ConnAPA Scope of Practice Review Request[1]

Date: August 15, 2022
Submitted to: The State of Connecticut Department of Public Health
By: The Connecticut Academy of Physician Assistants Legislative Committee

[1]Pursuant to CGA Chapter 368a, Sec. 19a-16d: (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, may submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly. https://www.cga.ct.gov/current/pub/chap_368a.htm#sec_19a-16d

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On behalf of more than 4000 licensed Physician Assistants (PAs) in the State of Connecticut, the Connecticut Academy of PAs (ConnAPA) seeks to modernize the PA Practice Act, CGA Chapter 370 Sec. 20-12a - 20-12i, to improve patient access to care and to promote flexible and efficient care delivery for the residents of the State of Connecticut.

When implemented, there will not be procedures or methods of providing care added to the PA profession. Even though the profession's scope of practice will not be expanded, updating the statutes is needed to accurately reflect how PAs are currently integrated into the healthcare system. Modernization is required to eliminate confusion and inconsistencies in care that these statutory discrepancies cause, and to remove unnecessary administrative tasks from our overburdened healthcare system.

ConnAPA maintains that these requests are not a change in the scope of PA practice. However, ConnAPA supports the scope of practice review process, and so offers this submission accordingly. ConnAPA was fortunate to have one of the first proposals vetted in 2011, with another session convened in 2018.

The COVID-19 pandemic has highlighted opportunities for innovation, teamwork, and new partnerships in healthcare and has exemplified the importance of decreased burden to practice to ensure patient access to resources. With a new public health crisis now amid the nation and region (monkeypox virus); and increasing concern for a polio outbreak in nearby New York[2] being larger than initially thought,[3] it is now imperative to codify language that improves access to care.

I. <u>A plain language description of the request</u>:

a. ConnAPA seeks to modernize Connecticut's PA practice act using language that most accurately reflects the current state of health care,~~;~~ with PAs functioning in adaptive, collaborative relationships within the healthcare team by removing references to supervision within statute. In addition, modernization will occur by removing overly prescriptive, PA-specific administrative burdens allowing PAs to practice to the fullest extent of their education, training, and experience.

b. ConnAPA seeks to consistently include PAs by professional title in all relevant past, present and future statutes where physicians and APRNs are included.

Background: PAs are Integral Members of the Healthcare Workforce

Increased access to health insurance since the Affordable Care Act of 2010, population growth and patient aging have created an exponential increase in demand for healthcare services that cannot be met by the current healthcare workforce. According to a study released by the Association of American Medical Colleges (AAMC), the United States has a projected physician shortage between 37,800 and 124,000 by 2034. While their data was collected prior to the COVID-19 pandemic, they note that "the pandemic has highlighted many of the deepest disparities…and access to health care…contributed to a rising physical and emotional toll…on healthcare workers, and exposed vulnerabilities in the healthcare system. [4] Meanwhile, the Bureau of Labor and Statistics (BLS) predicts a 31% growth in employment for PAs through 2030, which is said to be "Much faster than average."[5] Improving access to medical care provided by PAs can help meet growing patient demand in the face of a physician shortage.

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[2]New York State Department of Health. (2022, July 21). New York State Department of Health and Rockland County Department of Health Alert the Public to A Case of Polio In the County. Retrieved August 13, 2022, from https://health.ny.gov/press/releases/2022/2022-07-21_polio_rockland_county.htm

[3]Shanahan, E. (2022, August 5). *New York May Face 'Tip of the Iceberg' With Polio, Health Chief Says*. The New York Times. Retrieved August 13, 2022, from https://www.nytimes.com/2022/08/04/nyregion/polio-wastewater-cases-nyc.html

[4]IHS Markit Ltd. (2021, June). PDF. *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*. Washington, D.C.; Association of American Medical Colleges. https://www.aamc.org/media/54681/download?attachment

[5]U.S. Bureau of Labor Statistics. (2022, April 18). *Physician assistants : Occupational Outlook Handbook*. Occupational Outlook Handbook: Physician Assistants. Retrieved August 13, 2022, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm

Connecticut is experiencing many of the same challenges reflected in the national data. The SustiNet Healthcare Workforce Task Force report,[6] published in 2010, showed that Connecticut was already facing a shortage of many health care workforce categories, including physicians and PAs. According to the Robert Graham Center projections published in 2013, pressures from a growing, aging, increasingly insured population were again cited as contributing to workforce shortages. All states have an obligation to protect their residents by regulating the practice of medicine within the state. By licensing the PA profession through state law and designating a state agency to regulate PA practice, states both protect the public and define the role of PAs.

As the delivery of healthcare has evolved, state legislators have modified their approach to PA regulation in response to a growing body of information demonstrating the safety and high quality of PA practice[7] and the need to better utilize their healthcare workforce. The Connecticut Health Care Workforce Scan showed that 27% of physicians and surgeons are aged 60 or older, with impending retirement contributing to the impending physician shortage in the state.[8] In 2011, the Connecticut Department of Health's report on Health Care for Connecticut's Underserved Populations identified 104 designated Health Profession Shortage Areas. [9] The Robert Graham Center Report notes that Connecticut per capita has 72 PCPs per 100,000 people, compared to 98 per 100,000 throughout New England and 76 per 100,000 nationwide,[10] and called on Connecticut policymakers to consider strategies to bolster the primary care pipeline to address current and growing demand for PCPs to adequately meet health care needs. (See Figure 1.) [11]

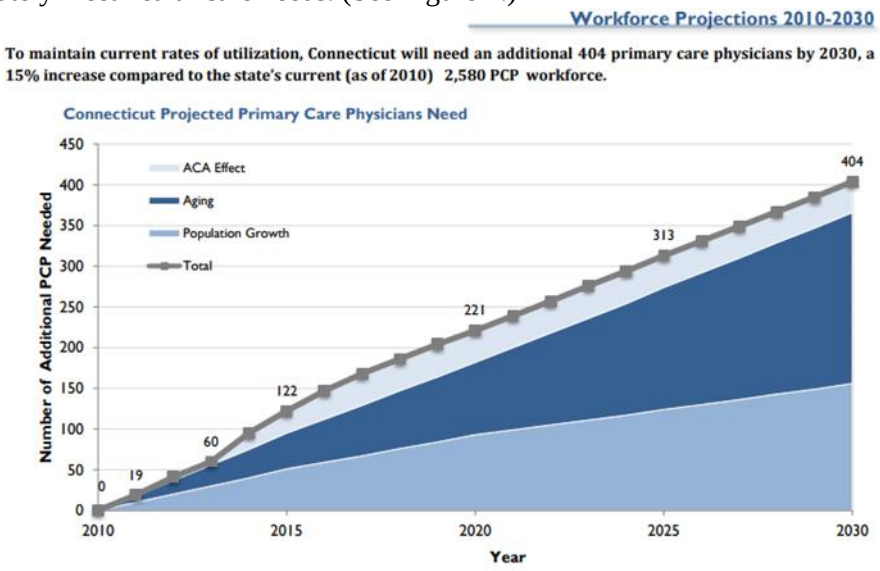

FIGURE 1

[6]SustiNet Healthcare Workforce Task Force (2010). Final Report, http://www.ct.gov/sustinet/lib/sustinet/taskforces/healthcareworkforce/sustinet_wkfrce_report_dh_ema_final_with_cover.pdf. Accessed July 30, 2017.

[7] Articles and Reports on the PA Profession: Selected Topics, American Academy of PAs, April 2018. https://www.aapa.org/wp-content/uploads/2017/11/Bibliography-on-the-PA-Profession-11_17_17.pdf. Accessed June 22, 2018.

[8]University of Connecticut Center for Public Health and Health Policy (2013). *Connecticut Healthcare Workforce S*can. http://www.healthreform.ct.gov/ohri/lib/ohri/sim/work_force/ct_healthcare_workforce_scan.pdf. Accessed July 30, 2017.

[9]Connecticut Department of Public Health (2011). *Healthcare for Connecticut's Underserved Populations.* http://www.ct.gov/dph/lib/dph/hisr/pdf/medically_underserved_issuebrief2011.pdf, Accessed July 30, 2017.

[10]Robert Graham Center. (2018, December). The state of Primary Care Workforce: Connecticut. Retrieved August 13, 2022, from https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/phys-workforce/Connecticut.pdf

[11] Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C. http://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Connecticut.pdf. Accessed June 21, 2018.

According to the National Commission on Certification of Physician Assistants (NCCPA), only 14.4% of the certified PAs in the state of Connecticut practice in Primary Care. That figure has decreased by 1.5% between 2017 and 2021, even as the number of licensed PAs in Connecticut increased by 34.2% in the same timeframe. The nationwide percentage of PAs in primary care is 23.7%.[12] By modernizing the PA Practice Act, Connecticut policymakers can reduce practice barriers for the deployment of PAs into the healthcare workforce and facilitate integration into more practices and settings in desperate need of medical practitioners, such as primary care.

II. <u>Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of and harm to public health and safety should the request not be implemented:</u>

ConnAPA seeks to modernize Connecticut's PA practice act using language that most accurately reflects the current state of health care with PAs functioning in adaptive collaborative relationships within the health care team. The concept of supervision was appropriate for the profession when it began as an untested concept 57 years ago, but the profession and healthcare have evolved. The use of this term is confusing, outdated, and inaccurate causing misinterpretation of statutory language, causing less than optimal use of the PA workforce by Connecticut health care facilities, and, ultimately, decreased access to care by Connecticut residents.

> **From the AAPA (The American Academy of Physician Associates):**
> *"Fifty years ago, when the PA profession began, typically, a PA practiced with a single physician, small medical group or in a hospital. Because the new profession had no track record to assure regulators of their excellent training or quality, practice laws were written with built-in precautions, such as designated physician supervisors and no prescriptive authority. Over time, countless studies documented the high quality medical care and expanded access PAs provide. As evidence of high quality care and patient safety became clear, legislators realized PA supervision laws were overly restrictive. So they began updating the laws, allowing PAs and physicians to practice in separate locations, authorizing PAs to prescribe, eliminating limits on PAs-to-physician practice ratios, and allowing individual teams to define their practices. Studies confirmed that quality remained high. Malpractice claims since 1990 reveal a remarkably low number of claims paid against PAs."*[13]

The word "supervise" no longer accurately depicts the professional relationship between PAs and physicians and diminishes the role PAs currently hold in the healthcare workforce. The antiquated terminology has led to variable interpretations of statute, creating a real or perceived barrier to utilization of PAs, with a bias toward NPs in a variety of settings. This was recognized in the 2019 Connecticut General Assembly when the relationship between physicians and PAs was redefined as collaborative, instead of the outdated dependent, supervisory model.[14] This is also the basis for the profession's title change to "Physician Associate" as it is in the best interest of patients and the healthcare system for PAs to hold a professional title that ensures clarity about the work of PAs.

Some higher functioning healthcare organizations in Connecticut currently employing PAs have already adopted the team-based care language and "collaboration" when referring to PAs in their public relations materials and websites. (See Figures 2-8) However, outdated language to supervision persists throughout relevant statutory language.[14] Therefore, adopting the language of "collaboration" in statute would provide

[12] Statistical Profile of Certified PAs: 2021 Annual Report. National Commission on Certification of Physician Assistants 2021. https://www.nccpa.net/wp-content/uploads/2022/08/2021StatProfileofCertifiedPAs-A-3.2.pdf. Accessed August 11, 2022.

[13] *"Collaboration" best describes PA practice,* American Academy of PAs, November 2016, https://www.aapa.org/wp-content/uploads/2017/02/COLLABORATION_Describes-PA-practice_11-2-16.pdf. Accessed July 30, 2017.

[14] Connecticut General Assembly. (2019, July). Public Act No. 19-144: AN ACT CONCERNING A COLLABORATIVE RELATIONSHIP BETWEEN PHYSICIAN ASSISTANTS AND PHYSICIANS. Retrieved August 13, 2022, from https://www.cga.ct.gov/2019/ACT/pa/pdf/2019PA-00144-R00HB-06942-PA.pdf

clarity to the professional relationship between physicians and PAs, which is already evolving in team-based practice.

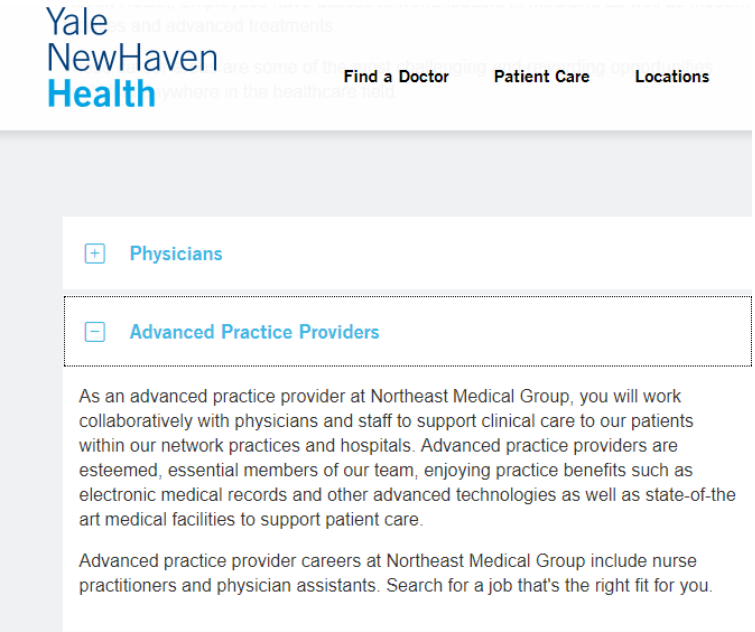

FIGURE 2 [15]

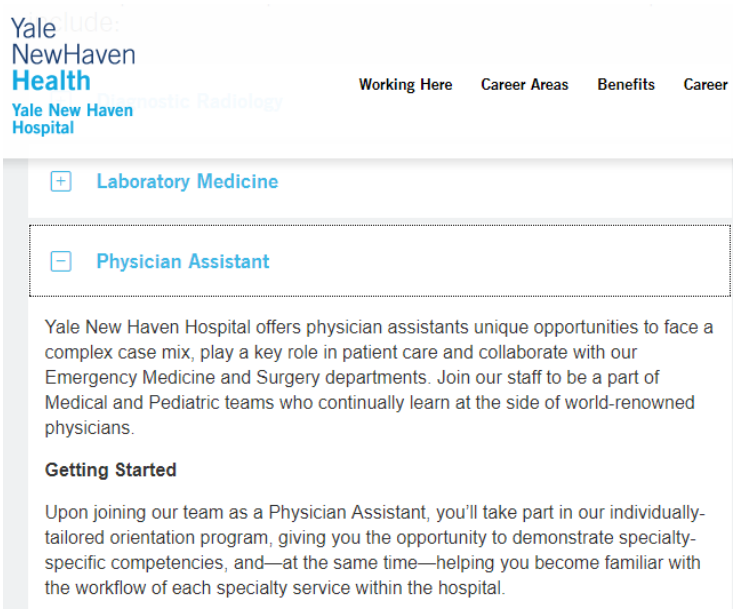

FIGURE 3 [16]

[15] https://www.ynhhs.org/careers/nemg/career-areas.aspx, accessed July 30, 2017.

[16] https://www.ynhh.org/careers/career-areas/other-clinical-professionals.aspx, accessed July 30, 2017.

FIGURE 4 [17]

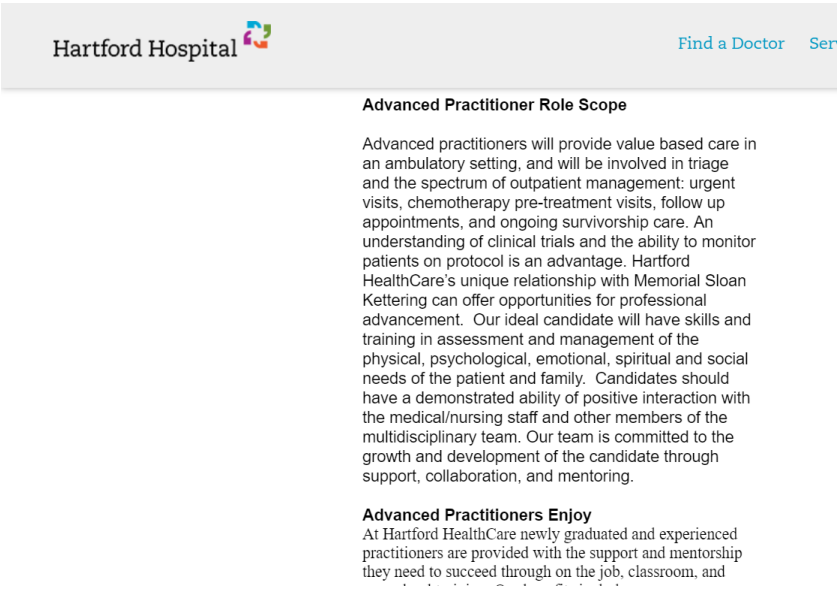

FIGURE 5[18]

[17] https://www.stvincents.org/health-professionals/multispecialty-group/for-med-professionals, Accessed July 30, 2017.

[18] https://hartfordhospital.org/health-professionals/for-job-seekers/career-opportunities/external-job-postings. Accessed June 22, 2018.

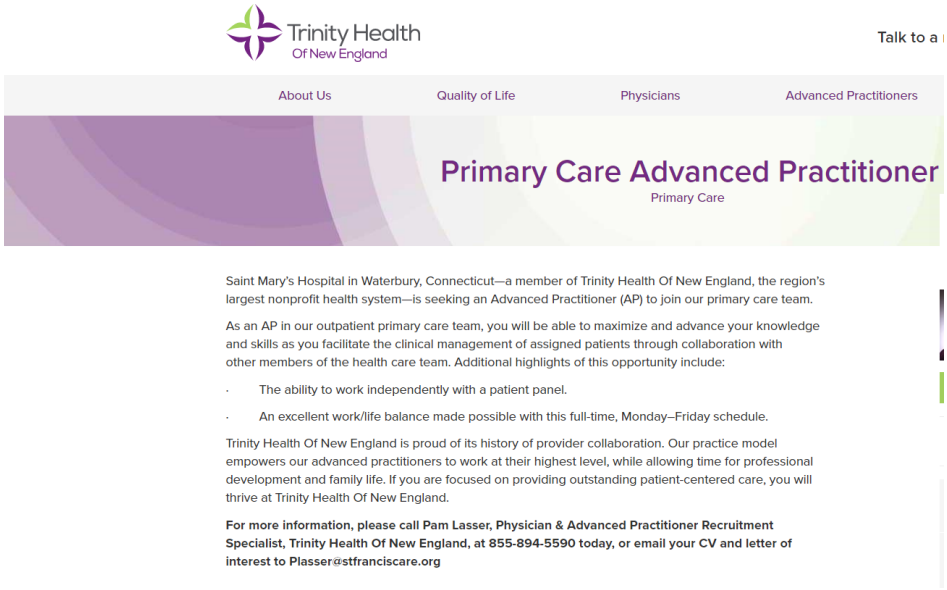

FIGURE 6[19]

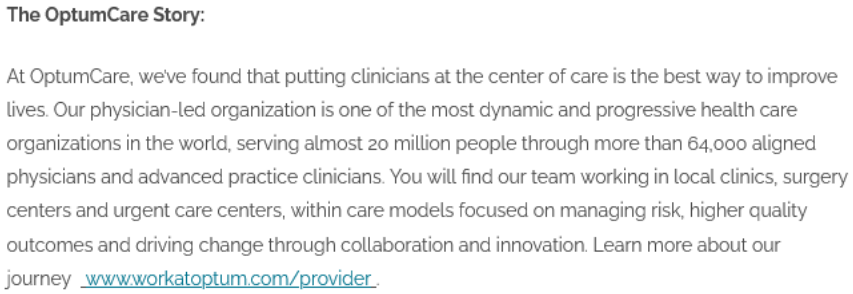

FIGURE 7[20]

[19] https://www.jointrinityne.org/Opportunities/Opportunity/primary-care-nurse-practitioner-physician-assistant-np-pa-smh. Accessed June 22, 2018.

[20] https://www.healthecareers.com/job/primary-care-physician-optum-prohealth-physicians-torrington-ct/2199136. Accessed August 11, 2022.

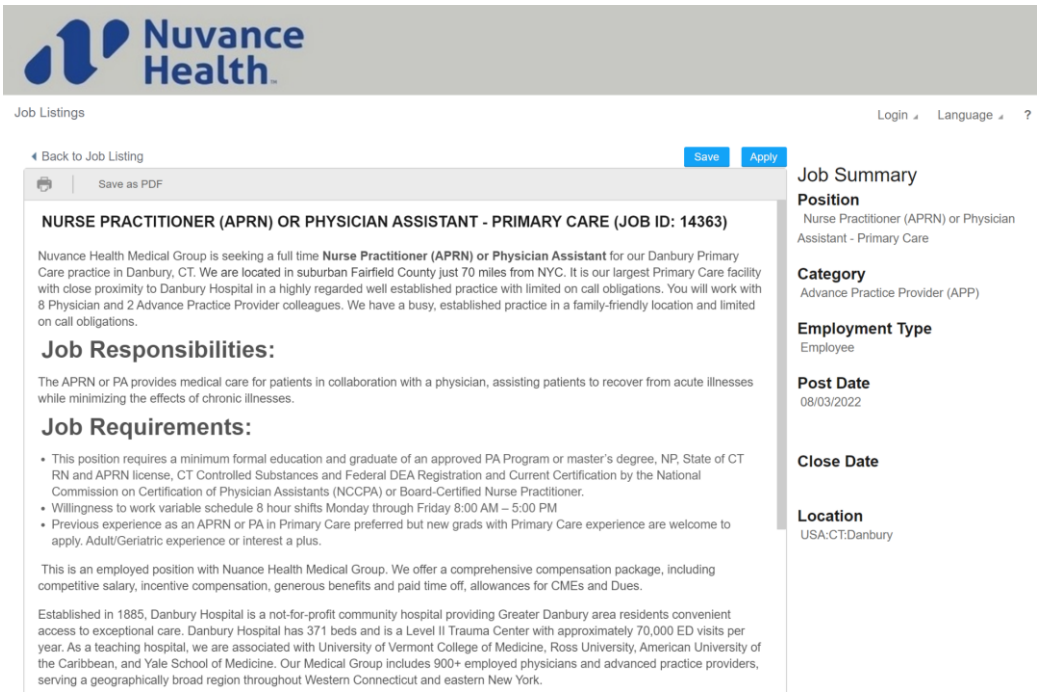

FIGURE 8[21]

The consequences of not adopting the adaptive collaboration requirements would be a lost opportunity for a universal understanding of the role PAs play on the health care team, perhaps limiting deployment into underserved areas where there is a higher percentage per capita of marginalized populations, or innovative care delivery due to the perception that PA "supervision" is onerous and a burden to the employer.

The limitations of deployment have already been evidenced throughout the COVID-19 pandemic. PAs are trained in general medicine and have the ability to practice and work in all areas of medicine, which allows for flexibility during times of need. As healthcare shifted to address the emerging crisis, it left many PAs in situations that were difficult to adapt to initially, leaving them unable to pivot effectively to address the crisis. This was seen not only in hospital environments, with PAs unable to move across specialties, but even in outpatient settings where there was confusion on the ability for PAs to do simple tasks such as vaccinate our citizens once the vaccine was released. While Governor Lamont did enact Executive Order language to help reduce some of the administrative supervisory burden, it did not go nearly as far as a number of other states which completely lifted the need for formal supervision of PAs. At the time of this submission, the State of New York remains in a situation where on a monthly basis the Governor is renewing an executive order that maintains supervision free practice for PAs.[22]

Currently Connecticut statutes require a delegation agreement between a PA and a physician. These agreements are often standardized documents from the employer, spelling out the language in statute, and are then sent to PAs and physicians to sign and return, depending on the service, these agreements can total in the dozens for a single PA. Such documents create administrative burden upon physicians, PAs, medical staff offices and practice administrators; but effectively do not improve patient care. These agreements do not align with current PA practice. New York, Rhode Island, Maine, Minnesota, North Dakota, West Virginia, Wyoming, Utah, and other states, do not require a written agreement, or have provisions to remove a written agreement after a specified period of practice**.**

[21] https://wchnprod-lm01.cloud.infor.com:1444/lmghr/CandidateSelfService/controller.servlet?dataarea=lmghr&context.session.key.HROrganization=1&context.session.key.JobBoard=EXTERNAL&context.session.key.noheader=true#. Accessed August 13, 2022.

[22] Hochul, K. (2021, September 27). No. 4: Declaring a statewide disaster emergency due to healthcare staffing shortages in the state of New York. Retrieved August 13, 2022, from https://www.governor.ny.gov/executive-order/no-4-declaring-statewide-disaster-emergency-due-healthcare-staffing-shortages-state

When practicing in collaboration with a physician, PAs are responsible for the care they provide. Legislation should not mandate physician liability for the acts of PAs. As fewer physicians own their medical practices, (with the latest figures from the AMA finding only 47.1% of physicians remaining practice owners as of 2016), and are subsequently becoming employed themselves, (with two thirds of physicians under 40 in employed positions), the model of PAs working as employees of the physician has become less common.[23, 24] As a result, employed physicians are reluctant to enter into supervisory agreements and accept liability for PAs, while the organization benefits financially from the increased business and revenue generated by the PAs. Numerous states continue to enact statutes and regulations that affirm PAs are responsible for the care they provide, and not physicians whom they collaborate with, simply by nature of an agreement.

The 2018 Scope of Practice review for the physician assistant profession, as organized by the Department of Public Health, led to discussion in the summer of 2019 among stakeholders to appropriately include PAs in dozens of statutes where PAs were not mentioned by professional title. The passage of which was delayed by the canceled 2020 legislative session, and eventually moved forward in 2021.[25] This was a step in the right direction, however dozens more statutes that were agreed upon by the group were not included in the subsequent bill that came from the Public Health Committee.

Beyond the non-inclusion of those statutes, new statutes continue to be put forward without mention of the PA profession. ConnAPA is then put into a position of having to speak with stakeholders, testify and advocate for inclusion into bills that should have included PAs initially. Leaving PAs out of such bills puts patients at a disadvantage. Such actions further delay patients from obtaining what they need. Adding PAs to a list of medical providers along with physicians and APRNs who can perform certain medical functions will increase efficiencies and access to care, while minimizing the administrative burden currently faced by physicians particularly with regards to signatures on medical, surgical, insurance and end of life forms.

Waiting for a physician signature can lead to delay of care and potentially patient harm. In a healthcare environment, where Connecticut is already lacking access to primary care that is on par with the rest of the Northeast, the non-inclusion of PAs in such statutes then forces patients to have to schedule additional appointments with physicians that are already hard to obtain. PAs are often finding difficulty with third-party acceptance of signatures on various forms, though in theory the current "delegation agreement" should allow for such certifications. This provides a barrier to care as mentioned above, and not correcting this issue will continue to lead to increased costs for scheduling new appointments with physicians and delayed services for the patient.

III. <u>The impact that the request will have on public access to health care:</u>

Thes requested changes would lead broadly to improved statutory and regulatory environments for PA practice and in turn increase access to care for CT residents by removing or clarifying current workplace-imposed barriers to PA practice. Current antiquated, exclusionary, or confusing language leads to practice restrictions that decrease Connecticut residents' access to care. Each of these problems with confusing language leads to variable interpretations of statute and widely variable restrictive institutional policy by health facilities or physician practices that triggers delays or denies access and, thus, increased costs.

As previously stated, the removal of "agency" and physician liability will open doors to increased collaboration with physicians and the organizations for which they provide services, adding to the available workforce and therefore access to care for all Connecticut residents, but especially marginalized populations.

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[23] Kane, Carol K. *"Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership*," AMA Economic and Health Policy Research, July 2015.

[24] Kane, Carol K. *"Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent,"* AMA Policy Research Perspectives, June 2017.

[25] Connecticut General Assembly. (2021, July 13). Public Act No. 21-196: AN ACT CONCERNING PHYSICIAN ASSISTANTS. Retrieved August 14, 2022, from https://www.cga.ct.gov/2021/act/Pa/pdf/2021PA-00196-R00SB-01070-PA.PDF

Reducing administrative burdens from an overtaxed healthcare system streamlines access to care, while mandated administrative busywork that has proven to be unnecessary only stresses the system without providing benefit to patient care.

Once PA inclusion in appropriate areas of statute is implemented, PAs will be able to provide ***more accessible, higher quality and more cost-effective care*** to patients and assure that their health care needs are served and protected. Along with our physician colleagues, PA practice authority and responsibility are exercised not only in primary care settings but also in many other settings including urgent care, emergency care, specialty care clinics from orthopedics to oncology, hospital-based medicine units, surgical centers, intensive care units, and specialty intensive care units.

PAs should be included in all statutes where both APRNs and physicians are delineated as being permitted to provide care. Anything less than full inclusion is an unwarranted reduction in access to care by PAs. Although ConnAPA testified and made requests throughout the 2016 legislative process to be included where appropriate in 2016 S.B.67, ConnAPA was not successful and the bill was signed into law as Public Act 16-39, AN ACT CONCERNING THE AUTHORITY AND RESPONSIBILITIES OF ADVANCED PRACTICE REGISTERED NURSES. The exclusion of PAs in some instances has created significant confusion regarding existing PA scope of practice that ultimately decreases access to care by CT residents who are served by PAs. PAs are certified in general medicine. PAs diagnose, treat and prescribe medicine. The inclusion of PAs where appropriate is not a change in PA scope of practice but, instead, making provision to allow PAs to practice to the full extent of their education and training.

The unintended consequence of Public Act 16-39 is that healthcare organizations and physicians view the expansion of the APRN's abilities to perform many of the "duties" previously limited to physicians as relieving the physician burden, making the APRN a preferred candidate for employment. As a result, while a PA may be more than capable, the job is often posted solely for APRNs. It bears mentioning that PAs are also afforded the ability to perform many of the physician functions as delineated in the written agreement. Unfortunately, by naming APRNs as having "authority", with no mention of PAs specifically, this has been interpreted to mean that PAs are not authorized to perform certain functions, by virtue of their not being included.

PAs are trusted healthcare providers. Studies have shown that when PAs practice to the full extent of their abilities and training, hospital readmission rates and lengths of stay decrease and infection rates go down. A Harris Poll found extremely high satisfaction rates among Americans who interact with PAs. The survey found that 93 percent regard PAs as trusted healthcare providers, 92 percent said that having a PA makes it easier to get a medical appointment and 91 percent believe that PAs improve the quality of healthcare.[26]

IV. A brief summary of state or federal laws that govern the healthcare profession making the request:

Physician assistants are licensed and regulated by the Department of Public Health in the State of Connecticut, with additional oversight by the Connecticut Medical Examining Board. The Connecticut General Statutes provide the foundation for PA practice. Federally, PAs are recognized as Medicare Part B providers of professional services and ordering and referring providers by the U.S. Department of Health and Human Services, as well as State Medicaid, administered by the Department of Social Services in Connecticut.

V. The state's current regulatory oversight of the healthcare profession making the request:

The Department of Public Health and the Medical Examining Board regulate the oversight of PAs in Connecticut.

[26] *Attitudes Towards Physician Assistants*. American Academy of PAs, October 2014. https://www.aapa.org/wp-content/uploads/2017/01/AAPA-HarrisSurvey-Methodology-and-Tables.pdf. Accessed June 24, 2018.

VI. All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request:

a. Education/Training

Physician assistants practice medicine in all medical and surgical specialties in all 50 states, the District of Columbia, the U.S territories and the uniformed services collaborating with physicians. PAs are educated in intensive medical programs accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

ARC-PA is the accrediting agency that protects the interests of the public and physician assistant profession by defining the standards for physician assistant education and evaluating physician assistant educational programs within the territorial United States to ensure their compliance with those standards. The average PA program curriculum runs approximately 24-32 months and requires at least four years of college and some health care experience prior to admission. There are currently 287 PA programs accredited in the United States, with 33 additional programs in development.

Due to an education modeled on the medical school curriculum, PAs learn to make life saving diagnostic and therapeutic decisions while working autonomously or in collaboration with other members of the healthcare team. PAs are certified as medical generalists with a foundation in primary care. Because of the close working relationship PAs have with physicians, PAs are educated in a medical model designed to complement physician training. PA students are taught, as are medical students, to diagnose and treat medical problems. The education consists of classroom and laboratory instruction in the basic medical and behavioral sciences (such as anatomy, pharmacology, pathophysiology, clinical medicine, and physical diagnosis), followed by clinical rotations in internal medicine, family medicine, surgery, pediatrics, obstetrics and gynecology, emergency medicine, and geriatric medicine as outlined by robust ARC-PA Accreditation Standards 5th edition for PA programs. All PA programs must meet the same ARC-PA standards.

In order to graduate, PA's are expected to meet strict and robust academic, clinical and behavioral competencies in comprehensive areas Medical Knowledge, Interpersonal & Communications Skills, Patient Care, Professionalism, Practice-based Learning & Improvement and Systems-based Practice. A PA's education does not stop after graduation. A number of postgraduate PA programs have also been established to provide practicing PAs with advanced education in medical specialties. In addition, PAs are required to take ongoing continuing medical education CME education to keep abreast of new clinical developments and advancements.

PA programs look for students who have a desire to study, work hard, and to be of service to their community. All PA programs in CT require applicants to have previous health care experience and a college level bachelor's degree. The typical nation-wide applicant already has a bachelor's degree and approximately four years of health care experience. Commonly, RNs, EMTs, armed services medics and paramedics apply to PA programs.

b. NCCPA Examination/Certification Requirements

Initial Certification

Graduates of an accredited PA program can take the Physician Assistant National Certifying Examination (PANCE) for certification administered by the National Commission on Certification of Physician Assistants (NCCPA). The multiple-choice exam assesses basic medical and surgical knowledge. After passing the PANCE, physician assistants are issued NCCPA certification and can use the "PA-C" designation until the certification expiration date.

Certification Maintenance

PA Certification is renewed every two years by attaining a minimum of 100 hours of CME. In 2014, a new 10-year board exam recertification maintenance cycle was initiated by the NCCPA. Offered at testing centers throughout the U.S., the multiple-choice Physician Assistant National Recertifying Exam (PANRE) is designed to assess on-going general medical and surgical knowledge. In 2022, an alternative pathway was added which functions as a longitudinal assessment (PANRE-LA) where the exam is administered over 12 quarters in years 7-9 of the certification cycle. PAs who fail to maintain their certification must take and pass either the initial certification or recertification exam again to regain their national certification.

See also: PA Education and Training and PA Certification and Licensure.

c. **Accredited PA Programs in Connecticut**

Currently, the State of Connecticut has six PA Programs offered by CT universities. There is PA program support of this request.

- Yale University School of Medicine Physician Associate Program
  https://medicine.yale.edu/pa/
- Yale University School of Medicine Physician Assistant Online Program
  https://paonline.yale.edu/
- Quinnipiac University School of Health Sciences Physician Assistant Program
  https://www.qu.edu/schools/health-sciences/programs/masters-degree/physician-assistant/
- University of Bridgeport Physician Assistant Institute
  https://www.bridgeport.edu/academics/programs/physician-assistant-ms/
- Sacred Heart University Physician Assistant Studies
  https://www.sacredheart.edu/academics/colleges--schools/college-of-health-professions/departments/physician-assistant-studies/
- University of St. Joseph Physician Assistant Studies Program
  https://www.usj.edu/academics/schools/sppas/physician-assistant-studies/

VII. A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request:

- **2022**
  - PAs authorized to certify conditions eligible for the Connecticut Medical Cannabis Program (PA 22-103)
  - PAs permitted to perform aspiration abortions (PA 22-19)
  - PAs included in language to supervise medical assistants as they administer immunizations (PA 22-58)
- **2021**
  - PAs authorized to order home health and hospice services in alignment with federal changes (PA 21-121)
  - PAs added to 77 areas in statute that authorized physicians and APRNs to perform functions/certifications, but omitted PAs (PA 21-196)
- **2019**
  - Description of relationship with physicians changed from "dependent" to "collaborative' (PA 19-144)
- **2018**
  - Scope of Practice review request submitted to DPH- session completed
  - 6:1 PA to physician supervision ratio repealed (PA 18-168)
  - PAs authorized to perform oral health screenings of public school students (PA 18-168)
  - PAs can certify a woman's pregnancy for the purposes of her application for health insurance outside of a normal enrollment window (PA 18-43)

- **2017**
    - Scope of Practice review request submitted to DPH- not selected for review
    - PAs permitted to give orders for peripheral IV with normal saline flush placement by a phlebotomist (PA 17-234)
    - Inclusion in work group to study projected shortage in psychiatry workforce (PA 17-146)

VIII. The extent to which the request directly impacts existing relationships within the health care delivery system:

The above requested changes will have a positive impact on the delivery of healthcare, and enhance relationships within the system. By aligning capabilities between collaborative APRNs and PAs, confusion will be eliminated as to why PAs, who are extensively trained & educated as described above, have such restrictive statutes. Those health care systems that are already treating PAs as being collaborative within the health care team will feel they are legally not overstepping the law when permitting PAs to collaborate. PAs will not be practicing independently, so there will not be the concern with some groups that a non-physician profession is promoted as practicing as an independent entity. ConnAPA embraces collaboration within the healthcare team and seeks to continue to build upon the profession-long history of partnership with physicians.

ConnAPA has and will continue to invite discussion between the Connecticut State Medical Society, the Connecticut Academy of Family Physicians, the Connecticut Hospital Association, the Connecticut nursing groups, and other vested stakeholders. ConnAPA has worked successfully in the past with these groups, and others, with consensus on issues such as the 2011 Scope of Practice session; and in 2019 a working group was organized to discuss over 120 areas of statute that should include PAs.

The above requested changes would have no identified negative impact on physicians or the relationship between physicians and PAs. ConnAPA is not seeking independent practice authority outside of the team-based Physician-PA model of care. Team practice with physicians has been a hallmark of the PA profession since its inception in the mid 1960's and continues to be true today. ConnAPA strongly emphasizes that nothing in this proposal or current American Academy of PAs (AAPA) policy supports independent practice by PAs, a standpoint that was reaffirmed by the AAPA House of Delegates in 2017.

ConnAPA believes that the removal of agency or the concept that a PA should be considered the "agent" of a physician will be widely accepted by the vast majority of physicians and collaborating physicians alike. The primary benefit of removal of "agency" would be to bring clarity to the collaborative dynamic of the physician and PA relationship and remove liability for the physician for acts of the PA. As previously stated, even when practicing in collaboration with a physician, PAs are responsible for the care they provide. Nothing in the law should require or imply that the collaborating physician is responsible or liable for the care provided by the PA unless the PA is acting on the specific instructions of a physician.

IX. The anticipated economic impact of the request on the health care delivery system:

ConnAPA has uncovered no data to suggest that any of these changes will increase health care costs. On the contrary, there are multiple studies that conclude that initiatives aimed at improving practice efficiencies of PA-physician teams decrease overall health care costs.[27,28]

[27] Timmons, E. *The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care,* Health Policy. 121 (2017) 189-196.

[28] Hooker, R.S. & Muchow, A.N. (2015). Modifying state laws for nurse practitioners and physician assistants can reduce cost of medical services. *Nursing Economic$,* 33(2):88-94.

X. Regional and national trends concerning licensure of the healthcare profession making the request and a summary of relevant scope of practice provisions enacted in other states:

While many laws and regulations use the term "supervision," the professional relationship between PAs and physicians is collaborative and collegial. "Supervision" fails to convey the sophistication of the team and to recognize the vast amount of autonomous decision making involved in PA practice. The most effective clinical teams are those that utilize the skills and abilities of each team member most efficiently. Ideally, state laws should define PA-physician collaboration in a way that allows for customization of healthcare teams to best meet the needs of patients in the particular setting or specialty in which the team works. It should be noted in the below chronology, that many of the state-level changes made reflect such a philosophy towards elimination of supervisory language in favor of collaborative language.

In many models of care, particularly in patient-centered medical homes, PAs serve as team leaders. A growing number of states are repealing laws that contain outdated supervision requirements, and instead allowing teams to determine how they collaborate at the practice level. These changes can only benefit the healthcare system, healthcare teams and the patients they care for.

In recent years, many states have been updating their laws and regulations to expand PA scope of practice and eliminate administrative barriers to care. Below is a sampling of changes made nationwide.

2021-2022 Other State's Legislative Changes for PA Practice

- **June 2022:** On June 7, New Hampshire Gov. Chris Sununu signed Senate Bill 228, which among other improvements redefines the PA-physician relationship as **collaborative** and not supervisory, as well as makes PAs responsible for the care they provide
- **October 2021:** On Oct. 7, Pennsylvania Governor Tom Wolf signed Senate Bills 397 and 398 which among other changes, create a permanent seat on the two medical boards and improve supervisory requirements
- **August 2021:** The New Hampshire Board of Medicine adopted amendments that eliminate PA-physician ratios, **removal of requirement to have a supervising physician** for licensure as well as removal of requirement for alternate supervising physician

2020-2021 Other State's Legislative Changes for PA Practice

- **July 2021:** On July 15 in Oregon, H.B. 3036 replaced references to supervision with **collaboration**, as well as eliminated PA-physician ratio requirements, submission of practice agreements, prescriptive improvements, and other modernizations to increase access to care
- **June 2021:** On June 29, Florida Gov. DeSantis signed H.B. 431 which authorizes **direct payment** to PAs for their services, removal of a the requirement for a supervision form, improved prescriptive abilities, authorized ability to authenticate a number of documents, and codified the ability for PAs to supervise medical assistants
- **May 2021:** Tennessee Gov. Lee signed H.B. 1080/S.B. 0671 which establishes "The Board of PAs" to regulate the profession with it's own governing body
- **April 2021:** On April 5, S.F. 0033 was signed into law in Wyoming which **repeals requirements for PAs to have a specific relationship** with a physician or other provider in order to practice. The new law also recognizes PAs' ability to practice medicine consistent with their education, training, and experience.
- **April 2021:** West Virginia Gov. Justice signed into law S.B. 714 on April 21, which among other changes eliminates the need to file practice agreements, improves prescribing abilities, elimination of delegatory language which allows PAs to work to the fullest extent of the education, training and abilities
- **March 2021:** In Utah, S.B. 27 was signed into law on March 17 which **repeals the requirement for physician supervision** and delegation service agreements, and makes PA responsible for the care they provide

2019-2020 Other State's Legislative Changes for PA Practice

- **July 2020:** On July 1, Vermont Gov. Scott signed S.128 into law, which **removes references to supervision** and introduces collaborative language, makes PAs responsible for the care they provide,

authorizes PAs for direct reimbursement, and defines a PAs scope of practice based on education, training and experience

- **May 2020:** On May 21, Oklahoma Gov. Stitt signed S.B. 1915 which **eliminates references of supervision** among other practice enhancing changes
- **May 2020:** Gov. Walz of Minnesota signed S.F. 13 on May 27 which **removes references to supervision**, delegation, and physician responsibility for care provided by PAs, **allowing PAs to practice to the full extent of their education, training, and experience**. It also removes delegated prescriptive authority, authorizing PAs to prescribe based on their own qualifications. New PAs (those with fewer than 2,080 practice hours) will be required to **collaborate** with a physician practicing in a similar medical specialty. Upon completion of 2,080 practice hours, a PA may enter into a practice agreement with the PA's employer.
- **March 2020:** Maine Gov. Mills signed L.D. 1660 which made numerous improvements including the **elimination of supervision**, the ability to **practice without a written agreement** for PAs with greater than 4,000 hours of experience, makes **PAs responsible for the care they provide**, and enacts direct reimbursement for services provided by PAs
- **March 2020:** Multiple states signed Executive Orders to lift administrative and supervisory requirements to adapt to the critical needs of the pandemic, with eight states (Maine, Michigan, New Jersey, New York, Louisiana, South Dakota, Tennessee, and Virginia) **completely waiving the requirement for a PA to have a relationship with a physician to practice**
- **January 2020:** Gov. Cuomo of New York signed S.O 4841 which authorizes PAs to execute orders not to resuscitate and orders pertaining to life sustaining treatments. To accomplish this, PAs were also included in the definition of the term "**attending practitioner**," which replaced "attending physician" in the Family Health Care Decisions Act.

2018-2019 State Legislative Changes for PA Practice

- **July 2019:** Missouri Gov. Parson signed into law S.B 514, which among other improvements removes references to supervision and uses **collaborative** language instead.
- **July 2019:** S.B 1406 was signed into law in Hawaii, which allows for relationships with groups instead of single physicians when creating work agreements; among other improvements.
- **June 2019:** In South Carolina, S.132 was signed which improved prescriptive abilities and enacted the ability for PAs to **sign clinical patient related documents** that would otherwise be signed by a physician
- **May 2019:** Indiana Gov. Holcomb signed H.B. 1248 into law on May 5, which eliminates references to supervision and utilizes **collaboration** instead, **removed the need for physicians to issue written delegation** and protocols
- **April 2019:** North Dakota enacted H.B. 1175 which **eliminates the need for a PA to have a written agreement** with a specific physician in most settings, **removes references to supervision**, and **removes references to physician responsibility** for PA actions, making PAs responsible for the care they provide.
- **March 2019:** In West Virginia, S.B. 668 was signed into law, removing the requirement for PAs who work in hospitals to have written agreements with specific physicians to practice and **removes physician responsibility** for PA provided care with whom the physician had no involvement.
- **February 2019:** Gov. Northam of Virginia signed HB1952/SB1209 into law which allows PAs to practice in **collaboration** and consultation with physicians and podiatrists and was supported by the Medical Society of Virginia and the Virginia Academy of Family Physicians

Select Additional State's Legislative Changes for PA Practice

- **April 2018:** Tennessee passed SB 1515 which more appropriately changed the terminology used to describe the PA-physician team relationships from "supervision" to "**collaboration**."
- **July 2017**: The Governor of State of West Virginia, signed S.B. 1014 into law allowing PAs to work with "**collaborating**" rather than "supervising" physicians, expanding PA prescriptive authority for Schedule III medications to 30 days from the current restriction of 72 hours, allows PAs to be reimbursed at the same rate as physicians and APRNs by prohibiting discrimination by insurance plans, adds an additional PA to the medical board, and authorizes PAs to **sign** an extensive list of forms that previously had to be signed

by a physician, including death certificates, and eliminates the requirement for current and continuous NCCPA certification for license renewal. The law becomes effective September 2017.

- **June 2017:** The State of Illinois passed the PA Modernization Act SB1585. The Act replaces references to "supervising physicians" with references to **"collaborating physicians"** throughout the Act and **r**eplace**s** references to "supervision agreement" with references to "**collaborative agreement**" throughout the Act.

  [Of note, the Illinois Medical Practice Act also includes the following provision:
  S*ec. 54.5. (e):*
  A physician shall not be liable for the acts or omissions of a physician assistant or advanced practice nurse solely on the basis of having signed a supervision agreement or guidelines or a collaborative agreement*, an order, a standing medical order, a standing delegation order, or other order or guideline authorizing a physician assistant or advanced practice nurse to perform acts, unless the physician has reason to believe the physician assistant or advanced practice nurse lacked the competency to perform the act or acts or commits willful and wanton misconduct.*]

- **April 2017: New Mexico** passed legislation entitled *AN ACT RELATING TO THE PRACTICE OF MEDICINE; PROVIDING FOR **COLLABORATION** BETWEEN A PHYSICIAN ASSISTANT AND A LICENSED PHYSICIAN.*
- **March 2017**: **Michigan** House Bill 5533 **removes physician responsibility for PA practice**, making each member of the healthcare team responsible for their own decisions. It also **r**emoves the rigid ratio restriction that arbitrarily limited the number of PAs with whom a physician may practice**.** Last, the new law grants PAs more autonomy to serve patients by recognizing PAs as full "prescribers" rather than limiting their care to "delegated prescriptive authority."

As it relates specifically to moving away from a supervisory relationship to a collaborative one, Alaska has used **"collaborative relationship**" to describe the physician-PA team for decades.

XI. Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions:

ConnAPA emphasizes that the proposed changes do not change the current scope of practice for PAs. Instead, these changes will serve to codify the relationship within the healthcare team that PAs have already established.

As previously mentioned, Connecticut APRNs were granted collaborative practice, and cited the significant manpower shortages in healthcare (which still exist), the need for all providers to be allowed to practice to the full extent of their education and training, and the lack of data that granting collaborative practice diminishes quality of care. It is assumed that Connecticut's nursing organizations continue to stand by these claims, which should also be applied to the PA profession.

The Connecticut State Medical Society was willing to support APRNs when they were granted collaborative practice in 1999.[29] In 2014, CSMS spoke in favor of allowing APRNs to remain in a collaborative relationship when APRNs sought independent practice.[30]

Many physician leaders in the State of Connecticut support the endeavors of ConnAPA to modernize the PA Practice Act with the use of language that reflects the collaborative dynamic of the healthcare team. Here are quotes of one such physician leader who has supported and continues to support ConnAPA's efforts:

[29] https://ctatatelibrarydata.org/wp-content/uploads/lh-bills/1999_PA168_SB333.pdf
[30] https://www.cga.ct.gov/asp/menu/CommDocTmyBillAllComm.asp?bill=SB-00036&doc_year=2014

"I've carefully reviewed the…ConnAPA…proposals and believe these will expand the reach of our physician assistants for the benefit of medical practice and the population of Connecticut.

I have worked in New Haven hospitals for the last 27 years. I developed the Physician Assistant Program in my department…and was unquestionably the largest employer of PAs in the State by the late 1990's. I was faced with the fact most practicing internists in New Haven decided not to provide continuing care for their hospitalized patients…PAs serve in major administrative positions at Yale New Haven Hospital, provide care to the overwhelming majority of in-patients and many outpatients, and are integral to the functioning of the institution.

As maintained by the ConnAPA, the current licensing language, suggesting supervision rather than collaboration, is very outdated, and ultimately inconsistent with current practice…In summary, I'm in full agreement with the ConnAPA scope of practice request, and urge a positive response from the Connecticut Department of Public Health."

XII. <u>A description of how the request relates to the healthcare profession's ability to practice to the full extent of the profession's education and training:</u>

State laws have far-reaching effects on PA practice and patient access to care. These state laws governing PA practice serve two main purposes: to protect the public from incompetent performance by unqualified non-physicians and to define the role of PAs in the health care system. Since the inception of the PA profession in the mid-1960s, the way that states regulate PAs has evolved to reflect a growing body of knowledge about PA practice. It is now possible to identify the specific concepts in PA Practice Acts that enable PAs to practice fully and efficiently while protecting public health and safety.

The State of Connecticut has made progress integrating many of these concepts into existing statute but not all. The lack of some of these key components restrict PAs from practicing to the full extent of their education and training, and delays or otherwise denies care to the Connecticut residents they serve.

ConnAPA is eager to inform the DPH Licensing & Investigations Section and this DPH Review committee of the specific qualifications of PAs which include, but are not limited to, their education, clinical training, professional competencies, and certification and recertification standards, thus allowing the DPH to be able to write an inclusive, factual and comprehensive report.

We have aimed to support this current proposal with a comprehensive review of the qualifications and competencies of PAs as one of the three licensed medical providers in our state. We trust the factual evidence presented will provide clarity with respect to the different, yet well-defined educational model, maintenance of certification and life-long learning of a PA that qualifies PAs to practice medicine safely and effectively for the residents of CT. The conclusions reached in the Institute of Medicine (IOM) 2010 report state, **"Scope of practice regulations in all states should reflect the full extent of not only nurses but of each profession's education and training. Elimination of barriers for all professions with a focus on collaborative teamwork will maximize and improve care throughout the healthcare system."**

In Conclusion:

ConnAPA recognizes that lack of access to the healthcare system is a barrier for black, Hispanic, low income and other marginalized populations. The FDA Office of Minority Health and Health Equity is working to help address this disparity. Removing unnecessarily restrictive language, to allow PAs to practice to their fullest ability, will help break down such barriers. Access is equity!

ConnAPA salutes the Department of Public Health and the Public Health Committee for its unwavering efforts to improve unfettered access to high quality health care by improving efficiencies in the health care system. We respectfully request that these proposed changes to the Connecticut PA Practice Act be thoughtfully considered and adopted.