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# Expanding Access to Care: Scope of Practice Laws

*Kathleen Hoke and Sarah Hexem*

Allied healthcare professionals play an integral role in the healthcare system: healthcare teams depend on nurses; comprehensive patient care often cannot be achieved without a pharmacist; dental offices thrive with the work of dental hygienists; and emergency medical technicians play a vital role in emergency care. The contributions of these and other allied healthcare professionals are typically defined by state laws governing the particular practice. These laws may be hurdles or enablers to expanding access to care in a community. We examine scope of practice laws for nurse practitioners (NPs) and allied dental providers to demonstrate how these laws may impact access to care and population health.

## Nurse Practitioners

Nurse practitioners (NPs) have rapidly become integral to the healthcare workforce, particularly primary care. In 21 states and the District of Columbia, NPs have “full practice authority,” meaning they can practice to the full extent of their education and training without physician oversight.<sup>1</sup> In the remaining 39 states, NPs can practice to their full scope — including prescribing medications and serving as primary care providers — if they have a physician practice, or “collaborative,” agreement.

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role can advance the Triple Aim: better care, reduced costs, and improved health. Yet while research on the *potential* of optimizing NP practice abounds, fewer studies explore the practical implications of removing barriers to independent practice and the actual impact on care, cost, and health.

## Better Care

The National Governors’ Association conducted a 30-year literature review and concluded that NPs provide primary care equal in quality to physicians; and on several indicators, including patient satisfaction, NPs perform better.<sup>2</sup> In 2014, the Federal Trade Commission questioned the value of legislative restraints on NP practice, which have historically protected physicians, and called upon states to narrowly tailor limitations on practice “to address well-founded health and safety concerns.”<sup>3</sup> There is no evidence that care provided by NPs in states requiring physician collaboration is better — or worse — than in states that enable NPs to practice independent of such agreements. Administrative burdens that arise from requiring a collaborative practice agreement arguably threaten patient satisfaction and reduce time for care in both physician and NP practices. Evidence from progressive states supports that care quality is not compromised; further research is needed to better understand that dynamic.

## Reduced Cost

Since 1981, studies have found that NP care matches the quality of physician care at equal or lower cost.<sup>4</sup> Research on the cost of NP care has increasingly focused on the cost savings due to the type of care typically provided by nurse practitioners (e.g., noninvasive treatments, self-managed chronic conditions), beyond

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**Kathleen Hoke, J.D.**, is the Director of the Network for Public Health Law — Eastern Region and a professor at the University of Maryland Carey School of Law. **Sarah Hexem, J.D.**, is the Policy Director at the National Nurse-Led Care Consortium.

the historical focus on lower salaries, reimbursements rates, and cost of education.<sup>5</sup> However, little research exists quantifying the cost of practice barriers. Anecdotal evidence suggests that the cost NP practices pay for collaborative agreements can be prohibitive and varies by market. The administrative burden associated with collaboration also has a cost for which the collaborating NP practice is not compensated. Thus, while the NP care is cost-effective, cost barriers may limit the extent to which NPs can deliver that care. Laws enabling full practice alleviate those burdens and costs for NPs as well as collaborating physicians.

#### *Improved Health*

With 20 million newly insured, an aging population, and pervasive health disparities, the need for meaningful access to high-quality, cost-effective primary

Evidence-based policy on NP practice has evolved over decades. Lessons learned from this experience can be helpful in developing policy on enhanced scope of practice for other allied health professionals, though each area of practice involves different issues of training, education, access, and types of care.

#### **Allied Dental Providers**

Timely preventive dental care is critical to both oral health and overall health. Lack of access to dental care is particularly acute among the elderly and individuals from low-income and rural communities; people of color disproportionately lack access to dental care.<sup>8</sup> Many factors contribute to lack of access, including low income, lack of insurance, low health literacy, and a dearth of dentists in some areas.<sup>9</sup> One approach to increasing access is expanding the scope of practice

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and preventive care has never been greater. Improving population health by securing access to care for more individuals has been a driving force in the push to remove barriers to NP care.<sup>6</sup> One study found a strong association between restrictions on NP practice and the percentage of patients with NP primary care providers; the fewer barriers to access to NPs, the higher the percentage of patients receiving primary care from NPs.<sup>7</sup> As states continue to modernize their laws, the natural experiment of federalism provides an opportunity to explore variations across states. An even greater research gap stems from full appreciation of the barriers to access beyond state laws requiring physician oversight. For example, a law may require collaborative agreements, but leave the terms of that agreement to providers' discretion. State law might provide NPs with full practice authority, yet the managed care organizations in the state might not include NPs within their network or contract with NPs as primary care providers. As states increasingly remove legislative barriers to practice, it is imperative that researchers continue to analyze the impact of those policies to fully optimize the care delivered by NPs.

of allied dental providers, such as dental hygienists, therapists and assistants. Allied dental providers may be more plentiful in and available to rural and underserved communities where dentists may be sparse or unavailable.<sup>10</sup> States have explored expanded scope options and researchers are encouraged to evaluate the new provisions and pilot programs to determine whether the goal of increased access is met without diminution in quality of care.

#### *Telemedicine*

State laws govern the practice of allied dental providers, including defining the scope of practice for each type of provider. These scope provisions generally address the required level of supervision by a dentist, including variations in certain settings, and the type of services allied dental providers may perform.<sup>11</sup> One approach to enhancing the reach of allied dental providers is to permit the required supervision by a dentist via telemedicine. Alaska now allows telemedicine for supervision in designated remote areas;<sup>12</sup> California recently expanded a pilot program that broadens the scope of practice for allied dental providers to

better enable the use of telemedicine.<sup>13</sup> Delaware and Arizona allow dentists to practice via telemedicine in certain circumstances,<sup>14</sup> and given the trend in this direction, we can expect other states to pass such laws. States should be encouraged to make clear in these provisions that telemedicine may be used to satisfy the supervision requirement.

#### *Practice by Setting*

Another approach is to permit independent practice by allied dental providers in certain settings. Many state laws describe the different practice settings in which allied dental providers may perform dental services; these provisions typically allow for lesser supervision by a dentist but balance that with a slightly modified scope of practice or impose certain qualifications on the providers who may practice in the special settings. Although most patients receive dental care in the traditional setting of a private dentist's office, many receive care in institutional or public practice settings. This is particularly true for vulnerable populations. Increasing access to care in these settings could allow for care to reach those who otherwise cannot physically or financially gain access.

Public health settings are the most common practice setting in which an allied dental provider may practice independently or with less supervision than in the private setting. What qualifies as a public health setting is determined by state law; states commonly include federally qualified health centers, state or local public health facilities, long-term care institutions, Head Start and WIC centers, and schools. Some programs provide care to homebound individuals. In 2015, Illinois created the "public health dental hygienist" who may practice independently in a variety of public settings.<sup>15</sup> Maryland recently expanded its law to include long-term care facilities,<sup>16</sup> and Arizona expanded its law to include long-term care facilities, private schools, and homebound settings.<sup>17</sup> Modifying the supervision rules in these settings may increase access to care and improve public health as long as patient safety and quality of care are assured.

#### *Dental Therapists*

Emerging state laws are addressing the access issue by expanding the type of allied dental providers permitted to practice, particularly creating the dental therapist, mid-level professionals who provide basic preventive and restorative oral healthcare. Compared to other allied dental providers, state and tribal laws tend to grant an expansive scope of practice, require less supervision, and may specify permissible practice settings for therapists. The Commission on Dental Accreditation recently approved national accredita-

tion standards for dental therapy education, which may facilitate development of a consistent scope of practice for the field.<sup>18</sup> The Alaska Native Tribal Health Consortium created the first U.S. dental therapists in 2005. Minnesota law has recognized dental therapists and advanced dental therapists since 2009.<sup>19</sup> Like some NPs, these dental therapists must enter into a written collaborative management agreement with a dentist and must practice primarily in settings that serve low income, uninsured, and underserved patients or in a dental health professional shortage area. Maine and Vermont recently passed laws creating the dental therapist, who may practice more independently.<sup>20</sup> With more rigorous education and training requirements than dental hygienists, the dental therapist may safely provide quality care, increasing access particularly to vulnerable populations.

#### **Conclusion**

While the nurse practitioner example is illuminating for those seeking to increase access to oral healthcare through expanded scope of practice, research on the effectiveness and impact of the various state law approaches on oral health is nascent. And there are confounding issues, such as the fact that health insurance rarely includes dental care and dental insurance can be costly. Yet innovative policy approaches to expanding access to oral healthcare should be encouraged — then evaluated. Given the high demand for oral healthcare — indeed all healthcare — policymakers should consider options that are rational but may not yet have a full evidence base. Pilot programs can help in that regard.

Public health improves as access to quality healthcare expands. One mechanism to expand access to care is allowing allied healthcare providers to practice at the top of their license. As state and tribal laws take on this issue, we encourage researchers to study the public health and economic impact, informing policymakers and public health officials of the factors that will help meet the Triple Aim: better care, reduced costs, and improved health across the population.

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