The Ramifications of Regulatory Reform

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This article examines the regulatory reform proposals for the health care workforce recently proposed by politicians and members of the Pew Health Professions Commission. These proposals attempt to address issues related to state practice acts, competence, advanced practice, "boundary-less" practice, the disciplinary process, consumerism, and umbrella legislation. Questions are presented for each issue to guide practitioners when deliberating about possible actions professional organizations can take in proposing legislation at the state level. Various external forces shape each issue and lead to the need to seek such regulatory reform as improving disciplinary processes and activity, assessing competence beyond the entry level, and increasing involvement of consumers. However, there are risks associated with any proposed regulatory reform, particularly if one realizes the potential financial costs associated with competency assessment and advanced-practice regulation. We must also carefully examine any reform proposals that advocate title protection and the licensing of invasive procedures in place of licensing professionals. The fact remains that the impact on quality of care and long-term cost-effectiveness from the unrestricted use of less qualified professionals and unlicensed aide-level personnel to provide skilled services has not been adequately determined.

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He rapidly changing practice environment has caused many practitioners to question the need for state practice acts because of restrictions created by these licensure laws on their ability to practice as autonomously as is necessary in an atmosphere requiring flexibility. The alternatives to licensure, however, raise the issue of whether these less restrictive state laws, such as certification, can limit the ability of administrators to reassign tasks of the professional to lower paid, less qualified personnel (Huston, 1996). Currently, 53 jurisdictions provide some type of regulation of occupational therapy practitioners (American Occupational Therapy Association [AOTA], 1997). Of these jurisdictions, 39 states, the District of Columbia, and Puerto Rico license both occupational therapists and occupational therapy assistants. The remaining states only license occupational therapists or, in place of licensure laws, have certification, registration, or trademark laws.

Not only are practitioners questioning the need for licensure, but also many state governments are seeking to consolidate or eliminate some of their regulatory boards to relieve strained state budgets (Keep News, 1996). For example, the governor of Michigan moved by executive order to dissolve the regulatory boards of physical therapy and occupational therapy, which, if he had not later rescinded this order, would have given control of regulatory decisions to a single state employee ("Therapists in Danger of Losing Licensure Boards," 1997). The governor of Massachusetts made a similar, although unsuccessful, proposal for eliminating "unnecessary" boards, including the one regulating physical therapy, to the state legislature. There have also been national-level discussions to change major aspects of the regulatory system that governs the health care workforce. For instance, reports made by the Pew Health Professions Commission (Gragnola & Stone, 1997) have criticized the current regulatory system for creating rigid limitations on practice, exacerbating the turf-guarding behavior of professionals, raising costs of health care through restriction of competition among professional groups, disenfranchising consumers, and focusing on paper credentials instead of the professional’s competence.

How does one sort out the well-founded complaints about the regulatory system from the superficial complaints? More importantly, how does one assess the proposed solutions for improving regulation of the health care workforce? This article discusses some of the emerging issues in regulation of professionals, which require the attention of occupational therapy practitioners.

Title Protection

Many professionals and health care providers believe that practice acts or the traditional licensure laws are too restrictive and that these laws ought to be replaced with protected title legislation, known as certification (Gragnola & Stone,
Certification allows services similar to those delivered by an occupational therapist, nurse, or physician to be delivered by a range of professionals, as long as these persons are appropriately trained and do not claim that they are something they are not. In fact, occupational therapy practitioners in Indiana, Vermont, and Wisconsin are regulated by certification. Certification laws provide basic public protection by outlining for each profession the entry-level and ongoing educational standards required in order to perform generally defined responsibilities.

In contrast, licensure restricts the actions of particular professionals to a specific scope of practice. Because of the growing impossibility of outlining scopes of practice that are unique to only one profession, Gragnola and Stone (1997) advocated the state certification of all professionals in place of the current regulatory practice of licensing. Only invasive and dangerous procedures would then be reserved through state licensing for members of specific professions. Procedures or tasks, unless restricted, could be done by anyone who demonstrates and documents their competence to perform these procedures to the satisfaction of the public. Because of the deletion of the exclusive scope of practice that is inherent in licensure laws, certification thus reflects more of a "buyer beware" philosophy.

Title protection and the licensing of professionals to perform certain regulated procedures have been implemented in the Canadian province of Ontario and are being considered by the Alberta and British Columbia provinces (Cutshall, 1996). For instance, Ontario's law authorizes nurses to independently perform 3 of 13 controlled procedures that have been registered, which include performing a procedure on tissue below the dermis; administering a substance by injection or inhalation; and putting an instrument, hand, or finger beyond certain points of the body ("Emerging Licensing Issues," 1996). Nurses may perform other controlled procedures when under supervision of the appropriate professional licensed to perform the procedure, for example, dispensing a drug under the supervision of a physician. Nurses who are midwives may independently perform an additional controlled procedure that involves managing labor or conducting the delivery of a baby. Therefore, many unrestricted tasks considered in the past to be part of the exclusive role of the nurse can now be legally delegated in Ontario to other practitioners, as long as those other practitioners are appropriately trained and do not represent themselves as nurses.

Certifying professionals has an advantage over licensing professionals in that certification allows scopes of practice to overlap among appropriate professions. Therefore, a client has more choice in selecting a health care provider to address his or her specific health problem. With the dissolution of often arbitrary legal boundaries between such professions as physical therapy and occupational therapy, not only can professionals more appropriately use their skills without fear of restriction, but also the evolution of practice is facilitated, and employers have increased flexibility in the assignment of work to various professionals.

The disadvantage of certification is that employers may misuse care providers. Professional groups believe that weakening the ability of state regulatory boards to protect the public through the replacement of licensure laws with certification is tantamount to creating a system of "institutional licensure," or the regulation of health care employees by their employers (Keepnews, 1996). Budget constraints may force employers to use workers inappropriately, leading to problems of public protection. For instance, Barter, McLaughlin, and Thomas (1994) reported a rapid increase over a 3-year period in hospitals' use of unlicensed assistive personnel in place of nurses without the simultaneous implementation of measures to determine the impact of this work reassignment on patient care and physician and patient satisfaction.

In Indiana, for example, occupational therapy practitioners were being replaced with aide-level personnel who were expected by some employers to provide occupational therapy services without adequate supervision. Because of the lack of exclusive scope legislation in Indiana for occupational therapy and the relative silence of Medicare on the supervision and use of aides to extend professional services, several employers used unlicensed personnel to provide greater aspects of occupational therapy services. In response, the Indiana Occupational Therapy Association mounted a successful legislative initiative in 1997 to strengthen the public protection component of the certification law ("Occupational Therapists," 1993). According to Christine Kroll, then president of the Indiana Occupational Therapy Association (personal communication, November 25, 1997), language was added requiring occupational therapy practitioners to adequately supervise and appropriately delegate skilled services to aide-level personnel or otherwise be subject to disciplinary action.

As long as Medicare, other third-party payers, employers, and consumers value the services provided by state-certified occupational therapists and occupational therapy assistants, strengthening the certification law in Indiana is expected to achieve its intended purpose of controlling the unrestricted use of unlicensed personnel. However, with the advent of managed care approaches that pay for outcomes rather than for services, the provider is given discretion in what services are used to produce the outcome. Personnel other than occupational therapy practitioners may thus provide services seemingly similar to occupational therapy as long as the services are not labeled as occupational therapy and as long as these personnel are trained to implement these types of services. Given this scenario, strengthening the certification law of a single profession does not ensure adequate supervision of less trained personnel or the realignment of tasks to less qualified professionals.
Competence

The increasing interest in professional competence seems in stark contrast to the trend of implementing legislation that allows employers to assign tasks normally completed by professionals to less trained personnel (Tamblyn, 1994). However, this emphasis on competence raises concerns that regulatory laws focus primarily on educational credentials rather than on the professionals’ ability to competently perform the tasks expected of them, regardless of their educational background. Although educational credentials will continue to be useful in regulating entry-level practice, ways to recognize qualifications for continued practice under a protected title have become equally important. The fact that many state regulatory laws have taken the approach of mandating continuing education units rather than measuring continuing competence has become a major factor in the argument for regulatory reform (Gragnola & Stone, 1997).

This interest in continuing competence has been facilitated by providers of and payers for health care services who have become intolerant of the costs associated with poor treatment outcomes. Practitioners who are incompetent, who have not consistently updated their knowledge and skills, are a factor in services that produce poor outcomes. The concept of evidence-based practice has arisen from this need to ensure that services are not only thought to be effective, but also have been shown to be effective through research and through a track record of outcomes data (Berg, 1998). The ability of professionals to select the best treatment approach and skillfully provide the appropriate services according to the evidence indicating the intervention’s effectiveness and efficacy is an aspect of competence. In fact, members of the American Medical Association (AMA) are concerned with physician awareness of medical advances that considerably improve practice. Because lack of awareness of medical advances may contribute to declines in a physician’s competence, the AMA plans to “initiate a program to alert doctors periodically when medical studies show unequivocally that doctors or hospitals are not delivering the best care or doing the right thing for patients” (Findlay, 1997b, p. 1A).

Consequently, regulation of professionals in all jurisdictions will be expected to include measurement of the qualifications of practitioners not only at the time of entry into the profession, but also throughout the professional’s lifetime of practice. As a result, there is considerable pressure to develop creative and cost-effective ways to assess competence. In response to this growing pressure, the AMA plans to work with state medical societies to administer a program to accredit physicians, which will involve verifying a physician’s training, licenses, continuing medical education, and participation in peer review programs (Findlay, 1997a). Thus, it is imperative for occupational therapy practitioners to develop a common language for describing and ultimately measuring competence rather than wait for a system of competency measurement to be imposed by external groups who may not seek the input of those professionals affected by the competency program. Therefore, occupational therapy practitioners must pilot and assess approaches, such as credentialing examinations, practice audits, required practice hours, peer review, and mandatory continuing education, in order to recommend to state legislatures specific strategies for cost-effectively measuring and improving continuing competence (Kane, 1994).

Advanced Practice

Complicating the issue of competence is the difficulty in differentiating among the knowledge and skills important for continuing competence, advanced practice, and specialty practice. The question is whether regulation should have a role in determining the competence of those practitioners in specialty practices or of those practitioners who have obtained advanced education. To answer this question, a profession has to resolve the problem of how to define specialty and advanced practice. One proposal suggested by the National Council of State Boards of Nursing (NCSBN) is to develop definitions of nursing practice on the basis of arenas of practice, for example, generic practice, highly specialized practice (e.g., nurse anesthetist, nurse midwife), advanced practice (e.g., nurse practitioners, clinical nurse specialists), and functional practice (e.g., educators, administrators) (Curtin, 1992).

After differences in knowledge and skill have been delineated among generic, advanced, and specialized practice, members of a profession must determine whether there would then be a need for occupational therapy practitioners in advanced or specialized practice to maintain credentials for generic practice (Miettinen & Flegel, 1992). The answer to this question depends on whether occupational therapy is a single, undifferentiated area of professional activity. Occupational therapy practitioners have grappled with this dilemma for years and have advocated for ultimately maintaining in all areas of practice the core of what constitutes “authentic” occupational therapy (Schwartz, 1998).

Resolving the issues related to advanced practice may become increasingly important in occupational therapy, especially if the Accreditation Council for Occupational Therapy Education (1997) succeeds in its preliminary proposal to layer additional standards for accreditation of master’s or doctoral entry-level educational programs. The implication is that somehow practitioners are prepared differently for entry-level practice at each level of education. The concept of advanced practice licensing is further complicated by practitioners who obtain postprofessional degrees. However, if distinct standards of practice or competencies are expected of these advanced practitioners, a separate category for state regulation may be necessary in
order to enhance public protection.

Additionally, in those states with licensure laws that rigidly define occupational therapy, advanced or specialized practitioners may be practicing outside of the law. An example is the occupational therapy licensure law in Kentucky ("Occupational Therapists," 1994) that restricts the use of some physical agent modalities by occupational therapy practitioners. This is problematic for practitioners who have obtained additional certification as hand therapists from the Hand Therapy Certification Board, which is a private and voluntary credentialing process. The test used for obtaining the hand therapy credential covers the use of physical agent modalities (Hand Therapy Certification Commission, 1998). However, in accordance with the Kentucky occupational therapy licensure law, occupational therapy practitioners who have obtained the hand therapy certification, and who may thus be potentially qualified, are still unable to legally incorporate certain physical agent modalities into their practice because of the lack of provisions in the law for such a specialized practice as hand therapy.

Occupational therapy licensure laws may thus eventually need modification to accommodate specialty certification, especially as more therapists obtain an array of specialty credentials awarded by professional organizations, such as the AOTA board certification programs in neuromusculoskeletal and pediatrics. The work of other professional groups serves as examples of the type of modifications needed for state regulation to address the problems created by advanced and specialized practice. For instance, some states have developed various approaches for recognizing nurses who have obtained advanced education and skills, which involve the following: (a) licensing of advanced practitioners (e.g., nurse practitioners, clinical nurse specialists) through the creation of a separate license or through providing a second level to the existing nursing license, (b) expanding the basic definition of nursing, (c) giving the physician increased delegative powers to nurse practitioners, or (d) registering the advanced practitioner with the state (Robinson, McKenzie, & Niemer, 1996).

"Boundary-less" Practice

In addition to competency, the regulatory debate also has brought to the forefront issues created by "boundary-less" practice, or practice that extends beyond the boundaries of current jurisdictions (Simpson, 1997). There are several factors creating boundary-less practice, including globalization of the economy, telemedicine, and multistate managed care plans. With the globalization of the economy, there is growing pressure to freely move goods and services. For instance, the North American Free Trade Agreement contains elements designed to increase professional mobility ("Emerging Licensing Issues," 1996). Through the collaborative efforts of AOTA and state associations, state regulatory laws for occupational therapy contain standard language. However, to continue ensuring free mobility, occupational therapy practitioners will need to encourage adoption across regulatory boards of similar standards related to competence. The pressure to encourage mobility, though, must be balanced by the importance of maintaining appropriate competency standards for each jurisdiction.

Teleoccupational therapy (if appropriate to co-opt the term as defined in nursing as telenursing or by others as telehealth or telemedicine) includes use of the telephone, cellular phones, videophones, facsimiles, computers, teleconferencing, videoconferencing, and interactive video to provide therapeutic intervention either directly to the client or indirectly through supervision of direct-care providers (Helminger & Milholland, 1997; Simpson, 1997). As occupational therapy practitioners assume an increasing role in consulting with professionals, caregivers, and clients via communication technologies, practice will no longer be confined to state lines. For example, if an occupational therapist consults with a caregiver in another state via the phone or supervises client care provided by an occupational therapy assistant in another state via interactive video, is the therapist practicing in another state without the appropriate license? In what legal danger is the occupational therapy assistant when following the supervisory guidelines of a therapist licensed in a state other than the state in which he or she is practicing? With the advent of corporate medicine, the likelihood of an occupational therapist consulting across state lines in other facilities owned by his or her employer is increasing.

Other professional groups are already examining this issue of boundary-less practice. For example, the NCSBN has created a task force to determine the implications for developing a regional or multistate licensure system for nurses (Sharp, 1997; Simpson, 1997). Regional regulation would allow a nurse to practice in all states that sign on to an agreement so that the nurse would not need to be licensed separately in each state.

Disciplinary Process

Some professionals believe that the advent of regional regulation strengthens arguments against the need for individual state regulation of health professions. However, most professionals still maintain that state regulation remains the best method for implementing disciplinary processes and thus continue to view state licensure laws as a relevant approach to professional credentialing (Sharp, 1997). In response to arguments that state regulation is important for protecting the public, the Pew Health Professions Commission (1995) has charged that states do not adequately maintain a fair, cost-effective, and uniform disciplinary process to remove practitioners who are incompetent. The need for licensure laws is often challenged by state officials on the basis of the lack of disciplinary activity by regulatory boards ("Therapists in Danger of Losing Licensure Boards," 1997). The fallacy of this method for determining the need for regulatory boards is the assumption that disciplinary activity is the sole...
are often ill equipped in terms of resources to communicate effectively with the public regarding the disciplinary process. These staffs may not include the investigative personnel necessary to address public complaints. Thus, lack of disciplinary activity by a regulatory board may more likely be associated with state agency staffing problems. Consequently, many members of the public who complain to boards are often poorly informed about the progress of their complaints or are prevented from participating in hearings. As a result, the public frequently accuses regulatory boards of not vigorously pursuing allegations of misconduct or incompetence. In many instances, when regulatory boards finally act, the time involved in resolving the issue is lengthy. The public may view the sanctions imposed as inadequate as well.

Consumer Focus

Partly as a result of public dissatisfaction with the ability of regulatory boards to remove from practice practitioners who are incompetent, there is mounting pressure to create a role for the public in assessing the competence of various professionals. This movement has also arisen from the growing “social movement for empowering the disenfranchised and the customer-driven focus of profit-making enterprises” (Cutshall, 1996, p. 111). It is not uncommon for licensure boards and boards of professional organizations, credentialing bodies, and managed health plans to include public members. The benefits of public participation are increased public trust, better understanding of issues by both the public and the profession, and greater accountability. However, the potential loss by the profession of the ability to be truly self-regulating needs to be considered, especially in those circumstances where an equal or even higher percentage of public representatives than professionals occurs on a regulatory or credentialing board.

Umbrella Legislation

Uniform regulatory legislation is a natural consideration given that many of the regulatory issues so far described affect multiple health professions in varying degrees. Uniformity may mean the creation of one act for all professions with some sort of oversight body but, at the other end of the continuum, may simply mean parallel legislative language in various professional acts (Cutshall, 1996). Parallel legislative language is the least threatening to most professional groups because it involves interjecting similar wording regarding specific procedures into the laws of multiple professions, such as generic descriptions of the disciplinary process. The advantage of uniformity is the consistency of public policy, which may result in improved communication to the public. For instance, by inserting generic language regarding the disciplinary process in all the regulations of health care professionals, the public may better understand how its interests are served and how assistance with a problem is obtained.

Additionally, consistency of policy provides equity regarding governmental approaches to professional regulation. In other words, the same privileges and responsibilities are awarded to all professionals. This may be important, for example, in determining that referral language indicating oversight authority by the medical profession is equally unnecessary for several different health care professions. Unfortunately, there are dangers to uniformity that include the inability of policy to address the nuances in clinical practice that differentiate one profession from another. For instance, there may be legitimate reasons that the disciplinary process should vary among different professions and should not be generic for all regulated health care professionals, especially if the dangers of incompetence are more severe in one profession than in another.

On the other end of the continuum of umbrella legislation is the approach of creating one regulatory act for all health professions with a single oversight body or board. Although seemingly cost-effective for state governments, a single oversight body wields a great deal of power and may succumb to special interests that are more organized and better funded for one professional group at the expense of other professional groups. The time given to resolving issues in one profession may preclude any major work from being accomplished for other professions when the workload of a single oversight group must somehow be divided fairly among the various constituencies.

Summary

All of these complicated issues related to title protection versus licensure; measurement of competence in generic, advanced, and specialized practice; regulation of boundaryless practice; implementation of fair and equitable disciplinary processes; involvement of consumers; and creation of umbrella legislation raise questions that occupational therapy practitioners should address, questions that other professionals are also asking and answering (Cutshall, 1996, p. 112):

1. Does overemphasizing public protection (discipli-
2. Is the unencumbered use of unlicensed workers and flexibility in the use of professionals really an improvement over licensure laws that restrict tasks to a given profession? Without outcomes data that indicate the skills required for certain interventions, the replacement of professionals with unlicensed personnel or with cheaper, less qualified professionals may be occurring without knowledge of the cost benefit of this trend to society.

3. What is the importance of ownership by the profession of its own professional standards? What happens to a profession when substantive responsibility and autonomy for decision making is removed through the payment rules generated by managed care organizations, through overreliance on legal regulation, or through coercive requirements of credentialing bodies? Will these professionals become disempowered and cynical, having little choice but to function as unionized workers? A healthy answer is to seek strategies that hold the profession responsible but do not attempt to do its work nor attempt to denigrate professional decision making. Yerxa (1995) said it best by stating that “occupational therapists are the only people who can and should define our practice, education, ethics, values and research. We owe this to society and the people we serve” (p. 298).

4. How much will the increasing public demands for regulation of competency cost the individual professional directly and the health care consumer indirectly? Will the public pay for these additional costs, and at what point is a protected title not worth the cost? Would competition among professionals for fewer jobs and promotions be a strong enough incentive for practitioners to participate voluntarily in a competency evaluation program and regularly complete in-depth ethics education? Very few of the proposed strategies for both regulating and mandating competency evaluation address these concerns related to costs and to capitalizing on the internal motivation of practitioners who wish to remain updated in order that they may help their clients obtain the most desired outcomes (Moyers, 1992).

5. What principles should guide the process for selecting public representatives on regulatory boards or credentialing bodies? Little is known about public participation in terms of the best way to select, orient, and train public members. Other issues involve the way to determine the specific role of public members on regulatory and credentialing boards, the extent to which participation in disciplinary action is important, whether public members truly represent the public view, or the influence of these public members on professional standards development.

6. Is there a need for regulatory boards to collaborate with each other particularly in terms of keeping jurisdictions informed of current regulatory issues, pertinent research studies and pilot projects, legislative and regulatory proposals in other states, and regulation implemented by the regulatory boards of other health professions? Many disciplines have organizations similar to that of the NCSBN and physical therapy’s Federation of State Boards established in 1986. In the absence of such an organization, do occupational therapy practitioners expect state and national associations to take the lead in facilitating this collaboration among regulatory boards? Because much of this discussion about professional regulation is occurring at the state level, how can we better prepare and assist state occupational therapy organizations in working with legislatures and regulatory bodies in their respective jurisdictions?

The main motivation for improving professional regulation is to achieve a system that considers the interest of every party involved in the dialogue fairly and that questions strategies that ignore the complexity of the issues. For instance, proposed strategies should be devised in consideration of state governments looking to control expenditures related to regulation, consumer advocacy groups raising concerns about the competence of practitioners, employers needing to capitalize on shrinking revenues, credentialing bodies and professional organizations seeking to have an impact on professional standards, and individual practitioners desiring protection of their professional autonomy. The need to forge a variety of partnerships among multiple groups, such as state boards and professional associations, is evident for achievement of the interdependent goals of protecting the public and promoting the profession of occupational therapy.

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