California HealthCare Foundation

Scope of Practice Laws in Health Care: Exploring New Approaches for California

Overview

In health care, scope of practice (SOP) laws establish the legal framework that controls the delivery of medical services. They dictate which professions may provide specific services, the settings in which they may provide them, and the parameters of their professional activities. The reach of SOP laws stretches from physicians to physical therapists, podiatrists to dental hygienists.

With few exceptions, determining SOP laws is the work of state governments. State legislatures consider and pass the statutes that govern health care practices. Regulatory agencies, such as medical and other health profession boards, implement those statutes, through the writing and enforcement of rules and regulations.

Due to the individualized, state-specific nature of this process, SOP laws and regulations vary widely among the health care professions. Some states allow individual professions broad latitude in the services they may provide, while others employ strict SOP limits. In some states, certain professions are not recognized at all.

Influencing the design of these legal frameworks is the large number of interest groups involved in SOP decision-making. These constituencies each bring their own goals, biases, and agendas to a process that is often highly politicized and lacking in standardized guidelines. This has resulted in episodic, and at times seemingly intractable, political battles over modifications to SOP laws, both in California and nationwide.

The cumulative effects of legal SOP boundaries are substantial, and not limited to market share or inter-professional competition. SOP laws can facilitate or hinder patients' ability to see a particular type of provider, which in turn influences health care costs, access, and quality.

Key Findings

- In California, the state legislature enacts scope of practice (SOP) laws, and all major changes to those laws;
- Most of the health professions boards, which implement the laws through regulation, function under the administrative oversight of state agencies such as the Department of Consumer Affairs, the Department of Public Health, or the Emergency Medical Services Authority;
- Policy and political battles over SOP laws have arisen in numerous state legislatures;
- The states of Iowa, Minnesota, New Mexico, and Virginia, and the province of Ontario, have established or are implementing processes to review changes to SOP laws. In addition, a bill in Texas proposing a new SOP review mechanism was recently defeated; and
- These processes have met with varying degrees of success, but have garnered positive evaluations from policymakers who have employed them in their SOP decision-making.

ISSUE BRIEF

March 2008

The Center for the Health Professions at the University of California, San Francisco has identified a number of relevant models for reviewing and modifying SOP laws. The analysis, completed in November 2007, was funded by the California HealthCare Foundation.

This issue brief highlights those models, comparing and contrasting SOP review programs and statutes across the United States and Canada. These review programs seek to complement legislative SOP decision-making with formal review processes, additional expertise, and the use of empirical evidence.

The issue brief also compares California SOP laws for four professions to those of other state and federal programs that offer broader, more expansive practice provisions. Given the often contentious nature of SOP discussions, the models presented here offer California ideas on how to approach the SOP review process in a more impartial manner.

The full UCSF analysis, *Promising Scope of Practice Models for the Health Professions*, is available online at http://futurehealth.ucsf.edu/pdf_files/Scope%20Models%20Fall%202007.pdf.

Professional Regulation and Scope of Practice Decision-Making: The California Experience

In California, as in most states, the state legislature makes SOP laws, and major modifications to those statutes. SOP laws, once enacted, come under the administrative authority of one of the following: the Department of Public Health (CDPH); the Emergency Medical Services Authority (EMSA); or the boards, bureaus, and committees housed in the Department of Consumer Affairs.

Scope of Practice Laws in California: Health Care Professions

The state of California administers scope of practice laws for a broad range of health care professionals. Regulated professions include:

- Acupuncturists;
- Audiologists;
- Behavioral sciences (marriage and family therapists, licensed clinical social workers, etc.);
- Chiropractors;
- Dentists, dental assistants and dental hygienists;
- Hearing aid dispensers;
- Home health aides;
- Laboratory professionals;
- Medical assistants;
- Midwives (nurse midwives and direct entry midwives);
- Naturopaths;
- Occupational therapists and occupational therapist technicians;
- Optometrists and opticians;
- Orthodontists and oral surgeons;
- Osteopaths;
- Paramedics and emergency medical technicians;
- Pharmacists and pharmacy technicians;
- Physical therapists and physical therapy assistants;
- Physicians (including psychiatrists, ophthalmologists, etc.);
- Physician assistants;
- Podiatrists;
- Psychiatric technicians and psychological assistants;
- Psychologists;
- Radiologic technologists;
- Registered nurses (including nurse practitioners), nursing assistants, and licensed vocational nurses;
- Respiratory care practitioners; and
- Speech pathologists.

Source: California Department of Consumer Affairs. "DCA Boards/Bureaus." www.dca.ca.gov/about_dca/entities.shtml; California Department of Public Health. www.cdph.ca.gov/certlic/occupations/Pages/default.aspx; California Emergency Medical Services Authority. www.emsa.ca.gov; California Board of Chiropractic Examiners. www.chiro.ca.gov.

These agencies provide administrative and regulatory oversight of the respective professions under their authority. This includes:

- Establishing minimum qualifications and levels of competency for licensure;
- Licensing, registering, and certifying practitioners; and
- Investigating complaints and disciplining violators.

The DCA has 15 boards, two bureaus, and two committees, which regulate the majority of the medical and behavioral science professions. The boards and bureaus are semi-autonomous bodies, with members appointed by the governor and the legislature; the department provides administrative support. The committees are under the purview of the bureaus in which they are housed.[1]

The CDPH regulates a smaller number of professions, including home health aides, radiologic technologists, and laboratory technicians; EMSA regulates paramedics, while local EMS agencies regulate emergency medical technicians (EMTs); and chiropractors fall under the Board of Chiropractic Examiners.

Given the role of the state legislature in SOP decision-making, changes to these laws are largely a function of the political process. Interest groups with strong lobbies play a significant role in shaping or blocking legislation. This has spawned numerous inter-professional battles, some of which have continued for years.

For example, psychiatrists and psychologists have clashed repeatedly over legal authority to prescribe psychotropic drugs. Both professions may treat patients through individual and group therapy, but psychologists do not have drug-prescribing authority. Psychologists have long sought to add drug prescribing to their practice scope, but psychiatrists, who may prescribe psychotropic drugs, have consistently fought this SOP expansion. In 2007, SB 993, authored by Sen. Sam Aanestad, R-Penn Valley, and Sen. Ron Calderon, D-Montebello, would have allowed psychologists to prescribe drugs. However, the bill faced opposition from organizations representing psychiatrists and other medical professionals with prescribing authority, and the bill failed to clear the Senate Business, Professions, and Economic Development Committee.[2]

The competition between physicians and nurse practitioners (NPs) is another policy area of significant legislative activity. NPs are registered nurses with advanced clinical training, who serve as primary care providers in a broad spectrum of acute and outpatient settings. The two professions have a long and contentious history concerning practice boundaries.

In 2007, two bills sought to expand SOP laws for NPs, in particular, allowing NPs to prescribe drugs without physician oversight. Physician lobbying organizations opposed both bills. One, AB 1643, authored by Assemblymember Roger Niello, D-Sacramento, was not scheduled for a committee hearing, and the author decided not to pursue the bill. The second bill, SBX1 24, by Sen. Roy Ashburn, R-Bakersfield, was removed at the author's request prior to its scheduled hearing before the Senate Health Committee; as of late February, a hearing had yet to be scheduled.[3]

Eye and vision care is another area where competition among professions has occurred. Ophthalmologists and optometrists have found themselves on opposite sides of debates on whether optometrists, whose SOP is generally the more restricted of the two, should be allowed to expand their SOP into areas such as diagnosis and treatment of glaucoma, and the prescription of medications.

In 2000, SB 929, by then-Sen. Richard Polanco, D-Los Angeles, expanded the SOP of optometrists to allow the treatment of additional diseases and conditions. The bill also declared a moratorium on further optometry SOP modifications until Jan. 1, 2009. That modification

process is now under way. SB 1406, introduced in February 2008 by Sen. Lou Correa, D-Santa Ana, would expand optometrists' SOP. It would permit optometrists to diagnose and treat the eyes, or any part of the visual system, for all conditions for which they are trained and authorized by the state Board of Optometry.

Scope of Practice Decision-Making: Other States, Other Models

Several state governments have begun to establish independent review committees to evaluate SOP modification proposals. These committees, using standardized review mechanisms and expert staff, evaluate proposals and transmit their findings to legislators. Policymakers then have objective, evidence-based reviews on which to draw in their deliberations. As illustrated by the brief descriptions that follow, four states and one Canadian province have established flexible, transparent review processes to support legislative decision-making.

Minnesota: Health Occupations Review Program

In 2001, Minnesota established the state Health Occupations Review Program, to provide legislators with impartial information on SOP modification proposals. The program reviews legislation on SOP changes, and emerging professions, at the request of state policymakers.

The program serves in an advisory capacity only, but generates important background information that helps legislators make informed decisions. The program helps frame issues; develops benchmark research that places proposals in context of other states' decisions; examines other professions in the state for standard practices; and raises questions for legislators to consider when reviewing SOP proposals.

The program consists of representatives from existing state health licensing boards. Initial review panels are composed of six members of those boards, with review processes taking an average of three to nine months.

Legislators have given the program favorable reviews, including one policymaker who suggested that all health care profession bills go through program reviews.

In one example of the review process, a program panel evaluated a 2006 proposal to expand SOP for athletic trainers. The panel provided valuable analysis on key elements of the proposal, including:

- The plan to rename trainers' clients as "patients," as opposed to "athletes," would make Minnesota the first state to do so, but Michigan previously had changed its definition of "athlete" to "individual;"
- The plan to reduce from one year to six months the period of temporary trainer registration, which covers the time between completion of education and passage of the state credentialing exam, would be consistent with state rules for physician assistants and respiratory therapists;
- The plan to provide a three-month grace period for new trainers to be employed without a physician protocol (a formal physician-generated treatment guideline) in place was illogical, because this would make the standard for new trainers less stringent than that for trainers who are already registered, and who must work with physician protocols; and
- Athletic trainers are allied health professionals and should be required to adhere to HIPAA regulations.

New Mexico: Scope of Practice Review Commission

In 2007, the New Mexico Legislature passed House Joint Memorial 71, and House Memorial 88, requesting that the Interim Legislative Health and Human Services Committee establish an empirical process to provide legislators with objective information when deciding on proposed SOP changes. The committee will begin its study in the summer of 2008, as part of the state's health care reform initiative.

Texas: Scope of Practice Review Bill Fails to Clear the Legislature

In an example of the difficulties associated with modifying the scope of practice (SOP) review process, Texas state Rep. Dianne Delisi saw her second attempt to establish a formal review mechanism go down to defeat in the 2007 legislative session.

Delisi authored a bill in 2005 to create a Health Professions Scope of Practice Review Commission, which would evaluate proposed changes to SOP laws. The bill failed, and Delisi re-introduced it in the 2007 session.

The proposal called for a nine-member commission, including two public representatives and one representative from the Health, Law and Policy Institute at the University of Houston, as well as formal process protocols to evaluate proposed SOP changes. These protocols included an examination of other states that have implemented similar SOP review processes, with evaluations of subsequent impacts on access to care.

Further, the bill included notice requirements for committee meetings that are similar to those of corporate boards; made commission meetings open to the public; and articulated quorum requirements for commission votes.

The bill was referred to the House Public Health Committee in late March, 2007, where it died without receiving a hearing; Delisi plans to retire at the end of 2008.

Iowa: Reviewing Committees

In 1997, the Iowa General Assembly established a three-year pilot program to review SOP processes, after a state task force found that the existing system for resolving inter-professional conflicts was inadequate.

The pilot program instituted SOP review committees. These committees conducted impartial assessments of proposed changes in health profession regulations, used objective criteria to evaluate proposals, and developed non-binding recommendations for legislators.[4] The program sought to enhance both consumer protection and choice.

Under the program, committees received proposals for review in two ways, either by a request from the Iowa General Assembly, or a recommendation from the state Public Health Department. Reviews had to be completed within nine months. Review committees commonly had five members:

- One member representing the profession seeking a change in scope of practice;
- One member of the health profession directly affected by, or opposed to, the proposed change;
- One impartial health professional, whose constituency would not be affected by the proposed change; and
- Two members of the general public.

The program was well-received by the constituencies that interacted with it. Based on the pilot project's success, legislators extended the program twice—first until 2002, then until 2007.

Between 1997 and 2002, committees reviewed four proposals, two each from the General Assembly and the Public Health Department. The review process provided policymakers with information to aid their efforts to resolve conflicts among health professions:

- The Dubuque District Dental Assistant Society requested mandatory certification of dental assistants (DAs), which at the time were not governed by formal state regulation. The reviewing committee found that the lack of formal regulation could constitute a consumer protection issue, and that the lack of education or training requirements meant there were no minimum competency standards. The committee also found that there could be more cost-effective methods to regulate the profession than mandatory certification. The committee recommended that all DAs be required to register with the Board of Dental Examiners, and that the board should establish education and examination requirements. This recommendation became law in 2000, and the governor vetoed a bill in 2004 that would have eliminated the new exam requirements;

- The Iowa Midwives' Association requested formal recognition of direct entry midwifery, through legislative recognition of the Certified Professional Midwife credential established by the North American Registry of Midwives, and the establishment of a Board of Certified Professional Midwife Examiners within the state Public Health Department. Direct entry midwifery, also known in some states as lay midwifery, is performed by trained midwives who do not have a formal nursing degree or registered nurse license. The review committee recommended that legislators reject the association's request, but recommended legalization of direct entry midwifery. It further recommended that the state establish a Midwifery Advisory Council, composed of a range of professionals currently in clinical practice, to formulate regulations and clinical protocols for the profession.
- The Iowa Optometric Association requested that optometrists receive approval to use all classifications of pharmaceutical agents to diagnose and treat the eye. The review committee tapped the Des Moines University Osteopathic Medical Center to assist in its evaluation. University personnel attended committee meetings, evaluated laws in other states, reviewed clinical studies, and examined the curricula of Iowa optometry schools. The committee ultimately recommended against the association's request; and
- A committee reviewed the adequacy of existing nurse's aide education and competency testing regulations, recommending that all candidates for the nurse's aide registry be required to take a 75-hour training course.

Program reviews were positive. A survey of the initial pilot program, which queried review committee members, health care professionals, legislators, administrators, and program staff found that respondents felt the program had had a positive impact on health care policy, and 75 percent indicated that the review process should be continued.

Likewise, a 2002 evaluation identified a number of important program benefits:

- It had provided a mechanism to impartially review legitimate public policy issues outside the political arena;
- It helped give a voice to previously disenfranchised constituencies;
- It delivered legitimate public policy recommendations;
- It was cost-effective—all four reviews cost less than $20,000; and
- It was still needed, as SOP disputes among health professionals would continue to occur, demonstrating the need for a formal resolution mechanism.

The program ended in 2007; the Public Health Department is not aware of any effort to reinstate it.

Virginia: Board of Health Professions

Virginia employs 13 health boards to regulate their respective professions. In addition, a separate Board of Health Professions evaluates and makes recommendations to the state legislature on SOP regulatory issues. The board consists of 18 members, one from each of the 13 regulatory boards, and five citizens (consumers), all appointed by the governor.[5]

In a 2000 study, for example, the state legislature requested that the board examine the appropriate level of regulation for certified occupational therapy assistants (COTAs). The board's examination included:

- A public hearing;
- A survey of all states that regulate occupational therapists or COTAs, showing aggregate numbers of complaints, disciplinary actions, and malpractice claims over a two-year period; and
- A survey of occupational therapists in Virginia, detailing supervision and delegation patterns for COTA activities.

The legislature, following the recommendations in the board report, decided that COTAs needed no additional regulatory oversight in 2000.[6]

Ontario: The Regulated Health Professions Act

The Regulated Health Professions Act of 1991 (RHPA) established a common framework for the regulation of Ontario's 23 health professions, and the 21 "colleges" (similar to state boards in the United States) that regulate them, and provides provincial policymakers with enhanced flexibility in health care planning and delivery.

While the Ministry of Health is responsible for the overall administration of RHPA, the act also established the Health Professions Regulatory Advisory Council (HPRAC), which plays a key role in delivering analyses on SOP modifications. HPRAC reviews all proposals for new professions to come under RHPA regulation, as well as SOP modifications to currently regulated professions, and makes recommendations to the ministry on how to proceed.

As part of the review process, proposed SOP regulations pass through a process of "consultation." The ministry must notify every college of the proposal and permit each college's regulatory council to submit arguments to HPRAC. In addition, the registrar of each college also must notify its respective members of all proposals.

HPRAC consists of five to seven individuals, made up entirely of members of the public, who are recommended for their posts by the ministry. Public sector employees, current and former members of all regulated professions, and all former HPRAC members are ineligible to serve on the council.[7]

In its 17-year history, HPRAC has provided analysis on issues as diverse as studies on whether to regulate naturopathy, acupuncture, and traditional Chinese medicine; SOP expansion proposals for dental hygienists and nurse practitioners; proposals to allow optometrists to prescribe medications; and a broad-based review of the regulatory framework for diagnostic imaging and MRI professionals.

Scope of Practice Laws: Four Professions, Differing Approaches

Nationwide, SOP laws for the health professions vary widely from state to state, despite relatively standard education, training, and certification programs. A comparison of specific practice authorities of four important professions in California to more expansive authorities in other states highlights the variability of specific services that these professionals may provide, regardless of the fact that their education and training prepares these professionals to provide them.

The four examples of professions whose SOP could be expanded include:

1. Nurse practitioners and independent practice;
2. Physical therapists and the authority to refer and diagnose;
3. Physician assistants and the prescription of controlled substances; and
4. Paramedics and the administration of intravenous infusions.

The successful implementation of expansive SOPs for these four professions, in state-by-state comparisons with California, illustrates how some practitioners may be used more productively, without compromising patient safety and quality of care. Further, these examples illustrate how SOP modifications can have an impact on health care cost and access. Given the often contentious nature of SOP expansion proposals, these practice authority examples from other states provide California an opportunity to review its proposals in a more impartial fashion.

1. Nurse Practitioners and Independent Practice

Nurse practitioners (NPs) are registered nurses who receive advanced training that allows them to serve as primary care providers. Although most states now require NPs to be certified by a national certification body, SOPs vary widely. For example, most states require NPs to practice in collaboration with a physician, but some states permit NPs to practice independently, without physician involvement. Significant variation also exists in NP authority to diagnose, order tests, make patient referrals to other providers, and prescribe drugs and controlled substances.

California: Mandated Physician Collaboration

NPs in California do not have a formal SOP beyond that of registered nurses. NPs may exceed the SOP of a registered nurse through individual "standardized procedures;" NPs must develop these procedures in collaboration with physicians under a written, jointly developed practice protocol. NPs may practice only in collaboration with physicians, and individual physicians may supervise no more than four drug-prescribing NPs. If a standardized procedure protocol specifically permits it, NPs also may diagnose, order tests and durable medical equipment, refer patients to other providers according to their practice protocol, and "furnish" or "order" drugs, including Schedules II-V controlled substances.[8]

Other States: Greater Autonomy for Nurse Practitioners

NPs are explicitly authorized to practice independently without physician oversight in 10 states and the District of Columbia; the states include Alaska, Arizona, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon, and Washington. In all these states, the authority of NPs to practice independently includes the authority to prescribe drugs without physician involvement.[9]

Elsewhere in the United States, NPs practice with varying degrees of physician oversight. For example, stricter states, such as Oklahoma and Virginia, require NPs to practice under direct physician supervision. Most states, on the other hand, require NP-physician collaboration.

States may also require ranging levels of physician involvement depending on geographical location some states require differing levels of physician oversight, depending on location (such as inner cities or rural areas), practice setting (nursing homes, hospitals, etc.), and specific medical service.

For a more complete discussion of NP scopes of practice, the UCSF analysis, *Overview of Nurse Practitioner Scopes of Practice in 50 States*, chart and discussion, is available online at http://futurehealth.ucsf.edu; and the CHCF issue brief, *Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners*, is available online at www.chcf.org/topics/view.cfm?itemID=133568.

2. Physical Therapists and the Authority to Refer and Diagnose

According to the Bureau of Labor Statistics, physical therapists (PTs) "provide services that help restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities of patients suffering from injuries or disease." PTs are licensed in all states, based on completion of an accredited PT program and a licensure exam. There is broad variation, nationwide, in the ability of PTs to:

- Treat patients without a referral from another provider;
- Initiate treatments without a referral;
- The categories of providers that may make a referral to a PT;
- Restrictions in the time before direct patient access can be made; and
- Specific diagnoses that allow direct access to a PT without a referral.[10]

California: Regulation of Physical Therapists

PTs in California must possess a post-baccalaureate degree in physical therapy, pass the National Physical Therapy Examination (NPTE), and pass the California Law Examination. California PTs enjoy a comparatively broad SOP, and are not required to have a referral from a physician to provide treatment. However, although PTs are authorized to perform physical therapy evaluations and treatment planning, they are not permitted to diagnose patients—and under California law, a disease or other physical condition cannot be treated without a diagnosis. Thus, PTs may not treat a patient without a prior diagnosis by a physician.[11]

Illinois' Alternative: Physical Therapists Enjoy Broad Practice Authorities

There are nuanced differences among the states in SOP laws for PTs. For example, Illinois SOP laws for PTs could be considered broader than California's. PTs in Illinois may not treat patients without a referral, but the group of providers that may refer patients to PTs extends significantly beyond physicians; the list includes dentists, advanced practice nurses, physician assistants, and podiatrists. Oral referrals from these providers constitute sufficient authorization, and while PTs are not permitted to diagnose patients, a diagnosis is not a prerequisite to PT treatment.[12]

Overall, 19 states allow patients unlimited, direct access to PTs, while another 31 states allow limited direct access, depending on factors such as the patient's condition.

3. Physician Assistants and Prescription of Controlled Substances

Physician Assistant (PA) programs require candidates to complete an accredited education program, and pass a national exam. PAs provide diagnostic, therapeutic, and preventive health care services under physician supervision, but again, specific laws and regulations vary among the states. For example, in some states, PAs may be principal care providers in rural or inner-city clinics, where a physician is present for only one or two days a week. The duties of PAs are determined by the supervising physician and by state law.[13]

California: Limited Advances in Prescribing Authority

In October 2007, the California legislature passed AB 3, which expanded PA prescribing authority. Under AB 3, PAs may now order controlled substances without advance approval by a supervising physician, if the PA completes specified training and meets other requirements.

However, California PAs do not have complete independence when prescribing drugs. PAs still must be supervised by physicians, and an individual physician may supervise a maximum of four PAs. In addition, under AB 3, each supervising physician who delegates the authority to issue a drug order to a PA must first prepare general written formularies and protocols that specify all criteria for the use of a particular drug. Protocols for Schedule II controlled substances, which generally have the highest potential for abuse and dependence, also must address the diagnosis for which the drug is being issued.

Indian Health Service's Alternative: Facility-Specific Prescribing

PAs have worked in the Indian Health Services (IHS) since the mid-1970s. Approximately 160 PAs nationwide work in IHS federal, urban, and tribal health facilities. In the IHS, PAs play a significant role in relieving physician shortages in primary care.[14] While grounded in the core requirement that a PA must be supervised by a medical doctor, the IHS policy on PAs recognizes the value of tailored SOPs, to meet individual and site-specific needs.

All PAs must have a supervising physician, and each facility must outline the scope of work for PAs employed at that facility. Facility medical managers determine individual PA clinical privileges, which are based on the individual PA's education, training, experience, and current competence. The supervising physician must meet with the PA in person on a periodic basis to discuss patient management.

PAs may receive prescribing privileges, based on their education and clinical competencies, and further, may prescribe controlled substances if authorized by the facility. IHS PA policy notes that, although PAs employed by IHS need not be licensed by the state in which they are practicing, U.S. Drug Enforcement Agency regulations require that PAs be authorized to prescribe controlled substances by the state in which they are licensed to practice.

The IHS recognizes that its PAs are often required to practice in isolated settings, where on-site physician consultation is not always available. IHS practice policy allows PAs to practice at remote sites, or after hours, without a supervising physician on site, as long as telephone or two-way radio contact with an advising physician is available. The advising physician may be either the PA's clinical supervisor, or a designated alternative. Notably, accountability for physician supervision may be determined prospectively, by scheduling, or retrospectively, by chart reviews, as determined by the physician-PA team.

Other States: More Expansive Prescribing Authority

According to the American Academy of Physician Assistants, four states (Alabama, Florida, Kentucky, and Missouri) do not allow PAs to prescribe controlled substances. The remaining states authorize PAs to prescribe controlled substances, to varying degrees. For example, Schedule II prescriptions by PAs in North Carolina and South Dakota are limited to 30-day supplies. Other states, such as Colorado, Georgia, Kansas, and Mississippi, do not have similar restrictions. The New York legislature recently passed legislation giving PAs broader authority to prescribe controlled substances.

4. Paramedics and Administration of Intravenous Infusions

California: Local Scope of Practice Variations

Paramedics are specially trained and licensed to render immediate medical care in the pre-hospital setting to the seriously ill or injured. They are typically employed by public safety agencies, such as fire departments, and by private ambulance companies. California has three levels of emergency providers: Emergency Medical Technician (EMT)-I (Basic); EMT-II (Intermediate); and EMT-P (Paramedic). Paramedics have the highest degree of training, as well as corresponding SOP authority. Paramedics are trained and licensed in advanced life support (ALS) practices, which include the use of a laryngoscope, endotracheal and nasogastric intubation, and the administration of 21 drugs.[15]

California's SOP protocols for paramedics are particularly complex. Not only do they differ from other states, they also vary from county to county within the state. Paramedics come under the jurisdiction of the state Emergency Medical Service (EMS) Authority, which implements regulations governing paramedic training, scope of practice, and licensure. However, actual day-to-day emergency medical service operations are the responsibility of local county or multi-county EMS agencies.

Notably, while paramedic licensure is valid statewide, paramedics also must have local agency accreditation to practice in the area where they are employed. This involves adhering to local agency protocols, and training in any "local optional scope of practice," or specific medical tasks performed by EMS personnel in that jurisdiction, that is required by the local EMS agency.

In addition to the state's basic SOP, paramedics may perform other procedures or administer other medications deemed appropriate by the medical director of the local EMS agency, and approved by the director of the state EMS Authority. Further, the state EMS Authority can approve the use of additional skills, and the administration of additional medications by paramedics, upon request by a local EMS medical director.

Local agencies also may constrict SOPs of paramedics. For example, under the state SOP, paramedics may monitor and adjust intravenous solutions containing potassium, equal to or less than 20 milli-equivalents per liter (mEq/L). However, this procedure is not permitted in Sacramento, San Mateo, Santa Clara, and Santa Cruz counties, although it is allowed in Marin, San Francisco, and Solano counties.

Paramedics Nationwide: Wide Variations in Scopes of Practice

The wide variability nationwide in laws and regulations affecting paramedics and other emergency professionals prompted the National Highway Traffic Safety Administration (NHTSA) to issue its National Emergency Medical Services Scope of Practice Model, designed as a guide for states in developing their scope of practice legislation. NHTSA issued findings that the "patchwork of EMS personnel certifications has created considerable problems, including but not limited to: public confusion; reciprocity challenges; limited professional mobility; and decreased efficiency due to duplication of efforts." NHTSA's national practice model would include intravenous infusion in the paramedic's scope of practice.[16]

Conclusions

When health care practitioners are not being used to their full capacity in terms of their education, training, and competence, systemic inefficiencies inevitably occur. These inefficiencies may manifest themselves in higher costs, insufficient access to practitioners, and concerns over quality and safety.

Efforts to address the mismatches between SOPs and competence, and the lack of uniformity among the states, have been limited. Some states' efforts are still in an early stage, and their impact has yet to be determined.

California policymakers recently have shown some willingness to seek complementary support for their SOP decision-making. ABX1 1, the failed comprehensive health care reform bill by Assembly Speaker Fabian Núñez, included a proposal to establish a Task Force on Nurse Practitioner Scope of Practice.

States that have attempted to de-politicize the SOP modification process with clearly delineated review programs appear to be making headway. These programs can equip policymakers with the unbiased professional analysis that will help them make difficult, often technical decisions on important public health issues.

Endnotes

1. California Department of Consumer Affairs. "About DCA." www.dca.ca.gov/morabout.shtml.
2. Walters, D. Medical Turf Wars Rage Anew. *Sacramento Bee.* May 7, 2007.
3. State of California Legislative Counsel. Bill Information. www.leginfo.ca.gov/cgi-bin/postquery?bill_number=sbx1_24&sess=CUR&house=S&author=ashburn.
4. Iowa Code, sec. 147.28A.
5. Code of Virginia, sec. 54.1-2510.
6. Study on the Appropriate Level of Regulation for Certified Occupational Therapy Assistants. Released 2000. Richmond, VA: Virginia Board of Health Professions.
7. "Adjusting the Balance: A Review of the Regulated Health Professions Act," Released 2001. Toronto, Ontario: Health Professions Regulatory Advisory Council. www.hprac.org/en/reports/resources/RHPA_Review_2001_Report.pdf.
8. Pearson, L. The Pearson Report. *The American Journal for Nurse Practitioners.* February 2007.
9. For more comprehensive information on nurse practitioner scopes of practice, see Christian, S., Dower, C., and O'Neil, E. Overview of Nurse Practitioner Scopes of Practice in 50 States, chart and discussion. San Francisco, CA: UCSF Center for the Health Professions. September 2007. http://futurehealth.ucsf.edu.
10. Federation of State Boards of Physical Therapy. "Direct Access." www.fsbpt.org/publications/DirectAccess/.
11. Physical Therapy Board of California. "Practice Issues". www.ptbc.ca.gov/laws_regs/practice.shtml. Accessed November 2007. "Direct Access." www.ptbc.ca.gov/forms_pubs/direct_access.pdf.
12. 225 Illinois Compiled Statute 90/1.
13. Occupational Outlook Handbook, 2008-09 Edition. Released December 2007. Washington, D.C.: U.S. Dept. of Labor, Bureau of Labor Statistics. www.bls.gov/oco/ocos081.htm.
14. "The PA Difference: Why Should IHS Federal/Tribal/Urban Clinics Hire Physician Assistants." Released May 2007. Washington, D.C.: U.S. Department of Health and Human Services, Indian Health Service. www.ihs.gov/NonMedicalPrograms/NC4/Documents/IHS_WhyHirePhysicianAssistants_allareas_2007.pdf.
15. California Emergency Medical Services Authority. California's Emergency Medical Services Personnel Programs 1999-2007. www.emsa.ca.gov/aboutemsa/ems_prog.pdf.
16. "National EMS Scope of Practice Model." Released February 2007. Washington, D.C.: U.S. Department of Transportation, National Highway Traffic Safety Administration. www.emsa.ca.gov/EMSScopeofPractice.pdf.

Authors:

Sharon Christian, J.D., Research Analyst, and Catherine Dower, J.D., Associate Director, Health Law & Policy, Center for the Health Professions at the University of California, San Francisco

Writer: Stephen Robitaille, consultant

For more information, contact:

California HealthCare Foundation
1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org