



Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards

Report of the FSMB Workgroup on Team-Based Regulation

Adopted as policy by the Federation of State Medical Boards

April 2017

INTRODUCTION

Integrated services among multiple health care providers have become increasingly prevalent in the provision of quality health care. The high-performing interprofessional health care team is widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective health care delivery system. The team-based model has been formalized and implemented to help address the growing complexities of health care delivery, coordinating and responding to multiple patient needs, keeping pace with the demands of new technology, delivering care across different settings, and responding to recent health care trends such as patient-centered medical homes, accountable care organizations, and an emphasis on population health.

State health professional licensing boards are responding to the changing landscape of health care not only by collaborating to determine discipline of their individual members, but also by seeking opportunities to have a greater understanding of the roles, responsibilities, and approaches of all members of the health care team.

In April 2015, the Federation of State Medical Boards (FSMB) Chair, J. Daniel Gifford, MD, FACP, appointed the Workgroup on Team-Based Regulation to identify and recommend model practices and strategies for achieving greater cooperation and collaboration among health professional boards in carrying out their shared responsibility to protect the public.

In order to accomplish this charge, the workgroup conducted an environmental scan and analysis of health care delivery models and methods that utilize interdisciplinary collaboration and team based-approaches to patient care, examined the defined roles and responsibilities of individual team members in such scenarios, and identified characteristics of a high functioning health care team.

This policy document is intended as a resource outlining emerging model practices for state medical and osteopathic boards (hereinafter “state medical boards”) seeking to incorporate

regulatory strategies to achieve increased cooperation and collaboration among health professional regulatory boards.

Over the course of 13 months, the workgroup reviewed current processes to establish accountability among health care teams and identified existing state-based mechanisms for the oversight of issues that involve multiple practitioners and span the authority of multiple health regulatory boards. The workgroup evaluated data from the 2015 FSMB Member Board Survey and several state-based examples as well as international models of team-based care, based on a survey of members of the International Association of Medical Regulatory Authorities (IAMRA).

SECTION ONE. BACKGROUND.

The role of health care providers is changing in the United States and globally¹ as the demand for health care services is increasing.² Partly in response, team-based care has recently drawn the attention of a wide range of health care institutions in the United States, including the Agency for Healthcare Research and Quality (AHRQ),³ Institute of Medicine (IOM, now known as the National Academy of Medicine)⁴ Health and Medicine Division (HMD) of the National Academies of Sciences Engineering, and Medicine (the Academies),⁵ the American Medical Association (AMA),⁶ and the Association of American Medical Colleges (AAMC).⁷

The delivery of health care has slowly evolved from a sole provider responsible for the patient's health from cradle to grave to an entire team of health professionals responsible for coordinating the care necessary for a patient's wellbeing.⁸ Health care teams are viewed as tools that help break down the hierarchy characteristic of most health organizations, ensuring that patients receive patient-centered, high quality care.⁹ Team-based care is often aligned with enhanced patient-centered care so that patients may benefit from creative, complex problem solving and the diverse academic backgrounds, experiences, and perspectives of many health care professionals.¹⁰ Health care teams can also reduce redundant or duplicative services, affording patients more efficient and streamlined health care solutions.¹¹

Studies have identified teamwork as requisite for high quality, safe patient care, especially as clinical care is becoming more complex and specialized.¹² In addition to enhancing quality, team-based care has been shown to lower health care costs¹³ and may provide better treatment for resource-limited populations and communities.¹⁴ Members of such teams report positive satisfaction and reduced stressors that ordinarily contribute to burnout.¹⁵

SECTION TWO. DEFINING "TEAM-BASED CARE."

The literature addressing team-based care is comprehensive, and a number of definitions have been offered for the term. For example, the National Academy of Medicine defines team-based care as "an approach to health care whereby a group of people work together to accomplish a common goal, solve a problem, or achieve a specified result."¹⁶ The Agency for Healthcare Research and Quality offers the following definition for team-based care: "[T]he provision of

health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers, to the extent preferred by each patient, to accomplish shared goals within and across settings to achieve coordinated, high-quality care.”¹⁷

For the purposes of this report, specific to state-based medical regulation in the United States, team-based care is defined as: “[T]he provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable.”¹⁸ It should be noted parenthetically that a wide range of terms are actually used to describe collaborative working arrangements between professionals.¹⁹ Descriptors such as interdisciplinary, interprofessional, and multidisciplinary are often used in the existing literature to refer to different types of teams.²⁰ The generic term for “team-based care” is used throughout this document to refer to health care provided by teams, and the term “interprofessional” is used when the members of such teams include a range of health service workers, both professionals and non-professionals, with the majority being from professional groups.²¹

A team-based care model usually consists of an interdisciplinary group of health care providers, typically organized around a lead provider, where all professionals on the team collaborate to deliver health care to patients. Members of the care team generally take collective responsibility for the care of the patient because their multidisciplinary skills are blended as care is administered. However, in order to coordinate all health professionals involved, efficient and deliberate delineation of responsibilities is an underlying requirement of a well-working health care team.²²

SECTION THREE. EXAMPLES OF STATE-BASED MODELS AND APPROACHES.

The following section identifies and summarizes several standards and procedures that have been implemented successfully to address regulatory issues associated with team-based care, allow for oversight of teams of interdisciplinary health professionals, and establish accountability of the health care team. These examples may provide options for consideration by state medical boards seeking to incorporate regulatory strategies to achieve greater cooperation and collaboration among health professional boards in the best interest of caring for the public.

Statutory Authority: State medical boards are charged by state legislatures to regulate the practice of medicine in order to fulfill their mission to protect the public, with statutory authorization codified in each state’s respective Medical Practice Act. State nursing, pharmacy, and physician assistant regulatory boards are similarly authorized by state statute. A number of state statutes authorize collaboration on regulatory matters among health professional licensing boards.

a. Joint Rulemaking or Authority

For example, in Massachusetts the statute authorizing the Board of Registration in Nursing states that “advanced practice nursing regulations which govern the ordering of tests, therapeutics and prescribing of medications shall be promulgated by the board [of Registration in Nursing] in conjunction with the Board of Registration in Medicine.”²³ The statute further requires that the boards meet, consult, and concur on the content of the advanced practice nursing regulations in order for the regulations to take effect.²⁴ Similarly, South Dakota’s Nurse Practice Act authorizes joint control and regulatory authority of nurse practitioners and nurse midwives to the South Dakota Board of Nursing and the Board of Medical and Osteopathic Examiners, specifying that the boards may jointly “license, supervise the practice, and revoke or suspend licenses or otherwise discipline any person applying for or practicing as a nurse practitioner or nurse midwife.”²⁵

b. Joint Committees

More commonly, state medical and/or nurse practice acts establish joint committees authorized to develop and recommend rules to be adopted by the state health professional licensing boards that oversee the particular licensees that are subject to the recommended rules.²⁶ This construct often arises in the regulation of advanced registered nurse practitioners and supervising physicians.²⁷ For example, the state legislature in Florida established a joint committee to determine minimum standards for the content of establish protocols pursuant to which an advanced registered nurse practitioner may perform medical acts and the minimum standards for supervision of such acts by the physician.²⁸ The Florida joint committee standards are required by statute to be adopted as rules by the Florida Board of Nursing and the Florida Board of Medicine for purposes of carrying out their responsibilities respectively.²⁹ The North Carolina Medical Practice Act requires the North Carolina Medical Board to appoint and maintain subcommittees to work jointly with a subcommittee of the Board of Nursing and the Board of Pharmacy to develop rules to govern the performance of medical acts by registered nurses and clinical pharmacist practitioners, respectively.³⁰ The rules developed by the joint committees must be adopted as rules by the Board of Medicine, Board of Nursing, and Board of Pharmacy in order to become effective.³¹

Two notable characteristics are typical of joint committee statutes. The first commonality is a statement of clarification regarding disciplinary authority. In the Florida statutes discussed above, the joint committee authorizing language states “neither board shall have disciplinary powers over the licensees of the other board.”³² In the North Carolina statute establishing a joint subcommittee of the North Carolina Medical Board to work with subcommittees of the Board of Nursing and Board of Pharmacy, the North Carolina Medical Board is delegated the responsibility for ensuring compliance with the rules promulgated by its subcommittee.³³ The second common characteristic in joint committee statutes is the deliberate effort by the legislature to ensure that the joint committee is comprised of representatives from each of the state health professional licensing boards that might adopt the joint committee’s regulations.³⁴

c. Interagency Advisory Committees

It is also common for boards to utilize interagency advisory committees or panels to encourage interdisciplinary collaboration. Advisory panels or committees review rule changes, policy developments, or legislation and/or make recommendations in areas affecting the represented licensees. However, these entities are advisory and the ultimate authority remains with the state health professional licensing board. Advisory entities are typically facilitated by a single health professional licensing board or are established as stand-alone entities. For example, advisory boards are established by statute in Virginia and advise the Virginia Board of Medicine on matters of licensure, discipline, and regulation.³⁵ Alternatively, in Minnesota, the Health Licensing Board Executive Directors Forum is an advisory group of state licensing board executive directors that makes recommendations on issues relating to the powers and duties under each participating board's respective practice act.

Interagency Cooperation: The primary responsibility and obligation of state health professional licensing boards is to protect consumers of health care by ensuring that all health care professionals in a state are properly licensed and comply with various laws and regulations pertaining to the practice of medicine. One of the most important roles of state health professional licensing boards is the responsibility for disciplining health professionals who engage in unprofessional, improper, or incompetent practice of their respected professions. However, as team-based care becomes more prevalent, it will become increasingly challenging for health licensing boards to effectively address complaints and implement appropriate disciplinary action when it involves interdisciplinary teams. Accordingly, the complaint intake, investigation, and disciplinary processes are areas ripe for opportunities to accommodate and encourage team-based regulatory models.

a. Coordinated Complaint Intake

It is the duty of state medical boards, acting in accordance with the respective state Medical Practice Act, to review and investigate complaints and adverse information about licensees.³⁶ It is longstanding FSMB policy that states should reduce barriers to cooperation and communication among health regulatory boards and that consideration should be given to implementing a system for joint review of complaints involving multiple practitioners and authorizing sharing of complaint information among regulatory boards.³⁷ As the delivery of health care evolves to accommodate the team-based care model, it is important that complaint intake and investigation processes evolve as well. Generally, the current complaint intake process does not reflect the team-based care model of health care delivery; it is the responsibility of the complainant to determine which regulatory board to file with, and which member of the health care team is ultimately responsible for a perceived or actual injury, mistreatment or mishap. In practice, the patient may not know which health professional is, in fact, responsible for the misconduct and may have difficulty as a result when attempting to file a complaint.

Two approaches are common among state medical boards when receiving complaints in circumstances involving the delivery of health care directly or indirectly by a physician. The first approach establishes the state medical board as the direct recipient of complaints: the state medical board reviews the complaint to determine whether the board has jurisdiction over the health professional at issue, and the state medical board refers the complaint to the appropriate health professional regulatory board when there are other actors implicated in the complaint who are not under the jurisdiction of the state medical board.

Alternatively, some state medical boards receive complaints from a central agency or office that is responsible for determining which board should investigate the complaint. For example, in Washington, D.C., complaints received by the District of Columbia Board of Medicine are first referred to the district's Complaints Review Unit (CRU). An initial review determines whether the Board of Medicine has jurisdiction over the health care professional who is the subject of the complaint and whether the conduct complained of may be a violation of law or regulation governing the practice of the health care profession. Complaints that pass the initial review are then forwarded to the licensed health care provider who is the subject of the complaint for a response. If the Board of Medicine does not have jurisdiction over a particular complaint, it is referred to the agency or department with jurisdiction or authority to address the complaint.³⁸

b. Shared Investigatory Data

In addressing complaints involving interdisciplinary health care teams, a number of state medical boards share investigatory data with other health regulatory boards. This practice may be codified by statute, as seen in Minnesota, where each health-related licensing board is required to establish procedures for exchanging information with other Minnesota state boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. The procedures must provide for the forwarding to other regulatory bodies of all information and evidence, including the results of investigations that are relevant to matters within that licensing body's regulatory jurisdiction. Each health-related licensing board has access to any of the offices of the Department of Human Services that relate to a person subject to the jurisdiction of the licensing board.³⁹ It should be noted that commitments by the state's health professional regulatory boards to share investigatory information may include statements authorizing the sharing of such information, even if the information is deemed confidential.⁴⁰

c. Joint Investigations

State medical boards are responsible for investigating complaints and/or reports received from patients, other state medical boards, health professionals, government agencies and health care organizations about physicians who may be incompetent or acting unprofessionally, and to take appropriate action against a physician's license if the person is found to have violated the law. A few state medical boards reported that they conduct joint investigations with other health professional regulatory boards.⁴¹ Joint investigations are seen as an effective mechanism

for regulatory coordination of health professional teams, even though they are often implemented through an informal process.ⁱ

d. Joint Meetings

Several states have found that joint meetings of state health regulatory boards are effective in addressing team-based care regulatory issues and to achieve better oversight of health professional teams. Participation in formal and informal meetings, where representatives from a number of health professional boards and public members may come together regularly to discuss pressing issues facing each board individually and as a group, have been cited as useful by many state medical boards. For example, the Oregon Board of Medicine meets monthly with sixteen (16) health regulatory boards. The Minnesota Board of Medical Practice meets periodically with other health licensing boards to discuss pending legislation and to share perspectives or current issues before the boards. These joint meetings have been seen as beneficial, especially in providing a venue for state health professional regulatory boards to discuss proposed rule changes and to ensure that potential new rules do not conflict with existing regulations of a separate health regulatory professional board.

Interdisciplinary Duty to Report: In April 2016, the FSMB adopted as policy *Position Statement on Duty to Report*⁴² which articulates that the reporting of misconduct, observed impairment, incapacity or incompetent performance by licensees to the state medical board is essential for medical boards to fulfill their mission to regulate the medical profession in the interests of patients. In order to provide state medical boards with all relevant information that allows them to operate effectively, many state medical boards require licensees and other entities to report evidence of misconduct by other licensees. The FSMB's *Essentials of a State Medical and Osteopathic Practice Act*⁴³ provides model language requiring such reporting, as does the National Council of State Boards of Nursing's *Model Act*⁴⁴ and the National Association of Boards of Pharmacy's *Model Act*.⁴⁵

SECTION FOUR. CONCLUSION AND STRATEGIES.

The purpose of this report has been to provide a resource outlining emerging model practices for state medical boards seeking to incorporate regulatory strategies to achieve increased cooperation and collaboration among health professional regulatory boards as they fulfill their mission to protect the public.

The Federation of State Medical Boards recommends:

1. State medical boards should be authorized and encouraged, within their jurisdictions and where appropriate, to:
 - a. Conduct joint investigations with other health professional licensing boards

ⁱ Note: The Interstate Medical Licensure Compact authorizing statute, which has been enacted by eighteen (18) member states at the date of publication, codifies that a member state medical board may participate with other member boards in joint investigations of physicians licensed by the member boards. *See* <http://licenseportability.org/wp-content/uploads/2016/01/Interstate-Medical-Licensure-Compact-FINAL.pdf>.

- b. Share investigatory data with other health professional licensing boards
 - c. Create or develop processes to facilitate communication and collaboration among professional licensing boards and their representatives
- 2. State medical boards should consider developing, implementing, evaluating, and monitoring a simple and sensible complaint intake processes, in collaboration with other health professional licensing boards and members of public and/or patient advocacy groups as appropriate and as statutes and rules permit, which are designed to be user-friendly and easy to use by patients who file complaints because they have been harmed and/or have been subjected to professional misconduct by one or more health care professionals in a team-based care setting.
- 3. States should monitor, evaluate, and study the outcomes of collaborative efforts among state health professional licensing boards.
- 4. State medical boards are encouraged to collaborate with other state health professional regulatory boards to implement one or more of the regulatory strategies or practices outlined in this report.
- 5. State medical boards are encouraged to support cross-discipline reporting and to urge licensees to report evidence of impairment and/or misconduct by other health professionals to their corresponding regulatory board.

Appendix 1. Model Regulatory Language

The [Name of Board] shall establish procedures for exchanging information with other [name of state] boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. The procedures must provide for:

1. Conducting joint investigations with other health professional licensing boards;
2. Sharing investigatory data with other health professional licensing boards; and
3. Creating or developing processes to facilitate communication and collaboration among professional licensing boards and their representatives.

ENDNOTES

- ¹ Ontario College of Social Workers and Social Service Workers. (2008). Health Professions Regulatory Advisory Council (HPRAC) Consultation on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals Discussion Guide Submission. Retrieved from: <http://ocswssw.org/wp-content/uploads/2015/01/HPRAC-Interprofessional-Collaboration-May-2008.pdf>
- ² Salsberg, E., & Grover, A. (2006). Physician Workforce Shortages: Implications and Issues for Academic Health Centers and Policymakers. *Academic Medicine*, 81(9), 782-787.
- ³ Agency for Healthcare Research and Quality. Practice Facilitation Handbook. Module 19. Implementing Care Teams. Retrieved June 3, 2016, from <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod19.html>
- ⁴ Institute of Medicine. Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes. Washington, DC: The National Academies Press, 2015.
- ⁵ Institute of Medicine. Improving Diagnosis in Health Care. Washington, DC: The National Academies Press, 2015.
- ⁶ American Medical Association. Real-world solutions to enhance practice effectiveness - STEPS Forward. (n.d.). Retrieved August 15, 2016, from <https://www.stepsforward.org/>; Report 6 of the Council on Medical Service (2014) *Development of Models/Guidelines for Medical Health Care Teams*; Report of the Council on Medical Education and the Council on Medical Service (2012) *The Structure and Function of Interprofessional Health Care Teams*.
- ⁷ Greenberg, R. (May-June 2016). Association of American Medical Colleges. *Teamwork: The Heart of Health Care* Retrieved from <https://www.aamc.org/newsroom/reporter/may-june2016/461994/teamwork.html>
- ⁸ Institute of Medicine. Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes.
- ⁹ Agency for Healthcare Research and Quality. Module 19. Implementing Care Teams.
- ¹⁰ Lumague, M., Morgan, A., Mak, D., Hanna, M., Kwong, J., Cameron, C., . . . Sinclair, L. (2006). Interprofessional education: The student perspective. *Journal of Interprofessional Care*, 20(3), 246-253.; Barker, K. K., & Oandasan, I. (2005). Interprofessional care review with medical residents: Lessons learned, tensions aired – A pilot study. *Journal of Interprofessional Care*, 19(3), 207-214.
- ¹¹ Hopkins, K., Sinsky, C.A., Team-based care: saving time and improving efficiency. *Family Practice Management*. 2014 Nov-Dec ;21(6):23-9.
- ¹² The American College of Obstetricians and Gynecologists. (2016). Collaboration in Practice: Implementing Team-Based Care. Retrieved from: <https://www.acog.org/-/media/ED931411E3C0430DB86F6FC579C84764.pdf>; West M.A., Borrill C., Dawson JF, Scully J., Carter M., Anelay S., Patterson M.G., Waring J. The link between the management of employees and patient mortality in acute hospitals. *International Journal of Human Resource Management*. 2002;13:1299–1310.; National Coalition on Health Care. Institute for Healthcare Improvement. (2002). Accelerating Change Today A.C.T. for America's Health. Robert Wood Johnson Foundation, 1–40. Retrieved from http://www.improvingchroniccare.org/downloads/act_report_may_2002_curing_the_system_copy1.pdf; Edmondson, A. (1999). Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly*, 44(2), 350.; Ferlie E.B., Shortell S.M. Improving the quality of health care in the United Kingdom and the United States: A framework for change. *The Milbank Quarterly*. 2001;79:281–315.; Berwick D.M. A user's manual for the IOM's 'Quality Chasm' report. *Health Affairs*. 2002;21:80.; Morey, J. C., Simon, R., Jay, G. D., Wears, R. L., Salisbury, M., Dukes, K. A., & Berns, S. D. (2002). Error Reduction and Performance Improvement in the Emergency Department through Formal Teamwork Training: Evaluation Results of the MedTeams Project. *Health Serv Res Health Services Research*, 37(6), 1553-1581.; Baker, J. P., Gustafson, S., Beaubien, J. (2005). Medical teamwork and patient safety: the evidence-based relation. Agency for Healthcare Research and Quality. Retrieved from <http://www.ahrq.gov/research/findings/final-reports/medteam/index.html>.
- ¹³ Baldwin, D.C. (2007). Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA. *Journal of Interprofessional Care*, 21(Sup1), 23-37; Burl, J. B., Bonner, A., Rao, M., & Khan, A.M. (1998). Geriatric Nurse Practitioners in Long-Term Care: Demonstration of Effectiveness in Managed Care. *Journal of the American Geriatrics Society*, 46(4), 506-510; Curley C., Mceachern, J. E., & Speroff, T. (1998). A Firm Trial of Interdisciplinary Rounds on the Inpatient Medical Wards. *Medical Care*, 36 (SUPPLEMENT); McDonough, R.P. and W.R. Doucette. 2001. Dynamics of pharmaceutical care: Developing collaborative working relationships between pharmacists and physicians. *Journal of American Pharmaceutical Association* 41 (5):682-92; Shortell, S. 1994. The performance of intensive care units. *Medical Care* 32(5):508-25;

-
- Wagner, E.H., R.E. Glasgow, C. Davis, A.E. Bonomi, L. Provost, D. McCulloch, P. Carver, and C. Sixta. 2001. Quality improvement in chronic illness care: A collaborative approach. *Joint Commission Journal on Quality Improvement* 27 (2):63-80.
- ¹⁴ Pinto, R. M., Wall, M., Yu, G., Penido, C., & Schmidt, C. (2012). Primary Care and Public Health Services Integration in Brazil's Unified Health System. *Am J Public Health American Journal of Public Health*, 102(11).
- ¹⁵ Amos, M. A., Hu, J., & Herrick, C. A. (2005). The Impact of Team Building on Communication and Job Satisfaction of Nursing Staff. *Journal for Nurses in Staff Development (JNSD)*, 21(1), 10-16.; Willard-Grace, R., Hessler, D., Rogers, E., Dube, K., Bodenheimer, T., & Grumbach, K. (2014). Team Structure and Culture Are Associated With Lower Burnout in Primary Care. *The Journal of the American Board of Family Medicine*, 27(2), 229-238.
- ¹⁶ Institute of Medicine. Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes.
- ¹⁷ Schottenfeld, L., Petersen, D., Peikes, D., Ricciardi R., Burak, H., McNellis, R., Genevro, J. (2016). Creating Patient-centered Team-based Primary Care. Agency for Healthcare Research and Quality. Retrieved from <https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#ref1>
- ¹⁸ Naylor M.D., Coburn K.D., Kurtzman E.T, et al. Team-Based Primary Care for Chronically Ill Adults: State of the Science. Advancing Team-Based Care. Philadelphia, PA: American Board of Internal Medicine Foundation, 2010; Mitchell P., Wynia M., Golden R., et al. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. ; Okun, S., Schoenbaum S., Andrews D., et al. 2014. Patients and health care teams forging effective partnerships. Discussion Paper. Washington, DC: Institute of Medicine.
- ¹⁹ Xyrichis A, Lowton K: What fosters or prevents interprofessional teamworking in primary or community care? A literature review. *J Nurs Stud* 2008, 45:140-143.
- ²⁰ Leathard, A. (2003). *Interprofessional collaboration: From policy to practice in health and social care*. Hove: Brunner-Routledge.
- ²¹ Institute of Medicine. Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes.
- ²² Agency for Healthcare Research and Quality. Module 19. Implementing Care Teams.
- ²³ M.G.L.A. 112 § 80.
- ²⁴ M.G.L.A. 112 § 80.
- ²⁵ SDCL § 36-9A-5.
- ²⁶ See e.g. Ala. Code 1975 § 34-21-85; Fla. Stat. § 464.003; Fla. Stat. § 458.348; N.C.G.S.A. § 90-8.2; 18 VAC 90-30-30; W. Va. Code § 30715e.
- ²⁷ See e.g. 18 VAC 90-30-30; W. Va. Code § 30715e.
- ²⁸ Fla. Stat. § 458.348; see also Ala. Code 1975 § 34-21-85; 18 VAC 90-30-30; W. Va. Code § 30715e.
- ²⁹ Fla. Stat. § 458.348.
- ³⁰ See N.C.G.A. § 90-8.2.
- ³¹ See N.C.G.A. § 90-8.2.
- ³² See Fla. Stat. § 458.348(2).
- ³³ See N.C.G.A. § 90-8.2.
- ³⁴ See e.g. Fla. Stat. § 464.003; 18 VAC 90-30-30; W. Va. Code § 30715e.
- ³⁵ See e.g. Va. Code Ann. § 54.1-2956.
- ³⁶ Federation of State Medical Boards. (2015). Elements of a State Medical and Osteopathic Board. Retrieved from http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_Elements_Modern_Medical_Board.pdf.
- ³⁷ Federation of State Medical Boards. (2005). Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety. Retrieved from http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/2005_grpol_scope_of_practice.pdf.
- ³⁸ District of Columbia Board of Medicine. (n.d.). Retrieved August 15, 2016, from http://doh.dc.gov/sites/default/files/dc/sites/ddoe/publication/attachments/Medicine_Complaint_Review_and_Investigations_Process.pdf.
- ³⁹ M.S.A. § 214.10.
- ⁴⁰ See e.g. N.C.G.S.A. § 90-16; Tex. Occ. Code Ann. § 301.466.
- ⁴¹ 2015 Federation of State Medical Boards Member Board Survey
- ⁴² Federation of State Medical Boards. (2016). Position Statement on Duty to Report. Retrieved from https://www.fsmb.org/Media/Default/PDF/BRD_RPT_16-1_Ethics_Duty_to_Report.pdf

⁴³ Federation of State Medical Boards. (2015). Essentials of a State Medical and Osteopathic Practice Act. Retrieved from http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_essentials.pdf

⁴⁴ National Council of State Boards of Nursing. (2012). NCSBN Model Act. Retrieved from https://www.ncsbn.org/14_Model_Act_0914.pdf

⁴⁵ National Association of Boards of Pharmacy (2016.) Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy. Retrieved from: <https://nabp.pharmacy/publications-reports/resource-documents/model-pharmacy-act-rules/>

REFERENCES

- Agency for Healthcare Research and Quality. Patient Centered Medical Home Resource Center. Defining the PCMH. Retrieved June 3, 2016, from http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/PCMH_Defining%20the%20PCMH_v2.
- Agency for Healthcare Research and Quality. Practice Facilitation Handbook. Module 19. Implementing Care Teams. Retrieved June 3, 2016, from <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod19.html>.
- American Medical Association. Report of the Council on Medical Education and the Council on Medical Service (2012) *The Structure and Function of Interprofessional Health Care Teams*.
- American Medical Association. Real-world solutions to enhance practice effectiveness - STEPS Forward. (n.d.). Retrieved August 15, 2016, from <https://www.stepsforward.org/>.
- American Medical Association. Report 6 of the Council on Medical Service (2014) *Development of Models/Guidelines for Medical Health Care Teams*.
- Amos, M. A., Hu, J., & Herrick, C. A. (2005). The Impact of Team Building on Communication and Job Satisfaction of Nursing Staff. *Journal for Nurses in Staff Development (JNSD)*, 21(1), 10-16.
- Baker, J. P., Gustafson, S., Beaubien, J. (2005). Medical teamwork and patient safety: the evidence-based relation. Agency for Healthcare Research and Quality. Retrieved from <http://www.ahrq.gov/research/findings/final-reports/medteam/index.html>.
- Baldwin, D. C. (2007). Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA. *Journal of Interprofessional Care*, 21(Sup1), 23-37
- Barker, K. K., & Oandasan, I. (2005). Interprofessional care review with medical residents: Lessons learned, tensions aired – A pilot study. *Journal of Interprofessional Care*, 19(3), 207-214.
- Bendix, J. (2013, September 10). Building a team-based medical practice. Modern Economics. Retrieved from <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/accountable-care-organization/building-team-based-medical-practice>.
- Berwick D.M. A user's manual for the IOM's 'Quality Chasm' report. *Health Affairs*. 2002;21:80.
- Bodenheimer T. Building Teams in Primary Care: Lessons from 15 case Studies. Oakland: California HealthCare Foundation; July 2007.
- Bodenheimer T. The future of primary care: transforming practice. *New England Journal of Medicine*. 2008;359(20):2086-9.

Bovbjerg, R., Aliagathe, P., Gittler, J. (2015). State Discipline of Physicians: Assessing State Medical Boards through Case Studies. Retrieved from <https://aspe.hhs.gov/basic-report/state-discipline-physicians-assessing-state-medical-boards-through-case-studies>.

Burl, J. B., Bonner, A., Rao, M., & Khan, A. M. (1998). Geriatric Nurse Practitioners in Long-Term Care: Demonstration of Effectiveness in Managed Care. *Journal of the American Geriatrics Society*, 46(4), 506-510.

Cohen S.G., Bailey D.E. What makes teams work: Effectiveness research from the shop floor to the executive suite. *J Manage* 1997;23:239-290.

Coleman K, Reid R. Safety Net Medical Home Initiative. Continuous and team-based healing relationships: improving patient care through teams. Implementation guide. 1st ed. Burton T, ed. Seattle, WA: MacColl Center for Health Care Innovation at the Group Health Institute and Qualis Health; December 2010.

Curley, C., Mceachern, J. E., & Speroff, T. (1998). A Firm Trial of Interdisciplinary Rounds on the Inpatient Medical Wards. *Medical Care*, 36(SUPPLEMENT).

Disability Rights Washington. (n.d.). Retrieved August 15, 2016, from <http://www.disabilityrightswa.org/how-file-complaint-against-health-care-provider-or-facility>.

District of Columbia Board of Medicine. (n.d.). Retrieved August 15, 2016, from http://doh.dc.gov/sites/default/files/dc/sites/ddoe/publication/attachments/Medicine_Complaint_Review_and_Investigations_Process.pdf.

Edmondson, A. (1999). Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly*, 44(2), 350.

Federation of State Medical Boards. (2005). Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety. Retrieved from http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/2005_grpol_scope_of_practice.pdf.

Federation of State Medical Boards. (2015). Elements of a State Medical and Osteopathic Board. Retrieved from http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_Elements_Modern_Medical_Board.pdf.

Federation of State Medical Boards. (2012). Tri-Regulator Symposium Features Former HHS Secretary Donna Shalala, HRSA Administrator Mary Wakefield. [Press Release]. Retrieved from <https://www.fsmb.org/Media/Default/PDF/Publications/tri-regulator-symposium-media-advisory6.pdf>.

Ferlie E.B., Shortell S.M. Improving the quality of health care in the United Kingdom and the United States: A framework for change. *The Milbank Quarterly*. 2001;79:281-315.

Greenberg, R. (May-June 2016). Association of American Medical Colleges. *Teamwork: The Heart of Health Care* Retrieved from <https://www.aamc.org/newsroom/reporter/may-june2016/461994/teamwork.html>.

Hopkins, K., Sinsky, C.A., Team-based care: saving time and improving efficiency. *Family Practice Management*. 2014 Nov-Dec ;21(6):23-9.

Institute of Medicine. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press, 2015.

Institute of Medicine. *Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes*. Washington, DC: The National Academies Press, 2015.

Interprofessional Education Collaborative. (2011). *Core Competencies for Interprofessional Collaborative Practice*. Retrieved from <https://ipecollaborative.org/uploads/IPEC-Core-Competencies.pdf>.

Katzenbach, J. R., & Smith, D. K. (1993). *The wisdom of teams: Creating the high-performance organization*. Boston, MA: Harvard Business School Press.

Leathard, A. (2003). *Interprofessional collaboration: From policy to practice in health and social care*. Hove: Brunner-Routledge.

Lessons from the Field: Promising Interprofessional Collaboration Practices. 2015. White Paper, The Robert Wood Johnson Foundation. Retrieved from <http://www.rwjf.org/content/dam/farm/reports/reports/2015/rwjf418568>.

Loudin B, Gainer L, Mayor M, et al. *Elevating the Role of the Medical/Clinical Assistant: Maximizing Team-Based Care in the Patient-Centered Medical Home*. Seattle, WA: The Commonwealth Fund, Qualis Health and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute; August 2011.

Lumague, M., Morgan, A., Mak, D., Hanna, M., Kwong, J., Cameron, C., . . . Sinclair, L. (2006). Interprofessional education: The student perspective. *Journal of Interprofessional Care*, 20(3), 246-253.

Martinez, R., Brekken, S.A, Wiberg, S. "The Minnesota Tri-Regulator Collaboration." *Minnesota Physician*. April 2016. Retrieved from https://issuu.com/mppub/docs/mn_physician_apr_2016.

McDonough, R.P. and W.R. Doucette. 2001. Dynamics of pharmaceutical care: Developing collaborative working relationships between pharmacists and physicians. *Journal of American Pharmaceutical Association* 41 (5):682-92.

McGlynn, E. A., Asch, S. M., Adams, J., Keesey, J., Hicks, J., Decristofaro, A., & Kerr, E. A. (2003). The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine* 348(26), 2635-2645.

Michigan Department of Licensing and Registration. (n.d.). Retrieved August 15, 2016, from http://www.michigan.gov/lara/0,4601,7-154-63294_27723_27777_72411---,00.html.

Mitchell P., Wynia M., Golden R., et al. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC.

Morey, J. C., Simon, R., Jay, G. D., Wears, R. L., Salisbury, M., Dukes, K. A., & Berns, S. D. (2002). Error Reduction and Performance Improvement in the Emergency Department through Formal Teamwork Training: Evaluation Results of the MedTeams Project. *Health Serv Res Health Services Research*, 37(6), 1553-1581.

National Coalition on Health Care. Institute for Healthcare Improvement. (2002). Accelerating Change Today A.C.T. for America's Health. Robert Wood Johnson Foundation, 1–40. Retrieved from http://www.improvingchroniccare.org/downloads/act_report_may_2002_curing_the_system_copy1.pdf.

Naylor M.D., Coburn K.D., Kurtzman E.T., et al. Team-Based Primary Care for Chronically Ill Adults: State of the Science. Advancing Team-Based Care. Philadelphia, PA: American Board of Internal Medicine Foundation; 2010.

Nebraska Department of Health and Human Services. (n.d.). Retrieved August 15, 2016, from http://dhhs.ne.gov/Pages/reg_invest-p.aspx#Overview.

Okun, S., Schoenbaum S., Andrews D., et al. 2014. Patients and health care teams forging effective partnerships. Discussion Paper. Washington, DC: Institute of Medicine.

Østbye T, Yarnall KS, Krause K.M., et al. Is There Time for Management of Patients With Chronic Diseases in Primary Care? *The Annals of Family Medicine*, 3(3), 209-214.

Pinto, R. M., Wall, M., Yu, G., Penido, C., & Schmidt, C. (2012). Primary Care and Public Health Services Integration in Brazil's Unified Health System. *Am J Public Health American Journal of Public Health*, 102(11).

Pollak, K. I., Krause, K. M., et al. (2008). Estimated time spent on preventive services by primary care physicians. *BMC Health Services Research*, 8(1), 245.

Ritchie, C., Andersen, R., Eng, J., Garrigues, S. K., Intinarelli, G., Kao, H., et al. (2016). Implementation of an Interdisciplinary, Team-Based Complex Care Support Health Care Model at an Academic Medical Center: Impact on Health Care Utilization and Quality of Life. *PLoS ONE*, 11(2).

Safford, B., Manning, C.A. Six Characteristics of Effective Practice Teams. *Family Practice Management*. 2012 May-June;19(3):26-30.

Salsberg, E., & Grover, A. (2006). Physician Workforce Shortages: Implications and Issues for Academic Health Centers and Policymakers. *Academic Medicine*, 81(9), 782-787.

Schottenfeld, L., Petersen, D., Peikes, D., Ricciardi R., Burak, H., McNellis, R., Genevro, J. (2016). Creating Patient-centered Team-based Primary Care. Agency for Healthcare Research and Quality. Retrieved from <https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#ref1>.

Shojania, K. G., Ranji, S. R., et al. (2006). Effects of Quality Improvement Strategies for Type 2 Diabetes on Glycemic Control. *JAMA*, 296(4), 427--40.

Shortell, S. 1994. The performance of intensive care units. *Medical Care* 32(5):508-25.

Wagner, E.H., R.E. Glasgow, C. Davis, A.E. Bonomi, L. Provost, D. McCulloch, P. Carver, and C. Sixta. 2001. Quality improvement in chronic illness care: A collaborative approach. *Joint Commission Journal on Quality Improvement* 27 (2):63-80.

Washington State Department of Health. (n.d.). Retrieved August 15, 2016, from <http://www.doh.wa.gov/LicensesPermitsandCertificates/FileComplaintAboutProviderorFacility/HealthProfessionsComplaintProcess#13>.

West M.A., Borrill C., Dawson JF, Scully J., Carter M., Anelay S., Patterson M.G., Waring J. The link between the management of employees and patient mortality in acute hospitals. *International Journal of Human Resource Management*. 2002;13:1299–1310.

Willard-Grace, R., Hessler, D., Rogers, E., Dube, K., Bodenheimer, T., & Grumbach, K. (2014). Team Structure and Culture Are Associated With Lower Burnout in Primary Care. *The Journal of the American Board of Family Medicine*, 27(2), 229-238.

Xyrichis A, Lowton K: What fosters or prevents interprofessional teamworking in primary or community care? A literature review. *J Nurs Stud* 2008, 45:140-143.

Yarnall K.S.H, Pollak K.I., Østbye T, Krause K.M, Michener JL. Primary Care: Is There Enough Time for Prevention? *American Journal of Public Health*. 2003;93(4):635-641.

FSMB WORKGROUP ON TEAM-BASED REGULATION

Ralph C. Loomis, MD, Chair
FSMB Treasurer, North Carolina Medical
Board

Claudette E. Dalton, MD
FSMB Board, Virginia Board of Medicine

Kathleen Haley, JD
Oregon Medical Board

Lyle R. Kelsey, MBA
Oklahoma Board of Medical Licensure and
Supervision

Susan Ksiazek, RPh
National Association of Boards of Pharmacy

Louis J. Prues, DMin, MBA
Michigan Board of Medicine

Jean L. Rexford
FSMB Board, Connecticut Medical
Examining Board

Cheryl L. Walker-McGill, MD
FSMB Board, North Carolina Medical Board

Katherine A. Thomas, MN, RN, FAAN
Texas Board of Nursing

Ex Officio

Arthur S. Hengerer, MD, FACS
FSMB Chair

Gregory B. Snyder, MD, DABR
FSMB Chair-elect

Humayun Chaudhry, DO, MACP
FSMB President and CEO

FSMB Support Staff

Lisa A. Robin, MLA
Chief Advocacy Officer

Shiri Ahronovich Hickman, JD
Director, State Policy and Legal Services

Natalie Weiner, MPP
Legislative Associate