Improving Access to Health Care in California: Testing New Roles for Providers

Introduction
Many Californians, along with Americans in most other parts of the nation, do not have access to a regular source of health care. While much of the current policy debate focuses on improving or expanding insurance coverage, addressing the ability to pay for health care only removes one roadblock. Attention must also be paid to the health care workforce, such as ensuring adequate supplies of doctors, nurses, and other health workers.

Recent years have seen a small but growing number of efforts to examine this aspect of the problem. Some are part of a big picture approach to rethink strategies, systems, and the practice models in which professionals deliver care. Others are happening at the point of care itself via new ways to connect providers and patients, such as retail health clinics staffed by nurse practitioners, or physician offices that offer dental work.

In addition to an overview of workforce innovation initiatives taking place in California and elsewhere, this issue brief provides a detailed look at a unique program: the California Health Workforce Pilot Project (HWPP). Administered by the Office of Statewide Health Planning and Development (OSHPD), the project offers the opportunity to safely assess new approaches to the delivery of care, including programs that:

- Allow health care workers to acquire new skills;
- Seek to develop new health care job categories or speed training in existing categories; and
- Teach new roles to people with no health care training.

Finally, the authors propose possible avenues to further California’s explorations of workforce innovation by drawing on HWPP’s experience, with particular focus on a demonstration project to expand the role of some registered dental hygienists in treating underserved populations.

Policies and Practice Models
The American health care system is witnessing an explosion of interest in finding new and better ways to deliver care—particularly those innovations that promise to improve access while advancing quality and controlling costs. Examples of recent legislation, conferences, and high profile policy recommendations that target the health workforce include:

- The California Health Professions Workforce Taskforce. California law now requires the Office of Statewide Health Planning and Development to work with the Workforce Investment Board to establish a Health Professions Workforce Taskforce, which will assist in the development of a health professions workforce master plan for the state.¹

- Specialty Care Access Initiative. Begun in 2006, the Specialty Care Access Initiative is a partnership of several organizations and sponsors designed to better understand access to specialty care in California and support efforts in the safety net to address access problems.²
Prescription for Pennsylvania. Governor Ed Rendell’s comprehensive 2007 overhaul of Pennsylvania’s health care system included prominent attention to increasing access to health care professionals – particularly non-physician providers—and expanding practice laws to allow them to perform to the fullest extent of their training and ability.3

Retooling for an Aging America: Building the Health Care Workforce. This report, produced by the national Institute of Medicine’s Committee on the Future Health Care Workforce for Older Americans, found that the nation’s health care workforce is woefully unprepared to meet the needs of the country’s aging population and outlined policy and financing reform solutions.

The U.S. Oral Health Workforce in the Coming Decade. This report resulted from a workshop convened by the Institute of Medicine. It found that the current oral health workforce fails to meet the needs of many segments of the U.S. population. The workshop examined promising workforce strategies to improve access, as well as ways to improve the regulatory framework and structure of oral health care delivery.

Amid all the exploration of legal and policy changes, another much larger and wide-ranging set of innovations has taken place at the point of contact between health care professional and patient. Across the country, health care providers are testing how practice model changes might make access to clinicians easier.

Physicians providing dental care. A program sponsored by the American Dental Association and the American Academy of Pediatrics trains pediatricians to look for dental decay and apply fluoride to their young patients’ teeth. In another example, in a state with notable shortages of dentists in rural areas, primary care doctors who do their residency training in Maine learn and provide basic dental services to patients who would not otherwise have access to oral health care.4

Physician assistants and nurse practitioners delivering specialty medical care. A growing number of high-demand medical specialty practices—particularly in orthopedics, dermatology, and gastroenterology—have incorporated physician assistants and nurse practitioners as colleague clinicians who provide timely and comprehensive specialty services to patients, thus reducing wait times without compromising safety or quality of care.5

Nurse practitioners offer primary care in retail clinics. Retail health clinics, which are staffed primarily by nurse practitioners, are now found throughout the United States. A recent study found that retail clinics provide less costly treatment than physician offices or urgent care centers for three common illnesses (otitis media, pharyngitis, urinary tract infection) “with no apparent adverse effect on quality of care or delivery of preventive care.”6

These innovations are changing the way care is delivered and are being watched and studied for lessons that can be used in other, similar settings. Because health professions’ laws and practice patterns may vary by state, the ease with which adaptations can be made may also differ. Questions may arise as to whether practice act authority for a particular profession may need to be updated to allow the provision of specific services or whether practitioners need additional education and training to provide those services.

California Health Workforce Pilot Projects Program

As California explores new ways to make the best use of health care workers, the state is able to draw upon the resources of the Health Workforce Pilot Project (HWPP). Established in 1972, HWPP permits temporary legal waivers of certain practice restrictions or educational requirements to test expanded roles and accelerated training programs for health care professionals.7,8
HWPP staff has since processed over 170 applications. The majority were approved and have been completed. Approved projects are educational or training programs that do any of the following:

- Teach new skills to existing categories of health care personnel;
- Develop new categories of health care personnel;
- Accelerate training within existing categories of health care personnel; or
- Teach new health care roles to people with no prior training.

Demonstration projects, which typically last from one to three years, consist of a teaching phase, a clinical training phase, and an employment phase in which trainees provide a specific health care service. State regulations mandate that each project comply with or provide:

- Minimum safety, quality, and feasibility standards;
- Requirements for sponsor, trainee, and supervisor selection;
- Curriculum, evaluation, and monitoring plans;
- Provision of informed consent;
- An application review process;
- Recordkeeping and continuing approval; and
- Regular OSHPD HWPP site visits.9

Through the site visits and any data submitted to the HWPP office, OSHPD staff prepares an evaluation of each project. These evaluations, which are written as final or “closing” reports for each project, assess:10

- New health skills taught or extent to which existing skills have been reallocated;
- Implications of the project for existing licensure laws, with suggestions for changes in the law where appropriate;
- Implications of the project for health services curricula and health care delivery systems;
- Teaching methods used in the project;
- Quality of care and degree of patient acceptance;
- Extent that those who acquire the new skills could find employment in the health care system, assuming laws were changed to accommodate them; and
- Cost of the care provided in the project, the likely cost of such care if performed by the trainees after the conclusion of the project, and the cost of the same care when delivered by current providers.

The project director’s closing report for any project may be provided to the California legislature.11 The value of these evaluations to lawmakers considering statutes that would affect the practice of medicine, nursing, pharmacy, and dentistry has been clearly demonstrated. Many—though far from all—of the projects appear to have contributed at least in part to legislative decisions regarding the regulation of health care professionals in California. This outcome is consistent with the original HWPP legislative purpose. As noted in the law establishing the HWPP, “it is the intent of this legislation that existing health arts licensure laws incorporate innovations developed in approved projects that are likely to improve the effectiveness of health care delivery systems.”12

Although a long list of health professions can participate in HWPP demonstrations (see shaded box on page 4), a handful of professions make up the majority of participants. From 1972 to 2005, the HWPP office estimated that roles in the nursing field (including nurse practitioners) represented the largest number of projects, followed by dental auxiliaries (including dental hygienists) and medical auxiliaries.13
Some subsets of professions are noteworthy. From 1974 to 1984, the nurse practitioner profession was involved in 40 pilot projects. At least six legal expansions are attributable in part to demonstration outcomes. The physician assistant profession was involved in four pilot projects, leading to the passage of expanded scopes of practice in 1981 and 1983.15

Practical challenges to successful HWPP projects include inherent risk to patient safety, significant project costs, and opposition from other professions. In addition, trainees do not have absolute immunity against malpractice claims, although they are protected for services rendered under the delegation of project directors. As noted above, most of the HWPP demonstrations undertaken over the past three decades have overcome any challenges and succeeded in meeting their training objectives. This is not to say however, that all projects were effective in changing laws to the extent desired by project sponsors. Legislative decisions remain in the hands of the state legislature, which is in no way bound by the outcomes of the HWPP projects or the evaluations OSHPD submits. In addition, many of the approved projects found that the sponsors’ original objectives to educate and train professionals were not feasible or affordable. Each of these experiences also provided lessons to members of the profession as well as the respective project sponsors.

Illustrative examples of HWPP projects include:

**Nurse Practitioners.** Several dozen nursing projects were approved in the early-to-mid 1970s, shortly after the HWPP program was established. Under these projects, over 2,000 nurse practitioners and nurse midwives were prepared to practice under proposed expanded nursing practice act authority, which was progressing through the legislature at the same time. By the time the Nurse Practice Act took effect in 1975, a workforce of nurses with advanced training was equipped with the skills needed under the new law and ready for employment.16

**Pharmacy.** From the mid-1970s through the early 1980s, a number of HWPP projects were approved that focused on pharmacists prescribing and administering medications. While some ended in early termination, the projects likely contributed to the passage of AB 502 (1983, Maddy), which permitted pharmacists to initiate drugs based on a physician’s diagnosis.

**Paramedics.** One HWPP project focused on testing and demonstrating that paramedics (EMT-P) can administer selected vaccines and immunizations at outreach clinics sponsored by a county fire department. The project was approved in 1998; 14 paramedics were trained, and five vaccination clinics were held over four months by 11 paramedics at fire stations in Alameda County. OSHPD found that “…the main value of the paramedic-based program is not in cost savings but in use of fire stations and paramedics as a way of reaching out into the community to enhance overall efforts to achieve immunization of all children.” In its evaluation, the OSHPD HWPP office determined there was “…no need for statewide changes in existing law governing the scope of practice for paramedics.” This finding was based

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**HWPP Demonstration Projects**

HWPP demonstration projects may be in any of the following fields:14

- Expanded-role medical auxiliaries
- Expanded-role nursing
- Expanded-role dental auxiliaries
- Maternal child care personnel
- Pharmacy personnel
- Mental health personnel
- Other health care personnel including, but not limited to, veterinary personnel, chiropractic personnel, podiatric personnel, geriatric care personnel, therapy personnel, and health care technicians.

Projects must be sponsored by a community hospital or clinic, a nonprofit educational institution, or a government agency engaged in health or educational activities. Projects operating in rural and Central Valley areas are given priority.
on its analysis that while paramedics could safely provide childhood immunizations (which would necessitate a change in the practice act), “with only one year of experience in one community with paramedics providing immunizations to 184 children, a change in the scope of practice for paramedics statewide is not warranted.”

**Dental Hygienists.** In 1990, an HWPP project was approved to test and demonstrate that dental hygienists could provide preventive oral health care independent of dentist supervision. The project ran for eight years, by which time legislation had passed to establish a new category of dental auxiliary—the registered dental hygienist in alternative practice (Chapter 753, Statutes of 1997). The dental hygienists who had completed their training and established independent practices under the HWPP project were considered to have satisfied state licensing requirements for this new category and the change in law authorized them to continue their practice.

**From Pilot Projects to Policy**
California’s HWPP program is flexible, making it useful for professionals to either respond to changing laws by accelerating educational programs to meet new requirements, or help inform discussion about proposed new scope of practice laws. By their nature, state practice acts are variable and evolving (see shaded box). Similarly, regulatory, research, and policy publications on health care professions’ practice acts have evolved over the past two decades. Many health professions in the United States are still subject to practice acts that vary widely by state, setting, and patient population. However, a national, if incremental, trend towards expanding and overlapping scopes of practice among non-physician clinicians is occurring. States leading in broader practice authorities do not tend to revert to earlier restrictions, and other states often follow in legal expansions.

Several developments are driving the evolution of practice acts. First are the changes in demographics and disease burden—with increased demands to care for the aging and chronically ill—that translate into tremendous stress being placed upon primary care clinicians. With appropriate changes in practice acts, for example, nurse practitioners and physician assistants could more fully complement the physician workforce. In contrast to a declining number of primary care physician trainees in California, enrollment in nurse practitioner and physician assistant training programs has increased. Second, research and practice have clarified that collaboration between physicians and other clinicians improves delivery of care. Models are being tested and implemented to promote interdependent and complementary relationships among health professions, while minimizing competition. Third, it is important to acknowledge that practice acts which prohibit professionals from applying their full range of skills inhibit the efficient delivery of care. Because many professional education programs now train students to high, national standards, state practice acts that fail to recognize those advanced authorities create an artificial gap between a professional’s competence and the care they are permitted to deliver.

The full impact of practice act revisions is difficult to measure, but studies largely report positive outcomes. Findings include reduced costs, increased access to care for underserved populations, and similar, if not higher, quality of care. Some of the evidence for the value of expanded practice acts comes from legislative grants of more permissive practice authority to health professionals treating certain populations. Historically, both in California and the nation, barriers to fuller
scopes of practice have been less prominent under certain conditions: in safety-net institutions, such as community clinics and public hospitals, where loss of income is less of a risk; in rural areas that have greater difficulty attracting providers; and for low-reimbursement procedures that threaten to overwhelm clinicians. Lawmakers and professionals can look to these successful experiments to better ensure that all Californians have equal access to a wide range of competent providers governed by one evidence-based practice act per profession.

Potential Demonstration Projects in California
California, like other states, faces myriad health care challenges and problems. California also falls roughly in the middle of the practice continuum of expansive and restrictive states for several professions, providing plenty of room for workforce innovation experimentation. With more than three decades of experience using the HWPP, the state is well-positioned to continue its exploration of workforce innovations.

For example, the need for improved access to oral health care services in California might support a demonstration project for Registered Dental Hygienists in Alternative Practice (RDHAP). The proposed project is presented here in rough form and would need to be much more fully developed by members of the profession and interested policy makers, as well as potential sponsors, educators, employers, and delivery site administrators.

Modification of Documented Relationship Requirement and Expansion of Scope of Practice for RDHAPs
Background. In 1998, California recognized the Registered Dental Hygienist in Alternative Practice profession. The goal was to improve access to dental care for underserved populations by permitting dental hygienists to practice independently in certain settings.

RDHAPs are experienced registered dental hygienists with baccalaureate degrees who work independently. Candidates must complete an additional 150 hours of coursework in clinical practice and practice management. They are not permitted to place permanent restorations, devise comprehensive treatment plans, or make a diagnosis beyond a hygiene assessment. RDHAPs may render services in: residences of the homebound; schools; residential facilities and other institutions; and certified dental health professional shortage areas. They are prevention specialists who provide community-based case management, behavioral management, desensitization, and health promotion (all currently unreimbursed) in addition to clinical prevention services.

Today, the state has over 250 RDHAPs. As a prerequisite for licensure, candidates must provide the California Dental Board with documentation of an existing relationship with a dentist for referral, consultation, and emergency services. If the hygienist provides services to the patient 18 months or more after the first encounter, RDHAPs must obtain written verification (valid for two years) that a patient has been examined by a dentist or physician. These requirements are in place to ensure patient safety and coordination between RDHAPs and dentists or physicians. Unfortunately, in practice, the requirements serve only as a time-consuming administrative process with no relationship to safety nor assurance of care coordination.

Need. Low-income children, the elderly, and the disabled have more dental disease and difficulty getting dental treatment than the general population. They often cannot travel to dental offices, and those who seek care soon find that relatively few dentists accept Denti-Cal coverage. California’s nursing homes and long term care institutions are mandated to provide or arrange oral health services for residents. However, long term care organizations have had limited success because of the costs of travel time, inherent difficulties with providing services outside of a dental office, and the challenge of finding clinicians experienced in treating patients with complex conditions.
California’s RDHAPs have already expanded access to dental treatment for underserved patients. Compared to dentists who rely on office-based equipment, RDHAPs bring their practices to the patient. Many are found to need restorative care beyond the RDHAP scope of practice.

**Hypothesis.** Registered dental hygienists in alternative practice would be more effective if they were able to stabilize their patients with certain carious lesions using interim therapeutic restorations (ITRs) and have a mechanism for collaborative practice which would ensure that there is a dentist willing to accept a referral if necessary.

**Demonstration.** A pilot project revising the documented relationship into a collaborative practice agreement, and expanding the scope of practice to include ITR, would make it possible to test whether RDHAPs would be more effective in providing dental care for their patients. To evaluate the demonstration project, outcomes for patients receiving the ITR in select sites could be measured, as well as the timing and execution of appropriate referrals. This would be compared to the same measures in a practice using the existing model. Finally, the evaluation could measure provider opinion and experience using a different collaborative practice model.

**Rationale.** The RDHAP profession was created to expand disease prevention in non-dental office settings. A central premise is that the workforce would assist seriously underserved areas. However, this legislative intent may be undercut by the weakness of the documented relationship and the inability to stabilize dental disease at the point of contact. A pilot project studying these two changes may help to improve the oral health of underserved patients in California.

**Conclusion**

California’s Health Workforce Pilot Projects program offers an extremely useful vehicle for testing workforce practice and education innovations. With more than thirty years of history and scores of successfully completed projects, the program has demonstrated its worth. As health care professionals and policy makers seek better ways to organize and deliver care, the HWPP continues to be a valuable proving ground for California and a model other states may wish to consider replicating.

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**Alternative Study Option**

If a scope of practice waiver under the HWPP is not available or approved, alternative studies may be conducted. One potential model is an independent scientific review comparing data on therapeutic pharmaceutical agent-certified optometrists, ophthalmologists, primary care physicians and non-physician clinicians.

The research, commissioned by the California Optometric Association in 1999 and conducted by a neutral third party, included chart evaluations of the four groups of clinicians’ treatment of common eye conditions based on the American Academy of Ophthalmology’s standard of care. The report concluded that optometrists were at least as cost-effective and competent as each clinician group for each examined condition. The results provided solid responses to evidence-based questions of safety, quality, and cost.

The report led to the legislative revision to allow optometrists a broader practice authority. The study design could be used as a model to compare the competence of two professions with overlapping scopes of practice. It might be particularly valuable to begin by focusing on a specific underserved setting, such as long term care facilities or community clinics.
**ABOUT THE FOUNDATION**

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

**ENDNOTES**

1. California AB 2375 (Hernandez, April 10, 2008); Bill Analysis (April 1, 2008).

2. Specialty Care Access Initiative, A Partnership of Kaiser Permanente, California Association of Public Hospital and Health Systems and California Primary Care Association. Roundtable Forum #3: Improving Specialty Care through Scope of Practice. March 6, 2008. See also information at on the SCAI at the Safety Net Institute: www.safetynetinstitute.org/content/SpecialtyCareAccessInitiative.htm.


11. Ibid.


14. California Health and Safety Code §128160 (a)


19. For example, “[O]nly the coordinated efforts of multiple, diverse health professionals can meet the needs of tomorrow’s patients.” Taillie, J.; foreword by Clyde H. Evans. *Academic Health Centers Take Leading Role to Advance Interdisciplinary Education and Practice in Prevention.* Association of Academic Health Centers, 2003.


26. California Business and Professions Code §§1774–1777; California Code of Regulations §§1073.3(e), 1090(a)–(c), 1090.1

27. In 2006, the Pacific Center for Special Care at the University of the Pacific School of Dentistry received a policy development grant for people with special needs. One workgroup established by Pacific developed a proposal for a distance collaboration system whereby oral health professionals working in community settings, such as school-based settings, day programs, residential care, and long term care facilities, could use electronic communication technology to collaborate with dentists in dental schools, offices, and clinics. (Glassman, P. *Distance Collaboration Concept Paper* (Draft). University of the Pacific School of Dentistry, August 2007.) The university is in the process of securing funding to implement this teledentistry pilot project, which could serve as an excellent model for dental care delivery.


31. Mertz, *Registered Dental Hygienists in Alternative Practice*

32. See note 22.