

A Guide for Emerging Professions

TIPS FOR STAKEHOLDERS AND ADVOCATES OF EMERGING PROFESSIONS
TO PROFESSIONALIZE AND INTEGRATE WITH THE HEALTH CARE SYSTEM

Emerging Professions Guide for Professionalization

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Introduction

The purpose of this Emerging Professions Guide is to provide background information and constructive knowledge that can assist stakeholders in professionalizing emerging health professions. This Guide is not intended to help an individual practitioner build a business, obtain a license, or get reimbursed from Medicaid. It is, however, intended for stakeholders who represent the interests of an entire profession as they develop strategies to change policies and structures that will integrate the profession into the existing health care system.

Estimates for health care expenditures account for about \$10,000 per person per year, and will approach 20% of gross domestic product by 2025¹. And it is a field filled with opportunity – according to one study by the federal Bureau of Labor Statistics, 21 of the 30 fastest growing jobs are in health care.²

And the concept of health care itself is expanding. Whether it is taking care of ourselves, taking care of others, educating others about healthy activities, or participating in local efforts to improve the lives of communities, it is all a part of health care. Where a need exists for these services, informal roles can evolve into professions with the specific intention of filling a gap in the health care system. The health care marketplace is accommodating of change, and new professional roles are finding niches that align with broader policy and economic goals.

Not every stakeholder and not every health profession will want to follow the options laid out in this Guide. Some professions will have legitimate reasons to remain outside the formal structures of the health care system -- becoming part of the health care system can bring significant burdens. For example, enrolling as a Medicaid provider subjects professionals to a long list of legal and financial requirements. In some states, licensed health professionals are required to pay special taxes. And some professions may struggle with a natural tension between the interests of large employer organizations and those of individual practitioners.

That said, many emerging professions are seeking greater recognition and participation in the health care system – and the health care system needs this participation.

New and emerging professions – such as Community Health Workers, Doula, Community Paramedics, Dental Therapists, Medical Scribes, Health Education Specialists, Peer Support Specialists, and many yet-untitled roles -- are often uniquely positioned to fill gaps in the health care system or to take advantage of new models of care or payment. They also often have more diverse backgrounds than traditional health professions, which gives employers an opportunity to hire workers who reflect underserved or underrepresented populations. The health care system will need more of every kind of professional, and a key goal of this Guide is to speed the integration of emerging professions into the health care workforce to meet these needs.

As stakeholders review the Guide, some professions are likely to be further along in some areas than others. Unique circumstances in each state or health care community often mean there is

¹ <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

² https://www.bls.gov/emp/ep_table_103.htm

varying expertise around some topics or processes. And there will be variation in the level of interest or the urgency in moving towards professionalization – each profession will need to chart its own course, based on its own capacity and environment. This Guide will provide a framework for stakeholders to divide work into attainable goals and track the progress of development in a rational, incremental, and purposeful way.

In 2015, an article was published in the journal *Integrated Medicine*³ which sought to define the various stages of professionalization for health professions. The author used the following events and activities to define a continuum of the professionalization process:

Event	Activity
Informal Collaboration	Assembly of a group of people with common skills or knowledge
Formalized Collaboration	Formation of professional association (often national)
Authorized Practice	Passage of governmentally sponsored licensure or registration
Standardized Qualifications	Administration of professional examinations
Educational Identity	Establishment of distinctive programs for professional education
Educational Uniformity	Standardization of process for professional education
Consolidated Beliefs	Establishment of professional code of ethics, values, and philosophies
Enhanced Communication	Publication of a professional journal
Regulated Education	Accreditation of educational process
Enlarged Influence	Expansion of practice scope
Intensified Training	Expansion of education to accommodate growth of practice scope
Specialization	Division into multiple and more restricted professions

The process of professionalization is not necessarily linear, and events can be implemented simultaneously or concurrently. In fact, it can be beneficial to coordinate the implementation of steps in the process.

This Guide is divided into nine chapters, and condenses the process listed above. Each chapter focuses on a specific aspect of the health care system as it pertains to professionalization. For example, professional regulation is one chapter, and details the multiple ways a profession can choose to use regulation for its interests – certification, licensure, etc. Of course there are people who devote entire careers to professional regulation, the breadth of which could never

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4566463/>

be encapsulated in a Guide. The goal is to define options, weigh pros and cons, give examples, and point to resources and tips for stakeholders considering their options.

The information in this guide was current when developed in late 2017. It is not legal advice, and any information should be verified from the original source of that information – especially information about payment or reimbursement.

Finally, a word about terminology. For this Guide the term “professionalize” is used to describe the process towards further integration within the American health care system’s existing structures. It is not used to assign different value or appropriateness of one practitioner versus another. Any health-related practitioner – whether fully licensed and credentialed by a health plan, or completely independent and paid directly by clients – can be very professional in performing their craft. As this guide recommends pathways towards professionalization within the health care system, these recommendations will be presented only as options to consider by professionals and their stakeholder organizations, all of whom are seeking to improve people’s lives.

Scope of Practice

“What exactly do you do?”

Every health-related profession has a core set of services that it provides to customers, patients, and clients. However, not every profession can clearly define what those services are. The extent to which a profession can delineate exactly what services and benefits it provides can determine how deeply the profession can integrate into the existing health care system.



A “scope of practice” is a distinct, agreed-upon set of services that a profession is trained to perform. In a recent report from the Federation of State Medical Boards, scope of practice is defined as “the activities that an individual health care practitioner is permitted to perform within a specific profession. Those activities should be based on appropriate education, training, and experience.

Scope of practice is established by the practice act of the specific practitioner’s board, and the rules adopted pursuant to that act.”⁴

A scope of practice does not include functions or roles that any professional (or even a non-professional) can provide. For example, everyone can provide emotional support to another person, but not everyone is trained to provide therapy. A psychologist’s training gives them a set of professional skills that are then translated into specific services attached to diagnostic or billing codes that are reimbursable.

Practice parameters may be codified into practice acts, usually in statute or rule. A practice act is a living document that may evolve based on changes made to practice scopes. For example, the Minnesota Nurse Practice Act⁵ enacted by the legislature outlines the qualifications for nurses, their responsibilities and the range of services and activities they can undertake, forms of discipline and penalties etc. The practice act has undergone a few major revisions based on changes in nurse practice standards relating to authority to practice as it relates to physician supervision.⁶ See below for more on how to navigate changes to scope.

⁴ https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/2005_grpol_scope_of_practice.pdf

⁵ <https://mn.gov/boards/nursing/laws-and-rules/nurse-practice-act/>

⁶ <https://mn.gov/boards/nursing/resources/news/?id=21-37188>

A scope of practice is often closely tied to regulation of the profession, and can be an integral factor in determining how a profession is regulated, but not always.

For the purpose of this guide, scope of practice and regulation will be treated separately, because there are necessary distinctions. First, a scope of practice defines the work one profession provides – it does not automatically exclude others from providing the same services, which regulation can do. Second, often a scope of practice is a needed starting point to begin discussions and processes that create regulation. More detail about regulation will be discussed in Chapter 3.

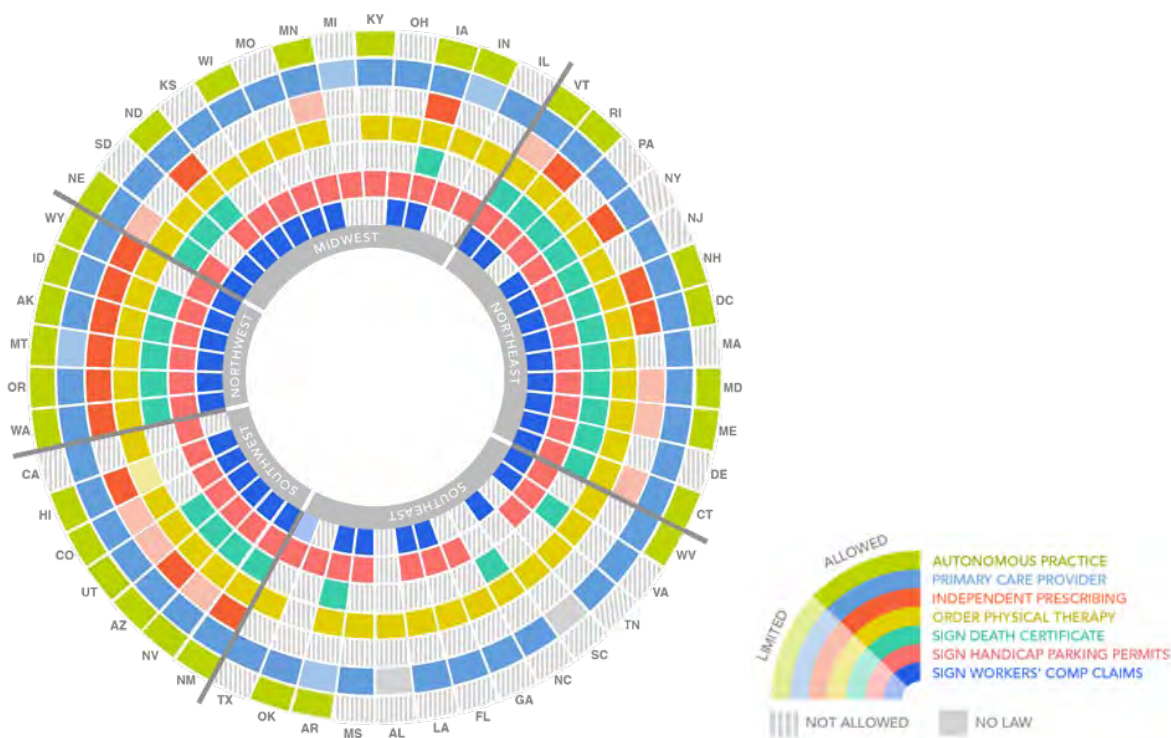
The definition of a scope of practice may sound relatively simple, but developing one can often be a difficult, contentious task. And for emerging professions, a lack of specific evidence or a lack of clarity about the role can make definitions even more challenging.

While a scope of practice should align closely with the training professionals receive, not all stakeholders – both within a profession itself and within the broader cluster of similar professions – will agree that a new profession is adequately trained to provide some services. If legal structures like regulation are not in place, not everyone may agree on who should speak for the profession with authority. An inclusive process can address many of these concerns.

Scopes of practice can be relatively broad and fluid – for example, defining the wide range of services a Community Health Worker can provide – or they can be very detailed and rigidly defined by government entities like licensing boards – for example a surgeon. In developing a scope of practice, unfortunately there is no established process that every profession must follow, no legal definition of what a sufficient scope of practice looks like, and no standardized result or document. Some scopes of practice are loosely defined lists of services that a group of stakeholders have developed, while others are written directly into state statutes and rules, with meticulously defined job duties and functions.

Often, one group of professionals will view another similar profession providing similar services as encroaching on their existing scope of practice, or “turf.” As a result, scopes of practice can become more specific – and legally circumscribed – as stakeholders work to define their turf. In general, turf issues are a natural part of the health care system, and don’t have to be contentious. More on dealing with turf issues and advocacy will be discussed in Chapter 7.

Scopes of practice can also vary widely between states or other jurisdictions. For example, the advanced practice nursing profession has undergone significant formalization of scopes of practice in the last few decades, and they continue to evolve. Below is a recent graph that shows the variation among states for some services nurse practitioners are allowed to provide, or not:

Figure 1. Nurse Practitioner Scopes of Practice, by state⁷

Complicating the situation more, each state or region has its own landscape of trained professionals, which can impact the scopes of practice for other professions. Another consideration is that a scope of practice generally defines the work a given profession is trained to do, but some professions have supervisory requirements that can further limit the scope of practice of an individual professional. More will be discussed on supervision in Chapter 6.

How to Develop a Scope of Practice

For emerging professions, defining a scope of practice is a key step in the process of professionalization. A scope of practice that aligns specific training with clearly-defined competencies and services can help a profession define its niche in the health care system. While no step-by-step guide exists for developing a scope of practice, a handful of useful documents have been developed, and are condensed below. Links to additional resources and examples are listed at the end of this chapter. Here are some tips for starting the process, and for making an existing scope of practice more impactful:

⁷ <https://www.bartonassociates.com/locum-tenens-resources/nurse-practitioner-scope-of-practice-laws/>

Always keep the purpose in mind

A scope of practice may have multiple goals – establishing a clearer definition of roles and responsibilities, aligning training with services delivered, etc. – but its primary purpose is patient safety. A 2006 report from a consortium of national regulators titled “Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations”⁸ puts the primary purpose into stark focus, stating:

“The question that healthcare professionals must answer today is whether their profession can provide [a] proposed service in a safe and effective manner. If an issue does not address this question, it has no relevance to the discussion.”

A scope of practice should remove doubts about whether a professional is qualified to provide the services described, and whether they can be trusted in providing care to patients and clients.

Research similar professions and other states

Health regulatory and licensing boards have deep understanding of the scopes of practice for licensed professionals in their state, and are a valuable resource to stakeholders. They are charged with maintaining and interpreting scopes of practice of the professionals they license or regulate. Boards are usually government entities within the structure of the state’s health department. Some states have specific departments for health professional licensure. Some professions are influenced by associations on the national level, but state boards are generally more in tune with local issues and concerns.

In researching other professions, pay very close attention to the terminology used to define a service provided. For example, in Minnesota statute, a Nurse Midwife’s scope of practice begins by defining the following services:

“(1) the management, diagnosis, and treatment of women's primary health care including pregnancy, childbirth, postpartum period, care of the newborn, family planning, partner care management relating to sexual health, and gynecological care of women across the life span...”⁹

Some overlap of services between professions is unavoidable, and often innocuous, but in developing the scope of practice for a Doula, there is likely very little overlap in responsibilities. Assisting during pregnancy and childbirth, or care for the newborn is a potential overlap of service, but a doula is likely not trained in “management,” “diagnosis,” or “treatment” of women’s “primary health care,” so these terms should be avoided when developing a Doula’s scope of practice.

Another example comes from the development of covered services in Medicaid for Community Paramedics (CP) in Minnesota, in 2011 and 2012. The Legislature was interested in authorizing

⁸

<http://www.micnp.org/files/professional/Changes%20in%20Healthcare%20Professions%20Scope%20of%20Practice%20Legislative%20Considerations-2.pdf>

⁹ <https://www.revisor.mn.gov/statutes/?id=148.171>

coverage of CP services in Medicaid – but a scope of practice did not exist. So the Legislature charged the Medicaid agency with developing a set of recommendations for CP services to be covered.¹⁰

A group of stakeholders was identified and invited to participate. The group included CP advocates, a representative from higher education who teaches CPs, state regulators, and representatives from professions who perform similar work such as nurses and home care agencies. The group reviewed background documents and materials describing scopes of practice of similar professions, identified which services a CP could provide based on training and skills, and finalized a list of services that should be covered. The list of services included both existing services for which reimbursement codes already exist, and a number of services that were new.

Ultimately, the Legislature used the list and refined them into a handful of services that accurately capture the training and skills of trained Community Paramedics, and which are now covered in Minnesota’s Medicaid program.

While this example was narrow in focus and did not create a full scope of practice for Community Paramedics, the process was instructive on how a group of stakeholders can come to agreement, even without a clear scope of practice defined. In the end, detailed information about how well Community Paramedics are trained alleviated the concerns of other professions and stakeholders.

Consensus-based common reference language or national model practice acts, if developed and available, offer an expedited route to developing a scope of practice. Consistency in language across state boundaries ensures professional mobility, and name recognition of the profession in the eyes of the public.

Develop a goal-oriented process

Developing a scope of practice will not happen quickly. Interested stakeholders should plan for months – if not years – of work.

The American Nurses Association (ANA) published a journal article in 2015 detailing some best practices for developing nursing scope of practice changes,¹¹ and it included a list of six questions all change processes should seek to answer. Below, the list of questions has been modified to make it specific to emerging professions:

1. **Who?** Identify numbers of professionals involved and their educational preparation.
2. **What?** Explain the services to be provided in detail, and where possible, use broadly accepted terminology and language.
3. **When?** Determine when these services are needed – i.e., at what point in a patient’s life experience or disease state – and when the professionals will provide the service.

¹⁰ <http://mnemscop.org/wp-content/uploads/2012/03/Community-Paramedics-Legislative-Report.pdf>

¹¹

<http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-20-2015/No2-May-2015/Best-Practices-for-Developing-Specialty-Scope-and-Standards.html>

4. **Where?** Describe practice environments in sufficient detail to understand where the service will be delivered – in a hospital, clinic, or nursing home, in a patient’s home, and/or in a community setting.
5. **Why?** Determine what niche or gap is filled; the historical perspective of the development of the profession; current issues and future trends in health care that point to the need for the profession.
6. **How?** Identify the process to become this type of professional, including development through formal education, continuing education, and practice experiences.

The ANA article and other experts also recommend some additional guidelines:

1. Convene experts with specific roles and functions

When recruiting experts, in addition to valuable experience, some factors to balance include: representation from the profession itself – including all sides of any known professional divisions within the field; representation from similar professions with an interest; representation from appropriate racial, ethnic, linguistic, geographic, and socio-economic backgrounds; and representation from government, academia, and other fields with experience developing scopes of practice.

At various times in the process, legal input, or detailed perspective about curriculum may be needed from experts with very specific knowledge. Drawing on this expertise in a focused manner that is respectful of everyone’s time will make meetings more efficient and more productive. Smaller working groups are a good way to focus work on specific tasks.

2. Establish ground rules for the process

Inclusion and respect for diverse opinions should be communicated early and often, and meaningfully honored throughout the process. Another common trait of successful processes is the development of a group ethic to “get it right.” Having a clear focus on producing a useful product can minimize factions, and keep things moving forward.

3. Establish a realistic timeline

Unless there is funding to hire staff, the work will likely be in-kind contributions from busy professionals. The ANA suggests planning 12-18 months, but it could be shorter for some emerging professions, depending on the complexity of services involved. The ANA also suggests identifying the best times for meetings, using conference calls (even in the evenings), and adjusting the frequency of meetings to fit schedules.

4. Identify a lead writer

The process is a group effort, but it should be one person’s responsibility to document the scope of practice, in part because the language needs to be specific and clear. The lead writer should be someone who can meet deadlines.

5. Be inclusive and transparent

Hold public meetings, use social media, invite a broad range of stakeholders, publish draft documents, and announce the final results as soon as they are completed. Define and communicate a process for input, and respond openly to feedback from stakeholders and the public.

If one doesn't exist yet, the scope of practice process could also be used to develop a code of ethics for the profession.

6. Develop a process to minimize revisions

Online document sharing tools offered by DropBox¹², Google Docs¹³ and others can help manage the number of drafts, and allow multiple people to edit at the same time. Once the documents are nearing completion, formalize the process for making new revisions by soliciting input during fixed times, compiling and publishing suggested revisions, and obtaining pre-defined approval for changes – perhaps by an identified subgroup.

7. Know the audience

The public is the main audience, but eventually a scope of practice will be useful to Legislators, regulators, insurance companies, other professions, and higher education institutions. Make sure there are no potentially divisive statements such as assumptions about other professions, politically charged language, or unrelated comments.

How to Modify Scope of Practice

Scopes and practice acts may need to be clarified, refined or updated with the passage of time as new training or gaps in implementation become evident. Additional impetus for scope change may come from differentiation over time in the profession's roles or range of permissible services such as prescriptive authorities, delegation, or supervision.

Changing or updating a scope is a big undertaking. It is recommended that a lead sponsor be identified who can track all technical changes that need to be made so nothing gets left out. Guidelines noted above used in drafting the initial scope could be followed for scope changes as well. Typically, revisions are proposed by state licensing or regulatory boards but professional associations can certainly lead this process. External factors regarding the political climate, legislative appetite for scope change and timing are critical to take into account along with the urgency of scope change.

In 2015-2016, MDH in partnership with representatives from professional health care associations, state health licensing boards, state legislators, the National Conference of State

¹² <https://www.dropbox.com/>

¹³ <https://www.google.com/>

Legislatures (NSCL) and the National Governors Association developed two tools to assist in developing and assessing legislative proposals to change a scope of practice.¹⁴ The first tool is a framework to describe and evaluate scope of practice legislation. It is meant to be used by both scope proposers and evaluators to guide their legislative journey. It helps stakeholders in summarizing and organizing key information about the scope of practice proposals to facilitate an objective review for legislators, and it helps legislators assess the proposal. The second tool helps stakeholders assess the progress once the initial scope is in place, and identify future barriers and related strategies to accomplish the intent if the proposed changes to scopes of practice. A link to the tools is in the Resources section below.

Examples of Scope of Practice Development Efforts

Most scopes of practice are defined in statute or rule, and examples can often be found on the websites of state regulatory boards. Some additional instructive examples of scopes of practice are listed below.

- The CHW Core Consensus, or “C3” project was a recent effort to develop a national guidelines for a scope of practice for Community Health Workers. The full report, linked below, includes information about the process taken to develop the guidelines, and a discussion about the limitations of the effort:
<https://sph.uth.edu/dotAsset/28044e61-fb10-41a2-bf3b-07efa4fe56ae.pdf>
- In 2001, the state of Michigan conducted a study on the scopes of practice of numerous health professions. The study is instructive in detailing how specific language and terminology is used to describe knowledge, skills, and abilities of various health professions: <https://www.msms.org/Portals/0/Documents/ScopePracBook.pdf>
- Organizing the information can be done in different ways. This 1995 example of a scope of practice for acupuncturists from California structures the information into a table format: http://www.thesupplycenter.com/2009/business/practice_scope_summary.pdf
- In Ohio, state statute defines the scope of practice for Community Health Workers as the tasks and duties that a supervising nurse delegates to a CHW. The statute focuses more attention defining what is not allowed by a CHW than what services can be delegated, which leaves the determination of an individual CHW’s scope of practice to the supervising nurse: <http://codes.ohio.gov/oac/4723-26>
- In Minnesota, emergency medical services professionals do not have a state inscribed scope of practice. Instead, there is an evidence and consensus based, National Emergency Medical Services (EMS) Scope of Practice Model that specifies the education, training and licensure levels for EMS personnel, and is updated based on gains in technology and medical research findings. Operationalization of the scope ultimately falls to the state EMS directors who issue standing orders to their ambulance services that determines what EMS personnel can and cannot do:
https://www.ems.gov/pdf/education/EMS-Education-for-the-Future-A-Systems-Approach/National_EMS_Scope_Practice_Model.pdf

¹⁴ <http://www.health.state.mn.us/divs/orhpc/scope.html>

- Another example comes from the development of covered services in Medicaid for Community Paramedics (CP) in Minnesota, in 2011 and 2012. The Legislature was interested in authorizing coverage of CP services in Medicaid, but a scope of practice did not exist. So the Legislature charged the Medicaid agency with developing a set of recommendations for CP services to be covered. The effort is an example of how a group of potentially contentious stakeholders came to agreement:
<http://mnemscp.org/wp-content/uploads/2012/03/Community-Paramedics-Legislative-Report.pdf>

Resources

For researching other professions, O*Net is a database of professions that includes information about knowledge, skills, and abilities of the role, as well as tasks, work activities, and education:
<https://www.onetonline.org/>

A report from the Connecticut General Assembly on scope of practice:
https://www.cga.ct.gov/2009/pridata/Studies/PDF/Scope_of_Practice_Final_Report.PDF

A whitepaper from 2010 that discusses options for making scopes of practice – and the efforts to develop them – more closely align with broader health goals:
<https://www.ncsbn.org/ReformingScopesofPractice-WhitePaper.pdf>

This database maintained by NSCL can serve as a useful reference for scope bills introduced in other states. Currently, only three professions (nurse, oral health, physician assistants) are tracked but NSCL hopes to expand it to include other professions in the future:
<http://scopeofpracticepolicy.org/>

The National Conference of State Legislatures (NSCL) and the National Governors Association Scope of Practice tools, developed by the Minnesota Department of Health:
<http://www.health.state.mn.us/divs/orhpc/scope.html>

The Federation of State Medical Boards issued a report in 2005 that discusses how scope of practice acts impact access and safety:
https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/2005_grpol_scope_of_practice.pdf

Education

“What kind of training do you have?”



A profession without an established curriculum to train students is at a disadvantage. In order to feel comfortable enough to spend valuable resources and hire someone, an employer will want to know that the education and training an individual has obtained means they are skilled and qualified. Patients also want to know that a professional is capable and well-trained. Standardizing the education and training students receive can be very helpful in defining the scope of practice for the profession, in clarifying regulatory requirements of the profession, and in establishing a niche in the health care marketplace.

Education and training for emerging professions can be one of the most daunting, and time-consuming aspects of professionalization. The health care system is complex enough, but navigating the higher education system – with its myriad processes and rules – can be discouragingly slow. However, there are interim steps that can make a difference

more quickly, and it is important for many reasons to work towards the goal of a common curriculum for an emerging profession. Developing a curriculum is an iterative, ongoing process, and stakeholders should be prepared for years of work.

Developing a Curriculum

Curriculum development – sometimes referred to as “instructional design” – is generally the responsibility of the profession itself, and it requires inclusion and flexibility. It works best when all interested stakeholders are in the loop, even known opponents. And it is important to remember that a curriculum is an ongoing process. The relationships and structures built while developing the curriculum will be useful when revisions are needed in response to frequent changes in the role or health care landscape.

It is important at the initial phases of the process to identify all relevant stakeholders and announce the intent to develop a curriculum. It should not be done in isolation. Engaging experts in curriculum development is also crucial at the early stage. Community and technical colleges that offer degrees and certificates in health-related fields are a good source of expertise.

The University Of California San Diego School Of Medicine published a concise summary of steps to consider when developing a curriculum for health professions:¹⁵

- **Step 1: Problem Identification and General Needs Assessment**
 - Identification and critical analysis of a health care need.
- **Step 2: Needs Assessment of Targeted Learners**
 - Assessing the needs of the targeted group of learners.
- **Step 3: Goals and objectives**
 - Once the needs of targeted learners have been identified, goals and objectives for the curriculum can be written.
- **Step 4: Educational Strategies**
 - Once objectives have been clarified, curriculum content is chosen and educational methods are selected that will most likely achieve the educational objectives.
- **Step 5: Implementation**
 - There are several components:
 - procurement of political support for the curriculum
 - identification and procurement of resources
 - identification and address of barriers to implementation
 - introduction of the curriculum: piloting
 - administration of the curriculum
 - refinement of the curriculum
- **Step 6: Evaluation and Feedback**
 - It usually is desirable to assess the performance of both individuals (individual evaluation) and the curriculum (called program evaluation).
 - The purpose of evaluation may be formative (to provide ongoing feedback so that the learners or curriculum can improve) or summative (to provide a final "grade" or assessment of the performance of the learner or curriculum).

This list is not intended to be comprehensive, but a starting point. The development of each curriculum must be responsive to the conditions and landscape of the individual profession. Again, it is strongly recommended that an expert in curriculum development be involved at the earliest stages possible.

Another key consideration is determining where a curriculum will be taught. Some professions prefer coursework to be taught by community-based programs, but this can lead to difficulties in standardization and replication. Community and technical colleges and universities are the most obvious partner for teaching a curriculum. In addition many states have training centers for economic development programs -- Opportunities Industrialization Centers are an example that are active in 22 states.¹⁶

¹⁵https://meded.ucsd.edu/index.cfm/ugme/MedEDTechEval/educational_development/curriculum_development/

¹⁶ <http://www.oicofamerica.org/>

Location of the education and training matters for the development and distribution of the profession. Often where the students come from is where they will want to practice. If the profession wants to grow in rural areas, there should be training programs in rural areas.

Online curriculum is a powerful way to ensure access to education and training. Many community and technical colleges already offer online courses, and have expertise in developing online curricula.

Expert Advice

It is strongly recommended to seek advice from experts and stakeholders who have participated in the development of curricula or specific job-related training programs. Anne Willaert works for South Central Community College in Mankato, Minnesota, and has decades of experience developing curricula for new health professions. Among other curricula, Ms. Willaert led the development of Minnesota's Community Health Worker and Peer Support Specialist curricula, and assisted in the development of the Community Paramedic curriculum – all three of which are now taught in multiple states. Ms. Willaert shared some additional advice on the steps listed above for this guide:¹⁷

- Start by surveying for gaps in services and the need for the profession
 - Questions to ask:
 - Is this already an identified profession, is there an accrediting body, what are other states or countries calling this profession?
 - What is the return on investment, or business case?
 - How do you get people to pay attention or see an interest in the need for this service or profession?
 - Utilize data, research other states, related professions, and best practices.
- Form partnerships and bring in a broad range of interested parties:
 - Private and public industry
 - State agencies
 - People already acting in the role
 - Education institutions
 - Professions they would practice with
 - Others with an interest or potential conflict
- Identify required competencies
 - Survey the competencies with a number of professions
- Build a competency based curriculum from agreed upon competencies
- At the same time as building the curriculum, start conversations with partners and ask:
 - Where will this person work?
 - What will the compensation be?
 - What role will they play?

¹⁷ Email exchange, October 12, 2017 with Anne Willaert, Statewide Director of the Minnesota Advanced Manufacturing Partnership Project: <http://www.southcentral.edu/About/minnesota-advanced-manufacturing-partnership.html>

- How will they fit within the regulations that exist?
- If working under supervision, whose license will they be reporting to?
- This is the beginning of building the policy around the position and will impact its ability to emerge into society
- Identify barriers
 - For example, two large barriers related to the Community Health Worker profession were the fear expressed by CHWs of “over-professionalizing” or changing the concept of how they identified themselves. The second was potential discrimination and fear from other healthcare professions CHWs would be working with
 - One way potential barriers were avoided was to invite and listen to the board of nursing and other related healthcare professions and their associations at the beginning of the discussions
- From the beginning, stakeholders need to identify the best entity to house the interests of the new profession as it relates to sustainability

There are also some steps to consider with regards to internal processes in higher education institutions:

- To justify the need for a new course, collect data and statistics to identify the workforce needs
 - Not just for the new profession but any projected shortfalls for similar professions, as well as known growth and predicted changes
- Approval of curricula in a higher education institution must be faculty driven
 - Competencies and curricula have to be written by faculty
 - Faculty have to guide the approval process through the system
- All curricula must pass through an academic standards committee, which is governed by faculty
 - These committees follow institution policies, which may be publicly available

Aspects of a Curriculum

Training for many health professions include both formal classroom (didactic) education, and applied (practical) training while under supervision. Depending on the profession and the training needed, there are multiple ways to achieve both forms of education.

Didactic education can range from education materials in a three-ring binder developed by an employer to a lecture in an accredited medical school. It can be studied individually, in group settings, in a formal classroom, or online.

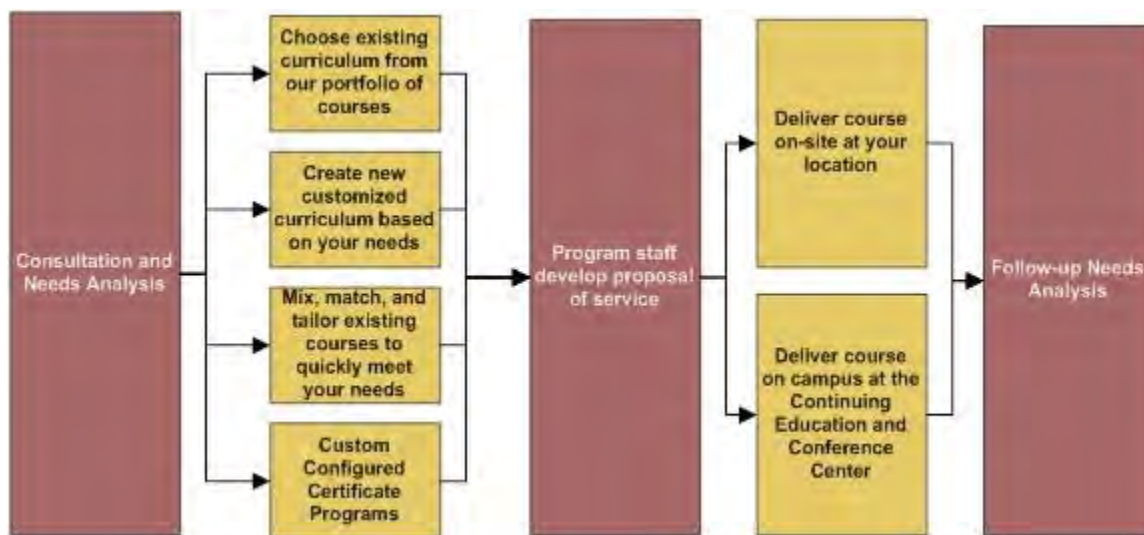
For credit or not

A crucially important consideration for emerging professions is whether stakeholders want the course work to be for credit by a higher education institution or not. If a student receives credit

by a college for course work – or more formally, if the courses “articulate” – those credits can be transferred to another college, and can be applied to other degree programs if the individual wants to pursue a higher degree. Articulation means the profession can more easily become a step on a career ladder for professionals. However, approval of articulation in higher education is a part of the lengthy bureaucratic process mentioned above. It is driven by faculty, and can potentially add years to implementation. Delays in training can significantly hinder the initial development of a profession. That said, once in place, articulation will make it easier to maintain a consistent definition of the profession, and can make the process of regulation easier. For information on regulation, see chapter 3.

On the other hand, articulation may not be vital to a profession. Some professions may not wish to be a step on the health care career ladder, or they may only require training that is purely technical in nature, which leads to a skill-based certificate rather than a professional license. Many colleges and universities offer a faster way to get a new course off the ground: customized training. An example is the customized training program at the University of Minnesota,¹⁸ which works closely with industry partners to develop specific curricula – often with a specific cohort of students in mind. The school and industry partners work to identify the needs of a company or industry, they develop a curriculum based on any existing curricula and the specific needs for the training, and the school teaches the course either on-site at the company, in classrooms, or a combination of both. The chart below demonstrates the University of Minnesota’s process:

Figure 2: University of Minnesota Customized Training Process¹⁹



Because customized training courses typically do not articulate, approval of a new course can be much quicker, and the profession can grow more quickly. However, it may be a challenge down the road to maintain consistency in the definition of the profession if courses vary widely.

Stakeholders weighing their options on articulation or not should consult directly with school administration and faculty in order to assess willingness and manage expectation. One option

¹⁸ <https://ccaps.umn.edu/customized-training>

¹⁹ *ibid*

is to develop a customized training program as a pilot project, and simultaneously begin the longer process of articulation approval.

Practical training is as old as medicine itself. Physicians must complete residency before being fully licensed, dentists are frequently trained at the shoulder of another dentist, and many mental health professionals must work under the supervision of a more senior member of their profession before they can practice independently.

Apprenticeship is one model of on-the-job training for consideration by emerging professions. Apprentices work one-on-one with a seasoned professional and learn the profession over a defined period of time, potentially years, depending on the complexity of the job. An apprentice often stays with the employer after completing the apprenticeship. According to a report published by the Washington State Department of Labor and Industry²⁰, over 20 health care professions already include some form of apprenticeship component for training, and over 50 different professions in health care could benefit from the apprenticeship model.

Some potential benefits of an apprenticeship model of training are: quicker integration into the workplace/clinical environment; directly pertinent training for the individual apprentice with immediate feedback; and development of supervisory and leadership skills within the profession. Potential drawbacks include non-reimbursable services and time lost by the supervising professional; potential inconsistency in training; and a reliance on enough individual supervisors to provide necessary training. Stakeholders considering apprenticeship should develop clear guidance for supervising professionals, in order to maintain consistency, and provide support.

Professions currently using apprenticeships for training include: Medical Assistants; Home Health Aides; Emergency Medical Technicians; Dental Assistants; Laboratory Assistants; Pharmacist Assistants.

Internship is another model of on-the-job training that can be more team-based than apprenticeship. An internship is generally a shorter-term, project-based training that prepares a student for specific job functions and roles. It may or may not lead to work with the hosting employer. Interns may work individually or with other interns, and may be supervised by multiple professionals. Internships that involve providing care to a specific population, or in a specific care setting can be an effective way to hone a student's skills.

Some potential benefits of internship models include: experience working with a broad range of professionals in a team-based environment; relatively shorter term training and completion; and greater consistency in training. Some potential drawbacks include a reliance on larger institutions who can provide adequate space and expertise; possible isolation and neglect of the intern; and possible disconnect between needed training and the organization's priorities.

The Health Occupations Student Association (HOSA) has published a list of organizations that currently run many kinds of internship programs,²¹ and who may be receptive to a specific

²⁰

<http://www.lni.wa.gov/tradeslicensing/apprenticeship/files/pubs/apprenticeshipshealthcareindustrymauldin.pdf>

²¹ <http://hosa.org/internships>

internship program for a professional to complete training. Larger hospitals, safety net clinics, and public health agencies are also potential options. It is important for stakeholders looking at internship to build enough infrastructure to accommodate students completing their training. If securing an internship is the individual student's responsibility, clear guidance for employers is recommended.

Professions currently using internship for training include: Physicians; Pharmacists; Nurses; Community Health Workers; Health Care Administrators.

Continuing education is a common way for graduates to keep their skills sharp after graduation. Often a condition of licensure, many professions are required to continue learning new skills in order to ensure the profession keeps up with technology and changes in care delivery. A regulating body will establish the minimum requirements for continuing education, which can be based on specific skills, a set number of hours of additional education, or a combination. The responsibility to meet these requirements will fall on the individual professional. For emerging professions, stakeholders should consider whether continuing education should be required. There may not be an entity that can approve courses or monitor compliance. Without a proper infrastructure in place, it may be a challenge for individuals to find continuing education opportunities.

Some common examples of continuing education for emerging professions include skills-based trainings such as CPR or motivational interviewing, community meetings on pertinent health topics, and attendance at policy forums, seminars, and professional conferences.

Defining Competencies

For many health professions, education and training are competency-based²², or in other words, focused on specific skills needed to do a job rather than abstract concepts. But first, these competencies must be identified and documented.

One method of identifying competencies commonly used for curriculum development is known as DACUM – short for “Developing a Curriculum.”²³ DACUM is a systematic, facilitated process that defines the specific duties and tasks of a role or profession, as well as the knowledge, skills, traits and any tools a worker needs to do the job. The process is useful for new roles as well as professions that have developed over time, because it can capture existing components and desired skills of a yet undefined role. DACUM can produce a meaningful list of competencies that can be translated into a curriculum.

Another source of information on competencies for professionals in public health is an assessment tool developed by the Public Health Foundation.²⁴ Beyond the minute tasks and functions of a profession, this tool can provide broader context on the competencies of a role as it interacts with larger public health stakeholders and systems. This is important context for

²² <https://www.ed.gov/oii-news/competency-based-learning-or-personalized-learning>

²³ <http://www.dacum.org/>

²⁴ http://www.phf.org/resourcestools/Pages/Competency_Assessments_For_Public_Health_Professionals.aspx

emerging professions looking to bridge health care sectors and provide services in public health programs.

As mentioned above, it is also useful to research the competencies of similar professions – both as a way to identify potential friction points between professions, and because it may be possible to incorporate competency-based components from other curricula into a new curriculum. A comprehensive tool for the competencies of known professions is O*Netonline.org.²⁵ O*Net lists competencies of professions by tasks, technology skills, knowledge, skills, abilities, work activities, and work context.

Health regulatory boards are another good source of information for competencies of the professions they regulate.

Resources

O*Net database with competencies of professions: <https://www.onetonline.org/>

Graphic flowchart for curriculum development planning:

https://www.k4health.org/sites/default/files/Components%20of%20a%20Health%20Professional%20Curriculum_edited.pdf

US Department of Labor Toolkit to start an apprenticeship program:

https://www.doleta.gov/oa/employers/apprenticeship_toolkit.pdf

University of Virginia Guide to starting an internship program:

<http://www.virginia.edu/career/intern/startinganinternship.PDF>

Wisconsin's apprenticeship program:

<https://dwd.wisconsin.gov/apprenticeship/individuals.htm>

²⁵ <https://www.onetonline.org/>

Regulation

“How can I be sure you know what you’re doing?”

Regulation of health professions is certainly about formal recognition of the profession and the ability to seek payment from some payers, but the core of regulation is about safety. Professional regulations and restrictions are intended to create mechanisms to ensure competence and protect the public. And if a profession is providing care to sick or vulnerable patients, society has an expectation that practitioners are adequately trained, that specialized skills are up-to-date, and that unscrupulous providers are policed. That said, how regulation is implemented is often a source of controversy and friction between professions and stakeholders.

Some states refrain from regulating emerging professions, relying more on market forces to define the boundaries of a profession. Other states prefer detailed processes and procedures to ensure professional conduct is safe and consistent. This guide does not take a side in the ongoing philosophical debate, other than to assume that regulation of health professions is a deeply imbedded aspect of our health care system, there are advantages and disadvantages to any regulatory process, and there are common paths that emerging professions may wish to explore. In Minnesota, state statute includes specific criteria for determining whether regulation of a profession is appropriate. The criteria include²⁶:

- (1) whether the unregulated practice of an occupation may harm or endanger the health, safety and welfare of citizens of the state and whether the potential for harm is recognizable and not remote;
- (2) whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability;
- (3) whether the citizens of this state are or may be effectively protected by other means; and
- (4) whether the overall cost effectiveness and economic impact would be positive for citizens of the state.

Regulation of health professions generally takes place at the state level. There are different interpretations about what regulatory terms mean from state to state, but in general there are three main levels of health professional regulation: Licensure, Registration, and Certification. Some jurisdictions may require a Permit to practice in a specific health-related field, but this is less common.

As stakeholders weigh whether to enact a regulatory structure for an emerging profession -- or the appropriate level of regulation -- below are the primary levels of regulation, and some common variables to consider.

²⁶ <https://www.revisor.mn.gov/statutes/?id=214.001>

Licensure

A license is the most complex form of health professional regulation. Obtaining a license is often mandatory if an individual wishes to practice under a specific professional title, such as a physician or a pharmacist. Because safety is the primary objective, licensure is most often required for professions performing tasks with the potential to harm people if not done properly. Licensure is also most common among professions who are expected to act independently, without supervision.

The process of licensure is defined in statute and/or rule by the state government, and is often managed by a governing board of professional peers and experts. A licensure statute will define the scope of practice, minimum qualifications, continuing education requirements for license renewal, and disciplinary and termination processes to exclude individuals who act outside ethical principles or fail to meet competency standards.

Some advantages of licensure include:

- Title protection
- Clearly defined scope of practice
- More consistency within the profession
- Increased quality through continuing education requirements
- Mechanism for policing bad actors
- Reduced competition from title protection
- Strong case for reimbursement by government and private insurance.

Some disadvantages of licensure include:

- Fees
- Barrier to entry in the marketplace
- Time lost to bureaucracy and paper work
- Ongoing “turf” conflicts with professions performing similar work
- Barriers to evolution in professional practice
- Requirement of legislation for major changes
- Fines and penalties for non-compliance

On the issue of fees, it takes money to run a licensing system. An entity such as a board or state agency must process the licenses, police bad actors, respond to public inquiries, and maintain standards. There are staff costs, information technology costs, governance costs like, board meeting expenses, legal fees, and other costs to consider. Some states may appropriate funds to support this activity, but the primary funding source is the license fee.

The fee is established by defining the costs to implement and maintain a license – *spread across the number of licensees*. As a rule of thumb, the fewer the potential licensees, the more expensive the license. Other factors such as the complexity of the regulations or the number of complaints to resolve will impact the license, but the number of professionals is the main factor. Depending on the variables, license fees can be up to \$1,000 per year. However, many license fees are in the neighborhood of a couple hundred dollars per year.

An emerging profession that expects to have a small number of practitioners may want to look at other options for regulation, at least initially.

Examples of commonly licensed professions: physician; dentist; pharmacist; psychologist; independent clinical social worker; nurse practitioner.

Registration

Registration provides independent recognition of professionals, and includes some form of public register or roster of professionals who have met minimum requirements. Generally, the primary purpose of maintaining a register or roster is title protection. However, a register does not limit professional activities the way a license can – someone not listed on a register or roster can still perform the same duties, just under a different title.

Confusingly, the most common profession using the term “registration” today is a Registered Nurse. Back in the history of nursing, registration meant something different.²⁷ Today, however, Registered Nurses are actually *licensed*. For this guide, a more narrow definition of registration will be used, which excludes registered nursing. But not nursing assistants, who are actually *registered*.

Registration includes an eligibility process, which can be verification of a specific educational requirement, or less frequently, an assessment of knowledge and skills. Evidence of certification, if available for the profession, may be a registration requirement. The cost of registration can be much lower than licensure because registration does not usually include complex renewal requirements, or detailed mechanisms for policing bad actors.

Once a professional has registered with the governing body – often a state department – they will be listed on the official register or roster as having met minimum requirements. An official roster will include the professional’s work address and contact information, and may include the professional’s specific credential. Some rosters may also include details about a professional’s specialization. For example, a roster of health care interpreters may include the language(s) interpreted, an area of health care expertise, or a region where the person works.

Registration is voluntary, but participation may be required by other entities. An example is that Medicaid or an insurance company may require a professional to register before their services can be reimbursed.

Registration can be a useful step for emerging professions looking to professionalize because it is cost effective, and it can be structured to include professionals with a wide range of education, expertise, and experience. Registration is common among professions with a minimal amount of education or training, and/or work under supervision of another profession.

Some advantages of registration include:

- Title protection
- Some consistency within the profession
- Publication of contact information for all registered professionals

²⁷ https://en.wikipedia.org/wiki/Registered_nurse

- A case for reimbursement by government and private insurance.

Some disadvantages of registration include:

- Fees
- Time lost to bureaucracy and paper work
- Lack of a defined scope of practice
- Potential for confusion about titles used in the marketplace

Examples of commonly registered professions: nursing assistant; sign language and spoken language interpreter; athletic trainer; doula.

Certification

The line between certification and licensure can be, unfortunately, blurry – depending on the requirements. Requirements for certification can often be as stringent as licensure. And in some cases, certification can be an additional credential for an already licensed professional, such as a Certified Nurse Practitioner. However, for the purposes of this guide, the two primary distinctions are that certification is frequently managed by a private, non-governmental organization, and it is often voluntary.²⁸ Certification is a profession regulating itself, often without government oversight.²⁹

Voluntary certification generally does not protect the title of the profession. Others may continue to use the same title in the marketplace, but they cannot call themselves certified without a proper credential.

A certification process will include some form of eligibility requirement – usually verification that a certain level of education has been achieved. There may also be an assessment by the certifying entity to ensure competence and consistency. Depending on the complexity of the process chosen by the certifying body, certification may be a one-time step that grants an individual a credential in perpetuity, or it may include continuing education requirements and steps for renewal. Some certifying bodies also create mechanisms to maintain ethical standards and revoke certifications from bad actors.

Professions that opt for certification should be prepared to organize themselves, which can be challenging. If a certification process – and the body it creates – is not transparent and inclusive, discord may arise, and even competing certifications can exist. Changes to a certification process run by a private entity can be easier than with government-administered licensure, but that does not mean a certifying body can act credibly without the input and feedback of the whole profession.

Some advantages of certification include:

- Voluntary self-regulation by a profession
- More consistency within the profession
- Potential for increased quality through continuing education

²⁸ https://www.nremt.org/rwd/public/document/certification_licensure

²⁹ <https://www.fsmtb.org/media/1128/member-boards-agencies-member-services-government-relations-resources-licensure-v-certification.pdf>

- Potential for policing bad actors
- A case for reimbursement by government and private insurance.

Some disadvantages of certification include:

- Fees
- Time lost to bureaucracy and paper work
- Generally a lack of clear title protection
- Confusion between certified and non-certified professionals, or multiple certifications
- Potentially, less credibility than government-sanctioned licensure.

Examples of commonly certified professions: emergency medical technician; health education specialist; hearing instrument dispenser; peer support specialist; massage therapist; natural health practitioner; acupuncturist.

Permit

Finally, a *permit* can be as simple as completing a form, paying a fee, and receiving a document that grants the right to participate in an activity, perhaps for a period of time. The permitting entity may require proof of minimum educational attainment, or proof of insurance. A permit may limit others from engaging in similar activity, but may not provide title protection. An example is a city permit to practice as a massage practitioner, or a body art practitioner.

Resources

A history of Physician Assistant regulation in North Carolina:

http://pahx.org/pdf/NCMJ_Model_Legislation.pdf

Article in the AMA Journal of Ethics on self-regulation in medical professions:

<http://journalofethics.ama-assn.org/2005/04/oped1-0504.html>

Article from the Cato Institute on potential drawbacks of professional regulation:

<https://object.cato.org/pubs/pas/pa-621.pdf>

Article in Frontiers in Public Health on Australia's experience with professional regulation:

<https://www.frontiersin.org/articles/10.3389/fpubh.2016.00091/full>

Report on the development of a professional regulation council in Canada:

http://www.hprac.org/en/projects/resources/RegulatingaNewProfession_CriteriaProcess_Nov2011.pdf

Minnesota House brief on health regulation:

<http://www.house.leg.state.mn.us/hrd/pubs/ss/ssreghrocc.pdf>

Funding and Payment

“How do you make a living?”

This section will detail some options for stakeholders to consider as they seek funding and payment for services. Payment can come in many forms. Fee-for-service payment by public programs like Medicaid or some insurance companies is a relatively simple concept – provide the care, submit a claim to the payer for services rendered, and receive reimbursement. But there are many nuances to establishing approval for payment, and there are specific terms and processes required. Managed care organizations and other insurance companies may each have very different models for payment.

Grants are a common source of funding for a project that employs new professions, and are frequently leveraged for pilot projects, or for projects that serve a specific population or geographic area.

Recent health payment reforms have in some ways made entry into the system as an independent practitioner more challenging – requirements for electronic billing and the expanded use of electronic medical records – but there are opportunities.

Preparing to Ask for Payment

In seeking payment from any funder, there are a few key considerations to have defined well before approaching them with a request for payment or reimbursement.

First, what services are you planning to provide? The more clearly you can define the service in terms that the payer will relate to, the better. For example, a Community Health Worker (CHW) may provide multiple services during a single visit with a client. This may include education services about a diagnosis, enrollment services for public programs, referrals to other providers, transportation services, or follow-up from instructions detailed in a care plan from another provider.

For a payer like Medicaid, each of these CHW services may have unique definitions, billing codes and limitations. Some billing codes are limited to a subset of provider types, limited by time and frequency, or even limited to a specific population of clients. There are also billing codes that may cover the same service, but which fall into a broader category, such as care coordination. An understanding of these differences – from the funder’s perspective – will allow stakeholders to make more pertinent arguments for payment.

For a grantor, alignment with the goal of the grant program is crucial. A grant Request for Proposal (RFP) may require a detailed description of the specific work a new provider will be contributing to a grant project. In writing an application, pay close attention to what the grantor is asking for in the RFP, and, where possible, tailor the description of the work performed by a professional to fit the goals of the grant. For example, if a grant is looking to fund “innovative models to engage diverse communities in addressing social determinants of health,” the application for funding a project should highlight specific skills and competencies of the profession that connect directly with the goals of new ways to deliver services, community

engagement, and addressing the root causes of health, not only clinical interventions. A deep knowledge of how the skills and competencies of a profession can be applied towards policy solutions will help identify which grant programs are a good fit, and which are not worth the effort to apply.

In all cases, the services to be provided should align with a defined scope of practice. See Chapter 1 for more information about scope of practice.

Second, what population are you planning to serve? Doulas, for one example, offer meaningful coaching and support services to pregnant women before, during, and after the birth of a child. But a funder may be interested in paying for services to pregnant women, and not during the birth itself. Another funder may be more interested in health education for new mothers, which would limit the available population covered by that plan or targeted by a program or a grant. Populations can also be subdivided by geography, by ethnicity and/or language, or by which employer contracts with which insurance company. On the other side of the coin, programs may need to serve a larger population before agreeing to cover a service – for example, Medicaid may require a service to be available state-wide to its entire enrolled population before approval.

Third, how much do you expect to be paid? Grantors will expect a projected salary for an individual funded by grant dollars, and often will require the assumptions used to calculate that salary. Insurance company reimbursement rates for services are often set by comparing the proposed new service to similar services by similar providers, with similar levels of education. Medicaid, for example, has staff who set rates based on comparable services already established. Making the case for higher funding may be difficult without evidence of the value at the individual practitioner level. Knowledge about what a profession can charge in the open marketplace is important as rates are determined, and should be shared with key decision-makers. A valuable source of data on what current professions are paid is O*Netonline.org.³⁰ O*Net lists median wages for known professions. Salary.com is another source of information for known professions, and can be searched by region or city.³¹

Fourth, what does the service cost at a system or program level. Public programs and insurance companies have strong incentives to reduce costs and improve the quality of health care. If a new profession can make a case that providing care will reduce overall costs to the health care system, payers may be more easily persuaded. For example, Community Paramedics have successfully made the case in multiple states that some services they are trained to provide – visiting patients in their home after a hospitalization to make sure discharge plans and instructions are followed – can avoid costly readmissions to the hospital, and save potentially millions of dollars. Having data and rational estimates of potential cost savings can persuade policy makers and company leadership to say yes to coverage for a new type of provider.

All of these considerations can be made stronger with good data to back up the assumptions. For more information on potential data resources, see Chapter 9.

³⁰ <https://www.onetonline.org/>

³¹ <http://salary.com/>

Medicaid

This section will start with a large caveat: at the time of writing, the Medicaid program is the focus of major reform legislation in Congress. Some of the policies and mechanisms described below may no longer be valid. Consult your state’s Medicaid agency for updates.

Briefly, the Medicaid program is a joint federal-state health insurance program that offers coverage for over 80 million low-income Americans. Funding is split between the federal and state governments. The program has grown recently in states that opted to expand coverage under a provision of the Affordable Care Act. And, there is significant variation in eligibility for enrollees between states³².

Coverage of services also varies considerably from state to state. The federal government sets the minimum standard for basic benefits in the program, while states have the discretion to cover additional services if they choose. It is possible for states to cover an additional service in Medicaid using state-only dollars, but this is rare. For states to receive the federal share of funding for any additional benefits, states must first authorize the coverage on the state level, and then receive formal approval from the federal government through either a State Plan Amendment³³ or a Waiver³⁴. For more information on these processes, contact your state’s Medicaid agency. Every state has a Medicaid Director, who is responsible for negotiating state plan amendments and waivers with federal partners. For specific information, contact your state’s Medicaid Director³⁵.

Seeking payment from Medicaid is difficult, but it is often the most direct way for an emerging profession to create a stable, scalable source of funding for services. Medicaid can be a testing ground for new models and services, and the program serves a large population with the most health needs – Medicaid coverage for services provided by emerging professions should be a key goal of stakeholders seeking to professionalize their fields.

Medicare

The Medicare program provides health insurance to senior and disabled Americans. This guide will not provide as much detail about Medicare coverage as Medicaid, in large part because securing coverage in Medicare is very complex, and established nationally – below is a greatly summarized schematic of the process³⁶:

³² <https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>

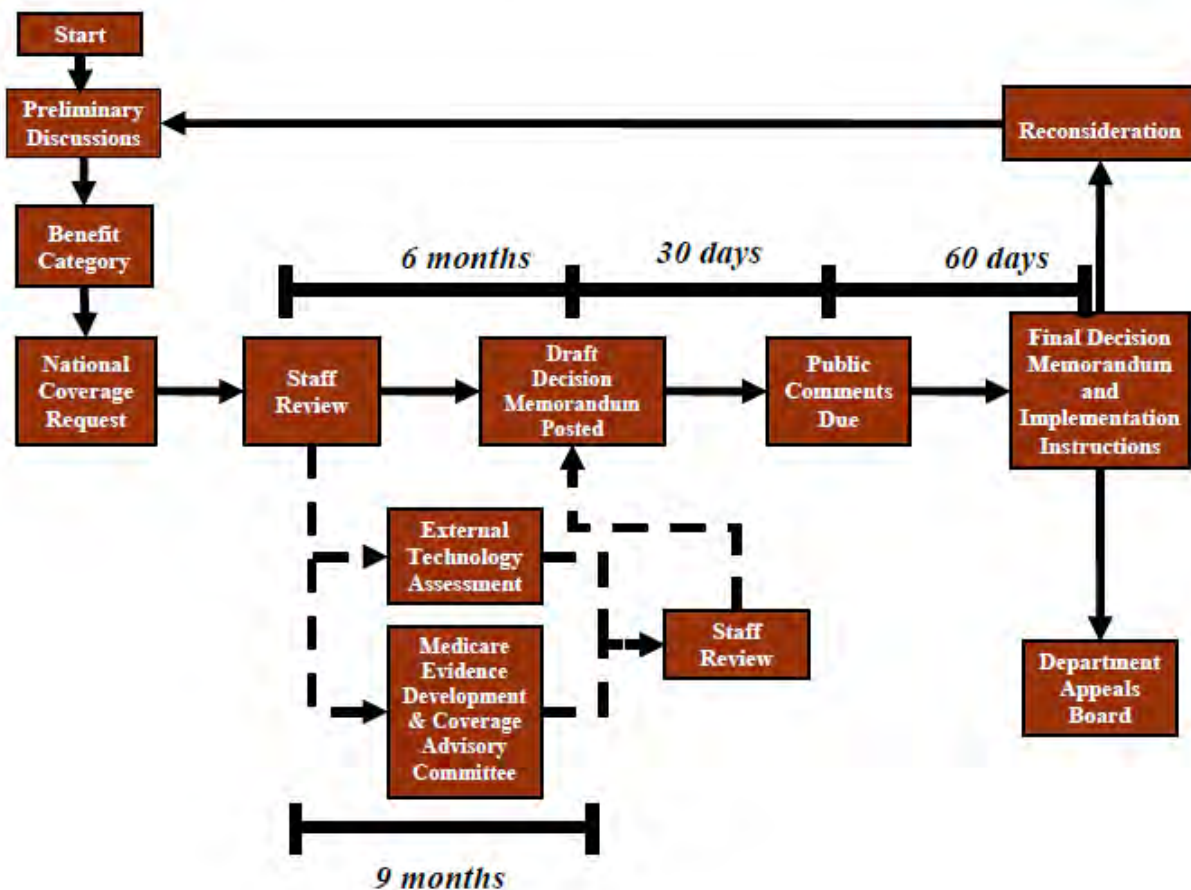
³³ <https://www.macpac.gov/subtopic/state-plan/>

³⁴ http://familiesusa.org/sites/default/files/product_documents/State-Plan-Amendments-and-Waivers.pdf

³⁵ <http://medicaiddirectors.org/about/medicaid-directors/>

³⁶ <https://www.cms.gov/Medicare/Coverage/CouncilonTechInnov/Downloads/Innovators-Guide-Master-7-23-15.pdf>

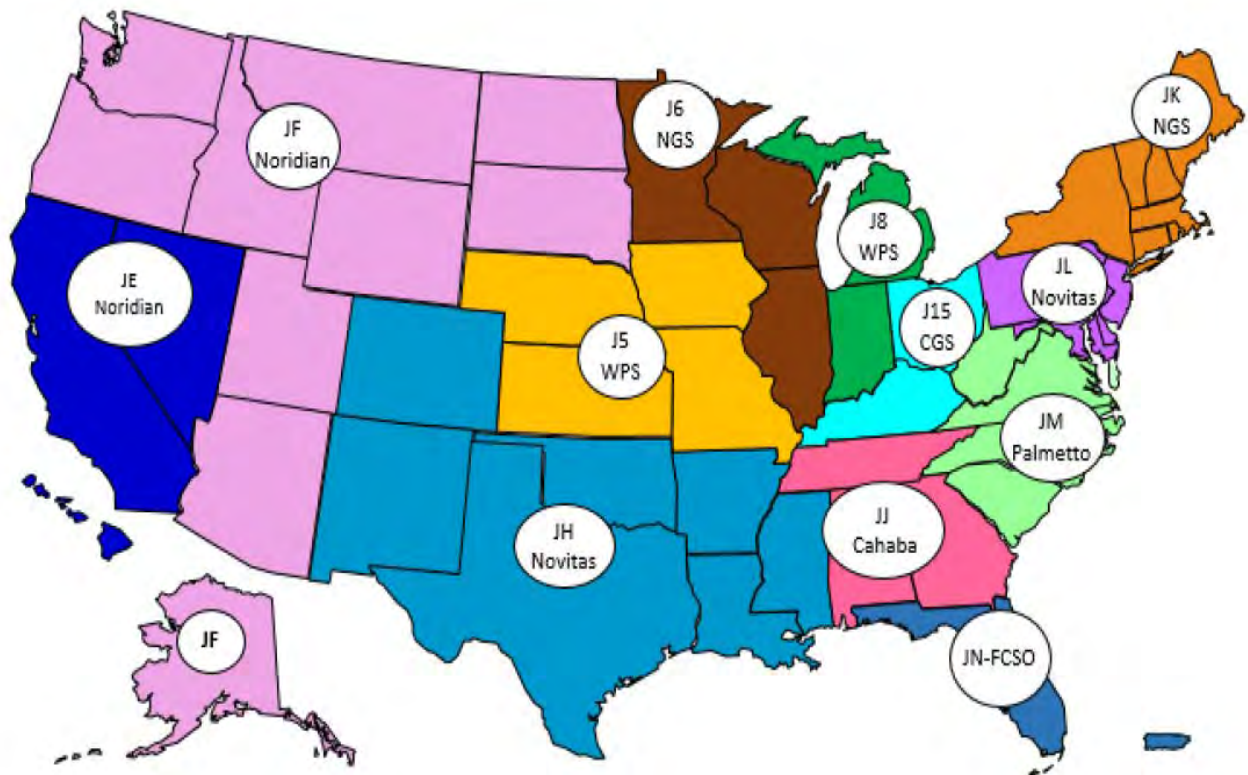
Figure 3: Medicare National Coverage Determination Process Schematic



Coverage for Medicare Part A (hospitalization) and Part B (outpatient) is determined both nationally and regionally. The overall benefit set is defined nationally, while reimbursement for services is administered regionally. Regional administration is contracted out to Medicare

Administrative Contractors (MACs)³⁷. These administrators have a small amount of discretion in how benefits are interpreted, but most benefits are consistent across the program. Contracts for administrative regions change periodically – here is a map of the Medicare A/B administrative regions and the names of contractors as of 2017:

Figure 4: Medicare Administrative Contractor Regions, 2017



Because enacting a change to the Medicare benefit set requires a profession to have fully established many of the processes outlined in this guide, and more, Medicare coverage is not a recommended strategy for stakeholders in the beginning stages of professionalizing their fields. However, there are options within the Medicare program an emerging profession can pursue to have services reimbursed.

³⁷ <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html>

One option is known as Medicare Part C, or Medicare Advantage³⁸. Under this model, insurance companies contract with Medicare to provide both Part A and Part B services, but are granted some flexibility in how care is delivered and coordinated. Because Medicare Advantage insurance companies are responsible for the health outcomes of their enrollees – and because they want to save money – they may be interested in using emerging professionals to provide care to Medicare beneficiaries in a new way. For more information on working with these private insurance companies, see the next section below on Private Insurance.

Another option is known as “**incident to**” billing³⁹ under Parts A and B. In essence, a supervising provider, usually a physician, can delegate services to professionals under direct supervision, and bill Medicare for those services provided incident to physician services, even though another professional provided the care. The physician must be nearby when the service is delivered, but can be in another room. The services themselves must be an integral part of the patient’s plan of care, and must be “of a type commonly furnished in a physician’s office or clinic.”

Delegating incident to services is entirely at the discretion of the supervising physician, who is responsible for the care, and liable if anything happens. Stakeholders who want to pursue this payment option for emerging professions should research incident to billing thoroughly before approaching a potential supervising provider or clinic for partnership.

A word of caution: incident to billing carries significant financial risk. Before submitting any claims for incident to services, the supervising provider should contact the regional Medicare Administrative Contractor (MAC) and gain assurance in writing that any incident to services are covered. If a claim is submitted improperly to the MAC, it is possible that a subsequent claims audit would require the provider to pay back the claims.

Private Insurance

Private insurance companies are often the same entities who contract with Medicaid or Medicare to cover enrollees in those programs, but may offer other insurance products to customers in the private market as well. These products are sold to individuals who purchase health insurance directly, and, much more frequently, companies who buy insurance as a benefit for their employees.

For many emerging professions, seeking coverage for their services from this part of the insurance market can be difficult. There is wide variation of services covered by insurance products – not only when companies contract with Medicaid or Medicare, but especially among products in the individual and employer markets. This variation can be an opportunity for emerging professions on a small scale, but often creates an obstacle to professionalization more broadly. While there are coverage requirements and minimum standards for some private insurance products in each state⁴⁰, there is less regulation of the private market, and

³⁸ <https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html>

³⁹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>

⁴⁰ <https://www.cms.gov/ccio/resources/data-resources/ehb.html>

the services covered by private insurance plans are often tailored for each customer. One employer's plan from an insurance company may cover a service that another employer's plan does not.

Another possible barrier for emerging professions to penetrate this market is a process known as “**credentialing**.”⁴¹ In addition to licensure, insurance companies may require that a billing provider become credentialed – in essence, approval from the insurance company to bill them for services – in order to avoid potential fraud, and/or to maintain a network of providers. Unfortunately, insurance companies require credentialing in different ways. For example, one insurance company may require both a dentist and dental therapist working under a collaborative management agreement to become credentialed before billing for the dental therapist's services, another company may only require the dentist to be credentialed, and a third may not require credentialing for dentists at all. Each insurance company should have their credentialing requirements available online or through their provider help desk.

A potential resource for emerging professions interested in working within the private insurance market are health care group purchasing organizations, often a group of large employers and stakeholders. These purchasing alliances work with insurance companies to decrease cost, but also to more closely meet the health needs of employees and individual insurance. Some states have mandated group purchasing alliances created by statute⁴² and there may be a private purchasing alliance in states as well⁴³. For emerging professions, these entities can be an ally in seeking insurance coverage for new services.

Accountable Care Organizations

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other providers who come together voluntarily to provide coordinated care to their patients. These organizations enter into agreements with payers like Medicare or Medicaid, and if quality and cost targets are met, savings created can be shared with the ACO. And for emerging professions, the ACO model is a relatively new opportunity to provide services in a coordinated system – without some of the restrictions of traditional payment models.

Payers define the parameters of ACOs. The Medicare ACO program⁴⁴, for example, stipulates the population that can be served by an ACO, and the health care providers who can participate. The ACO itself is a voluntary agreement between a group providers. This organization can include doctors, hospitals, clinics, nursing homes, dentists, mental health providers – any health care provider or facility that the group believes can improve the care of the defined population.

Once formed, the ACO will apply to the payer to enter into a contract. The contract will define the population to be served, the timeframe, and – most importantly – the baseline quality and cost measures to be used in calculating any shared savings.

⁴¹ <https://www.ncqa.org/Portals/0/Newsroom/2014/CredentialingFactSheetFinal.pdf>

⁴² <https://www.thebalance.com/health-insurance-options-for-small-business-owners-3515220>

⁴³ No definitive list of group purchasing organizations is available, but each state's insurance commissioner will know which organizations are active in their state: http://www.naic.org/state_web_map.htm

⁴⁴ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>

In establishing the baseline estimate the payer will use predictive modeling software to compute an average cost for the care of the population served – as if nothing will change. The baseline will also include targets for standardized quality measures such as the number of patients who have their diabetes under control, or the number of patients with depression who are screened periodically.

If it is in their interest, the ACO will sign a contract with the payer to provide care for the population, and if the ACO beats the baseline estimate on cost and quality, they will receive a portion of the savings below the baseline estimate. This “bonus” payment will be tallied at the end of the contract period, and is in addition to the normal claims submitted by ACO providers. There are also ACO models that penalize ACOs who do not meet baseline estimates, but these are still rare.

For emerging professions, the ACO is an opportunity worthy of exploration⁴⁵. An ACO can be a group of providers who usually do not work closely together, but who have the chance to experiment. Emerging professions can often be the workforce that bridges these unfamiliar organizations together in new ways. And as long as the ACO reaches its cost and quality goals, it doesn’t matter who provides the services. Because an ACO bonus payment is not reimbursement for individual services, the ACO can use the money any way it deems appropriate – including salaries of emerging professions.

Some examples of emerging professions in ACO models include:

- Hennepin Health⁴⁶, an integrated, county-based safety net ACO in Minneapolis, Minnesota uses Community Health Workers to improve care in many areas – including primary care, dental, mental health, and even coordination of services for recently released prisoners.
- In Fort Dodge Iowa⁴⁷, Community Paramedics are seeing patients in their homes under the ACO model, and are coordinating care between a hospital, local public health, and home health agencies.
- ACOs in multiple states⁴⁸ are incorporating new mental health professions such as peer support specialists in the delivery of behavioral health services.

Health Care Organizations and Systems

As emerging professions seek direct payment or reimbursement for services, it should be remembered that some larger health care organizations – managed care organizations (MCOs), large hospitals, and some clinics – have the financial means and incentive to hire new staff as they look to meet health reform goals. If an emerging professional can make the case that the services they provide fit the mission of the larger organization like a hospital system, or a

⁴⁵ <http://www.ajmc.com/journals/ajac/2017/2017-vol5-n2/evolving-health-workforce-roles-in-accountable-care-organizations>

⁴⁶ <http://www.commonwealthfund.org/publications/case-studies/2016/oct/hennepin-health>

⁴⁷ <https://www.unitypoint.org/fortdodge/paramedicine-program.aspx>

⁴⁸ <https://www.nasmhpd.org/sites/default/files/Assessment%20Integrating%20Behavioral%20Health%20into%20ACOs.pdf>

Federally Qualified Health Center – and/or can save them money overall, they may be interested in hiring.

Managed care organizations have a powerful incentive to control cost, and many achieve this goal by coordinating care in new ways to avoid expensive interventions like hospitalization. Depending on the population the MCO serves, coordinating that care may involve using emerging professions. And MCOs have the discretion to include these services in the care of patients, if it benefits the individual and the MCO's bottom line. MCOs may wish to hire emerging professionals who can address a gap in the continuum of care. A mandated example of this is in Michigan, where any MCO who contracts with the state's Medicaid program must hire a Community Health Worker for every 20,000 covered lives.⁴⁹

The way hospitals are paid creates a strong incentive for them to control costs. Recent federal reforms have created financial penalties for hospitals whose patients are readmitted for the same diagnosis as a previous inpatient admission.⁵⁰ Now, hospitals have a strong incentive to keep people healthy after they are discharged. And this is a growing opportunity for emerging professions. More hospitals are building programs and directly hiring community paramedics⁵¹, community health workers⁵², and other emerging professions as a strategy to reduce readmissions⁵³ and improve health outcomes for their patients. Some larger hospital systems have also developed their own emerging professions to meet staffing needs. An example is the Allina health system in Minnesota, which has created a profession known a "care guide."⁵⁴

Federally Qualified Health Centers (FQHCs)⁵⁵ are community-based, safety net outpatient clinics that provide primary care to underserved populations. There are FQHCs in all 50 states.⁵⁶ They are reimbursed by federal programs differently than many clinics. FQHCs are paid a flat rate for each visit when a program recipient receives care at the clinic. This rate is intended to cover the costs of delivering care throughout the clinic's population (including the salaries of all providers involved in the delivery of care), and create an incentive for more follow-up care.

FQHCs have limited budgets, but are often on the forefront of experimentation, testing new, cost-effective models of care⁵⁷. For emerging professions, FQHCs can be a potential employer if the services provided fit the clinic's mission and help the clinic improve care and control overall costs. Services that address primary care access or cultural barriers are often a good fit.

Another consideration is that increasingly, quality outcomes are impacting the bottom line of health care providers and organizations. Health care providers are required to submit data to national and state organization that measure the quality of care they deliver.

⁴⁹ <http://nashp.org/state-community-health-worker-models/> click on Michigan on the map.

⁵⁰ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>

⁵¹ <http://www.chcf.org/publications/2017/01/community-paramedics-team-hospitals>

⁵² <http://www.hhnmag.com/articles/6386-the-first-line-of-offense-community-health-workers>

⁵³ <https://www.ahrq.gov/sites/default/files/publications/files/medreadmissions.pdf>. See Section 6

⁵⁴ <https://www.allinahealth.org/For-Medical-Professionals/Clinical-trials-and-research/Division-of-Applied-Research/Robina-Foundation-Care-Guide-Project/>

⁵⁵ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf>

⁵⁶ <https://findahealthcenter.hrsa.gov/>

⁵⁷ <https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers/project-examples>

For emerging professions, knowledge about quality measurement is vital. Health care organizations and providers are increasingly paid based on their quality outcomes – in other words, providers who do not meet quality goals are actually paid less. This means that an emerging profession that understands how to help organizations and providers meet quality goals can make a strong case for integrating into the health care system.

For example, physicians will soon be responsible – and financially at risk – for making sure a certain percentage of their diabetic patients keep their blood glucose under control. If a number of patients speak a different language, or are from another culture, a Community Health Worker can help the physician by making sure patients understand and follow instructions to manage their disease. This creates an incentive for the physician to hire a CHW.

Grants

Grants are typically not designed to sustain a program or activity, but are a common way to fund the development of a new program or model. The funder offering a grant will have a purpose in mind when looking to award a grant, so it is important to match purposes of the grantor and the grantee. When considering whether to apply, the proposed activities should fit the funder's goals, not the other way around.

When a funder publishes a Request for Proposal (RFP) announcing available funding, objectives, and processes for applicants, the document will also define who is eligible to receive funding. As stakeholders for emerging professions at various stages of professionalization, there are some basic components that should be in place before applying for a grant.

- Time and resources to research and write
 - Grant writing is technical in nature and time-consuming.
 - Read the RFP multiple times, and make sure a proposal can meet all of the funder's requirements.
 - It is usually possible to contact the funder with questions.
- Fiscal agent
 - Unless the grant is to an individual, which is rare, there must be an entity that can manage the funds and be responsible for the deliverables defined by a grant contract.
 - A grantor – especially a government funder – may require the fiscal agent to carry insurance, provide worker's compensation, or have other legal structures in place.
 - If there is no entity in place, a larger organization may be willing to act as fiscal agent for the grant.
 - Many grants limit eligibility to a non-profit organization.
- Defined individuals with clear responsibilities
 - Someone will need to research and write the grant application.
 - Someone will need to sign an application form, and if funded, a contract with the funder.
 - Someone will need to submit invoices and progress reports to the funder.

- Everyone involved in a proposed project, including partner organizations, should sign off on project deliverables and timelines.
- First-time applicants may want to enlist the services of a professional grant writer.
- A detailed plan
 - Before applying, the proposed project should be defined to the point where the only remaining need is grant funding.
 - Contingencies and known risks should be factored in up front.
 - Proposed deliverables should be realistic and achievable.
 - If the funder requires measurement of outcomes, follow the funder's guidelines.
 - If no measures are required, create evaluation measures that can demonstrate outcomes, and that can be used in a broader context. A grant project can be a valuable source of data for the profession – See Chapter 9 for more information.

There are many sources of information on writing successful grant proposals.⁵⁸

The primary sources of grants of interest to emerging professional stakeholders are federal, state, and foundations.

Federal grants are all posted and processed on the website Grants.gov.⁵⁹ All application materials, background information, and forms are available from this portal. Grants posted on Grants.gov will include information about the statute that created the grant program, eligibility requirements, and deadlines.

State grants⁶⁰ can be administered by individual state departments or a central grantmaking department, and may be funded with state appropriated dollars, federal flow-through dollars, or a combination of funding sources. State-funded grants will be created by state statute – which is a good source of information about goals and requirements of the grant.

Foundations⁶¹ generally have more flexibility in awarding grants than government entities, but each foundation has a unique mission or niche that it wants to address. Some are very focused in scope, some have political goals, and some are not transparent in their decision-making. A foundation's mission statement is a valuable source of information to ensure that a proposal will be considered.

⁵⁸ <https://www.mcf.org/sites/default/files/files/pages/writingagrantproposal.pdf>

⁵⁹ <https://www.grants.gov/>

⁶⁰ <https://www.grantwatch.com/state-grants.php#>

⁶¹ <http://foundationcenter.org/find-funding>

Resources

Johns Hopkins guide for health care reimbursement:

<http://guides.library.jhu.edu/c.php?g=202609&p=1335380>

O*Net, online resource with salary information for known professions:

<https://www.onetonline.org/>

CMS Medicaid State Manual, with policies and procedures: <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

Practical Guide to Medicaid State Plans Amendments and Waivers:

https://store.samhsa.gov/shin/content/SMA13-4773/SMA13-4773_Mod9.pdf

Searchable Database of all Medicaid State Plan Amendments, by state:

<https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html>

CMS Innovators Guide to Navigating Medicare:

<https://www.cms.gov/Medicare/Coverage/CouncilonTechInnov/Downloads/Innovators-Guide-Master-7-23-15.pdf>

Accountable Care Organizations background: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>

Map of states with Medicaid ACO activities: <https://www.chcs.org/resource/medicaid-aco-state-update/>

List of Medicare ACOs: <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2017-Medicare-Shared-Savings-Program-Participants/futz-eezk/data>

Manual for writing federal grants – with good instructions for all grantwriters:

<https://www.ruralcenter.org/sites/default/files/Grant%20Writing%20Manual.pdf>

Business Matters

“Who pays the bills?”

Business Models

As stakeholders consider how their profession will evolve in the health care marketplace, the actual business of providing services often gets neglected. And policy decisions can have impacts on how business models will expand the profession. A good entrepreneur will seize a good opportunity. A good policy environment will be thoughtful about potential barriers and seek to allow the business side of the profession to thrive.



Solo Practice / Sole Proprietor

Some professionals prefer to work on their own. Dentists, chiropractors, and psychologists commonly structure their businesses as a solo practice or sole proprietor. These professions often set up a storefront and have patients and clients come to them. Other sole proprietors work with multiple partners at many locations, and prefer the flexibility of working outside of an organizational structure – for example, health care interpreters.

As the title presumes, sole proprietors are responsible for the every aspect of the business: marketing; maintaining a base of clients; office space; staff; insurance; taxes; contracting; meeting enrollment requirements of payers, submitting claims for reimbursement; accounting; everything.

If a large portion of the profession prefers this business model, advocates and stakeholders will need to focus attention on the right needs for the profession to grow. Sole proprietors will likely need information and guidance on business matters -- plus information on regulation, resources to connect with each other, and information to stay engaged with the latest policy developments that impact the profession. For more information about advocacy, see Chapter 7.

Employee Model

Many emerging professions start out as employees of a large organization. This may relieve the responsibility for running the business from the professional, but relying on organizations to hire the profession has other considerations that stakeholders should weigh.

Often, health care organizations may have reservations about hiring a new profession if there isn't ample evidence to demonstrate value. Return on investment for an employer is often the primary factor in making hiring decisions.

If a number of the professionals will likely work for government agencies, classification of the position is a consideration. Classification is a formal process of defining a professional role, based on knowledge, skills, and abilities, as well as required education and/or experience. Government human resources agencies create these classifications, which impact hiring practices, salary ranges, and even seniority rosters within agencies.

For emerging professions it may be difficult to fit the knowledge, skills, and abilities of the profession into an existing classification. The role of an emerging profession is likely new to HR departments, and may need a classification created for it. The federal Office of Personnel Management provides guidance⁶² on classification of health care professionals⁶³, and it may be useful for stakeholders wishing to pursue classification for an emerging profession.

Agency

Another common business structure for emerging professions is the agency, which hires or contracts with individual professionals, and negotiates contracts with other organizations to deliver services. Agencies can retain a level of flexibility and independence for the professionals themselves, while taking care of much of the business aspects. Agencies can also offer benefits to the professionals, such as group health insurance, or paid time off.

Agency models exist throughout health care, and work well for professions with less training, or without a desire to “hang a shingle” and run their own businesses. Language interpreters, home health, and local public health are common examples.

Unions

According to a report from the Bureau of Labor Statistics,⁶⁴ over 17 million health care workers are members of a labor union, and that number is growing. Members pay dues to the union, and join collective bargaining efforts on issues like wages, benefits, and working conditions. Unions themselves, looking to increase their membership, often market their services among health care professions.

There are many unions that actively organize in health care,⁶⁵ and each profession should weigh the pros and cons of union membership before pursuing this option.

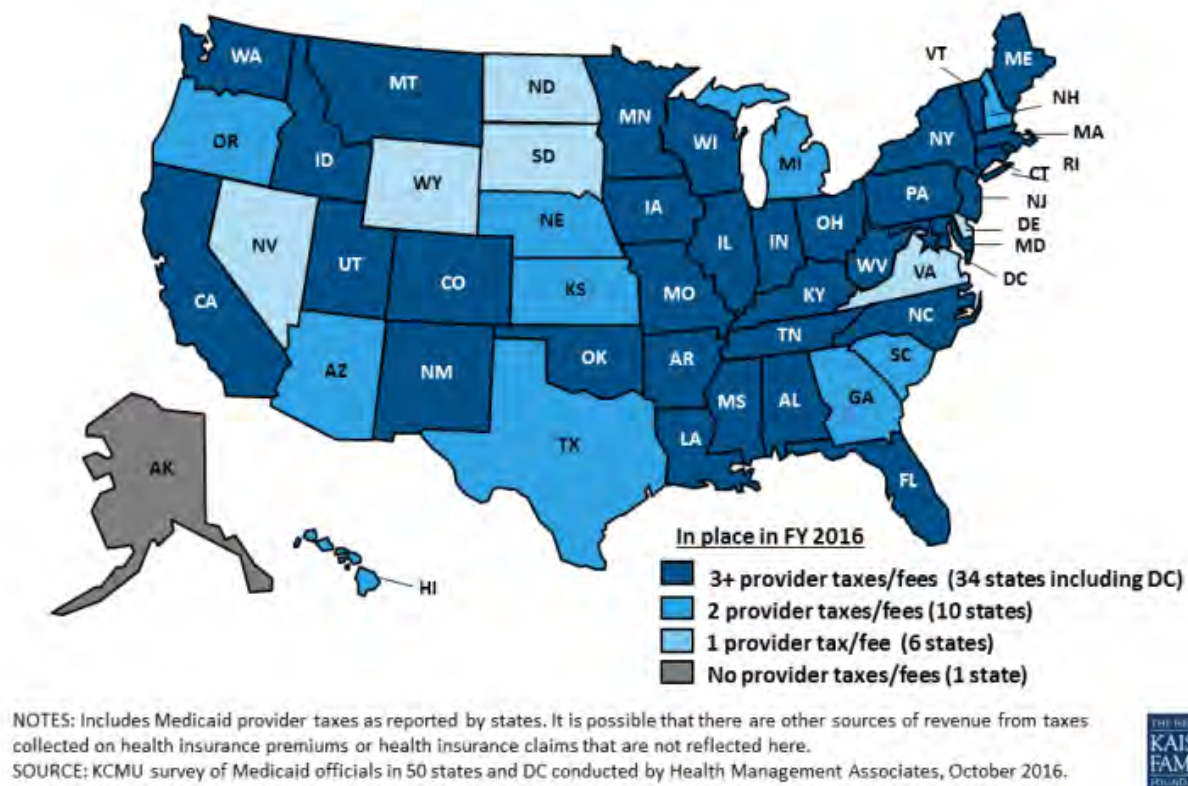
Taxes

In most states, health care providers pay additional taxes. These taxes are used for many purposes, such as funding Medicaid or other health insurance programs for low income families. The Kaiser Family Foundation tracks states with provider taxes:

⁶² <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/>
⁶³ <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/standards/0600/gso600.pdf>

⁶⁴ <https://www.bls.gov/news.release/pdf/union2.pdf>

⁶⁵ https://en.wikipedia.org/wiki/List_of_labor_unions_in_the_United_States

Figure 5: States with Provider Taxes or Fees in place, in 2016⁶⁶

As stakeholders pursue policy options for regulation or payment, it is recommended to research the requirements for a provider tax in each state, and what stipulations make the profession subject to taxation.

Resources

SCORE is a low-cost, small business mentoring program: <https://www.score.org>

Brief on how to structure the business of a clinical practice: <http://www.peicklaw.com/FAQ-How-do-I-start-my-own-clinical-practice.shtml>

Guide for physicians to choose the right practice entity:
<http://www.aafp.org/fpm/2005/1100/p42.html>

Health care business plan template (requires login):
<http://www.ihl.org/resources/Pages/Tools/BusinessPlanTemplate.aspx>

Sample health care business plans:
http://www.bplans.com/medical_and_health_care_business_plan_templates.php

⁶⁶ <https://www.kff.org/medicaid/fact-sheet/states-and-medicare-provider-taxes-or-fees/>

FAQ on business model issues related to the National Provider Identifier requirements:

<https://questions.cms.gov/faq.php?id=5005&faqId=1965>

NPI fact sheet for sole proprietors: [https://www.cms.gov/Regulations-and-Guidance/Administrative-](https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProviderIdentifierStandards/downloads/npi_fact_sheet_sole_proprietor_web.pdf)

[Simplification/NationalProviderIdentifierStandards/downloads/NPI FactSheet Sole Proprietor web.pdf](https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProviderIdentifierStandards/downloads/npi_fact_sheet_sole_proprietor_web.pdf)

“The Classifier’s Handbook” with information on classified positions in government:

<https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/classifierhandbook.pdf>

Legal Concerns

“Are you allowed to do this?”

All patients, clients, and health care consumers rely on the assumption that the care they receive will be provided safely, and according to the laws that protect their rights. It is the health professional’s responsibility to ensure these laws are followed. This section is not legal advice, but provides information and resources on common legal structures within the health care system that emerging profession stakeholders should be familiar with as they seek to professionalize their field.

Confidentiality

The Health Insurance Portability and Accountability Act (HIPAA)⁶⁷ of 1996 provides the legal backbone of patient confidentiality and privacy rights and health information security in the United States. Anyone working in health care needs to be at least familiar with HIPAA, and the subsequent “privacy rule” that refined the standards for identifiable health information.⁶⁸

HIPAA defines what “protected health information” is. It also establishes rules for securing this information, and sets forth requirements if the information is disclosed to someone who does not have the legal right to possess it.

For children, the Family Education Rights and Privacy Act (FERPA)⁶⁹ defines protections of education records as well, which may include health services received in a school.

States may have laws and rules governing privacy and information security as well. In Minnesota, for example, there are privacy laws in addition to HIPAA⁷⁰

Consent

For emerging professions, the need to obtain consent before providing services to a patient or client is less common than for a risky medical procedure, for example, but an employer or organization may require it. Consent – also referred to as “informed consent”⁷¹ – can be used in both clinical and research settings.

A form of consent that is likely more pertinent to emerging professions is the consent to share health information. Because of the restrictions under HIPAA, it may be illegal for partner organizations to share health information about a patient without legal consent from the patient to do so. It is now common practice for care models that include multiple entities and sectors to obtain consent from the patient to share health information. In some states, entities

⁶⁷ <https://www.hhs.gov/hipaa/for-professionals/index.html>

⁶⁸ <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>

⁶⁹ <https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>

⁷⁰ <http://www.health.state.mn.us/e-health/privacy/index.html>

⁷¹ <https://www.ncbi.nlm.nih.gov/books/NBK133402/>

are required to obtain patient consent before sharing health information – particularly about treatment, payment, and health care operations.⁷²

Supervision

Supervision of an employee is a familiar concept in most jobs, but in the health care world, supervision carries more legal and professional responsibility. Health care supervision goes beyond basic administrative functions. A supervisory relationship exists to assure that care is delivered in a safe manner, to provide initial and continuing education to supervisees, and to provide professional and personal support in performing difficult tasks. It also creates serious legal implications for the supervisor if something goes wrong. Close supervision is often linked to better patient safety in complex medical situations, but may not be as vital for the delivery of simpler services, or non-medical care⁷³.

In the US health care system, most emerging professions will work under the supervision of another professional – physician, dentist, nurse practitioner, etc. In many ways, this can be a benefit because it can free the emerging profession from many technical and legal responsibilities. The supervising provider is usually responsible for billing insurance companies for work performed by the supervisee, for reporting quality measures, and for providing on-the-job training. And in many cases, the supervising provider is liable for the care delivered by a supervisee, so the supervisee may not need to carry professional liability insurance.

There can be significant differences in supervisory requirements from state to state, or from program to program. Regulatory requirements and even reimbursement for services may depend on complying with the correct definition of supervision. Supervision is usually a one-to-one relationship, but some professions, such as social workers, may also include group supervision components.

For **some** medical procedures, the Medicaid program uses the following definitions of “direct” and “general” supervision⁷⁴:

- Direct supervision means immediate availability to furnish assistance and direction throughout the performance of the procedure.
- General supervision means that the service is performed under the supervisory practitioner’s overall direction and control but his or her presence is not required during the performance of the procedure.

In other words, under direct supervision, the supervising provider should be in or near the same room while a specific procedure is administered by the supervisee. Not all procedures or tasks performed by a supervisee may fall under this requirement. For general supervision, the supervising provider has a level of trust with the supervisee and can allow specific procedures to take place without being in the same facility. However, some programs may require that

⁷² <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html>

⁷³ <https://www.ncbi.nlm.nih.gov/pubmed/27283436>

⁷⁴ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R169BP.pdf>

even under general supervision, the supervising provider must be immediately available by phone or other telecommunication during the delivery of these procedures⁷⁵.

For some professions, supervision is defined more specifically by the regulatory structure. For example, many emergency medical system (EMS) providers – paramedics, emergency medical technicians -- work under a status known as “delegated practice.”⁷⁶ Essentially, supervisees work directly under the professional license of the medical director of the agency. Each paramedic has an individual scope of practice which is determined by the medical director, based on the paramedic’s skills. The medical director is vicariously responsible – and liable – for all activities performed by professionals under delegated practice.

Another, more detailed kind of supervision is known as a “collaborative management agreement.” Nurse practitioners, physician assistants, and other professions with a high level of technical training tend to work under this arrangement. A supervisee in this relationship is licensed, but their scope of practice is defined by a collaborative management agreement – in essence, contract – that details the supervisor and supervisee responsibilities and duties. An example is dental therapists in Minnesota⁷⁷. The full scope of practice for dental therapists is defined by the license, but a supervising dentist may limit the procedures an individual dental therapist can perform under the collaborative management agreement.

Additional resources to consult for examples or guidance are the state licensing board and a professional association of the supervising professional.

Medical Liability

A medical liability – or medical malpractice – insurance policy pays for legal expenses in the event of legal action against the policy holder, and it establishes an amount that could be paid out to injured patients who successfully sue. Some policies may also cover costs associated with disciplinary proceedings by a regulatory board⁷⁸.

The financial risk of being sued for injuring a patient is proportionate with the overall risk of the procedures involved. Procedures performed by a surgeon, for example, have much higher risk than those by a community health worker. The surgeon would definitely want the financial protection of insurance. The community health worker’s interaction is less risky for the patient, and – depending on the wishes of the supervising provider or the employer – may not need a comprehensive policy. Some form of insurance is recommended, if there is risk of legal action against the professional.

In some cases, an employer may require coverage, or be required to provide coverage for employees providing services under contract. When an employer is contracting for services, it is common for the language of the contract to include a requirement. Grantors may also require some form of liability coverage.

⁷⁵ <https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/provider-supervision-req.pdf>

⁷⁶ <http://www.jems.com/articles/2011/02/liability-ems-licensing.html>

⁷⁷ <https://mn.gov/boards/dentistry/licensure/processingandapplications/dental-therapists.jsp>

⁷⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1255954/>

While this may not be as important for many emerging professions as for doctors, medical liability insurance should at a minimum be explored by stakeholders looking to professionalize the field. And it should be discussed openly with all supervising providers.

Many companies⁷⁹ can provide liability insurance for emerging professions, and most policies are negotiable.

In 2011, The National Conference of State Legislatures published a summary of medical liability laws in all 50 states⁸⁰. The summary provides statutory references, and is a valuable starting point for stakeholders looking to understand the requirements in their state, and the requirements on other professionals – especially supervising providers. As this information changes, verify all requirements with individual states.

Code of Ethics

A code of ethics is a good way to establish the mission, values, and principles of a profession. It is a public statement that the profession places value on integrity, and defines what that means. A code of ethics may not be legally binding, but establishing definitions of ethical behavior can help guide individuals through difficult, boundary-testing situations. Some common guidelines in a code of ethics are:

- Clear statements defining boundaries between professionals and clients who are in a personal relationship.
- Statements affirming objectivity, and maintaining the best interest of the client.
- Statements defining discrimination and bias as unethical.
- Guidelines to avoid conflict of interest.

Resources

CMS guide on HIPAA rules and regulations: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf>

Foundations in Privacy Toolkit: <https://www.gpmlaw.com/Practices/Health-Law/Foundations-in-Privacy-Toolkit>

CMS guidance on supervision: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R169BP.pdf>

Dental Therapist Collaborative Management Agreement template: https://mn.gov/boards/assets/NEW_ADTCMA_tcm21-285564.pdf

NCSL list of medical liability laws and legislation: <http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx>

⁷⁹ https://www.piaa.us/wcm/Join/Member_Directory/wcm/Member_Center/Member_Directory_Public.aspx

⁸⁰ <http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx>

List of insurance companies that offer liability insurance to a range of professions:

https://www.piaa.us/wcm/Join/Member_Directory/wcm/Member_Center/Member_Directory_Public.aspx

An online guide for developing a code of ethics, with examples and templates:

<http://gogreenplus.org/nuts-and-bolts-guide/people-nuts-and-bolts-guide/human-resources-employee-effectiveness/code-of-ethicsconduct/>

Advocacy

“Who speaks on your behalf?”



When a bill about an emerging profession comes up in the state legislature, someone needs to speak on behalf of the profession. When the Medicaid agency needs an answer about what services a profession is trained to provide, someone needs to answer the question, and do so as an authority. Advocacy is the common thread that connects all the efforts described in this guide – it is the way work will get done.

Leadership

In order to professionalize, there must be a clear, recognized authority that represents the profession, whether an individual, a group, or both. And the leader must speak on behalf of the vast majority of the profession, or they risk losing credibility. Identifying an individual or group as the leader of an effort

to professionalize can happen organically as a profession comes together around a common interest, or there may need to be a deliberate process to select an individual or group.

At the development stage, the leader must be open, inclusive, flexible and willing to compromise. Later, an association may need leadership with additional skills to represent and defend the profession’s interests, but the skills mentioned above will always be needed for an effective leader in this role.

Association

If there is sufficient will and agreement, a profession may want to formalize their advocacy in the form of an association. Reaching out to other associations is one source of information, and there are examples of association development⁸¹ from non-healthcare fields that can be instructive as well. The role of an association varies depending on the desires of members. Some roles include:

- Representing the interests of a profession and, in essence, serving as the public voice of the profession at the national and international levels

⁸¹ http://www.fernley.com/resources/start_an_association.asp

- Protecting the profession by guiding terms and conditions of employment
- Ensuring that the public receives the highest possible standards of care by maintaining and enforcing training and practice standards, as well as ethical approaches in professional practice
- Influencing national and local health policy development to improve health care standards and ensure equitable access to quality, cost- effective services
- Potentially acting as a labor or trade union for organizations and health care workers that choose to conduct collective bargaining⁸²
- Providing networking and professional development opportunities
- Offering monetary benefits such as discounts for conferences, scholarships and grants, even group rates on health insurance or other discounts negotiated on behalf of members.⁸³

And the key benefit of an association is to leverage the power of the professionals themselves. An association that credibly speaks for its membership will be listened to by decision-makers.

Lobbying

States have differing laws and rules about lobbying, organizations that hire lobbyists, and individuals who must register as lobbyists, so consult a legal expert for details. Federal law defines a lobbyist as “any individual who is employed or retained by a client for financial or other compensation for services that include more than one lobbying contact, other than an individual whose lobbying activities constitute less than 20 percent of the time engaged in the services provided by such individual to that client over a 3-month period.”⁸⁴ Contacts to influence specific legislation or rule is considered lobbying, when done by someone hired to do so. Any information provided at the request of an official is generally not considered lobbying.

The laws governing lobbying activity can be vague. That said, anyone can talk to a legislator about issues they care about, as long as laws are followed. An advocate should not be afraid to request an appointment or seek information from any official. Legislators and state agency officials are in their positions to respond to citizens. Many leaders find ways to contribute meaningful information to the legislative and regulatory processes outside the definition of lobbying. Many other leaders decide to hire a lobbyist – or register as a lobbyist themselves – when they decide to push for specific legislation.

Turf

For some professions, the very idea of their existence can be viewed as a threat by another profession who occupies a similar sphere of the health care world. For example, nurse practitioners in many states have been seeking the authority to prescribe medications, and are frequently criticized by providers who can prescribe medications as less competent or

⁸² http://www.who.int/workforcealliance/knowledge/toolkit/27_1.pdf

⁸³ <http://www.jobs.net/Article/CB-4-Talent-Network-Healthcare-6-Ways-Professional-Healthcare-Associations-Advance-Your-Career>

⁸⁴ https://www.senate.gov/legislative/Lobbying/Lobby_Disclosure_Act/3_Definitions.htm

dangerous. In one state, dentists opposed to the licensure of dental therapists in their state were actively lobbying legislators when legislators came in for dental work.⁸⁵ In Texas, the medical association sued to take away marriage and family therapists' ability to diagnose a mental health condition.⁸⁶

While challenging for advocates to deal with, turf battles are a natural outgrowth of a profession protecting its own place in the marketplace and in the perceived hierarchy of health professions.

There is good news though. First, the demographic shifts in the United States – with more retirees simultaneously expanding the need for health care and reducing the workforce to provide that care – turf battles between professions are less common. The health care system simply needs more of every kind of profession, so one profession's case to limit the role of another loses its impact. Second, cost and quality goals in health care reform include the concept that every health professional should work "at the top of their license." This means trained professionals not providing services at the highest skill level of their training is a waste of capacity and resources. Third, with broader use of team-based care, professions are working together in new ways, and seeing the value each role can provide in delivering quality, cost-effective care.

Overlap in scopes of practice between professions is unavoidable. The role of the advocate is to define, refine, and maintain an established scope of practice for the profession. The most effective way to accomplish this is to work collaboratively and transparently with similar professions. But it may be necessary to respond to misleading statements or misinformation provided by advocates from other professions.

Partnership

For emerging professions, it is important to identify natural allies and potential partners – a broad coalition is more powerful than one interest group. Allies may be willing to assist with advocacy, research, or lobbying efforts. Some examples of potential allies include:

- Legislators and staff
- University faculty
- Schools of public health
- Disease advocacy groups such as the Cancer Society or Alzheimer's Association
- Foundations with a focus on health care
- State Medicaid or public health agency staff
- Safety net hospitals and clinics
- Patient advocacy groups
- Legal Aid

⁸⁵ https://www.washingtonpost.com/politics/the-unexpected-political-power-of-dentists/2017/07/01/ee946d56-54f3-11e7-a204-ad706461fa4f_story.html?utm_term=.16e808512789

⁸⁶ <https://www.dallasnews.com/opinion/commentary/2016/10/27/word-diagnosis-sparking-mental-health-turf-war>

Planning

The Global Health Workforce Alliance of the World Health Organization has published a toolkit they call Human Resources for Health (HRH).⁸⁷ The toolkit is global in perspective, but it offers meaningful insight into the role of advocates who wish to further the goals of health professions.

Figure 6: World Health Organization “HRH Action Cycle”

Phase	Objectives	Outcomes
Situation analysis	<ul style="list-style-type: none"> Conduct a stakeholder meeting. Review existing HR documents, strategies, and reports. Gather information. Identify root causes. 	<ul style="list-style-type: none"> A list of key stakeholders and members of the leadership group. HRH situational analysis report with root causes identified. Data on the quantity and composition of the existing health workforce and gaps identified. Information on influence of country context known (e.g., labor market, environment).
Planning	<ul style="list-style-type: none"> Develop a set of short- and long-term recommendations. Calculate the cost to implement the recommendations. Review the recommendations with the planning group. 	<ul style="list-style-type: none"> HRH policy and plan. Short-term and long-term recommendations developed. Alignment of key stakeholders around the recommendations, with priority actions identified. Costs calculated for implementing the recommendations.
Implementation	<ul style="list-style-type: none"> Develop an implementation plan. Advocate for funding. Clarify roles and responsibilities. Establish a budget and mechanisms for distribution of the funding. 	<ul style="list-style-type: none"> A detailed implementation plan. Commitment of the leadership group to support and monitor progress. Adequate funding and resources procured.
Monitoring and Evaluation	<ul style="list-style-type: none"> Identify relevant stakeholders to be involved in finalizing indicators for each component of the M&E plan. Identify output and outcome indicators and gain agreement from the leadership group on their definitions. Identify the sources of data. Clarify the roles and responsibilities of individuals for monitoring the M&E plan. 	<ul style="list-style-type: none"> A clear, realistic M&E plan. Commitment of individuals to collect data and measure results. A plan and timetable to communicate results of M&E.

Ref: A Guide to Develop and Implement Strategies to Achieve an Effective and Sustainable Health Workforce, GHWA, and WHO

The International Council of Nurses published a helpful guide to encourage nurses to advocate for their profession⁸⁸. The guide includes a useful 10-step framework for advocacy:

⁸⁷ <http://www.who.int/workforcealliance/knowledge/toolkit/hrhtoolkitpurposepages/en/>

⁸⁸ http://www.whpa.org/ppe_advocacy_guide.pdf

A 10-step advocacy framework

Advocacy is about:

1. **Taking action**—overcoming obstacles to action;
2. **Selecting your issue**—identifying and drawing attention to an issue;
3. **Understanding your political context**—identifying the key people you need to influence;
4. **Building your evidence base**—doing your homework on the issue and mapping the potential roles of relevant players;
5. **Engaging others**—winning the support of key individuals/organisations;
6. **Elaborating strategic plans**—collectively identifying goals and objectives and best ways to achieve them;
7. **Communicating messages and implementing plans**—delivering your messages and counteracting the efforts of opposing interest groups;
8. **Seizing opportunities**—timing interventions and actions for maximum impact;
9. **Being accountable**—monitoring and evaluating process and impact; and
10. **Catalysing health development**—building sustainable capacity throughout the process.

Resources

World Health Organization guide for health professions advocacy:

<http://www.who.int/workforcealliance/knowledge/toolkit/hrhtoolkitpurposepages/en/>

International Council of Nurses guide on advocacy for nurses”

http://www.whpa.org/ppe_advocacy_guide.pdf

Integration and Team-based Models

“Who do you work with?”

Emerging professions may have difficulty defining their role within the landscape of health care professions, but the biggest challenge may be defining an individual practitioner’s role within a health care team. It is not a foregone conclusion that working with others in a clinic, hospital, or office setting will go smoothly. In fact, emerging professions may encounter resistance from other team members, who are used to doing things a certain way. Below are some lessons learned by professions as they have fit themselves into the traditional flow of health care delivery, and even changed the organizations that employ them.



Integration

Whether contracting for services or working as an employee within a large organization, emerging professions can run into challenges almost immediately, especially if the organization is unfamiliar with the new role. What is the new person trained to do? What are the professional boundaries between the new person and the existing staff? What new populations can be served by the organization because of the new role? How will the new person change the organization’s culture and processes?

Integration of an emerging profession will likely not happen without intentional, consistent effort. And it can take multiple attempts and iterations to learn how best to fit a new role into a well-established framework. Careful planning and support from relevant stakeholders should be baked into new projects. In fact, it can be counterproductive – and even risky to the long-term prospects of the profession – to simply place an emerging professional in a new environment and simply hope for the best.

Some common themes within organizations that successfully integrate new professions are:

- Ongoing support from leadership;
- Building rapport and cultural understanding among team members;

- Identifying solutions to communication issues such as language barriers, HIPAA and information sharing restrictions, and EHR documentation;
- Inclusion of the new professional as a full member of the care team and any relevant committees, e.g. quality improvement;
- Providing sufficient orientation and learning curve for new professionals to successfully carry out the requisite responsibilities with other team members;
- Allowing sufficient time and opportunity to discuss the process of change and make the needed changes to the status quo to fully integrate the professional; and,
- Developing appropriate protocols, forms, and documents (e.g. front desk/scheduling flow sheets) to ensure formalization of an integrated new position.⁸⁹

Emerging professions stakeholders can also cultivate relationships with key partners, and create structures to spread relevant information more quickly:

- Individual champions
 - Every successful integration of emerging professions took place because someone in a key position in an organization had the vision to make it happen – and committed to following it through. Champions within organizations can come from any level of leadership. They can present concrete, personal examples of successful integration to their peers in other organizations, to public audiences, and to policymakers.
- Early adopter organizations
 - It is important to collect examples of successful integration. This is especially true in the early stages of the profession's development, when data resources are few and far between. Whenever possible, stories, data, and outcomes from early employers of new professionals should be captured and compiled. Grant-funded projects by early adopter organizations are a valuable source of this information.
- Communities of Practice
 - Once a large enough number of emerging professionals are practicing in the field, one idea to share best practices is to create a community of practice, or a learning community. These groups of peers can have enormous impact on the development of a profession by creating space to share lessons learned and by creating a source of support for each other. In Minnesota for example, there are communities of practice for Community Health Workers themselves⁹⁰, but also for supervisors of CHWs⁹¹, who find value in sharing their unique challenges and insight with each other.

Emerging professions can also speed integration by using evidence-based practices when available. Peer-reviewed studies on new delivery models and interventions using emerging professions are increasingly common. When enough similar studies are published -- and results are measurably positive -- these findings can be published as an evidence-based practice. There

⁸⁹ <http://www.health.state.mn.us/divs/orhpc/workforce/emerging/chw/2016chwttool.pdf>

⁹⁰ <https://wellshareinternational.org/program/mnchwpeernetwork/>

⁹¹ <http://mnchwalliance.org/event/mn-chw-supervisor-roundtable-3/>

are clearinghouses of these practices – examples are linked in the Resources section below. When proposed as a project or intervention, funders can be more confident of a successful outcome because the model has been tested. And when implemented, employers can be confident they are improving the care delivered.

Team-based Care

Health care is rapidly moving away from the traditional – or more accurately, antiquated – model of a lone physician delivering care for patients in isolation. Now, health care is much more coordinated across sectors, and delivered by teams of professionals. Health care is still relatively hierarchical, but less so than in the past – in part because managing the complex health needs of patients often requires a team approach.

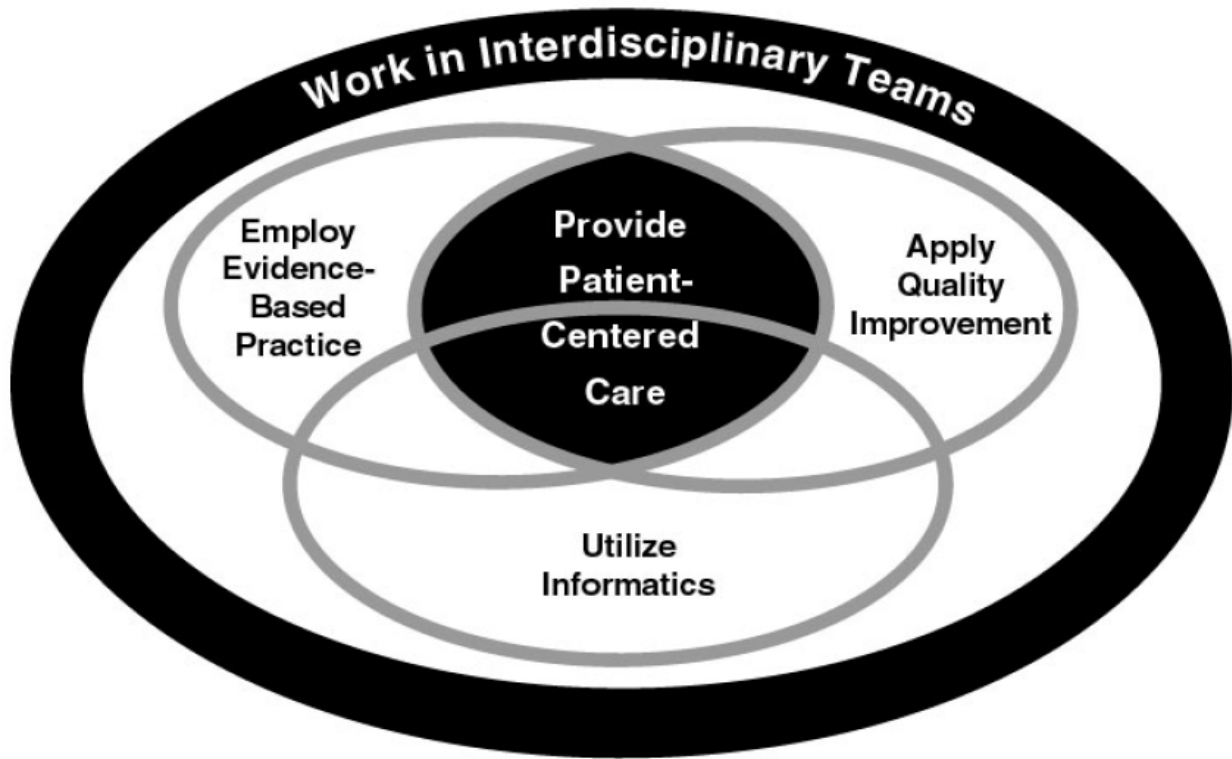
In 2003, The Institute of Medicine published a report called *Health Professions Education: A Bridge to Quality*.⁹² One primary intent of the report was to push health care towards greater quality through team-based care. The report outlined five “core competencies” that all health professionals should receive training for:

1. Provide patient-centered care
 - Identify, respect, and care about patient differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.
2. Work in interdisciplinary teams
 - Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.
3. Employ evidence-based practice
 - Integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible.
4. Apply quality improvement
 - Identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; design and test interventions to change processes and systems of care, with the objective of improving quality.
5. Utilize informatics
 - Communicate, manage knowledge, mitigate error, and support decision making using information technology.

⁹² <https://www.nap.edu/catalog/10681/health-professions-education-a-bridge-to-quality>

The report also described how these competencies overlap for health professionals⁹³:

Figure 7: Overlap of Core Competencies for Health Professionals



Much has changed since 2003, but these core competencies remain pertinent, and in many ways, are being implemented across the health care landscape. Training programs for many professions now include learning opportunities for interdisciplinary teams. And with the broad implementation of electronic health records, health care teams are using informatics in new and exciting ways to manage the health of patients and populations, not just to manage disease.

For emerging professions, team-based models of care delivery are a golden opportunity. Not only does team-based care create space for new roles in health care, but increasingly, health professionals are being trained to work with others, and to maximize the unique skillset each profession brings. Some examples of team-based care that use emerging professions are:

⁹³ *ibid*

- Patient Centered Medical Home⁹⁴
 - A “medical home” is not a place, but a concept. This primary care clinical model is effective in coordinating care for patients with complex care needs, such as multiple chronic conditions. The model puts the patient and family at the center of a care team, and coordinates all levels of care for the patient. Care coordinators follow-up with the patient frequently, and arrange care across sectors on behalf of the patient.
 - For emerging professions, there are many ways to contribute to this team-based model – either internally as a member of the clinic’s care team, or externally as a partner providing care.
- Accountable Health Communities model⁹⁵
 - Designed to address gaps between medical care and community services, this developing model defines a population to be served, and builds partnerships across multiple sectors in health care – hospital, clinic, long-term care, public health, schools, community organizations, any entity that can contribute to the health of the population. The model seeks to address the unmet social needs of patients.
 - For emerging professions, this model is an opportunity to bridge gaps between sectors in the health care and public health systems.

Accountable Care Organizations (ACOs)

As described in Chapter 4, ACOs are a flexible, innovative way to manage the health of a population. Partnerships developed under an ACO are unique to each organization because they are based on available resources and the defined need of the population to be served. Each ACO determines how it will coordinate services across partners and sectors.

For Emerging Professions, an ACO is an opportunity to contribute to this team-based, coordinated model – often without needing the normal structures of reimbursement and regulation. ACOs are free to provide care in any way they deem beneficial to the population, and professions that can address gaps across partner organizations are desirable in the model.

ACOs have been around long enough to begin analysis on effective workforce models. One study, published in the American Journal of Managed Care⁹⁶, discovered that ACOs are altering the makeup of their workforce to take advantage of new professions and new roles. There is variation in workforce models between ACOs, but the study concluded that team-based ACO workforce models which leverage new roles and professions are showing effectiveness in meeting the needs of patients, especially high-risk patients.

⁹⁴ <https://pcmh.ahrq.gov/page/defining-pcmh>

⁹⁵ <https://innovation.cms.gov/initiatives/ahcm>

⁹⁶ <http://www.ajmc.com/journals/ajac/2017/2017-vol5-n2/evolving-health-workforce-roles-in-accountable-care-organizations/P-1>

Resources

Minnesota's Health Care Homes and Chronic Disease Management; Understanding the Integration of Community Health Workers: http://mnchwalliance.org/wp-content/uploads/2012/12/HCHs_and_CHWs_Issue_Brief-FINAL.pdf

Healthy People 2020 Evidence-Based Practices: <https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources>

The Community Guide Evidence-Based Practices: <https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources>

SAMHSA Evidence-Based Programs:

<https://www.samhsa.gov/capt/tools-learning-resources/finding-evidence-based-programs>

Discussion paper on the core principles and values of effective team-based health care: <https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-values.pdf>

American Medical Association toolkit on developing and implementing team-based care: <https://www.stepsforward.org/modules/team-based-care>

American Congress of Obstetricians and Gynecologists guide for implementing team-based care: <https://www.acog.org/Resources-And-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care>

Safety Net Medical Home Initiative implementation guide for continuous and team-based healing relationships, with case studies and links to examples: <http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Team-Based-Care.pdf>

SAMHSA-HRSA Center for Integrated Health Solutions report on integrated primary care and behavioral health teams: [https://www.integration.samhsa.gov/workforce/team-members/Essential Elements of an Integrated Team.pdf](https://www.integration.samhsa.gov/workforce/team-members/Essential_Elements_of_an_Integrated_Team.pdf)

Examples of integration of Community Health Workers into health care teams in California: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Supporting%20the%20Integration%20of%20Community%20Health%20Workers%20into%20Health%20Care%20Teams_2017_06_26.pdf

Data Collection and Evaluation

“How do I know the profession is making a difference?”



For emerging professions in the early stages of professionalizing, demonstrating impact can be difficult, because there likely isn't a large pool of data available. This section of the Guide may be an afterthought for many stakeholders, but ignoring the collection of data can set the goals of a profession back, or even hinder progress in future

years. Stakeholders should be thoughtful about data collection, and should incorporate it into all plans to professionalize. Below is a list of some common sources of data that can be useful to emerging professions stakeholders.

Workforce Data

For emerging professions, it can be difficult to analyze the size and scope of the profession because common data sources, such as regulatory boards, may not yet exist, and other data sources may not include a consistent definition of the profession. There are some broad data sources that researchers can use to measure workforce for emerging professions. A recent study⁹⁷ by the Center for Health Workforce Studies at the University of Washington identified four potential sources of workforce data:

- The American Community Survey⁹⁸ is conducted by the US Census Bureau, and includes self-reported occupation information, searchable by geographic area.
- The Current Population Survey⁹⁹, also conducted by the Census Bureau, is used to measure labor statistics. The survey includes income data by profession.
- The National Provider Identifier (NPI) Registry¹⁰⁰ lists all providers who have an NPI number, by profession, name, and address. Some states are requiring emerging professionals to obtain an NPI number.

⁹⁷ http://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2017/01/leveraging_data_allied_health_supply_estimates_pb_dec_2016_skillman.pdf

⁹⁸ <https://www.census.gov/acs/www/data/data-tables-and-tools/>

⁹⁹ <https://www.census.gov/programs-surveys/cps.html>

¹⁰⁰ <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProviderStand/DataDissemination.html>

- The Occupational Employment Statistics¹⁰¹ dataset published by the Bureau of Labor Statistics includes detailed information on employment by profession.

The Occupational Employment Statistics is a particularly valuable source of information. The federal Bureau of Labor Statistics (BLS) defines health professions at a granular level, and monitors the number of people working under these titles. Every profession is given a Standard Occupational Classification (SOC) code, and monitored over time.¹⁰² This public data can be very useful in measuring the size, growth, and distribution of a profession.

If a code for a specific profession does not exist, it is possible to create a new code in the dataset for an emerging profession. The process for revision of SOC codes¹⁰³ is open for public input, and incorporates the most current definition of the profession. For emerging professions, it is strongly recommended to pursue a new SOC code, and to update the definition of the code as the profession evolves.

Training programs and higher education institutions that teach professionals are another useful source of basic workforce data. Schools maintain data on the number of graduates and some demographic information about them, but in order to measure their own effectiveness, many schools also track where their graduates are working. This can be useful data to track the growth and distribution of the profession in lieu of a formal regulatory structure.

Claims Data

Health care claims data are incredibly useful for analysis of a profession's impact. Health care claims are requests for reimbursement from providers to insurance companies. Most insurance companies and public health care programs use the same set of codes for reimbursement of services, which makes analysis easier. As mentioned above, each enrolled provider is given a unique 10-digit identifier called a National Provider Identifier (NPI) code, or a similar code for some state-only provider types. The billing provider includes a code for the service(s) delivered. A claim will also include information about the patient who received the service – including the diagnosis and demographic information. Patient data is private and usually must be de-identified for analysis. The combination of these data sources can generate powerful information about the utilization of a service, what populations receive the service most frequently, and the growth and distribution of a profession over time.

For emerging professions, establishing reimbursement from insurance companies is a key source of information because claims data can measure how services provided impact the rest of the health care system. For example, good claims data can compare a group of patients who received care from a profession with a group of patients who did not, and can analyze the quality of care received. In many cases, the services provided by emerging professions can save costs to the rest of the health care system by addressing health issues before they become worse. Claims data can measure these potential savings.

¹⁰¹ <https://www.bls.gov/oes/>

¹⁰² <https://www.bls.gov/soc/>

¹⁰³ <https://www.bls.gov/soc/#revision>

Increasingly, states are collecting claims data into large databases that are used to measure cost trends and develop policies. At the time of publication, over 40 states have a claims database or have strong interest in developing one.¹⁰⁴

Quality Reporting Data

The largest set of standardized quality measures nationally is the Healthcare Effectiveness Data and Information Set (HEDIS).¹⁰⁵ Quality measures can be process measures – such as the percentage of patients who were screened for depression – or outcome measures – such as the percentage of diabetic patients who have their blood glucose under control. The data submitted for these measures may not directly include the services provided by emerging professions, but within health systems, it can be possible to compare the quality outcomes of populations who have received care from an emerging profession with those who have not.

It is also possible to develop new measures¹⁰⁶ that specifically include emerging professions, though this can be time consuming. Development of new measures will require the convening of a technical expert panel, time for public comment on the measure, and testing.

Electronic Health Record Data

Virtually all hospitals, medical and primary care clinics, and local public health departments now have electronic health record (EHR) systems, and a growing number of mental health providers, dental clinics, and nursing homes and others are implementing EHR technology. EHR systems collect, use and share large quantities of information about a clinic visit or health encounter. Information may include lab tests and results, patient demographics, medications, prevention services, care delivered, follow-up and much more. This is in addition to what is submitted for financial claims and quality improvement reporting. In addition, EHRs can be used to understand the factors influencing an individual's health such as gender, geography, race, ethnicity, and genetics. Also, some EHR's support tracking logs and other tools and functions to better support care coordination especially as they relate to transitions of care.

EHR systems manage large volumes of information needed to better support health and care services and population health. Information is vital for functions such as decision support, clinical diagnosis, care plans and communication across multiple providers and more. Stakeholders can find information from a variety of roles within an organization, and each will bring a different perspective. Some roles are specially trained and or certified in the new discipline of health informatics.

- For clinical, health care information you may find specialists such as: CMIO – chief medical informatics officer, or CNIO Chief Nursing informatics office.
- For technology and security information your will find traditional IT roles such as CIO – chief information officer or CTO – chief technology officer or CSO – chief security officer.

¹⁰⁴ <https://www.apcdouncil.org/state/map>

¹⁰⁵ <http://www.ncqa.org/tabid/59/Default.aspx>

¹⁰⁶ <http://www.ncqa.org/tabid/414/Default.aspx>

Most professional organizations now expect employees to have a core level of competencies in both health informatics principles and knowledge of the use of technology. For informatics, this means a basic understanding computers and technology, but also of health information standards and roles. Also an understanding of systems thinking and operational understanding of EHRs is important.

Within a large health system, the CMIO/CNIO and CIO can be a key ally. Also a necessary ally is an “informatician” or individual with skills to translate needs and requirements into EHR technology. Often, EHR systems do not include modules specific to emerging professions. An informatician can facilitate the process to identify what is collected, used, and shared and if the current EHR can support that activity or if an additional module is necessary.

For example, after a Community Paramedic visits a patient in her home, the information collected about the patient will likely be entered into the EHR so it can be shared with and used by other providers on the care team. How this information is collected and ultimately analyzed can help a Community Paramedic program demonstrate quality outcomes, and make a business case for expansion of services.

It is helpful to identify one of more of these stories (sometimes called “use cases”) to provide concrete examples for how the health professional collects, uses and shares information as they do their work. A high level diagram of the information steps or flows is often a very effective tools to explain the work of the health professional and how they fit into the larger context.

Other data sources

Time and Motion Study: The goal of this direct observation study method is to quantify every action performed by a professional during a typical work period. In short, a researcher will follow a worker around during a set time period and document every task and function performed by the worker. This information can be used to define a professional role more clearly, and to look for efficiencies. It may sound like an antiquated way to measure work, but these studies are common in health care¹⁰⁷ – especially for complex processes where important decisions must be made in sequence, like surgeries or emergency room protocols.

For emerging professions, time and motion studies can be useful to ensure reimbursement rates for services are fair. When reimbursement rates are established in health insurance programs, rate-setting staff look at comparable professions as a benchmark. For emerging professions without a history of data collection or examples, it may be very difficult to make comparisons to existing roles. A time and motion study can be used to define the true complexity of work performed by a professional.

¹⁰⁷ <http://www.sciencedirect.com/science/article/pii/S1532046414000562>

The Agency for Healthcare Research and Quality (AHRQ) has developed a tool¹⁰⁸ for time and motion studies, and a spreadsheet for conducting a study¹⁰⁹.

IPEDS:¹¹⁰ The National Center for Education Statistics maintains the Integrated Postsecondary Education Data System (IPEDS), which collects data from every higher education institution in the country. Data elements include educational program types, enrollment, graduation rates, and faculty information. This information can be useful to estimate the “pipeline” of professionals being trained, and make policy decisions about distribution of the workforce.

There is also a crosswalk database that links IPEDS education data with Standard Occupational Classification (SOC) codes from the Bureau of Labor Statistics, which can allow researchers to analyze on how many graduates of an education program are practicing in a specific profession.

Grants as a source of data

Grant-funded projects are an incredibly valuable source of anecdotal information about a profession, especially in the early stages of professionalization. Grant projects can provide meaningful financial information, utilization data, project-specific outcomes, and can lead to the development of evidence-based practices. Stakeholders should strive to keep an inventory of grant projects that directly involve emerging professions, and should request and store available project reports and outcomes. Most government-funded grants are public information, and documents are easy to request from the granting agency. Foundation grants may be private information, but there will likely be outcome information the funder is willing to share. This infrastructure will give stakeholders and advocates a collection of stories, and can be the basis for analysis of outcomes across projects or sectors.

While grants are project-based and funders can require a wide range of measures to report, that doesn’t mean stakeholders can’t offer guidance on what measures are the most valuable to collect. And grant funding doesn’t preclude the ability for a profession to define how it wants to measure itself. Stakeholders should consider the creation of standard measures for grant projects. In some cases, funders will see the value of collecting data consistently, and will work to allow flexibility in data collection.

Evaluation

Evaluation is a methodological approach to measuring the impact of a project or change with respect to specific objectives. An evaluation can include existing data sources or not, it can use standardized measures or measures specific to a project, and it can analyze the effectiveness of a project from multiple angles. It can also be narrow in scope, or wide-reaching and inclusive of multiple perspectives. It depends on the goal of the evaluator.

¹⁰⁸ <https://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/time-and-motion-study>

¹⁰⁹ <https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/time-and-motion-studies-database>

¹¹⁰ <https://nces.ed.gov/ipeds>

For emerging professions, the flexibility of evaluation makes it a very useful tool to build a base of evidence for the effectiveness of the profession.

There are four main types of evaluation:

- Formative evaluation: ensures that a program or program activity is feasible, appropriate, and acceptable before it is fully implemented. It is usually conducted when a new program or activity is being developed or when an existing one is being adapted or modified.
- Process/implementation evaluation: determines whether program activities have been implemented as intended.
- Outcome/effectiveness evaluation: measures program effects in the target population by assessing the progress in the outcomes or outcome objectives that the program is to achieve.
- Impact evaluation: assesses program effectiveness in achieving its ultimate goals.

Selecting the appropriate evaluation types will depend on the nature of the project, and the purpose of the evaluation.

Regardless of the type of evaluation, the process generally includes the following steps¹¹¹:

- Step 1: Define the stakeholders
 - Your stakeholders are supporters, implementers, recipients, and decision-makers related to your program. Getting them involved early on will help you get different perspectives on the program and establish common expectations. This helps to clarify goals and objectives of the program you'll evaluate, so everyone understands its purpose.
- Step 2: Describe the program
 - Taking the time to articulate what your program does and what you want to accomplish is essential to establishing your evaluation plan. Your descriptions should answer questions like: What is the goal of our program? Which activities will we pursue to reach our goal? How will we do it? What are our resources? How many people do we expect to serve?
 - Articulating the answers to those questions will not only help with accountability and quality improvement, but it will also help you promote the program to its beneficiaries.
- Step 3: Focus the design of your evaluation
 - Evaluations can focus on process, means, resources, activities, and outputs. They can focus on outcomes or how well you achieved your goal. You may also choose to evaluate both process and outcomes.
 - As you begin formulating your evaluation, think about the specific purpose of the evaluation—what questions are you trying to answer? How will the information be used? What information-gathering methods are best suited for collecting what our organization needs to know?
- Step 4: Gather evidence

¹¹¹ <https://www.nwcphp.org/evaluation/tools-resources/program-evaluation-tips>

- Qualitative and quantitative data are the two main forms of data you may collect.
- Qualitative data offers descriptive information that may capture experience, behavior, opinion, value, feeling, knowledge, sensory response, or observable phenomena. Three commonly used methods used for gathering qualitative evaluation data are: key informant interviews, focus groups, and participant observation.
- Quantitative methods refer to information that may be measured by numbers or tallies. Methods for collecting quantitative data include counting systems, surveys, and questionnaires.
- Step 5: Draw conclusions
 - This is the step where you answer the bottom-line question: Are we getting better, getting worse, or staying the same? Data comparisons show trends, gaps, strengths, weaknesses. You can compare evaluation data with targets set for the program, against standards established by your stakeholders or funders, or make comparisons with other programs.
- Step 6: Present findings and ensure use
 - It is important that all the work you put into program evaluation gets used for quality improvement. When you present your findings and recommendations, it is important to know the values, beliefs, and perceptions of your group; build on the group's background and build on common ground; and state the underlying purpose for your recommendations before you get to the details.

There are many tools available online for planning and performing an evaluation – some are included in the Resources below – but stakeholders may want to consider using the services of a seasoned evaluator.

There are also frequent qualitative and quantitative data sources used in an evaluation:¹¹²

- Surveys and questionnaires
- Focus groups
- Pre- and post-program knowledge testing
- Observation
- Key stakeholder interviews
- Document review

A well planned and executed evaluation can highlight positive outcomes, and help spread best practices more quickly.

¹¹² <https://www.cdc.gov/healthyyouth/evaluation/index.htm#tabs-811330-2>

Resources

Explanation of claims data:

<https://www.cdc.gov/workplacehealthpromotion/model/healthcare-cost-data/interpreting.html>

How to develop new HEDIS quality measures: <http://www.ncqa.org/tabid/414/Default.aspx>

Quality Measures Development Overview document from CMS:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QualityMeasuresDevelopmentOverview.pdf>

AHRQ Toolkit for evaluation: <https://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/assess/purpose.html>

The Rural Health Information Hub published a toolkit for developing CHW programs, which includes valuable information about evaluation: <https://www.ruralhealthinfo.org/community-health/rural-toolkit/4/program-evaluation>

Conclusion

As mentioned in the introduction, each profession must chart its own path towards professionalization and integration with the larger health system. Some professions will leap ahead in one area and wait to develop other aspects. Others will push forward with every aspect of professionalization at the same time. The success of each effort will depend in large part on previous examples, existing structures, addressing the concerns of any opposition, and especially, partnerships.