THE CONNECTICUT ACADEMY OF PHYSICIAN ASSISTANTS (CONNAPA)

ConnAPA Submission to the CT Department of Public Health pursuant to sHB6549

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S OVERSIGHT RESPONSIBILITIES RELATING TO SCOPE OF PRACTICE DETERMINATIONS FOR HEALTH CARE PROFESSIONS.

By:
The Connecticut Academy of Physician Assistants Government Affairs Committee

August 15, 2016

[sHB6549 *Section 1. (NEW) (Effective July 1, 2011) (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.]*

(1) A plain language description of the request:

On behalf of more than 2300 practicing Physician Assistants (PAs) in the state of Connecticut, the Connecticut Academy of PAs (ConnAPA) respectfully requests specific revisions to modernize existing CT state statutes and the PA Practice Act. Modernization of the PA Practice Act can be achieved by adopting recommendations from leading physician groups and federal organizations. Removing existing barriers will increase patient access to quality and cost effective health care and allow CT PAs to practice to the full extent of their education and training. This proposal reflects updates to the Physician Assistant law based on current education, training and practice.

Background - The Changing Landscape of Health Care:

For more than 20 years, health care providers and leaders have endeavored to respond to policy changes designed to move health care from a fragmented system to a seamless, value-based model of care. The Affordable Care Act and the large number of aging baby boomers have created an exponential increase in demand for healthcare services that cannot be met by the current healthcare workforce. In addition, multiple studies and reports have outlined both an overall shortage of physicians as well as a deficit of those practicing in primary care disciplines. While the resolution of these issues will require a multifaceted approach, PAs are recognized by most experts as an integral component of the solution at both the national and state levels.

Nationally, research has shown staggering numbers surrounding the increasing physician shortage. According to the Association of American Medical Colleges (AAMC) Center for Workforce Studies, there is a current shortage of about 63,000 doctors with an expected rise to nearly 130,600 by 2025[1]. A further consideration is the fact that active physicians are a part of the aging populous. In the Physician Workforce Measures report (2011), the AAMC reported that 40.3% of all active physicians are 55 years of age or older, thus nearing retirement themselves. This information reinforces the need for training additional health care providers, such as PAs, to fill the physician void and meet the increasing needs of the patient population. Increasing usage of PAs to meet patient needs is also reflected in the Bureau of Labor and Statistics' (BLS) expectation of 38% growth in employment for physician assistants through 2022[2] while the AAMC workforce studies (2015) indicate that increased employment opportunities are likely to be significantly greater.

At the state level, Connecticut is experiencing many of the same challenges reflected in the national data. The report of the SustiNet Healthcare Workforce Task Force (2010)[3], created to support PA 09-148, provided valuable information about health workforce needs in the state of CT. Connecticut is already facing a shortage of many, even most, health care workforce categories including physicians and PAs. [See Figure 1]

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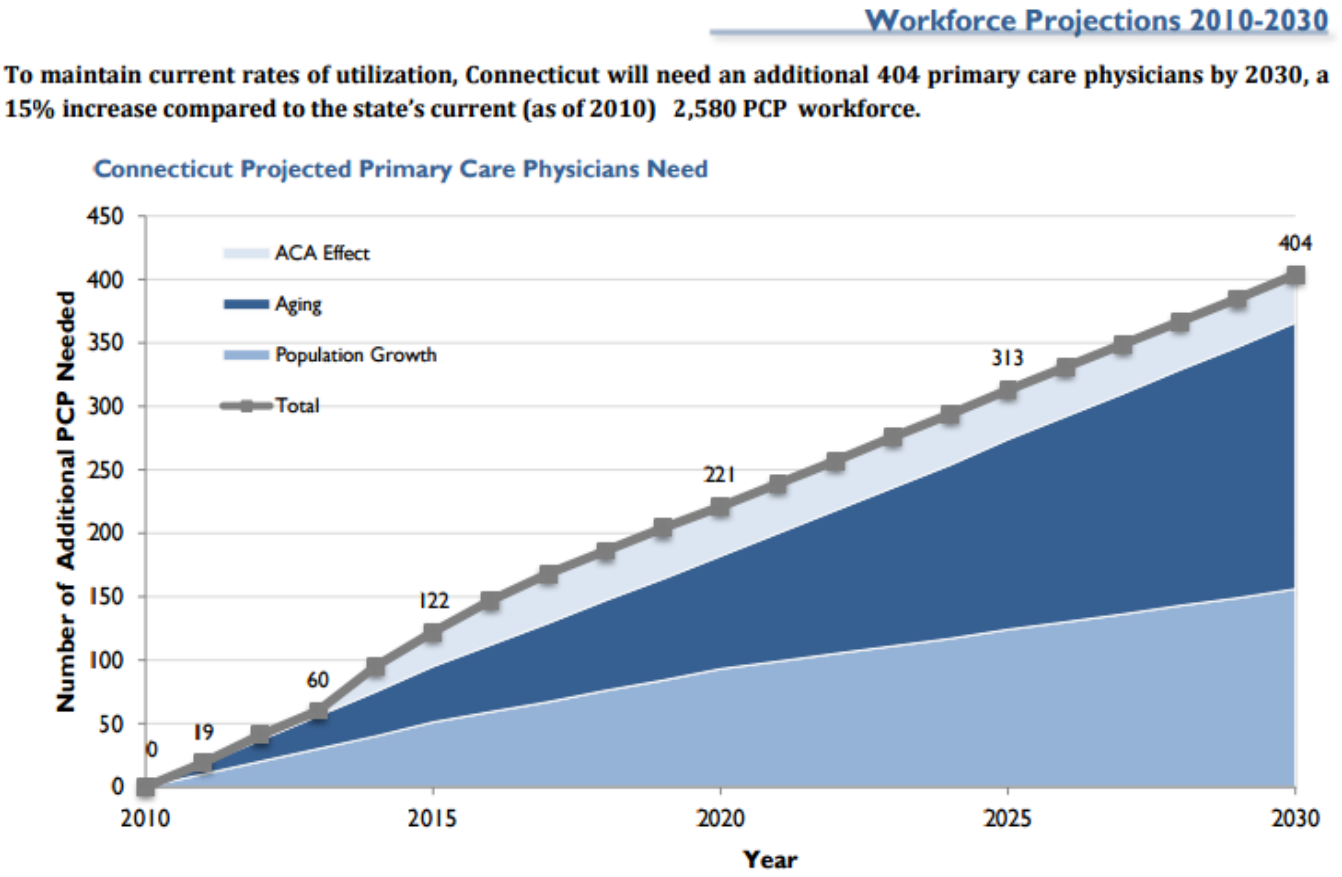
[1] Association of American Medical Colleges (2011). 2011 State Physician Workforce Data Book: Center for Workforce Studies Retrieved from: https://www.aamc.org/download/263512/data/statedata2011.pdf

[2] Bureau of Labor Statistics, U.S. Department of Labor (2015). Occupational Outlook Handbook, 2014-15 Edition, Physician Assistants. Retrieved from: http://www.bls.gov/ooh/healthcare/physician-assistants.htm

[3] SustiNet Healthcare Workforce Task Force (2010). Final Report Retrieved from: http://www.ct.gov/sustinet/lib/sustinet/taskforces/healthcareworkforce/sustinet_wkfrce_report_dh_ema_final_with_cover.pdf

Figure 1:



Suggested citation: 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.

[1] Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: care, health, and cost. *Health Affairs, 27*(3), 759–69. doi:10.1377/hlthaff.27.3.759

[2] Petterson, S. M., Liaw, W. R., Phillips, R. L., Rabin, D. L., Meyers, D. S., & Bazemore, A. W. (2012). Projecting US Primary Care Physician Workforce Needs : physician supply meet demands of an increasing and aging population? *Health Affairs, 27*(3), w232–w241. Also see Colwill, J., Cultice, J., & Kruse, R. (2008). Will generalist physician supply meet demands of an increasing and aging population? *Health Affairs, 27*(3), w232–w241.

[3] *Council on Graduate Medical Education Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-city Areas.* (1998). Washington, D.C.

[4] http://ctsdc.uconn.edu/projections.html. For full description of the methodology, see http://www.graham-center.org/tools-resources/state-projections.htm.

According to these Robert Graham Center projections, pressures from a growing, aging, increasingly insured population call on Connecticut to address current and growing demand for PCPs to adequately meet health care needs. The reports recommends policymakers in Connecticut to consider strategies to bolster the primary care pipeline.[4]

The Connecticut Department of Labor tracks occupations, annual wages, and projected openings. Growth is projected in nearly every healthcare category, with double-digit growth projected for physician assistants. This high rate of growth is driven by unmet needs of the patients in our state, where 26% of Connecticut family physicians and 28% of internists are not accepting new patients. On average, Connecticut patients wait 18 days for a routine office visit.[5]

[4] 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

[5] Aseltine, R., et. al. (2010). CT 2009 Primary Care Survey. CT Medicine, 74, 281-291.

In the report, titled Analyzing Trends in Connecticut's Allied Health Workforce it is noted that overall, Connecticut has more practitioners per 100,000 people than the national average.[6] However, according to the National Commission on Certification of Physician Assistants (NCCPA), of more than 2300 PAs practicing in CT only 15.8% of PAs practice in Primary Care compared to the national average of 28.3%.[7] In still another report released by NCCPA, there appears to be a gross mal-distribution of PAs within CT, **ranking the state last in the US in terms of utilization of PAs in primary care settings**.[8] This grim statistic occurs in the face of rising primary care needs within the state of CT. According to the CT Department of Labor (2014) report, the future needs of the CT's population underscores a dire need for preventive and primary care services. Reducing practice barriers for PAs by clarifying and modernizing the PA Practice Act is a necessary step toward reversing these concerning statistics.

Data gathered from the Connecticut Health Care Workforce Scan shows that 27% of physicians and surgeons are age 60 or older.[9] In the years ahead, as demand continues to increase, the CT's healthcare systems will need to be ready to replace almost 20% of their workforce. In 2011, the Connecticut Department of Public Health published a report on Health Care for Connecticut's Underserved Populations. In this report, Connecticut was identified as having 104 designated Health profession shortage areas, with multiple areas designated as either health profession shortage areas or medically underserved areas.[10]

The US Department of Health and Human Services, Health Resources and Services Administration Workforce Report anticipated an double digit increase in PA positions in the next decade and also supported the use of mid-levels to alleviate impending physician shortages, citing the following "Data suggest that the number of nurse practitioners and physician assistants will grow rapidly and could mitigate the projected shortage of physicians if this workforce is effectively integrated into the primary care delivery system".[11]

A compendium of literature analyzing the utilization of PAs as primary care providers highlights and soundly supports positive national and state-wide impacts on: 1) Quality & Outcomes 2) Cost Effectiveness & Productivity 3) Public Policy, Workforce and Access to Care.[12] [See Appendix A]. These national and state of CT data clearly demonstrate the need for not only increasing the primary care workforce with PAs but also for reducing any practice barriers for existing CT PAs by modernizing the PA Practice Act to achieve the goals of improved access to high quality and cost effective care.

Collaboration in Practice: Implementing Team-Based Care

Passage of the Patient Protection and Affordable Care Act in 2010 highlighted the need to develop alternate care delivery and payment models that improve patient outcomes to achieve the "Triple Aim" of improving

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[6] Connecticut Department of Labor (2014). Analyzing Trends in Connecticut's Allied HealthWorkforce.Retrieved from: http://www.ctdol.state.ct.us/OWC/CETC/Committees/IndustrySectors/AlliedHealth/Final%20AHWPB%20Workforce%20Trends%20Report%20June%202014.pdf

[7] National Commission on Certification of Physician Assistants, Inc. (2016, March). 2015 Statistical Profile of Certified Physician Assistants: An Annual Report of the National Commission on Certification of Physician Assistants. http://www.nccpa.net/Uploads/docs/2015StatisticalProfileofCertifiedPhysicianAssistants.pdf

[8] National Commission on Certification of Physician Assistants (2015). 2014 Statistical Profile of Certified Physician Assistants. Retrieved from: https://www.nccpa.net/uploads/docs/2014StatisticalProfileofCertifiedPhysicianAssistants-AnAnnualReportoftheNCCPA.pdf

[9] University of Connecticut Center for Public Health and Health Policy (2013). Connecticut Healthcare Workforce Scan. Retrieved from: http://www.healthreform.ct.gov/ohri/lib/ohri/sim/work_force/ct_healthcare_workforce_scan.pdf

[10] Connecticut Department of Public Health (2011). Healthcare for Connecticut's Underserved Populations. Retrieved from: http://www.ct.gov/dph/lib/dph/hisr/pdf/medically_underserved_issuebrief2011.pdf

[11] U.S. Department of Health and Human Services (2013). Projecting the Supply and Demand for Primary Care Practitioners Through 2020. Retrieved from: http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf

[12] AAPA Articles on the PA Profession - Selected Topics. May 2016. https://www.aapa.org/workarea/downloadasset.aspx?id=2147486774

the experience of care of individuals and families, improving the health of populations, and lowering per capita costs.[13] Even before the Affordable Care Act, *Crossing the Quality Chasm*, published by the Institute of Medicine in 2001, proposed the core expectations that health care be safe, effective, patient centered, timely, efficient, and equitable. [14] It also proposed a set of rules that emphasized patient-centered care that is coordinated, safe, evidence based, and transparent; cooperation between health care providers to ensure care coordination, and consistent and appropriate exchange of information; and improved access to care and creation of a safe and responsive system of care through a well-functioning team.

In 2014, as part of a presidential initiative, John C. Jennings, MD, (then President of American Congress of Obstetricians and Gynecologists) convened a Task Force on Collaborative Practice to revise ACOG's 1995 *Guidelines for Implementing Collaborative Practice* publication.[15] The task force was charged with updating and broadening the original publication, exploring team-based practice among all specialties as a model of health care delivery that encouraged a patient- and family-centered approach, responded to emerging demands, and reduced undue burdens on health care providers. In doing so, the task force was asked to first consider efficiency, quality, and value in the implementation of team-based care models rather than giving primary consideration to either current or proposed payment reimbursement methods.

The major and over-arching findings of the report from ACOG in March 2016, ***Collaboration in Practice: Implementing Team-Based Care,*** revealed increased quality, efficiency, and value associated with team-based care and encourages providers to work collaboratively by seamlessly sharing information, expertise and resources to provide a higher level of patient care than any individual provider could deliver alone. **The report represents more than a year of collaborative efforts by a multidisciplinary healthcare task force of 20 national medical organizations representing physicians, PAs and advanced practice nurses who have endorsed the findings of the report. [See Table 1]**

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[13] Institute for Healthcare Improvement. IHI triple aim initiative: better care for individuals, better health for populations, and lower per capita costs. Cambridge (MA): IHI; 2015. Available at: http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx

[14] Institute of Medicine (U.S.). Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academies Press; 2001. Available at: https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf

[15] American Congress of Obstetricians and Gynecologists. Collaboration in Practice: Implementing Team-Based Care. An inter-professional Task Force on Collaborative Practice to revise ACOG's 1995 Guidelines for Implementing Collaborative Practice publication. March, 2016. Available at: http://www.acog.org/Resources-And-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care

Table 1: Endorsements of American Congress of Obstetricians and Gynecologists Report: March 2016[16]

As found in: American Congress of Obstetricians and Gynecologists. ***Collaboration in Practice: Implementing Team-Based Care.*** March 2016.

The following organizations have reviewed and endorsed this report:

- American Academy of Pediatrics (AAP)
- American Academy of Physician Assistants (AAPA)
- American Association of Nurse Practitioners (AANP)
- American College Health Association
- American College of Clinical Pharmacy (ACCP)
- American College of Nurse–Midwives (ACNM)
- American College of Osteopathic Obstetricians & Gynecologists (ACOOG)
- American College of Physicians (ACP)
- American Society of Addiction Medicine
- Association of Physician Assistants in Obstetrics and Gynecology (APAOG)
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
- Gerontological Advanced Practice Nurses Association (GAPNA)
- Institute for Healthcare Improvement
- Institute for Patient- and Family-Centered Care (IPFCC)
- National Association of Nurse Practitioners in Women's Health (NPWH)
- National Association of Pediatric Nurse Practitioners (NAPNAP)
- National Organization of Nurse Practitioner Faculties (NONPF)
- National Partnership for Women & Families
- Pacific Business Group on Health
- Society for Physician Assistants in Pediatrics (SPAP)

All states have an obligation to protect those within their borders by regulating the practice of medicine within the state. By including the PA profession in state law and designating a state agency to regulate PA practice, states both protect the public and define the role of PAs. Including Connecticut, other states have modified their approach to PA regulation over the years in response to a growing body of information demonstrating the safety and high quality of PA practice and the need to better utilize their healthcare workforce.

The American Academy of Physician Assistants (AAPA), the national professional society for physician assistants (PAs) founded in 1968, advocates on behalf of the profession and patient care provided by PA-physician teams.[17] The AAPA represents more than 108,000 PAs across all medical and surgical specialties in all 50 states, the District of Columbia, the U.S territories and the uniformed services. The AAPA's ***Model State Legislation for PAs*** (Model Law) was adopted by the AAPA over 20 years ago to describe best practices in the regulation of the profession, achieve regulatory efficiency and promote consistency across states.[18] This Model Law was first drafted in 1991 and revised in 1994, 1998, 2001, 2002, 2004, 2005, 2009, 2013, 2015 and 2016 to incorporate changes in program accrediting agencies and to reflect changes in PA practice standards. The AAPA model legislation reflects two principal concepts:

- **PAs should be licensed to practice medicine**
- **PA scope of practice should be based on the PA's skills, education and experience.**

16 Ibid.

17 *American Needs PAs.* American Academy of Physician Assistants. Accessed: August 2016 *https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2458*

18 American Academy of PAs. Model state legislation for physician assistants. https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=548

The AAPA has also identified ***Six Key Elements of a Modern PA Practice Act***[19] that the Academy believes all state PA practice acts should contain and which are also reflected in the AAPA's Guidelines for State Regulation of PAs.[20] Together these elements create an ideal PA practice act that allows PAs to practice fully and efficiently while protecting public health and safety. The six elements are:

1. **"Licensure" as the regulatory term**
2. **Full prescriptive authority**
3. **Scope of practice determined at the practice level**
4. **Adaptable supervision requirements***
   (*New AAPA recommendations include replacing "supervision" with "collaboration")
5. **Chart co-signature requirements determined at the practice**
6. **No restriction on the number of PAs with whom a physician may collaborate**

To date, ConnAPA has been successful leading efforts with the CT General Assembly to adopt and the Governor to endorse enabling legislation for many of the 6 key elements – whole or in part – in the CT PA Practice Act. ConnAPA's current proposal includes recommendations to both add to and revise current legislation to achieve all 6 key elements as a whole including: 1) Replacing "supervision" with "collaboration" 2) Amend ratio restrictions for PAs and collaborating physicians 3) Removing remaining chart co-signature requirements.

Physician & PA Collaboration in Practice

The AAPA adopted a substantive upgrade to the Model Law in 2015 in part to achieve improved statutory and regulatory environments for PA practice and remove workplace-imposed barriers to PA practice and foster PA-positive workplace environments. The updates modernize PA practice and the language used to describe the profession, as well as align the Model Law with new AAPA policies, such as replacing the term "supervision" with "collaboration" and utilization of the term "PA" throughout the legislation.

The act of collaboration more accurately articulates the dynamic, day to day relationship between PAs and physicians than the term supervision. The scope of PA practice does not change with the modernized language of "collaboration" over "supervision". Each PA's scope of practice will continue to be defined by the individual clinician's education and experience, state law, and health care facility policy. Instead of a "delegation agreement", the PA scope of practice will determined in a "collaboration agreement" between the physician and PA at the practice level.

According to the findings of the American Congress of Obstetricians and Gynecologists (ACOG) consensus report, ***Collaboration in Practice,*** team-based care offers patients and health systems greater value, efficiency, and quality than antiquated models of care. Specifically, the report states "Team composition should include qualified personnel who can provide services that meet the needs of the populations being served; often, the lead or primary provider will be a healthcare provider such as … a PA."[21]

The ACOG guide defines six guiding principles for implementing team-based care. One principle defines leadership as "situational and dynamic," and promotes "a ***collaborative approach*** to team leadership that

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19 American Academy of PAs. Six Key Elements for Model State PA Practice Acts: https://www.aapa.org/six-key-elements/#sthash.gcBrESXI.dpuf

20 American Academy of PAs. Guidelines for State Regulation of PAs. https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=6442451363

21 ACOG March 2016 ***Collaboration in Practice: Implementing Team-Based Care.***

best meets patient needs and goals."[22] Using this approach, "each team member who can best address the priority needs of the patient assumes the lead provider role for that patient."[23]

Another guiding principle addresses clinical responsibility in a team model. "All team members are accountable for their own practice and to the team."[24] Creating an environment that supports continuous learning, professional responsibility in decision-making, agreement on performance measures, respect, and cost-effective decisions based on the best available data, "promotes responsibility and accountability of all team members," individually and collectively.[25] **The report further emphasizes the need for all healthcare providers to be able to function to the full extent of their education, certification, and experience so that the patients' needs are met.**

ConnAPA's Role & Proposals

Since 1975, the major mission of the Connecticut Academy of Physician Assistants (ConnAPA) has been to promote quality, cost effective, and accessible health care to CT residents, to promote the professional and personal development of physician assistants (PAs), and to serve and act to represent CT PAs with regard to legislation pertaining to PA practice, licensure, and other matters deemed pertinent to the profession.

Connecticut PAs provide acute, chronic and preventive care for all populations and in all settings — home, office, hospital and urgent care centers in all medical and surgical specialties in Connecticut within dynamic, collaborative relationships with physicians. PAs provide medical services to patients that include, but are not limited to, the evaluation and diagnosis of complaints, the ordering of diagnostic tests, and the prescribing, dispensing and administration of drugs and medical devices.

PAs in Connecticut practice under requirements defined in Chapter 370, Section 20. The sections proposed for revision all relate to PA practice and include: Sections 20-8a, 20-9, and 20-12, subsections a,b,c,d,h. ConnAPA respectfully requests revisions to the CT PA Practice Act to:

1. **<u>Modernize current language replacing the term "supervision" with "collaboration" to reflect recommendations and guidelines by several national medical organizations for "Adaptable Collaborative Requirements" for PA practice.</u> These changes would lead broadly to improved statutory and regulatory environments for PA practice, would help to remove workplace-imposed barriers to PA practice and begin to foster more PA-positive workplace environments.**

2. **<u>Amend Ratio Restriction reference to physicians and PAs to allow decision of appropriate ratios to be determined at the practice level.</u> This change would adopt recommendations of several national medical and physician organizations which support practice level determination and would allow for more flexible innovation and appropriate use of all members of the health care workforce.**

[22] Ibid.

[23] Ibid.

[24] Ibid.

[25] Ibid.

3. **<u>Amend current statute as follows to allow PAs to practice to the full extent of their education and training</u>:**
    a. **Remove the need for "agency" statute language - the concept that a PA should be considered the "agent" of a physician.**
    b. **Include "PAs" by professional name specifically in all relevant health law & replace the term "Physician Assistant" with "PA" where it currently exists in CT statute.**
    c. **Revise current statute to remove physician co-signature requirement on PA medical charts for new Schedule II & III medications**
    d. **Identify PAs as "licensed practitioners" to order restraint & seclusion per CMS rule in 2006**
    e. **Identify PAs as eligible providers to certify patients for "debilitating medical conditions" in the context of the Medical Marijuana Program**

These revisions and amendments to the CT PA Practice Act will ultimately modernize and refine current statute leading to improved clarity which, in turn, will lead to an improved health care system and improved access to quality care for residents in CT while enhancing and protecting patient safety.

A. ADAPTABLE COLLABORATIVE REQUIREMENTS
ConnAPA respectfully requests to modernize current language replacing the term "supervision" with "collaboration" to reflect recommendations and guidelines by several national medical organizations for "Adaptable Collaborative Requirements" for PA practice.

"Collaboration" means the process in which PAs and physicians jointly contribute to the healthcare and medical treatment of patients with each collaborator performing actions he or she is licensed or otherwise authorized to perform. Collaboration is continuous but is not to be construed to require the physical presence of the physician at the time and place that services are rendered."[26] Several medical organizations, including the American Congress of Obstetricians and Gynecologists[27] and the American Osteopathic Association[28] have policy or recommendations supporting adaptable collaboration requirements as well as the National Governors Association[29] and the Renal Physicians Association[30] who support the role of the PA in health care delivery in the future.

As previously cited, significant literature continues to emerge supporting the role of the PA as an ever-growing and important part of the health-care team as we face continued provider shortages and rising healthcare

[26] AAPA Model State Legislation for PAs 2015.

[27] ACOG March 2016 ***Collaboration in Practice: Implementing Team-Based Care.***

[28] American Osteopathic Association and American Academy of PAs. A joint statement of the American Osteopathic Association and the American Academy of PAs, July 2013 https://www.aapa.org/workarea/downloadasset.aspx?id=1700.

[29] National Governors Association. The Role of Physician Assistants in Health Care Delivery. Published September 2014 http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1409TheRoleOfPhysicianAssistants.pdf.

[30] Renal Physicians and Physician Assistants: Excellence in Team-Based Medicine. A Joint Statement of the Renal Physicians Association and the American Academy of Physician Assistants. Published May 2014. https://www.aapa.org/workarea/downloadasset.aspx?id=2776.

costs.[31,32,33,34] "The education that PAs receive produces a sophisticated and flexible workforce, well suited to succeeding in a rapidly changing health care environment. The profession offers a scalable and affordable source of health care. PAs will continue to play an important role in health care delivery in the future, particularly in light of new, integrated models of care."[35] If PAs are to practice in the most efficient and effective way possible in Connecticut, state laws and regulations must define the relationship between PAs and physicians in a way that works well in all practice settings. A more adaptable approach based on the individual PA's specific area and extent of experience that allows teams to provide better care to more patients.

Modernizing CT statute with up-dated language striking references to "supervision" and replacing with "collaboration" better articulates the formal relationship of providers who work in partnership to provide a higher level of patient care than any individual provider could deliver alone. The use of "collaboration" to define the formal relationship between physicians **will not change day-in and day out dynamic care model of the team**. Team practice with physicians has been a hallmark of the PA profession since its inception in the middle 1960's, and this continues to be true today.

The dynamic act of collaboration more accurately articulates the day-in and day-out relationship between PAs and physicians. CT law already states quite clearly that a physician need not be physically present as long as the PA and physician can contact one another easily which continues to be a key element of AAPA model legislation. It is imperative, however, that the PA and a collaborating physician continue to have access to each other.

The scope of PA practice does not change with the modernized language of "collaboration" for "supervision". Each PA's scope of practice continues to be defined by the individual clinician's education and experience, state law, and health care facility policy. The details of collaboration will continue to be left to the PA-physician team at the practice level as current legislation states with regard to PA and physician practice agreements.

B. AMEND RATIO PROVISION

ConnAPA respectfully requests that current language be amended to allow the decision of appropriate ratios of PAs to collaborating physicians to be determined at the practice level. This supports the stance of other professional physician organizations that any ratio restrictions regarding working relationships between PAs and physicians should be determined at the practice level. The American Academy of Family Physicians (AAFP), the American Medical Association (AMA)[36], the American Academy of Physician

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[31] Roderick S. Hooker and Linda F. McCaig. Use of Physician Assistants and Nurse Practitioners in Primary Care, 1995 -1999. Health Affairs, 20, no.4 (2001):231-238

[32] Michael Sargen, BA, Roderick S Hooker, PhD, PA, Richard A Cooper, MD. Gaps in the Supply of Physicians, Advance Practice Nurses, and Physician Assistants. J Am Coll Surg March 2011: 1-9

[33] Michael J. Dill, Stacie Pankow, Clese Erikson and Scott Shipman. Survey Shows Consumers Open To A Greater Role For Physician Assistants and Nurse Practitioners. *Health Affairs*, 32, no.6 (2013):1135-1142.

[34] Linda V. Green, Sergei Savin and Yina Lu. Nonphysicians, And Electronic Communication. Primary Care Physician Shortages Could Be Eliminated Through Use Of Teams. Health Affairs, 32, no.1 (2013):11-19. http://content.healthaffairs.org/content/32/1/11.full.html

[35] National Governors Association. The Role of Physician Assistants in Health Care Delivery. Published September 2014

[36] AMA Ratio of Physician Assistants to Supervising Physicians. Issue Brief
https://portal.utpa.edu/portal/page/portal/utpa_main/daa_home/hshs_home/pasp_home/pasp_jobs/jobs_files/ratio.pdf

Assistants (AAPA)[37], the American College of Physicians (ACP)[38], and the Federation of State Medical Boards[39] all have guidelines, policies, acts, or recommendations that either intentionally do not include a specific ratio or purposely state that the ratio should be determined at the practice level.

Physician assistants (PAs) practice medicine as part of a physician-led team. The physician-PA team is a well-accepted component of the health care workforce. Early state laws governing physician-PA practice restricted the number of PAs that a physician could supervise. These restrictions hampered physicians' ability to customize care for their particular specialty, setting and patient population. Allowing the number of supervised PAs to be determined at the practice level is preferable to restrictions in law.[40]

State laws and regulations should not include a specific numerical limit on the number of PAs that one physician may collaborate with, nor should they stipulate that a physician can collaborate only with specific, named PAs. The number of PAs that a particular physician works with should be determined by several factors that may vary widely across practice settings. In primary care settings, for example, a physician might collaborate with multiple PAs, while in a complex surgical setting, a team of one PA and one surgeon might be appropriate. Any physician-to-PA ratio in statute or rule cannot account for these differences.

ConnAPA is not the only organization that supports the standard that appropriate ratios should be determined at the practice level. The principle that physicians and PAs at the practice level should determine the number of PAs with whom a physician may practice is supported by several national medical organizations, including the American Medical Association[41], the American College of Emergency Physicians[42], the American College of Physicians[43], and the Federation of State Medical Boards.[44]

Any number specified in state law may be too many PAs for some situations and too few PAs in other situations. Six may be an appropriate number in many clinical settings; but in a trauma surgery case it may be appropriate for a physician to collaborate with only one PA, although current law would allow six. On the other hand, if a physician at a well child clinic works with six PAs during the week, and wants to hire two additional PAs to see patients every other Saturday, that physician would be prohibited from doing so according to current state law. Ideally, the language defining the ratio of PAs to a collaborating physician should be deleted from statute and not determined by state-wide authorities but rather by each health institution or individual practice. The Medical Examining Board would still have full authority to discipline a physician who is improperly collaborating PAs.

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37 AAPA Issue Brief. State Law Issues: Ratio of PAs to Supervising Physicians Nov 2010 https://www.aapa.org/workarea/downloadasset.aspx?id=632

38 American College of Physicians. Internists and Physician Assistants: Team-Based Primary Care. Philadelphia: American College of Physicians; 2010: Policy Monograph. https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/internists_asst.pdf

39 Federation of State Medical Boards. Essentials of a State Medical and Osteopathic Practice Act. April 2015. https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_essentials.pdf

40 Ibid.

41 American Medical Association. (1998). Ratio of Physicians to Physician Extenders (H-35.975). Compendium of AMA Policy. Chicago, IL.

42 American College of Emergency Physicians. (2007). Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department. Irving, TX.

43 American College of Physicians. (2009). Internists and Physician Assistants: Team-Based Primary Care. Philadelphia, PA.

44 Federation of State Medical Boards of the United States, Inc. (2010). A Guide to the Essentials of a Modern Medical and Osteopathic Practice Act. Euless, TX.

C. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION AND TRAINING

a) ConnAPA respectfully requests to remove the need for "agency" statute language - the concept that a PA should be considered the "agent" of a physician.

With previously suggested modernization of current language, ConnAPA and requests the removal of language requiring the collaborating physician to assume responsibility for care provided by the PA. Rather, the PA should be responsible for their professional actions. In The Physicians Foundation November 2012 report titled "Accept No Substitute: A Report on Scope of Practice," the authors specifically note that there is a lack of evidence and few, if any, studies available to "refute the growing body of research presented by non-physicians and their advocates that tends to show that their clinical outcomes are at least as good as those of physicians."[45]

This new model would remove the concept that a PA should be considered the "agent" of a physician. In the past, rather than amending health law outside the PA practice act, PAs sought to be able to perform specific regulated medical and surgical tasks as the "agent" of a physician. Current advocacy efforts seek to have PAs specifically named in all relevant health law, removing the need for "agency" language.

Even when practicing in collaboration with a physician, PAs are responsible for the care they provide. Nothing in CT 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. Therefore, the AAPA and ConnAPA request new language to articulate that the PA should be responsible for their professional actions.

b) ConnAPA respectfully requests to include "PAs" by professional name specifically in all relevant health law & replacing the term "Physician Assistant" with "PA" where it currently exists in CT statute.

Several areas of current CT statute both within and outside of areas specific to PA practice create confusion as to whether PAs are included or excluded by virtue of not being specifically named along with physicians or advanced practice registered nurses. This confusion has become ever more apparent since passage of legislation advancing APRN scope of practice in 2014 with Public Act 14-12 and in 2015 with S.B. 67. 47. The confusion has led to numerous practice disparity issues thus limiting patient access to care. By creating significant healthcare workforce disparities between APRNs and PAs, current CT statute creates both literal and subjective disparities between PAs and APRNs that have fomented perceived and possibly true bias against PAs. These disparities, real or perceived, lead to fewer PA employment opportunities and/or PA job loss. (See Appendix B) The end result of this path may very well mean less access to care by PA providers and, overall, no net gain in access to care. The health care landscape in CT should be free of any potential bias for one care giving profession over another.

The lack of inclusion of PAs in CT statute has led to widely variable interpretations by CT care institutions that utilize both PAs and APRNs leading to institutional policies that either limits or outright prevents PAs from providing care to the full extent of their education and training. Some case examples are illustrated in Appendix B.

In addition to laws and regulations that specifically regulate PA practice, PAs should be included in other relevant areas of law. This should include, but not be limited to, laws that grant patient provider immunity from testifying about confidential information; mandates to report child and elder abuse and certain types of

[45] The Physicians Foundation. Report titled "*Accept No Substitute: A Report on Scope of Practice"*. November 2012. As cited in: CT DPH Report to the General Assembly. An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations: *Scope of Practice Review Committee Report on Advanced Practice Registered Nurses.* Feb 2014.

injuries, such as wounds from firearms; provisions allowing the formation of professional corporations by related healthcare professionals; and mandates that promote health wellness and practice standards. Laws that govern specific medical technology should authorize those appropriately trained collaborating physicians and PAs to use them.

With the expansion of patient populations in CT with more complex and chronic conditions, the time is now for PAs to be able to practice at the top of their education and experience.[46] Once PAs are included in specific instances in CT statute where physicians and other advanced practice providers are included, the confusion can be clarified, PAs will be able to provide the comprehensive care their patients deserve and begin practicing to the fullest extent of their education and training. Additionally, CT state laws, regulations, and policies should allow PAs to sign any forms that require a physician signature. **Currently, due to widely variable interpretations of CT statute, PAs are unable to sign for several different types of forms including but not limited to: Pre-op physicals at many local hospitals, DCF Group home standing orders, anti-coagulation clinics at some local community hospitals, home health agency orders, Physical therapy orders, orders for Diabetic shoes, Durable Medical equipment, Disability forms, Patient transfer forms, Orders for a paramedic transferring a patient to another facility, W-10 forms, VNA orders, Forms for United Illuminating, Homecare orders, DNR orders. [See Appendix B]**

This action chiefly and simply has to do with providing clarification. The inclusion of PAs where appropriate is not a change in PA scope of practice. Once clarified, PAs who are primary care providers or hospital medicine or surgical care providers will be able to provide improved access, higher quality and more cost effective care to their patients and assure them that their health care needs are protected.

c) ConnAPA respectfully requests to revise current statute to remove physician co-signature requirement on PA medical charts for new Schedule II & III medications.

Current CT statute authorizes full prescriptive authority for PAs with the one exception of requiring a physician co-signature on medical charts of PAs when starting a **new** Schedule II or III medication. The AAPA model legislation also endorses full PA prescriptive authority, including controlled substances in Schedules II through V, as well as limited dispensing authority.

Requiring co-signature in these instances routinely places an unnecessary time burden on physicians and PAs. By modifying current chart co-signature language, PAs would be able to maximize practice efficiency in the delivery of patient care for Connecticut residents. Currently, collaborating physicians must document approval of any NEW prescriptions and orders of Schedule II and III drugs, even in routine cases. **ConnAPA requests to allow decisions about when physician co-signature should be used to be made at the practice level, so that physician-PA teams can maximize efficiency in the delivery of patient care.**

PA education includes extensive training in pharmacology and clinical pharmacology and therapeutics that meets or exceeds the educational qualifications and competencies of other licensed care providers in CT who are currently authorized to prescribe Schedule II & III medications. PAs are required to register as prescribers of controlled medications with the CT Department of Consumer Protection for Controlled Substance Registration, to register with and use the CT Prescription Monitoring Program (PMP) system when prescribing controlled substances, and to register with the Federal Drug Enforcement Administration. PAs are also

[46] AAPA's Strategic Planning White Paper. https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2147485944

required to meet the same state mandated CME requirements relating to safe opioid prescribing as other licensed care providers in CT.

A requirement in state law for physicians to review every chart for patients prescribed a new Schedule II or III medication by a PA can cause inefficiencies in patient care delivery. Strict co-signature requirements place a constraint both on the amount of time for actual quality physician oversight of the PA and on the amount of time for physician-patient interaction.

d) ConnAPA respectfully requests to identify PAs as "licensed practitioners" to order restraint & seclusion per CMS rule in 2006

From a federal/Centers for Medicare and Medicaid Services perspective, PAs have had the right to order restraint and seclusion for many years. However, confusing language in various Medicare documents and the Code of Federal regulations have cast doubt on that ability. Below is an explanation of a rule finalized by CMS in 2006 that supports the ability of PAs to order restraint and seclusion. As always, that authority must be authorized under state law and by facility policy**. Changing the language to "licensed practitioner" should help clear up any remaining confusion.**

Patients' Rights Conditions of Participation (issued December 8, 2006 and effective January 8, 2007)

The Centers for Medicare and Medicaid Services (CMS) issued final regulations clarifying that under Medicare's Conditions of Participation for Hospitals physician assistants may order patient restraint or seclusion as a delegated responsibility, when such delegation is allowed by state law and hospital policy. The rule was issued December 8, 2006, and takes effect on January 8, 2007. It amends and finalizes provisions issued as an interim final rule on July 2, 1999. The rule sets forth the Patients' Rights

Conditions of Participation requirements, which address the notice of rights to patients, the exercise of rights, privacy and safety, confidentiality of patient records, and seclusion and/or restraint of patients. Only the section on restraint and seclusion was open for public comment from July 2-August 31, 1999. In the preamble to the December 8, 2006, final rule, where CMS staff discuss a range of public comments and explain some of their decision making, they state, "For the purposes of this rule, a LIP is any individual permitted by State law and hospital policy to order restraints and seclusion for patients independently, within the scope of the individual's license and consistent with the individually granted clinical privileges. This provision is not to be construed to limit the authority of a physician to delegate tasks to other qualified healthcare personnel, that is, physician assistants and advanced practice nurses, to the extent recognized under State law or a State's regulatory mechanism, and hospital policy. It is not our intent to interfere with State laws governing the role of physician assistants, advanced practice registered nurses, or other groups that in some States have been authorized to order restraint and seclusion or, more broadly, medical interventions or treatments."

e) ConnAPA respectfully requests to identify PAs as eligible providers to certify patients for "debilitating medical conditions" in the context of the Medical Marijuana Program

As primary care providers in CT, PAs should be authorized by law through their collaboration agreements to certify their patients for "debilitating medical conditions" such as: cancer, glaucoma, HIV/AIDS, Parkinson's Disease, MS, damage to spinal cord with objective evidence of injury, PTSD and other illnesses recently added to the list in order for appropriate patients to become eligible for medical marijuana.

PA education includes extensive training in pharmacology and clinical pharmaco-therapeutics that is equivalent or exceeds the requisite education and training required for other clinicians in CT who have independent practice authority with regard to certifying patients for medicinal marijuana.[47]

Additional specific training, education or testing is not required as a prerequisite to physician or APRN certification authority. Therefore, PAs should be granted that same authority to certify patients for medicinal marijuana through their practice agreements with collaborating physicians. As is current CT statute, PAS who are prescribers of controlled medications should register with the CT Department of Consumer Protection and the Federal Drug Enforcement Administration.

(2) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

A. ADAPTABLE COLLABORATIVE REQUIREMENTS

Modernizing statute with "collaboration" language will lead to improvements in access to care, quality of care, and cost effective care for CT residents in all medical and surgical settings. There are over 2300 PAs in CT that make up one profession of three including physicians and APRNs who are licensed to practice medicine. However, current CT statute is not fully utilizing the PA profession to the fullest extent of PA education and training as part of that CT health care workforce.

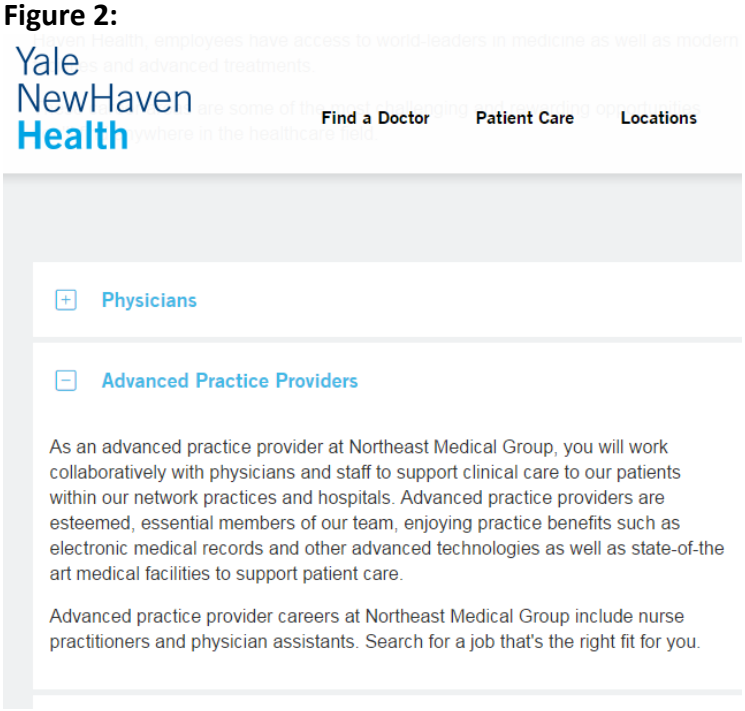
Among the many public health benefits of replacing "supervision" with "collaboration", the biggest improvement would be to bring improved clarity and accuracy of the collaborative partnership between PAs and physicians to both the patient population and public at large. The word "supervise" no longer accurately depicts the professional relationship between PAs and physicians. The PA profession has continuously evolved since its inception in the mid-1960s. The profession is now at a point where collaboration more fully captures the education and training of PAs and the manner in which they interact with physicians. The change in terminology would in no way diminishes the importance of the PA and physician health care team.

Current antiquated, exclusionary or confusing language leads to practice restrictions that decrease CT residents' access to care. Each of these problems with current statutory language leads to variable interpretations of statute and widely variable restrictive institutional policy by health facilities or physician practices that triggers delays or denials access and, thus, increased costs. Additionally, the confusing, exclusionary and antiquated language has led to perceived institutional bias against the PA workforce by the care institutions that seek to employ advance practice providers. The confusion also extends to patients of PAs who don't understand why as their Primary Care Provider is unable to provide certain care to them in the time they are seeing them in the office or in the hospital.

[47] CT DPH Report to the General Assembly. An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations: *Scope of Practice Review Committee Report on Advanced Practice Registered Nurses.* Feb 2014. http://www.ct.gov/dph/lib/dph/practitioner_licensing_and_investigations/scope_of_practice_2014/Report_to_the_General_Assembly-APRN_2_3_14_final_report_no_appendix_rev.pdf

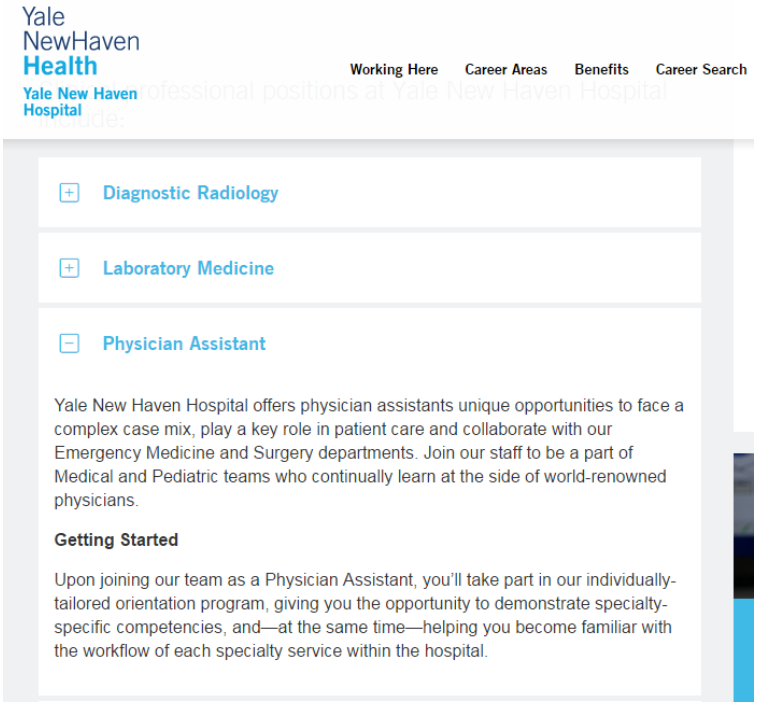
In addition, CT health care institutions public relations efforts already highlight the team-based approach to health care underscoring the **collaborative** partnerships with physicians, PAs and APRNs as Advanced Practice Providers (APPs).[48] [See Figure 2 and 3]

Figure 2:



Accessed August, 2016: https://www.ynhhs.org/careers/nemg/career-areas.aspx

Figure 3:



Accessed August, 2016: https://www.ynhh.org/careers/career-areas/other-clinical-professionals.aspx

[48] Yale New Haven Health website: https://www.ynhhs.org/careers/nemg/career-areas.aspx

B. AMEND RATIO PROVISION

By removing the ratio provision, we would be able to offer Connecticut residents increased access to care in all medical and surgical settings. Currently, CT statute specifies that a physician may collaborate with a maximum of six PAs. A specific number should not be included in the law because decisions about the appropriate number of PAs that a physician can collaborate should be made at the practice level. A multitude of factors unique to each practice will dictate the suitable ratio of PAs to a physician [i.e. types of medical or surgical services being provided, the training and experience of the PAs, the complexity of the patient population, and the institutional approach to collaborations between multiple advance practice providers (i.e., PAs, APRNs, Residents) with physician.

In a 2010 article in the Annals of Emergency Medicine (Volume 55, Issue 2 , Pages 133-141, February), a study evaluating ED wait times nationally "found that hospital EDs perform fairly poorly in seeing acutely ill patients within the time recommended by the triage nurse and in keeping ED visits for admitted patients within 4 or 6 hours. Less than one fifth of EDs were able to treat at least 90% of their emergent or urgent patients (those triaged to be treated in an hour or less) within an hour; only half kept the ED visit shorter than 6 hours for at least 90% of their admitted patients." This article cites staffing as one of the throughput items that delays smooth passage of patients through the ED.

There is no doubt that crowded emergency rooms, delays in treatment and understaffing adversely affects both the quality of care delivered and ultimately the overall health of the community. It is not hard to extrapolate or make similar comparisons of this example to any busy clinical setting. Current legislation in Connecticut limits supervision by or collaboration with a physician to six full time equivalent PAs. It is clear that addressing this barrier to care is low hanging fruit. Amending the language would, in essence, put more qualified "boots on the ground" and would go a long way to improve quality of health care delivery in Connecticut. Finally, throughout the current 46 years of the PA profession, there remains no evidence to suggest that states without supervision ratios provide any less quality care compared to states that limit the number of PAs a physician may supervise.

C. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION AND TRAINING

a. ConnAPA respectfully requests removal of agency and include PAs in statute where currently excluded to assure patients' health care needs are fully served and protected.

The primary benefit of removal of "agency" would be to bring clarity to the collaborative dynamic of the physician and PA relationship and remove redundancy. 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.

Defining and incorporating the dynamic relationship between PAs and physicians as suggested by the ACOG guiding principles of *Collaboration in Practice* into CT statute would serve to modernize the team-based practice model in CT. Because the state of CT licenses both physicians and PAs and can discipline or revoke or restrict the license of both types of providers, it is redundant and unnecessary for the law to require physicians or PAs to file notice of collaborative arrangements with an agency. Collaborative agreements would continue to be reviewed annually by the PA and collaborating physician.

By including "PA's" by name where appropriate, there are multiple potential benefits that, in sum, allow PAs to practice to the full extent of their education and training. PAs are trained as general comprehensive care practitioners in the medical model for emphasis on patient care, prevention, health promotion, and living well with chronic conditions. As the needs for additional primary care providers in CT expand, PAs are being utilized in CT and other states as primary care providers. Currently benefits of adding PAs specifically in statute include:

- Increased access to health care is becoming increasingly important as the number of insured individuals and families has increased with further implementation of the Affordable Care Act;
- Increased choice for patients concerning health care providers;
- Ability for PAs to spend additional time with patients;
- Decreased costs over time related to increased disease prevention and health promotion activities;
- Reduction in duplication of services.

More specifically, due to widely variable interpretations of CT statute, PAs are unable to sign for several different types of forms including but not limited to: Pre-op physicals at many local hospitals, DCF Group home standing orders, anti-coagulation clinics at some local community hospitals, home health agency orders, Physical therapy orders, orders for Diabetic shoes, Durable Medical equipment, Disability forms, Patient transfer forms, Orders for a paramedic transferring a patient to another facility, W-10 forms, VNA orders, Forms for United Illuminating, Homecare orders, DNR orders. [See Appendix B]

b. ConnAPA respectfully requests to revise current statute to remove physician co-signature requirement on PA medical charts for new Schedule II & III medications.

PAs, are faced with multiple barriers imposed in practice regarding electronic medical records (EMR) limitations with regard to be identified as requiring "co-signatures" for new schedule II & III medications. Because PAs are required for "medical chart co-signatures" on any new start of schedule II & III medications, this has created multiple additional office and hospital inefficiencies which **adds unnecessary time to both the PAs and collaborating physician's day**. Both PA and physician continue to have to dedicate time away from patients in order for a co-signature to take place. In addition, due to EMR limitations, when the "co-signature" requirement is "turned on" for EMR platforms, it also requires PAs to "flag" physicians for refills and discontinuations of schedule II & III medications which is not required by CT statute.

Removing the physician co-signature requirement would not pose any additional risk to CT residents. PAs have extensive education, clinical experience in pharmacology and clinical pharmaco-therapeutics, are nationally board certified, are required to sit for board recertification exams every 10 years, are required to maintain CME requirements of 100 hours every 2 years along with CT state CME requirements for chronic pain, are required to register for controlled substances at the state and federal level. This is all required for on-going licensure renewal and re-certification maintenance. PAs are also required to register and utilized the CT Prescription Drug Monitoring program for on-going patient safety and monitoring like CT physicians and APRNs. Additionally, PAs not only meet but exceed post-graduate training in the areas of clinical practice, post-graduate pharmacology, CME when compared to APRN colleagues as is documented in the DPH Report to the General Assembly in February, 2014.[49]

[49] CT DPH Report to the General Assembly. An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations: Scope of Practice Review Committee Report on Advanced Practice Registered Nurses. Feb 2014.

Finally, physician supervisors are in the best position to make a determination that the PA is competent to decide when those medications are medically necessary through a collaboration agreement. Therefore, requiring a co-signature each time the PA exercises that authority is redundant.

c. ConnAPA respectfully requests to include "PAs" by professional name specifically in all relevant health law & replacing the term "Physician Assistant" with "PA" where it currently exists in CT statute.

This action chiefly and simply has to do with providing clarification. The inclusion of PAs where appropriate is not a change in PA scope of practice. Once clarified, PAs who are primary care providers or hospital medicine or surgical care providers will be able to provide improved access, higher quality and more cost effective care to their patients and assure them that their health care needs are protected.

Also, replacing the term "Physician Assistant" with "PA" seeks to modernize PA practice and statute language to better align with the Model Law with new AAPA policies. The change is to provide clarity and to remove any confusion. Many states including CT have PA programs that endorse and title the PA professional as a Physician Associate while others use title of Physician Assistant.

d. ConnAPA respectfully requests to identify PAs as "licensed practitioners" to order restraint & seclusion per CMS rule in 2006

Changing the language to "licensed practitioner" should help clear up any remaining confusion and allow PAs to use these orders in the most critical of times to keep their patients safe without delay.

e. ConnAPA respectfully requests to identify PAs as eligible providers to certify patients for "debilitating medical conditions" in the context of the Medical Marijuana Program

There are currently over 320 PA's who practice primary care medicine in CT and serve as patient's primary care providers. As a primary care provider, PAs manage patients with "debilitating medical conditions" including: cancer, glaucoma, HIV/AIDS, Parkinson's Disease, MS, damage to spinal cord with objective evidence of injury and PTSD.

The primary health benefit is that access to timely and appropriate health care for these patients will protected and delivered by their PA primary care provider who is in the best position to know health care needs. The harm that would come would be requiring them to see an unfamiliar provider who has no more specific training than his/her PA provider but is nonetheless recognized by the CT to certify for "debilitating medical conditions".

(3) The impact that the request will have on public access to health care;

A. ADAPTABLE COLLABORATIVE REQUIREMENTS

These 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 that are in place due to variable interpretations of current statute. Current antiquated, exclusionary or confusing language leads to practice restrictions that decrease CT 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 denials access and, thus, increased costs.

B. AMEND RATIO PROVISION

By eliminating the restriction on the number of PAs any one physician may supervise, Connecticut will remove a barrier that stands in the way of increasing access to care. A recent article in the *Journal of the American College of Surgeons* (2011, 212 991-999) states that there will not be enough physicians, PAs and APRNs to meet the demands that will made of health care professions by 2025. Clearly any state that is unable to grow its population of advanced clinicians to meet this looming tidal wave of consumer health care demands will risk much including:

1. Overall delays in treatment
2. Higher cost to the community because of deferred care
3. Heightened patient dissatisfaction and the associated liability risks that ensue
4. Increased dissatisfaction of practitioners because of unmanageable workloads

By allowing practices rather than the state to determine the appropriate number of PAs per supervising physician, Connecticut's community of advanced practitioners will have more flexibility to address these concerns.

C. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION AND TRAINING

a. Removal of agency and including PAs in statute where currently excluded to assure patients' health care needs are fully served and protected.

Once PA inclusion in appropriate areas of statute are clarified, PAs will be able to provide improved access, higher quality and more cost effective care to their patients and assure them that their health care needs are served and protected. With the passage of S.B.67 this last legislative session, there has been a negative impact current CT PA practice and CT residents' access to health care by PAs.

CT PAs practice medicine with nearly identical clinical roles and responsibilities as APRNs and often with APRNs as colleagues in the same clinic, hospital or other health care facility. Along with our physician colleagues, PAs and APRNS practice authority and responsibilities 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, intensive care units, and specialty intensive care units.

Although ConnAPA testified and made requests throughout the legislative process to be included where appropriate in S.B.67, ConnAPA was not successful. The exclusion of Physician Assistants has created significant confusion regarding existing PA scope of practice which ultimately decreases access to care by CT residents who are served by PAs. PAs are experts 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.

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.

b. Revise current statute to remove physician co-signature requirement on PA medical charts for new Schedule II & III medications.

Removing the physician co-signature requirement would increase patient access to care by freeing both physicians and PAs from the excessive time burdens that over-prescriptive tasks like co-signatures require.

c. Replace the term "Physician Assistant" with "PA" where it currently exists in CT statute.

Replacing the term "Physician Assistant" with "PA" will provided much need clarification to CT health institutions and providers as to the services PAs are authorized and duty bound to provide by their education and training. This clarification will lead to increased patient access to care by removing current barriers that exist. [See Appendix B]

d. Identify PAs as "licensed practitioners" to order restraint & seclusion per CMS rule in 2006

Identifying PAs as "licensed practitioners" to order restraint and seclusion when appropriate will provide much needed clarity to CT institutions which will ultimately lead to increased timely access to this care by patients who need it to maintain their safety.

e. Identify PAs as eligible providers to certify patients for "debilitating medical conditions" in the context of the Medical Marijuana Program

CT PAs should be authorized by law to certify their patients for "debilitating medical conditions" such as: cancer, glaucoma, HIV/AIDS, Parkinson's Disease, MS, damage to spinal cord with objective evidence of injury, PTSD and other illnesses recently added to the list in order for appropriate patients to become eligible for medical marijuana.

(4) A brief summary of state or federal laws that govern the health care profession making the request;

Physician assistants are licensed and regulated by the state. They also fall under the Connecticut Medical Examining Board. Physician Assistants participate in Medicare, a Federal program, and Medicaid, a State sponsored program.

(5) The state's current regulatory oversight of the health care profession making the request;

The oversight of PAs in CT is regulated by the Department of Public Health and the Medical Examining Board.

(6) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

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.[50] PAs are educated in intensive medical programs accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).[51]

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 210 PA programs accredited in the United States.[52]

Thanks 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 4th edition for PA programs. All PA programs must meet the same ARC-PA standards.[53]

In order to graduate, PAs 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.[54] 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

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[50] *PAs Practice Medicine:* American Academy of Physician Assistants. Accessed: August 2016. https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2147483705

[51] Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) http://www.arc-pa.org/

[52] Accreditation Review Committee – Physician Assistants (ARC-PA). Accessed August 2016 http://www.pasconnect.org/arc-pa-181-pa-programs-now-accredited/

[53] Accreditation Review Committee – Physician Assistants (ARC-PA) Standards for PA Program Accreditation. March 2016. http://arc-pa.org/documents/Standards%204th%20Ed%20March%202016.pdf

[54] *Competencies for the Physician Assistant Profession.* Adopted 2012 by the AAPA, ARC-PA, NCCPA, and PAEA https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2178

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.

For more information on accreditation visit the ARC-PA website:
http://www.pasconnect.org/arc-pa-181-pa-programs-now-accredited/

Examination/Certification Requirements

Initial Certification

Graduates of an accredited PA program can take the Physician Assistant National Certifying Examination (PANCE) for certification. 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 – approximately every 2 years after it must be renewed by attaining a minimum of 100 hours of CME.

Certification Maintenance

In 2014, a new 10-year board exam re-certification maintenance cycle was initiated along with five divided 2-year periods for CME maintenance that are required for national certification by the National Commission on Certification of PAs (NCCPA).[55] During every two-year period, every PA must earn and log a minimum of 100 hours of CME and submit a certification maintenance fee to NCCPA by December 31 of their certification expiration year. By the end of the 10th year of the certification maintenance cycle, PAs must have also passed a recertification exam. 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. PAs who fail to maintain their certification must take and pass either the initial certification or re-certification exam again to regain their national certification.

Other Resources

1. AAPA Website: PA Education & Training: https://www.aapa.org/what-is-a-pa/?utm_source=aapa.org&utm_medium=blue_buttons&utm_content=what&utm_campaign=homepage
2. AAPA Website: PA Certification & Licensing: https://www.aapa.org/what-is-a-pa/?utm_source=aapa.org&utm_medium=blue_buttons&utm_content=what&utm_campaign=homepage

Currently, the state of Connecticut has five PA Programs that make up the **CT PA Educational Consortium.** The **CT PA Educational Consortium** comprised of the CT universities below fully support ConnAPA Proposal and will be requesting to join the DPH Review committee if the proposal is chosen for review.

1. **Yale University School of Medicine PA Program**: https://medicine.yale.edu/pa/
2. **Quinnipiac University School of Health Sciences:** https://www.qu.edu/school-of-health-sciences/graduate-programs/master-of-health-science-physician-assistant/faq/
3. **University of Bridgeport PA Program:** http://www.bridgeport.edu/academics/graduate/physician-assistant-ms/

[55] The National Commission on Certification of Physician Assistants http://www.nccpa.net/CertificationProcess

4. **Sacred Heart University PA Program:** http://www.sacredheart.edu/academics/collegeofhealthprofessions/academicprograms/physicianassistant/
5. **St Joseph's University PA Program:** http://www.usj.edu/academics/schools/school-of-health-natural-sciences/physician-assistant/

(7) 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;

2016

- Physician Assistants included in the omnibus Opioid Addiction Prevention legislation as prescribers (HB 5053, PA 16-43)

2015

- PAs included in the telemedicine practice authority (SB 467, PA 15-88)

2014

- Printed name of physician no longer a necessity on PA prescriptions and written orders (HB 5537, PA 14-231)
- PAs included in the statute governing new rules for medical spas (SB 418, PA 14-119)
- Physician Assistants given authority to counsel patients and administer Hepatitis C vaccine (SB 257, PA 14-203)

2013

- Physician Assistant authority included in and outlined in medical spa legislation (bill was vetoed; SB 1067, PA 13-284)

2012

- Legislation to extend the deadline for examination of fluoroscopy requirements by physician assistants (HB 6618, Public Act, 11-242)
- Significant update to the Scope of Practice of Physician Assistants (HB 5515, PA 12-37)

(8) The extent to which the request directly impacts existing relationships within the health care delivery system;

The above requested changes would have the most direct impact on physicians and the relationship between physicians and PAs. ConnAPA embraces physician collaboration for PAs and believes in enhancing the physician-PA team. Given these fundamental beliefs, ConnAPA leadership and PAs in affiliation with ConnAPA leadership have reached out to and received support from many physicians with whom we work in collaboration. Many of these physicians have offered to testify in support either in writing or in person should this proposal be recommended to the Public Health committee for continued legislative action.

ConnAPA has attempted to reach out to various physician organizations including the CT State Medical Society (CSMS) but busy summer schedules have up-ended plans for face to face meetings. ConnAPA is currently working to meet with the CSMS, the CHA, and any other potential stakeholder who wishes to meet.

A. ADAPTABLE COLLABORATIVE REQUIREMENTS

That said, the above requested changes would have no direct 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 – period. 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 absolutely nothing in this proposal or current American Academy of PAs (AAPA) policy supports independent practice by PAs.

B. AMEND RATIO PROVISION

ConnAPA, like many previously cited physician organizations believe the restriction on how many PAs with whom a physician can collaborate hampers the physician's ability to customize care for his particular specialty, practice setting and patient population. Several physician organizations have already spoken out in favor of removing restrictions on the number of PAs a physician can collaborate with including the American College of Emergency Physicians, the American College of Physicians and The Federation of State Medical Boards.

C. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION AND TRAINING

a. Removal of agency and including PAs in statute where currently excluded to assure patients' health care needs are fully served and protected.

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 redundancy.

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. Collaborative agreements would continue to be reviewed annually by the PA and collaborating physician.

ConnAPA also believes that most physicians will see added benefit to patients and the practice setting as a whole with including "PA's" by name in statute where appropriate to provide distinct clarification where there is confusion regarding PA practice.

b. Revise current statute to remove physician co-signature requirement on PA medical charts for new Schedule II & III medications.

ConnAPA believes this request will be supported by the vast majority of physicians as this will be a time saver for them as a whole. Additionally, physicians with whom we have spoken state that PAs meet or exceed the requisite education and training to prescribe these agents compared to other providers who currently have no co-signature requirement. Most physicians believe oversight exists to maintain patient safety with on-going practice and delegation/collaboration agreement reviews, as well as with the initiation of the CT Prescription Drug Monitoring program.

c. Replace the term "Physician Assistant" with "PA" where it currently exists in CT statute.

Replacing the term "Physician Assistant" with "PA" will not directly impact physicians.

d. Identify PAs as "licensed practitioners" to order restraint & seclusion per CMS rule in 2006

Identifying PAs as "licensed practitioners" to order restraint and seclusion will positively impact physicians in that PAs will be able to eliminate the variable institutional requirements now in place that require them to either be called or to co-sign orders within a certain time frame.

e. Identify PAs as eligible providers to certify patients for "debilitating medical conditions" in the context of the Medical Marijuana Program

Identifying PAs as authorized by law to certify their patients for "debilitating medical conditions" should not directly impact physicians. Most physicians ConnAPA has engaged on this issue support the premise that PA education includes the requisite extensive training in pharmacology and clinical pharmaco-therapeutics certifying patients for "debilitating medical conditions" and that there is no additional specific training, education or testing is required for physicians or APRNs.

(9) The anticipated economic impact of the request on the health care delivery system;

A. ADAPTABLE COLLABORATIVE REQUIREMENTS

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.

B. AMEND RATIO PROVISION

ConnAPA has uncovered no data to suggest that any of these changes will increase health care costs.

C. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION AND TRAINING

a. Removal of agency and including PAs in statute where currently excluded to assure patients' health care needs are fully served and protected.

ConnAPA has uncovered no data to suggest these changes will increase health care costs. On the contrary, improved practice efficiencies will lead to decrease overall health care costs by leading to less practice hurdles for PAs to navigate due to widely variable interpretations of statute.

b. Revise current statute to remove physician co-signature requirement on PA medical charts for new Schedule II & III medications.

ConnAPA has uncovered no data to suggest this change will increase health care costs. On the contrary, improved practice efficiencies will lead to decrease overall health care costs.

c. Replace the term "Physician Assistant" with "PA" where it currently exists in CT statute.

ConnAPA has uncovered no data to suggest this change will increase health care costs.

d. Identify PAs as "licensed practitioners" to order restraint & seclusion per CMS rule in 2006

ConnAPA has uncovered no data to suggest this change will increase health care costs. On the contrary, improved practice efficiencies will lead to decrease overall health care costs.

e. Identify PAs as eligible providers to certify patients for "debilitating medical conditions" in the context of the Medical Marijuana Program

ConnAPA has uncovered no data to suggest this change will increase health care costs.

(10) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

A. ADAPTABLE COLLABORATIVE REQUIREMENTS

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.

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. In 2015 alone, 40 states made 119 legislative improvements and 31 states made 82 regulatory improvements. Some of these updates were minor in nature, but many removed antiquated barriers to efficient practice that allow for PAs and physicians to spend more time treating patients and to expand access to care. States that have made significant and expansive changes to PA scope of practice in 2016 include:

- PAs in Maine gaining full prescriptive authority through Chapter 2 joint rule making between the allopathic and osteopathic board.
- Minnesota eliminating PA to physician ratios in House File 1036.
- Washington State added PAs to 22 sections of the state's mental health code. Additionally, Washington also promulgated rules clarifying that PAs may exercise the same authority as physicians regarding restraint and seclusion of patients in private psychiatric hospitals.
- Florida joined 48 states and the District of Columbia in allowing PAs to prescribe controlled medications with HB 423 (Rx provisions effective 1/1/17).
- New Jersey removed countersignature requirements, eliminated on-site requirements and allowed for scope to be determined between PAs and physicians through S1184.
- Kentucky, with the signing of SB 154, now allows for co-signature requirements to be determined between the physician, institution or practice and the PA.

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. Since AAPA adopted policy regarding collaboration in May 2015, various state PA organizations have been working to update their state laws and regulations to accurately reflect the PA-physician relationship. This includes legislation introduced in the 2016 legislative session in Rhode Island (S 2639/H 7489). In 2017, the AAPA tentatively expect up to 10 states to have active legislation to make the change from "supervision" to "collaboration."

B. AMEND RATIO PROVISION

As previously stated, ConnAPA is not the only organization that believes the appropriate ratio should be determined at the practice level. As previously cited earlier in this proposal, the American College of Emergency Physicians (ACEP), the American College of Physicians (ACP), the Federation of State Medical Boards all have guidelines, policies, acts, or recommendations that either intentionally do not include a specific ratio or purposely state that the ratio should be determined at the practice level.

By comparison, twelve states have no ratio restrictions, including nearby Massachusetts, Vermont, Rhode Island and Maine, along with Alaska, Arkansas, Minnesota, Montana, New Mexico, North Carolina, North Dakota, and Tennessee.[56] For more information on why the appropriate number of PAs should be determined at the practice level rather than in state law, see AAPA Issue Brief.[57]

C. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION AND TRAINING

a. Removal of agency and including PAs in statute where currently excluded to assure patients' health care needs are fully served and protected.

As just reviewed in Question 10, Section A, many states have been updating their laws and regulations to expand PA scope of practice. In 2015 alone, 40 states made 119 legislative improvements and 31 states made 82 regulatory improvements. Some of these updates were minor in nature, but many removed antiquated barriers to efficient practice that allow for PAs and physicians to spend more time treating patients and to expand access to care. Please refer to the bulleted list on the previous page for more specifics.

b. Revise current statute to remove physician co-signature requirement on PA medical charts for new Schedule II & III medications.

If the proposed changes are made to chart co-signature language, Connecticut would join other states in the Northeast region with this type of practice including Maine, Maryland, New York, Vermont, Rhode Island, Delaware and New Jersey. Each of these states has no medical chart co-signature requirements in existing statute. Other states without co-signature requirements are Alaska, Arizona, Arkansas, Washington DC, Florida, Idaho, Illinois, Kentucky, Louisiana, Maryland, Michigan, Minnesota, North Carolina, North Dakota, Ohio, Oregon, South Dakota, Texas, Washington, Wisconsin and Wyoming.[58]

c. Replace the term "Physician Assistant" with "PA" where it currently exists in CT statute.

ConnAPA is not aware of any state that has been successful with this effort to date. Washington State added PAs to 22 sections of the state's mental health code.

d. Identify PAs as "licensed practitioners" to order restraint & seclusion per CMS rule in 2006

CT PAs practice medicine with nearly identical clinical roles and responsibilities as APRNs although specific statutory practice authority varies including the ability to order restraint and seclusion. From a Centers for Medicare and Medicaid Services perspective, PAs have had the right to order restraint and seclusion for many years. However, confusing language in various Medicare documents and the Code of Federal regulations have cast doubt on that ability. ConnAPA seeks this change to bring harmonization of PA and APRN practice in CT in-patient institutions. Washington promulgated rules clarifying that PAs may exercise the same authority as physicians regarding restraint and seclusion of patients in private psychiatric hospitals.

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[56] AAPA. State Law Issues: Ratio of PAs to Supervising Physicians. August 2016. https://www.aapa.org/workarea/downloadasset.aspx?id=799&loggedIn=True

[57] AAPA Issue Brief. State Law Issues: Ratio of PAs to Supervising Physicians Nov 2010 https://www.aapa.org/workarea/downloadasset.aspx?id=632

[58] American Academy of PAs. Six Key Elements for Model State PA Practice Acts: https://www.aapa.org/six-key-elements/#sthash.gcBrESXI.dpuf

e. Identify PAs as eligible providers to certify patients for "debilitating medical conditions" in the context of the Medical Marijuana Program

At this time, ConnAPA has uncovered no national or regional data to date on this issue, but we continue our research. However, the trend in the state of CT in the last few years has been to improve relevant scope of practice provisions for this issue among practitioners who practice primary care. Of the three professions in CT that practice allopathic medicine and serves as primary care providers for CT residents, PAs are currently the last group of medical professional to be granted authority to certify patients for "debilitating medical conditions even with the structure of the delegation or collaboration agreement.

(11) 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; and

The CSMS and other physicians who practice in CT will have questions and probably mount objections about these requested changes to the PA Practice Act. However ConnAPA is convinced that, with face to face meetings and review of the literature, we will dispel any arguments and reach consensus on the proposal as a whole. To reiterate, ConnAPA is confident in our aim and assertion that nothing that will change about the current formal relationship and day-in and day-out health care dynamic between the physician and the PA by modernizing the statute by using "collaboration" instead of "supervision". The scope of PA practice does not change with the modernized language of "collaboration" over "supervision".

With the recent enabling legislation for the CT APRNs in the past 2 years, ConnAPA anticipates there will be questions and concerns raised by the Connecticut APRN Society as well. However, given the evidence cited in the CTAPRN Scope of Practice Proposal of 2013[59] which includes several studies including a retrospective cross-sectional analysis of data collected from the US Veteran's Health Administration (VHA) from 2005-2010 that determined that APRN and physician assistant visits were substantially similar to those of physicians[60,61], ConnAPA again anticipates being able to reach consensus with the CT APRN Society as well.

To be clear, ConnAPA strongly emphasizes that the changes requested in this proposal do not directly or indirectly assert a request or even a consideration for independent practice authority. In addition, there is nothing in current AAPA policy that supports independent practice by PAs and no state is seeking independent practice authority outside the time-honored, collaborative partnership model between physicians and PAs. Team practice with physicians has been a hallmark of the PA profession since its inception in the mid-1960s, and continues to be true today.

The CSMS worked with ConnAPA in 2011-12 and joined the CHA and the CT AAFP affiliate in endorsing the 4th and 5th element of the Six Key Elements as recognized by the American Academy of Physician Assistants

[59] Request for Consideration of Scope of Practice Change, Connecticut APRN Society, August, 2013.

[60] Morgan, P.A., Abbott, D.H., McNeil, R.B., & Fisher, D.A. (2012). Characteristics of primary care office visits to nurse practitioners, physician assistants and physicians in United States Veterans Health Administration facilities, 2005-2010: a retrospective cross-sectional analysis. Human Resources for Health, 10, 8 pages.

[61] Dill, M.J., Pankow, S., Erikson, C. & Shipman, S. (2013). Survey shows consumers open to greater role for physician assistants and nurse practitioners. Health Affairs, 32(6), pp. 1135-1142.

as fundamental for a modern state PA Practice Act. In consideration of successful past consensus building experiences with the DPH, CSMS, CHA, and the CT AAFP, ConnAPA fully expects to be able arrive at consensus agreement on these current proposals.

(12) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

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.

These concepts inform the "*Six Key Elements of a Modern PA Practice Act"* and *"AAPA Model State Legislation for PAs"* that should be in every state's PA Practice Act so that physician-PA teams can care for patients as effectively and efficiently as possible. The state of CT has made progress integrating many of these concepts into existing statute but currently lack at least key elements and aspects of others. The lack 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 CT 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 re-certification 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. Conclusions reached in the Institute of Medicine (IOM) 2010 report[62] 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."**

[62] Institute of Medicine. The Future of Nursing – Leading Change & Advancing Health. https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Recommendations.pdf

In Summary:
All of the changes included in this document are proposed to improve the quality of care and experience of Connecticut patients while patient safety is enhanced and protected. Additionally, PAs are qualified and competent to provide all services included and as stipulated in this proposal due to nationally accredited medical education and training programs and a national board certification to practice medicine in the United States. In turn, each of these proposals will help facilitate the goals of the Affordable Care Act.

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 CT PA Practice Act be thoughtfully considered and adopted.

APPENDIX A

Articles on the PA Profession - Selected Topics

Quality and Outcomes

1. Carzoli, R.P., Martinez-Cruz, M., Cuevas, L.L., Murphy, S. & Chiu, T. (1994). Comparison of neonatal nurse practitioners, physician assistants, and residents in the neonatal intensive care unit. *Pediatrics Adolescent Medicine,* 148(12):1271-1276.
Patient charts were analyzed to compare care provided in the neonatal intensive care unit (ICU) by teams of resident physicians and teams of physician assistants (PAs) and nurse practitioners (NPs). Results demonstrated no significant differences in management, outcome, or charge variables between patients cared for by the two teams.
http://archpedi.jamanetwork.com/article.aspx?articleid=517388 (abstract)

2. Dhuper, S. & Choski, S. (2009). Replacing an academic internal medicine residency program with a physician assistant-hospitalist model: a comparative analysis study. *American Journal of Medical Quality,* 24(2):132-139.
This study describes a comparative analysis of replacing medical residents with PA-hospitalist teams on patient outcomes in a community hospital. Quality of care provided by the PA-hospitalist model was equivalent to resident physician provided care.
http://ajm.sagepub.com/content/24/2/132.abstract (abstract)

3. Christine Everett et al., (2013) *Physician Assistants And Nurse Practitioners Perform Effective Roles On Teams Caring For Medicare Patients With Diabetes*, 32 HEALTH AFF.1942
Medicare claims and electronic health record data from a large physician group was used to compare outcomes for two groups of adult Medicare patients with diabetes whose conditions were at various levels of complexity: those whose care teams included PAs or NPs in various roles, and those who received care from physicians only. Outcomes were generally equivalent in thirteen comparisons.
http://content.healthaffairs.org/content/32/11/1942.abstract (abstract)

4. Brett E. Glotzbecker, MD, Deborah S. Yolin-Raley, PA-C, Daniel J. DeAngelo, MD, PhD, Richard M. Stone, MD, Robert J. Soiffer, MD, and Edwin P. Alyea III, MD Impact of Physician Assistants on the Outcomes of Patients With Acute Myelogenous Leukemia Receiving Chemotherapy in an Academic Medical Center. *Journal of Oncology Practice* June 2013.
The data demonstrated equivalent mortality and ICU transfers, with a decrease in length of stay, readmission rates, and consults for patients cared for in the PA service. This suggests that the PA service is associated with increased operational efficiency and decreased health service use without compromise of health care outcomes.
http://jop.ascopubs.org/content/9/5/e228.full 2

5. Hooker, RS, Nicholson JC Le T. Does the employment of physician assistants and nurse practitioners increase liability? *J Med Licensure and Discipline*. 2009;95(2):6-16.
17 years of data compiled in the United States National Practitioner Data Bank (NPDB) was used to compare and analyze malpractice incidence, payment amount and other measures of liability among doctors, PAs and advanced practice nurses (APNs). Seventeen years of observation suggests that PAs may decrease liability, at least as viewed through the lens of a national reporting system. During the first 17-year study period, there was one payment report for every 2.7 active physicians and one for every 32.5 active PAs. In percentage terms, 37 percent of physicians, 3.1 percent of PAs and at least 1.5 percent of APNs would have made a

malpractice payment during the study period. The physician mean payment was 1.7 times higher than PAs and 0.9 times that of APNs, suggesting that PA employment may be a cost savings for the health care industry along with the safety of patients. The reasons for disciplinary action against PAs and APNs is largely the same as doctors.
http://mss.fsmb.org/FSMBJournal/V95/Vol95N2.pdf

6. Horman, B.M., Bello, S.J., Hartman, A.R. & Jacobs, M. (2004). The effects of a full-time physician assistant staff on postoperative outcomes in the cardiothoracic ICU: 1-year results. *Surgical Physician Assistant,* 10(10): 38-41.
Despite an increased volume of patients and increase in case severity, increasing the role of PAs in a cardiothoracic ICU resulted a decreased length of stay, increased survival post-arrest and very low invasive procedure complication rate.
https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=6442451072

7. Moote, M., Englesbe, M., Bahl, V., Hu, H.M., Thompson, M., Kubus, J. & Campbell, D., Jr. (2010). PA-driven VTE risk assessment improves compliance with recommended prophylaxis. *Journal of American Academy of Physician Assistants,* 23(6):27-35.
A PA-driven venous thromboembolism (VTE) risk assessment process resulted in a dramatic increase in the number of patients within the health system who were prescribed appropriate orders for VTE prophylaxis according to published guidelines and according to individual patient risk.
http://www.ncbi.nlm.nih.gov/pubmed/20653258 (abstract)

8. Miller, W., Riehl, E., Napier, M., Barber, K. & Dabideen, H. (1998). Use of physician assistants as surgery/trauma house staff at an American College of Surgeons-verified level II trauma center. *The Journal of Trauma: Injury, Infection, and Critical Care,* 44(2):372-376.
Utilization of a trauma surgeon-PA model resulted in a 43% decrease in transfer time to the OR, 51% decrease in transfer time to the ICU, 13% decrease in overall length of stay and 33% decrease in length of stay for neurotrauma intensive care.
http://www.ncbi.nlm.nih.gov/pubmed/9498514 (abstract)

9. John P. Nabagiez, MD, Masood A. Shariff, MD, Muhammad A. Khan, MD, William J. Molloy, PA-C, Joseph T. McGinn, Jr, MD. Physician assistant home visit program to reduce hospital readmissions*. J Thorac Cardiovasc Surg* 2013;145:225-33
A PA home care (PAHC) program was initiated to improve the care of patients who had undergone cardiac surgery. The 30-day readmission rate was reduced by 25% in patients receiving PAHC visits. The most common home intervention was medication adjustment, most commonly to diuretic agents, medications for hypoglycemia, and antibiotics.
http://www.jtcvsonline.org/article/S0022-5223(12)01200-7/fulltex 3

10. U.S. Congress, Office of Technology Assessment. (1986). *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis* (Health Technology Case Study 37). Washington, DC.
Within their areas of competence, PAs, NPs and CNMs provide care whose quality is equivalent to that of care provided by physicians.
http://ota.fas.org/reports/8615.pdf

11. Virani et al. (2015). Provider type and quality of outpatient cardiovascular disease care. *Journal of American College of Cardiology*, 66(16), 1803-12.
The large national study sought to determine whether there were clinically meaningful differences in the quality of care delivered by teams of physicians and PAs or NPs versus physicians-only teams. Patients with coronary artery disease, heart failure and atrial fibrillation received comparable outpatient care from physicians, PAs and NPs. There was a higher rate of smoking cessation screening and intervention and cardiac rehabilitation referral among CAD patients receiving care from PA/NPs.
http://www.ncbi.nlm.nih.gov/pubmed/26483105 (abstract)

12. Wilson IB, Landon BE, Hirschhorn LR, et al. Quality of HIV care provided by nurse practitioners, physician assistants, and physicians. *Ann Intern Med. (2005) 143(10):729-736.*
For the measures examined, the quality of HIV care provided by NPs and PAs was similar to that of physician HIV experts and generally better than physician non–HIV experts. Nurse practitioners and PAs can provide high-quality care for persons with HIV. Preconditions for this level of performance include high levels of experience, focus on a single condition, and either participation in teams or other easy access to physicians and other clinicians with HIV expertise
http://annals.org/article.aspx?articleid=718840

Cost Effectiveness and Productivity
1. Peter L. Althausen, MD, MBA,Steven Shannon, BS,Brianne Owens, MD,Daniel Coll, PA-C, Michael Cvitash, PA-C, Minggen Lu, PhD,Timothy J. O'Mara, MD, Timothy J. Bray, MD Impact of Hospital-Employed Physician Assistants on a Level II Community-Based Orthopaedic Trauma System *J Orthop Trauma* Volume 27, Number 4, April 2013
The indirect economic and patient care impact of PAs on the community-based orthopaedic trauma team was evaluated. By increasing emergency room pull through and decreasing times to OR, operative times, lengths of stay, and complications, PAs are clearly beneficial to hospitals, physicians, and patients.
http://www.researchgate.net/publication/228066130_Impact_of_Hospital-Employed_Physician_Assistants_on_a_Level_II_Community-Based_Orthopaedic_Trauma_System

2. Hooker, R.S. (2002). Cost analysis of physician assistants in primary care. *Journal of the American Academy of Physician Assistants,* 15(11),39-50.
This study examines the cost associated with employing PAs from the employers perspective. Analysis of data on record for episode, patient characteristics, health status, etc., found that for every medical condition managed by PAs, the total episode cost was less than similar episode managed by a physician.
https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=6442451074 4

3. Hooker, R. S. (2000). The economic basis of physician assistant practice. *Physician Assistant*, 24, 67.
Cost-benefit analysis of PA-delivered primary care suggests the use of resources is less than physicians under comparable conditions. The PA compensation to production ratio establishes the PA as one of the most cost-effective clinicians to employ.
https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=6442451073

4. Morgan, P.A., Shah, N.D., Kaufman, J.S., & Albanese, M.A. (2008). Impact of physician assistant care on office visit resource use in the United States. *Health Services Research.* 43(5 Pt 2),1906-1922.
Analysis of Medicare's Medical Expenditure Panel Survey (MEPS) data found adult patients who saw PAs for a large portion of their yearly office visits had, on average, 16 percent fewer visits per year, than patients who saw only physicians. These findings account for adjustments for patient complexity.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2654167/pdf/hesr0043-1906.pdf

5. Pedersen DM; Chappell B; Elison G; Bunnell R. The productivity of PAs, APRNs, and physicians in Utah. JAAPA. 2008; 21(1):42-4, 47 (ISSN: 1547-1896). University of Utah Physician Assistant Program, Salt Lake City, USA.
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Data from twenty-six primary care practices and approximately 2 million visit records found PAs/NPs attended to 1 in 3 adult medicine visits and 1 in 5 pediatric. Primary care practices that used more PAs/NPs in care delivery realized lower practitioner labor costs per visit than practices that used less.
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After controlling for practice characteristics, higher use of PAs and NPs was found in three states (Minnesota, Montana, and South Dakota).Higher availability of PAs or NPs was associated with favorable PA scope-of-practice laws.
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Increased use of PAs, NPs and pharmacists will decrease the impact of the predicted physician shortage. Concerns that quality will be reduced with the use of these clinicians are unfounded for a variety of reasons, including the increasing focus on safety, high professional, educational and credentialing standards and the increase of team-based care which has the potential to allow for better use of the skills of each member of the team, including the physicians.
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PAs and NPs can conduct evaluations, prescribe medications, order and interpret testing, and perform some procedures independent of direct physician supervision. They can provide many aspects of care that neurologists currently perform, such as education of patients and families, counseling, resource management, and follow-up care. PAs and NPs have the potential to improve outcomes at a lower cost to patients and to the system by improving outpatient access, potentially reducing the need for emergency care. They also perform patient education, which may also decrease the overuse of the medical system.
https://www.aan.com/uploadedFiles/Website_Library_Assets/Documents/6.Public_Policy/1.Stay_Informed/2.Position_Statements/3.PDFs_of_all_Position_Statements/15%20Neurology%20Advanced%20Practice%20Providers%20v001.pdf

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Substantial variation exists in PA-to-population ratio among states related in part to state practice laws. At a local level, counties without PAs are more likely to be rural than counties with PAs. States with more favorable laws governing PA practice have a higher PA-to-population ratio. Distribution of PAs is likely to remain geographically uneven in absence of significant policy efforts to attract PAs to practice in rural communities.

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State imposed limits on PA practice impact the PA workforce. In 1989 Montana authorized prescriptive authority for PAs and by 1991 the number of PAs in Montana increased nearly three-fold. Initiation of prescriptive authority for Texas PAs saw a three-fold increase in the number of PAs practicing in rural areas.
May 2016

APPENDIX B

Below are answers to a ConnAPA Questionnaire asking CT PAs to share their stories or cases of practices hurdles in CT:

Examples of PAs not being able to practice to the full extent of their training:

1. In an ED setting, misinterpretation of the Medicaid bylaws resulted in Supervising Physicians having to co-sign every chart for every Medicaid patient that was cared for by a PA. After 2 years of back and forth, the hospital is still reluctant to let this misinterpretation go even though it was recognized by legally as a true misinterpretation.

2. PA signatures are not accepted for pre-op physicals in local hospitals in the Waterbury area.

3. PA signatures are not accepted for DCF group home standing orders.

4. PA signatures are no longer accepted for the anti-coagulation clinic at a local community hospital, despite being accepted for years in the past.

5. PAs at local Federally Qualified Health Care Center are required to have face to face meetings with physicians weekly, which places an undue time constraint on physicians and takes away from patient care hours.

6. The PA's in our emergency department have also been told that in order to comply with state Medicaid regulations, they must document the name of the physician working with them that day in the ED and document that they were available at all times for consultation if necessary. There is no such requirement for APRN's. Initially the physicians were being made to co-sign every PA Medicaid chart, putting us in a poor light compared to the APRN's in the department.

7. Many PAs have relayed stories of needing physician co-signatures for:
    a. HHA orders
    b. Physical therapy
    c. Diabetic shoes
    d. Durable Medical equipment
    e. Disability forms
    f. Patient transfer forms
    g. Orders for a paramedic transferring a patient to another facility
    h. W-10 forms
    i. VNA orders
    j. Forms for United Illuminating
    k. Homecare orders
    l. DNR orders

These examples illustrate incorrect interpretations of the current state statutes and impede seamless patient care. These misinterpretations also place an undue burden on the physician's already limited time.

Other Major points made by PA respondents:

8. "All medical providers, including PAs, are required to use the CT PMP system when prescribing controlled substances so why do PAs still require a co-signature on our medical charts for Schedule II & III meds?"
9. "PAs training in pharmacology far exceeds that of APRNs who can practice independently."

Restraints & Seclusion:

10. I had at the hospital yesterday regarding restraints (at the table, was the Hospitalist attending, 3 RNs in charge of regulatory departments, the hospital attorney who is also a former RN and me – a PA). They will not budge on allowing PAs to order restraints. Basically, because state statute says "physician and LIPs" can order. I tried to explain that the CMS rule since 2006 gives PAs the authority to order restraints. But they cite CT law as what is restricting them so they will not allow PAs to order restraints. They also do not view all APRNs as LIPs - only ones who have gotten their specific independent license - of which there are very few at our hospital currently. The hospital medical Staff Bylaws and restraint policy do not allow APRNs to order restraints; however the CNO is allowing APRNs to order restraints anyhow - interesting. When I spoke with DPH, the two individuals with whom I spoke (names redacted) referred to PAs as LIPs and also another person in our group spoke with a DPH representative who also referenced PAs being "LIPs". If the DPH is not confused, then why does this confusion exist at all? I am hopeful that perhaps CMS and/or CT DPH will clarify this going forward, and we can make improvement on this at some point in the future.

Delays or Denies Access to Care Unnecessarily:

11. Described by multiple PAs: PAs are excluded from jobs that are advertised for APRNS solely because "APRNs can practice independently." In fact, the majority of APRNS in CT do not practice independently (or bill independently) as this requires them to carry their own malpractice insurance and negotiate their reimbursement rates with insurers. As the number of patients needing care increases, it is detrimental to deny PAs jobs whom are qualified to care for patients in any setting/specialty.

12. Recently, our department leadership notified us that all Workers Compensation patients must be seen by the attending physician during every ED visit. In reviewing the guidelines from the state Workers Comp commission, they state that patients seen by a "'physician**'s** assistant" or APRN will only be reimbursed at 70% of the fee schedule, and the supervising physician is required to co-sign all paperwork prepared by a PA or APRN.

13. I work for a federally qualified health center that took over a private practice I was working for about 5 or 6 years ago. Since then they have only hired 1 other PA and there were some personality problems so that person was let go. When the HC posts for positions, it is always for APRNs. I've asked in the past why not PA and they say APRNs don't need "supervision" and "chart review" the way PAs do. The administration claims that they can't hire PAs if they don't have MDs who want to add on the role of supervisor and they can't "make" the MDs be supervisors. Also, though said in a more politically correct way, they believe that "supervision" takes away from the provider's patient care time and therefore productivity. I've been a PA for 14 years and my relationship with the MDs I work for has always been wonderful. The MDs understand the role and benefit to PAs working day to day with them, but the administrators only see more oversight that is need for PAs vs APRNs.

14. I wanted to make you aware of a situation that has been occurring at Middlesex Hospital. Last August we were notified that PAs are no longer able to sign W-10 forms for patient requiring home care only when it involves Middlesex Hospital Homecare. We are allowed to sign the W-10s when a patient is discharged to a skilled nursing facility or home care organization different than Middlesex Homecare. The problem I have with this is that I can write for a handful of narcotic scripts yet cannot order a wet to dray dressing change by Middlesex Homecare which is owned by Middlesex Hospital. This only creates longer patient stays/increased costs until the attending physician/surgeon comes to sign the W-10.

Potential Workplace Hiring Bias - based on confusion about or misinterpretation of legislation:

15. I applied for a position in Endocrinology in Torrington in a practice that was recently acquired by Charlotte Hungerford Hospital. They are looking for a "physician extender" and are convinced that person needs to be an APRN. I met with them to make my case that there is no disadvantage to hiring a PA vs APRN. They indicated that recent legislation with APRNs made a lot of management convinced that it is easier to hire an APRN because there is less work necessary. I'm afraid my dilemma is going to be more common place for PAs working in outpatient offices. With 17+ years in outpatient adult primary care, I would love to be able to work where I have experience and can have the greatest impact, but it feels I'm going to be squeezed out by the way current laws seem to favor nurse practitioners over PAs.

16. I just wanted to let you know about a phone conversation I had with a recruiter for Hartford Healthcare who I have known personally for a long time. After accepting the position I will be starting win Nov, I was asking her about her experience since the new APRN legislation went through. She said, "Without a doubt, the medical directors, for which she is recruiting non-physician providers, are telling her they want to hire APRNs instead of PAs, because it's easier from a management perspective due to CT law. There are more restrictions on us for hiring PAs." I told that I was noticing more positions being advertised for APRNs and MDs. She agreed that this is what she is experiencing.

17. In 2012, I was initially denied a position within an urgent care setting due to inaccurate interpretation of the supervision statute. This clinic wanted only APRNs because "they can work without a supervising physician". I was eventually hired a year later but was told I could only work when a MD was present on site.

Certification of Chronic Illness in Patient's Requesting Medicinal Marijuana

18. As a PA in my CT practice, I am the primary care provider of ~1000 CT residents. Currently, 3 of my patients suffer with end-stage cancer diagnoses including: 1) 56 year old male with Stage IV metastatic prostate cancer 2) 52 year old male with stage IV intrahepatic cholangiocarcinoma with metastatic disease to the lungs and omentum. 3) 35 year old male with Stage IVA squamous cell carcinoma of the left tonsil. Each of these individuals suffers from chronic, intermittent daily waves of nausea and pain that has not been managed successfully with conventional medical therapy despite numerous palliative interventions. Each of them have posed the question of "Do you think medical marijuana could help?" I've responded with other medication adjustments as I view medicinal marijuana as a choice when other conventional therapies have failed.

    However, in the back of my mind, I know that medicinal marijuana may eventually help any one of these or future patients. However, PAs are restricted from certifying patients with "debilitating medical conditions" that would make them eligible for medicinal marijuana. And, I'm not really sure why?

    Although as a PA primary care provider, I have the education and training to evaluate and identify signs and symptoms suspicious for initial cancer-defining illnesses, and even though PAs refer patients to the appropriate specialists and prescribe medications for chemo/radiation side effects, we are not given the authority to certify that the patient has a "debilitating medical condition". As a primary care provider, I'm stunned that my only option is to send them to another physician in my group as PAs are not even allowed this "certification" privilege as a part of our delegation agreement. This needs to be addressed with our Public Health legislators and officials.

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