presentation. State House, Augusta.

February 21, 1997. Maine Occupational Therapy Board, Gardiner.

February 24, 1997. Maine Counseling Board, Gardiner.

March 20, 1997. Belgrade Lions, Sunset Grill, Belgrade Lakes.

April 10, 1997. Maine Social Workers Conference. Workshop, Bangor Civic Center, Bangor.

April 14, 1997. Maine Board of Licensure in Medicine, Augusta.

April 21, 1997. Maine State Board of Nursing's conference: "Professional Boundaries, the Nurse's Challenge," Holiday Inn by the Sea, Portland.

May 1997. 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.

May 21, 1997. Maine Provider Coalition at MCD, Augusta.

May 28, 1997. Maine Paramedics Association, Maine Medical Center, Portland.

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

June 24, 1997. Workshop on draft revised recommendations, Mid-Maine Medical Center, Waterville (MaineGeneral Medical Center).

July 10, 1997. Maine Board of Podiatric Medicine, Gardiner.

**October 1997. Final report and appendices published: "Improving Public Policy for Regulating Maine's Health Professionals." Pamphlets published.**

**October 16, 1997. Project forum for Maine legislators and regulatory board members, Augusta.**

October 17, 1997. Public policy course for students in Master's in Nursing program, Husson College, Bangor.

October 23, 1997. Eastern Agency on Aging's Annual Meeting. Luncheon speaker. Black Bear Inn, Orono.

November 20-21, 1997. Maine Rural Health Association annual meeting/conference. Panel, Samoset Resort, Rockport.

**November 25, 1997. First Annual Maine Health Workforce Issues Forum convened by Commissioner Kevin Concannon, Department of Human Services. Augusta Civic Center, Augusta.**

**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 (Pew Health Professions Commission).

# APPENDIX C

## Agendas

**Health Professions Regulation Workshop - September 17, 1993**
**Health Professions Regulation - Maine Program - September 16, 1994**
**Practicing for a Lifetime: Continuing Competency in the Health Professions - November 22, 1996**

# HEALTH PROFESSIONS REGULATION WORKSHOP

Spare Time Function Facility - Lewiston Fairgrounds
729 Main Street - Lewiston, Maine

## PROGRAM

### Friday, September 17, 1993

9:00 Registration

9:30 Welcome

- *John A. LaCasse, Eng.Sc.D.*
  *President*
  *Medical Care Development*

9:45 Pew Health Professions Commission Agenda for Action

- *Leonard J. Finocchio, MPH*
  *Director of State-Based Initiatives*
  *Pew Health Professions Commission*
  *San Francisco, California*

10:30 Ontario's New Health Professions Regulatory System

Introduction by Richard Rockefeller, MD

- *Alan Burrows*
  *Director of Professional Relations*
  *for the Ministry of Health*
  *Province of Ontario, Canada*

11:30 - 11:45 BREAK

11:45 Health Professions Regulation ~ Problems & Prospects

Introduction by Judy Kany, Project Director
Health Professions Regulation
Medical Care Development

- *Richard D. Morrison, Ph.D.*
  *Executive Director*
  *Board of Health Professions*
  *Commonwealth of Virginia*

12:30 - 1:15 LUNCH (included)

1:15 Supply & Changing Demands for Health Professionals in Maine

Introduction by Neil Rolde, Author

- *Lisa Miller, MPH*
  *Public Health Consultant*

2:00 Regulation of Health Professionals in Maine Panel:

Moderator, Representative Joseph G. Carleton, Jr.

- *Senator John J. Cleveland*
  *Senate Chair*
  *Joint Standing Committee on Audit and Program Review*

- *Superintendent Brian Atchinson*
  *Bureau of Insurance*

- *Betsy Mahoney*
  *Edmund S. Muskie Institute for Public Affairs*
  *University of Southern Maine*

- *Patrick Cote, RN, EMT-P*
  *Medical Care Development*

- *Christine Zukas-Lessard*
  *Director*
  *Division of Medicaid Policy & Programs*
  *Department of Human Services*

3:30 - 3:45 BREAK

3:45 Identification of Issues Involved in the Development of a Health Professions Regulatory System

Introduction by Donald Nicoll

- *Small Group Facilitators:*

Robert Clarke, Executive Director
Maine Health Care Finance Commission
Robert Kany, Ph.D., Consultant, Colby College
Donald Nicoll, Public Policy Consultant
Harvey Picker, CEO, Camden Health Conference

5:00 Update on the Federal Health Care Proposal

- *The Honorable George J. Mitchell*
  *U.S. Senate*

# *HEALTH PROFESSIONS REGULATION - MAINE PROGRAM*

## *Friday, September 16, 1994*

8:30 AM — Registration and Coffee

9:00 — Welcome and Introduction
- ♦ *John A. LaCasse, Eng.Sc.D.*
  *President, Medical Care Development*

9:15 — Brief reviews of other projects on health professions regulation:
**Colorado.**
- ♦ *Vic Harris, Ph.D., Executive Director, Colorado Health Professions Panel, Inc.*

**Virginia.** Introduction by Betsy Mahoney, Edmund S. Muskie Institute for Public Affairs, University of Southern Maine
- ♦ *Richard Morrison, Ph.D., Executive Director, Board of Health Professions Commonwealth of Virginia*

**Washington.** Introduction by Representative Joseph G. Carleton, Jr.
- ♦ *Stephen Boruchowitz, MPA*
  *Department of Health*
  *Licensing and Certification*
  *State of Washington*

10:00 — Public members of regulatory boards. Brief overview of the work of the **Citizens Advocacy Center**, Washington, D.C. Introduction by Christine Zukas-Lessard, Director, Division of Medicaid Policy & Programs Department of Human Services
- ♦ *David A. Swankin, Esq.*
  *President, Citizens Advocacy Center*

10:15 — Brief report on the formation of the **Pew Health Professions Commission's Task Force on Health Professions Regulation** Introduction by Representative Charlene Rydell
- ♦ *Leonard J. Finocchio, MPH*
  *Director of State-based Initiatives, Pew Health Professions Commission*

10:30 — Coffee and Conversation

11:00 — **Regulation of the Health Professions in Europe.** Introduction by Superintendent Brian Atchinson, Bureau of Insurance
- ♦ *Professor Louis H. Orzack, Ph.D.*
  *Rutgers University*

12:00 Noon — Lunch

1:00 PM — **The democratizing effect of the computer: new relationships between patients, physicians, and other health care practitioners and the implications for the health care system using the office of Charles Burger, M.D. as a model.** Introduction by Harvey Picker
Maine Health Care Finance Commission
CEO, Camden Health Conference
- ♦ *Richard Rockefeller, M.D.,*
  *President, and Deborah Deatrick, MPH,*
  *Executive Director, Health Commons Institute*

2:00 — **Overview of responses to Topics Paper**
- ♦ *Judy Kany, Project Director*
  *Health Professions Regulation*
  *Medical Care Development*

2:30 — Small Group Discussions

3:15 — Small Group Discussions

4:00 — Adjourn

*Special Guests: Maine Health Care Reform Commission Members: Neil Rolde and Peter Hayes.*

## PRACTICING FOR A LIFETIME:
## *CONTINUING COMPETENCY IN THE HEALTH PROFESSIONS*

# *AGENDA*

***November 22, 1996***

**8:30** **Registration and Coffee**

**9:00** **Welcome and Introduction. John A. LaCasse, Eng. Sc.D.**, President, Medical Care Development.

**9:15** ***Pew: Next steps.*** **Christine Gragnola.** Center for the Health Professions, University of California at San Francisco, Pew Health Professions Commission Taskforce on Health Care Workforce Regulation

**9:45** ***Rising to the challenge: Can licensing move beyond continuing education?*** **David A. Swankin, Esq.** President, Citizens Advocacy Center. Introduction by Donald Nicoll.

**10:00** ***Patient-oriented outcomes data management: What are the issues that arise and what are the appropriate responses?*** **Robert Keller, MD.** Executive Director, Maine Medical Assessment Foundation. Introduction by Christine Zukas-Lessard.

**10:30** ***Assuring quality for the public.*** **Margaret Risk, RN.** Executive Director, College of Nurses of Ontario. Introduction by Representative Libby Mitchell.

**11:00** ***Using data base management as a competency assessment tool.*** **Ellen Klapper and Larry Batz.** Professional Examination Service. Introduction by Betsy Mahoney.

**11:30** ***The dental boards' approach to continued competency.*** **Edward Carlson, DDS.** Chairman, American Association of Dental Examiners Continued Competency Committee. Introduction by Representative Joseph Carleton.

**12:00** **Lunch**

**1:00** ***The stethoscope award: assessing clinical competence of medical students using an actor trained to be a standardized patient.*** **Mark H. Swartz, M.D.** The Mount Sinai Medical Center. Jane Cox, Actor. Introduction by Judy Kany.

**2:00** ***Use of computerized simulations (CST) to measure decision-making competency in the nursing management of client care.*** **Carolyn Yocom, Ph.D., RN.** FAAN National Council of State Boards of Nursing, Inc. Introduction by Judy Kany.

**2:45** *Through the Patient's Eyes*. **Margaret Gerteis, Ph.D.** The Picker Institute. Introduction by Harvey Picker.

**3:15** **Small Group Discussions.** Introduction by Saskia Janes, MA, Medical Care Development, Inc.
***Session A***: Let's talk about the educational and assessment tools we heard about and saw demonstrated today. (Moderator: David Swankin; Recorder: Laurie Senechal)
***Session B***: Assuring and assessing continued competency: What should the state's role be? (Moderator: Edward David, M.D., J.D. Chair, Board of Licensure in Medicine; Recorder: Saskia Janes)
***Session C***: What should the role be for organizations other than the state? (Moderator: Betsy Mahoney; Recorder: Judy Kany)

**4:00** **Adjourn**

# APPENDIX D

## Health Professions Regulation - Maine
## Policy Development Topics for Consideration

# 1994 TOPICS PAPER SURVEY

## HEALTH PROFESSIONS REGULATION - MAINE
## POLICY DEVELOPMENT TOPICS FOR CONSIDERATION

Please examine the following regulatory principles and topics to help determine both the need for, and the form of, regulation of each health profession in Maine. The questions we want answered then follow. Following the Topics Paper and attached to it are pages containing the repeated questions with space for responding.

This is our first effort. We invite you to raise any criticisms of, or suggest refinements to, any of the topics, alternative positions, or criteria discussed. We would especially appreciate hearing about things that should have been asked that would help the public in light of our changing health care system and the needs of Maine people.

### I. PRINCIPLES

Some of the basic principles Maine could follow in addressing regulation across the many health professions could include the following:

- Protect the public from risk of harm.
- Focus on quality of care.
- Enhance access.
- Regulate in the least restrictive manner.
- Evaluate cost effectiveness.
- Focus on the consumer.
- Establish a coordinated regulatory system.
- Foster innovation.

Please rate the principles in a range from "Essential" to "Unnecessary."

| | Essential <--> Unnecessary |
|---|---|
| Protect the public from risk of harm. | [] [] [] [] [] |
| Assure the competence of the profession. | [] [] [] [] [] |
| Protect against hazardous acts. | [] [] [] [] [] |
| Focus on quality of care. | [] [] [] [] [] |
| Enhance access. | [] [] [] [] [] |
| Regulate in the least restrictive manner. | [] [] [] [] [] |
| Evaluate cost effectiveness. | [] [] [] [] [] |
| Inform and empower consumers. | [] [] [] [] [] |
| Establish a coordinated regulatory system. | [] [] [] [] [] |
| Foster innovation. | [] [] [] [] [] |

### II. STATUTORY REGULATION

<u>Topic 1: The public need for regulating the profession by Maine statutory law</u>.

At present, Maine statutory law governs a number of the health professions. Sometimes the statutory regulation is in great detail. Other times the regulation is largely left to rulemaking. (Statutory law and administrative rules both carry the effect of law. Statutory law can only be changed through the legislature, whereas administrative rules, including those created through emergency rulemaking, are created by the executive branch to implement the statutory law.)

Whether or not other professions deserve new regulation is often debated. Should some of the unregulated professions become regulated? Should some regulated professions be deregulated or the degree of regulation changed? Should practitioners be required consistently to meet minimum levels of competence to assure public health and safety?

Regulate only when the public cannot be protected by other means, such as disclosure or a strict contract. The appropriateness of regulation of a health profession by Maine law depends upon whether a clear and present danger to the public's health, safety and welfare exists. There is widespread agreement that the public should be protected from unqualified, incompetent, and unfit health care providers, and that the performance of potentially dangerous procedures should be regulated in order to minimize risk of physical or emotional harm to patients.

As opposed to regulating a profession in its entirety, should we, instead, focus regulation upon potentially harmful acts or activities, i.e., the health care services themselves, which may put the public at risk?

| Topic 1 QUESTIONS: | Agree | | | | Disagree |
|---|---|---|---|---|---|
| (1a) There is a need to ensure the regulation of this profession through Maine law. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1b) Disclosure or a strict contract is an adequate alternative to regulation for this profession. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1c) The focus of regulation should be on potentially harmful health care <u>services</u>, instead of regulating <u>professions</u>. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1d) The focus should be upon minimal entry competencies of a profession. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1e) Require that the need to regulate be periodically justified. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1f) The periodic justification should be made to the legislative committee covering health care matters. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1g) New regulation should prove the public at risk. | [ ] | [ ] | [ ] | [ ] | [ ] |

**<u>Topic 2: Appropriate level of regulation</u>.**

Evaluate the potential effects of disclosure vs. regulation. Evaluate the possibility of a strict contract instead of regulation.

If regulation is deemed necessary, first consider registration, then certification, and only as a last resort making it illegal for a person to practice without a license.

The regulatory terms licensure, certification and registration represent significantly different degrees of state-imposed regulation, in descending order:

<u>Licensure</u> is the most restrictive form of state regulation. There are two types of licensure acts:

1. Practice acts which make it illegal for a person to practice without a license, and
2. Title acts which make it illegal for the person to use the title of the profession without a license.

Under regulation by <u>certification</u>, persons may not call themselves state certified unless they meet certain state requirements. (Separate from the legal regulatory term just described, non-governmental agencies, such as professional societies, grant "certification" to those who meet predetermined qualifications, including passing an examination.)

<u>Registration</u> is the least restrictive form of regulation, usually taking the form of requiring individuals to file their names, addresses and qualifications with a government agency before practicing the occupation. Registration generally requires no qualifications, but could do so.

| Topic 2 QUESTIONS: | Agree | | | Disagree | |
|---|---|---|---|---|---|
| (2a) Instead of regulation, "disclosure" is adequate to protect the consumer. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2b) A strict contract sufficiently protects the public. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2c) The state should license fewer professions. Instead it should "certify" that an individual has met certain standards. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2d) The minimal level of regulation necessary to protect the public for this profession's services is "licensure." | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2e) Regulation of this health professional's employer rather than the individual practitioner provides the necessary public protection. | [ ] | [ ] | [ ] | [ ] | [ ] |

## III. SPECIFIC REGULATION

Having established whether regulation by Maine statutory law is appropriate and if so, in what form, let us address five remaining topic areas. These pertain to each profession and all types of regulation, and comprise:

- scope of practice
- entry to practice
- continuing competence, re-entry to practice, liability, and matters of conduct
- complaints, discipline and other disputes
- regulatory boards, coordination, consumers, and other topics

### A. Scope of practice

Any review of regulation must address the range of functions or activities a profession may or may not perform and under what conditions.

**Topic 1: Scope of practice**

If a definition appears desirable, should the definition specify the conditions the profession can treat, or the treatments it can apply, or both? Should the definition indicate the profession's approved area of focus, or should it go further to stipulate all of the activities in which its members may participate? Should variations in practical experience influence the statutory scope of practice definition? These variations can occur because the supply and mix of available professionals also varies across different practice settings, areas of the state, and even times of day or night.

| Topic 1 QUESTION: | Agree | | | Disagree | |
|---|---|---|---|---|---|
| (1a) A statute or rule should "describe" a scope of practice for this profession, instead of "defining" it. | [ ] | [ ] | [ ] | [ ] | [ ] |

**Topic 2: Exclusiveness of practice rights**

Legislation typically regulates professions in one of two ways. One approach is to license or certify certain individuals as competent to practice and signify competence by restricting use of a specified title, while allowing others to practice as long as the others do not use the restricted title. A second approach is to grant licenses to practice to some in a way that exclude others from practice altogether.

| Topic 2 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (2a) Optimal use of personnel is prevented because of the exclusiveness of some practice rights. | [] [] [] [] [] | |
| (2b) The licensed scope of practice for other professions prevent individuals from this profession from providing services for which they are qualified. | [] [] [] [] [] | |

**Topic 3: Overlapping scopes of practice**

Certain independent professions treat some of the same conditions as others do, but with different treatments. In other cases, independent professions share forms of treatment, but apply them to differing conditions, or differing degrees of severity. Health professions legislation could recognize these cases of overlap explicitly, or ignore them and let the consumers decide.

Currently there is talk of common core curricula, cross training, cross credentialing, and moving away from a trend toward narrow credentialing. Some suggest more flexibility in regulation of the professions, facility licensure, and reimbursement for better allocation of available skills. Others encourage looking at innovative proposals to make more effective use of the health work force through demonstration projects, waivers of regulations, and multidisciplinary cooperative ventures.

| Topic 3 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (3a) Overlaps in the scopes of practice between professions should be acknowledged. | [] [] [] [] [] | |
| (3b) Waivers of restrictions should be allowed for demonstration projects. | [] [] [] [] [] | |

**Topic 4: Supervision**

The members of several professions commonly supervise the work of other persons not belonging to their profession in a hospital or other institution, in a professional office or clinic or in another setting. This may mean that one profession generally supervises the work of another profession, that one professional practitioner supervises the work of another professional practitioner in individual cases, or that a professional supervises the work of a non-professional employee. Some participants may wish to question the limits or the desirability of one or more of these supervisory relationships. Others may consider them wholly suitable in every case.

If supervision itself seems appropriate, how direct the supervision should be is still an open question. It may be sufficient for the supervision to be at arm's length, say through periodic inspection, or it could be more direct, through continuous supervision, either on the same premises or in the same room.

Some suggest a greater flexibility in regulatory law to recognize the extensive supervision provided in facilities regulated by the Department of Human Services.

In another form of supervision, gatekeepers or primary care practitioners determine what may be reimbursable under many managed care insurance plans.

| Topic 4 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (4a) Maine law or rules should allow greater flexibility for regulating supervised health practitioners within a licensed health care facility. | [] [] [] [] [] | |

(4b) Dieticians or other professions mostly practicing in a licensed facility should be certified by the state as meeting minimal standards, instead of licensed. [] [] [] [] []

(4c) The requirements for supervision of this profession are unnecessarily stringent. [] [] [] [] []

**Topic 5: Delegation**

At present, physicians, dentists, nurses, and other health professionals delegate acts in the practice of their disciplines to other persons. The extent of delegation, especially of unlicensed personnel, varies from state to state.

| Topic 5 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (5a) It is appropriate for members of this profession to delegate acts licensed to them to other persons who are not licensed to perform these acts. | [] [] [] [] [] | |
| (5b) Legislative mechanisms are necessary to validate the delegation. | [] [] [] [] [] | |
| (5c) Allowing supervised delegation to unlicensed people lowers cost without sacrificing quality. | [] [] [] [] [] | |
| (5d) There is more delegation because of the movement from individual to enterprise liability. | [] [] [] [] [] | |

**Topic 6: The regulatory implications when one professional supervises a person in another regulated profession**

When a member of a health profession supervises a person in another profession, a problem occurs when an act (or omission of an act) by a person under supervision becomes the subject of a complaint or disciplinary hearing in which someone alleges that professional misconduct or negligence took place. Depending on the circumstances, the supervisor alone may be held accountable, the supervised person may be held accountable or both may be held accountable. The responsibility for examining the complaint could rest with one regulatory board, two regulatory boards working independently, or both working together. The institution in which the incident occurred may take disciplinary action of its own, or may play a role in the complaints or disciplinary proceedings of the regulatory board.

| Topic 6 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (6a) The enterprise and not the individual supervisor should be liable. | [] [] [] [] [] | |
| (6b) There should be an umbrella board for hearing complaints. | [] [] [] [] [] | |

**B. Entry to practice**

A number of topics cluster around the subject area of entry to practice. Who can join the profession, what conditions they must meet and which groups should be able to develop these rules comprise some primary concerns. Maine could also try to achieve consistency between its entry-to-practice rules and those of other states.

**Topic 1: Practice entrance standards**

The conditions and qualifications an individual must attain to enter into practice as a health professional in Maine usually involve satisfactory completion of two or all of the following:

1) educational course work at a university or technical college
2) national, state or other qualifying examinations
3) a period of apprenticeship, internship and/or residency.

The following organizations may be involved in the determination of minimal entry level standards:

- the technical college, college, or university and its faculty and trustees
- the public's expectations of competency
- employers
- state government agency or board
- work force planning organization
- professional association
- the federal government through Medicare and Medicaid
- the national (or other) school accrediting agency
- quality assurance requirements, outcomes measurements, managed care organizations
- insurance contracts with employers and individuals
- those forming facility licensure regulations involving health professionals
- hospitals and other institutions through "credentialing and privileging"

| Topic 1 QUESTIONS: | Agree | | | | Disagree |
|---|---|---|---|---|---|
| (1a) The standards an individual must meet to enter practice in this profession should be established by the professional association. | [] | [] | [] | [] | [] |
| (1b) When new standards are established, it is O.K. to grandfather current practitioners. | [] | [] | [] | [] | [] |
| (1c) Regulatory boards should deal with candidates for entry to practice whose mental capacity or morality is at issue. | [] | [] | [] | [] | [] |
| (1d) The final authority over entrance to practice should rest with the specific employer. | [] | [] | [] | [] | [] |
| (1e) The final authority over entrance to practice should rest with Maine law. | [] | [] | [] | [] | [] |
| (1f) Health care and education need to be linked together more effectively. | [] | [] | [] | [] | [] |
| (1g) A reliable data base for determining health personnel needs should be developed. | [] | [] | [] | [] | [] |
| (1h) The accreditation process is unnecessarily expensive and unwieldy. | [] | [] | [] | [] | [] |
| (1i) Multi-credentialing of health care workers should be encouraged. | [] | [] | [] | [] | [] |
| (1j) Base the educational system more on health outcomes. | [] | [] | [] | [] | [] |
| (1k) Involve providers (hospitals, long term care, community health centers, etc.) in establishment of professional licensing standards. | [] | [] | [] | [] | [] |

**Topic 2: The interjurisdictional mobility of the professions**

Some believe that mobility across the U.S. for members of all professions is desirable. They believe that ideally, a professional acceptable to the regulatory board in Maine should be able to practice in any other state merely by applying to do so, and the same should be true for professionals from other states. The North American Free Trade Agreement (NAFTA) and the General Agreement of Tariffs and Trade (GATT) will provide limitations on future restrictions on

services of health professionals from other participating countries, similar to the current situation in Europe, where health professionals' licenses from other European countries are honored.

The principle breaks down whenever any state wishes to set higher or different standards for entry to practice than another, or to limit the number of practitioners, or requires that the other state reciprocate. A state may force practitioners from other states to complete further course work, a period of internship and/or certain examinations. There may be an opportunity to achieve greater consistency in entry to practice between Maine and other states.

| Topic 2 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (2a) You either meet the standard or you don't. Eliminate reciprocity. | [] [] [] [] [] | |
| (2b) Maine professions should work with other states to achieve consistency in entrance to practice standards. | [] [] [] [] [] | |
| (2c) I favor national entry to practice standards. | [] [] [] [] [] | |
| (2d) In some professions, licensees from other NAFTA nations may practice in Maine more easily than licensees from other states. | [] [] [] [] [] | |
| (2e) There should be national competence based exams for all of the health professions. | [] [] [] [] [] | |
| (2f) It is difficult for Mainers in this profession to enter practice in some other states. | [] [] [] [] [] | |

**C. <u>Continuing competence, liability, and matters of conduct</u>**

Once some professionals enter practice, few demands may be placed upon them to maintain their skills. The question of continuing competence is a special concern when it involves professionals practicing on their own away from the oversight and competency requirements of institutions. A parallel concern is the competence of individuals who become licensed and then return to their professions, possibly many years later. Similarly, the personal, ethical, and business conduct of professionals is the subject of increasing attention, often resulting in the enforcement of disciplinary measures on those who "bring the profession into disrepute" and distracting attention from competence.

The topics here are principally these: the mechanisms for ensuring continuing competence among professionals of long standing and the authority to deal with misconduct of a personal, ethical or business nature, and liability issues.

**<u>Topic 1: Continuing competence</u>**

There is increasing sensitivity among health professionals to the question of how to ensure that practitioners continue to be minimally competent years after they have passed their qualifying examinations. Rapid advances in health care technology and frequent rethinking of preferred modes of treatment have made this a persistent, even growing concern.

Some suggest requirements that professionals periodically pass tests of their competence, or successfully complete courses designed to bring their skills up to date, and removing from practice licensees whose practice falls below minimum standards. Others suggest ongoing peer review. Others suggest focusing more on patient satisfaction surveys, quality assurance report cards, and/or outcomes, and less on credentials.

| Topic 1 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (1a) It is the responsibility of the regulatory board to ensure continuing competence. | [] [] [] [] [] | |

(1b) Continuing educational units (CEUs) are an effective mechanism to update skills. [] [] [] [] []

(1c) Competence is best measured in patient outcomes. [] [] [] [] []

(1d) Periodic re-examination of health professionals should be required. [] [] [] [] []

(1e) Health professionals should have to prove continuing competence, not just continuing education credit. [] [] [] [] []

**Topic 2: Liability and quality assurance**

Maine's Medical Liability Demonstration Act has won acclaim nationally. So far 20 practice parameters and risk management protocols have been developed in four medical specialties. Compliance authorizes the specialists to assert an "affirmative defense" in any medical liability case arising from alleged medical malpractice. "The goal of the project is to decrease both the cost of defensive medicine and the participating doctors' liability risk."

Many suggest that protection of the consumer, access, and quality should drive the health care system, not reimbursement. Be pro-active guardians of quality of care. Develop mechanisms to encourage the provision of high quality care. Enhance quality and quantity of service for lowest possible costs.

| Topic 2 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (2a) More parameters and protocols should be developed under the Medical Liability and Demonstration Act. | [] [] [] [] [] | |
| (2b) Practice guidelines should be developed for this profession's work. | [] [] [] [] [] | |
| (2c) Each profession should develop a quality assurance plan. | [] [] [] [] [] | |
| (2d) Quality assurance reviews should include consumer input. | [] [] [] [] [] | |
| (2e) Quality assurance should focus on outcomes. | [] [] [] [] [] | |
| (2f) There should be mandatory reporting of changes in credentialing and privileging by hospitals. | [] [] [] [] [] | |

**Topic 3: Reimbursement, fees, and business restrictions**

The direction is clearly towards capitation fees and away from fee-for-service. Some believe this change will help remove reimbursement as a driver of additional professions seeking licensure.

Entrepreneurial practice restrictions like "self-referral" receive criticism from those who regard them as anticompetitive, monopolistic devices for restraint of trade, bringing the restrictions into disrepute with the public.

| Topic 3 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (3a) Health professions' licensure laws are inappropriate for restrictions on where and how one can do business. | [] [] [] [] [] | |
| (3b) Regulatory boards should regulate unreasonable professional fees. | [] [] [] [] [] | |
| (3c) If fee-for-service, fees should be posted for consumer information. | [] [] [] [] [] | |

(3d) Capitation payments will pretty much replace fee-for-service and reduce reimbursement as a driving force behind more professions seeking licensure. [ ] [ ] [ ] [ ] [ ]

**D. Complaints, discipline and other disputes**

The ways in which professionals may violate the rules, and the means of enforcing them when they do, raise several issues including when should the public know or participate.

**Topic 1: Complaints, discipline, and due process**

Maine's Administrative Procedures Act was developed in the late 1970's. Its provisions apply to our current boards' rule development, adjudicatory proceedings, and process for revoking or suspending licenses. However, penalties and other provisions vary from one health profession's practice act to another and there are ongoing efforts to standardize procedures.

There are disciplinary limitations. Assistance from the Attorney General's Office has not always been readily forthcoming, although efforts have been made to improve that situation this past year. If the perpetrator had no license, what then, since most board disciplinary measures are limited to license related penalties?

Penalty options can include imposing fines, requiring additional education, mandating supervised practice or even requiring restitution to the victim. Consent agreements can be developed. A mandatory alternative dispute resolution process has been suggested.

| Topic 1 QUESTIONS: | Agree | Disagree |
|---|---|---|
| (1a) Substance abuse treatment of health professionals should remain confidential. | [ ] [ ] [ ] [ ] [ ] | |
| (1b) All complaints against health professionals should become public information. | [ ] [ ] [ ] [ ] [ ] | |
| (1c) One complaint board should handle disciplinary measures for all professions. | [ ] [ ] [ ] [ ] [ ] | |
| (1d) The professional association's role should be advisory and to provide expertise when needed. | [ ] [ ] [ ] [ ] [ ] | |
| (1e) The public needs to be better informed of its right to complain and to whom to complain. | [ ] [ ] [ ] [ ] [ ] | |
| (1f) Require an alternative dispute resolution process. | [ ] [ ] [ ] [ ] [ ] | |

**Topic 2: Other areas of ongoing concern and dispute**

During the expected life of a modern health profession's act, a large number of disputes and ongoing problems commonly arise that do not fall within the individual complaint or discipline categories. These often concern differences between the profession and the other professions, the institutional employers, sub-groups within the profession, the general public or patients affected by the profession, and may involve any number of issues. Conditions of work, technologies, economics, and attitudes can all undergo major change within a few months and upset a previous consensus or aggravate dormant hostilities.

Rather than allowing these disputes to continue or worsen until the next reform of health professions legislation, the statutes might establish or recognize a forum and a set of procedures that would enable the parties to negotiate timely settlements.

| Topic 2 QUESTIONS: | | Agree | | | | Disagree |
|---|---|---|---|---|---|---|
| (2a) | Establish a dispute mechanism for resolving problems between health professions. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2b) | Inter-professional recognition needs to be fostered. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2c) | Other disciplines are providing the same services, but are not regulated. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2d) | A health professions regulation commission, made up largely of public members, can serve as a dispute resolution mechanism. | [ ] | [ ] | [ ] | [ ] | [ ] |

**E. <u>Regulatory boards, coordination, consumers, and other topics</u>**

**<u>Topic 1: Regulatory boards</u>**

Should both public and professional board members receive more training? Should the composition of the boards include more public members? One third? One half? A majority, or should it include fewer? Do public members add a dimension? What can be done to improve their contribution? To what degree are public policy goals achieved through the present regulatory board structure? Should there be a broader mission for the boards including, as examples, removing barriers to access and/or developing quality assurance measures? Instead of regulatory boards created in public law out of public policy concerns, could professional associations take care of all this?

Some note a lack of communication between regulatory boards and between professions. Should professions with commonalities be consolidated into regulation by one board? Potential candidates might include the mental health professions, vision care or allied health professions.

| Topic 1 QUESTIONS: | | Agree | | | | Disagree |
|---|---|---|---|---|---|---|
| (1a) | A regulatory board, created by public law, is the most appropriate regulator of this profession. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1b) | State agency personnel with an advisory board is the most appropriate regulator of this profession. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1c) | Health profession boards should be associated with the expected Maine Department of Health, instead of the Department of Professional and Financial Regulation. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1d) | The state agency associated with the professional boards should develop "sunrise" standards for recommendations about the regulation of new professions. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (1e) | Professions with commonalities should be consolidated into regulation by one board. | [ ] | [ ] | [ ] | [ ] | [ ] |

**<u>Topic 2: Coordination and the health care system</u>**

Maine is the fifth most rural state. Some have suggested the following elements for a successful rural health system:

- consumer focus
- comprehensive
- community wide
- flexible regulation and reimbursement
- community input and governance
- interdisciplinary approach
- cost sensitive and effective
- linked with other community based services

Given Maine's rural nature, how does our current health professions regulatory scheme fit into our current and changing health care system?

Partly due to the debate over health care reform and the rapid move towards more management of care, there is increasing discussion of quality assurance, capitation payments, outcomes research, coordination, interdisciplinary approaches, new provider networks, primary care practitioners, gatekeepers, utilization review, moving away from independent practices in any profession, commitment to innovation, community based, HMOs, collaboration, team provider, partnership, ranges of appropriate care, practice guidelines, consumer surveys, prevention consensus, technical competence and levels within a profession.

| Topic 2 QUESTIONS: | Agree | | | | Disagree |
|---|---|---|---|---|---|
| (2a) Maine's health professions regulatory system can be better designed to meet the requirements of the changing health care system. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2b) Promote evolution in the roles played by individual professions. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2c) Promote flexibility in how individual professionals can be used. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2d) Decrease control of work domain boundaries. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2e) Encourage cross training. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2f) Consider waivers for innovation. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2g) Transform autonomous "practice acts" into a coordinated regulatory system. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2h) Encourage health work force planning. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2i) Develop a more streamlined regulatory structure. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2j) Better use the regulatory structure and licensing requirements for data collection and work force planning. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2k) Develop strong coordination between the health care delivery system, the health professions regulatory system, and educational institutions. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2l) Effective cooperative teams should pervade the system. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2m) There should be an umbrella advisory coordinating council. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2n) Reorganize autonomous boards into a coordinated system. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (2o) Coordinate accreditation, licensing and utilization standards. | [ ] | [ ] | [ ] | [ ] | [ ] |

**Topic 3: Consumers**

Provide accessible, affordable, appropriate health services for all. Promote awareness of and access to quality care.

A number of people have suggested that the focus should shift to consumer education and information. Promote consumer education, information, participation, and empowerment. Some believe that educated consumers can be the real regulators.

Some also suggest that consumer involvement in regulatory structures should be increased. De-mystify the regulatory system; the laws and rules should be written for lay people's understanding and use. Establish a regulatory system which is consumer driven for health care instead of profession driven; the public good must come before professional interest.

Help the public to exercise freedom of choice of health care providers within a range of safe options. Avoid monopolies by professions which work to limit access, increase cost, and compromise the quality of health care. Instead let all who are competent to perform a task do so.

Make price and quality information available. Encourage capitation payments to stop reimbursement from being a driver for licensure. Restrict limitations on professional practice which unjustifiably raise the cost of care. Prohibit unjustified

business practice restrictions unrelated to professional competence or public health and safety. Promote productivity, cost effectiveness, incentives for innovation, and systematic evaluation and assessment. Reduce time spent by health professionals on activities that can be performed by alternative providers. Support the efforts of the health industry to make better use of health personnel. Increase efficiency without reducing quality or access.

| Topic 3 QUESTIONS: | Agree | | | | Disagree |
|---|---|---|---|---|---|
| (3a) The laws and rules for all professions should be made easily available. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (3b) Information about disciplinary or other adverse actions should be made public. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (3c) Providers' prices, outcomes, and other quality information should be posted. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (3d) Public members should comprise most of an umbrella advisory group. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (3e) Complaint boards should mostly have public members. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (3f) Consumer information about the qualifications of regulated health practitioners should be made readily available. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (3g) Promote consumer education, information, participation, empowerment. | [ ] | [ ] | [ ] | [ ] | [ ] |
| (3h) Facilitate free choice among providers within a range of safe options. | [ ] | [ ] | [ ] | [ ] | [ ] |

**Topic 4: The other matters that should concern this policy development**

Anything not covered in earlier topics.

Topic 4 QUESTION: Are there any other matters to address?

# APPENDIX E

# Overview of 1994 Topics Paper Responses

# HEALTH PROFESSIONS REGULATION - MAINE

**Conference/workshop**
**Spare Time Function Facility, Lewiston, Maine**
**September 16, 1994**

## OVERVIEW OF 1994 TOPICS PAPER RESPONSES

by Judy Kany, Project Director for Health Professions Regulation

Copies of the raw data from the responses to the Topics Paper circulated in July are in the conference packets. More Topics Papers arrived after the tabulations and are still arriving.

Here are some conclusions I feel comfortable making after looking at the data and reading the hundreds of comments made by the very wide variety of Mainers responding:

### ASSERTIONS

1. **THERE IS A GREAT AMOUNT OF AGREEMENT ABOUT PRINCIPLES AND MOST ISSUES REGARDING THE REGULATION OF HEALTH PROFESSIONALS.**

2. **THERE IS A GREAT AMOUNT OF CONFUSION ABOUT SOME WORDS ASSOCIATED WITH REGULATION.**

3. **THE REGULATORY FOCUS SHOULD BE ON THE LICENSURE OF INDIVIDUAL PRACTITIONERS.**

4. **OVERLAPPING SKILLS BETWEEN PROFESSIONS SHOULD BE ACKNOWLEDGED--AND CONSUMERS SHOULD BE ABLE TO CHOOSE AMONG PROFESSIONS FOR THOSE OVERLAPPING SERVICES.**

5. **WE CAN EXPECT THE FOCUS DURING THE NEXT FEW YEARS TO BE ON QUALITY IMPROVEMENT, OUTCOMES, AND CONSUMER INFORMATION. THAT INCLUDES CONSUMER INFORMATION ABOUT COSTS.**

6. **SUPERVISION AND DELEGATION ARE GOING TO CONTINUE TO BE TROUBLESOME AREAS AS ORGANIZATIONS CHANGE FURTHER.**

7. **ANOTHER TOUGH AREA WILL BE CONTINUED COMPETENCY.**

8. **HEALTH CARE AND EDUCATION NEED TO BE LINKED TOGETHER MORE EFFECTIVELY--ALONG WITH HEALTH WORK FORCE PLANNING AND THE REGULATORY SYSTEM.**

9. **THERE SHOULD BE NATIONAL ENTRY TO PRACTICE STANDARDS AND NATIONAL COMPETENCY EXAMS.**

10. **THERE IS TOO LITTLE SHARING AND INTERMINGLING OF IDEAS BETWEEN MAINE HEALTH PROFESSIONS. THIS NEEDS TO CHANGE.**

**********

1) **THERE IS A GREAT AMOUNT OF AGREEMENT ABOUT BOTH PRINCIPLES AND MOST ISSUES REGARDING THE REGULATION OF HEALTH PROFESSIONALS.**

A. **Here are PRINCIPLES for Maine to follow while developing a new, coordinated regulatory system across the many health professions. These principles were rated as "Essential" by those responding to the Topics Paper:**

- Protecting the public from risk of harm -- 96%.
- Assuring the competence of the profession -- 94%.
- Protecting against hazardous acts -- 94%.
- Focusing on quality of care -- 85%.
- Enhancing access -- 73%.
- Regulating in the least restrictive manner -- 72%.
- Informing and empowering consumers -- 72%.
- Establishing a coordinated regulatory system -- 62%.
- Fostering innovation -- 61%.

THE ONLY PRINCIPLE LISTED IN THE TOPICS PAPER NOT RECEIVING STRONG SUPPORT IS evaluating cost effectiveness where 49% find it essential and 17% unnecessary.

Some desirable principles may be appropriate for other portions of the health care system, instead of for the regulation of health professions.

COMMENTS ON PRINCIPLES--QUOTES:
"What about outcome evaluation in terms of health status or quality of life?"
"I don't know if it's a regulatory principle but we desperately need to change health care quality from an inspection dominated (process, structure) to a prevention dominated (integration, outcomes) mode."
"My own view is that its main purpose (regulation) should be to protect the public from harm by informing and empowering consumers."
"Encourage the use of lesser trained personnel to do predetermined tasks they do now in some situations. Allow them to do the same task in all instances. For example, allow paramedics to perform intubations, IV, medication administration, and cardiac treatment beyond the prehospital arena."
"Focus on patient needs and continuum of care. Minimum levels of competence should be maintained at all levels -- not just entry."

B. **There is a great amount of agreement on most of the regulatory issues.**

2) **THERE IS A GREAT AMOUNT OF CONFUSION ABOUT SOME WORDS ASSOCIATED WITH REGULATION.** Words like certification, accreditation, licensure, and registration conjure up incredibly varied images for most people.

3) **THE REGULATORY FOCUS SHOULD BE ON THE <u>LICENSURE</u> OF <u>INDIVIDUAL</u> PRACTITIONERS. Individual responsibility is a pretty basic Maine value.**

- 90% believe the public is better protected by regulation of the individual instead of the health professional's employer.
- And 94% say that regulation of the individual practitioner should be in the form of licensure.
- Over 80% believe that disclosure or strict contracts are inadequate alternatives to regulation for health professionals.

QUOTES:
"Each health profession should be responsible for regulating its own profession, with accountability to one body with encompassing authority to oversee safety, access and professional competence issues."
"... neither a professional society nor an employer should be the final arbiter of the right to practice a health profession or of the standards which are the community standard of care."
"This one is great for hospitals, but a real problem for (some professions) where the employer has an interest in regulating (another profession) now."

4) **OVERLAPPING SKILLS BETWEEN PROFESSIONS SHOULD BE ACKNOWLEDGED say 90% of our respondents. -- AND CONSUMERS SHOULD BE ABLE TO CHOOSE AMONG PROFESSIONS FOR THOSE OVERLAPPING SERVICES, say 83%.**

- 62% believe optimal use of personnel is prevented because of the "exclusiveness" in some professions' practice acts.
- 61% say other disciplines are providing the same services, but are not regulated.
- 60% side with allowing waivers of restrictions for demonstration projects.

QUOTES:

"Need to increase scope of practice at mid-level of clinical practice--PAs, NPs, RNs, paramedics."

"Cookbook definitions change too often and can be too limiting."

"Only if there is tort reform, their explicit boundaries can relax."

"Practices do not have "rights," they have authority. The public interest is not served best when appropriately trained personnel are prevented from performing functions for which they are qualified."

"More important to emphasize linkages between professions."

"Have a registration level so all people can practice but consumer will know that the professional has to answer to a board for ethical issues."

"Maine statutes must recognize that overlapping does occur in different professional scopes of practice and often this is in the best interest of the consumer and should be celebrated and not subjected to endless debate."

"More important to assess patient needs and design system to provide continuum of care across practice environments to reduce duplication of services: i.e., the EMS and home health agencies together."

"Have all mental health regulated together and separate by level of education -- doctoral, masters, bach., etc., supervision, exam, national certification, etc. This would allow for one board with sub committees. Currently many insurance companies will not pay for a Licensed Clinical Professional Counselor with vast clinical experience but will pay for a new LCSW with little experience. The consumer needs to be empowered and to choose for self."

"Agree if professionals meet standards of minimal competency for both overlapping fields."

"Choices imply consumer knowledge of the marketplace and their own needs."

"Consumers are not educated enough to determine differences, POSSIBLY with a tremendous amount of education this can change."

5) **WE CAN EXPECT THE FOCUS DURING THE NEXT FEW YEARS TO BE ON QUALITY IMPROVEMENT, OUTCOMES, AND CONSUMER INFORMATION. THAT INCLUDES CONSUMER INFORMATION ABOUT COSTS.**

- The laws and rules for all professions should be made easily available, say 99% of our responders.
- Substance abuse treatment of health professionals should remain confidential -- 68%.
- 78% say information about disciplinary or other adverse actions should be made public.
- Providers' prices, outcomes, and other quality information should be posted -- 76%.
- Consumer information about the qualifications of regulated health practitioners should be made readily available -- 93%.
- 94% would promote consumer education, information, participation, empowerment.
- 87% recommend facilitating free choice among providers within a range of safe options.
- 88% say the public needs to be better informed of its right to complain and to whom to complain.
- More parameters and protocols should be developed under the Medical Liability and Demonstration Act -- 72%, and
- 72% believe practice guidelines should be developed for the work of all of the professions.
- Each profession should develop a quality assurance plan -- 83%. Several people mentioned we should talk about quality improvement, instead of quality assurance as used in the Topics Paper.
- Quality assurance should focus on outcomes, 81% agree -- and should include consumer input, 84% say.
- 80% say there should be mandatory reporting of changes in a practitioner's credentials and privileges by hospitals.
- 63% say health professions' licensure laws are inappropriate laws for restrictions on where and how one can do business.

- 60% believe it is inappropriate for regulatory boards to regulate unreasonable professional fees.
- 85% believe fees should be posted for consumer information, if fee-for-service.

QUOTES:

"The focus of regulation should be outcome based. Outcomes should be compared to preestablished standards wherever possible. The preestablished standards should first address potentially harmful practices and services but should go on to raise the standard of care generally and to foster rapid adoption of changes in effective technology and scientific knowledge."

"This questionnaire reflects the medical model. Alternative health care systems do exist and are cost effective. The government's obligation should be to insure safety, availability, access to ALL care."

"Involve CONSUMERS!"

"Were it not, no one would submit to treatment. Substance abuse is a disease and should be viewed no differently than diabetes or coronary artery disease. Any other view is based on stereotypes and discrimination from a less enlightened age."

"When final. The fact of an investigation of allegations should not be."

"Perhaps I'm wrong, but it seems a doctor has to be extremely dangerous before anything is done."

"Volume might warrant a full time panel for disciplinary matters in health care alone."

"The regulatory board authority should be limited to qualification. Discipline should be with another board."

"Should be of peers and public."

"Membership into state professional association is not based on credentialing. Therefore, it is very risky to use as expertise - The national credential or certification board may be more appropriate."

"The percent of trade association's membership on the board should equal the percent of the members of the profession who belong to it."

## 6) SUPERVISION AND DELEGATION ARE GOING TO CONTINUE TO BE TROUBLESOME AREAS AS ORGANIZATIONS CHANGE FURTHER.

There is little agreement on supervision questions. Should Maine allow greater flexibility for regulating supervised health practitioners within a licensed health care facility? Are the requirements for supervision of professions unnecessarily stringent?

- There is considerable agreement -- 76% -- that gatekeepers should be regulated.
- There is little agreement about questions of delegation.
- Given the statement "It is appropriate for members of this profession to delegate acts licensed to them to other persons who are not licensed to perform these acts." -- 40% agree, 18% express neutrality, and 43% disagree.

QUOTES:

"Institutional credentialing and privileging should be acknowledged in law and extended to non-institutional provider entities (medical offices, clinics)."

"Shouldn't be any gatekeepers. Should be a team."

"Not only should they be regulated, but also prove competency in areas of patient needs -- i.e., treating individuals with disabilities. Individuals with varying disabilities (C.P., L.D., Mitt., etc.) needs are not met with a one size fits all approach."

"Supervision should be required but professionals should be allowed to choose -- but the supervisor should have clinical background for the counseling profession -- Gatekeepers are not supervisors; they are case managers."

"Debatable!! Depends on who they are, but they certainly need a broad understanding of the skills."

"With limited resources (fiscal & human), the rural nature of Maine and resulting unique circumstances, it makes good sense to not only delegate, but to ensure (via certification, registration, etc.) that the person with responsibility is appropriately qualified. Cross-training is another option which I support."

"The person delegated to should also share liability. In case of CNM or Nurse in Advanced Practice -- the CNM should be totally liable for her acts unless she acted on direct orders of the MD supervisor. As a licensed person she should know when to refuse to act as ordered. She should at least know safety limits."

"Enterprise and supervisor should be mutually accountable."

## 7) ANOTHER TOUGH AREA WILL BE CONTINUED COMPETENCY.

- It is O.K. to grandfather current practitioners, say 62% of our respondents.
- Regulatory boards should deal with candidates for entry to practice whose mental capacity or morality is at issue, according to 70%
- The final authority over entrance to practice should NOT rest with the specific employer (87%), but with Maine law (86%).
- 77% believe regulatory boards should ensure continuing competence.
- 66% say that health professionals should have to prove continuing competence, not just continuing education credit.
- 61% say continuing educational units (CEUs) are an effective mechanisms to update skills.

QUOTES:

"The standard for valuable content and attendee comprehension of the subjects presented in CME is so loose as to be inconsistent and almost forces us to base our reliance on CME as a competency builder on faith alone."

"Health professionals should be accountable for their continuing competence. CEUs have not proven to be effective in this."

"Need a process--not necessarily exams--Maine EMS has established several pathways for re-licensure."

"For a period of time."

"Not without instruction, of course."

"As long as there is an educational process to keep them up to date."

"Only if the person being grandfathered meets the new standards. Otherwise, they should be allowed a specific time to meet the new standards or lose license."

"No. You must train them and provide money for that if necessary."

## 8) HEALTH CARE AND EDUCATION NEED TO BE LINKED TOGETHER MORE EFFECTIVELY--ALONG WITH HEALTH WORK FORCE PLANNING AND THE REGULATORY SYSTEM.

- Health care and education need to be linked together more effectively, say 93%.
- Encourage health work force planning -- 82%.
- 59% want to encourage multi-credentialing of health care workers.
- 39% say to base the educational system more on health outcomes.
- 71%: Better use the regulatory structure and licensing requirements for data collection and work force planning.
- 88%: Develop strong coordination between the health care delivery system, the health professions regulatory system, and educational institutions.
- Involve providers (hospitals, long term care, community health centers, etc.) in establishment of professional licensing standards, 63% agree. It is also strongly suggested we "Involve CONSUMERS!"

QUOTE:

"Involve CONSUMERS!"

## 9) THERE SHOULD BE <u>NATIONAL</u> ENTRY TO PRACTICE STANDARDS AND NATIONAL COMPETENCY EXAMS.

- 96% say Maine professions should work with other states to achieve consistency in entrance to practice standards.
- 85% of respondents say "I favor national entry to practice standards."
- 92% agree there should be national competence based exams for all of the health professions.

QUOTES:

"National certification has higher requirements than licensure."

"If there is a national standard and exam then reciprocity would be great but not as it stands now."

"I can see a decline in standards and performance (outcome!) if the Feds dictate what is acceptable. The bottom line is what they see first. The standards should be developed by the states and agreed upon, not dictated by the Feds."
"Agree. But allowance should be made for special needs, such as modified scopes of practice for practitioners in outlying areas who might have narrower ranges of expertise than national criteria call for."
"Perhaps. The drawback is that the people of Maine would lose whatever direct voice they have in the setting of baseline licensure standards and a least common denominator would apply nationwide. How would license revocation occur? The alternative could be that all states adopt uniform licensing standards (like the Uniform Commercial Code and other such codes). This would then avoid the circumstances of Alabama requiring one year of postgraduate training for doctors while Maine requires two (three if an International Medical Graduate)."
"Agree -- and national exams appear to be a strong trend in health care."
"The best minds in medical education have yet to devise a way to prospectively measure and predict competency after the fact based on outcomes and to give written exams which test only for a least common denominator baseline knowledge below which no physician should be permitted to practice in any capacity."
"It seems funny that hairdressers need so many more hours of schooling to get a Maine license when they have passed exam in other state."
"Special permits in nuclear medicine will only allow health care worker to practice in State of Maine. This is because it is on the job training without formal education. (It should be abolished.) No other state, to my knowledge, would agree to license this type of "education" received in Maine by these health care workers who are previously X-ray trained only."

## 10) THERE IS TOO LITTLE SHARING AND INTERMINGLING OF IDEAS BETWEEN MAINE HEALTH PROFESSIONS. THIS NEEDS TO CHANGE.

- Maine's health professions regulatory system can be better designed to meet the requirements of the changing health care system: 76% agree.
- Promote flexibility in how individual professionals can be used: 78% agree.
- Promote evolution in the roles played by individual professions -- 77%.
- 70% would encourage cross training.
- 68% say that effective cooperative teams should pervade the system.
- 80% of respondents believe a dispute mechanism for resolving problems between health professions should be established.
- 91% agree that inter-professional recognition needs to be fostered.

QUOTES:
"Evolution will occur without being 'promoted'."
"Yes!"
"Why not an association for all Maine health professionals?"
"I believe we still need multiple boards to regulate practitioners with perhaps an ongoing "linkages" board to facilitate relationships between professions--question of expertise."
"Why not a joint investigative process?"
"Please."

## SUMMARY

In summary, there is a considerable amount of agreement from a wide variety of health professionals and others about both the principles and ingredients for a new, coordinated health professions regulatory system for Maine.

# APPENDIX F

## Focus Group Protocol - 1996

# FOCUS GROUP PROTOCOL - 1996

Saskia Janes

## Purpose

The focus groups were designed to address two goals. The first goal was to learn more about what the target population had to say on the topic of health professions regulation in general and more specifically about issues identified by the project and included in the preliminary recommendations (please see June 1995 report). The second goal was to encourage dialogue among health professionals in different occupations, legislators, and citizens-at-large 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 provided the opportunity to listen and learn from professionals in different areas of the state. The information collected in these discussions is to be used as an indicator of issues and concerns and to inform the project's continuing discussion 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.

## Target Population

It is a misconception to assume that any one individual can fully represent their profession's opinion. Each person speaks for him/herself. These individuals may, however, offer insights about the opinion of an entire group of professionals although the degree of accuracy may vary greatly. Since the purpose of this series of focus groups had two goals, we chose to diversify the target population rather than conduct discussions with homogeneous groups. The guiding principle was the degree to which sharing and cross dialogue would occur within the group. The driving force in determining participant selection is the purpose of conducting the groups.

## Question Development

Generally, focus group questions are developed in a particular sequence that is designed to introduce the subject for discussion. This target population was already familiar with the topic of health professions regulation. Instead of using sequencing in the questions, we chose to introduce the subject of health professions regulation by providing an overview of the origins of the project and project activities. Questions were developed from the recommendations and reflected general concerns and areas related to regulation. Questions were developed based on key areas of interest found in those recommendations. The questions were not tested prior to group implementation because these areas had already been identified by representatives of the target population in an indicator survey early in the project and in a series of discussions that followed.

## Recruitment of Participants

Twenty-two focus groups were conducted in Maine during the summer and fall of 1996. These groups consisted of people who worked in the health field including health care professionals, administrators, and policy-makers. Every attempt was made to bring together a broad cross-section of representatives from these general categories. The following groups were identified:

- Physicians (allopathic and osteopathic)
- Dentists, dental hygienists, podiatrists, chiropractors, optometrists, and naturopaths
- Mid-level practitioners: nurses, nurse practitioners, physician assistants
- Allied health professionals: occupational therapists, physical therapists, speech pathologists
- Behavioral health professionals: counselors, psychologists, psychiatrists, social workers,
- Community health professionals: health educators, home health care, nursing care facilities, hospitals, counseling agencies
- Policy makers: legislators, regulatory board members, university trustees
- Citizens-at-large
- Faculty, etc.

The number of participants in each group ranged from 5 to 25 with an average of 10 participants. The recommended number of participants for focus groups is 6-10 people which allows for an adequate discussion of complex issues. All participants were recruited based upon their indication of interest in participating (returning a form from the May 1996 newsletter) and role representation. Attempts were made to ensure that all segments of health professions regulation areas were represented in the groups. A list of professionals in different geographic areas was generated by the project director, advisory committee, and project staff. Letters of invitation were sent to those individuals on the list. In addition, when a particular profession (i.e., a physician, allied health professionals) did not appear on the list for a particular area, other methods of recruitment were used (i.e., consultation with the hospital administrator or other agencies and from other providers, listings in the yellow pages of the telephone book). Not all of those who indicated an interest in participating were able to attend due to personal or group scheduling.

Selection bias can be a problem in focus group populations and every effort was made to include a random cross section of health professionals. However, in a rural state and in small communities, there are limitations on participants who are available to volunteer to attend a two hour discussion. In addition, the specialized nature of the subject matter creates its own limitations and people must have some working knowledge of the topic as well as be willing to participate. An additional factor in selection bias lies in the use of outside recruiters. We relied on a significant amount of participation on the part of the hospital administrators and other providers in recruiting people to the groups. Although, in all but one case, the project sent the letters of invitation, including a project update, describing the project.

These letters were the same for 21 groups. In one case, all participants were chosen by a hospital staff person and that person sent a letter of invitation which was different from the one we developed. All groups included at least one participant (and usually more) recruited locally by non-project staff. This, however, does not eliminate bias since the bias of the recruiter may also be present. No selection process is perfect and the best choices were made with the knowledge that was available to the project at the time. Selection involves trade off and is limited by our human capacities. In diverse focus groups on highly specialized topics with a dual purpose, the element of bias in selection may actually serve to enhance the chance that groups will meet the stated goals and conditions.

Twenty-one groups were held at hospitals and one group was held at Medical Care Development. Hospitals were chosen as the site for groups for their convenience in terms of location, because they were familiar to the participants some of whom were frequently on site, and because they had the facilities needed to conduct a discussion.

**Verification**

All group discussions were audiotaped and two were transcribed completely. Due to the enormous amount of raw data, descriptive statements were generated in the interest of data reduction. All group participants received a draft of the group discussion summary featuring descriptive statements for their review in order to be certain that it accurately reflected the meeting's key points and discussion topics.

**Methods of Analysis**

An inductive process is used to analyze focus group data. The goal is to derive understanding based on the discussion as opposed to testing or confirming a preconceived hypothesis or theory. Therefore, coding was used as a means of organizing the material generated in the discussions into categories that reflect responses to major questions. In addition, responses were organized into categories based on the responses of a particular group of providers to further identify any particular issues and concerns of those groups. Themes and patterns and similarities and differences were identified across all focus groups. Another factor that emerged from these groups is the fact that patterns of response were not necessarily uniform across all sites.

We used a combination of field notes and tape-based analysis. Field notes consisted of descriptive statements analysis with selected tape consultation for clarity. Emerging themes were identified for each question in each group and then overall. Coding categories were developed and the data was coded and sorted. All the data was reviewed a second time to be sure all pertinent data was included. Additional data was collected from the moderators' debriefing which followed each group, the results of those findings appear in the focus group report.

Individual quotes were chosen to provide insight into the ways in which participants responded. In addition, an attempt was made to capture as many common insights into topics and issues as was possible considering the amount of material.

# APPENDIX G

## UNECOM Graduate Competencies for the Twenty-First Century

# UNECOM GRADUATE COMPETENCIES FOR THE TWENTY-FIRST CENTURY

**(University of New England College of Osteopathic Medicine, 1996)**

Graduates will have the knowledge, skills, and professional perspective to:

1. Integrate Osteopathic philosophy in all aspects of their professional activities, including:
   - using Osteopathic principles to guide health care delivery
   - using Osteopathic manipulative medicine in therapeutic management

2. Understand health and illness in the context of the interrelationships of the structure and function of the mind and body, by:
   - mastering a core of basic and clinical sciences
   - understanding the etiology, natural history, and prevention of core diseases
   - using this knowledge in the provision of health care

3. Prevent illness; diagnose and manage acute and chronic illness; and maintain health.

4. Gather and interpret patient information, including history and physical examinations and diagnostic testing.

5. Incorporate the practice of health promotion and disease prevention in the care of patients, families, and communities.

6. Use the principles of scientific inquiry in:
   - understanding the design and conduct of clinical research
   - interpreting and critically evaluating research literature
   - evaluating practice guidelines

7. Use scientific, economic, and ethical principles in managing cost-effective and quality care to patients, families, and populations--including the use and evidence-based selection of:
   - diagnostic testing
   - treatment modalities
   - preventive techniques

8. Understand the influence of the physical and social environment on the health of individuals, families, and communities.

9. Effectively teach patients, students, colleagues, and others.

10. Apply the principles of patient-centered care, including:
    - understanding the patient's experience of health and illness
    - communicating effectively -- listening, informing and educating
    - enhancing patient self-care competence
    - honoring individual and community values, beliefs, ability and preferences

11. Critically appraise non-traditional healing modalities and provide guidance to patients in their use.

12. Recognize and discuss with patients, families, and colleagues the ethical and legal issues involved in clinical and preventive care.

13. Pursue continuous professional development and competency through study, consultation, and personal reflection.

14. Use information technology to search out, organize and analyze information to guide clinical decision-making and quality care management.

15. Function in an integrated health care system, either as an independent practitioner or as a member of a multidisciplinary team.

16. Recognize the economic and political environment in which health care occurs and its effect on the organization and business climate in which health care is provided.

# APPENDIX H

## Substitutes for Selected Health Professions

## SUBSTITUTES FOR SELECTED HEALTH PROFESSIONS

Source: Begun, James W. and Lippincott, Ronald C., *Strategic Adaptation in the Health Professions, Meeting the Challenges of Change*, Jossey-Bass Publishers, San Francisco, 1993.

| PROFESSION | SUBSTITUTE OCCUPATIONS & PROFESSIONS |
|---|---|
| Administrators, health care | General business administrators and clinicians without health care administration entry education (P) |
| Administrators, long-term care | General business administrators and health care administrators without long-term care entry education (P) |
| Chiropractors | Physical therapists (P), physicians (P) |
| Dental hygienists | Dentists (P), dental assistants (S) |
| Dentists | Dental assistants (S), dental hygienists (S), denturists (S), oral surgeons (S) |
| Denturists | Dentists (P) |
| Dietitians | Dietetic assistants (S), dietetic technicians (S) |
| Medical record administrators | Noncredentialed personnel (P), medical record technicians (S) |
| Medical technologists | Pathologists (P), medical lab technicians (S) |
| Nurse anesthetists | Anesthesiologists (P) |
| Nurse-midwives | Lay midwives (P), obstetricians (P) |
| Nurses, registered | Physician assistants (P), physicians (P), licensed practical nurses (S), nurse assistants and aides (S), physical therapists (S), recreational therapists (S), respiratory therapists (S), other therapists and technicians (S) |
| Occupational therapists | Occupational therapy assistants (S), physical therapists (S), recreational therapists (S), registered nurses (S), other therapists (S) |
| Optometrists | Ophthalmologists (P), opticians (S), optometric technicians (S) |
| Pharmacists | Physicians (P), pharmacy technicians (S) |
| Physical therapists | Chiropractors (P), physicians (P), occupational therapists (S), physical therapy assistants (S), other therapists (S), registered nurses (S) |
| Physician assistants | Nurse practitioners (P), physicians (P), registered nurses (S) |
| Physicians - DOs | MDs (P), others listed as substitutes for MDs |
| Physicians - MDs | DOs (P), chiropractors (S), dentists (S), nurse anesthetists (S), nurse-midwives (S), nurse practitioners (S), optometrists (S), physician assistants (S), podiatrists (S), psychologists (S), surgical assistants (S), various therapists and technologists (S) |

| | |
|---|---|
| Podiatrists | Physicians (P), chiropractors (S) |
| Psychologists | Medical social workers (P), psychiatric nurse practitioners (P), psychiatrists (P), other counselors (P) |
| Radiologic technologists | Noncredentialed personnel (P), radiologists (P) |
| Recreational therapists | Occupational therapists (S), other therapists (S), therapeutic recreational assistants (S) |
| Respiratory therapists | Registered nurses (S), respiratory therapy technicians (S) |
| Social workers, medical | Other counselors (P), social service assistants (S) |
| Speech-language pathologists & audiologists | Noncredentialed personnel (P) |

P = Substitutes for the primary work domain of the profession; S = substitutes for secondary tasks of the profession.

# APPENDIX I

## Ethical Conduct Workshop

# ETHICAL CONDUCT WORKSHOP

The Maine Department of Professional and Financial Regulation hosted a conference on January 31, 1997. The afternoon session consisted of an Ethical Conduct Workshop: Models of Ethical Decision Making presented by Deborah Long, Ed.D. She believes that Lawrence Kohlberg's (1927-1988) research "transformed the landscape of moral development theory." Some excerpts from Dr. Long's handout follow:

- Individuals must progress through the stages of moral judgment in sequence.
- Once a way of moral judgment has become established, that method will not deteriorate because levels are not reversible.
- Individuals cannot fall from a higher to a lower stage; neither can they jump from the first stage to the third.
- Individuals at one stage cannot comprehend moral reasoning at a stage more than one beyond their own.
- Individuals are cognitively attracted to reasoning at one level above their own.
- Movement through the stages is affected when a person's cognitive outlook is inadequate to cope with a given moral dilemma.

Adapted from *The Moral Manager* (1988) by Clarence C. Walton. New York: Harper Business.

Kohlberg's Six Stages

| LEVEL | STAGE | SELF-PERCEPTION |
|---|---|---|
| Stage 1 | Obey or pay | Outside the Group |
| Stage 2 | Self-interest | Outside the Group |
| Stage 3 | Win others' approval by helping them | Inside the Group |
| Stage 4 | Law and order | Inside the Group |
| Stage 5 | Respect individual rights and abide by critically examined values | Above the Group |
| Stage 6 | Act in accordance with logically developed and universally accepted principles | Above the Group |

Mitigating factors:

- Professional standards, codes of conducts, and guidelines espoused by the private and public sector.
- Internal controls, such as adequate supervision and training of staff and careful review of work.
- Team review/auditing of critical cases or issues.
- Peer reviews by an independent group from another organization or from a regulatory body.
- Affiliation and peer pressure within the organization.
- The individual's personal integrity, ethical capacity and orientation.
- Government regulation.

(from *Ethical Decision Making Skills, Issues for Professional and Occupational Licensing Boards*, Deborah Long, Ed.D., 123 Woodleaf Drive, Chapel Hill, NC 27516, 1997. Reprint permission granted.)

# APPENDIX J

## Summary of Credential Eligibility Requirements for Regulated Maine Health Professionals

# SUMMARY OF CREDENTIAL ELIGIBILITY REQUIREMENTS FOR REGULATED MAINE HEALTH PROFESSIONALS

October 1, 1997

**(For licensure and other purposes, contact the regulatory boards for complete, up-to-date information. The summaries of the practice acts are for quick reference only and have no legal standing.)**

## ALCOHOL AND DRUG COUNSELORS
## 32 MRSA 6201-6221

**Board.** State Board of Alcohol and Drug Counselors: 11 member board, representing a broad geographic distribution of the state and from among the professional associations representative of the field. Included on the board: the Director of the Office of Substance Abuse or a designee, a university faculty member involved in the training of alcohol or drug counselors, five licensed alcohol and drug counselors, two nonproviders including one public member and a family member of a consumer of alcohol and drug counseling services or a consumer of such services who has abstained from alcohol or drug use for at least two years.

**Licensure or other regulation.** Licensure in order to practice without supervision or to engage in private practice. Registration for others in practice. (Editor's note: Both categories fit within the definition of licensure and perhaps it would assist communication and understanding to call one a license--and rename the other a "limited license.") Both licensed alcohol and drug counselors and registered alcohol and drug counselors must meet state requirements and can have licenses or certificates of registration suspended or revoked by the state after a formal hearing. After denial, an applicant can re-apply after a specified period.

**Scope of practice.** Provides alcohol and drug counseling to the public for a fee, monetary or otherwise.

**Requirements for licensure.** (1) 18 years of age. (2) Abstention from alcohol or drug use which, in the judgment of the board, has been or could have been detrimental to the applicant's performance or competency as a substance abuse counselor. This includes no violations of OUI for at least two years.

For a licensed alcohol and drug abuse counselor, (1) obtained at least an associate's degree in an appropriate social science field from an accredited institution or program approved by the board with a concentration in the 12 core functions outlined by the board. (2) Completed at least 4,000 supervised direct client service hours in the 12 core functions. (3) Documented experience with a wide variety of clients in various treatment settings while working independently.

For a registered alcohol and drug abuse counselor, (1) completed 300 hours of education in appropriate social science fields or its equivalent in alcohol and drug counseling training, with at least half in college level courses related to the Board's 12 functions. (2) Completed 4,000 supervised direct client service hours in the 12 core functions. (3) Documented related counseling experience in one setting or client population.

**Endorsement.** Examination requirements may be waived by the board, at its discretion, if the applicant has been certified or licensed by an approved national credentialing agency.

**Examination.** For a licensed alcohol and drug abuse counselor, passage of the written and oral exams prescribed by the board.

For a registered alcohol and drug abuse counselor, passage of the written exams prescribed by the board.

**Continuing education requirements.** Five continuing education units (50 hours) every two years

**Requirements for continued competency assessment or re-licensure.** None.

## ATHLETIC TRAINERS
## 32 MRSA 14351-14362

**Board.** The Commissioner of the Department of Professional and Financial Regulation shall administer, adopt rules, and enforce the standards for athletic trainers. The Commissioner shall select members of the athletic training community to serve on an Advisory Council. The membership will include athletic trainers from each of the following: high schools, clinical or industrial organizations, colleges or universities, and professional sports.

**Licensure or other regulation.** Registration.

**Scope of practice.** "Athletic training" means:

- Prevention of athletic injuries;
- Recognition and evaluation of athletic injuries;
- Management, treatment and disposition of athletic injuries;
- Rehabilitation of athletic injuries;
- Organization and administration of an athletic training program; and
- Education and counseling of athletes, recreational athletes, coaches, family members, medical personnel and communities in the area of care and prevention of athletic injuries.

An athletic trainer may not make a medical diagnosis for the treatment of the recreational athlete, for other than emergency care or the care of minor sprains, strains and contusions. The athletic trainer must refer the athlete to a physician, podiatrist, dentist, or physical therapist.

Education, clinical training, and experience requirements for licensure. Graduation from a college approved by the department and completion of that college's curriculum in athletic training or other curricula satisfactory to the department and completion of an athletic training education program approved by the National Athletic Trainers' Association or a program of practical athletic training acceptable to the department.

**Examination.** Passage of the National Athletic Trainers' Association Board of Certification exam or current certification by the National Athletic Trainers' Association approved by the department.

**Continuing education requirements.** Yes.

## CHIROPRACTORS
## 32 MRSA 451-558

**Board.** Board of Chiropractic Examination and Registration: Five active chiropractors, two public members

**Licensure or other regulation.** Licensure.

**Scope of practice.** Chiropractic means the art and science of identification and correction of subluxation and the accompanying physiological or mechanical abnormalities. The term subluxation means a structural or functional impairment of an intact articular unit. Chiropractic recognizes the inherent recuperative capability of the human body as it relates to the spinal column, musculo-skeletal and nervous systems. Chiropractic methodologies used for the identification or correction of subluxation and the accompanying physiological or mechanical abnormalities include diagnostic,

therapeutic, adjustive or manipulative techniques utilized within the chiropractic profession, excluding prescriptive medication or surgery.

**Education requirements.** Two years post-secondary and diploma from 4-year accredited chiropractic college.

**Reciprocity or endorsement.** Reciprocity. (Reciprocity or mutual recognition: that state must recognize Maine licensing requirements and accept them for licensure.)

**Examination.** Oral, written, and practical exams.

**Continuing education requirements.** 24 hours for two years for re-licensure.

**Requirements for continued competency assessment or re-licensure.** None.

**Accrediting organization for education program.** By a chiropractic accrediting agency approved by the US Department of Education or by the board.

## CHIROPRACTIC ASSISTANTS
## 32 MRSA 555-558

**Board.** Board of Chiropractic Examination and Registration: five active chiropractors, two public members.

**Licensure or other regulation.** A certificate of qualification as designated by rule of the board.

**Scope of practice.** Under the direction and supervision of a chiropractor, ancillary diagnostic or therapeutic services as used in a chiropractic practice, other than the adjustive or manipulative techniques, if those services are rendered under the supervision and control of a chiropractor. This does not necessarily require the chiropractor's presence. May serve as chiropractor's agent when a licensed chiropractor delegates treatment activities performed by custom or usage, is present, and provides direct control.

**Education requirements.** Course of study approved by the board or a course of study provided by an accredited chiropractic college.

**Examination.** As determined by the board or conducted by an accredited chiropractic college.

**Requirements for continued competency assessment or re-licensure.** None.

**Accrediting organization for education program.** By a chiropractic accrediting agency approved by the US Department of Education or by the board.

## COMPLEMENTARY HEALTH CARE PRACTITIONERS
## ACUPUNCTURISTS AND NATUROPATHS
## 32 MRSA 12501-12526

**Board.** Board of Complementary Health Care Providers: seven members including two acupuncturists, two practitioners of naturopathic medicine, one public member, one allopathic or osteopathic physician, and one pharmacist.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Acupuncturists are practitioners of acupuncture. Acupuncture means the insertion of fine metal needles through the skin at specific points on or near the surface of the body with or without the palpitation of specific points on the body with or without the application of electric current or heat to the needles or skin, or both. The practice of acupuncture is based on traditional oriental theories and serves to normalize physiological function, treat certain diseases and dysfunctions of the body, prevent or modify the perception of pain, and promote health and well-being.

Naturopaths or naturopathic doctors practice naturopathic medicine and have a limited scope of prescriptive authority. Naturopathic medicine means a system of health care for the prevention, diagnosis and treatment of human health conditions, injuries and diseases that uses education, natural medicines, and therapies to support and stimulate the individual's intrinsic self-healing processes.

**Education, clinical training, and experience requirements for licensure.** Acupuncturists: a bachelor's degree from an accredited college, an RN license, or successful completion of the training program and any competency exam required by the Board of Licensure in Medicine to be qualified as a physician's assistant, in addition to 1,000 hours of classroom instruction in acupuncture and related subjects, and 300 hours of clinical experience in the field of acupuncture.

Naturopaths: graduation from an approved naturopathic medical college.

**Endorsement.** Yes, for acupuncturists.

**Examination.** Acupuncturists: Certification by the National Commission for the Certification of Acupuncturists or passage of a written exam administered by the board.

Naturopaths must have passed a competency-based exam approved by the board.

**Continuing education requirements.** 30 hours every two years for acupuncturists. For naturopaths, 25 hours annually with an additional 15 hours for those who hold a specialty certification in naturopathic acupuncture.

When practicing without malpractice insurance, naturopaths need to disclose to each patient that they do not have insurance.

## COUNSELING
## 32 MRSA 13851-13863

**Board.** Board of Counseling Professionals Licensure: two public members including one consumer of counseling services, one member of the university faculty involved in the training of counselors, two registered counseling professionals not yet qualified for licensure, and eight licensed counseling professionals, including two clinical professional counselors, two professional counselors, two marriage and family therapists, and two pastoral counselors.

**Licensure or other regulation.** Licensure and registration. Licensure prohibits others from calling themselves a clinical professional counselor, a professional counselor, marriage and family therapist, licensed pastoral counselor, or conditional license holder, but does not prohibit others from the practice of counseling. Others who practice counseling as defined in the scope of practice must register unless exempted. There are a number of exemptions to the requirement that individuals engaging in the procedures of counseling for remuneration be licensed or registered--exemptions include government employees and the clergy, among others. Both licensees and registrants are subject to discipline with the ultimate censure being the revocation of the privilege of being licensed or registered as a counselor.

**Scope of practice.** Professional counselor means a person who, for a fee, offers to render a service involving the application of principles and procedures of counseling to assist those served in achieving more effective personal, emotional, educational and vocational development and adjustment.

Procedures of counseling means methods and techniques that include, but are not limited to, the following:

- Assessment means selecting, administering and interpreting instruments designed to assess personal, interpersonal and group characteristics;
- Consulting means the application of scientific principles and procedures in counseling to provide assistance in understanding and solving a current or potential problem that the client may have in relation to a third party, be it an individual, a family, a group or an organization;
- Counseling means assisting individuals, families or groups through the counseling relationship to develop understanding of intrapersonal and interpersonal problems, to define goals, to make decisions, to plan a course of action reflecting their needs, and to use information and community resources, as these procedures are related to personal, social, educational and vocational development; and
- Referral means the evaluation of information to identify needs or problems of the counselee and to determine the advisability of referral to other specialists, informing the counselee of that judgment, and communicating as requested or deemed appropriate with referral sources.

**Education, clinical training, and experience requirements for licensure.** For a licensed professional counselor, a master's degree in counseling or an allied mental health field from an accredited institution or program approved by the board. Such schooling shall have included a minimum core curriculum as adopted by the board and two years of experience after obtaining the master's degree, with a minimum of 2,000 hours of supervised experience.

For a licensed clinical professional counselor, a master's degree in counseling or an allied mental health field from an accredited institution. Such schooling will include a minimum core curriculum as adopted by the board of at least 45 semester hours and two years of experience to include at least 3,000 hours of supervised clinical experience with a minimum of 100 hours of personal supervision.

For a licensed marriage and family therapist, a master's degree in marriage and family therapy or its equivalent from an accredited institution or program approved by the board. Such schooling shall have included a minimum core curriculum to include a one year practicum adopted by the Board and two years of experience after the master's, with at least 1,000 hours of direct clinical contact with couples and families and 200 hours of supervision, at least 100 of which shall be individual supervision.

For a licensed pastoral counselor, a Master of Divinity degree or its equivalent from an accredited institution, including a minimum graduate core curriculum to include 20 credit hours of counseling and human relations and 400 hours of clinical pastoral education. Additional requirements include two years of experience after the degree with at least 1,000 hours of direct clinical contact, 200 hours of supervision, requirements for which are detailed in the statutes and rules, and a request from a religious organization to perform these services.

Supervision may be provided by a qualified and duly certified or licensed counseling professional, clinical social worker, psychologist or psychiatrist, except for where statutes call for more specific qualifications for the supervisor.

**Requirements for registration.** There are no credential standards for registration. However, disclosure of training and expertise and a description of the individual's practice must be provided to the Department of Professional and Financial Regulation. Each registrant must post and make a copy available to each client of: the client bill of rights approved by the Board, the code of professional ethics approved by the Board, and the name and telephone number of the Board's complaint officer and a description of the complaint process.

**Endorsement.** Endorsement for licensure. See provisions for licensure by comity. 32 MRSA 13857.

**Examination.** Exam prescribed by the board for L.C.P.C., L.P.C., marriage and family therapists, and pastoral counseling licenses. No exam required for registration.

**Continuing education requirements.** 55 hours every two years for re-licensure

**Requirements for continued competency assessment or re-licensure.** None.

## DENTISTS
## 32 MRSA 1061-1100-Q

**Board.** Board of Dental Examiners: Five active dentists, one active dental hygienist, and one member of the public. The Board may affiliate with the American Association of Dental Examiners.

**Licensure or other regulation.** License.

**Scope of practice.** Any person is considered to be practicing dentistry who:

- Performs, or attempts, or profess to perform, a dental operation or oral surgery or dental service of any kind, free of charge or for remuneration;
- Takes impressions of a human tooth, teeth, or jaws, by any means or method, or who performs any operation to replace a part of a tooth;
- Supplies artificial substitutes for the natural teeth, or who furnishes, supplies, makes, or repairs a prosthetic denture, bridge, appliance, or any other structure to be worn in the human mouth;
- Places such an appliance in the human mouth, adjusts it, or delivers the same to a person other than the dentist upon whose prescription the work was performed;
- Diagnoses or professes to diagnose, prescribes for or professes to prescribe, or treats or professes to treat, disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaw or adjacent structure;
- Extracts or attempts to extract human teeth, or corrects or attempts to correct malformations of teeth or jaws;
- Repairs or fills cavities in human teeth;
- Diagnoses, makes and adjusts appliances to artificial casts or malposed teeth for treatment of malposed teeth in the human mouth;
- Uses an X-ray machine for the purpose of taking dental X-rays;
- Gives or professes to give interpretations or readings of dental X-rays;
- Supervises dental hygienists, dental radiographers, denturists, and dental assistants; or
- Administers an anesthetic in connection with a dental operation.

A dentist has the right to prescribe drugs or medicines and administer general and local anesthetics as may be necessary for dental treatment.

**Education, clinical training, and experience requirements.** DMD or DDS degree diploma from a dental school accredited by the American Dental Association Council of Accreditation.

**Endorsement.** Upon discretion of the board and after a face-to-face interview, after proof of licensure and five years' experience.

**Examination.** (1) Parts I and II from the National Board of Dental Examiners, (2) Northeast Regional Dental Board exam, (3) jurisprudence exam given by the Board, and (4) a personal interview for those who completed the previous requirements more than a year prior to application for licensure. Exams limited to one repeat.

**Continuing education requirements.** 40 hours during the two years prior to renewal of license. Must relate to professional competency and to the licensee's practice setting.

**Requirements for continued competency assessment or re-licensure.** In addition to the CEU requirements, the American Association of Dental Examiners has formed a committee to examine the possibilities for continued competency assessment.

**Accrediting organization for education program.** American Dental Association.

## DENTAL HYGIENISTS
## 32 MRSA 1061-1100-Q

**Board.** Board of Dental Examiners: five dentists, one dental hygienist, and one member of the public.

**Licensure or other regulation.** License with a requirement of "direct supervision" (on premises in the dental office) for several duties. A larger number of duties can be performed with "general supervision" by the dentist, where the dentist is not required to be in the dental office or at the public health site while procedures are being performed.

**Scope of practice.** By rule, practicing under the supervision of a dentist.

**Education, clinical training, and experience requirements.** Two years' training in a school of dental hygiene approved by the board or a full-time student half way through an approved dental school.

**Endorsement.** By discretion of the board and after an interview in person to individuals licensed in other states.

**Examinations.** (1) National Board of Dental Hygiene Exam, (2) Northeast Regional Board of Dental Hygiene (NERB) exam, (3) jurisprudence exam given by the board, and (4) a personal interview by the board, if the NERB was completed more than one year before application.

**Continuing education requirements.** 20 hours every two years.

**Requirements for continued competency assessment or re-licensure.** None.

## DENTURISTS
## 32 MRSA 1061-1100-Q

**Board.** Board of Dental Examiners: five dentists, one dental hygienist, and one member of the public.

**Licensure or other regulation.** Licensure to engage in the practice of denturism under the supervision of a dentist.

**Scope of practice.**

- Taking of denture impressions and bite registration to make, produce, reproduce, construct, finish, supply, alter, or repair a complete upper or lower prosthetic denture;
- Fitting of an upper or lower prosthetic denture; and/or
- The procedures incidental, as defined by the board.

**Education, clinical training, and experience requirements** (until January 1, 2000). High school graduate with (1) 10 years of training and postsecondary education in anatomy, physiology, or pathology or (2) a diploma from a post-secondary board-approved denturism program.

**Endorsement.** At the board's discretion with five years' licensed experience after personal interview.

**Examination.** Clinical and written exams, as prepared by or approved by the board.

**Continuing education requirement.** 20 hours per biennium.

**Requirements for continued competency assessment or re-licensure.** None.

## DENTAL RADIOGRAPHERS
## 32 MRSA 1100-I - 1100-Q

**Board.** Board of Dental Examiners: five dentists, one dental hygienist, and one member of the public.

**Licensure or other regulation.** Licensure. Unlawful to practice dental radiography without a license except for (1) dental hygienists, (2) resident physicians or students enrolled in schools of medicine, osteopathy, dentistry, dental hygiene and dental assisting or radiologic technology, (3) while providing services in US Armed Forces or public health service or employed by Veterans' Administration or other federal agency, and (4) licensed radiologic technologists.

**Scope of practice.** Use of ionizing radiation on the maxilla, mandible and adjacent structures of human beings, for diagnostic purposes.

**Education requirements.** High school diploma.

**Examination.** Passed a test in dental radiologic technique and safety approved by the board.

**Requirements for continued competency assessment or re-licensure.** None.

## DIETITIANS
## 32 MRSA 9901-9915

**Board.** Board of Licensing of Dietetic Practice: two dietitians, one dietetic technician, two public members.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Dietetics means the professional discipline of assessing the nutritional needs of an individual, including recognition of the effects of the individual's physical condition and economic circumstances, and the application of scientific principles of nutrition to prescribing means to ensure the individual's proper nourishment and care.

Licensed dietetic technician: a person licensed in Maine who practices under the supervision of a licensed dietitian.

**Education, clinical training, and experience requirements for licensure.** Dietitian: Bachelor's degree from a US accredited college as recognized by the council on Post Secondary Education or an equivalent if the degree was obtained outside of the US; and completion of the academic requirements established by the American Dietetic Association or the equivalent. In addition, there is an experience requirement.

Dietetic technician: Graduation from a dietetic technician program approved by the Commission on Accreditation of the American Dietetic Association or a bachelor of science degree from an accredited college in food and nutrition; plus an experience requirement.

**Endorsement.** Yes.

**Examination.** Completion of exams given by the American Dietetic Association or its equivalent as determined by the board.

**Continuing education requirements.** Yes

**Requirements for continued competency assessment or re-licensure.** None.

## EMERGENCY MEDICINE SERVICES
## 32 MRSA 82-94

**Board.** Board of Emergency Medical Services: one member representing each regional council and seven persons in addition. Of the additional persons, one is a physician, one an attorney, one a representative of the public, one a professional nurse, and three licensed emergency medical services personnel -- one a representative of for-profit ambulance services, one a representative of non-transporting emergency medical services, and one a representative of not-for-profit ambulance services.

**Licensure or other regulation.** Licensure. No ambulance service, ambulance, first responder service or emergency medical services person based in Maine may operate unless licensed by the board.

A wilderness emergency medical technician is not licensed, but licensed Maine emergency medical personnel may apply the techniques taught in a wilderness emergency medical technician course approved by Maine EMS.

**Scope of practice.** From basic life support to advanced triage and interventions as approved by the Board for First Responders, Emergency Medical Technicians (EMT), EMT-Intermediate(s), EMT-Critical Care(s) (note: no new licenses will be issued at this level after 1/1/98), and EMT-Paramedics.

Education, clinical training, and experience requirements for licensure. All must complete cardiopulmonary resuscitation certification requirements as specified by rule adopted by the Board.

First Responder: successful completion of a Maine EMS approved First Responder course (approximately 45 classroom hours).

EMT: successful completion of a Maine EMS approved EMT course (about 111 classroom hours). Clinical experience: approximately eight hours and must include a minimum of five patient assessments.

EMT-Intermediate: EMT requirements plus successful completion of a Maine EMS approved EMT-I course (approximately 62 hours). Also 100 hours with specific clinical objectives to be accomplished during this time.

EMT-Paramedic: EMT requirements plus successful completion of a Maine EMS approved EMT-Paramedic course (minimum 325 classroom hours) and 384 clinical hours with specific objectives to be accomplished.

For First Responders and Emergency Medical Technicians (EMTs): minimum age is 16; however, applicants under the age of 18 must have parental permission and be sponsored by an EMS service that has an approved program of supervision for licensees who are under 18. For EMT-Intermediates and EMT-Paramedics, the minimum age is 18.

**Examination.** First Responder: National Registry First Responder Examination and Maine EMS practical exam.

EMT: Maine EMS Exam and Maine EMS practical exam.

EMT-Intermediate: Maine EMS EMT-I exam and Maine EMS practical exam.

EMT-Paramedic: Maine EMS EMT-Paramedic exam plus Maine EMS practical exam.

If candidates fail either the written or practical test three times, they must complete additional training before retesting.

**Continuing education requirements.** First Responder: 24 hours every three years.

EMT: 34 hours every three years.

EMT-Intermediate: 42 hours every three years.

EMT-Paramedic: 54 hours every three years.

**Requirements for continued competency assessment or re-licensure.** Skills demonstration every three years.

**Accrediting organization for education program.** Maine EMS.

**Specialty Organizations.** National Association of EMTs and Maine Paramedic Association.

## MASSAGE THERAPISTS
## 32 MRSA 14301-14311

**Board.** The Commissioner of the Department of Professional and Financial Regulation administers, adopts rules, and enforces the law concerning massage therapists. The Commissioner may select members of the profession and others to advise.

**Licensure or other regulation.** Registration or certification.

**Scope of practice.** A massage therapist is a person who provides or offers to provide massage therapy for a fee.

Massage therapy means a scientific or skillful manipulation of soft tissue for therapeutic or remedial purposes, specifically for improving muscle tone and circulation and promoting health and physical well-being. The term includes, but is not limited to, manual and mechanical procedures for the purpose of treating soft tissue only, the use of supplementary aids such as rubbing alcohol, liniments, oils, antiseptics, powders, herbal preparations, creams or lotions, procedures such as oil rubs, salt glows and hot or cold packs or other similar procedures or preparations commonly used in this practice. The term specifically excludes manipulation of the spine or articulations and excludes sexual contact as defined in Maine's Criminal Code.

**Education, clinical training, experience, and examination requirements for licensure.** For registration as a massage practitioner: high school diploma and submission of criminal history, three character references, and a doctor's certificate.

For certification as a massage therapist: high school diploma and passing the National Certification Examination for Therapeutic Massage and Bodywork administered by the Psychological Corporation; or a diploma from a school of massage therapy that is accredited by the Commission on Massage Training Accreditation/Approval, or its successor.

**Requirements for continued competency assessment or re-registration.** None.

## NURSES AND NURSING
## 32 MRSA 2101-2265

**Board.** State Board of Nursing: six professional nurses, one licensed practical nurse, two public members.

**Licensure or other regulation.** Licensure for professional nurses and practical nurses. Registry with the Department of Human Services for Certified Nursing Assistants.

**Scope of practice.** Professional nursing means the performance, by a registered professional nurse, for compensation, of professional services defined as follows:

- Diagnosis and treatment of human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being and execution of the medical regimen as prescribed by a licensed physician or dentist or otherwise authorized person acting under the delegated authority of a physician, podiatrist, or dentist:
    1. Diagnosis in the context of the nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to the effective execution and management of the nursing regimen. Nursing diagnosis is distinct from medical diagnosis.
    2. Human responses means those signs, symptoms and processes which denote the individual's health needs or reaction to an actual or potential health problem.
    3. Treatment means selection and performance of those measures essential to the effective management and execution of the nursing regimen.
- Delegation of selected nursing services to licensed practical nurses and to assistants to nurses who have completed or are currently enrolled in a course sponsored by a state-approved facility or a facility licensed by the Department of Human Services;
- Supervision and teaching of nursing personnel;
- Administration of medications and treatment as prescribed by a legally authorized person;
- Teaching activities of daily living to care providers designated by the patient and family; and
- Coordination and oversight of patient care services provided by unlicensed health care assistive perso

Advanced practice registered nursing means the delivery of expanded professional health care by an advanced practice registered nurse (APRN) consistent with advanced educational qualifications, and for which competency has been maintained, and may include prescribing and dispensing drugs in accordance with rules adopted by the Board. A certified nurse midwife or certified nurse practitioner who is approved by the Board as an advanced practice registered nurse may choose to perform medical diagnosis or prescribe therapeutic or corrective measures when these services are delegated by a physician. Certified nurse practitioners, certified nurse-midwives, and certified registered nurse anesthetists perform services in specialty areas

Practical nursing means performing tasks and responsibilities for compensation within a structured health care setting, reinforcing the family and patient teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or physician, podiatrist, or dentist.

Certified Nursing Assistants (CNA) can perform tasks assigned by a registered professional nurse from the Skills Checklist of the PRESCRIBED CURRICULUM FOR NURSING ASSISTANT TRAINING PROGRAMS, which may include the administration of medication for experienced CNAs who complete a 120 hour standardized medication course as provided by the board.

**Education, clinical training, and experience requirements.** For professional nursing: high school diploma and completion of an approved program of not less than two years in professional nursing.

For advanced practice registered nursing holding a professional nursing license: completion of a formal education program acceptable to the board in an advanced nursing specialty area, and holding a current certification credential for advanced

nursing from a national certifying body whose certifying program is acceptable to the Board. There are pharmacology course requirements for certified nurse practitioners and certified nurse midwives who are authorized prescriptive authority upon approval to practice.

For practical nursing: a high school diploma and graduation from a state approved educational program.

For CNAs: a valid certificate of training from a Maine Department of Education approved training program directed by a professional nurse that includes completion of the Board of Nursing's PRESCRIBED CURRICULUM FOR NURSING ASSISTANT TRAINING PROGRAMS and includes 80 hours of classroom instruction, 20 hours of skills laboratory, and 50 hours of correlated, supervised clinical practice. Admission requirements for the training program include a minimum age of 16 and completion of the ninth grade of school, with a high school diploma preferred. For those who have completed the federally required 75 hours of training for CNAs elsewhere, the Board of Nursing's 75-hour PRESCRIBED BRIDGE COURSE FOR NURSING ASSISTANT TRAINING can be used to complete the Maine requirements. An alternative for eligibility for listing on the Maine Department of Human Service's MAINE REGISTRY OF CERTIFIED NURSING ASSISTANTS is continuous employment since December 1987 by certain licensed providers.

**Endorsement.** Yes, if the applicant has passed the National Council licensure exam or another acceptable exam.

**Examination.** National Council Licensure Examination.

**Continuing education requirements.** APRNs must complete 75 hours of continuing education every two years for continuing approval to practice as an APRN.

**Requirements for continued competency assessment or re-licensure.** A nurse who is employed in a hospital or nursing home and involved in direct patient care shall, at the beginning of the nurse's employment, participate in an individualized controlled learning experience adjusted for competency based upon practice standards and protocols. Each hospital or nursing home shall develop a plan with the employee for compliance and contain a mutually agreed upon completion date. A copy of the plan must be made a part of the nurse's personnel file. The staffing plan for the hospital or nursing home must reflect current trainee competence.

**Accrediting organization for education program.** Maine State Board of Nursing for nursing programs. The Maine Department of Education for CNA educational programs.

**Specialty organizations.** At both the national and state levels.

## NURSING HOME ADMINISTRATORS
## 32 MRSA 61-66

**Board.** Nursing Home Administrators Board: one professional nurse with nursing home experience, two public members, three experienced nursing home administrators, and one experienced administrator of an intermediate care facility for the mentally retarded.

**Licensure or other regulation.** A medical care facility other than a hospital may not operate except under the supervision of a licensed administrator and an individual may not be an administrator of such a facility unless the holder of a current administrator's license.

**Scope of practice.** See 32 MRSA 62.

Education, clinical training, and experience requirements for licensure. Bachelor's degree in nursing or social work, human services, management or administration related field, or as approved by the Board. Completion of 1040-hour

Administrator-in-Training program in patient care, personnel management, environmental management, organizational management, laws, regulations, codes and governing boards, in addition to a clinical rotation beyond the primary training site for two weeks in alternative types of facilities.

**Examination.** National and state exams.

**Endorsement.** Endorsement.

**Continuing education requirements.** 24 hours each year.

**Requirements for continued competency assessment or re-licensure.** None.

## OCCUPATIONAL THERAPY
## 32 MRSA 2271-2286

**Board.** Board of Occupational Therapy Practice: three occupational therapists, one occupational therapist or occupational therapy assistant, and one public member.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Occupational therapy is defined as follows:

- The assessment, planning and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximum physical and mental functioning of the individual in daily pursuits
- Assessment and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities or anticipated dysfunction, using:
    1. Treatment techniques, such as task-oriented activities, to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits;
    2. Assessment techniques such as assessment of cognitive and sensory motor abilities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped; and
    3. Specific occupational therapy techniques such as daily living skill activities, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance and treatment techniques for physical capabilities for work activities.

A certified occupational therapy assistant must practice under the supervision of an occupational therapist.

**Education, clinical training, and experience requirements.** Successful completion of the academic and field work requirements of an accredited educational program. In addition, an applicant to be an occupational therapist must complete the six months fieldwork requirement. The occupational therapy assistant program requires two months of field work.

**Examination.** National exams of the National Board for Certification in Occupational Therapy.

**Continuing education requirements.** For re-licensure after two years, 36 contact hours of study equivalent to 3.6 CEUs are required.

**Requirements for continued competency assessment or re-licensure.** None.

Accrediting organizations for education programs. For occupational therapists, the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the American Occupational Therapy Certification Board. For occupational therapy assistants, the American Occupational Therapy Certification Board.

## OPTOMETRISTS
## 32 MRSA 2411-2446

**Board.** Board of Optometry: five practicing optometrists and one public member.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Practice of optometry is defined as any one or combination of the following:

- The examination of the eye and related structures without the use of invasive surgery or tissue-altering lasers to ascertain defects, abnormalities, or diseases of the eye;
- The determination of the accommodative or refractive states of the human eye and evaluation of visual functions;
- The correction, treatment or referral of vision problems and ocular abnormalities by the prescribing, adapting and application of ophthalmic lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision therapy, ocular pharmaceutical agents and prosthetic devices and other optical aids, and by using other corrective procedures to preserve, restore or improve vision, excluding invasive surgery or tissue-altering lasers;
- The fitting, bending and adjusting of eyeglasses with ophthalmic lenses unless performed under the order of another optometrist or a physician;
- The replacement or duplication of an ophthalmic lens without a written prescription from a person licensed under the laws of this State to practice either optometry or medicine; and
- The dispensing, prescribing and administering of non-legend therapeutic pharmaceutical agents (when additional requirements are met).

Optical mechanics are not precluded from performing merely mechanical work.

**Education and other requirements.** Graduate of a recognized school of optometry.

Use of therapeutic pharmaceutical agents requires credentials for therapeutic license, to include an approved course with 100 hours in ocular therapeutics and 25 hours of supervised clinical training. An advanced therapeutic license requires additional coursework focusing on glaucoma and pharmacology.

In order to treat glaucoma independently, an optometrist with an advanced therapeutic license must provide evidence of 50 glaucoma-related referrals to, and consultations with, physicians.

**Examination.** National Board of Examiners in Optometry exam. In addition, the Board administers an oral exam consisting of the practical aspect of the practice of optometry. Written exam for therapeutic license. If failed three times, the Board requires 100 hours of continuing education and a wait of two years.

**Continuing education requirements.** 25 hours a calendar year, at least 15 hours of which must be in diagnosis and treatment of ocular disease for holders of an advanced therapeutic license.

**Requirements for continued competency assessment or re-licensure.** Every optometrist holding a nonactive license for three years who desires an active license shall submit to a practical examination for professional and technical proficiency conducted by the Board.

**Accrediting organization for education program.** American Optometric Association's Council on Optometric Education.

## OSTEOPATHIC PHYSICIANS AND PHYSICIAN ASSISTANTS 32 MRSA 2561-2600

**Board.** Board of Osteopathic Licensure: six practicing osteopathic physicians, actively engaged in practice for at least five years, and three public members.

**Licensure or other regulation.** Licensure. Temporary licenses for fellows, interns or resident physicians in hospitals, locum tenens, camp physicians, and visiting instructors.

A physician assistant may not practice under the supervision of an osteopathic physician until the physician assistant has applied for and obtained a license issued by the Board, which must be renewed biennially.

**Other licensing requirements.** No cause exists that would be considered grounds for disciplinary action against a licensed physician.

**Scope of practice.** Practice of osteopathic medicine. The license entitles an individual to whom it is granted the privilege to practice osteopathic medicine in any county in this State, in all its branches as taught in American Osteopathic Association (AOA) approved schools or colleges of osteopathic medicine with the right to use drugs that are necessary in the practice of osteopathic medicine.

Physicians may delegate the rendering of medical services to assistants that have completed a training program approved by the board. Physician will supervise and be legally liable for the activities of the assistants.

**Education and experience requirements.** Graduate of a school or college of osteopathic medicine approved by AOA. Internship of 12 months in a hospital accredited by the AOA or its equivalent.

**Endorsement.** Endorsement, but the board at its discretion may require an examination.

**Examination.** Exam, approved by the board, including osteopathic theories and methods (manual medicine). Must submit to mental or physical examinations when directed by the board. If fails initial exam, entitled to one re-examination within one year.

**Continuing education requirements.** For re-licensure, 100 hours of educational programs approved by the board during the preceding two year period, at least 40 hours of which must be osteopathic medical education.

Requirements for continued competency assessment or re-licensure. The Board shall determine the skill and competence of an osteopathic physician applying for reinstatement who has not been engaged in the active practice of osteopathic medicine for more than a year.

No cause exists for revoking or suspending the applicant's license. Must submit to a physical or mental examination if requested by the Board.

**Accrediting organization for education program.** American Osteopathic Association.

**Specialty organizations.** There are 17 specialty Boards specific to osteopathy.

## PHARMACY
## 32 MRSA 13701-13805

**Board.** Maine Board of Pharmacy: two public members and five licensed pharmacists. Of the pharmacists one must be a hospital pharmacist, one a chain pharmacist, and one an independent pharmacist. In addition to licensing individual practitioners, the Board is responsible for registering facilities, including in-state drug outlets, manufacturers and wholesalers without facilities in the state, and licensing of rural health centers that want to contract for pharmaceutical services with a pharmacy.

**Licensure or other regulation.** Licensure of pharmacist, registration of pharmacist technician.

**Scope of practice.** Practice of pharmacy means:

- the interpretation and evaluation of prescription drug orders;
- the compounding, dispensing, and labeling of drugs and devices, except labeling by a manufacturer, packer or distributor of nonprescription drugs and commercially packaged legend drugs and devices;
- participation in drug selection and drug utilization reviews;
- the proper and safe storage of drugs and devices and the maintenance of proper records for these drugs and devices;
- responsibility for advising, when necessary or regulated, of therapeutic values, content, hazards and use of drugs and devices; and
- the offering or performing of those acts, services, operations or transactions necessary in the conduct, operation, management and control of a pharmacy.

A pharmacist means an individual licensed by the state to engage in the practice of pharmacy.

Pharmacist technician means a person employed by a pharmacy who works in a supportive role to, and under the direct supervision of, a licensed pharmacist.

**Education, clinical training, and experience requirements for licensure.** Pharmacist: 1500 hours of internship and a pharmacy degree from an accredited program or from an equivalent program outside of the US.

**Endorsement.** Reciprocity.

**Examination.** Pharmacist: Pass an exam given by the Board or the NABPLEX (exam from the National Association of Boards of Pharmacy).

**Continuing education requirements.** 15 hours per year.

**Requirements for continued competency assessment or re-licensure.** None.

**Accrediting organization for education program.** American Council on Pharmaceutical Education.

## PHYSICAL THERAPISTS
## 32 MRSA 3111-3118

**Board.** Board of Examiners in Physical Therapy: two physical therapists, one physical therapist assistant, one physician, one public member.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Physical Therapy means:

- The evaluation, treatment and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction and pain from injury, disease and any other bodily condition;
- The administration, interpretation and evaluation of tests and measurements of bodily functions and structures for the purpose of treatment planning;
- The planning, administration, evaluation and modification of treatment instruction;
- The use of physical agents and procedures, activities and devices for preventive and therapeutic purposes; and
- The provision of consultative, educational and other advisory services for the purpose of reducing the incidence and severity of physical disability, bodily malfunction and pain.

A physical therapist assistant assists in the practice of physical therapy.

When treating a patient without referral from a doctor of medicine, osteopathy, podiatry, dentistry, or chiropractic, a physical therapist (PT) or physical therapist assistant (PTA) may not make a medical diagnosis, must refer the patient to a licensed doctor of medicine, surgery, osteopathy, podiatry, dentistry, or chiropractic if there is no improvement within 30 days, and must consult with a licensed doctor of medicine, surgery, osteopathy, podiatry, dentistry, or chiropractic if treatment is required beyond 120 days. A PT may delegate to a PTA or to a physical therapy aide treatment procedures or patient-related activities commensurate with the education and training of the person, but not including interpretation of referrals, performance or evaluation procedures or determination and modification of patient treatment programs. Physical therapy aides must be directly supervised by a PT or PTA. Some direct supervision of PTAs is required, including a visit with a new patient.

**Education, clinical training, and experience requirements for licensure.** For a PT, graduation from an accredited school of a program in physical therapy and an exam approved by the board.

For a PTA, graduation from an accredited educational program for physical therapy assistants and an exam approved by the board.

**Endorsement.** Endorsement. See rules, Chapter 1, Section 3.

**Examination.** The exams for PT and PTA are those of the American Physical Therapy Association, the Assessment Systems, Inc., Professional Examination Services, or such other national examination approved by the board.

**Requirements for continued competency assessment or re-licensure.** None.

**Accrediting organization for education program.** Accredited by an agency recognized by the US Commissioner of Education or the Council on Post Secondary Accreditation and approved by the board. For applicants educated in foreign countries, see 32 MRSA 3114-A(1)(B).

## ALLOPATHIC PHYSICIANS - MEDICAL DOCTORS AND PHYSICIAN ASSISTANTS 32 MRSA 3263-3300

**Board.** Board of Licensure in Medicine: 10 total, seven who are actively engaged in the practice of medicine in Maine and three public members.

**Licensure or other regulation.** Licensure for physicians. Licensure and registration of supervisory relationship with physician for physician assistants.

**Scope of practice.** For physicians (MDs): full and complete practice of medicine in all its forms.

Physicians may delegate the rendering of medical services to physician assistants (PAs) that have completed a training program approved by the board. Physicians will supervise and be legally liable for the activities of the assistants.

**Education, clinical training, and experience requirements for licensure.** For MDs: graduation from a medical school accredited by the Liaison Committee on Medical Education, plus 24 months in an accredited graduate educational residency program. There are additional requirements if one has graduated from an unaccredited medical school.

For PAs: graduation from master's level physician assistant program.

**Endorsement.** No.

**Examination.** For MDs: exam of the Federation of State Medical Boards or National Board of Medical Examiners, and a State of Maine exam.

For PAs: exam of the National Council on Certified Physician Assistants.

**Continuing education requirements.** 100 hours every two years for MDs and PAs.

**Requirements for continued competency assessment or re-licensure.** Considerations in addition to CMEs are now being studied by the board and by a national committee of the Federation of State Medical Boards.

**Accrediting organization for educational programs.** Accreditation Council of Graduate Medical Education.

**Specialty organization.** American Board of Medical Specialties has 24 member boards.

## PODIATRISTS
## 32 MRSA 3551-3655-A

**Board.** Board of Licensure of Podiatric Medicine: four podiatrists and one public member.

**Licensure or other regulation.** Licensure.

**Scope of practice.** The practice of podiatry is defined as follows:

- The diagnosis and treatment of maladies of the human foot and ankle by medical, mechanical or surgical means; and
- Administration of local anesthesia and prescription of narcotic drugs for the treatment of ailments within the scope of practice with approval of the Drug Enforcement Administration.

**Education, clinical training, and experience requirements for licensure.** Four years of post-secondary education plus graduation from an accredited school of podiatric medicine and one year of postgraduate clinical training in a podiatric residency training program approved by the American Podiatric Medical Association.

**Endorsement.** Endorsement.

**Examination.** PMLexis exam prescribed by the board. In addition, an oral exam by the board.

**Continuing education requirements.** 25 credit hours of continuing medical education every two years

**Requirements for continued competency assessment or re-licensure.** None.

**Accrediting organization for education program.** Council on Education of the American Podiatry Association.

## PSYCHOLOGISTS
## 32 MRSA 3811-3840

**Board.** State Board of Examiners of Psychologists: seven members who must be either psychologists or psychological examiners with at least one being an examiner and two public members.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Psychologist is defined as follows:

- A person who holds him or herself out to be a psychologist, or provides to individuals or the public services that involve the application of recognized principles, methods and procedures of the science and profession of psychology for remuneration;
- These services include diagnosing, assessing and treating mental, emotional and psychological illness, disorders, problems and concerns and evaluation and treatment of vocational, social, educational, behavioral, intellectual and learning and cognitive disorders; and
- These functions may be performed through recognized psychological techniques, including, but not limited to, psychological testing, psychological interviews, psychological assessments, psychotherapy, personality counseling, behavior modification, cognitive therapies, learning therapies, biofeedback, hypnotherapy and psychological consultation to individuals and organizations.

A psychological examiner renders services for remuneration involving the application of recognized principles, methods and procedures of psychology, but limited to interviewing or administering and interpreting tests of mental abilities, aptitudes, interests and personality characteristics, for such purposes as psychological evaluation or for educational or vocational selection, guidance, or placement. An examiner may provide intervention, such as consultation, behavior management or social skills training under the supervision of a psychologists, but may not offer psychotherapy services.

School psychologists need, in addition to the license, a certificate from the Maine Department of Education assuring that the applicant has some special areas of training and experience.

**Education, clinical training, and experience requirements for licensure.** For psychologists: a doctorate degree reflecting comprehensive training in psychology from an accredited institution recognized by the Board as maintaining satisfactory standards and passage of exams deemed necessary by the board. For psychological examiners: a master's degree reflecting comprehensive training in psychology from an accredited institution recognized by the board as maintaining satisfactory standards, passage of exams as the board deems necessary, one year of supervised experience for psychological examiners and two years for psychologists.

**Endorsement.** Conditional license only until oral exam is passed. Conditional licensee must have Letter of Agreement signed by licensed psychologist for supervision.

**Examination.** Written exam developed by the association of state and provincial psychology boards. In addition, an oral exam by the board.

**Continuing education requirements.** Psychologists are required to complete 40 hours of approved continuing education coursework every two years.

**Requirements for continued competency assessment or re-licensure.** None.

**Accrediting organization for education program.** The board shall recognize that valid comprehensive training in psychology must be received in or accepted by a single program, but may be obtained through a degree given by administrative units other than a department of psychology, including programs approved by the National Association of School Psychologists or the American Psychological Association designation program. The board shall adopt a list of these programs. Individuals with degrees from programs not on that list shall be evaluated on a case-by-case basis.

## RADIOLOGICAL TECHNOLOGISTS
## 32 MRSA 9851-9861

**Board.** Radiologic Technology Board of Examiners: two radiologists, three radiographers, one nuclear medicine technologist, one radiation therapy technologist, a representative of the Department of Professional and Financial Regulation, one radiation physicist, two licensed practitioners who are not radiologists, and one public member.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Radiologic technology: the use of a radioactive substance or equipment emitting ionizing radiation on human beings for diagnostic or therapeutic purposes.

Radiographer: a person, other than a licensed physician, dentist, chiropractor, podiatrist, or osteopath, who applies ionizing radiation to human beings for diagnostic purposes.

Nuclear medicine technologist: a person, other than a licensed physician, dentist, chiropractor, podiatrist, or osteopath, who uses radionuclide agents on human beings for diagnostic or therapeutic purposes.

Radiation therapy technologist: a person, other than a licensed practitioner, who applies ionizing radiation to human beings for therapeutic purposes.

Radiologic technologist: any person who is a radiographer, a radiation therapy technologist, or a nuclear medicine technologist licensed by the State of Maine.

**Education, clinical training, and experience requirements for licensure.** Radiographer: high school diploma or equivalent and completed an approved course of study in radiologic technology.

Nuclear medicine technologist: high school diploma or equivalent and completed an approved nuclear medicine technology program.

Radiation therapy technologist: completed an accredited course in radiologic technology and radiation therapy technology.

**Endorsement or reciprocity.** Reciprocity for licensed and nationally certified individuals.

**Examination.** Radiographer: possess current national certification or pass the exam of the American Registry of Radiologic Technologists.

Nuclear medicine technologist: possess current national certification or pass the Nuclear Medicine Technologist Certification Board exam.

Radiation therapy technologist: possess current national certification or pass an exam of the American Registry of Radiologic Technologists for radiation therapy technology.

**Continuing education requirements.** 24 CEUs every two years.

**Requirements for continued competency assessment or re-licensure.** If a technologist's license has been expired for more than two years, that individual must apply for a new license and meet all requirements for initial licensure, including passing entry level exams.

**Accrediting organization for education program.** Committee on Allied Health, Education and Accreditation.

## RESPIRATORY CARE PRACTITIONERS
## 32 MRSA 9701-9713

**Board.** Board of Respiratory Care Practitioners: three respiratory care practitioners and two public members.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Respiratory care means the therapy, management, rehabilitation, diagnostic evaluation and care, administered on the order of a physician or surgeon, of patients with deficiencies and abnormalities affecting the cardiopulmonary system and associated aspects of other bodily systems, including, but not limited to, the following:

- Direct and indirect pulmonary care services that are of comfort, safe, aseptic, preventive and restorative care to the patient;
- Direct and indirect services such as the administration of pharmacological, diagnostic and therapeutic agents that are necessary to implement a treatment, disease prevention, or a pulmonary rehabilitative or diagnostic regimen prescribed by a physician;
- Observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing, including determining whether or not these exhibit abnormal characteristics;
- Implementation based on observed abnormalities, referral, respiratory care protocols or changes in treatment, pursuant to a prescription by a person authorized to prescribe respiratory care or the initiation of emergency procedures;
- Diagnostic and therapeutic use of the following:
    (1) Administration of medical gases, aerosols and humidification;
    (2) Environmental control mechanisms and hyperbaric therapy;
    (3) Pharmacological agents related to respiratory care procedures;
    (4) Mechanical or physiological ventilatory support;
    (5) Bronchopulmonary hygiene;
    (6) Cardiopulmonary resuscitation;
    (7) Maintenance of natural airways;
    (8) Insertion and maintenance of artificial airways;
    (9) Specific diagnostic and testing techniques employed in the medical management of patients to assist in diagnosis, monitoring, treatment and research of pulmonary abnormalities, including measurement of ventilatory volumes, pressures and flows, collection of specimens of blood and collection of specimens from the respiratory tract;
    (10) Analysis of blood gases and respiratory secretions and pulmonary function testing; and
    (11) Hemodynamic and physiologic measurement and monitoring of cardiac functions as they relate to cardiopulmonary pathophysiology; and
- Initial and follow-up instruction and patient evaluation in a nonhospital setting for the diagnostic and therapeutic uses described above.

**Education, clinical training, and experience requirements for licensure of respiratory care practitioners.** Respiratory therapist (RRT): Credentialed by the National Board for Respiratory Care as a registered respiratory therapist or graduation from an accredited program for respiratory therapists and passage of an exam approved by the board.

Respiratory care technician (CRTT): graduation from an accredited program for respiratory care technicians and passage of exam or credentialed by the American Medical Association's Joint Review Committee for Respiratory Therapy Education and passage of an exam recognized by the board..

**Examination.** RRT: passage of the National Board of Respiratory Care's advanced practitioner exam.

CRTT: passage of the National Board of Respiratory Care's entry level exam.

**Continuing education requirements.** 30 hours over a two year period.

**Requirements for continued competency assessment or re-licensure.** None.

**Accrediting organization for education program.** American Medical Association/Joint Review Committee for Respiratory Therapy Education.

## SOCIAL WORKERS
## 32 MRSA 7001-A-7063

**Board.** State Board of Social Worker Licensure: seven members: two public members, two licensed social workers, and three licensed clinical social workers, licensed master social workers or certified social workers--independent practice, at least one of whom must be practicing in a nonclinical setting.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Social work means engaging in psychosocial evaluation and intervention, including therapy, to affect a change in the feelings, attitudes and behavior of a client, whether an individual, group or community. It also means engaging in community organization, social planning, administration and research.

Licensed social worker (LSW):
- Conduct basic data gathering of records and specific life issues of individuals, groups, couples and families;
- Assess the data, formulate and implement a plan to achieve specific goals relating to specific life issues;
- Serve as an advocate for clients for the purpose of achieving goals;
- Refer clients to other professional services;
- Plan, manage, direct or coordinate social services;
- Participate in training of social work students and supervise other LSWs and other professionals; and paraprofessionals engaged in related activities.

Licensed master social worker (LMSW):
- Perform all functions of the LSW;
- Engage in administration, research, consultation, social planning and teaching related to the functions of social work;
- Engage in non-clinical private practice; and
- Provide consultation required by the LSW and LSW conditional licenses.

Licensed clinical social worker (LCSW):
- Perform all functions of an LMSW.
- Practice social work in a clinical setting without consultation;
- Engage in clinical private practice of social work; and
- Provide consultation.

**Education, clinical training, and experience requirements for licensure.** For LSW: Bachelor of social work degree from an accredited program or a BA/BS degree plus documentation of 96 hours of consultation, concurrent with 3200 hours of social work employment occurring within a two to four year timeframe.

For LMSW: MSW degree from an accredited program.

For LCSW: MSW degree from an accredited program, a LMSW conditional (clinical) license, meeting of consultation requirements in the clinical setting (an organized professional environment in which mental disorders are evaluated, prevented, diagnosed and treated using psycho-social means of assessment).

**Endorsement.** Endorsement.

**Examination.** Yes, unless clinical license prior to 1984.

**Continuing education requirements.** Yes.

**Requirements for continued competency assessment or re-licensure.** LSW: documentation of required consultation.

**Accrediting organization for education program.** Council on Social Work Education.

## SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
## 32 MRSA 6001-6031

**Board.** State Board of Examiners on Speech-language Pathology and Audiology: two speech-language pathologists, two audiologists, one physician with a specialty in otolaryngology, and two public members.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Speech-language pathologists identify, assess and provide treatment for people with communication and swallowing disorders. Audiologists identify, assess and provide habilitation and rehabilitation for people of all ages with either peripheral or central auditory impairment. Both professionals may:

- Manage and supervise programs and services related to human communication and its disorders;
- Counsel families, individuals and caregivers with respect to speech-pathology or audiology; and
- Provide consultation, make referrals and develop preventive programs.

A speech-language pathology aide works under the supervision of a licensed speech-language pathologist.

A speech-language pathology assistant is also supervised by a licensed speech-language pathologist.

"Supervision" means the direct observation of work and the assessment of written records of service by a licensed speech pathologist, licensed audiologist or licensed physician commensurate with the skills of the person as determined by the supervisor.

Education, clinical training, and experience requirements for licensure. Master's degree or its equivalent, as determined by the board, which is consistent with the requirements for the American Speech and Hearing Association Certificate of Clinical Competency in Speech Pathology or Audiology. The board may establish the requirements for academic course work, supervised clinical practicum, supervised professional employment and written examination.

For a speech-language pathology aide to become registered after October 1, 1997, two years of post-secondary education and a training plan endorsed by a speech-language pathologist or an audiologist are required. All speech-language

pathology aides must meet the minimum qualifications for a speech-language pathology assistant adopted by the board no later than January 1, 2005.

For a "speech-language pathology assistant" to become registered, an associates degree in the field of communication disorders, or its equivalent as determined by the board, and the applicant must meet such other minimal qualifications as the board may establish.

**Endorsement.** Applicants licensed in other states or District of Columbia or territory of the U.S. which maintains professional standards deemed by the board to be equivalent to the Maine standards.

**Examination.** National Examination in Speech Pathology or Audiology.

**Continuing education requirements.** 50 hours every two years.

**Requirements for continued competency assessment or re-licensure.** None.

## VETERINARIANS
## 32 MRSA 4851-4874

**Board.** Maine State Board of Veterinary Medicine: five veterinarians and one public member.

**Licensure or other regulation.** Licensure.

**Scope of practice.** Practice of veterinary medicine includes:

- To diagnose, treat, correct, change, relieve or prevent animal disease, deformity, defect, injury or other physical or mental conditions;
- To prescribe or administer any drugs, biologic, apparatus, application, anesthetic or other therapeutic or diagnostic substance or technique;
- To use any manual or mechanical procedure for artificial insemination, testing for pregnancy, or for correcting sterility or infertility; and
- To give advice or recommendation regarding any of the above.

A licensed veterinary technician may perform, under the supervision and direction of a veterinarian such duties as drug administration, nursing care, X-ray film exposure and processing, bandage changes, dental prophylaxis, restraint, blood and fecal collections, diagnostic laboratory procedures and other duties, except no one but a veterinarian may diagnose, make prognoses, prescribe or initiate treatment or surgery or perform surgery.

An animal health assistant may, under the direct supervision of a licensed veterinarian or a veterinary technician, perform duties of an animal health care nature, not including diagnosing, making prognoses, performing surgery, reading or interpreting laboratory tests or prescribing or initiating treatment.

**Education, clinical training, and experience requirements for licensure.** For a veterinarian: graduation from a school of veterinary medicine approved by the American Veterinary Medical Association or completion of the program of the Educational Commission for Foreign Veterinary Graduates as approved by AVMA.

For a veterinary technician: completion of a minimum of two years in a college program that is certified according to the standards adopted by the American Veterinary Medical Association's Committee on Veterinary Technical Education and Activities or its equivalent as determined by the board.

**Endorsement.** Endorsement. At its discretion, the Board may orally or practically examine an applicant who meets educational or experience requirements.

**Examination.** For a veterinarian, the Professional Examination Service's National Written Veterinary Examination and the Clinical Competency Test. In addition, the Board shall administer an exam known as the state law and regulation exam.

For an animal technician, the Animal Technician Examination administered by the Professional Examination Service.

**Continuing education requirements.** 12 hours of continuing education relevant to the practice of veterinary medicine annually.

**Requirements for continued competency assessment or re-licensure.** None.

**Accrediting organization for education program.** American Veterinary Medical Association.