The ACA Indirectly but Significantly Affects Health Professions Regulation

This article is based on a presentation by Health Policy Consultant Catherine Dower, JD at the 2014 FSBPT Annual Meeting.

The Affordable Care Act (ACA) was passed in 2010 and many of its most significant sections have been implemented across the U.S.

Despite its heft (the law and its accompanying rules number into thousands of pages), the ACA is notoriously free of direct changes to health professions regulation. However, the indirect effects are numerous.

The law already has been challenged and upheld at various judicial levels. The public perception of ACA has been filled with frustration and confusion, especially from those trying to get healthcare coverage.

This much is certain, however: the ACA has expanded U.S. healthcare coverage. The U.S. can now compete with other countries in the world that spend less on healthcare and cover more of their population. Meanwhile, insurance exchanges and primary care are being scrutinized. Accountable Care Organizations (ACOs) are being looked at for their financial arrangements, partnering, and integrated systems.

How ACA Affects Health Professions Regulation
The ACA affects health professions regulation in areas of technology, consumers, interpersonal care, and integrated care throughout the ACA and ACOs.

Four technological areas affect health professions regulation: electronic health records (EHRs), communication, telehealth, and personal devices.

Everyone needs EHRs, but they reduce productivity in the short term until health professionals can get up to speed. EHRs also are expensive and it is hard to integrate systems. That alone

makes IT communication among healthcare providers, between providers and patients, and between providers and their licensing boards very important. In addition, many professions are using telehealth for patients unable to get into clinics. Smartphone cameras can capture acceptable views of ailments, such as rashes for dermatologists to review. Those personal devices raise challenges in privacy but alternatively could be used to locate appropriate healthcare providers.

Now more than ever before, there is a vast range of consumers engaged in their healthcare. There are more devices and tools to assess / test the level of engagement of the consumer on health literacy and their willingness to be compliant, especially in the home. The new tools can be crafted and tailored to specific healthcare professions.

In addition, more healthcare professionals will have to work in teams, which may be difficult for some. People must understand expectations for each healthcare profession on the team. They will have to understand new skills, expectations, and work habits for inter-professional care and how to work together.

Care can be integrated across the life continuum, across systems and specialties, and across geographic locations. An across-the-life continuum example would be diagnosing pre-diabetes in a child to help when that girl is grown and becomes pregnant. Finding ways to connect across systems and specialties remains a challenge, as does connecting across geographic locations. Because patients and the workforce are so mobile, there must be ways to cope with scope of practice laws that are different from state to state. Also, there will be more use of telehealth and integrated care.

Also, healthcare providers will now be paid partially on the quality of care. No longer are third-party payers only looking at the number of visits / interventions, but looking instead at quality outcomes in both primary and specialty care. It is too expensive to pay based only on the number of visits. There is a need to track costs to outcomes to reduce total costs. ACOs are one tool that will be utilized to reduce costs.

Old Assumptions vs New Realities

While not in ACA, healthcare regulations are being discussed. Are they obsolete, irrational, or irrelevant? They can be a change agent, but tend to be reactionary and slow. It will take effort and creative thinking to improve society through regulation.

For instance, under the old formula and assumptions on workforce supply and demand, ratios of licensees to population are used. As a result, there always appeared to be a need for more healthcare professionals. Under the new reality, with teams serving panels of patients, it is more difficult to know how many professionals will be needed. Self-care and DIY (do it yourself) also come into play. Patients are more informed and can use online information to help themselves.

As a result, there is nuanced supply and demand.

Likewise on training and education. The old assumptions included professional control; formal education for practitioners, including some internships or apprenticeships; and university-based education. Old assumptions also included clinical training in selected sites, rarely in community or homes, where patients normally get care, and professional silos. An example of professional silos would be medical and nursing students not taking common core courses together, like anatomy, due to old habits and perceptions.

Under the new reality, information is web-based and readily available but quality varies. Information gathering is also driven by problems. Healthcare professionals now must be tech-savvy, must work in teams and understand rather than mistrust other professionals so they can work collaboratively, must listen to clients, and must integrate care across life continuum, geography, and professions.

The old assumptions under licensure and discipline are that the professions define and control care but there is a slow response time to complaints and the administrative process is slow. The new reality is providers have professional and public roles, there is real time / immediate access to data on outcomes and disciplinary actions, and that public opinion and market judgment are significant.

The old assumptions for performance data include that it is guarded and not shared, narrowly sourced, and dated. The new reality is performance data is open-sourced for consumers and professionals, richly sourced and varied, and moving to real time.

Other changes include new legal and regulatory models that will push for expanding and overlapping scopes of practice and integration across professions.

Integration across Professions

Physical therapists have longed worked with occupational therapists, but they should also work with nursing and medicine. Working across the professions should increase in a practice sense and a regulatory sense. With more integration and training professionals together early, there will be less mistrust when they work together.

As more people move toward working in a team, there will be pushback from the different professions when a complaint is made; the board that deals with disciplinary actions may be different. Regulatory boards will have to come together to discuss how to deal with such problems in a more standardized way.

Employers are confused, especially about integrated systems that merge the qualifications for certification, licensure, and credentialing and, more specifically, in the unlicensed professions.

Collaboration across those boards may work to help employers understand the differences.

Accountability is more apparent in practice today using evidence instead of just habit. People are pushing professionals to rethink old habits and instead to look for evidence. That will happen in regulatory systems as well, such as number of requirements for training, experience, etc. Professionals must be accountable for requirements, discipline, and licensure and understand whether their methods are legitimate to maintain.

Creativity is interesting and exciting, but also makes us uncomfortable. This is what is happening now. Change has to be embraced to move forward to improve healthcare in the future.

Catherine Dower, JD is a health policy consultant focusing on practice redesign and health professions regulation. She most recently served as Health Policy and Law Director at the UCSF Center for the Health Professions, where she directed the Innovative Workforce Models in Health Care project and co-directed the Health Workforce Tracking Collaborative. For more than 20 years – with hundreds of presentations, publications, and testimony – she has been engaged in state and national efforts to reform health professions regulation and legal scopes of practice. Catherine received her undergraduate and law degrees from UC Berkeley and is licensed to practice law in California.