



Report to the General Assembly

Scope of Practice Review Committee Report on Physician Assistants

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Department of Public Health
Report to the General Assembly

Scope of Practice Review Committee on Physician Assistants

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Executive Summary

In accordance with Connecticut General Statutes (CGS) Section 19a-16d through 19a-16f, the Connecticut Academy of Physician Assistants (ConnAPA) submitted a scope of practice request to the Department of Public Health seeking to revise the Physician Assistant (PA) relationship to physicians described in Chapter 370 of the Connecticut General Statutes (CGS). The overarching goals in the ConnAPA proposal were to:

1. Modernize the current PA practice statute by replacing the term supervision with collaboration;
2. Allow PA's to practice to the full extent of their education, training and experience;
3. Promote administrative simplification by eliminating the administrative burden to collaborating physicians imposed by redundant chart documentation requirements; and
4. Remove the barrier that prohibits PA's from certifying "debilitating medical conditions" in the context of the Medical marijuana Program.

A scope of practice review committee was established to review and evaluate the request as well as subsequent written responses to the request and additional information that was gathered through the review process. The review committee consisted of the ConnAPA, educational institutions that train PAs, medical societies and other physician professional associations, Advanced Practice Registered Nurse (APRN) associations, and the Connecticut Hospital Association.

The review committee recognized and acknowledged the important role that PAs play in the health care system. The physician organizations that participated on the committee acknowledged that their supervisory role included a great deal of collaboration. However, these participants did not feel that the supervisory relationship between physicians and PAs was burdensome or that it needed to be changed.

The group did agree that there are many statutes within the CGS, and outside of the statutes that govern the PA profession, that could be updated to include PAs. However, the committee recognized that those changes are not necessarily scope of practice changes. Many of the statutes that can be updated are among those that have been updated, or are being reviewed, to include APRNs. The APRNs committee that participated on the committee were open to working collaboratively with ConnAPA to propose updates to those statutes that would also include PAs.

Background

Connecticut General Statute Section 19a-16d through 19a-16f establishes a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of these statutes, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner

of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request;
2. Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and
3. The Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, non-voting member of the committee.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The ConnAPA submitted a scope of practice request to modify the relationship that a PA has with the healthcare team with specific focus on eliminating the current statutory requirements identified in CGS, section 20-12a related to the supervisory role of a physician to a physician assistant. The ConnAPA proposed that the statutes governing their profession be revised to achieve the following goals:

5. Modernize the current PA practice statute by replacing the term supervision with collaboration;
6. Allow PA's to practice to the full extent of their education, training and experience;
7. Promote administrative simplification by eliminating the administrative burden to collaborating physicians imposed by redundant chart documentation requirements; and
8. Remove the barrier that prohibits PA's from certifying "debilitating medical conditions" in the context of the Medical marijuana Program.

Impact Statements and Responses to Impact Statements

Written impact statements in response to the scope of practice request submitted by the ConnAPA were received from the following:

- Connecticut Academy of Family Physicians;
- Connecticut Advanced Practice Registered Nurse Society
- Connecticut Association of Nurse Anesthetists;
- Connecticut Dermatology and Dermatological Surgery Society;
- Connecticut Ear, Nose and Throat Society;
- Connecticut College of Emergency Physicians;
- Connecticut Hospital Association;
- Connecticut Nurses Association;
- Connecticut Orthopedic Society;
- Connecticut Society of Radiological Technologists
- Connecticut State Medical Society;
- Connecticut Urology Society;
- Multicare, Musculoskeletal Medicine & Pain Management Associates, P.C.;
- Northwest Nurse Practitioner Group;
- Quinnipiac University;
- University of Saint Joseph, Connecticut; and
- Yale New Haven Health.

The Department received seventeen impact statements, all expressing further interest in the proposed changes to the PA statutes. Almost all of the impact statements expressed that further investigation of the request was necessary to fully understand the impact and to assess if the current requirements regarding the relationship between the physician and the PA is creating gaps and/or difficulty in accessing healthcare; and if such relationship is truly burdensome and leads to increased healthcare costs.

Impact statements acknowledged the valuable role the PA has within the healthcare team. However, a significant number of the impact statements expressed concern that the training a PAs receive and expertise they possess do not prepare PAs to practice without physician supervision. These impact statements expressed that permitting PA's to practice without supervision, could lead to quality of care issues for some patients in Connecticut's.

Scope of Practice Review Committee Membership

In accordance with Connecticut General Statute Section 19a-16e, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by the ConnAPA.

Membership on the scope of practice review committee included

1. Connecticut Academy of Family Physicians
2. Connecticut Advanced Practice Registered Nurse Society
3. Connecticut Association of Nurse Anesthetists
4. Connecticut Association of Physician Assistants
5. Connecticut Ear, Nose and Throat Society
6. Connecticut College of Emergency Physicians
7. Connecticut Hospital Association
8. Connecticut Nurses Association
9. Connecticut Orthopedic Society
10. Connecticut Society of Radiological Technologists
11. Connecticut State Medical Society
12. Connecticut Urology Society
13. Department of Public Health
14. Northwest Nurse Practitioner Group
15. Quinnipiac University
16. The Kowalski Group
17. University of Saint Joseph

18. Yale New Haven Health

Scope of Practice Review Committee Evaluation of Request

ConnAPA's scope of practice request included all of the required elements as outlined below.

Health & Safety Benefits

The ConnAPA described a number of health and safety benefits it believes can result from changing the relationship between the PA and the physician from supervising to collaborative. These benefits included that the proposed revisions will decrease healthcare costs and increase access to healthcare.

Access to Healthcare

The ConnAPA proposal described that increased access to health insurance, population growth and patient aging have created a demand for healthcare services that cannot be met within the current healthcare workforce. The ConnAPA also referenced The Sustinet Healthcare Workforce Task Force Report, published in 2010 which indicated, at the time the report was published, that Connecticut was already encountering a health care workforce shortage, which included physicians and PA's. Lastly, the ConnAPA asserted that the current PA scope of practice language has led to practice restrictions that have decreased access to care for Connecticut residents.

Laws Governing the Profession

The statutes governing the profession of physician assistant are found in the Connecticut General Statutes, Section 20-12a through Section 20-12i. Additionally, the submission included national legislative changes from 2016-2018 related to PA scope of practice and efforts to eliminate administrative barriers to care.

Current Requirements for Education and Training and Applicable Certification Requirements

The current general requirements for licensure as a physician assistant in Connecticut and in accordance with Connecticut General Statutes, Section 20-12b are:

- A baccalaureate or higher degree in any field from a regionally accredited institution of higher education;
- Graduated from an accredited physician assistant program;
- Passed the certification examination of the national commission;

- Has satisfied the mandatory continuing medical education requirements of the national commission for current certification by such commission and has passed any examination or continued competency assessment the passage of which may be required by the national commission for maintenance of current certification by such commission; and
- Has completed not less than sixty hours of didactic instruction in pharmacology for physician assistant practice approved by the department.

The ConnAPA referenced initial national certification and certification maintenance requirements, including but not limited to, attaining a minimum of 100 hours of continuing medical education approximately every two years. Successful completion and maintenance of the certification requirements permits the PA to use the initials PA-C. Connecticut has six PA programs offered by Connecticut universities.

Summary of Known Scope of Practice Changes

Since 2012 multiple revisions have been made to the scope of the PA practice in Connecticut, with a significant revision with Public Act 18-168, Section 79 which repealed the cap on the number of PA's who could be supervised by an individual physician. This revision aligned Connecticut's PA scope of practice with all of the American Academy of Physician Assistant's six elements of a modern PA scope of practice.

Impact on Existing Relationships within the Health Care Delivery System

The ConnAPA's proposal emphasizes that team practice with physicians is the hallmark of the PA profession and will continue to support that PA's practice fully and efficiently while protecting public health and safety. In addition, the ConnAPA indicated that the association's leadership has engaged in discussion regarding their proposed revisions to many physicians who support the proposal. However, ConnAPA acknowledges that consensus has not been met in previous discussions with all associations, academies, and societies.

Economic Impact

The ConnAPA suggests that the request to revise the PA practice to move from physician supervision to a model of collaboration will enhance practice and result in positive impact to the healthcare delivery system. The ConnAPA referenced several areas that will promote efficiencies whereby there will be better deployment of PAs within the healthcare workforce and result in decreases in overall health care costs.

Regional and National Trends

The proposal referenced multiple journal articles and medical organizations which support adaptable collaboration requirements that included in part, the American College of Physicians, the American Academy of Family Physicians, the American Congress of Obstetricians and the American Academy of Physician Assistants (AAPA). The AAPA has published a document listing each state and the six elements of a Modern PA Practice Act. Such document identifies the six key elements as follows:

1. Licensure as regulatory term;
2. Full treatment;
3. Scope determined at Practice Site;
4. Adaptable supervision/collaboration requirements;
5. Chart co-signature determined at the practice level; and
6. Physician may practice with unlimited numbers of PA's.

Notably, the AAPA document has identified Connecticut as enacting all six key elements, along with Massachusetts and Rhode Island, as three of the six states in the New England area enabling all six key elements of a modern PA practice act.

Other Health Care Professions that may be Impacted by the Scope of Practice Request as Identified by the Requestor

The ConnAPA emphasized that the proposed revisions are not an effort for consideration for independent practice authority. The ConnAPA described being prepared for conversations with physician groups who may be in disagreement with the proposed revisions to the PA practice. ConnAPA acknowledged that Advanced Practice Registered Nurse organizations/associations may have questions as well, but the ConnAPA indicated they anticipate reaching consensus with this group of practitioner.

Description of How the Request Relates to the Profession's Ability to Practice to the Full Extent of the Profession's Education and Training

The ConnAPA described that governance of state laws serves two purposes: to ensure a competent workforce and define the role of PA's in the healthcare system. The ConnAPA cited the Institute of

Medicine (IOM Report 2010), “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.”

Findings/Conclusions

The ConnAPA submitted a scope of practice request to revise the scope of practice of a PA. Currently, Connecticut General Statutes require a PA to work under the supervision, control, responsibility and direction of a Connecticut licensed physician. The ConnAPA is proposing, in part, that the statute be revised to replace the term supervision with collaboration.

The scope of practice review committee reviewed and discussed all of the information provided in the ConnAPA’s scope of practice request during the two scope of practice review committee meetings conducted on December 4 and 10, 2018.

The ConnAPA the scope of practice request describes the associations goals as follows:

1. Establishing a collaborative relationship with the physician and healthcare team rather than a supervisory role;
 - This portion of the request was to replace the term supervision with collaboration. The committee members, other than the PAs and academic institutions that train PAs, were not supportive of this revision and felt that supervision is appropriate role for a PA to work in relationship to a physician. The physician organizations stated that the current supervisory role of PAs is not burdensome.
2. Allow the PA to practice to the full extent of their education, training and experience;
 - This portion of the request had two components: 1) eliminate the concept that a PA is an agent of the physician, and 2) include PA by professional name in all relevant health statutes.
 - The physician organizations opposed the elimination of the concept that a PA is an agent of the physician. Representatives from the physician organizations stated that they are comfortable with the existing status of a PA being an agent of the physician, and the physician being responsible for the care provided by a PA under supervision.
 - Members of the committee were supportive of PAs being included in many of the various statutes that have been updated to include APRNs since the APRN

scope of practice was updated. However, the group encouraged the PAs to identify those statutes and propose the appropriate revisions. The group also acknowledged that APRNs continue to update statutes related to their scope of practice. The APRNs expressed a willingness to work collaboratively with PAs to update all statutes that should reflect the scope of practice of PAs and APRNs.

3. Decreasing administrative burdens

- This portion of the request proposed to remove the statutory requirement that a supervising physician review and approve, in the record, every time a PA prescribes a schedule II or III controlled substance. This portion of the request also proposed to remove the supervising physician's responsibility to review the care provided by a PA.
 - The group discussed how the requirement for a physician to sign off and approve a PA prescribing certain controlled substances only applied to the initiation of a controlled substance prescription, but that PAs are allowed to renew prescriptions without a physician review and approval. The group discussed the potential benefits of reviewing each initiation of a controlled substance prescription for a patient. The physician organizations at the table did not feel it was burdensome to review and approve schedule II and III controlled substance prescriptions prescribe by a PA under their supervision.
 - The physician organizations did not feel it was burdensome that the statutes require a supervision physician to review the care provided by PAs under their supervision.

4. Remove the barriers that are currently in place regarding certification of marijuana for debilitating condition.

- The committee did not address this portion of the request as it pertains to statutes under the jurisdiction of the Department of Consumer Protection.

The ConnAPA and representatives from academic institutions committee members asserted that the level of education and training that the PA receives are sufficient to revise the PA statutes as requested by ConnAPA. Representatives from the ConnAPA referenced the expansion of the Advanced Practice Registered Nurse (APRN) scope which includes collaboration, and that such scope should be a model for Connecticut.

The medical organizations/associations reinforced the integral role the PA serves as a member of the healthcare team all settings. However, there was general agreement across the physician organizations/associations that the supervisory role that physicians currently provide, and is required by statute, is not burdensome. The physician organizations discussed how they already

work collaboratively with PAs who work under their supervision and reinforced that the manner and degree of supervision varies with each individual PA based on that PA's skills and training. These organizations felt that physician supervision of PAs is an important aspect of that relationship.

There was overall agreement among the committee members that there are statutes throughout CGS, and outside of those in Chapter 20 that govern the PA profession, that could be updated to include PAs and align with APRNs and physicians included in those statutes.

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Appendix A

Scope of Practice Law

Connecticut General Statutes 19a-16d - 19a-6f

Sec. 19a-16d. Submission of scope of practice requests and written impact statements to Department of Public Health.

Requests for exemption. Notification and publication of requests. (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.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) 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;

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

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

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

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

(G) 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;

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

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

(J) 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;

(K) 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

(L) 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.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 19a-16e. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or

(C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted 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.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the

department a written statement identifying the nature of the impact not later than October first of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October fifteenth of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

Sec. 19a-16e. Scope of practice review committees.

Membership. Duties. (a) On or before November first of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each timely scope of practice request submitted to the department pursuant to section 19a-16d. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 19a-16d to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

(b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the

committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.

(c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.

Sec. 19a-16f. Report to General Assembly on scope of practice review processes. On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections 19a-16d and 19a-16e and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on the effectiveness of such processes in addressing scope of practice requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

Appendix B

Review Committee	Email
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CT State Medical Soc. (CSMS)

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CT APRNs

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CT Nurses Association

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CT Academy of Family Physicians

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PA Lobbyist

Kowalski, Linda Lkowalski@thekowalskigroup.com;

Appendix C
Scope of Practice Request



(ConnAPA)

ConnAPA Scope of Practice Review Request¹

Date: August 15, 2018

Submitted to: The State of Connecticut Department of Public Health

By: The Connecticut Academy of Physician Assistants Government Affairs Committee

¹ Pursuant to Public Act 11-209, AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S OVERSIGHT RESPONSIBILITIES RELATING TO SCOPE OF PRACTICE DETERMINATIONS FOR HEALTH CARE PROFESSIONS: *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.
<https://www.cga.ct.gov/2011/ACT/Pa/pdf/2011PA-00209-R00HB-06549-PA.pdf>

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Appendix 23

On behalf of more than 2600 licensed Physician Assistants (PAs) in the state of Connecticut, the Connecticut Academy of PAs (ConnAPA) seeks to modernize the PA Practice Act to improve patient access to care and promote flexible and efficient care delivery for the residents of the State of Connecticut.

I. A plain language description of the request:

- a. **ADAPTIVE COLLABORATION REQUIREMENTS and modernize current PA practice statute by replacing the term “supervision” with “collaboration”² to reflect guidelines³ and recommendations from the American Academy of PAs,^{4,5} as well as several medical organizations, (including the American College of Physicians,⁶ the American Academy of Family Physicians,⁷ the American Congress of Obstetricians and Gynecologists,⁸ the American Osteopathic Association⁹, the National Governor’s Association¹⁰ and more^{11,12}) that support adaptable collaboration requirements. Such changes have been shown to decrease the overall cost of healthcare and increase access to care.¹³ As well such changes would improve the statutory and regulatory environments for PA practice, would help to remove barriers to PA employment, and would foster more PA-positive workplace environments. Adaptive collaboration means the continuous process by which a PA provides services within a healthcare team that includes one or more physicians. Adaptive collaboration would be determined by written agreement at the practice level.**

² “Collaboration” best describes PA practice, American Academy of PAs, November 2016, https://www.aapa.org/wp-content/uploads/2017/02/COLLABORATION_Describes-PA-practice_11-2-16.pdf, accessed July 16, 2018.

³ Guidelines for State Regulation of PAs (2017), American Academy of PAs, https://www.aapa.org/wp-content/uploads/2017/02/Guidelines_for_State_Regulation_of_PAs-1.pdf accessed July 16, 2018.

⁴ Model state legislation for physician assistants, American Academy of PAs, https://www.aapa.org/wp-content/uploads/2017/02/Model_State_Legislation_May_2016-1.pdf, accessed July 16, 2018.

“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 shall be continuous but shall not be construed to require the physical presence of the physician at the time and place that services are rendered.

⁵ Six Key Elements of a Modern State PA Practice Act, American Academy of PAs, https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief_Six-key-elements_0117-1.pdf, accessed July 30, 2017.

⁶ Doherty RB, Crowley RA, for the Health and Public Policy Committee of the American College of Physicians. *Principles Supporting Dynamic Clinical Care Teams: An American College of Physicians Position Paper*. Ann Intern Med. 2013;159:620-626. doi: 10.7326/0003-4819-159-9-201311050-00710. <http://annals.org/aim/article/1737233/principles-supporting-dynamic-clinical-care-teams-american-college-physicians-position>, accessed July 30, 2017.

⁷ Team-Based Care, American Academy of Family Physicians <http://www.aafp.org/about/policies/all/teambased-care.html>, accessed July 30, 2017.

⁸ 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. American Congress of Obstetricians and Gynecologists. March, 2016. <http://www.acog.org/Resources-And-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care>, accessed July 30, 2017.

⁹ Osteopathic Physicians and Physician Assistants: Excellence in Team-Based Medicine, A Joint Statement of the American Osteopathic Association and the American Academy of Physician Assistants July 2013. <https://www.osteopathic.org/inside-aoa/public-policy/state-government-affairs/Documents/aoa-aapa-statement.pdf> accessed July 30, 2017.

¹⁰ National Governors Association. The Role of Physician Assistants in Health Care Delivery. September 2014 <http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1409TheRoleOfPhysicianAssistants.pdf>.

¹¹ Major groups support PA practice and collaboration, American Academy of PAs, November 2016. https://www.aapa.org/wp-content/uploads/2017/02/COLLABORATION_Major-groups-support-PAs_11-2-2016.pdf, accessed July 30, 2017.

¹² Physician Assistants: Modernize Laws to Improve Rural Access. National Rural Health Association, April 8, 2018. https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/04-09-18-NRHA-Policy-Physician-Assistants-Modernize-Laws-to-Improve-Rural-Access.pdf. Accessed August 12, 2018.

¹³ The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care, Health Policy. 121 (2017) 189-196.

b. **ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION, TRAINING AND EXPERIENCE:**

-Eliminate the concept that a PA should be considered the “agent”¹⁴ of a physician by removing language in statute requiring the collaborating physician to assume responsibility of care provided by the PA. PAs should be responsible for their own professional actions. Nothing in statute should require or imply that the physician is responsible or liable for the care provided by a PA, unless the PA is acting on the specific instructions of the physician or, if employed directly by the physician, under the concept of *Respondeat Superior*.¹⁵

-Include PAs by professional name specifically in all relevant health statutes and regulation to harmonize statutes with physicians and advanced practice nurses and to facilitate timely and efficient delivery of healthcare services.

For example:

-Specify PAs as “licensed practitioners” authorized to order patient restraint & seclusion.¹⁶

-Allow PAs to sign any forms that require a physician signature, including DNR.

- c. **PROMOTE ADMINISTRATIVE SIMPLIFICATION by eliminating the administrative burden to collaborating physicians imposed by redundant chart documentation requirements.** The written agreement requirement in statute addresses the medical duties and functions of the PA, including the initiation of controlled substances, as well as the physician responsibility to review the care provided by the PA. Given that prescribing controlled substances is clearly addressed statutorily in the required written agreement, the additional requirement for documentation of the physician’s “approval” in the patient’s medical record for controlled substances is redundant and does not add value to the care of the patient.
- d. **REMOVE THE BARRIER that prohibits PAs from certifying “debilitating medical conditions” in the context of the Medical Marijuana Program.** PAs diagnose and treat a wide variety of complex conditions every day in Connecticut. In private practice especially, PAs often have their own panel of patients that they are responsible for. It is intuitive that PAs should be able to have the ability to officially certify the medical conditions that qualify for Connecticut’s Medical Marijuana Program.

Background: PAs are Integral Members of the Healthcare Workforce

Increased access to health insurance since the Affordable Care Act of 2010, population growth and patient aging have created an exponential increase in demand for healthcare services that cannot be met by the current healthcare workforce. According to a study released by the Association of American Medical Colleges (AAMC), “...physician demand will grow faster than supply, leading to a projected...shortfall of between 42,600 and 121,300 physicians by 2030.” That is a higher predicted shortfall than last year’s report and takes into account “projected rapid growth in the supply of APRNs

¹⁴ <https://legal-dictionary.thefreedictionary.com/agent>. Accessed June 21, 2018.

¹⁵ <http://legal-dictionary.thefreedictionary.com/respondeat+superior>. Accessed June 21, 2018.

¹⁶ See §482.13(e)(5). The Centers for Medicare and Medicaid Services (CMS) Medicare Conditions of Participation for Hospitals require specificity in State law with regards to who may order restraints or seclusion. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Accessed July 30, 2017.

and PAs and their role in care delivery.”¹⁷ Meanwhile, the Bureau of Labor and Statistics (BLS) predicts a 37% growth in employment for PAs through 2026, which is said to be “Much faster than average.”¹⁸ Improving access to medical care provided by PAs can help meet growing patient demand in the face of a physician shortage.

Connecticut is experiencing many of the same challenges reflected in the national data. The Sustinet Healthcare Workforce Task Force report,¹⁹ published in 2010, showed that Connecticut was already facing a shortage of many health care workforce categories, including physicians and PAs. According to the Robert Graham Center projections published in 2013, pressures from a growing, aging, increasingly insured population were again cited as contributing to workforce shortages. All states have an obligation to protect their residents by regulating the practice of medicine within the state. By licensing the PA profession through state law and designating a state agency to regulate PA practice, states both protect the public and define the role of PAs. As the delivery of healthcare has evolved, state legislators have modified their approach to PA regulation in response to a growing body of information demonstrating the safety and high quality of PA practice²⁰ and the need to better utilize their healthcare workforce. The Connecticut Health Care Workforce Scan showed that 27% of physicians and surgeons are aged 60 or older, with impending retirement contributing to the impending physician shortage in the state.²¹ In 2011, the Connecticut Department of Health’s report on Health Care for Connecticut’s Underserved Populations identified 104 designated Health Profession Shortage Areas.²² The Robert Graham Center Report called on Connecticut policymakers to consider strategies to bolster the primary care pipeline to address current and growing demand for PCPs to adequately meet health care needs. (See Figure 1.)²³

¹⁷ IHS Inc., *The Complexities of Physician Supply and Demand 2018 Update: Projections from 2016 to 2030*, March 2018, https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf. Accessed June 22, 2018.

¹⁸ Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2017-18 Edition*, Physician Assistants, on the Internet at <https://www.bls.gov/ooh/healthcare/physician-assistants.htm>. Accessed June 21, 2018.

¹⁹ Sustinet Healthcare Workforce Task Force (2010). Final Report, http://www.ct.gov/sustinet/lib/sustinet/taskforces/healthcareworkforce/sustinet_wkfrce_report_dh_ema_final_with_cover.pdf. Accessed July 30, 2017.

²⁰ Articles and Reports on the PA Profession: Selected Topics, American Academy of PAs, April 2018. https://www.aapa.org/wp-content/uploads/2017/11/Bibliography-on-the-PA-Profession-11_17_17.pdf. Accessed June 22, 2018.

²¹ University of Connecticut Center for Public Health and Health Policy (2013). *Connecticut Healthcare Workforce Scan*. http://www.healthreform.ct.gov/ohri/lib/ohri/sim/work_force/ct_healthcare_workforce_scan.pdf. Accessed July 30, 2017.

²² Connecticut Department of Public Health (2011). *Healthcare for Connecticut’s Underserved Populations*. http://www.ct.gov/dph/lib/dph/hisr/pdf/medically_underserved_issuebrief2011.pdf. Accessed July 30, 2017.

²³ Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C. <http://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Connecticut.pdf>. Accessed June 21, 2018.

Workforce Projections 2010-2030

To maintain current rates of utilization, Connecticut will need an additional 404 primary care physicians by 2030, a 15% increase compared to the state's current (as of 2010) 2,580 PCP workforce.

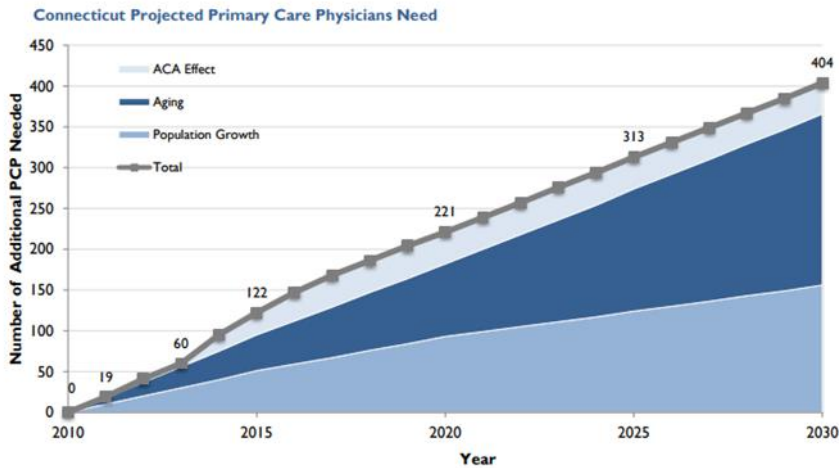


FIGURE 1

According to the National Commission on Certification of Physician Assistants (NCCPA), only 15.9% of the certified PAs in the state of Connecticut practice in Primary Care. That figure has stayed steady for several years, even as the number of licensed PAs continues to increase in CT. The NCCPA goes on to find that there appears to be a gross mal-distribution of PAs within CT, **ranking the state second to last in the US in terms of utilization of PAs in primary care settings.**^{24,25} The nationwide percentage of PAs in primary care is 26.7%. By modernizing the PA Practice Act, CT policymakers can reduce practice barriers for the deployment of PAs into the healthcare workforce and facilitate integration into more practices and settings in desperate need of medical practitioners, such as primary care.

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

a. ADAPTIVE COLLABORATION REQUIREMENTS

From the AAPA:

“Fifty years ago, when the PA profession began, typically, a PA practiced with a single physician, small medical group or in a hospital. Because the new profession had no track record to assure regulators of their excellent training or quality, practice laws were written with built-in precautions, such as designated physician supervisors and no prescriptive authority. Over time, countless studies documented the high quality medical care and expanded access PAs provide. As evidence of high quality care and patient safety became clear, legislators realized PA supervision laws were overly restrictive. So they began updating the laws, allowing PAs and physicians to practice in separate locations, authorizing PAs

²⁴ 2015 Statistical Profile of Certified Physician Assistants by State, National Commission on Certification of Physician Assistants 2015, <https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2015StatisticalProfileofCertifiedPhysicianAssistantsbyState.pdf>, Accessed June 22, 2018.

²⁵ 2017 Statistical Profile of Certified Physician Assistants: An Annual Report of the National Commission on Certification of Physician Assistants., National Commission on Certification of Physician Assistants 2018, <http://prodcmsstoragesa.blob.core.windows.net/uploads/files/2017StatisticalProfileofCertifiedPhysicianAssistants.pdf>, Accessed June 22, 2018.

to prescribe, eliminating limits on PAs-to-physician practice ratios, and allowing individual teams to define their practices. Studies confirmed that quality remained high. Malpractice claims since 1990 reveal a remarkably low number of claims paid against PAs.”²⁶

The word “supervise” no longer accurately depicts the professional relationship between PAs and physicians and diminishes the role PAs currently hold in the healthcare workforce. The antiquated terminology has led to variable interpretations of statute, creating a real or perceived barrier to utilization of PAs, with a bias toward NPs in a variety of settings. In some instances however, higher functioning healthcare organizations in Connecticut currently employing PAs have already adopted the team-based care language and “collaboration” when referring to PAs in their public relations materials and websites. (See Figures 2, 3, 4, 5, 6) Therefore, adopting the language of “collaboration” in statute would provide clarity and understanding to the professional relationship between physicians and PAs, which is already evolving in team-based practice.

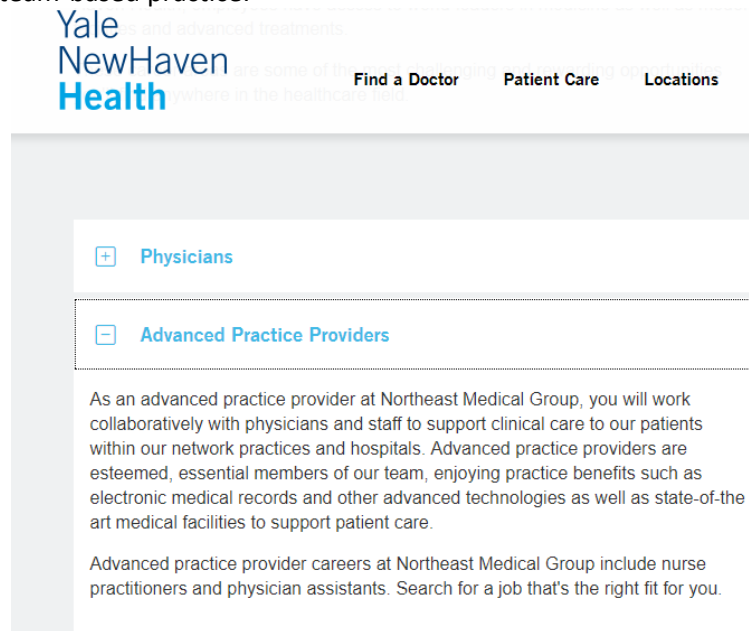


FIGURE 2 ²⁷

²⁶ “Collaboration” best describes PA practice, American Academy of PAs, November 2016, https://www.aapa.org/wp-content/uploads/2017/02/COLLABORATION_Describes-PA-practice_11-2-16.pdf. Accessed August 14, 2018.

²⁷ <https://www.ynhhs.org/careers/nemg/career-areas.aspx>, accessed July 30, 2017.

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Diagnostic Radiology

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+ Laboratory Medicine

- Physician Assistant

Yale New Haven Hospital offers physician assistants unique opportunities to face a complex case mix, play a key role in patient care and collaborate with our Emergency Medicine and Surgery departments. Join our staff to be a part of Medical and Pediatric teams who continually learn at the side of world-renowned physicians.

Getting Started

Upon joining our team as a Physician Assistant, you'll take part in our individually-tailored orientation program, giving you the opportunity to demonstrate specialty-specific competencies, and—at the same time—helping you become familiar with the workflow of each specialty service within the hospital.

FIGURE 3²⁸

St. Vincent's Medical Center

FIND A DOCTOR MEDICAL SERVICES PATIENTS & VISITORS COMMUNITY & WELLNESS HEALTH PROFESSIONALS BLOG AND NEWS

THE MSG TEAM ADVANTAGE: OUR TEAM OF PHYSICIANS, APRNS AND PAS ARE COMMITTED TO:

- Delivering comprehensive care by multi-disciplinary teams
- Improving continuity of care for individuals
- Improving coordination of care among the full spectrum of healthcare professionals
- Strengthening preventative approaches to tackle major disease burden
- Enhancing private and public collaboration to improve the availability of quality of care for chronic disease patients
- Emphasizing patient-centric care and patient empowerment
- Supporting professional development and quality improvement
- Strengthening organizational and infra-structural support for successful MSG relationships.

FIGURE 4²⁹

²⁸ <https://www.ynhh.org/careers/career-areas/other-clinical-professionals.aspx>, accessed July 30, 2017.

²⁹ <https://www.stvincents.org/health-professionals/multispecialty-group/for-med-professionals>, Accessed July 30, 2017.

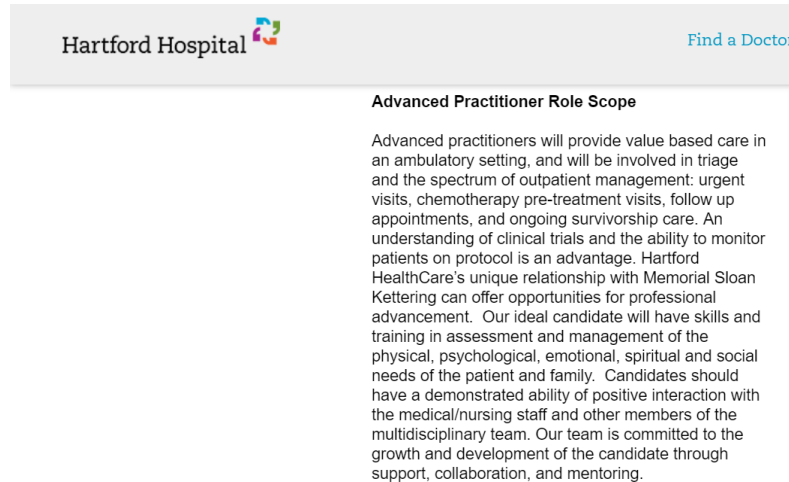


FIGURE 5³⁰



FIGURE 6³¹

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

b. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION, TRAINING AND EXPERIENCE

The primary benefit of removing “agency” would be to further provide clarity to the collaborative relationship between the physician and PA. When practicing in collaboration with a physician, **PAs are responsible for the care they provide**. Legislation should not mandate physician liability for the acts of PAs through this agency, supervisory relationship. As fewer physicians own their medical practices, with the latest figures from the AMA finding only 47.1% of physicians remaining practice owners as of 2016,

³⁰ <https://hartfordhospital.org/health-professionals/for-job-seekers/career-opportunities/external-job-postings>. Accessed June 22, 2018.

³¹ <https://www.jointrinityne.org/Opportunities/Opportunity/primary-care-nurse-practitioner-physician-assistant-np-pa-smh>. Accessed June 22, 2018.

and are subsequently becoming employed themselves, with two thirds of physicians under 40 in employed positions, the model of PAs working as employees of the physician has become less common.^{32, 33} As a result, employed physicians are reluctant to enter into supervisory agreements and accept liability for PAs, while the organization benefits financially from the increased business and revenue generated by the PAs.

The consequence of not removing “agency” would be the continued hesitancy on the part of some physicians to collaborate with PAs for fear of assigned liability for having done so. This has created a perceived bias in favor of APRNs in some organizations, because the physicians feel unencumbered by any responsibility for the actions of the APRN.

Adding PAs to the list of medical providers along with physicians and APRNs who can perform certain medical functions will increase efficiencies and access to care, while minimizing the administrative burden currently faced by physicians particularly with regards to completion of certain medical forms and signatures. Waiting for a physician signature can lead to delay of care and potentially patient harm. Often PAs are finding difficulty with acceptance of signatures on various forms, though in theory the current “delegation agreement” should allow for such certifications. This provides a barrier to care as mentioned above and not correcting this issue will continue to lead to increased costs for scheduling new appointments with physicians for simple signatures and delayed services for the patient.

c. PROMOTE ADMINISTRATIVE SIMPLIFICATION by eliminating the administrative burden to collaborating physicians imposed by redundant chart documentation requirements.

Removing the physician ‘documentation of approval’ for the initiation of Schedule II and III controlled substances (often implemented in practice as co-signature) would not pose any additional risk to CT residents. PAs have extensive education, clinical experience in pharmacology and clinical pharmacotherapeutics, 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 prescribing controlled substances and pain management³⁴, and are required to register for controlled substance prescribing at the state (DCP) and federal (DEA) levels. This is all required for on-going licensure renewal and re-certification maintenance. PAs are also required to register and utilize the CT Prescription Drug Monitoring Program for ongoing patient safety and monitoring in exactly the same manner as CT physicians and APRNs. Additionally, PAs not only meet, but also exceed post-graduate training in the areas of clinical practice, post-graduate pharmacology, and CME requirements when compared to APRN colleagues according to the State of CT DPH.³⁵

³² Kane, Carol K. “Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership,” AMA Economic and Health Policy Research, July 2015.

³³ Kane, Carol K. “Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent,” AMA Policy Research Perspectives, June 2017.

³⁴ State of Connecticut Department of Public Health Licensing Requirements>Continuing Education <https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/Physician-Assistant/Continuing-Education>, accessed August 14, 2018.

“Connecticut licensed physician assistants must also complete not less than one contact hour of training or education in prescribing controlled substances and pain management in the preceding two- year period.”

³⁵ 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.

Additionally, physicians and PAs currently are statutorily required to enter into an agreement delineating how controlled substances are to be prescribed by the PA, as well as how the physician will review the care provided by the PA. Requiring the physician to also add documentation in the patient's chart is redundant, does not add value to the patient's care, and is an unnecessary time expenditure for the physician, already identified as a limited (and shrinking) workforce. Additionally, implementation of the electronic health record has been particularly complicated around this issue, as organizations struggle to implement the work flow to meet this onerous requirement.

Failure to remove this administrative redundancy will continue to burden the physicians and cause consternation for the organizations utilizing electronic health records. Significant time, energy and financial resources have been wasted as implementation teams struggle to meet this medical record documentation rule.

d. REMOVE THE BARRIER that prohibits PAs from certifying “debilitating medical conditions” in the context of the Medical Marijuana Program.

As primary care providers in Connecticut, 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, multiple sclerosis, spinal cord damage, epilepsy, PTSD, sickle cell disease, and other illnesses recently added to the list in order for appropriate patients to become eligible for medical marijuana.³⁶

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 authority to certify patients for medical marijuana.³⁷

Additional specific training, education or testing is not required as a prerequisite to physician or APRN certification authority. As primary care and specialty providers, the conditions listed by the Department of Consumer Protection are ones that PAs diagnose and treat on a daily basis in Connecticut. Therefore, PAs should be granted the same authority to certify patients for medicinal marijuana through their practice agreements with collaborating physicians. Doing so will increase access to care options for “debilitating medical conditions.”

Not removing this prohibition on PA abilities will continue to prohibit or delay access by patients who are cared for by PAs, to substances that can be of great assistance in relieving their serious, chronic medical conditions.

III. The impact that the requestor believes the request will have on the profession's ability to obtain or expand third party reimbursement for the services provided by the profession:

The request put forth in this document, ConnAPA feels should have little effect on the ability to obtain or expand third party reimbursement. The Connecticut General Statutes already [mandate](#) that insurance companies reimburse for the services performed by PAs. There remain some difficulties with PA enrollment and classification with some private insurers, and federal issues of direct reimbursement that are generally outside the scope of this request. However, with that said, it is believed that the changes requested in this proposal will increase the accountability of PA reimbursement. By maintaining

³⁶ CT Department of Consumer Protection, *Qualification Requirements*. <https://portal.ct.gov/DCP/Medical-Marijuana-Program/Qualification-Requirements>. Accessed July 5, 2018.

³⁷ 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. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/practitioner_licensing_and_investigations/Scope_of_practice_2014/ReporttotheGeneralAssemblyAPRN2314finalreportnoappendixrevpdf.pdf?la=en. Accessed July 5, 2018

a “supervisory” relationship, it will continue to propagate the all too common practice of physician attestations that then push billing under the physician, instead of the PA who actually provided the service. Eliminating this practice will help to increase transparency and provide accountability for PA services.

IV. *The impact that the request will have on public access to health care:*

a. ADAPTABLE COLLABORATION 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. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION, TRAINING AND EXPERIENCE through removal of “agency” and inclusion of PAs in relevant statute alongside physicians and APRNs, where currently excluded, to assure patients’ health care needs are fully served and protected.

As previously stated, the removal of “agency” and physician liability will open doors to increased collaboration with physicians and the organizations for which they provide services, adding to the available workforce and therefore access to care.

Once PA inclusion in appropriate areas of statute is implemented, PAs will be able to provide improved access, higher quality and more cost-effective care to patients and assure that their health care needs are served and protected. Along with our physician colleagues, PAs 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, surgi-centers, intensive care units, and specialty intensive care units.

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

The unintended consequence of Public Act 16-39 is that healthcare organizations and physicians view the expansion of the APRN’s abilities to perform many of the “duties” previously limited to physicians as relieving the physician burden, making the APRN a preferred candidate for employment. As a result, while a PA may be more than capable, the job is often posted solely for APRNs. It bears mentioning that PAs are also afforded the ability to perform many of the physician functions as delineated in the written

agreement. Unfortunately, by naming APRNs as having “authority”, with no mention of PAs specifically, this has been interpreted to mean that PAs are not authorized to perform certain functions, by virtue of their not being included.

PAs are trusted healthcare providers. Studies have shown that when PAs practice to the full extent of their abilities and training, hospital readmission rates and lengths of stay decrease and infection rates go down. A Harris Poll found extremely high satisfaction rates among Americans who interact with PAs. The survey found that 93 percent regard PAs as trusted healthcare providers, 92 percent said that having a PA makes it easier to get a medical appointment and 91 percent believe that PAs improve the quality of healthcare.³⁸

c. PROMOTE ADMINISTRATIVE SIMPLIFICATION by eliminating the administrative burden to collaborating physicians imposed by redundant chart documentation requirements.

Removing the physician “documentation of approval” of Schedule II and III controlled substances would increase patient access to care by freeing both physicians and PAs from the excessive time burdens that over-prescriptive tasks such as unnecessary and redundant documentation impose.

d. REMOVE THE BARRIER that prohibits PAs from certifying “debilitating medical conditions” in the context of the Medical Marijuana Program.

By eliminating the restriction on PAs’ ability to certify debilitating conditions that qualify patients for the Medical Marijuana Program, patients will have increased access to alternative forms of treatment that the State of Connecticut Legislature deemed effective enough to permit in CT in 2012. PAs are primary and specialty care providers, who while working in the context of the overall healthcare team, often have their own panel of patients. When a patient presents with one of the listed conditions and a request for medical marijuana certification, a PA is then unable to certify them when they are the primary medical provider for the patient, thus limiting their patients access to care. While the patient could then further delay their care and see a physician within the practice who could certify the condition, it is far more appropriate for the primary provider to assess the appropriateness for such certification.

V. *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 Department of Public Health in the State of Connecticut, with additional oversight by the Connecticut Medical Examining Board. Federally, PAs are recognized as Medicare Part B providers of professional services and ordering and referring providers by the U.S. Department of Health and Human Services, as well as State Medicaid, administered by the Department of Social Services in Connecticut.

VI. *The state's current regulatory oversight of the health care profession making the request:*

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

³⁸ *Attitudes Towards Physician Assistants*. American Academy of PAs, October 2014. <https://www.aapa.org/wp-content/uploads/2017/01/AAPA-HarrisSurvey-Methodology-and-Tables.pdf>. Accessed June 24, 2018.

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

a. Education/Training

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

ARC-PA is the accrediting agency that protects the interests of the public and physician assistant profession by defining the standards for physician assistant education and evaluating physician assistant educational programs within the territorial United States to ensure their compliance with those standards. The average PA program curriculum runs approximately 24-32 months and requires at least four years of college and some health care experience prior to admission. There are more currently 234 PA programs accredited in the United States, with 32 additional programs in development.

Due to an education modeled on the medical school curriculum, PAs learn to make life saving diagnostic and therapeutic decisions while working autonomously or in collaboration with other members of the healthcare team. PAs are certified as medical generalists with a foundation in primary care. Because of the close working relationship PAs have with physicians, PAs are educated in a medical model designed to complement physician training. PA students are taught, as are medical students, to diagnose and treat medical problems. The education consists of classroom and laboratory instruction in the basic medical and behavioral sciences (such as anatomy, pharmacology, pathophysiology, clinical medicine, and physical diagnosis), followed by clinical rotations in internal medicine, family medicine, surgery, pediatrics, obstetrics and gynecology, emergency medicine, and geriatric medicine as outlined by robust ARC-PA Accreditation Standards 4th edition for PA programs. All PA programs must meet the same [ARC-PA standards](#).

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

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

b. [NCCPA Examination/Certification Requirements](#)

Initial Certification

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

designation until the certification expiration date. Approximately every 2 years thereafter, 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 maintenance of certification by the National Commission on Certification of PAs (NCCPA). 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.

See also: [PA Education and Training](#) and [PA Certification and Licensure](#).

c. Accredited PA Programs in Connecticut

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

- Yale University School of Medicine Physician Associate Program
 - <https://medicine.yale.edu/pa/>
- Yale University School of Medicine Physician Assistant Online Program
 - <https://paonline.yale.edu/>
- Quinnipiac University School of Health Sciences Physician Assistant Program
 - <https://www.qu.edu/school-of-health-sciences/graduate-programs/master-of-health-science-physician-assistant/faq/>
- University of Bridgeport Physician Assistant Institute
 - <http://www.bridgeport.edu/academics/graduate/physician-assistant-ms/>
- Sacred Heart University Physician Assistant Studies
 - <http://www.sacredheart.edu/academics/collegeofhealthprofessions/academicprograms/physicianassistant>
- University of St. Joseph Physician Assistant Studies Program
 - <https://www.usj.edu/academics/schools/sppas/physician-assistant-studies/>

VIII. 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:

- **2018**
 - 6:1 PA to physician supervision ratio repealed (HB 5163, PA 18-168)
 - PAs authorized to perform oral health screenings of public school students (HB 5163, PA 18-168)
 - PAs can certify a woman's pregnancy for the purposes of her application for health insurance outside of a normal enrollment window (PA 18-43)
- **2017**
 - Scope of Practice review request submitted to DPH- not selected for review
 - PAs permitted to give orders for peripheral IV with normal saline flush placement by a phlebotomist (HB 7174)

- Inclusion in work group to study projected shortage in psychiatry workforce (HB 7222, PA 17-146)
- **2016**
 - Scope of Practice review request submitted to DPH- not selected for review
 - PAs 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)
 - PAs given authority to counsel patients and administer Hepatitis C vaccine (SB 257, PA 14-203)
- **2013**
 - PA authority included in and outlined in medical spa legislation (bill was vetoed; SB 1067, PA 13-284)

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

The above requested changes would have a positive 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 previously discussed this matter with the Connecticut State Medical Society, the Connecticut Academy of Family Physicians and the Connecticut Hospital Association. Each group has expressed hesitation for various reasons and on our own it seems that we have been unable to reach consensus on our requests. Bringing these parties together and discussing it in the same room will help to bring out each party's concerns and allow ConnAPA to provide reassurance and evidence that our requests will strengthen our team and provide increased access to care.

a. ADAPTABLE COLLABORATION REQUIREMENTS

The above requested changes would have a no identified negative impact on physicians or the relationship between physicians and PAs. ConnAPA is not seeking independent practice authority outside of the team-based Physician-PA model of care – 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, a standpoint that was reaffirmed by the AAPA House of Delegates in 2017.

- b. ALLOW PAs TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION, TRAINING AND EXPERIENCE through the 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 liability for the physician for acts of the PA.

As previously stated, even when practicing in collaboration with a physician, PAs are responsible for the care they provide. Nothing in the law should require or imply that the collaborating physician is responsible or liable for the care provided by the PA unless the PA is acting on the specific instructions of a physician.

- c. PROMOTE ADMINISTRATIVE SIMPLIFICATION by eliminating the administrative burden to collaborating physicians imposed by redundant chart documentation requirements, specifically the “documentation of approval” in the medical record for initiation of Schedule II and III controlled substances.**

ConnAPA believes the vast majority of physicians will support this request, 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 use of the CT Prescription Drug Monitoring Program.

Additionally, hospitals and other healthcare organizations will likely support this provision as the removal of any unnecessary regulatory burden increases availability of the physicians to provide additional healthcare services and reduces the probability of non-compliance with a rule that provides no additional value to the health and safety of the public.

- d. REMOVE THE BARRIER that prohibits PAs from certifying “debilitating medical conditions” in the context of the Medical Marijuana Program.**

ConnAPA feels that eliminating this barrier would be supported by physicians for similar reasons as the bullet listed above. By allowing PAs to certify conditions for medical marijuana, it eliminates unnecessary administrative burden. It additionally eliminates visits for the patient with the physician, which subsequently allows the physician to spend time seeing additional patients, instead of then delaying care to multiple patients by scheduling such a visit. PAs are educated and trained in the diagnosis of every medical condition for which the Department of Consumer Protection states can qualify our patients to apply for medical marijuana.

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

ConnAPA has uncovered no data to suggest that any of these changes will increase health care costs. On the contrary, there are multiple studies that conclude that initiatives aimed at improving practice efficiencies of PA-physician teams decrease overall health care costs.^{39,40}

XI. *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:*

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.

2017-2018 State Legislative Changes for PA Practice

In recent years, many states have been updating their laws and regulations to expand PA scope of practice and eliminate administrative barriers to care. 2017 and 2018 continued a trend towards positive changes in the regulatory environment for PA practice, with 5 additional states adopting language other than “supervision” to describe the PA-physician team.

- **July 2018:** On July 2, Rhode Island Gov. Gina Raimondo signed into law [H-7002 Sub A](#) which mandates insurance coverage for specified treatments related to mastectomies, including those ordered by PAs and NPs. Previous law had only required coverage for physician authorization.
- **July 2018:** Missouri enacted two bills, [SB 660](#) and [SB 718](#), which amends the definition of “mental health professional” to include psychiatric PAs to increase access to comprehensive psychiatric services as well as alcohol and drug treatment. Additionally, a number of other provisions to increase access to care were enacted including expanding prescriptive authority, encouraging methods to increase the number of providers with buprenorphine waivers, and other positive changes for PAs.
- **June 2018:** On June 22, the Rhode Island [2019 budget](#) was passed with the addition of PAs and NPs to the definition of **practitioner** as it relates to the definition of **medical marijuana**. This updated language will **allow** PAs to provide the certification that would allow a patient to utilize medical marijuana. PAs were previously able to certify for medical marijuana until the Department of Health

³⁹ Timmons, E. *The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care*, Health Policy. 121 (2017) 189-196.

⁴⁰ Hooker, R.S. & Muchow, A.N. (2015). Modifying state laws for nurse practitioners and physician assistants can reduce cost of medical services. *Nursing Economic\$,* 33(2):88-94.

- **May 2018:** Kansas updated **telemedicine** laws to mandate insurance payments for services provided by PAs
- **May 2018:** The District of Columbia removed **administrative barriers** to practice by amending requirements in regard to delegation agreements.
- **May 2018:** The Governor of Kentucky signed [HB 497](#) which amended the definition of “**Qualified Mental Health Professional**” to include PAs. This bill increases access to mental health care by **allowing** PAs to conduct evaluations of individuals who present a danger or threat of danger to themselves, family, or others for purposes of **involuntary commitment**.
- **May 2018:** May 8 saw Gov. Larry Hogan sign into law a bill that helped provide **access to care**, especially in rural settings, in regard to PA preparation and dispensing of medications (which could already be prescribed by the PAs).
- **April 2018:** Tennessee passed [SB 1515](#) which more appropriately changed the terminology used to describe the PA-physician team relationships from “supervision” to “**collaboration.**”
- **April 2018:** In Utah, PAs have faced administrative barriers to sign and **certify death** because the Vital Statistics Act only mentioned physicians and NPs, SB 68 now **adds PAs** to the Act.

2016-2017 State Legislative Changes for PA Practice

- **July 2017:** On Friday, July 7, Pennsylvania Gov. Tom Wolf approved [House Bill 424](#). The legislation amends the Pennsylvania Vital Statistics Law to allow PAs to sign death certificates.
- **July 2017:** The Governor of **State of West Virginia**, signed [S.B. 1014](#) into law allowing PAs to work with “**collaborating**” rather than “supervising” physicians, expanding PA prescriptive authority for Schedule III medications to 30 days from the current restriction of 72 hours, allows PAs to be reimbursed at the same rate as physicians and APRNs by prohibiting discrimination by insurance plans, adds an additional PA to the medical board, and authorizes PAs to **sign** an extensive list of forms that previously had to be signed by a physician, including death certificates, and eliminates the requirement for current and continuous NCCPA certification for license renewal. The law becomes effective September 2017.
- **June 2017:** **Texas** passed [H.B. 2546](#) which allows PAs to **sign** workers’ compensation forms and [H.B. 919](#), which allows PAs to **sign** death certificates if the PA was treating the decedent for the condition which contributed to his or her death or if the decedent was receiving hospice or palliative care.
- **June 2017:** **The State of Illinois passed the PA Modernization Act [SB1585](#). The Act replaces** references to “supervising physicians” with references to “**collaborating physicians**” throughout the Act and **replaces** references to “supervision agreement” with references to “**collaborative agreement**” throughout the Act.

[Of note, the [Illinois Medical Practice Act](#) also includes the following provision:
Sec. 54.5. (e):

A physician shall not be liable for the acts or omissions of a physician assistant or advanced practice nurse solely on the basis of having signed a supervision agreement or guidelines or a collaborative agreement, an order, a standing medical order, a standing delegation order, or other order or guideline authorizing a physician assistant or advanced practice nurse to perform acts, unless the physician has reason to believe the physician assistant or advanced practice nurse lacked the competency to perform the act or acts or commits willful and wanton misconduct.

- **June 2017:** The Governor of the **State of Nevada** signed Assembly Bill 199 authorizing PAs to *sign* and make determinations related to Provider Order for Life-Sustaining Treatment (POLST) forms. The new law allows PAs that have diagnosed a patient with a terminal condition to explain the features and procedures offered by a POLST form and to complete and execute the form. Assembly Bill 199 also authorizes a PA to revoke POLST forms if the PA determines the patient lacks the capacity to make decisions regarding the provision of life-sustaining treatment.
- **April 2017:** In **Mississippi**, new regulations were adopted by the Mississippi State Board of Medical Licensure (MSBML). Mississippi's new rules, which went into effect on April 17, made a number of significant improvements to PA licensure procedures and practice in the state, including **the removal of the physician/PA ratio**.
- **April 2017:** **New Mexico** passed [legislation](#) entitled *AN ACT RELATING TO THE PRACTICE OF MEDICINE; PROVIDING FOR **COLLABORATION** BETWEEN A PHYSICIAN ASSISTANT AND A LICENSED PHYSICIAN*.
- **April 2017:** **Utah** Gov. Gary Herbert recently signed [SB 162](#) **repealing the state's requirement for PAs to have all chart entries that contain a Schedule II or III prescription co-signed by a physician**.
- **March 2017:** **Arkansas** [Senate Bill 136](#), which was signed into law on March 9, 2017 states that PAs who are licensed by the Arkansas State Medical Board and meet specified criteria have the authority to examine, assess, and if necessary, involuntarily admit an individual who is experiencing a mental or behavioral health crisis.
- Also, in **Arkansas**, PAs will have greater authority to sign medical forms and certifications due to the enactment of [House Bill 1180](#), which became law on March 7, 2017. Under the new law, PAs will be able to sign several documents which previously could only be signed by physicians, including:
 - Certifications of disability for parking permits or placards;
 - Forms to accompany physicals for school athletics and bus drivers;
 - Forms related to do-not-resuscitate orders;
 - Forms excusing a potential jury member for medical reasons;
 - Death certificates;
 - Workers' compensation forms;
 - Forms relating to absences from school or employment; and
 - Authorizations for durable medical equipment.
- **March 2017:** **Virginia** passed [Senate Bill 1062](#)/[House Bill 1910](#) which became effective on July 1, 2017. The new law adds PAs to the definition of "mental health service provider" who has a duty to act when a patient threatens violence or serious harm to a third party.
- **March 2017:** **Michigan** [House Bill 5533](#) **removes physician responsibility for PA practice**, making each member of the healthcare team responsible for their own decisions. It also **removes the rigid ratio restriction that arbitrarily limited the number of PAs with whom a physician may practice**. Last, the new law grants PAs more autonomy to serve patients by recognizing PAs as full "prescribers" rather than limiting their care to "delegated prescriptive authority."

States that made significant and expansive changes to PA scope of practice in **2015-2016** include:

- PAs in Maine gained full prescriptive authority through Chapter 2 joint rule making between the allopathic and osteopathic board.
- Minnesota eliminated 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.

If the proposed changes were made to “approval in the medical record”/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.

XII. 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:

The CSMS and other physician organizations in CT will likely have questions about these requested changes to the PA Practice Act. We have previously had conversation telephonically about our proposal with physician groups, with mixed consensus. However, ConnAPA is convinced that, with face-to-face meetings and review of the literature, we will 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 enabling legislation for the CT APRNs passed in the past several years, ConnAPA anticipates there will be questions raised by the Connecticut APRN Society as well. We have reached out to discuss our submission with the APRNs and appreciate the input they were able to provide. However, given the evidence cited in the CTAPRN Scope of Practice Proposal *Request for Consideration of Scope of Practice Change, Connecticut APRN Society, August, 2013*, 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, 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 elements of the Six Key Elements as recognized by the American Academy of Physician Assistants 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.

XIII. 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.

The state of CT has made progress integrating many of these concepts into existing statute but not all. The lack of some of these key components restrict PAs from practicing to the full extent of their education and training, and delays or otherwise denies care to the 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. The conclusions reached in the [Institute of Medicine \(IOM\) 2010](#) report state, **“Scope of practice regulations in all states should reflect the full extent of not only nurses but of each profession’s education and training. Elimination of barriers for all professions with a focus on collaborative teamwork will maximize and improve care throughout the healthcare system.”**

In Conclusion:

ConnAPA 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

Articles on the PA Profession - Selected Topics

Quality and Outcomes of Care Provided by PAs

1. Yang, Y., Long, Q., et. al (2017). Nurse Practitioners, Physician Assistants, and Physicians Are Comparable in Managing the First Five Years of Diabetes. *The American Journal of Medicine*.

The article posits that the increased use of NPs and PAs is a potential solution to the issue of primary care provider shortages in the United States. In this specific investigation, the study found that diabetes management by NPs and PAs were similar to the treatment provided by physicians. Consequently, the researchers believe that employing NPs and PAs in broader sense may combat the shortages of providers observed in the health care setting.

[http://www.amjmed.com/article/S0002-9343\(17\)30904-X/fulltext](http://www.amjmed.com/article/S0002-9343(17)30904-X/fulltext)

2. Kurtzman, E.T., Barnow, B.S. (2017). A comparison of nurse practitioners, physician assistants, and primary care physicians' patterns of practice and quality of care in health centers. *Medical Care*.

A first-of-its-kind study found that PAs and nurse practitioners (NPs) delivered similar quality of care, services, and referrals in community health centers as physicians. Researchers at The George Washington University School of Nursing reviewed five years of data from the National Ambulatory Medical Care Survey's Community Health Center subsample and compared nine patient outcomes by practitioner type. The study could have implications for the structure of community health centers in the future.

http://journals.lww.com.lww-medicalcare/Abstract/publishahead/A_Comparison_of_Nurse_Practitioners_Physician.98777.aspx

3. Dies, N., Rashid, S., et. al (2016). Physician assistants reduce resident workload and improve care in an academic surgical setting. *Journal of the American Academy of Physician Assistants*.

The article investigates the educational demands and restricted hours of practice incurred by residents limiting the ability to provide adequate care at academic hospitals. This study sought to ascertain whether or not the employment of PAs would effect, and improve, patients eligible for discharge, resident workload, and residents perception of PAs as part of the physician and surgical team. The study concluded that PAs lessened the residents' workload and improved the residents' perception of PAs as part of surgical teams.

https://journals.lww.com/jaapa/fulltext/2016/02000/Physician_assistants_reduce_resident_workload_and.7.aspx

4. 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)

5. 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)

6. Nabagiez, J.P., Shariff, M.A., Khan, M.A., Molloy, W.J., & McGinn, J.T., Jr. (2013). Physician assistant home visit program to reduce hospital readmissions. *Journal of Thoracic Cardiovascular Surgery*, 145(1):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/abstract](http://www.jtcvsonline.org/article/S0022-5223(12)01200-7/abstract) (abstract)

7. U.S. Department of Health and Human Services, Health Resources and Services Administration. (2016). National Practitioner Data Bank. Rockville, Maryland.

Nationally, there were 1,399 liability claims paid against PAs in the 10 years from 2005-2014. The ratio of claims to PAs averaged 1 claim for every 550 PAs (1:550). By comparison, the number of physician claims paid from 2005-2014 totaled 105,756; the ratio for physicians during that decade averaged one claim for every 80 physicians (1:80). This data can be extracted from the Data Analysis Tool on the NPDB website.

<https://www.npdb.hrsa.gov/analysistool/> (Data Analysis Tool)

8. Rattray, N.A., Damush, T.M., et al. (2017). Prime movers: Advanced practice professionals in the role of stroke coordinator. *Journal of the American Association of Nurse Practitioners*.

The authors followed a stroke quality improvement clustered randomized trial and a national acute ischemic stroke directive in the VHA in 2011. The study examined the role of advanced practice providers in quality improvement activities among stroke teams. The authors conclude that the presence of PAs and NPs related directly to group-based evaluation of performance data, implementing stroke protocols, monitoring care through data audit, convening interprofessional meetings involving planning activities, and providing direct care. Further, the authors state that, because of their boundary spanning capabilities, the presence of PAs and NPs is an influential feature of local context crucial to developing an advanced, facility-wide approach to stroke care.

<https://www.ncbi.nlm.nih.gov/pubmed/28440589> (abstract)

9. Virani, S.S., Akeroyd, J.M., Ramsey, D.J, et al. (2016). Comparative effectiveness of outpatient cardiovascular disease and diabetes care delivery between advanced practice providers and physician providers in primary care: implications for care under the Affordable Care Act. *American Heart Journal*, 181:74-82.

This study found that physicians and advanced practice providers provided comparable diabetes and cardiovascular disease (CVD) care quality with clinically insignificant differences. The authors conducted the research with diabetic and CVD patients in 130 Veterans Affairs facilities, and found that there is a need to improve performance regardless of provider type.

<http://www.sciencedirect.com/science/article/pii/S0002870316301648> (abstract)

10. Schwarz, H. B., Fritz, J. V., Govindarajan, R., Murray, R. P., Boyle, K. B., Getchius, T. S., & Freimer, M. (2015). Neurology advanced practice providers: a position paper of the American Academy of Neurology. *Neurology: Clinical Practice*, 5(4):333-337.

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/siteassets/home-page/policy-and-guidelines/policy/position-statements/neurology-advanced-practice-providers/neurology-advanced-practice-providers.pdf>

11. Agarwal, A., Zhang, W., Kuo, Y., & Sharma, G. (2016). Process and outcome measures among COPD patients with a hospitalization cared for by an advance practice provider or primary care physician. *Plus One*.

Compared to patients cared for by physicians, patients cared for by PAs and APRNs were more likely to receive short acting bronchodilator, oxygen therapy and been referred to pulmonologist. Patients cared for by PAs and APRNs were less likely to visit an ER for COPD compared to patients cared for by physicians, conversely there was no difference in hospitalization or readmission for COPD between physicians and PAs/APRNs.

<http://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0148522>

12. Liu, H., et al. (2017). The impact of using mid-level providers in face-to-face primary care on health care utilization. *Medical Care*, 55(1): 12-18.

Greater use of NP/PAs in primary care visits in the Kaiser Permanente system in Georgia was not associated with higher specialty referrals, advanced imaging, ED visits, or inpatient stays. The authors conclude that using PAs and APRNs in face-to-face primary care may be a promising primary care delivery model from an efficiency standpoint.

http://journals.lww.com/lww-medicalcare/Abstract/2017/01000/The_Impact_of_Using_Mid_level_Providers_in.3.aspx (abstract)

13. Capstack, T.M., Segujja, C., Vollono, L., Moser, J.D., Meisenberg, B.R., & Michtalik, H.J. (2016). A comparison of conventional and expanded physician assistant hospitalist staffing models at a community hospital. *Journal of Clinical Outcomes Management*, 23(10): 455-460.

The researchers found that an expanded PA hospitalist staffing model at a community hospital provided similar outcomes and a lower cost of care than a conventional one. Researchers did a retrospective study comparing two hospitalist groups at a 384-bed community hospital in Annapolis, MD. One group had an

expanded PA staffing model, with three physicians and three PAs. The other group had a "conventional" staffing model, with nine physicians and two PAs.

http://www.turner-white.com/pdf/jcom_oct16_hospitalist.pdf

14. Nestler, D.M., Fratzke, A.R, et. al (2012). Effect of a Physician Assistant as a Triage Liaison Provider on Patient Throughout in an Academic Emergency Department. *Academic Emergency Medicine*.

The article discusses overcapacity issues that routinely inhibit various emergency departments. According to this article, studies suggest that triage liaison providers (TLPs) may benefit emergency departments struggling with overcapacity by shortening a patient's length of stay (LOS). Additionally, the article posits that enabling PAs to serve in such a role, TLPs, may reduce the number of patients who leave the emergency department without being seen. The findings of this study suggest that the LOS for patients was shorter, treatment room times were shorter, and fewer patients left without being seen.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3506172/>

15. 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. *American Medical Association, Archives of Pediatrics and Adolescent Medicine*, 148(12):1271-1276.

Patient charts were analyzed to compare care provided in the neonatal intensive care unit by teams of resident physicians and teams of PAs and 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)

16. *Colorado Health Institute, Collaborative Scopes of Care Advisory Committee. (2008). Final report of findings. Denver, CO. 6-7, 23-25.*

Governor Ritter issued Executive Order B 003 08 establishing the Collaborative Scopes of Care Study and creating an advisory committee to oversee the conduct of an evidence-based review that would inform the study findings. In issuing this executive order, the governor acknowledged "that it is clear from health manpower studies that we do not have sufficient numbers of providers, especially physicians and dentists, to meet the current [health care] needs of Coloradans." In general, the studies reviewed found no significant differences in patient outcomes or satisfaction with the care provided by PAs when compared to physicians.

<http://www.coloradohealthinstitute.org/key-issues/detail/health-care-workforce/collaborative-scopes-of-care-advisory-committee-final-report-of-findings>

17. Costa, D.K., Wallace, D.J., Barnato, A.E., & Kahn, J.M. (2014). Nurse practitioner/physician assistant staffing and critical care mortality. *Chest Journal*, 146(6):1566-1573.

ICUs are increasingly staffed with NPs and PAs. The authors examined the association between NP/PA staffing and in-hospital mortality for patients in the ICU, and found NPs/PAs to be a safe adjunct to the ICU team. The findings support NP/PA management of critically ill patients.

<http://www.ncbi.nlm.nih.gov/pubmed/25167081> (abstract)

18. 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)

19. Everett, C., Thorpe, C., Palta, M., Carayon, P., Bartels, C. & Smith M.A. (2013). Physician assistants and nurse practitioners perform effective roles on teams caring for Medicare patients with diabetes. *Health Affairs*, 32(11):1942-1948.

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)

20. Glotzbecker, B., Yolin-Raley, D.S., DeAngelo, D.J., Stone, R.M., Soiffer, R.J., & Alyea, E. P. (2013). Impact of physician assistants on the outcomes of patients with acute myelogenous leukemia receiving chemotherapy in an academic medical center. *Journal of Oncology Practice*.

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 healthcare outcomes.

<http://jop.ascopubs.org/content/9/5/e228.full>

21. Hormann, 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>

22. Pavlik, D., Sacchetti, A., Seymour, A. & Blass, B. (2016). Physician assistant management of pediatric patients in a general community emergency department: a real world analysis. *Pediatric Emergency Care*.

Based on the outcome measure of 72-hour recidivism, PA management of pediatric patients 6 years or younger is similar to that of attending emergency physicians (EPs). In addition, this study suggests that the PAs have the ability to recognize more severely ill children and elicit the input of a supervising physician in those individuals.

<https://www.ncbi.nlm.nih.gov/pubmed/27798540>

23. Peterson Center on Healthcare and Stanford Medicine Clinical Excellence Research Center. (2016). Uncovering America's most valuable care: executive summary.

This study looked at the best primary care practices in the country and put together a list of what makes them so good. Those practices that work closely with their PAs and ensured that PAs were able to work to the full extent of their education and experience ranked the highest.

<http://petersonhealthcare.org/identification-uncovering-americas-most-valuable-care/executive-summary>

24. 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>

25. Virani S.S., et al. (2015). Provider type and quality of outpatient cardiovascular disease care. *Journal of American College of Cardiology*, 66(16):1803-1812.

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)

26. Wilson, I.B., Landon, B.E., Hirschhorn, L.R., et al. (2005). Quality of HIV care provided by nurse practitioners, physician assistants, and physicians. *Annals of Internal Medicine*, 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. NPs 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>

27. Hooker, R.S., Nicholson J.C., & Le, T. (2009). Does the employment of physician assistants and nurse practitioners increase liability? *Journal of Medical Licensure and Discipline*, 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 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 healthcare industry along with the safety of patients. The reasons for disciplinary action against PAs and APNs are largely the same as physicians.

<http://www.paexperts.com/Nicholson%20-%20Hooker%20Article.pdf>

PA Cost Effectiveness and Productivity

1. Johal, J., Dodd, A. (2017). Physician extenders on surgical services: a systematic review. *Canadian Journal of Surgery*.

The study investigated whether or not the introduction of duty hour restrictions and the ensuing house trainee shortages required a long-term solution to provide safe and efficient patient care. A proposed solution was the employment of NPs and PAs in numerous health care settings. The study found that the employment of NPs and PAs to surgical and trauma services was cost-efficient while simultaneously not sacrificing quality of care.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5453759/>

2. Bachrach, D., Frohlich, J., Garcimonde, A. & Nevitt, K. (2015). The value proposition of retail clinics: building a culture of health. *Robert Wood Johnson Foundation and Manatt Health*.

Retail clinics are ambulatory care sites typically located in and associated with brand-name retailers, including pharmacies, groceries and “big-box” stores and are typically staffed by NPs and PAs with some physician oversight. The expertise and training of NPs and PAs is well-suited for retail settings. However, states’ varying regulatory and licensure schemes constrain the ability of retail clinics to make full use of these professionals in every state. Also, the authors argue that telehealth has the potential to reduce cost and improve both access to care for rural and underserved communities and support treatment of patients with acute and chronic conditions at retail clinics and beyond.

https://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/Retail_Clinic_RWJF.pdf

3. Eibner, C., Hussey, P., Ridgely, M.S., and McGlynn, E.A. (2009). Controlling health care spending in Massachusetts: an analysis of options. *RAND Corporation, TR-733-COMMASS*.

RAND identified a few options that appear to have the potential to slow the rate of increase in health spending in Massachusetts over the next decade. Those ideas include expanding the scope of practice of PAs and NPs and encouraging the greater use of PAs and NPs in primary care.

http://www.rand.org/pubs/technical_reports/TR733.html

4. Grzybicki, D., Sullivan, P., et. al (2002). The Economic Benefit for Family/General Medicine Practices Employing Physician Assistants.

The study sought to identify whether or not model PA practice in a family or general medicine practice environment was comparable, in terms of care provided and financial productivity, to a physician-only practice. The study found that the employment of family and/or general medicine PAs lead to significant economic benefits to the practices where they are employed.

<http://www.ajmc.com/journals/issue/2002/2002-07-vol8-n7/jul02-165p613-620> (link to PDF of entire study available at this website)

5. 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 employer’s 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.ncbi.nlm.nih.gov/pubmed/12474431> (abstract)

6. Hooker, R. S. (2000). The economic basis of physician assistant practice. *Physician Assistant*, 24(4): 51-71.

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>

7. Timmons, E.J. (2016). The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care. *Health Policy*, 1-8.

The author examines how changes to occupational licensing laws for nurse practitioners and physician assistants have affected cost and intensity of health care for Medicaid patients. The results suggest that allowing physician assistants to prescribe controlled substances is associated with a substantial (more than 11%) reduction in the dollar amount of outpatient claims per Medicaid recipient. Relaxing occupational licensing requirements by broadening the scope of practice for healthcare providers may represent a low-cost alternative to providing quality care to America's poor.

[http://www.healthpolicyjrn.com/article/S0168-8510\(16\)30344-X/abstract](http://www.healthpolicyjrn.com/article/S0168-8510(16)30344-X/abstract) (abstract)

6. Medical Group Management Association. (2016). The rising trend of nonphysician provider utilization in healthcare: an MGMA research & analysis report. Englewood, CO.

In this report, healthcare industry influencer Medical Group Management Association (MGMA) aims to help healthcare executives, practice administrators, and others understand how to incorporate PAs and nurse practitioners (NPs) into medical practice to maximize efficiency and profitability. MGMA found that 78% of better performing medical practices employ PAs and NPs. The analysis gives an overview of the PA and NP workforce, reimbursement, licensure, median salary, and state practice environments.

<http://www.mgma.com/store/surveys-and-benchmarking/e-reports/the-rising-trend-of-nonphysician-provider-utilization-in-healthcare> (abstract)

7. Anderson, T.J. & Althausen, P.L. (2016). The role of dedicated musculoskeletal urgent care centers in reducing cost and improving access to orthopaedic care. *Journal of Orthopaedic Trauma*, 30(5):s1-s2.

In 2014, the authors' practice opened the first dedicated orthopaedic urgent care in the region staffed by PAs and supervised by orthopaedic surgeons. Dedicated musculoskeletal urgent care clinics operated by orthopaedic surgery practices can be extremely beneficial to patients, physicians, and the health care system. They clearly improve access to care, while significantly decreasing overall health care costs for patients with ambulatory orthopaedic conditions and injuries. In addition, they can be financially beneficial to both patients and orthopaedic surgeons alike without cannibalizing local hospital surgical volumes.

<https://www.ncbi.nlm.nih.gov/pubmed/27870667>

8. Pedersen D.M., Chappell, B., Elison, G. & Bunnell R. (2008). The productivity of PAs, APRNs, and physicians in Utah. *Journal of the American Academy of Physician Assistants*, 21(1):42-47.

The Utah Medical Education Council believes that the demand for PAs will be high over the next 10 to 15 years, with several factors fueling this growth. Productivity is one of these factors. Even though Utah PAs

make up only approximately 6.3% of the state's combined clinician (physician, PA, APRN) workforce; the PAs contribute approximately 7.2% of the patient care full-time equivalents (FTE) in the state. This is in contrast to the 10% FTE contribution made by the state's APRN workforce, which has nearly triple the number of clinicians providing patient care in the state. The majority (73%) of Utah PAs work at least 36 hours per week. Utah PAs also spend a greater percentage of the total hours worked in patient care, when compared to the physician workforce. The rural PA workforce reported working a greater number of total hours and patient care hours when compared to the overall PA workforce.

http://journals.lww.com/jaapa/Abstract/2008/01000/The_productivity_of_PAs,_APRNs,_and_physicians_in.10.aspx (abstract)

9. 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>

10. Althausen, P.L., Shannon, S., Owens, B., Coll, D., Cvitash, M., Lu, M., O'Mara, T.J. & Bray, T.J. (2013). Impact of hospital-employed physician assistants on a level II community-based orthopaedic trauma system. *Journal of Orthopaedic Trauma*, 27(4):e87-e91.

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://journals.lww.com/jorthotrauma/Abstract/2013/04000/Impact_of_Hospital_Employed_Physician_Assistants.16.aspx

11. Essary, A.C., Green, E.P. & Gans, D.N. (2016). Compensation and production in family medicine by practice ownership. *Health Services Research and Managerial Epidemiology*, 3:1-5.

In this national survey of family medicine practices, PA productivity, as defined by mean annual patient encounters, exceeds that of both nurse practitioners (NPs) and physicians in physician-owned practices and of NPs in hospital or integrated delivery system-owned practices. Total compensation, defined as salary, bonus, incentives, and honoraria for physicians, is significantly more compared to both PAs and NPs, regardless of practice ownership or productivity. PAs and NPs earn equivalent compensation, regardless of practice ownership or productivity. Not only do these data support the value and role of PAs and NPs on the primary care team, but also highlight differences in patient encounters between practice settings.

<http://journals.sagepub.com/doi/abs/10.1177/2333392815624111>

12. Mafi, J.N., Wee, C.C., Davis, R.B., & Landon, B.E. (2016). Comparing use of low-value health care services among U.S. advanced practice clinicians and physicians. *Annals of Internal Medicine*, 165(4):237-244.

A comparison of NPs, PAs and physicians found that the three practitioners provided an equivalent amount of low-value health services. The purpose of the comparison was to dispel physicians'

perceptions that PAs and NPs provide lower-value care than physicians for patients presenting with upper respiratory infections, back pain, or headaches.

<http://annals.org/article.aspx?articleid=2529481> (abstract)

13. Resnick, C.M., Daniels, K.M., Flath-Sporn, S.J., Doyle M., Heald, R., and Padwa, B.L. (2016). Physician assistants improve efficiency and decrease costs in outpatient oral and maxillofacial surgery. *Journal of Oral Maxillofacial Surgery*, 1-8.

The addition of PAs into the procedural components of an outpatient oral and maxillofacial surgery practice resulted in decreased costs whereas complication rates remained constant. The increased availability of the oral and maxillofacial surgeon after the incorporation of PAs allows for more patients to be seen during a clinic session, which has the potential to further increase efficiency.

[http://www.joms.org/article/S0278-2391\(16\)30591-2/abstract](http://www.joms.org/article/S0278-2391(16)30591-2/abstract) (abstract)

14. Roblin, D.W., Howard, D.H., Becker, E.R., Adams, E.K. & Roberts, M.H. (2004). Use of midlevel practitioners to achieve labor cost savings in the primary care practice of an MCO. *Health Services Research*, 39(3), 607-625.

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 fewer.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361027/>

Policy, Workforce and Access to Care

1. Leach, B., Gradison, M., et. al (2017). Patient preference in primary care provider type. *Healthcare Journal*.

The study investigates the growing role of NPs and PAs which has enabled patients to choose their primary care provider. This begs the question as to whether or not there is any preference in what medical professional a patient wishes to see. The study concluded that the provider's qualifications and the patient's prior health care experiences were determinative. However, the study did find that physicians were preferred for their technical skills as opposed to PAs and NPs who were favored for their interpersonal skills.

<https://www.ncbi.nlm.nih.gov/pubmed/28602803> (abstract)

2. Dill, M., Pankow, S. et. al (2013). Survey Shows Consumers Open To A Greater Role For Physician Assistants And Nurse Practitioners. *Health Affairs*.

Evidence suggests that there is an impending physician shortage in the United States. Should the shortage come to fruition, alternative providers, like PAs and NPs, may become necessary to meet health care demands. The survey conducted in this study investigates whether or not there is a health care provider preference among patients seeking treatment. The study found that approximately half of those surveyed desired to have a physician as their primary care provider. However, when the preference was inquired into with varying hypotheticals and circumstances enabling the patient to be seen by a PA or NP more quickly, a majority of those surveyed decided to see a PA or NP. Consequently, it appears that health care consumers are at least open to the idea of receiving treatment from NPs and PAs.

<https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.1150>

3. Hooker, R.S., Everett, C.M. (2012). The Contribution of Physician Assistants in Primary Care Systems. *Health & Social Care in the Community*.

The potential shortages of primary care physicians are a rising global trend. A possible solution to the decrease in available primary care physicians but similar health care demands is the employment of PAs. Studies conducted, globally, insinuate that PAs can bridge the shortage by providing primary care functions; including the provision of comprehensive care while not sacrificing accountability or accessibility.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3903046/>

4. Sutton, J.P., Ramos, C., & Lucado, J. (2010). US physician assistant (PA) supply by state and county in 2009. *Journal of the American Academy of Physician Assistants*, 23(9):e5-e8.

Substantial variation exists in the PA-to-population ratio among states, which may be related in part to state practice laws. At a more 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. The distribution of PAs is likely to remain geographically uneven in the absence of significant policy efforts to attract PAs to practice in rural communities.

http://journals.lww.com/jaapa/Abstract/2010/09000/US_physician_assistant_PA_supply_by_state_and.18.aspx (abstract)

5. Salsberg, E. (2015). Is the physician shortage real? Implications for the recommendations of the Institute of Medicine Committee on the governance and financing of graduate medical education. *Academic Medicine*, 90(9):1210-1214.

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.

http://journals.lww.com/academicmedicine/Fulltext/2015/09000/Is_the_Physician_Shortage_Real_Implications_for.17.aspx

6. Green, L.V., Savin, S. & Lu, Y. (2013). Primary care physician shortages could be eliminated through use of teams, nonphysicians, and electronic communication. *Health Affairs*, 32(1):11-19.

Most existing estimates of the shortage of primary care physicians are based on simple ratios, such as one physician for every 2,500 patients. These estimates do not consider the impact of such ratios on patients' ability to get timely access to care. They also do not quantify the impact of changing patient demographics on the demand side and alternative methods of delivering care on the supply side. The authors provide estimates of the number of primary care physicians needed based on a comprehensive analysis considering access, demographics, and changing practice patterns. They conclude that some increasingly popular operational changes in the ways clinicians deliver care—including the use of teams or "pods," better information technology and sharing of data, and the use of PAs and other providers—have the potential to offset completely the increase in demand for physician services while improving access to care, thereby averting a primary care physician shortage.

<http://m.content.healthaffairs.org/content/32/1/11.full.html>

7. Timmons, E.J. (2016). Healthcare license turf wars: the effects of expanded nurse practitioner and physician assistant scope of practice on Medicaid patient access. Mercatus Working Paper, *Mercatus Center at George Mason University*, Arlington, VA.

The author examines how important changes to occupational licensing laws for nurse practitioners and PAs have affected cost and access to healthcare for Medicaid patients. The results suggest that allowing PAs to prescribe drugs (including controlled substances) is associated with a substantial (more than 11 percent) reduction in the dollar amount of outpatient claims per Medicaid recipient. Relaxing occupational licensing requirements by broadening the scope of practice for healthcare providers may represent a low-cost alternative to providing quality care to America's poor.

<https://www.mercatus.org/system/files/Timmons-Scope-of-Practice-v2.pdf>

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

A cost analysis was undertaken to determine how changing restrictive practice laws would impact the cost of care. The authors' case study focused on the state of Alabama because of its restrictive PA and NP laws. The cost analysis found that even modest changes to Alabama PA and NP laws would result in a net savings of \$729 million over a 10-year period. Underutilization of PAs and NPs by restrictive state law inhibits the cost benefits of increasing the supply of PAs and NPs.

<http://www.nursingconomics.net/necfiles/14ND/Hooker.pdf>

9. Hamel, L., Norton, M., Jankiewicz, A., & Rousseau, D. (2015). Experiences and attitudes of primary care practitioners after the ACA in Kaiser Family Foundation/Commonwealth Fund 2015 national survey of primary care providers. *Journal of the American Medical Academy,* 314 (19):2013.

Based on a survey of primary care clinicians in early 2015, this Visualizing Health Policy infographic examines the experiences and attitudes of primary care practitioners (PCPs) after the Affordable Care Act's (ACA's) major coverage provisions took effect in January 2014. Generally, primary care physicians have a more negative view of health reform's effect on the cost of patient care, but a more positive view of the law's impact on patient access to healthcare and insurance. Large shares—66% of nurse practitioners and physician assistants and 50% of physicians—report that they're currently accepting new Medicaid patients.

<http://jamanetwork.com/journals/jama/fullarticle/2470432>

10. Hing, E. & Hsiao, C. (2015). In which states are physician assistants or nurse practitioners more likely to work in primary care? *Journal of the American Academy of Physician Assistants,* 28(9):46-53.

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.

<http://www.ncbi.nlm.nih.gov/pubmed/26302324> (abstract)

11. IHS Inc. (2016). The complexities of physician supply and demand 2016 update: projections from 2014 to 2025. Prepared for the Association of American Medical Colleges. Washington, DC: Association of American Medical Colleges.

This 2016 report examines five scenarios commonly expected to affect physician supply (e.g., early or delayed retirement of physicians) and six scenarios expected to affect the demand for physician services

over the next decade (e.g., changing demographics, greater adoption of managed care models, or greater integration of advanced practice registered nurses and PAs). The U.S. could experience a shortfall of between 14,900 and 35,600 primary care physicians by 2025.

https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projection_s.pdf

12. Jones, P.E., & Hooker, R.S. (2001). Physician assistants in Texas. *Texas Medicine*. 97(1): 68-73.

The use of PAs in the state has helped address the maldistribution of physicians. PAs have high productivity and increase the number of patients being seen in a wider variety of healthcare settings.

<https://www.ncbi.nlm.nih.gov/pubmed/11192487> (abstract)

13. Mitchell, C.C., Ashley, S.W., Zinner, M.J., & Moore, F.D. (2007). Predicting future staffing needs at teaching hospitals. *Archives of Surgery*, 142, 329-334.

The study used a computer model to predict future staffing needs due to the impact of changes in resident work hours and service growth. The study estimates in the next 5 years the hospitals will need to hire 10 PAs at the cost of \$1,134,000, which is \$441,000 less expensive than hiring hospitalist physicians.

<http://archsurg.jamanetwork.com/article.aspx?articleid=400017>

14. Morgan, P., Himmerick, K.A., Leach, .B, Dieter, P. & Everett, C. (2016). Scarcity of primary care positions may divert physician assistants into specialty practice. *Medical Care Research and Review*, 1-14.

Despite state and federal efforts to encourage PAs to help fill primary care gaps, the proportion of PAs practicing in primary care continues to decline. Using job posting data from a leading labor analytics firm, this study finds that the decline could be due to a lack of job availability. In 2014, for example, only 18 percent of PA job postings were in primary care, compared with specialty positions. While policies have focused on increasing primary care PA supply, additional efforts are needed to increase labor demand via financial incentives, job-locating assistance and educational outreach.

<http://healthforce.ucsf.edu/publications/scarcity-primary-care-positions-may-divert-physician-assistants-specialty-practice>

15. Willis, J. B. (1993). Barriers to PA practice in primary care and rural medically underserved areas. *Journal of the American Academy of Physician Assistants*, 6(6):418-422.

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.

Appendix D

Impact Statements and ConnAPA Responses



CONNECTICUT ACADEMY OF
FAMILY PHYSICIANS

Meghan Bennett
Healthcare Quality Safety Branch
Connecticut Department of Public Health
Practitioner Licensing and Investigations Section
410 Capitol Avenue MS #12APP
Hartford, CT 06134

September 27, 2018

Dear Ms. Bennett:

On behalf of over 450 Family Physicians who are members of the Connecticut Academy of Family Physicians (CAFP) we are submitting comments regarding The Scope of Practice Request submitted by the Connecticut Academy of Physician Assistants (PAs).

The CAFP expresses continued concern over this request for the expansion of services provided by Physician Assistants. This concern is based on the impact it would have on the quality of care for patients in Connecticut.

We agree that Physician Assistants should practice to the fullest extent of their education and training. Thus, we supported their scope request in 2012. The passage of this bill allowed expanded scope but maintained patient safety. Physician Assistants were working as part of the healthcare team while still being supervised by physicians.

We have maintained an excellent working relationship with Connecticut's PAs and value their role as an integral part of the health care team. However, we do not believe that PAs possess the requisite training and expertise to practice completely without physician supervision.

If a scope of practice review committee is created, we request that a representative from the CAFP be allowed to participate.

Very truly yours,

Stacy Taylor, MD

Legislative Chair, Connecticut Academy of Family Physicians



Connecticut Association of Nurse Anesthetists

Donna Sanchez, MS, APRN, CRNA
Connecticut Association of Nurse Anesthetists
1224 Mill St. BLDG B. Suite 223
East Berlin, CT. 06023

September 25, 2018

Meghan Bennett
Connecticut Department of Public Health
Practitioner Licensing & Investigations Section
410 Capitol Avenue, MS #12APP
Hartford, CT. 06134

Dear Ms. Bennett,

My name is Donna Sanchez, MS, APRN, CRNA. I represent the Connecticut Association of Nurse Anesthetists (CANA). Certified Registered Nurse Anesthetists (CRNAs) are one of the four recognized Advance Practice Registered Nurses here in Connecticut as throughout our nation. Today, I am writing in response to a request for a change in the scope of practice for the Physician's Assistants. The Connecticut Association of Nurse Anesthetists have some concerns and questions pertaining to the Connecticut Academy of Physician Assistants scope of practice request. We are respectfully requesting that we be allowed to participate in any discussions related to a change in their scope of practice in the upcoming legislative session.

The burden of providing access to healthcare has many healthcare professionals seeking to increase their scope of practice. Each profession seeking a change or increase in their scope of practice must be looked at very carefully to ensure that the increase in their scope is in alignment with their training, education and licensure that they currently have within our state statutes. This process will best serve Connecticut's residents.

There are many requests within their proposal that appear to be reasonable and truly will improve access to care as far as decreasing duplicity and expediting the delivery of care. There are also requests within the proposal that warrants farther discussion to ensure the safety of Connecticut's residents. Requests to move from "supervision" to "collaboration" warrants farther investigation as their training is based on a dependent relationship not independent relationship with their MD colleagues.

Ms. Meghan Bennett
September 25, 2018
Page 2

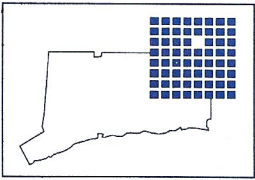
Full prescriptive authority is another request that needs to be discussed to ensure the safety of Connecticut's residents. Certified Registered Nurse Anesthetists (CRNAs) along with our other Advanced Practice Registered Nurses (APRNs) are trained and educated to be independent practitioners. In the way of background, CRNAs are fully trained, educated and licensed to delivery all types of anesthesia in any setting in which anesthesia is delivered including: traditional hospital surgical suites, obstetrical delivery rooms, critical access hospitals, ambulatory surgical centers, the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, pain management specialists, as well as public health services in the U.S. Military and the Department of Veterans Affairs facilities.

In conclusion, the Connecticut Association of Nurse Anesthetists believe the wide impact on healthcare delivery by this request for expansion of Connecticut's physician assistants' scope of practice requires farther review and we respectfully request to be included in these discussions.

If you have any questions, please feel free to contact me. I am at your service. Please reply to confirm delivery of this letter.

Sincerely,

Donna Sanchez, MS, APRN, CRNA
GRC Chair Connecticut Association of Nurse Anesthetists



CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS

A Chapter of the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

60 KINGS HIGHWAY • NORTH HAVEN, CT 06473 • (203) 234-8055 • FAX: (203) 234-2852

September 10, 2018

Meghan Bennett
Connecticut Department of Public Health
Practitioner Licensing and Investigations Section
410 Capitol Avenue MS #12APP
Hartford, CT 06134

Meghan.bennett@ct.gov

RE: Connecticut Academy of Physician Assistants' 2018 Scope of Practice Request

Dear Ms. Bennett:

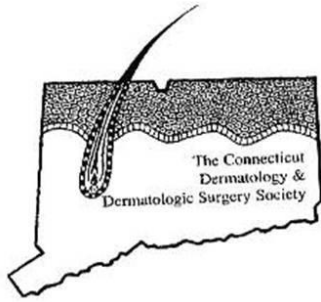
In accordance with Connecticut General Statutes 19a-16d-19a-16f, the Connecticut College of Emergency Physicians (CCEP) is submitting this impact statement in response to the Connecticut Academy of Physician Assistants submission for a scope of practice review request to the Department of Public Health.

If the Department of Public Health moves forward with the organization's request for a scope of practice review, CCEP respectfully requests participation in the scope of practice review committee. CCEP would like to participate in the scope of practice review committee to understand how this scope of practice change will impact emergency care and how patients would present to the emergency department for treatment.

Should you have questions or require further information, please contact me at your convenience.

Sincerely,

Daniel Freess, M.D.
President
Connecticut College of Emergency Physicians



October 1, 2018

Ms. Meghan Bennett
Healthcare Quality Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Bennett,

On behalf of the more than 150 dermatologists of the Connecticut Dermatology and Dermatologic Surgery Society, we oppose the Connecticut Academy of Physician Assistant's proposal to eliminate the supervisory role of physicians and replace it with "adaptive collaboration," a vaguely-described concept for restructuring the physician-physician assistant relationship. We support retaining physician-led team-based care and working together with physician assistants as important members of that team; however, for the reasons set forth below, we urge the Department of Public Health to reject the proposal.

The American Academy of Dermatology Association's (Academy's) guiding position on physician-led teams is set forth in its *Position Statement on the Practice of Dermatology: Protecting and Preserving Patient Safety and Quality Care*, which states that "under the direction of a board-certified dermatologist, the practice of dermatology benefits from a collaborative care team approach..."¹ The Position Statement states that "the optimum degree of dermatologic care is delivered when a board-certified dermatologist...provides direct, on-site supervision to all non-dermatologist personnel." Recently updated, the Position Statement also states that "the efficient utilization of a non-physician clinician may, at times, involve off-site supervision," and it outlines protocols for those situations. Through its Position Statement, the Academy establishes the guiding principle for all dermatologists to practice ethical medicine with the highest possible standards to ensure the best interests and welfare of each patient, and this includes the use of physician-led team-based care.

¹ <https://www.aad.org/Forms/Policies/Uploads/PS/PS-Practice%20of%20Dermatology-Protecting%20Preserving%20Patient%20Safety%20Quality%20Care.pdf>

We oppose removing “supervision” and replacing it with “collaboration.” The vague concept of “adaptive collaboration” is defined in the proposal as “the continuous process by which a PA provides services within a healthcare team that includes one or more physicians. Adaptive collaboration would be determined by written agreement at the practice level.” Under this new model, physicians could be excluded from leading the patient care team. This comes at a time when physician-led team-based care is most essential. In fact, new health care models, including accountable care organizations, require increased teamwork among physicians, nurse practitioners, physician assistants, and other providers of care. Efforts to disassemble the physician-physician assistant relationship would further compartmentalize the delivery of health care. The optimal way to provide dermatologic care is under the direction of a board-certified dermatologist, who retains ultimate responsibility for patient care and tasks delegated to care team members. The dermatologist also remains responsible for ensuring that all delegated activities are within the scope of each care team member’s training and level of experience.

Further, there are substantial differences in the education of physician assistants and physicians, both in depth of knowledge and length of training. After finishing a rigorous undergraduate academic curriculum, physicians receive an additional four years of education in medical school. This is followed by 3 – 7 years of residency and 12,000-16,000 hours of patient care training.

Medical students who attend schools accredited by the Liaison Committee on Medical Education are required to care for patients in both inpatient and outpatient settings in the following clinical rotations: family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery.² Similarly, students at colleges of osteopathic medicine that are accredited by the American Osteopathic Association’s Commission on Osteopathic College Accreditation must receive education in the following clinical disciplines: internal medicine, family medicine, pediatrics, geriatrics, obstetrics and gynecology, preventive medicine and public health, psychiatry, surgery, radiology, and basic knowledge of the components of research.³ All medical students must also select a number of specialty elective rotations to round out their exposure to the branches of medicine, ensuring a broad and comprehensive medical knowledge base upon which they build by choosing an area of practice specialization for graduate medical education, commonly known as residency.

In stark contrast, physician assistants complete a 26-month physician assistant program followed by 2,000 hours of clinical rotations, which emphasize primary care in ambulatory clinics, physician offices and acute or long-term care facilities.⁴ Rotations

² Web, Liaison Committee on Medical Education (LCME). LCME Accreditation Standards with annotations. www.lcme.org

³ Web, American Osteopathic Association (AOA). College of Medicine Accreditation Standards and Procedures. <http://www.osteopathic.org/inside-aoa/accreditation/COM-accreditation/Pages/standards-of-accreditation.aspx>

⁴ <https://www.aapa.org/what-is-a-pa/#tabs-2-how-are-pas-educated-and-trained>

could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.⁵ Unlike physicians, physician assistants are not required to complete a residency program. Physician assistants who elect to practice in dermatology are trained in the clinic by dermatologists.⁶

By any measure, the differences in training are significant. Given the wide array of challenges that confront the independent practitioner, particularly as the population ages, physicians' additional training and expertise allows them to substantively reduce the incidence of complications and to recognize and treat complications appropriately should it occur.

New research shows that dermatologists are more effective than physician assistants in diagnosing skin cancer. Researchers examined data from 33,647 skin cancer screenings in 20,270 patients at University of Pittsburgh Medical Center-affiliated offices from January 2011 through December 2015. Compared to dermatologists, physician assistants needed to perform more biopsies to detect melanoma and nonmelanoma skin cancer. To diagnose one case of melanoma, the number needed to biopsy was 39.4 for physician assistants and 25.4 for dermatologists. To diagnose one case of skin cancer, the number needed to biopsy was 3.9 for physician assistants and 3.3 for dermatologists.⁷

Dermatologists were more likely than physician assistants to diagnose noninvasive melanoma, which the authors note is more difficult to identify than invasive melanoma. According to the authors, early detection and treatment of noninvasive melanoma can result in improved patient outcomes and lower treatment costs.

As members of the health care delivery system, it is a common goal of both physicians and physician assistants to ensure that patients receive the highest quality care. We believe this is achieved when health care is delivered by a physician-led team; a model that is also supported by the public. According to three nationwide surveys, 84% of respondents prefer a physician to have primary responsibility for diagnosing and managing their health care and 91% of respondents said that a physician's years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency.⁸

There is a wide spectrum of training and expertise among health care professionals. In a clinical setting, it is often impossible for patients to know whether the person providing

⁵ https://www.aapa.org/wp-content/uploads/2016/12/Issue_Brief_PA_Education.pdf.

⁶ Web, The Society of Dermatology Physician Assistants, <http://hireadermpa.com/dermpa-training/>

⁷ [Matsumoto, M. et al \(2018, August\)](#). Estimating the cost of Skin Cancer Detection by Dermatology Providers in a Large Health Care System. *JAADermatol.* [April 2018](#) Volume 78, Issue 4, Pages 701–709.e1

⁸ Surveys of nearly 1,000 adults on behalf of the AMA Scope of Practice Partnership were conducted in 2008, 2010, 2012, and 2018.

their care is a physician, nurse, physician assistant, pharmacist, dentist, or dental hygienist. This creates a great deal of confusion for individuals receiving health care. Our patients have the right to know the credentials and the level of training of that person making the important medical diagnosis, pushing medications into an intravenous line, using a scalpel, or pointing a laser at their face, torso, arms, or legs.

Additionally, the nationwide surveys confirm increasing patient confusion regarding the many types of health care providers - including physicians, nurses, physician assistants, technicians and other varied providers. Nearly 80% of those surveyed support state legislation requiring all health care advertising materials to clearly designate the level of education, skills and training of all health care professionals promoting their services.

The survey revealed:

- 47 percent of patients incorrectly believe an optometrist is a medical doctor;
- 39 percent of patients believe a nurse with a “doctor of nursing practice” degree is a medical doctor;
- 44 percent of patients believe it is difficult to identify who is a licensed medical doctor and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials.

As physicians, our number one priority is the health and welfare of our patients. Our organizations appreciate the opportunity to provide written comments on this important public health issue. We respectfully urge you to carefully consider the ramifications of approving the Connecticut Academy of Physician Assistant’s request. The Connecticut Dermatology and Dermatological Surgery Society would like to participate in any hearing regarding this matter. We remain committed to providing high quality care and serving the best interests of our patients with physician assistants through physician-led team-based care. For further information, please contact Debbie Osborn, executive director of the Connecticut Dermatology and Dermatologic Surgery Society, at debbieosborn36@yahoo.com or (860)-567-3787.

Sincerely,



Omar Ibrahimi, MD, PhD, FAAD
President
Connecticut Dermatology and Dermatologic Surgery Society



MEMORANDUM

TO: Meghan Bennett, Practitioner Licensing and Investigations Section
Connecticut Department of Public Health

FROM: Karen Buckley, Vice President, Advocacy

DATE: September 27, 2018

SUBJECT: Impact Statement – Scope of Practice Request – Connecticut Academy of Physician Assistants

The Connecticut Hospital Association (CHA), a trade association representing 27 acute care hospitals in Connecticut, submits this impact statement, in accordance with Chapter 368a of the Connecticut General Statutes, in response to the scope of practice change requested by the Connecticut Academy of Physician Assistants. The change requested would modify the current statute to change supervision to collaboration and make other changes relevant to documentation changes.

The proposed changes would change the healthcare delivery system in Connecticut, and potentially across the region. Connecticut hospitals employ or utilize a significant number of licensed healthcare professionals including physicians, advanced practice registered nurses, physician assistants, and other allied health professionals. The request will impact the delivery of care to hospital patients and require hospital policies and procedures to be changed.

If the Department appoints a Scope of Practice Review Committee, CHA respectfully requests an appointment to the Committee.

KMB:ljs
By E-mail
cc: Jason Prevelige, MHS, PA-C, Connecticut Academy of PAs



September 28, 2018

Meghan Bennett

Connecticut Department of Public Health

Practitioner Licensing and Investigations Section

410 Capitol Avenue MS #12APP

Hartford, CT 06134

Meghan.bennett@ct.gov

The Connecticut Nurses' Association is submitting this impact statement regarding the scope of practice request from the Connecticut Academy of Physician Assistants. The Scope of Practice process is an invaluable opportunity to share, discuss, clarify misconceptions and promote agreement. We appreciate the opportunity to review research and reflect on the impact of a change in scope to the profession of nursing and any impact on the health care system.

Carefully reviewing, comparing and fully understanding the relationship between education, training and role in the health care system within the context of the CT health care systems and needs is a complex process.

Connecticut issues over 63,000 Registered Nurse Licenses as well as an additional 12,000 Licensed Practical Nurses. Nurses are the largest members of the health care team. As integral team members, their relationship and complimentary services will be directly affected by a change in scope of practice of physician assistants.

Nurse's code of ethics dictates that nurses have an ethical obligation to advocate for the health of the public and individuals and share their professional expertise and experience as an integral members of the health care team.

The many specific requests for change in the scope seem to be driven by a transition in practice from an extension of the physician to an independent practitioner. This has implications for the general public as consumers of health care as well as their interaction and authority with nurses.



There are concerns and questions based on this request to change their practice related to context of their education, training and experience.

It is unclear how changing the requirement of being an “agent “of the physician will impact the relationship to nursing care. We need to further understand and apply this to current nurse scope of practice and regulations regarding orders and care. Any scope of practice change should reflect the level of education and training not at the practice level.

Lastly, while this application contains interesting proposals it raises more serious questions than it answers and warrants deeper discussion and understanding of the request to evaluate the greater impact.

The Connecticut Nurses’ Association welcomes a seat at the table if this scope of practice request is selected to move forward.

Respectfully Submitted,
Kimberly Sandor
Executive Director
Connecticut Nurses’ Association

Mary Jane Williams
Chair of the Government Relations Committee
Connecticut Nurses’ Association



127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473-1715
Phone (203) 865-0587 Fax (203) 865-4997 www.csms.org

September 28, 2018

Meghan Bennett
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12HSR
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Bennett:

On behalf of the membership of the Connecticut State Medical Society (CSMS) please accept this statement, as consistent with the requirements of Public Act 11-209, regarding the recent submission for an expansion in scope of practice by the Connecticut Association of Physician Assistants (CONNAPA)

CONNAPA has submitted a request, which in the opinion of CSMS and its members, is a significant alteration to the scope and practice parameters for physician assistants. CSMS gladly participated in one of the first ever scope review committee established by Public Act 11-209. That productive process led not the release of a report to the General Assembly from DPH, but rather proposed legislation to drastically alter current statutes to more appropriately allow physician assistants to practice to the fullest of their training and capabilities.

Physician assistants are a valuable member of the healthcare team. They are well trained to deliver the services they provide. However, CSMS is concerned with the significance of this proposal. Therefore, we fully request that prior to any proposed policy or legislation that a scope of practice review committee be established and that CSMS be provided representation on the committee.

Sincerely,

A handwritten signature in black ink, appearing to read "Ken Ferrucci".

Ken Ferrucci
Senior Vice President of Government Affairs

The Connecticut Society of Radiologic Technologists
Affiliate of the American Society of Radiologic Technologists

October 1, 2018

Meghan Bennett
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health

Dear Ms. Bennett,

The Connecticut Society of Radiologic Technologists (CSRT) would like to submit an impact statement regarding the Scope of Practice change proposed by the Connecticut Academy of Physician Assistants.

The CSRT represents over 4,000 licensed radiographers in Connecticut and is an affiliate organization of the American Society of Radiologic Technologists (ASRT).

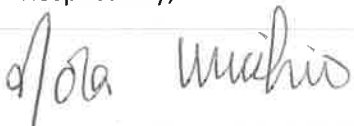
The CSRT would like the proposed legislation revised to ensure that Physician's Assistants would **not** be able to perform diagnostic imaging procedures. The legislation proposed earlier this year included vague wording in Sec. 3. Section 20-12a(3) (B): *"methods by which the physician and physician assistant will review medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that the physician assistant may prescribe, dispense and administer"*. Our concern is that this language could be misconstrued to include diagnostic imaging procedures.

It is the strong opinion of the CSRT that only qualified and licensed Radiologic Technologists who are educationally-prepared and clinically competent should administer ionizing radiation while performing diagnostic imaging procedures.

Physician Assistants may use fluoroscopy as described in *Sec. 20-12i: Use of fluoroscopy by physician assistants. Qualifications and examination. Certain activities not prohibited*. This chapter should stay intact and should not be removed or changed.

Thank you for the opportunity to submit this impact statement.

Respectfully,



Nora Uricchio, M.Ed., R.T.(R)(T)
President
Connecticut Society of Radiologic Technologists (CSRT)
NURicchio@mcc.commnet.edu

Connecticut Ear, Nose & Throat Society

P.O. Box 863, Litchfield, CT 06759
Tel (860) 567-3787 Fax (860) 567-3591 web: <http://www.ctentsociety.org>



September 24, 2018

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
40 Capitol Avenue MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear. Ms. Wilson:

On behalf of the membership of the Connecticut Ear, Nose & Throat Society please accept this statement, as consistent with the requirements of Public Act 11-209, regarding the recent submission for an expansion in scope of practice by the Connecticut Association of Physician Assistants (CONNAPA)

CONNAPA has submitted a request, which in the opinion of the Connecticut Ear, Nose & Throat Society and its members, is a significant alteration to the scope and practice parameters for physician assistants. The Connecticut State Medical Society (CSMS), with our support, gladly participated in one of the first ever scope review committee established by Public Act 11-209. That productive process led not to the release of a report to the General Assembly from the Department of Public Health (DPH), but rather proposed legislation to drastically change current statutes to more appropriately allow physician assistants to practice to the fullest of their training and capabilities.

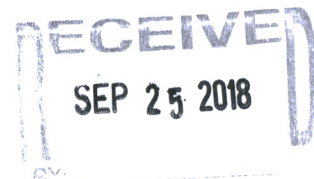
Physician assistants are a valuable member of the Ear, Nose, & Throat healthcare team. They are well trained to deliver the services they provide. However, given the significance of this proposal, we are concerned with its potential impact on the healthcare delivery system. Therefore, we fully request that prior to any proposed policy or legislation that a scope of practice review committee be established and that the Connecticut Ear, Nose & Throat Society be provided representation on the committee.

Sincerely,



Marc D. Eisen, MD PhD

President, Connecticut Ear, Nose & Throat Society





phone: 860-690-1146

email: ctorthoexec@gmail.com www.ctortho.org

September 19, 2018

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Meghan Bennett
Healthcare Quality Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Bennett,

On behalf of the more than 240 orthopaedic surgeon members of the Connecticut Orthopaedic Society (COS), we are writing regarding the Scope of Practice Request for the 2019 Legislative Session submitted by the Connecticut Academy of Physician Assistants.

As orthopaedic surgeons, we work closely with physician assistants in our State. The care they provide under the direction of a physician, oftentimes an orthopaedic surgeon, is an important component to the "team approach" of caring for patients.

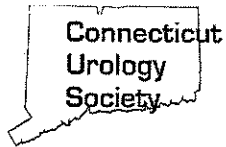
The scope change they are requesting directly impacts orthopaedic surgeons and patients. Orthopaedic surgeons have extensive experience and understanding of the duties performed by physician assistants in our practice and the COS respectfully requests participation and representation if the Department of Public Health grants the review and convenes a committee.

The COS seeks to ensure that patient safety be given the highest priority when considering expanding and adding to any professions scope of practice. Thank you for your review and consideration of our request and we look forward to hearing from you.

Sincerely,

Mariam Hakim Zargar, MD, MPH
President, Connecticut Orthopaedic Society

Cc: Connecticut Academy of Physician Assistants



P.O. Box 854, Litchfield, CT 06759 Tel- 860-567-3787
Debbie Osborn Executive Director email: debbieosborn36@yahoo.com

September 19, 2018

Meghan Bennett
Healthcare Quality Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134
Phone: **(860) 509-7590**
e-Mail: **Meghan.Bennett@ct.gov**

Dear Ms Bennett:

It is with significant concern that the Connecticut Urology Society writes to you and the Department of Public Health regarding 2018-2019 Physician Assistants Scope Review.

As president of the Connecticut Urology Society I represent the majority of urologists practicing in the state of Connecticut with over 84% membership. I am a board certified urologists practicing in Hartford Connecticut, who works on a regular basis with Physician Assistants in a clinical environment.

Let me talk briefly of our specialty training that allows us to practice independently in this state, it includes four years of medical school, followed by at least year of internship and four years of residency training (critical to independent care) in the specialty of urology. Some go on further to do additional surgical training for 1-3 years.

It is difficult for me to comprehend how physician assistants could have the training and experience required to practice with less oversight than which is currently given. I am fortunate to work in an integrated healthcare model where providers of all levels of training work together to take care of the needs of our patients, but it is a team based model which properly delineates tasks to physician extenders. We at the Connecticut Urology Society strongly believe that it is not in the best interest of Connecticut, a state that has one of the highest per capita physician to patient ratios in the country and a physician

community who not only believe in the team approach to the delivery of care but also have strong working relationships with PAs, to grant advanced privilege just because a few PAs would like it.

In closing, the Connecticut Urology Society would like to participate in any scope review process that makes determinations on whether or not the Physician Assistants receive more advanced scope. Thank you for your consideration of our request.

Please feel free to contact me if you have any further questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Wagner', with a long horizontal flourish extending to the right.

Joseph Wagner, M.D.

President

Connecticut Urology Society



September 28,2018

Meghan Bennett
Healthcare Quality Safety Branch
Practitioner Licensing & Investigations
Connecticut Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

My name is Monte Wagner, DNP, MPH, APRN-BC, Health Policy Co-chair of the Connecticut Advanced Practice Nurses Society, and I am submitting an impact statement on behalf of Advanced Practice Registered Nurses (APRNs) in Connecticut regarding the scope of practice request from the Connecticut Academy of Physician Assistants. There are several concerns and questions based on this request to change their practice.

1. A plain language description of the request;

The Connecticut Academy of Physician Assistants (ConnAPA) has requested a scope of practice change to language and statutes as follows:

- a. Change from “supervision” to “adaptive collaboration” of the physician assistants (PA’s) with physicians, where “adaptive” implies a gradual change from supervised to collaborative arrangements, as well as ratio restrictions of physicians to physician assistants determined at the practice level.
- b. Remove “agency” language (the concept that the PA is the “agent” of the physician, and as such the physician is responsible for the care provided by the PA).
- c. Include PA’s in all relevant statutes and regulations with physicians and nurse practitioners by specifying them as “licensed practitioners,” including signature authority for all forms that require physician signature, including restraint & seclusion per CMS requirements.
- d. Eliminate physician co-signature requirements on charts when schedule II-III drugs are newly prescribed and reviewed yearly.
- e. Allow physician assistants to be considered eligible providers to certify conditions for Connecticut’s Medical Marijuana Program.

2. Public Health and Safety Benefits and Risks

- a. Physician’s Assistants currently practice under the practice authority defined in Chapter 370: Section 20-12a, which defines the practice as a dependent relationship with a physician, providing patient services under the supervision, control, responsibility and direction of a physician. Under supervision, the physician assumes the responsibility for the supervision of services rendered. In this request, the practice is to change from supervision to collaboration, lifting the supervisory component and updating the

language to collaboration as is now used in several health care systems in Connecticut. It is common practice in health care today to collaborate between multiple levels of settings, such as acute, specialty, long-term and primary care, and within medical practices, which increasingly employ a multidisciplinary or inter-professional care approach. *The request does not define the level, extent or duration of collaboration, or even who the collaborator should be, and is therefore left open for interpretation, including the possibility of independent practice. The request implies that PA training is equivalent or even superior to APRN training and ignores that the practice models and years of training and experience are not comparable.*

- b. The terminology of “agency” infers that physicians are legally and financially liable for any action a physician assistant may take. Any organization hiring a licensed medical provider can be held liable of their actions regardless of supervisory or collaborative status. *The argument that physicians are reluctant to enter a supervisory agreement with a physician assistant is mitigated by the fact that medical practices are increasingly owned by a health care system and employment agreements have superseded the traditional supervisory or collaborative agreements. These employment agreements apply to APRNs just as well, and this argument should not be used to imply lack of parity with APRNs. As a matter of fact, employment agreements often stipulate a period of supervision, including chart reviews, as part of the on-boarding process. Furthermore, the term agency is not well defined and should be clarified.*
- c. Physician assistants are license practitioners and signature authority is not tied this this definition. This also applies to co-signature of medical records within a particular practice and is usually outlined in the employment agreement. *At a state level, many statutes still include language that limits signature authority for common health care-related forms to physicians, usually requiring a department by department review and approval (as the APRNs had to do over the past several years), and a universal update of these statutes may more accurately reflect daily practice today.*
- d. The requirement for physician co-signatures for DEA level II-V drugs reflects the supervisory relationship between physicians and physician assistants and should follow any changes in this regard.
- e. The certification for medical marijuana should be in line with prescribing for controlled substances under DEA regulations.

The change of scope of practice request is welcome as health care delivery models evolve in the state of Connecticut but raises questions about the definitions of collaboration and agency, and statutory changes needed to update signature and prescription authority for physician assistants.

The Connecticut Advanced Practice Registered Nurses Society supports efforts that improve access to health care, improves quality of care and patient satisfaction, and reduces health care costs for patients and payors. We welcome continued discussion of this request if this scope of practice review is selected to move forward.

Respectfully submitted,

Monte Wagner, DNP, MPH, FNP-BC
Co-chair, Health Policy



Steven C. Shifreen, MD
Christopher P. Norval, DC, MS, PA-C, LPTA
Julie W. Shifreen, RPT

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September 28, 2018

Connecticut Department of Public Health
Impact Statement

Dear Sir/Madam:

I have been a physician assistant since 2014 and a clinician in other healthcare fields since 1997. My approach to patient care has always been the utilization of safe multi-modal treatment strategies in order to optimize function and the overall health of patients. Our practice specializes in treating musculoskeletal injuries as well as individuals suffering from debilitating chronic pain. We provide medical care, chiropractic, osteopathic manual therapy, physical therapy, acupuncture, and nutritional consulting.

The chronic pain population is a complex subset, which involves individuals suffering from debilitating conditions, often a result from severe past injuries or failed surgical interventions. I provide care to help improve quality of life and day to day functioning, such as bathing, dressing, family responsibilities, and the ability to help individuals maintain employment so that they can provide for their families. Effective safe management of chronic pain requires a clinician to address not only the physical disability, but compounding biopsychosocial issues that are almost always associated.

In treating chronic pain, I am focused on being part of the solution to combat the opioid epidemic effecting our communities, while still effectively managing individuals suffering from debilitating daily pain. The Connecticut Medical Marijuana Program provides eligible patients an effective non-opioid treatment option. Due to preceding or subsequent biopsychosocial factors, patients are often concomitantly prescribed medications for anxiety and insomnia, which if untreated, dramatically compounds their chronic pain condition. The Connecticut Medical Marijuana Program provides eligible chronic pain patients with a potentially safer alternative, that could potentiate a reduction in opioid dosage or even elimination of the opioid from the treatment plan. Due to cannabis' ability to treat pain, muscle spasms, and compounding conditions such as anxiety and insomnia, my focus is to reduce poly-pharmacy, by reducing or

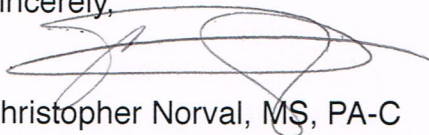
eliminating other central nervous system depressants (i.e. benzodiazepines, skeletal muscle relaxants, and hypnotics), thus increasing safety as well as treatment effectiveness.

As a physician assistant, I provide extensive education to my patients regarding each aspect of their treatment plan, including the risks and benefits of opioid management. After discussing treatment options, the inability to issue a medical marijuana certificate or even provide an annual certificate renewal, without referring them to a physician, is confusing, as well as neither time or cost effective for the patient. Many of my patients are disabled, on fixed incomes, and have difficulty securing transportation. Upon referral to a physician, patients do not understand why a Connecticut licensed physician assistant is not allowed to provide a potentially safer alternative, with the goal of reducing or eliminating poly-pharmacy of other central nervous system depressants and potentially reducing or eliminating opioids from the treatment plan.

Current authorized Connecticut Medical Marijuana providers, such as physicians and advanced nurse practitioners, may or may not have the appropriate training, experience, or speciality, however, respectively they have been granted authority to issue Connecticut Medical Marijuana certificates. It is my sincere hope that the Connecticut physician assistant scope of practice would provide physician assistants the ability to issue Connecticut Medical Marijuana certificates, in order to offer eligible patients a potentially safer alternative to opioids and other central nervous system depressants.

In providing medical care to patients, whether it be a physician, physician assistant, or advanced nurse practitioner, we all make clinical decisions based on our own education, training, and experience. Day-to-day patient care is frequently autonomous of other providers, however, collaboration is quintessential, no matter what letters follow the providers name. A collaborative team approach is definitively the best model, whether considering safety, outcomes, or economics. Before making a decision on a subject that I am uncertain about, I collaborate with other providers, sometimes it's the physician I work with, sometimes it's a toxicologist, a neurosurgeon, or a primary care provider. Likewise, the physician I work with collaborates with myself or other providers, when his training and experience is limited in a particular subject. Collaboration is a fundamental aspect of practicing medicine and truly describes the relationship between physicians, physician assistants, and advanced nurse practitioners, in particular with respect to specialization and sub-specialization in healthcare today.

Sincerely,



Christopher Norval, MS, PA-C



Steven Shifreen, MD

Christopher Norval
cpnorval@yahoo.com

Northwest Nurse Practitioner Group
Lynn Rapsilber DNP APRN ANP-BC FAANP

September 30, 2018

Meghan Bennett

Connecticut Department of Public Health
Healthcare Quality Safety Branch
Practitioner Licensing and Investigations Section
410 Capitol Avenue, MS#12APP
Hartford, CT 06134

Dear Ms. Bennett,

My name is Lynn Rapsilber DNP APRN ANP-BC FAANP and I am a nurse practitioner representing the Northwest Nurse Practitioner (NP) Group. This group is part of the Connecticut Coalition of Advanced Practice Nurses representing all the nursing population focused groups in the state. I am writing this response to the scope of practice request submitted on behalf of the Physician Assistants. The Northwest NP Groups has some reservations pertaining to this request and wish to be part of the discussion regarding the points articulated in the Physician Assistants scope of practice request document.

Realizing there is a shortage of health care providers now and in the future, scrutiny of scope of practice requests become paramount. While access to care for the residents of Connecticut is of utmost importance, unwavering regard for patient safety should not be compromised. With the residents of Connecticut at the forefront, a scope request review focuses on the education, training, licensure, current climate of practice in relationship to other states, permitting an examination of the evidence buttressing such a request.

While there are some aspects of this request focusing on reducing burden and redundancy, there is trepidation about the concept of “adaptive collaboration” and how this relates to the change from “supervision” to “collaboration” with a physician. Additionally, any request for advances to prescriptive authority need additional scrutiny to ensure this approval protects patient safety.

A thorough review performed by a convened scope of practice committee can determine, through evidence presented, whether the Physician Assistants scope of practice change is meritorious and should proceed. Northwest NP Group respectfully requests an opportunity to discuss this request further.

Sincerely,

Lynn Rapsilber DNP APRN ANP-BC FAANP

Northwest NP Group

253 Fairlawn Drive

Torrington, CT 06790



September 18, 2018

Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations Section
Connecticut Department of Public Health
410 Capitol Avenue MS#12HSR
P.O. Box 340308
Hartford, CT 06134
Attn: Meghan Bennett

RE: ConnAPA Scope of Practice Request Submission August 15, 2018 Impact on PA Education

Dear Reviewers,

I have been recently made aware of the submission by the Connecticut Academy of Physician Assistants for a revision of the scope of practice for Physician Assistants (PAs). It is imperative that you are aware of the impact that this request will have on Physician Assistant education. As the Department Chair and Program Director of one of the five accredited PA programs in the state of Connecticut, and representing our faculty. It is our responsibility to be educating PA students to practice to the maximum ability that licensure and scope of practice allows. The Accreditation and Review Commission of Physician Assistant Education (ARC-PA), the national accrediting agency for PA Programs, require this.

One of these key points in the education of future PAs is understanding the impact that restrictions of practice and regulations have on a profession's ability to provide access to quality health care to our communities. During the PA educational process each student is required to have over 1600 hours of didactic education, and an additional 2000 hours of direct patient care training, with exposures to primary care, pediatrics, women's health, hospital medicine, and psychiatry. In addition to being the core specialties in medicine. these are all specialties designated as areas deficient, or projected to have deficiencies in providers, especially in underserved communities. It is also vitally important to point out that the current scope of practice limits the access for the students to get a valuable educational experience. Reducing the restrictive regulations on physicians and PAs allows for a better physician lead healthcare team that with increased opportunities for physicians and PAs alike to mentor and become active in the medical education process for medical and PA students alike.

Throughout the PA educational process the concept of the role of the PA as an integrated member of the healthcare team is reinforced. The impact of the proposed scope of practice will have on the educational process is that it will provide better delineation of the role of the PA in the team, and the ability of the team to provide a more comprehensive yet streamlined coordination of health care and preventive services. PAs are not independent practitioners, and students are taught that they will have varying degrees of autonomy in their role on the team, they are not an independent provider. Additionally, the notion of the physician being solely responsible for the medical care of a PA is a misnomer that is quickly dispelled in the educational process. Students quickly understand that they are accountable for the care they provide, a concept deeply rooted into the curriculum of PA education. Because PA education is not taught to state specifics, but rather the standards that are more widely accepted nationally and

internationally, the proposed scope of practice changes in Connecticut will have minimal impact on PA education.

The proposal includes the request for PAs to practice to the full scope of their license and the ability of the PA to be fairly and justly reimbursed for the care that they provide. Currently the local and national limitations on the ability of the PA to prescribe certain medical therapeutics, and request certain patient needed resources create not only barriers to patient access to quality of life and health, it also creates a restriction on the scope of practice of the PA and their ability submit documentation, for compensation. The impact that the proposal for just reimbursement, and practice authority has minimal impact on the education of future PAs. The current curriculum in most programs includes education on resources, prescribing therapeutics appropriately, coding and billing, as well as the process for reimbursement. Program curriculum also includes education on the ethics and legal impacts of virtuosity and fraud.

Physician assistant education requires that students are provided an education across the life span, of basic medical topics as well as advanced specialty areas to prepare them for clinical practice. The design of our program begins with the foundations and fundamentals and then proceeds to more advanced and specialty topics, over 1600 hours of didactic course work prior to being sent on to the clinical phase. Because of this robust educational experience, the impact on the education of PAs that the proposed scope of practice would have is negligible.

Connecticut has historically been on the forefront of integrating PAs into the health services provided to the communities. It has been very proactive in recognizing the impact that PAs and APRNs have on serving communities that are underserved. Up until recent years Connecticut has also recognized the equity of the roles that each of the disciplines (PA and APRN) play as a part of the healthcare team. It is important to also note that despite the equity of the roles, the educational differences are based on the generalist (PAs) versus more concentrated (APRN) models of education and certification requirements that are the foundations of the programs, and not the limitations or quality of the services either profession are able to provided to the communities.

Beyond the minor curricular changes and educational sessions for the clinical preceptors and instructors of our PA students. The impact of the scope of practice changes on the didactic education of PAs will be minimal, as we are already teaching all students to practice at the national standards for scope of practice. As well as a being active, responsible members of the health care team. By reducing some of the administrative constraints of practice, the greatest potential impact on clinical education will be a positive one that can open the doors for more PAs and physicians to be educators and mentors for students.

If I can be of any further assistance, please contact me at Dennis.Brown2@quinnipiac.edu

Respectfully,

A handwritten signature in black ink, appearing to read 'Dennis J. Brown', enclosed in a large, loopy oval shape. A horizontal line extends from the right side of the signature.

Dennis J. Brown, DrPH, PA-C, DFAAPA
Department Chair & Program Director
Department of Physician Assistant Studies



UNIVERSITY OF SAINT JOSEPH

CONNECTICUT

September 27, 2018

Meghan Bennett
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12HSR
P.O. Box 340308
Hartford, CT 06134
Phone: (860)509-7546

Dear Committee Members:

I am writing in strong support of the Scope of Practice Review Request submitted by ConnAPA, requesting modernization of the PA Practice Act to include improvements that will allow PAs to better provide efficient, accessible care to the people of Connecticut.

As a PA practicing for 17 years, as well as a PA educator for the last 8 years, it is my opinion that the request prepared by the legislative committee of ConnAPA contains reasonable amendments that are in keeping with the current practice of PAs and supported by the robust educational preparation PAs receive during their training. Previously, I have served as assistant director for two PA Programs, and currently occupy the role of founding director of the PA Program at University of Saint Joseph, in West Hartford. Through my extensive work with oversight and development of PA training program curricula within these three institutions, I hope to offer insight and assurance to the committee members and other interested parties that the training of physician assistants is more than adequate to allow them to continue to provide safe, cost-effective, team-based healthcare in collaboration with physicians, were the requested changes adopted.

PA education entails rigorous, graduate level coursework, with most programs including 12-15 months of year-round, full-time didactic coursework, followed by 12 months of clinical training equating to approximately 1500 hours of supervised clinical practice where PA students train alongside medical and APRN students. Prior to PA training, students complete science intensive pre-requisite coursework, in the areas of biology, chemistry, anatomy, physiology, and biochemistry. PA education then builds upon this foundation with coursework in the basic medical and behavioral sciences, an in-depth study of clinical medicine, surgery, pharmacology, and application of content through practical and technical skills training. Curricular content, outcomes and continuous self-assessment are mandated through a highly diligent accrediting body, ensuring PA programs produce competent clinicians. Students must earn certification through a standardized national examination and complete continuing medical education annually to maintain certification. Training requirements for PAs meet or exceed those of other similarly functioning practitioners who have already been granted the same scope of practice abilities being requested by ConnAPA for the practicing PAs in Connecticut.

Changing existing agency language, inclusion of the PA profession by name in legislation, removing co-signature requirements and allowing PAs to certify patients for debilitating medical conditions all would allow PAs to practice to the extent of their education and training. In a state facing a significant physician shortage, especially in the area of primary care, it is imperative that well-qualified PAs be allowed to function fully to help meet the needs of the patients.

Changing the word “supervision” to “collaboration” within the practice act, does not change the fundamental functioning of modern PA practice and would serve to eliminate confusion that exists at the individual provider as well as institutional levels. In developing our program, we met with practitioners and administrators across the state in an effort to create clinical partnerships for training. Frequently, we would encounter misconceptions about the supervision requirements for PAs that resulted in individual practices or institutions choosing not to employ PAs because they felt it was too burdensome. Whether they believed they had to see every patient seen by a PA, or that they had to co-sign every chart or prescription, confusion existed as to the requirements placed on the supervising physician. The word “collaboration” better reflects the typical interaction between physician and PA, with written agreements being created at the practice level delineating clinical responsibilities reflective of the PAs skills, abilities, and training.

In summary, the requests for modernizing the PA Practice Act in Connecticut, submitted by ConnAPA, will increase access to care by removing barriers that currently exist and limit the ability of PAs to meet the needs of their patients. Research has shown that the quality of care that PAs provide is similar to that of other clinicians, thanks to the rigorous and in-depth training they are provided. Allowing the collaborative nature of the PA-Physician team dynamic to be reflected in the current laws governing PA practice is a necessary step toward providing quality, team-based care across the disciplines.

If I can provide any further insight or clarification into this matter, please do not hesitate to contact me.

Respectfully submitted,

A handwritten signature in black ink that reads "Carrie Walker PA-C". The signature is fluid and cursive, with the initials "PA-C" written in a slightly different style at the end.

Carrie Walker, MPAS, MS, PA-C

Founding Director and Chair

Physician Assistant Studies

University of Saint Joseph

(860) 231-5381

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Meghan Bennett
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12HSR
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September 28, 2018

Dear Ms. Bennett:

It is our pleasure to write in strong support of the proposed modernization of PA scope of practice laws currently under consideration by the Department of Public Health, as was recently submitted on August 15th, 2018 by the Connecticut Association of Physician Assistants. The proposal as described serves to modernize the antiquated terminology currently in regulation, and will more accurately reflect the working relationship that physicians and physician assistants have enjoyed for over half a century.

As the PA profession and our health care system have developed over the years, the relationships between the various categories of health care providers have matured. The term collaboration better recognizes the reality of the current practice environment; rather than a paternalistic system, a multitude of different health care disciplines collaborate together to work towards optimal patient care. In no way does this imply severing the team-based practice model that PAs and physicians have always enjoyed, and this should not be interpreted as a call for independent practice authority. Rather than relying on rigid regulatory requirements for the degree of physician involvement required without regard to the practice setting or degree of clinician experience, the optimal collaborative model can be determined at the practice or hospital level.

The proposed practice updates also serve to better clarify who is ultimately responsible for the professional actions performed while caring for patients. As medical professionals, PAs should be responsible for their own clinical decisions and actions. PAs make thousands of clinical decisions daily that do not involve the direct, real-time oversight of their supervising physicians; the consequences of those decisions should rest with the provider themselves, rather than passing the buck to a supervising physician of record who may have no involvement in the decision at the time that it is made.

As the leadership of an emergency medicine postgraduate training program for PAs and APRNs at Yale New Haven Hospital, we are fortunate enough to draw top-tier applicants from both here in Connecticut and from around the nation. Residency programs such as ours have existed for PAs in a variety of medical specialties since the 1970's. There are now more than thirty such emergency medicine residencies nationwide, with the Yale program being the only emergency medicine residency in Connecticut. For eighteen months, our PA residents go through a rigorous educational program of didactic lessons and clinical rotations that mirrors that of their physician resident colleagues.

home state that encourages PAs to make a career here, rather than moving on to states with more modern practice environments. By optimizing the practice laws here in Connecticut to allow these graduates to practice to the full extent of the education and training, we will be better situated to compete with other states that have already moved forward with similar updates to their practice laws. This will ultimately serve to improve patient access to timely, quality patient care.

We look forward to seeing these proposed changes progress, and are happy to assist with the process in any way. Thank you for the opportunity to offer our support to these proposals.

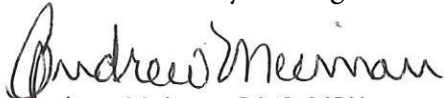
Sincerely,



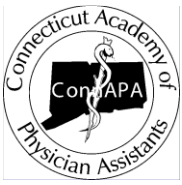
Kevin Burns, PA-C, DFAAPA
Co-Director, YNHH Emergency Medicine PA Residency Program
Assistant Clinical Professor of Emergency Medicine, Yale University School of Medicine
kevin.burns@yale.edu



Theresa Cohen, MPAS, PA-C
PA/NP Manager, Yale New Haven Hospital Emergency Department
theresa.cohen@ynhh.org



Andrew Meiman, PA-C, MPH
Co-Director, YNHH Emergency Medicine PA Residency Program
andrew.meiman@ynhh.org



Connecticut Academy of Physician Assistants

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October 14, 2018

Dear Ms. Bennett,

Please accept this letter in response to the impact statement submitted by the Connecticut Academy of Family Physicians (CAFP) to the Department of Health in regard to the Connecticut Academy of PA's (ConnAPA) proposal dated August 15, 2018.

ConnAPA appreciates the time the CAFPP has taken to review the submitted request and reflect on the impact to Family Physicians. Connecticut PAs continue to believe that our physician relationship is one that we respect as invaluable, and is not to be compromised.

However, we do not see that our proposal expands any services that are currently provided by PAs, as suggested by CAFPP. There is the possible exception of certifying patients for medical marijuana, but PAs already certify patients as having medical conditions. This is not so much an expansion of services but rather allowing access to appropriate care.

It's important to reassure Family Physicians that a change to collaboration from supervision does not eliminate physician involvement in patient care, or grant independent practice to PAs. A collaborative relationship will not affect the quality of care that PAs provide, and that Family Physicians already rely upon. A collaborative relationship with another healthcare profession is not unprecedented in this state.

The 2012 scope change for PAs that CAFPP refers to, did little to anticipate the drastic changes that have taken place in the medical landscape in the last several years. The 2012 PA bill merely tweaked the mandated requirements of physician supervision, but did not eliminate the burdensome requirements of physician "oversight, control, and direction of the services" of PAs. As a result, PAs have continued to run into barriers that prohibit ease of providing care to patients who need it.

Ultimately, CAFPP and ConnAPA have the same goal, to provide the most accessible, cost-effective access to quality care for the citizens of Connecticut. We look forward to working with the CAFPP in a formal session to discuss and alleviate all concerns. We thank the CAFPP for their involvement in this process, and the DPH for coordinating the effort.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



Connecticut Academy of Physician Assistants

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October 14, 2018

Dear Ms. Bennett,

Please accept this letter in response to the impact statement submitted by the Connecticut Academy of Nurse Anesthetists (CANA).

First, the Connecticut Academy of PAs (ConnAPA) appreciates the time taken by the CANA to review the submission. ConnAPA is pleased that the CANA recognizes the merit of the request and supports our efforts to increase access to high quality healthcare to the citizens of Connecticut.

Regarding the concern over PA training, and the relationship that is taught to PA students, it should be noted that PA education teaches students to practice to the highest level legally permitted in whichever state they may end up. PAs are not independent providers, but are taught to practice to varying degrees of autonomy within a physician-led, healthcare team.

Additionally, as a point of clarification, full prescriptive authority was not requested in the submitted document, as PAs already have full prescriptive authority of Schedule II-V controlled substances and legend drugs. What was requested was elimination of an approval process, often implemented as co-signatures, that occurs *after* the prescriptions or orders have been written, and does nothing for patient safety and simply adds administrative burden.

Ultimately it would seem that ConnAPA and CANA have the same goal, to provide increased, cost-effective access to high quality care to the citizens of Connecticut. Though we see no stated impact on the nurse anesthetist profession, we would welcome further conversation with these colleagues. We further thank the DPH for coordinating this discussion.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



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October 14, 2018

Dear Ms. Bennett,

Please accept this letter in response to the impact statement submitted by the Connecticut College of Emergency Physicians (CCEP).

First, the Connecticut Academy of PAs (ConnAPA) is grateful for the time taken by the CCEP to review the submission.

While CCEP does not make note of a specific concern, we agree that they should be involved in the conversation. As physicians whom often work with PAs daily, we acknowledge that our proposal impacts your profession. ConnAPA continues to assert that the day to day relationship will not change with physicians, but the new language will be more consistent with how PAs and physicians interact every day. As emergency medicine is one of the most common specialties PAs practice in, ConnAPA understands the potential for concern on behalf of the CCEP.

The opportunity to discuss the issue in person, to alleviate concerns and find agreement is looked forward to. Ultimately both CCEP and ConnAPA have similar goals, to ensure the safety and health of the citizens of Connecticut. ConnAPA is appreciative of the DPH for arranging this dialogue.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



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October 14, 2018

Dear Ms. Bennett,

Please accept this letter in response to the impact statement submitted by the Connecticut Dermatology and Dermatologic Surgical Society (CDDSS) to the Department of Health in regard to the Connecticut Academy of PA's (ConnAPA) proposal dated August 15, 2018.

ConnAPA appreciates the time the CDDSS has taken to review the submitted request and reflect on the impact to CT dermatologists. Connecticut PAs continue to believe that our physician relationship is one that we respect as invaluable, and is not to be compromised. We agree that physician education and training is more extensive than for PAs, and that is why PAs are not seeking independent practice. It is important to reassure CT dermatologists that a change from PA supervision to collaboration does not eliminate physician involvement in patient care, or grant independent practice to PAs. Though the CDDSS impact statement appears to oppose our request, there is conflicting information offered in the impact statement. The CDDSS states "...the practice of dermatology benefits from a collaborative care team approach."

As a note of clarification regarding the education of PAs, where the CDDSS states that PA education "could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry," ConnAPA would like to point out that those are all mandatory rotations as required by the body that is responsible for accreditation of PA programs (ARC-PA). There is not an option regarding those rotations, in addition to other rotations that can vary by program but may focus on primary care, elective rotations, orthopedics, research, etc.

In fact, the "optimal way to provide dermatologic care" is the same as it is in every specialty or primary care practice. The optimal care is one that provides timely access to cost effective, high quality and collegial team-based care. Yet unfortunately, wait times for access to dermatologic practices is a major problem. Care that is so delayed can often lead to worse outcomes.

Regarding the cited study out of the University of Pittsburgh Medical Center, which noted that more biopsies need to be performed by PAs than physicians to diagnose skin cancer, it should be pointed out that there are large flaws in the study. Flaws include the small sample size of physicians and PAs (15 of each), and even more strikingly the level of experience compared. The study reported that 13.5 years of experience, *after residency training*, was had by physicians, while the PAs in the study had only 6.9 years of dermatology experience starting with the date of hire. Certainly, there will be differences in diagnostic utilization when comparing experience levels, however this study held those levels at equal standing. There have been refutes of this study by PAs and physicians alike.

We agree with the CDDSS that patients can be confused about their providers level of education, training and skills as they receive a wide spectrum of health care. However, that does not apply to PAs any more than other providers. In fact, Connecticut General Statute, Chapter 370, Section 20-12d(c) already calls for proper identification by PAs.

Ultimately, CDDSS and ConnAPA have the same goal, to provide the most accessible, cost-effective access to quality care for the citizens of Connecticut. We look forward to working with the CDDSS in a formal session to discuss and alleviate all concerns. We thank the CDDSS for their involvement in this process, and the DPH for coordinating the effort.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



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October 14, 2018

Dear Ms. Bennett,

Please accept this letter as a response to the impact statement submitted by the Connecticut Hospital Association (CHA).

The Connecticut Academy of PAs (ConnAPA) appreciates the time the CHA has taken to review the submitted request, and acknowledge the potential impact to the policies and IT systems of the member hospitals. Ultimately our request should help alleviate administrative burden to the CHA member hospitals. We would welcome the expertise of the CHA at a formal session, as ultimately, there are likely to be a number of mutual goals and areas of agreement.

We thank the CHA for their willingness to be involved with our request, and the DPH for the organization of this effort.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



Connecticut Academy of Physician Assistants

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October 14, 2018

Dear Ms. Bennett,

Please accept this letter as a response to the impact statement submitted by the Connecticut Orthopaedic Society (COS).

The Connecticut Academy of PAs (ConnAPA) appreciates the time taken by the COS to review the submission and for their interest in participating in a review session. As accurately pointed out in their impact statement, PAs do work closely in teams with orthopedic surgeons, and very much value that relationship. Because of the close working relationship between PAs and orthopedic surgeons, we agree that the COS can offer valuable viewpoints if this submission is selected for review.

ConnAPA fully agrees with the COS that patient safety be given the highest priority. This review process will ensure just that, and ConnAPA looks forward to working with the Connecticut Orthopaedic Society.

We thank the COS for their willingness to be involved, and the DPH for coordinating this effort.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



Connecticut Academy of Physician Assistants

One Regency Drive • PO Box 30 • Bloomfield, CT 06002
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October 14, 2018

Dear Ms. Bennett,

Please accept this letter as a response to the impact statement submitted by the Connecticut State Medical Society (CSMS) to the submission by the Connecticut Academy of PAs (ConnAPA).

First ConnAPA appreciates the time taken by the CSMS to review the submission. PAs value and respect the physician-led healthcare team, and have no desire to change that dynamic.

A single point of correction to the letter however. In 2012, when ConnAPA last had a scope of practice review, a report was in fact developed and released after the process, which was developed to *support* the proposed legislation that was submitted and subsequently passed. Ultimately the purpose of the scope review process *is* to lead to legislation if deemed acceptable. Also, to say that the 2012 “drastically change[d] current statutes” is overstated, as it’s primary function was to clarify the delegation agreement and similar to this request, served to clarify and modernize language, without dramatically changing the scope of practice.

ConnAPA looks forward to an opportunity to sit down with the CSMS and other potentially impacted groups to discuss the proposal at length, provide reassurance and find concordance.

Very respectfully,

Michael Devanney, MHS, PA-C
President

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October 14, 2018

Dear Ms. Bennett,

Please accept this letter in response to the impact statement submitted by the Connecticut Society of Radiologic Technologists (CSRT) to the submitted proposal by the Connecticut Academy of PAs (ConnAPA). ConnAPA is appreciative of the time taken by the CSRT to review the submission and offer insightful comment.

ConnAPA recognizes the concern expressed regarding diagnostic imaging procedures. The intent of the passage quoted by CSRT was never meant to be interpreted as allowing PAs to perform radiographic diagnostic imaging procedures, outside the use of fluoroscopy under prescribed conditions as otherwise already authorized in statute, unless a PA also happens to be a fully qualified and licensed radiologic technologist.

ConnAPA fully agrees with the CSRT that only “qualified and licensed radiographic technologists...should administer ionizing radiation while performing diagnostic imaging procedures.”

ConnAPA appreciates this clarifying impact statement, and the opportunity to previously converse about this topic, and welcomes further discussion as necessary in a formal setting. ConnAPA further appreciates the work of the DPH to coordinate this dialogue.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



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October 14, 2018

Dear Ms. Bennett,

Please accept this letter as a response to the impact statement submitted by the Connecticut Ear, Nose & Throat Society to the submission by the Connecticut Academy of PAs (ConnAPA).

First ConnAPA appreciates the time taken by the CT ENT Society to review the submission. PAs value and respect the physician-led healthcare team, and have no desire to change that dynamic.

A single point of correction to the letter however, in 2012, when ConnAPA last had a scope of practice review, a report was in fact developed and released after the process which was developed to *support* the proposed legislation that was submitted and subsequently passed. Ultimately the purpose of the scope review process *is* to lead to legislation if deemed acceptable. Also, to say that the 2012 “drastically change[d] current statutes” is overstated, as it’s primary function was to clarify the delegation agreement and similar to this request, served to clarify and modernize language, without dramatically changing the scope of practice.

ConnAPA looks forward to an opportunity to sit down with the CT ENT Society and other potentially impacted groups to discuss the proposal at length, provide reassurance and find concordance.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



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October 14, 2018

Dear Ms. Bennett,

Please accept this letter in response to the impact statement submitted by the Connecticut Advanced Practice Registered Nurse Society (CTAPRNS).

First, the Connecticut Academy of PAs (ConnAPA), thanks the CTAPRNS for their review of the submitted document, and their interest in ConnAPA's request. While the submitted impact statement does not demonstrate any apparent impact on the APRN profession, there are a few points from the letter that should be addressed.

There was not a request in the document to change a PA to physician ratio, as there is no longer a ratio. That ratio was previously eliminated in Public Act No. 18-168.

The submitted document was clear that "independent" practice was not being sought, and that physicians continue to head the healthcare team. It also clearly stated that the "collaborator" would be a physician, as any other professional would be inappropriate.

Regarding the request to eliminate "agency," the term "agency" was clearly cited and means "*One who agrees and is authorized to act on behalf of another....*" The point raised about medical practices increasingly joining larger, hospital associated groups is exactly the concern that is raised. As physicians continue to become employees (just as PAs are in such groups), instead of financially vested in the group, there is increasing reluctance to accept responsibility for the action of another professional. Furthermore, why should a licensed healthcare provider *not* be held solely responsible for their own actions?

ConnAPA and the CTAPRNS share the goals of healthcare that has improved access, patient satisfaction, is cost-effective and is high quality. We thank DPH for the coordination of this effort and look forward to discussing it further all impacted professions.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee



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October 14, 2018

Dear Ms. Bennett,

Please accept this letter in response to the submitted impact statement by the NW Nurse Practitioner Group.

First, the Connecticut Academy of PAs (ConnAPA) appreciates the time taken by the Group to review the submitted document. It appears that the Group and ConnAPA have similar goals of providing increased access to high quality care. While the NW Nurse Practitioner Group's impact statement did not appear to address any impact on the nurse practitioner profession, there are a couple of points in the letter that warrant being addressed.

The nurse practitioners need not have any "trepidation about the concept of 'adaptive collaboration'...with a physician." As stated that relationship is one between PAs and physicians, and does not involve any other professions. Additionally, there was not a request for advancing prescriptive authority, as PAs already have full prescriptive authority. What was requested was easing administrative burden by eliminating a requirement of documentation that is often implemented as co-signatures, which occur *after* the medication has been prescribed/ordered, thereby doing little to ensure patient safety.

ConnAPA thanks the DPH for coordinating this discussion. ConnAPA looks forward to conversing further with potentially impacted professions at a formal session.

Very respectfully,

Michael Devanney, MHS, PA-C
President

Jason P. Prevelige, MHS, PA-C
Chair, Legislative Affairs Committee

Appendix E
Additional Information

**Number of Job Listings for Advanced Practice Clinicians
based on web site job postings 11-2018**

	<u>For PAs</u>	<u>For APCs</u>	<u>For APRNs</u>
Hartford HealthCare	9	43	12
ProHealth Physicians	0	6	3
Middlesex Hospital	1	2	3
Yale New Haven Health	22	14	28
State of CT	1		2

PA's Face New Obstacles in a Changing Market

*See citations below for data sources

Financial Incentives for Physicians to Supervise PAs are Changing

Fewer than Half of Physicians Own Practices

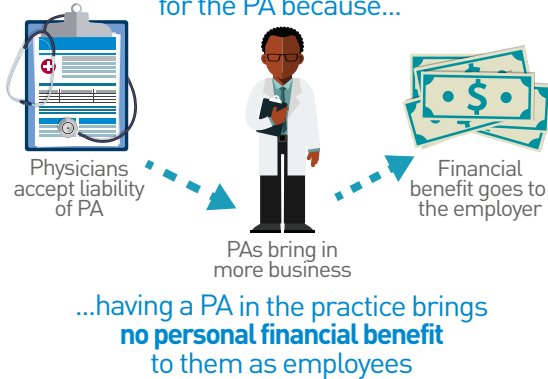
76.1% of Physicians Were Practice Owners in 1983¹

47.1% of Physicians Were Practice Owners in 2016²

38% Decrease in % of Physicians Who Own Practices from 1983 to 2016^{1,2}

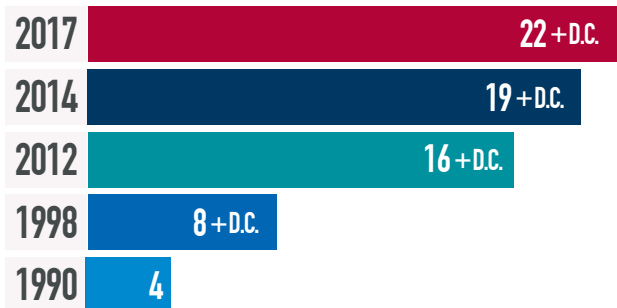
Physicians Are Increasingly Reluctant to Enter Into Supervisory Agreements With PAs

Physicians who are employees don't want to accept liability for the PA because...



Laws in Many States Do Not Require NPs to Have a Supervisory Agreement

Number of States Where NPs Have Full Practice Authority by Year³



Community Health Center CEOs Make PA vs NP Hiring Decisions Based on Practice Laws⁴

Broader PA and NP Authority^{5,6,7}



Increases Access to Care



Doesn't Diminish Quality of Care



Can Reduce Cost of Healthcare

PA Experiences Validate Marketplace Obstacles

45% of PAs

say they have personally experienced NPs being hired over PAs due to supervision requirements⁸

1. Kane, Carol K. "Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership," AMA Economic and Health Policy Research, July 2015. | 2. Kane, Carol K. "Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent," AMA Policy Research Perspectives, June 2017. | 3. Summers, Lisa. "Update: Transition to full practice authority for APRNs," <http://www.theamericannurse.org/2016/08/10/update-transition-to-full-practice-authority-for-aprns/> | 4. Pittman, Patricia, Leah Masselink, Bianca Frogner, and Leighton Ku. "Factors Determining Medical Staff Configurations in Community Health Centers: CEO Perspectives," *Journal of Healthcare Management* 61:5 September/October 2016: 364-377. | 5. Martsof, Grant R., David I. Auerbach, Aziza Arifkhanova. "The Impact of Full Practice Authority for Nurse Practitioners and Other Advanced Practice Registered Nurses in Ohio" RAND Corporation, Santa Monica, CA, 2015. | 6. Timmons, Edward J. "The Effects of Expanded Nurse Practitioner and Physician Assistant Scope of Practice on Medicaid Patient Access," Mercatus Working Paper, Mercatus Center at George Mason University, January 2016. | 7. Kurtzman, Ellen T., Burt S. Barnow, Jean E. Johnson, Samuel Simmons, Donna Lind Infield, and Fitzhugh Mullan. "Does the Regulatory Environment Affect Nurse Practitioners' Patterns of Practice or Quality of Care in Health Centers?" HRS: Health Services Research 52:1, Part II, February 2017. | 8. AAPA, "2017 Full Practice Authority and Responsibility Survey Report: A Report to the Joint Task Force on the Future of PA Practice Authority," February 2017.



The Six Key Elements of a Modern PA Practice Act

State	Licensure as Regulatory Term	Full Rx	Scope Determined at Practice Site	Adaptable Supervision/ Collaboration Requirements	Chart Co-Signature Determined at the Practice Level	Physician may practice with unlimited number of PAs	Number of Key Elements
Alabama	√	√					2
Alaska	√	√	√		√	√	5
Arizona	√	√	√	√	√		5
Arkansas	√		√	√	√	√	5
California	√	√	√	√			4
Colorado	√	√	√				3
Connecticut	√	√	√	√	√	√	6
Delaware	√	√	√	√	√		5
District of Columbia	√	√	√	√	√		5
Florida	√	√	√		√		4
Georgia	√			√			2
Hawaii	√	√	√	√			4
Idaho	√	√	√		√		4
Illinois	√	√	√	√	√		5
Indiana	√	√	√	√			4
Iowa	√						1
Kansas	√	√	√				3
Kentucky	√				√		2
Louisiana	√	√	√	√	√		5
Maine	√	√	√		√	√	5
Maryland	√	√		√	√		4
Massachusetts	√	√	√	√	√	√	6
Michigan	√	√	√	√	√	√	6
Minnesota	√	√	√	√	√	√	6
Mississippi	√	√				√	3
Missouri	√		√				2
Montana	√	√	√			√	4
Nebraska	√	√	√				3
Nevada	√	√	√				3
New Hampshire	√	√	√	√			4
New Jersey	√	√	√	√	√		5
New Mexico	√	√	√	√	√		5
New York	√	√	√	√	√		5
North Carolina	√	√	√	√	√	√	6
North Dakota	√	√	√	√	√	√	6
Ohio	√	√	√	√	√		5
Oklahoma	√			√	√		3
Oregon	√	√	√		√		4
Pennsylvania	√	√					2
Rhode Island	√	√	√	√	√	√	6

The Six Key Elements of a Modern PA Practice Act

State	Licensure as Regulatory Term	Full Rx	Scope Determined at Practice Site	Adaptable Supervision/ Collaboration Requirements	Chart Co-Signature Determined at the Practice Level	Physician may practice with unlimited number of PAs	Number of Key Elements
South Carolina	√	√					2
South Dakota	√	√	√	√	√		5
Tennessee	√	√	√			√	4
Texas	√	√	√	√	√		5
Utah	√	√	√	√			4
Vermont	√	√	√	√	√	√	6
Virginia	√	√			√		3
Washington	√	√		√	√		4
West Virginia	√						1
Wisconsin	√	√		√	√		4
Wyoming	√	√	√	√	√		5
Totals	51	44	38	31	32	14	

6/13/18

Several States have enacted provisions that include a partial key element. For more complete information on these provisions, please consult [AAPA's state-by-state summaries](#).



Physician assistant scope of practice

The AMA opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery.¹ The AMA believes that physicians must maintain the ultimate responsibility ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.²

With regard to physician assistants specifically, AMA policy states that physician assistants should be authorized to provide patient care services only so long as the physician assistant is functioning under the direction and supervision of a physician or group of physicians.³ Accordingly, the AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgment regarding such decisions as the drug of choice for an individual patient.⁴

AMA policy also addresses regulation of physician assistants. In particular, the AMA advocates in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel.⁵ The AMA also opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview.

This state law chart outlines several aspects of state laws regulating physician assistant practice.

- **Co signature** – 20 states⁶ require a certain percentage or number of PA charts to be co-signed by a physician
- **Ratio requirements** – 39 states⁷ have established limits on the number of PAs a physician can supervise or collaborate with

¹ AMA Policy H-35.989, Physician Assistants; AMA Policy H-35.988, Independent Practice of Medicine by Nurse Practitioners.

² AMA Policy H-35.988, Independent Practice of Medicine by Nurse Practitioners.

³ AMA Policy H-35.989, Physician Assistants.

⁴ *Id.*

⁵ AMA Policy H-35.965, Regulation of Physician Assistants.

⁶ AL, CA, CO, IN, KS, KY, LA, MS, MO, MT, NE, NV, NJ, OH, PA, SC, TN, UT, VT, VA

- **Prescriptive authority**
 - PAs are authorized to prescribe Schedule II-V medication in most states (44)
 - PAs lack the authority to prescribe Schedule II medication in 6 states (AL, AR, GA, HI, IA, WV)
 - PAs lack the authority to prescribe legend drugs in 1 state (KY)
- **Requirements for collaborative or supervisory arrangement**
 - In 47 states, PAs are supervised by physicians
 - In 2 states, PAs are subject to collaborative agreements with physicians (AK, IL)
 - 2 states allow for alternate arrangements: New Mexico calls for supervision for PAs with less than 3 years of clinical experience, and for specialty care PAs, and in Michigan, PAs work under a participating physician
- **Regulation** – In most states (43), PAs are regulated by the medical board. However, in 8 states (AZ, CA, IA, MA, MI, RI, TN, UT), PAs have a separate and independent regulatory board
- **Scope of practice determination** – In most states (47), PA scope of practice is determined with the supervising/collaborating physician at the practice site

⁷ No ratios in AK, AR, ME, MA, MI, MN, MS, NM, NC, ND, RI, TN

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
Alabama	Required (AAC 540-X-7-.23)	Physician may not supervise more than a cumulative 160 hours per week for all PAs. (AAC 540-X-7-.26)	Schedule III-V	Supervisory	The supervising physician shall be readily available for direct communication or by radio, telephone, or telecommunication. There shall be no independent, unsupervised practice by PAs Prescribing is subject to any limitations stated in protocols and medical regimens adopted by the Board and subject to any limitations by the supervising physician in the approved formulary (AAC 540-X-7-.23)	Alabama Board of Medical Examiners	Yes
Alaska	None	None	Schedule II-V	Collaborative	Collaborative plans must include at least monthly telephone, radio, electronic, or direct personal contact between the PA and the primary or alternate collaborating physician reviewing the PAs performance in the practice, knowledge, skills, patient care, and health care records. (12 AAC 40.430)	Alaska State Medical Board	Yes
Arizona	None	Physician may not supervise more than 4 PAs who work at the same time. (ARS. 32-2533)	Schedule II-V II-III limited to 30-days, no refills without written consent from physician; IV-V not more than 5 times in 6-months.	Supervisory	PA must meet in-person or by telecommunication with the supervising physician at least once each week to ensure ongoing direction and oversight of PA work. Patient records must also be made available to the supervising physician. A supervising physician shall develop a system for recordation and review of all instances in which the PA prescribes schedule II or schedule III controlled substances. (ARS 32-2531)	Arizona Regulatory Board of Physician Assistants	Yes
Arkansas	None	None	Schedule III-V	Supervisory	Continuous supervision is required, but does not necessitate physical presence at the time and place services are rendered.	Arkansas State Medical Board	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
					A supervising physician should be available for immediate telephone contact with the PA any time the PA is rendering services to the public. A supervising physician must be able to reach the location of where the PA is rendering services to the patients within one hour. (ACA 17-105-109)		
California	Sample of at least 10 charts per month, for at least 10 months during the year. (Minimum of 5% of the PAs medical records). (CCR 3502)	Physician may not supervise more than 4 PAs at any one time. (CCR 3516(b))	Schedule II-V	Supervisory	<p>A supervising physician shall be available in person or by electronic communication at all times when the PA is caring for patients.</p> <p>A supervising physician shall delegate to a PA only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice.</p> <p>A supervising physician shall observe or review evidence of the PAs performance until assured of competency. (CCR 1399.545)</p>	California Physician Assistant Board	Yes
Colorado	Required, but varies with PA experience. (Rule 400; 3 CCR 713-7)	Physician may not be the primary supervising physician for more than 4 individual PAs. (Rule 400; 3 CCR 713-7)	Schedule II-V	Supervisory	PAs are subject to tiered supervision requirements concerning performance assessments, chart reviews, in person meetings, and on-site supervision. If not physically on site, the physician supervisor must be readily available by telephone, radio, pager, or other telecommunication device. (CCR Rule 400)	Colorado Medical Board	Yes
Connecticut	None	Physician may	Schedule II-V	Supervisory	Physician should be continuously available by direct	Connecticut	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
		not be the supervising physician for more than 6 PAs practicing full time, or the part-time equivalent thereof. (CGS 20-12c)			communication either in person or by radio, telephone, or telecommunications. There should be active and continuing overview of the PA’s activities, personal review by the supervising physician of the PA’s practice on a regular basis, review of the charts and records of the PA on a regular basis, and designation of an alternate licensed physician in the absence of the supervising physician. (CGS 20-12a)	Medical Examining Board	
Delaware	None	Physician may not supervise more than 4 PAs at a given time. (Del. C. 1771)	Schedule II-V	Supervisory	If the supervising physician delegates the authority to a PA to treat patients in a setting where the supervising physician is not routinely present, the physician must assure that the means and methods of supervision are adequate to assure appropriate patient care. This may include telecommunication, chart review, or other methods of communication and oversight that are appropriate to the care setting and the education and experience of the PA. (Del. C. 1771)	Board of Medical Licensure and Discipline	Yes
District of Columbia	None	Physician may not supervise more than 4 PAs at a given time. (DCMR 4914.10)	Schedule II-IV	Supervisory	In an inpatient setting, supervision of a PA shall include, but not be limited to, continuing or intermittent physical presence of the supervising physician with constant availability through electronic communications. (DCMR 4914.2) In an outpatient setting, supervision of a PA shall include, but not be limited to, constant availability through electronic communications. (DCMR 4914.3)	DC Board of Medicine	Yes
Florida	None	Physician may	Schedule II-V	Supervisory	Except in cases of emergency, supervision requires the easy	Florida Board	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
		not supervise more than 4 currently licensed PAs at any one time. (Fla. Stat. 458.347(3))	7-day limit on Schedule II.		availability or physical presence of the licensed physician for consultation and direction of the actions of the PA. “Easy availability” includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the PA. (Fla. Stat. 458.347)	of Medicine	
Georgia	None	Physician may not serve as primary supervising physician to more than 4 PAs. (GCR 360-5-.05)	Schedule III-V	Supervisory	The supervising physician shall provide for immediate consultation between the PA and primary or alternate supervising physician. "Immediate consultation" means that the supervising physician shall be available for direct communication or by telephone or other means of telecommunication. (GCR. 360-5-.04(3))	Georgia Composite Medical Board	Yes
Hawaii	None, but supervising physician must personally review the records of each patient seen by the PA within seven working days.	Physician may not supervise more than 2 PAs at one time. (HAR 16-85-49)	Schedule III-V Schedule II may be allowed if PA is employed or extended privileges by a hospital or extended care facility.	Supervisory	Supervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place the services are rendered. The direct communication may occur through the use of technology which may include but is not limited to, two-way radio, telephone, fax machine, modem, or other telecommunication device. (HAR 16-85-49)	Hawaii Medical Board	Yes
Idaho	None, but a	Physician may	Schedule II-V	Supervisory	Supervision includes: an on-site visit at least monthly; regularly	Idaho Board	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
	periodic review of a representative sample of records is required.	not supervise more than 3 total PAs at the same time. The Board may authorize 6 total PAs if necessary and upon prior petition. (IAC 22.01.03.010)			scheduled conferences between the supervising physician and the licensee, and a periodic review of the patient services being provided by the licensee, the availability of the supervising and alternate supervising physician to the licensee in person or by telephone and procedures for providing backup and supervision in emergency situations (IAC 22.01.03.030)	of Medicine	
Illinois	None	Physician may not enter into collaborative agreements with more than 5 FTE PAs. (SB1585, Public Act 100-0453)	Schedule II-V	Collaborative	Collaboration with the PA shall not be construed to necessarily require the personal presence of the collaborating physician at all times at the place where services are rendered, as long as there is communication available for consultation by radio, telephone, telecommunications, or electronic communications. (SB1585, Public Act 100-0453)	Illinois State Medical Licensing Board	Yes
Indiana	Required, but varies with PA experience and authority. (Ind. C. 25-27.5-6-1(c))	Physician may enter into a supervising agreement with more than 4 PAs, but may not supervise more than four 4	Schedule II – V,	Supervisory	Supervision by the supervising physician or the physician designee must be continuous but does not require the physical presence of the supervising physician at the time and the place that the services are rendered. (Ind. C. 25-27.5-6-1)	Indiana Medical Licensing Board	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
		PAs at the same time. (IC 25-27.5-6-2)					
Iowa	Required only if PA is at a remote medical site: Supervising physician must review patient care weekly and sign all charts unless an exception is provided. (IAC 645-327.4(148C))	Physician may not supervise more than 5 PAs at one time. (IAC 645-326.8(148C))	Schedule III – V The PA may order Schedule II controlled substances which are listed as depressants in Iowa Code chapter 124 only with the prior approval and direction of a physician.	Supervisory	"Supervision" means that a supervising physician retains ultimate responsibility for patient care, although a physician need not be physically present at each activity of the PA or be specifically consulted before each delegated task is performed. Supervision shall not be construed as requiring the personal presence of a supervising physician at the place where such services are rendered except insofar as the personal presence is expressly required by these rules or by Iowa Code chapter 148C. (IAC 645-326.1(148C)) A supervising physician must visit a remote site to provide additional medical direction, medical services and consultation at least every two weeks.. When visits are less frequent than every two weeks in unusual or emergency circumstances, the board shall be notified in writing of these circumstances. (IAC 645-327.4(148C))	Iowa Board of Physician Assistants	Yes
Kansas	Required, but varies with time and physician-PA relationship.	Physician may not supervise more than 3 total PAs who	Schedule II-V	Supervisory	The types of supervision shall include direct supervision, indirect supervision, and off-site supervision as applicable per the written practice agreement. (KAR 100-28a-1a)	Kansas State Board of Healing Arts	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
	(KAR 100-28a-10)	provide services at a different practice location. (KAR 100-28A-17)			Additional requirements if the PA is practicing in a location different than the location that the supervising physician primarily practices. (KAR 100-28a-14)		
Kentucky	Required for a sufficient number of medical notes, sufficiency determined at practice. (KRS 311.856)	A physician may not enter into agreements with more than 4 PAs, and may not supervise more than 4 PAs at any one time. (KRS 311.854)	No legend drugs (Ky. Rev. Stat. 311.858 and 311.856)	Supervisory	Physician is required to provide adequate, active, and continuous supervision of a PA’s activities to assure that the PA is performing as directed and complying with the statutes and all related administrative regulations. (Ky. Rev. Stat. 311.856) Under specific conditions, a PA may perform services in a location separate from the supervising physician if the supervising physician is continuously available via telecommunication. (KRS 311.860)	Kentucky Board of Medical Licensure	Yes
Louisiana	Required, but varies based on practice site arrangement, and physician-PA relationship. (LAC 46, XLV 4512)	Physician may not serve as a primary for more than 4 PAs. (LAC 46, XLV 4507)	Schedule II-V	Supervisory	Supervision means responsible direction and control, with the supervising physician assuming responsibility for the services rendered by a PA in the course and scope of the PA's employment. Supervision shall not be construed in every case to require the physical presence of the supervising physician. However, the supervising physician and PA must have the capability to be in contact with each other by either telephone or other telecommunication device. Supervision shall exist when the supervising physician gives informed concurrence of the PA actions, and when a medical treatment plan or action is made in accordance with written clinical practice guidelines or protocols. (LAC 46, XLV 1503)	Louisiana State Board of Medical Examiners	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
Maine	None, but regular (at least quarterly) review of selected charts. (02-373 Ch. 2 § 4(5)(C))	None	Schedule II-V	Supervisory	<p>A supervising physician is responsible for providing continuous supervision of the PA. Constant physical presence of the supervising physician at the time and place that the services are rendered by the PA is not required so long as the supervising physician and the PA are, or can be, easily in contact with one another by electronic communication, including but not limited to telecommunication; and unless physical presence is necessary to provide the same quality of patient care as provided by the physician.</p> <p>Appropriate supervision shall include: active and continuing overview of the PA’s activities, immediate availability of the supervising physician, personal and regular review, and periodic, in person, education and review sessions. (02-373 Ch. 2 § 4(5))</p>	Board of Licensure in Medicine; joint rules with Board of Osteopathic Medicine	Yes
Maryland	None	Physician may not delegate medical acts to more than 4 PAs at any one time. (ACM Health Occupations 15-302(h))	Schedule II-V	Supervisory	<p>Physician supervision requires continuous physician supervision mechanisms that are reasonable and appropriate to the practice setting.</p> <p>Physician is expected to respond in a timely manner when contacted by the PA. (ACM Health Occupations § 15-302)</p>	Maryland Board of Physicians	Yes
Massachusetts	None	None	Schedule II-VI, Schedule II must be reviewed by	Supervisory	Physician must provide direct (physician in room), personal (physician in building), or general (physician available by telephone) supervision as appropriate. Supervision is adequate if it permits a PA who encounters a new problem not covered by a	Board of Registration of Physician Assistants	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
			supervising physician within 96 hours.		written protocol, or which exceeds established parameters, to initiate a new patient care plan and consult with the supervising physician. (263 CMR 5.04)		
Michigan	None	None, Reasonable standard-of- practice threshold.	Schedule II-V	Participating	<p>PAs in Michigan are no longer required to work under supervision or delegation of a physician (2017). PAs are required to work with a participating physician according to the terms in a written practice agreement.</p> <p>Notwithstanding any law or rule to the contrary, a PA may make calls or go on rounds without restrictions on the time or frequency of visits by a physician or the PA. (MCL 333.17076 (1))</p>	Michigan Task Force on Physician Assistants	Yes
Minnesota	None	None	Schedule II-V	Supervisory	<p>PAs may perform those duties and responsibilities as delegated in the physician-PA delegation agreement and delegation forms maintained at the address of record by the supervising physician and PA.</p> <p>Patient service must be limited to: services within the training and experience of the PA, services customary to the practice of the supervising physician, services delegated by the supervising physician under the delegation agreement, and services within the parameters of the laws, rules, and standards of the facilities in which the PA practices. (Minn. Stat. 147A.09)</p>	Board of Medical Practice	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
Mississippi	Required for 10% of charts per month. (MCA 73-26-5; R. 1.7)	None	Schedule II-V	Supervisory	<p>New graduate PAs and all PAs whose Mississippi license is their initial license require the on-site presence of a supervising physician for 120 days or its equivalent of 960 hours.</p> <p>The PA's practice shall be confined to the primary office or clinic of the supervising physician or any hospital(s) or clinic or other health care facility within 30 miles of where the primary office is located, where the supervising physician holds medical staff privileges. (MCA 73-26-5; R. 1.7)</p>	Mississippi State Board of Medical Licensure	Yes
Missouri	Required for 10% of charts every 14 days. (MAS 334.735)	Physician may not serve as supervising physician for more than 3 FTE licensed PAs. (MAS 334.735)	<p>Schedule II-V</p> <p>Schedule II (hydrocodone only) and III limited to 5-day supply with no refill.</p>	Supervisory	<p>A licensed PA shall practice with a supervising physician continuously present for at least 1 month before practicing where a supervising physician is not continuously present.</p> <p>Unless designated in the code or otherwise in the PA supervision agreement, the supervising physician must be on-site 66% of the time (per calendar quarter) that the PA is practicing.</p> <p>A PA shall be limited to practicing at locations where the supervising physician is no further than 30 miles by road, or otherwise so distanced as to create an impediment to effective intervention, supervision of patient care, or adequate review of services. (20 CSR 2150-7.135)</p>	Missouri Board of Medical Licensure	Limited
Montana	Required but varies with PA experience and tenure. (MAR 24.156.1623)	Physician may not supervise more than one PA unless certain criteria are met. (MAR	<p>Schedule II-V,</p> <p>Schedule II must not exceed 34 days</p>	Supervisory	<p>The supervising physician shall meet face-to-face with each PA a minimum of once a month for the purposes of discussion, education, and training, to include but not be limited to practice issues and patient care. (MAR 24.156.1622)</p> <p>On-site or direct supervision of a PA by a supervising physician</p>	Montana Board of Medical Examiners	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
		24.156.1622)			is not required if the supervising physician has provided a means of communication between the supervising physician and the PA or an alternate means of supervision in the event of the supervising physician's absence. (MCA 37-20-403)		
Nebraska	Required for at least 20% per month; 100% when less than 20 patients. (NAR Tit. 172, 90-006.08)	Physician may not supervise more than 4 PAs unless good cause is shown. (NAR Tit. 172, 90-006.01E)	Schedule II-V	Supervisory	For PAs with less than two years’ experience: A PA with a temporary NE license shall practice only when the supervising physician is actually present at the practice site, A PA licensed for less than 3 months must have the supervising physician physically present at least 20% of the time, and a PA licensed for more than 3 months must have the supervising physician present 10% of the time. (NAR Tit. 172, 90-006.07)	Nebraska State Board of Health; PA Committee	Yes
Nevada	Required for at least 10% of charts at least 4 times each year. (NAC 633.289(3))	Physician may not supervise more than 3 total PAs at one time. (NAC 633.288(6))	Schedule II-V	Collaborative Agreement with Supervising Physician	The supervising physician shall provide supervision in person at least once each month to the PA. They must be available for consultation at all times during which the PA is performing medical services, and shall develop and carry out a program to ensure the quality of care provided by the PA. (NAC 633.289(3))	Nevada Board of Medical Examiners	Yes
New Hampshire	Regular, ongoing evaluation of a representative sample of charts. (N.H.	Physician may not be the responsible supervising physician for more than 4	Schedule II-V	Supervisory	The supervising physician shall not be required to be physically present while the PA is providing care, so long as the supervising physician and the PA are, or can easily be, in contact with each other by an electronic communication device. (N.H. Rules, Med 602.01)	New Hampshire Board of Medicine	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
	Rules, Med 602.01)	PAs. (N.H. Rules, Med 602.02)					
New Jersey	Required, physician must personally review all charts and patient records and countersign all medical orders. (NJAC 13:35-2B.10)	Physician may not supervise more than 4 PAs at any one time. (NJAC 13:35-2B.10)	Schedule II-V	Supervisory	The PA shall not render care unless the following conditions are met: (1) In an inpatient setting, the supervising physician is continuously or intermittently present on-site with constant availability through electronic communications for consultation or recall; (2) In an outpatient setting, the supervising physician is constantly available through electronic communications for consultation or recall; (3) The supervising physician regularly reviews the practice of the PA; (4) The supervising physician personally reviews all charts and patient records and countersigns all medical orders. (NJAC 13:35-2B.10)	New Jersey State Board of Medical Examiners	No
New Mexico	None	None	Schedule II-V	Dependent on Practice Area	Collaboration shall not be construed to require the physical presence of the licensed physician at the time and place services are rendered. (SB 215)	New Mexico Medical Board	No
New York	None	Physician may not employ or supervise more than 4 licensed PAs in private practice; or more than 6 licensed PAs in a hospital	Schedule II-V	Supervisory	Supervision shall be continuous but shall not necessarily require the physical presence of the supervising physician at the time and place where the services are performed. (10 NYCRR 94.2)	New York State Office of the Professions	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
		setting. (10 NYCRR 94.2)					
North Carolina	None	None	Schedule II-V, Schedule II & III shall not exceed a legitimate 30 day supply	Supervisory	A primary supervising physician and a PA in a new practice arrangement shall meet monthly for the first six months to discuss practice relevant clinical issues and quality improvement measures. Thereafter, the primary supervising physician and the PA shall meet at least once every six months. (21 NCAC 32S .0213)	North Carolina Medical Board	Yes
North Dakota	None	None	Schedule II-V	Supervisory	Supervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place that the services are rendered. The supervising physician must be available continuously for contact personally or by telephone or other electronic means. (NDAC 50-03-01-04)	North Dakota Board of Medicine	Yes
Ohio	Required review of selected patient record entries made by,	Physician may enter into supervision agreements with	Schedule II-V II limited under R.C. 4730.411	Supervisory	The supervising physician shall be continuously available for direct communication with the PA by either of the following means: (1) Being physically present at the location where the PA is practicing; or (2) Being readily	State Medical Board of Ohio	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
	and medical orders issued by the PA. (R.C. 4730.21)	any number of PAs, but may not supervise more than 3 PAs at any one time. A PA may enter into supervision agreements with any number of supervising physicians. (R.C. 4730.21)			available to the PA through some means of telecommunication and being in a location that is a distance from the location where the PA is practicing that reasonably allows the physician to assure proper care of patients. (R.C. 4730.21)		
Oklahoma	Required only in a locum tenens arrangement.	Physician may not generally serve as the supervising physician for more than 4 PAs at any one time (OAC 435:15-3-13)	Schedule II-V Schedule III-V limited to 30-day supply with no refills Schedule II for administration on site.	Supervisory	The supervising physician must oversee the activities of, and accept responsibility for, the medical services rendered by a PA. The constant physical presence of the supervising physician is not required as long as the supervising physician and PA are or can be easily in contact with each other by telecommunication. (Okla. PA Act 519.2)	Oklahoma Medical Board	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
Oregon	None	Physician not acting as part of a supervising physician organization may supervise 4 PAs, unless the board approves otherwise. (ORS 677.510)	Schedule II-V	Supervisory	The supervising physician need not be physically present at all times when the PA is providing services, but maybe required to ensure that: (1) The PA have access to personal or telephone communication with a supervising physician when the PA is providing services; and (2) The proximity of a supervising physician and the methods and means of supervision are appropriate to the practice setting and the patient conditions treated in the practice setting. (ORS 677.510)	Oregon Medical Board	Yes
Pennsylvania	Required for 100% - decreasing with PA experience. (63 PS 422.13)	Physician may not supervise more than 4 PAs at any time. (63 PS 422.13)	Schedule II-V, Schedule II limited to 72 hours with notification to supervising physician within 24 hours of issuance.	Supervisory	The constant physical presence of the supervising physician is not required so long as the supervising physician and the PA are, or can be, easily in contact with each other by radio, telephone or other telecommunications device. An appropriate degree of supervision includes: active and continuing overview of the PA’s activities to determine that the physician’s directions are being implemented, immediate availability of the supervising physician to the PA for necessary consultations, and personal and regular review within 10 days by the supervising physician of the patient records upon which entries are made by the PA. (Pa. Code 18.122)	Pennsylvania State Board of Medicine	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
Rhode Island	None	None	Schedule II-V	Supervisory	<p>Supervision means overseeing the activities of, and accepting the responsibility for, the medical services rendered by the PAs. Supervision shall be continuous and under the direct control of a licensed physician expert in the field of medicine in which the PA practices.</p> <p>The constant physical presence of the supervising physician is not required in every circumstance. It is the responsibility of the supervising physician and PA to assure an appropriate level of supervision depending upon the services being rendered. (216 RICR 40-05-24.6.2)</p>	Board of Licensure for Physician Assistants	Yes
South Carolina	Required for 10% per month when PA works off- site (PA Pract. Act 40-47-955)	Physician may not simultaneously supervise more than 3 FTE PAs providing clinical service at one time. (PA Pract. Act 40-47-910. 955)	Schedule II-V For schedule II must only be an initial dose and must not exceed a72-hour supply	Supervisory	<p>Supervision must be continuous but must not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where the services are rendered, except as otherwise required for limited licensees.</p> <p>A PA must have 6 months of clinical experience with the current supervising physician before being permitted to practice at a location off-site from the supervising physician. The off-site location may not be more than 60 miles of travel from the supervising physician or alternate supervising physician without written approval of the board. (PA Pract. Act 40-47-910. 955)</p>	South Carolina Board of Medical Examiners	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
South Dakota	None	Physician may supervise up to 4 FTE PAs with board approval. (SDCL 36-4A-29.1)	Schedule II-V Schedule II not exceeding 30 days	Supervisory	Supervision may be by direct personal contact, or by a combination of direct personal contact and contact via telecommunication, as may be required by the board. If the office of a PA is separate from the main office of the supervising physician, the supervision shall include on-site personal supervision by a supervising physician as required by the board. (SDLRC 36-4A-29)	South Dakota Board of Medical and Osteopathic Examiners	Yes
Tennessee	Required for at least 20% of charts, and 100% of charts of specific categories of patients every 30 days. (TCR 0880-02-.18)	None	Schedule II-V II and III typically limited to 30-day supply	Supervisory	Supervision does not require the continuous and constant presence of the supervising physician. However, the supervising physician must be available for consultation at all times or shall make arrangements for a substitute physician to be available. (TCR. 0880-02-.18)	Tennessee Committee on Physician Assistants	Yes
Texas	Required chart review for prescriptive authority determined by practice agreement. (22 TAC 185.31)	None. Physician may delegate prescriptive authority to a maximum of 7 PAs or their FTE. (TAC 157.0512)	Schedule II-V, II only under Chapter 481 Provisions III-V limited to 90-day supply	Supervisory	Supervision shall be continuous, but shall not be construed as necessarily requiring the constant physical presence of the supervising physician at a place where PA services are performed while the services are performed. Telecommunication shall always be available. (22 TAC 185.14)	Texas Medical Board	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
Utah	Required for a sufficient number of charts and records to ensure that the patient's health, safety, and welfare will not be adversely compromised. (UAC R156-70a)	Physician may not supervise more than 4 FTE PAs without prior approval. (UAC R156-70a)	Schedule II-V	Supervisory	<p>The supervising physician shall provide supervision to the PA to adequately serve the health care needs of the practice population and ensure that the patient's health, safety and welfare will not be adversely compromised. The degree of on-site supervision shall be outlined in the Delegation of Services Agreement maintained at the site of practice.</p> <p>There shall be a method of immediate consultation by electronic means whenever the PA is not under the direct supervision of the supervising physician. (UAC R156-70a)</p>	Utah Physician Assistant Licensing Board	Yes
Vermont	Regular, review of selected charts with documentation within 72-hours of provision of care. (VAC 12-5-200:7)	Physician may not supervise more PAs concurrently than have been approved by the Board after review of the system of care delivery. (VAC 12-5-200:7)	Schedule II-V	Supervisory	As determined by the Board, supervision entails the direction provided, and review performed, by the supervising physician of the medical services provided by the PA. The supervising physician need not be present on the premises where the PA renders medical services and may provide supervision by telephonic or electronic means of communication. (VAC 12-5-200:5)	Vermont Board of Medical Practice	Yes
Virginia	Required if established in practice	Physician may not supervise more than 6 PAs	Schedule II-V	Supervisory	The physician shall provide continuous supervision as required by this section. However, the requirement for physician supervision of PAs shall not be construed as requiring the	Virginia Board of Medicine	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
	agreement. (18 VAC 85-50-101)	at any one time. (450 Va. C. 54.12952)			physical presence of the supervising physician during all times and places of service delivery by PAs. Each team of supervising physician and PA shall identify the relevant PA's scope of practice, including the delegation of medical tasks as appropriate to the PA's level of competence, the PA's relationship with, and access to, the supervising physician, and an evaluation process for the PA's performance. (450 Va. C. 54.12952)		
Washington	None	Physician may not enter into delegation agreements with more than 5 PAs, but may petition the commission for a waiver of this limit. (WAC 246-918-055)	Schedule II-V	Supervisory	The supervising physician and the PA shall determine which procedures may be performed and the degree of supervision under which the procedure is performed. (WAC 246-918-055)	Washington State Medical Commission	Yes
West Virginia	None	Physician may not enter into practice agreements with more than 5 FT PAs at any one time. (W. Va. C. 30-3E-9)	Schedule III-V, Schedule III shall be limited to a 30-day supply without refill.	Collaborative	Collaboration means overseeing the activities of, and accepting responsibility for, the medical services rendered by a PA. Constant physical presence of the collaborating physician is not required as long as the physician and PA are, or can be, easily in contact with one another by telecommunication. Collaboration does not require the personal presence of the collaborating physician at the place or places where services are rendered. (W. Va. C. 30-3E-1)	West Virginia Board of Medicine	Yes

State	Co-Signature	PA Ratios	Rx Authority	Supervision/ Collaboration Language	Supervision/Collaboration Requirements/“Barriers”	Physician/PA Board?	Scope Determined at Practice Site?
Wisconsin	None	Physician may not supervise more than 4 on-duty PAs at any time unless a written plan to do so has been submitted to and approved by the board. (WAC Med 8.10)	Schedule II-V	Supervisory	A supervising physician shall be available to the PA at all times for consultation either in person or within 15 minutes of contact by telecommunication or other means. (WAC Med 8.10)	Wisconsin Medical Examining Board	No
Wyoming	None	Physician may not supervise more than 3 PAs. (Wy. Med. Pract. Act 33-26-504)	Schedule II-V	Supervisory	Supervision means the ready availability of the supervising physician for consultation and direction of the activities of the physician assistant. Contact with the supervising physician by telecommunications is sufficient to show ready availability if the board finds that such contact is sufficient to provide quality medical care. (Wy. Med. Pract. Act 33-26-501)	Wyoming Board of Medicine	Yes

December 2017

JOB LISTING
IN OUR LOCAL
CHURCH BULLETIN

5/7/17

Employment Opportunities at Catholic Charities

APRN - Catholic Charities, Diocese of Norwich is seeking a consulting psychiatric APRN to provide psychiatric evaluations, medication evaluations, and medication follow-up appointments for clients served at our Norwich and Middletown behavioral health clinics. Experience working with children desired, but not required. Connecticut license to practice as an APRN is required. If interested, please send your resume to Laura Malone at lauramalone@ccfsn.org.

Full-time Clinical Site Supervisor (LCSW) -

Norwich, CT -Catholic Charities is seeking a full-time Behavioral Health Clinical Site Supervisor for our Behavioral Health Clinic in Norwich. This person will be responsible for managing our outpatient behavioral health clinic in Norwich. Responsibilities include supervision of staff, quality assurance, and utilization management. This position requires direct service responsibilities. Requirements: MSW, LCSW with at least five year's post-graduate experience. Please email resume, cover letter and salary requirements to Laura Malone, Executive Assistant at lauramalone@ccfsn.org

Fee for Service LCSWs - Catholic Charities, Diocese of Norwich, Inc. We are seeking Licensed Clinical Social Workers (LCSW) to provide fee for service clinical services for a diverse client population in our **Norwich, Middletown, and New London Offices.**

To apply:

Please email resume, cover letter, salary requirements, and the contact information for three professional references to Laura Malone, Executive Assistant at lauramalone@ccfsn.org

Hospitals, medical practices, clinics, FQHCs, and other entities that employ PAs would not experience a reduction in liability exposure. Connecticut's Supreme Court recently reaffirmed the well-settled legal principle that a hospital can be held liable for the act of its agents and employees, and recognized a viable claim for apparent agency.

“...[T]his court, the Appellate Court and the Superior Courts have consistently assumed that the doctrine of *respondeat superior* may be applied to hold hospitals vicariously liable for the medical malpractice of their agents and employees. Because a hospital may be held vicariously liable for the medical malpractice of its agents and employees under the doctrine of *respondeat superior*, it may also be held vicariously liable under the doctrine of apparent agency.

Cefaratti v. Aranow, 321 Conn. 593, 611 (2016)

Whether physicians would experience a reduction in personal liability if the law were changed would take years of lawsuits and case law to determine. There are numerous legal theories that would support claims against physicians who were in collaborative relationships with PAs.

The case that's referenced (Cefaratti) can be accessed on the state's judicial website at this link:

<https://www.jud.ct.gov/external/supapp/Cases/AROCr/CR321/321CR61.pdf>

"Supervision" is Limiting Access to Care by PAs

In a wide variety of settings across CT, PAs are finding that the care they provide is reduced to less than it should be based on their education, training, skill, and insurance/ legal authority. The underlying cause of these barriers of care is the mandate that CT PAs must be "supervised", which creates an intentionally restrictive relationship with physicians. The following list is condensed from scores of PA reports received since 2016.

CO-SIGNATURE: Physician co-signature of PA care is being required.

- for hospital anti-coagulation clinic
- for pre-op examinations
- for DCF group home standing orders
- for physical therapy
- for durable medical equipment
- for disability forms
- for patient transfer forms
- for paramedic transfer of a patient to another facility
- for DNR orders
- for forms for electric companies & other utilities
- for every schedule II & III prescription
- for incentive spirometers
- for signing of death certificates
- for orders on patients being discharged from a hospital to a skilled nursing facility
- for discharge from the hospital orders
- every medical spa patient
- for every worker compensation patient
- for every Medicaid chart
- for every chart of every patient seen

CONFUSION: Multiple statute changes have lead to significant confusion as to how they should be applied.

- supervising physician name is being required on prescriptions and orders
- the name of the physician working that day in the emergency room is being required
- documenting that a physician is available at all times for consultation is required
- "face to face" weekly meetings with a supervisor are still being required

DENIED/ DELAYED CARE: PAs are being prohibited from seeing certain patients, or from providing care.

- not allowed to see work comp visits in the emergency department
- not allowed to obtain informed consent
- not allowed to see initial work comp visits
- not allowed to mark patients for surgical procedures
- not allowed to see every other work comp follow up visit
- not allowed to see critical care Medicaid or Medicare patients, while the NPs are
- can't see Medicare patients who have not been seen by the MD within one year

LESS QUALIFIED: PAs are inaccurately perceived as being less qualified than APRNs.

- physicians feel they will have a greater personal liability with PAs than APRNs
- APRNs are perceived to have better medical education & training since they do not need to be supervised
- PA applying for primary care position told they are worth less money APRNs
- PAs are being required to have a physician on site, which is not being required of the APRNs
- hospital wants APRNs to supervise PAs
- hospitals place PAs in the nursing department, not the medical department

HIRING: PAs are being excluded from Advanced Practice Clinician jobs that they are fully qualified for.

- multiple instances of advertisement for positions where PAs would be qualified to offer care, but the position is offered only to an APRN
- in medical offices
- in specialty offices
- in Joslin Diabetes Center
- in urgent care centers, including Minute Clinics and The Nurse's Office
- in religious based medical care
- in hospitals
- in federally qualified health care centers
- in locations where a physician cannot be "made" to supervise a PA
- in locations where a physicians are concerned that they may have personal liability supervising a PA
- in locations where a administrators are concerned that they may have corporate liability with a PA
- a practice owner who is a PA sees APRNs as being easier to hire, even though she would prefer to hire PAs

Here are a few example stories from among the scores of reports from PAs in the field:

I would love to be able to work at CVS Minute Clinic and maybe the new law would help make that possible as they only have APRNs now. I have 23 yrs of experience including a lot of ER experience and I do internal medicine and diabetes management, so it would be a perfect fit for me to work there because I have honed my skills of knowing when a patient needs to go to ER, etc.

Also, it's affected me in trying to get jobs at inner city clinics AND one time at the Joslin. They would only hire APRN even though I'm fluent in Spanish. Very frustrating.

PAs at a 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.

XXX Hospital's legal team informed their department of surgery staff that PA's were not to sign death certificates. APRN's were not limited [although CT statutes are the same for both professions].

*Here is a section of the email: 'Please remember that any Attending physician or APRN licensed in the state of CT can sign the death certificate ... **From a legal perspective, Physician Assistants and resident physicians are not able to sign the death certificates.'***

This puts our profession as a disadvantage compared to APRN's in many departments especially overnight when most attendings aren't in house.

I have been practicing as a PA in CT since 1999. Two years ago, I was seeking a new position in adult primary care, and was not hired by XXX Hospital to work in an endocrinology office that they owned because I was a PA and not an APRN. The physician knew me personally and preferred to hire me, but the management would not hire me. I asked to meet with the manager as well as the MD and they explained that because he was the only physician in his practice, they felt hiring a PA would require more work especially when he was not in the office, because PAs need to have a physician available at all times, even if just by phone. They were also under the impression that the time that it would take to have the MD review my charts periodically was too much of a hassle, and because APRNs can now practice independently, that was not an issue. Despite my efforts to counter their concerns, I was not hired, completely because I was a PA and not an APRN.

I also had applied for positions within Hartford Healthcare, and candidly asked an acquaintance of mine who is part of the provider recruitment department, if physicians were requesting to hire APRNs instead of PAs in the office setting and she responded affirmatively that she had experienced this.

As a PA who has 17+ years in outpatient primary care, it is concerning to me to be limited because nurse practitioners have lobbied for better privileges in CT.