Improving Health Professions Decision-Making in the US: What Strategies Are Working?

Assessing the Impact of Regulation

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Health Reform Is Transforming the Health Care Landscape

- **Goals**
  - To increase access to basic health care services
  - To provide high quality, cost-effective care
  - To improve population health
What Changes With Health Reform?

- Shift in focus for the health care delivery system to primary and preventive care
- Integration of primary care, behavioral health and oral health services
- Better coordination of care
- Payment reform, moving away from fee-for-service and toward managed care arrangements
  - e.g., incentives for keeping people healthy and penalties for poor outcomes, e.g., inappropriate hospital readmissions
Workforce Implication of Health Reform

- New patient care delivery models (ex., Accountable Care Organizations, Patient Centered Medical Homes) are emerging

- Team-based approaches to care are used in these models
  - Team composition and roles vary, depending on the patient population
  - Teams may include: physicians, NPs, PAs, RNs, social workers, LPNs, medical assistants, and community health workers, among others

- Primary care providers roles are expanding to include behavioral health and oral health assessments
Workforce Issues

- Health care practitioner shortages and maldistributions

- Health professions students:
  - Have limited exposure to team-based models of care or interprofessional education
  - Are not trained in emerging functions

- Legal scope of practice is not well aligned with professional competence

- Shared responsibility needed for effective team-based care is difficult to achieve
Increased Interest in Scope of Practice Regulation

- Concern that scope of practice regulation directly impacts on:
  - Cost
  - Quality
  - Access
In the US, States Are Primarily Responsible for Regulating Health Professions

- Definitions
- Describes Regulatory Body
- Title Protection
- Professional Qualifications
- Education and Training
- Competency/ Certification Requirements
- Licensure Process
- SOP Including Limitations and Exceptions
- Licensure Renewal
- Discipline Process
- Continuing Education
- Appeals Process

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Issues With State Based Health Professions Regulation

- Mismatches between professional competence and state-specific legal scopes of practice
- Lack of uniformity in legal scopes of practice across states for some health professions
- Inconsistencies in training and education requirements, especially for emerging professions
- The process for changing state-specific scope of practice is slow and adversarial
State Strategies to Support Workforce Innovation

- Expand stakeholder input into SOP decision-making
- Use best available data and evidence to support SOP decision-making
- In the absence of evidence, allow time-limited demonstration projects that are carefully evaluated
- Target workforce innovations to underserved populations
SOP Policy Reform Strategy
Virginia: Expanded Stakeholder Input

- Virginia Board of Health Professions
  - Statutorily created advisory body
  - Comprised of 18 members – reps from each of 13 health professional licensing boards and 5 citizen members
  - Duties include: examining scope of practice conflicts and evaluating health professions to consider need for regulation and degree of regulation
  - Criteria used in SOP decision-making: risk for harm to consumers, specialized skills, autonomous practice, economic impact
SOP Policy Reform Strategy
Virginia:
Using Available Data to Inform SOP Decisions

- Virginia Healthcare Workforce Data Center
  - Based in the Virginia Department of Health Professions
  - Collects health workforce data through re-licensing surveys
  - Routinely releases reports of findings
  - Informs the work of the Board of Health Professions
  - Currently assisting with a series of reviews into the potential barriers to effective team delivery models posed by SOP restrictions
    - Dental hygiene is among the first professions to be assessed
In 2011, Maine legislature mandated a study of oral health care needs in the state.

In 2012, a series of reports were released:
- Assessment of Oral Health Delivery in Maine
- New or Expanded Oral Health Workforce Models in the U.S.
- Report of the Survey of Dental Safety Net Providers in Maine
- The Oral Health Workforce in Maine

In 2014, Maine passed a law recognizing dental hygiene therapists.
Licensed dental hygienist with 2 years of additional training and 2,000 hours of supervised clinical practice
Works under the direct supervision of a licensed dentist or a written practice agreement with a dentist
Can work in hospitals, schools, nursing homes, health centers, public health settings
At least 50% of patients served by dental hygiene therapists must be Medicaid patients or underserved adults
SOP Policy Reform Strategy
Alaska Dental Health Aide Therapist (DHAT)
Targeting Underserved Populations

- Started in 2003
- Only serves Alaskan tribal communities
- Trainees recruited from local tribal communities
- Education: certificate program with 20 months plus 400 hours of supervised clinical training
- DHATs provide a range of OH services including: prevention, education, diagnosis and treatment of dental caries, basic restorative care
  - Work under the general supervision of a dentist
Alaska Dental Health Aide Therapist (DHAT) Evaluation Findings

- DHATs provide safe, competent, and appropriate care
- Tribal communities in Alaska report increased access to oral health care
  - Reduced in wait times
  - Reduced travel times
- Patients are very satisfied with care from DHATS
- Wide acceptance of DHATs in the communities they serve
2009 legislation authorizing DTs and ADTs
DT Education: 4-year, 40 month bachelor’s degree
ADT Education: 26 month masters degree
Range of OH services include: diagnosis and treatment of dental caries, basic restorative services, including simple extractions; ADTs provide preventive services as well
Both work under the supervision of a dentist, but ADTs practice more autonomously
Half of caseload for both DTs and ADTs must be underserved populations
In 2014, there were 32 DTs in Minn; 6 of them were ADTs

- Worked in community clinics, hospitals and private practices
- Served over 6,300 new patients
  - 84% on public insurance
- Patients reported reduction in wait times
  - More pronounced in rural areas
- May reduce ER use by expanding capacity at dental clinics

Clinic impacts:
- Personnel cost savings
- Increased productivity of dental teams
- Improved patient satisfaction

May contribute to improved cultural competence of the oral health workforce
Established in 1972
- Allows time-limited demonstrations and evaluations of new approaches to health care delivery
- Does not require changes to law or regulation
- Recently completed pilot: The Virtual Dental Home
  - Community based oral health delivery system
  - Dental hygienists and dental assistants work in community settings and are remotely supervised by dentists
  - Settings include preschools, elementary schools and nursing homes
  - Services include education, triage, case management preventive procedures, and interim therapeutic restorations
  - Result: Positive evaluation led to adoption of the model by the state
    - Changes to SOP and reimbursement for services through the virtual dental home
States Are Adopting Their Own Strategies to Expand Access to Oral Health Services

+ Designed to address local needs and considers factors unique to that state
- Continues to contribute to state-to-state variation in SOP, training, qualifications for similar titles
  - Early stages in the development of oral health mid-levels
  - More convergence in these emerging models across states is likely over time
Thank you

Questions?