

Staff Findings
and Recommendations

Scope of Practice Determination for Health Care Professions

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Legislative Program Review
& Investigations Committee

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Introduction

Scope of Practice Determination for Health Care Professions

Scope of practice for health care professions has been defined as: “the rules, regulations, and boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability.”¹ The process to determine scopes of practice in Connecticut is the legislative process, as it is in each state. Professions wanting a new scope of practice, or to modify an existing scope, petition the legislature for the change. In Connecticut, the public health committee, as the legislature’s committee of cognizance for public health matters, is the entity responsible for initially considering scope of practice proposals.

Focus

Initiated in May 2009, the program review committee’s study focused on the state’s process to determine scopes of practice for health care professions and how the state reconciles differences among professions if they arise. An earlier staff briefing report presented to the committee in October, provided background information and preliminary analysis regarding the state’s scope of practice process. This report contains committee staff’s findings and recommendations about Connecticut’s scope of practice process. The report does not make any findings or recommendations on the actual practice scopes of health care professions, nor does it examine how well the state regulates health care professions.

The program review committee’s study specifically examines whether changes to the scope of practice process are necessary to make it more useful to legislators and other stakeholders. The committee was principally interested in knowing whether a different model for determining scopes of practice, or changes to the current model, would enhance the overall scope of practice determination process, particularly in terms of outcomes for the public.

Summary

An analysis of scope of practice legislation since 2005 shows the number of bills involving scopes of practice for health care professions is relatively low in comparison with the total number of bills filed with the public health committee. Despite the low number of scope bills, stakeholders, including several current and former public health committee members, agreed scope of practice issues are time consuming, complex, and, at times, contentious. Analysis of scope of practice legislation also shows 70 percent of the bills creating or modifying scopes of practice have been passed into law over the past five years. Certain professions also had more scope of practice bills than others, and several professions proposed scope of practice changes on a recurring basis if the legislature did not previously implement the requested scope change.

¹ *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards, 2005.

Overall, testimony received by the public health committee on scope of practice requests, as well as questions asked by committee members during hearing, generally gave attention to the key issues of public safety issues (including provider competency), access to care, and practices used in other states. Although the public health committee explored questions regarding these important factors, there were times during public hearings when professions provided contrasting information, could not answer the committee's specific questions or did not have quantitative data to support their positions. Moreover, the general opinion among public health members was members' inability to fully evaluate the information when it involves complex medical topics, based on their varied backgrounds.

Connecticut does not have a structured system to gather, analyze, and evaluate information about scopes of practice issues outside the legislative process, as is the case in other states. Combined with information collected from stakeholders, committee staff finds there is credibility to the claim that the process could be more beneficial for all stakeholders if it was more formalized and transparent and included information based on specific criteria. The process currently relies on ad hoc information provided to the public health committee by professions and the public health department, particularly during the public hearing process.

Information about best practices for determining scopes of practice for health care professions is limited in the national literature. Several documents provide guidelines for states to use when determining practice scopes. Although the state's process incorporates some of those guidelines, it is difficult to provide a full assessment the process based on best practices because scopes of practice are determined within the context of the legislative process and not according to any specific standards or criteria.

In two instances where differences between professions over scope of practices issues were protracted, the professions used a neutral mediator to help resolve their differences. The general consensus among stakeholders is the process was positive and produced legislation for the public health committee based on the compromises reached by the parties, although the stakeholders would not want mediation used for every scope of practice issue.

The findings based on committee staff's quantitative analysis of scope of practice legislation and outcomes mostly point to no severe deficiencies in the outcomes of the scope development process. What cannot be ignored, however, is the information collected by staff through its interviews with various stakeholders, including public health committee members, which clearly indicates those involved in the process believe it needs to be more structured so important information regarding scope proposals is presented to the legislature in a systematic way and according to specific criteria. As such, committee staff's recommendations are designed to achieve the following goals for enhancing the state's scope of practice determination process for health care professions: 1) create a more formal, standardized, and concise process for information gathering that is transparent; 2) create a process whereby knowledgeable professionals in the area of health care review and assess the information prior to the public health committee; and 3) allow the body of professionals to make recommendations based on their evaluation of the information.

Methodology

Since the legislative process determines scopes of practice for health care professions, it presents a unique challenge within this study regarding analysis of the process. As such, the findings and recommendations presented in this report have been formulated using a combination of qualitative and quantitative information.

Committee staff analyzed the state's scope of practice process from several perspectives. An examination of scope of practice legislation and public hearing testimony for three licensed health care professions (i.e., nurses, physical therapists, and dental hygienists) provided committee staff with more in-depth knowledge of what has occurred at the committee level regarding scopes of practice. Staff also conducted a survey of current and former public health committee members as a way to obtain collective information about the scope determination process based on members' experience with the process.

As a broad measure of the outputs and outcomes of the scope process, committee staff compared the current scope of practice for a profession with the scopes used in all other states for the same profession. Information regarding complaints filed against health care providers and whether there is any corresponding change in complaints upon changes to scopes of practice was also reviewed.

Information from interviews conducted with numerous stakeholders involved in the process, including current and former leaders of the public health committee, was relied upon to help understand the process, identify findings, and formulate recommendations about the process. A description of different models used to determine scopes of practice in several other states, including the New England states, is also provided in the report. National literature on best practices for states to use to determine scopes of practice was reviewed, and scope of practice issues and processes were discussed with a national scholar on scopes of practice for health care professions.

Report Organization

The report is organized into two sections, this introduction and staff findings and proposed recommendations. Findings and recommendations are organized according to: 1) scope of practice legislation analysis; 2) process outcomes; 3) stakeholders; 4) public health department; 5) other states; 6) best practices; and 7) current health care reform initiatives. Appendix A provides examples of written collaborative agreements between Advanced Practice Registered Nurses (APRNs) and physicians. Appendix B shows a 50-state comparison of the scopes of practice for APRNs. Appendix C contains a copy of the survey committee staff sent to public health committee members, and Appendix D includes the questions the public health department asks professions about scope of practice proposals during the department's meetings with such professions.

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Staff Findings and Recommendations

Scope of Practice Determination Process for Health Care Professions

The overall intent of specifying scopes of practice for health care professions in statute is to protect public health and safety. Practice scopes identify the parameters within which the legislature has determined health care professionals can safely practice. Defining scopes of practice for health care professions in law provides the state with public policy control over the range of services licensed health care professions may provide.

States use their statutes to designate practice scopes for individual health care professions, and scopes are based on multiple factors. To ensure the public receives health care from competent providers, scopes of practice work in combination with additional requirements placed on health care professions through state licensing standards.

Scope of Practice Legislation: Analysis

As a way to provide an initial reference point regarding Connecticut's process to determine practice scopes for health care professions, program review committee staff identified the legislative bills over the last five years filed with or introduced by the public health committee, given the committee has the initial jurisdiction over scope of practice matters. Of those bills, the number involving scope of practice proposals were identified, as were the scope of practice bills resulting in public acts. Table I-1 shows the results.

Table I-1. Scope of Practice Legislation for Health Care Professions.					
	2009	2008	2007	2006	2005
Bills filed with public health committee	263	136	292	120	328
Bills related to licensed health care professions*	38	20	44	20	62
Bills creating or modifying scopes of practice	11	6	11	4	11
Scope of practice bills resulting in public acts	5	4	10	4	7
* Includes bills filed with or introduced by the public health committee for the 29 licensed health care professions covered within the scope of this study as searched on the legislature's website by name of profession; does not include duplicate bills pertaining to more than one profession. Source: PRI staff analysis; public health committee data.					

As the table indicates, 184 (16 percent) of all the bills filed with the public health committee over the past five years pertained to the 29 licensed health care professions included within this study. Of those bills, 43 (23 percent) were identified as involving changes in a profession's scope of practice, while 30 (70 percent) became law. *Overall, the number of bills involving scopes of practice for health care professions is relatively low in comparison with the*

total number of bills filed with the public health committee. At the same time, of the bills creating or modifying scopes of practice, a high percentage has been passed into law since 2005.

Committee staff also finds *there are certain professions that tend to have more scope of practice bills than others.* Over the five-year period from 2005-09, the professions of nursing, optometry, and physician assistant had more scope of practice proposals than the other 26 licensed professions. In total, nursing had eight proposals, followed by physician assistant (5), optometry (4); another three professions each had three scopes of practice proposals. As noted, the overall number of scope of practice bills accounted for just under one-quarter of the total public health committee bills involving licensed health care professions.

Analysis of scope of practice legislative proposals shows *several professions tend to propose scope of practice topics on a recurring basis if the change is not implemented by the legislature in a previous year.* For example, between 1999-2006 legislation allowing physical therapists to treat patients without a formal referral from a physician was introduced in six of the eight legislative sessions before it was finally passed in 2006. Another example is the proposal to eliminate the written collaborative agreement requirement that Advanced Practice Registered Nurses (APRNs) must have with a licensed physician for the authority to prescribe certain drugs. The requirement was implemented in 1999, and since then three more proposals have been put forth to eliminate the requirement, with the possibility of a fifth bill in the next legislative session.

What cannot be determined from committee staff's analysis is the frequency of scope of practice ideas brought to the public health committee members or the Department of Public Health (DPH) that are never proposed in a bill. The public health department notes such proposals can be complex and require a lot of time to discuss despite not resulting in legislation, thus adding to the overall workload of both the department and the public health committee.

Although the number of legislative proposals involving scope of practice issues for health care professions is low in relation to the total number of health care profession bills introduced by the public health committee, the topics involve medical issues with ramifications on public safety and consumers' access to quality care. Information collected by committee staff from interviews with various stakeholders involved in the scope of practice process, including six current and former members of the public health committee, confirmed that from their vantage point the overall process is time-consuming and generally involves technical medical topics. Scope of practice issues may be contentious as well, as highlighted by protracted differences among health care professions, including the two recent scopes of practice issues settled through the use of a professional mediator (i.e., definition of dentistry and podiatrists' ability to perform ankle surgery).

Testimony analysis. Analysis of scope of practice legislation for three health care professions (nurses, physical therapists, and dental hygienists) since 1999 was included in the earlier staff briefing report. The analysis focused on the oral testimony presented to the public health committee.

Within that analysis, professional associations and practitioners affected by the scope of practice legislation were the main constituencies providing testimony. The public health committee generally asked questions pertaining to the factors identified in the national literature

as important when considering scope of practice changes, namely public safety (including provider competence through education and training) and impact on the public’s access to care. Another useful factor public health members asked questions about, as borne by the testimony, was whether professions had information about practices in other states to either support or oppose a scope of practice request.

For this report, committee staff examined the written testimony for scope of practice bills for the same three professions within the same time period. Written testimony was reviewed primarily for two reasons: 1) combined with oral testimony, it provides the full public record of scope of practice legislation before the public health committee for public hearing purposes; and 2) written testimony may contain additional information pertaining to public safety and consumers’ access to care not be presented in oral testimony, as well as information about the practices used by other states.

Nurses. In its briefing report, committee staff examined the oral public hearing testimony for the bills containing scope of practice changes for advanced practice registered nurses, particularly regarding the collaborative agreement requirement. APRNs are required to collaborate with physicians and must have a written collaborative agreement with a physician to prescribe certain drugs. To be consistent, committee staff examined the written testimony for the same APRN scopes of practice bills for this report.

Written testimony. The public health committee conducted hearings on three of the four bills dealing with the collaborative agreement subject over the time span examined. As indicated in Table I-2, testimony was provided by provider associations, practitioners, including nurses and physicians, and a university representative. Written testimony from the public health department summarized the bills and did not indicate the department’s support or opposition to the bills.

Table I-2. Scope of Practice Legislation (APRNs): Written Testimony			
Participant	Provided Testimony For Bill	Provided Testimony Against Bill	Provided Neutral Testimony
Provider Association*	Y	Y	N
Practitioner	Y	Y	N
DPH	N	N	Y
Other	N	Y	N
* APRN association testified in favor of the scope changes; physician groups testified against. Source: PRI staff analysis.			

Table I-3 shows the written testimony addressed the factors of public safety and access to care, as well as practices in other states, comparable to the oral testimony analyzed by committee staff. Written testimony was primarily provided by the different professions affected by the scope of practice requests, and the content of the testimony depended on which side of the collaborative agreement issue was supported. For example, testimony from physicians and physician groups centered on APRNs not having adequate education and training to work independently without the collaboration of a physician, which could jeopardize public health and safety. Written testimony from APRNs generally focused on greater access to care by consumers if the

collaborative agreement requirement was eliminated and that APRNs have historically provided safe, competent care.

Table I-3. Scope of Practice Legislation (APRNs): Key Factors Addressed in Written Testimony		
Key Factor	Factor Used to Support Bills	Factor Used to Oppose Bills
Public Safety	Y	Y
Access to Care	Y	N
Other States	Y	N

Note: Some specific testimony in support of the bills stated that national literature points to “APRNs providing safe, competent care for over 40 years,” and eliminating the collaborative agreement requirement would “remove a barrier to accessing this important group of primary providers”; testimony opposing the bills usually indicated APRNs did not have the requisite education and training to be primary care providers, jeopardizing public safety.
Source: PRI staff analysis.

Although the public health department did not testify on the original 1999 legislation allowing collaborative agreements, it provided written testimony on the subsequent bills. The department took a neutral position on each bill. DPH summarized the bills and made some suggestions on possible technical changes should the bills move forward in the legislative process.

As noted in committee staff’s earlier briefing report and upon additional review of public hearing transcripts for this report, public health committee members generally asked questions relevant to public safety and access to care, along with questions about practices used in other states. For example, at times, members queried those who testified about statistics to back up certain claims, such as the numbers of APRNs having difficulty finding physicians to sign collaborative agreements (answers to which were not provided at the hearings or in written testimony), or what would happen to patient safety and access to care if the collaborative agreement was cancelled for some reason. There were also occasions when committee members inquired about the education and training requirements of APRNs in terms of their overall competency to implement the scope change, as well as the legal ramifications (i.e., medical malpractice liability) on the parties entering into collaborative agreements. Information from committee staff’s interviews with various professions involved in this issue further indicates the public health committee asks questions pertaining to public safety and access to care, but that overall members tend not to have a lot of experience with issues involving the technical aspects of health care professions’ scopes of practice.

Outcome of bills. The original collaborative agreement bill of 1999 passed the public health committee on a 23-2 vote and received near unanimous votes in both the House and Senate. Of the three subsequent bills seeking to eliminate the collaborative agreement requirement, the first did not receive a public hearing before the public health committee, the second was not voted on by the committee after a public hearing was held, and the third bill was reported out of the public health committee on a 19-8 vote, made it to the House calendar, but was never taken up for a vote. Committee staff has been told there is a strong possibility the proposal to eliminate the collaborative agreement requirement may come up again in the 2010 legislative session.

Physical therapists. Each of the eight scopes of practice bills for physical therapists before the public health committee between 1999-06 involved changing the law to allow the profession to treat patients without a referral from a licensed physician (known as direct access). Hearings were held by the public health committee for six of the bills. The scope of practice for physical therapists was ultimately changed in 2006 allowing direct access to physical therapy services under most conditions.²

Written testimony. Table I-4 shows written testimony was provided to the public health committee by various stakeholders. Most of the testimony was provided by professional groups and practitioners. The public health department maintained a neutral position on the two bills for which it provided written testimony. In both instances, the department summarized the provisions of the bills. Testimony was also submitted by a Connecticut health insurance company, a medical malpractice insurance carrier, and a patient who utilized physical therapy services.

Table I-4. Scope of Practice Legislation (Physical Therapists): Written Testimony			
Participant	Provided Testimony For Bill	Provided Testimony Against Bill	Provided Neutral Testimony
Provider Associations*	Y	Y	N
Practitioners	Y	Y	N
DPH**	N	N	Y
Other	Y	Y	Y

*Physical therapy association, patient (support); chiropractic association, insurance company (oppose).
 **DPH provided testimony for two of the six bills.
 Source: PRI staff analysis.

Table I-5 shows whether the written testimony before the public health committee on the direct access issue referenced public safety, access to care, or if other states have similar requirements. The bulk of the testimony from stakeholders supporting and opposing the scope of practice changes addressed the issue of public safety, and some testimony addressed access to care and practices used in other states.

Table I-5. Scope of Practice Legislation (Physical Therapists): Key Factors Addressed in Written Testimony		
Key Factor	Factor Used to Support Bills	Factor Used to Oppose Bills
Public Safety	Y	Y
Access to Care	Y	N
Other States	Y	Y

Note: Testimony opposing physical therapy care without a physician’s referral generally state the change would result in physical therapists making medical diagnoses; physical therapists usually countered by noting the high number of states that allow direct access, while direct access would offer patients quicker access to care.
 Source: PRI staff analysis.

² A physician’s referral is required for any person seeking physical therapy services if the treatment requires a Grade V spinal manipulation or it involves a worker’s compensation injury.

Arguments in the written testimony mirrored those of the oral testimony. The written testimony from stakeholders in support of or opposition to allowing consumers direct access to physical therapy services without a physician's referral was relatively consistent across all six scope bills. Those in favor of the change primarily testified that the overall education and training of physical therapists was sufficient to support the change while maintaining public safety, consumers would have quicker access to care by not having to first get a physician's referral, and numerous other states allow the practice. Those opposing the scope change mainly testified that allowing direct access would result in physical therapists making medical diagnoses, which they were not properly educated or trained to do. Opponents of the bills also used information about practices in other states in their testimony, but did not address consumers' access to care. They noted that direct access in other states took on various forms and should not be used as a direct comparison.

Interestingly, written testimony in opposition to the direct access bill in 2006, when the law permitting direct access was enacted, could be considered the strongest testimony against the change in comparison with the testimony from the previous direct access bills. Testimony from the chiropractic association opposing direct access directly contradicted testimony of the physical therapy association which favored direct access. The point of disagreement centered on the number of other states allowing direct access and how direct access was defined in those states. The opposing group's written testimony specifically said the information provided on other states in support of the scope change was "inaccurate and misleading." A matrix showing a 50-state comparison of the direct access provisions in other states was also submitted to the public health committee as part of the opposing group's written testimony. Committee staff believes this example highlights some of the difficulties the public health committee has at times in obtaining objective and complete information from stakeholders regarding scope of practice changes.

Outcome of bills. Of the six bills heard by the public health committee on the direct access issue, three did not garner enough votes to pass the committee, two made it to the House, but were not voted on and, in 2006, Public Act 06-125 was passed allowing direct access to physical therapy services.

Dental hygienists. Over the 11-year span examined, five bills involved scope of practice changes for dental hygienists. The bills varied in their topics, including allowing dental hygienists to administer local anesthesia, creating an advanced dental hygiene practitioner, and expanding the dental hygiene scope of practice to include dental hygiene diagnosis.

Written testimony. Table I-6 shows written testimony on scope of practice proposals regarding dental hygienists was provided by professional associations, individual practitioners, DPH, and others (e.g., university dental hygiene instructor and municipal health department representatives.) The public health department usually submitted neutral testimony, but also took different positions on several of the bills. For example, DPH favored the bill in 2005 allowing dental hygienists to administer local anesthesia (in support of the recommendations from the state's ad hoc committee created to study the issue of access to dental care), while it testified against the 2009 bill creating an advanced dental hygiene practitioner position, mainly due to the additional resources needed by DPH to implement the change.

Table I-6. Scope of Practice Legislation (Dental Hygienists): Written Testimony			
Participant	Provided Testimony For Bill	Provided Testimony Against Bill	Provided Neutral Testimony
Provider Associations*	Y	Y	N
Practitioners	Y	Y	N
DPH	Y	Y	Y
Other	Y	N	N
* Dental hygienist associations (support); dental associations (oppose). Source: PRI staff analysis.			

Table I-7 highlights whether testimony on the dental hygienist practice scope legislation was based on any of the key factors either to support or oppose bills. Testimony in support of bills primarily referenced increased access to care, particularly for underserved consumers in the state. Opponents of the scope-expansion bills frequently cited insufficient education and training requirements on the part of hygienists or no similar practices used in other states as the main reasons to oppose the bills. Questions from committee members generally focused on aspects of the bills regarding access to care, with additional questions addressing public safety or the practices of other states.

Table I-7. Scope of Practice Legislation (Dental Hygienists): Key Factors Addressed in Public Hearing Testimony		
Key Factor	Factor Used to Support Bills	Factor Used to Oppose Bills
Public Safety	Y	Y
Access to Care	Y	Y
Other States	Y	Y
Note: testimony from proponents of the bill creating advanced dental hygienist practitioner position generally cited increased access to care if bill passed; testimony from a dentist opposing bill said access would not increase because hygienists would be taken away from preventive care and move to corrective care. Source: PRI staff analysis.		

Outcome of bills. Three bills ultimately became public acts: 1) Public Act 99-197 allowing dental hygienists with two years of experience to work without a dentist's supervision in a variety of public health facilities as long as the hygienist refers for treatment any patient with needs outside the hygienist's scope of practice and coordinates the referral for treatment to dentists; 2) Public Act 05-213 allowing dental hygienists to administer local anesthesia under certain requirements; and 3) Public Act 09-232 expanding the types of facilities where dental hygienists with the proper experience could practice without the general supervision of a licensed dentist to include programs offered or sponsored by the federal Special Supplemental Food Program for Women, Infants, and Children (WIC). Of the two remaining bills, one failed at the public health committee (2009) and one bill did not receive a public hearing (2003).

Summary of findings. Although it is difficult to fully quantify public hearing testimony and public health committee members' reaction to it, program review committee staff makes several observations based on its analysis of the public hearing record (oral and written testimony) for scope of practice legislation for specific professions.

Overall, public health committee members attending public hearings gave attention to the key issues of public safety (including provider competency), access to care, as well as practices used in other states, for scope of practice proposals.³ Although the committee explored questions regarding these important factors, there were times during public hearings when professions could not answer the committee's specific questions, did not have specific quantitative data to support their positions, or provided contradictory information. There were two specific instances when scopes of practice issues were so protracted, the professions turned to mediation to help resolve their differences, as discussed below. Committee staff was also told that on occasion several public health committee members met with opposing professions to discuss their scope of practice issues. The results were characterized to program review staff as positive in that they helped the professions move forward in resolving their differences.

Perhaps not as surprisingly, what also became evident to committee staff in the testimony was *supporters of scope changes frequently based their arguments on increased access to care by consumers if the change was implemented, while opponents typically countered by saying proponents of a scope change lacked the proper education and training to support the change in scope and that public safety would be affected if the change was implemented. At times, with resolution unclear, public health committee queried those who testified regarding their positions, but were usually presented with contrasting positions from the various professions presenting testimony.*

Overall, public health committee members frequently probed for answers to their questions about scope of practice changes, although it is difficult for program review committee staff to determine whether the members were satisfied with the testimony or the responses received during the hearing process based on public hearing transcripts. As indicated in Table I-1, however, a relatively high percentage of bills pertaining to health care professions' scopes of practice have been enacted into law since 1999, possibly indicating policymakers' general satisfaction with the bills. At the same time, in its discussions with current and former public health committee members, program review committee staff finds *the general concern among public health members is their difficulty to fully evaluate the information, particularly when it involves complex medical topics, given their varied backgrounds which may not include experience in health care scope of practice issues.*

Although the above analysis shows limited deficiencies in the process used to determine scopes of practice, when coupled with the information collected from stakeholders during interviews, committee staff finds *there is credibility to the claim that the process could be more beneficial for all stakeholders if it was more formalized and included information based on specific criteria.* The scope of practice determination process also needs to be as objective as

³ What is unknown from the public hearing testimony is the number of committee members present when scopes of practice issues were discussed or whether members read the written testimony or the hearing transcript to gain the full perspective of what transpired at the public hearings and what the testimony was regarding scope of practice bills.

possible. The process currently responds to ad hoc information provided by professions during the public hearing process. *Connecticut does not have a complete and structured system to fully gather and analyze information about scopes of practice issues outside of the legislative process, as some other states do (discussed below). There is no formal process for the legislature to obtain information from stakeholders based on standardized criteria focused on public health and safety outside of the public hearing process.*

Scope of Practice Process: Outputs and Outcomes

Two seemingly pertinent questions to ask about Connecticut's scope of practice determination process are: 1) what types of practice scopes does the process produce for licensed health care professions (i.e., outputs) in comparison with other states; and 2) is public safety affected by the state's process to determine scopes of practice (i.e., outcome). In other words, is Connecticut's process to determine scope of practice advancing or impeding the ability of licensed providers to practice to the full extent of their capabilities in accordance with their skills and competencies as reflected in their scopes of practice in relation to the practice scopes used in other states for comparable professions, and are competent health care providers providing care to consumers. Such information may be indicators of the state's relative success to determining scopes of practice for health care professions.

Comparative analysis: other states. One relevant example of how the scope of practice for a profession in Connecticut compares with those of other states is the level of physician oversight for nurse practitioners (i.e., collaborative agreement requirement). The issue was first addressed in this state in 1999, when the scope of practice for APRNs was changed allowing nurse practitioners to "collaborate" with physicians rather than "work under the direction of" a physician.⁴ The act required collaboration along with written collaborative agreements between APRNs and physicians relative to the exercise of prescriptive authority regarding the level of controlled substances nurse practitioners may prescribe⁵ and required a method of physician review of patient outcomes⁶ (see Appendix A for sample collaborative agreements). The issue of the level of physician oversight is a contested one in states throughout the country. In Connecticut, there have been several proposals before the public health committee to eliminate the collaborative agreement requirement but none has been adopted into legislation; collaborative agreements are still required for all APRNs.⁷

Table I-8 provides a summary of how the APRN scope of practice in Connecticut compares with other states in the categories of oversight requirements, practice authorities, and prescriptive authorities (Appendix B provides a more detailed state-by-state comparison). Specifically, the table shows Connecticut is one of 27 states that statutorily require APRNs to collaborate with a physician as a general oversight policy, while 11 states do not require physician involvement; supervision of APRNs by physicians is required in other states, and 21 states

⁴ The original bill for which the public health committee held a public hearing did not contain the written agreement requirement because compromise language between the parties was still being developed. The overall concept of the bill was based on an agreement reached by the parties after several years of discussions.

⁵ Schedule II and III drugs per the U.S. Controlled Substances Act.

⁶ This is to include a review of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures an APRN may prescribe, dispense and administer.

⁷ See HB 7161 (2007), HB 5243 (2009), and HB 6674 (2009).

(excluding Connecticut) require written practice protocols between APRNs and physicians. Under the category “authority to practice,” APRNs in 44 states, including Connecticut, have explicit statutory authority to make diagnoses.⁸ Connecticut is also one of 34 states requiring a written protocol for APRNs to prescribe drugs (a written collaborative agreement is used in this state). APRNs in Connecticut must also be nationally certified to practice, as is the requirement in 41 other states.

Table I-8. Overview of States’ Nurse Practitioner Scopes of Practice		
	<i>Total States</i>	<i>Connecticut</i>
Physician Oversight Requirements		
No MD involvement	11	
MD supervision	10	
MD collaboration	27	✓
Written practice protocol	21	
Practice Authorities		
Explicit authority to diagnose	44	✓
Explicit authority to order tests	20	
Explicit authority to refer to other providers	33	✓
Prescriptive Authorities		
Authority to prescribe <i>without</i> MD involvement	11	
Authority to prescribe <i>with</i> MD involvement	40	✓
Written protocol required to prescribe	34	✓
Authority to prescribe controlled substances	48	✓
National Certification Required		
Yes	42	✓
No	8	
Notes: 1) Some states may overlap in their requirements. For example, within oversight requirements, a state may require MD supervision and collaboration; 2) figures include District of Columbia; 3) information current as of late 2007, practices in some states may have changed; 4) under “practice authorities,” if a state requires physician supervision or collaboration as an oversight requirement, then APRNs must follow that protocol when making diagnoses, referring patients, or ordering tests. Source of data: University of California San Francisco Center for the Health Professions, Fall 2007.		

Based on the criteria in the table, Connecticut is within the norm of practices for APRNs in comparison with other states: the state does not have the most restrictive policies regarding the practice of APRNs, nor does it have the most progressive policies. This indicates to committee staff that *Connecticut’s process to determine practice scope policies for APRNs has produced a scope of practice that is comparable with many other states.*

Committee staff uses this scope of practice issue as a relevant example of how Connecticut’s scope of practice determination process and the requirements it has produced for APRNs, compare with other states. This example is but one scope of practice issue for one profession showing the results of Connecticut’s scope of practice process; there are 28 other

⁸ This is in accordance with each state’s oversight requirements. Thus, if a state requires physician supervision or collaboration, then APRNs must follow that protocol when making diagnoses, referring patients, or ordering tests.

health care professions licensed by the state covered within this study. To fully gain a systemic perspective of the output of Connecticut's scope determination process, comparable analyses should be done for each licensed profession. Moreover, a comparative analysis of Connecticut's scopes of practice with other states is one of many factors for the legislature to examine when deciding to create or modify scopes of practice and when judging the relative success of the process to determine scopes of practice for health care professions.

Complaints. Committee staff examined DPH data on the numbers of complaints made against licensed health care professions as a broad indicator for identifying the relative outcomes of the scope of practice determination process on the overall quality of services provided as measured in part by complaints against health care practitioners.⁹ Given the primary goal of the state defining scopes of practice is protection of public health and safety, the overall extent of complaints within the system offers a broad look at the outcomes of the scope process.

Committee staff compared the number of complaints for three health care professions (APRNs, dental hygienists, and physical therapists) in relation to scope of practice changes to determine whether there was a discernable number difference in complaints by profession following a scope change. In other words, did the level of complaints rise after a scope of practice change occurred, inferring a connection between the two factors, and that the scope of practice changes may have a negative outcome on patients' overall experience with their health care services.

Since 1999, legislation was enacted changing the scopes of practice for APRNs five times, physical therapists four times, and three times for dental hygienists. For example, APRNs were given the statutory authority to practice under written collaborative agreements with physicians for prescriptive authority rather than under the direct supervision of a physician in 1999, as noted above. The practice scope also changed in 2000 allowing APRNs to issue a written certificate authorizing and directing a person be taken to a hospital for medical examination based on psychiatric disabilities, and again in 2006 when APRNs were permitted to request, receive, and dispense sample medications in all health care settings. A key change in the scope of practice for physical therapists occurred in 2006, when patients no longer needed referral from a physician to obtain physical therapy services. Also, in 2005 dental hygienists were given the authority to administer local anesthesia under certain requirements.

Table I-9 shows the number of licensed health care providers, complaints by profession, and the corresponding ratios of complaints to licensees for 1999-2008. Although the number of complaints (and corresponding ratios of complaints to licensed practitioners) fluctuated somewhat for the three professions over the period analyzed, there does not appear to be a considerable rise in the number of complaints for any of the professions analyzed. What is also telling from the table is the relatively low volume of complaints within each profession. Although there are no

⁹ The Department of Public Health is the state agency responsible for receiving, investigating, and adjudicating complaints; professional boards for ten health care professions licensed in the state have the responsibility for handling disciplinary matters for those professions. Disciplinary matters for the remaining 19 licensed health care professions covered within the scope of this study are handled by the public health department. Professional boards exist for the following professions: chiropractic, dentistry, natureopathy, nursing, physical therapy, physicians and surgeons, podiatry, psychology, opticians, and optometry.

reference points for comparative purposes, the overall low numbers of complaints against providers in the three professions is notable. In addition, committee staff asked DPH licensing staff whether health care professions have made requests for complaint data in recent years. The theory behind the question is that the complaint information could be used to either support or oppose a change in scope of practice. The department said it rarely, if ever, received a request for complaint data within the past ten years.

Table I-9. Complaints Against Selected Health Care Professions									
	Advanced Practice Registered Nurse			Dental Hygienist			Physical Therapist		
	# Lic	#Comp	%	# Lic	#Comp	%	# Lic	#Comp	%
1999	1,947	10	.51	3,063	0	0	3,701	1	.03
2000	2,118	3	.14	3,117	2	.09	3,802	5	.13
2001	2,240	4	.18	3,137	1	.03	3,847	3	.08
2002	2,284	13	.57	3,036	0	0	3,997	1	.03
2003	2,388	10	.42	3,173	3	.09	3,965	4	.10
2004	2,580	18	.70	3,230	0	0	3,992	2	.05
2005	2,676	10	.37	3,301	1	.03	4,022	4	.10
2006	2,815	5	.18	3,331	3	.09	4,099	5	.12
2007	2,889	13	.45	3,406	4	.12	4,181	5	.12
2008	3,043	16	.52	3,511	6	.17	4,275	5	.12

Source: PRI staff analysis of DPH data.

Since changes were made to scopes of practice changes within each of the three professions analyzed, and the fact that very little change occurred in the overall numbers of complaints by profession as shown in the table, committee staff concludes that *no appreciable increase in the number of complaints after changes in scopes of practice were made. In very broad terms, this indicates the state's process to determine scopes of practice for those professions and the resulting scope changes had a limited negative impact on public safety based on the annual number and rate of complaints filed with the public health department.*

It should be noted the analysis of complaints provides a broad proxy for the possible impact of scope of practice changes on public safety. The analysis, however, must be interpreted within the context it is provided. Although the results show no dramatic increases in the numbers of complaints for any of the three professions after changes to the professions' scopes of practice occurred, there are many factors beyond complaints that determine whether the scope of practice determination process is achieving its primary goal of protecting public health and safety. Analyzing complaints is but one indicator of the relative success of the scope of practice process. It would be difficult to say with complete certainty that any increase or decrease in the number of complaints is the direct result of the process to determine scopes of practice. At the same time, any appreciable increase in complaints following a scope of practice change could indicate the scope change process was somehow deficient in its outcomes.

Stakeholders

The process to determine scopes of practice for health care professions involves different constituencies. Public health committee members, professional associations and lobbyists for health care professions, health care consumers, the Department of Public Health, and professional boards all have some stake in the overall process. Ultimately, however, the legislature makes the policy decisions whether scope of practice changes occur.

The perspective of stakeholders in the process to determine scopes of practice is an important component of this study. Committee staff collected information about the process from the various stakeholder groups in several ways. Extensive interviews with stakeholders were conducted. Testimony presented by stakeholders during the public hearing conducted by the program review committee on this topic was also examined, as discussed above. Program review staff also surveyed current and former public health committee members serving on the public health committee at any time since 2005 was also used.

Interviews. Committee staff conducted interviews with numerous constituencies in the state having a stake in the scope of practice determination process. Specifically, staff interviewed representatives of 14 of the 29 licensed health care professions, accounting for 82 percent of the total health care providers licensed by DPH.¹⁰ Staff also interviewed six current and former leaders of the public health committee, in addition to obtaining members' opinions of the process through program review staff's survey.

A common theme that became apparent from the interviews expressed by the various stakeholders about the state's process to determine scopes of practice for health care professions was the process generally works, yet improvements could be made. Some health care practitioners said they experience a certain level of frustration with the process in that it is resource-intensive and time consuming when dealing with scope of practice issues in the legislative process. There also is no formal structure for dialogue between professions when differences occur within the legislative process. Other significant comments and concerns expressed by stakeholders about the process include:

General

- The primary factor for the legislature to consider within the scope of practice process should be the protection of public health and safety.

Public Health Committee

- Although public health members have a responsibility to be versed in scope of practice issues before the committee, the current scope of practice process operates under the wrong premise in that it requires legislators to know all there is about individual health care professions and their scopes of practice, which is not a realistic expectation. There is a gap among members' understanding of scope of practice issues and their ability to fully evaluate the information they receive.

¹⁰ Based on DPH licensing statistics as of June 2009.

- Committee members are frustrated with the complexity of scope of practice issues and the amount of time it takes to understand the issues and their ramifications.
- Members seem to get bogged down with the amount of work and time necessary to deal with scope of practice changes; they need to have assistance in dealing with the complex scope issues.

Department of Public Health

- The public health department usually takes a neutral position regarding scopes of practice and works well within the process; DPH should become more proactive in getting parties to compromise.
- The legislature needs to more fully utilize the public health department for information about scope issues.

Process/Information

- Misinformation and misleading information has been put forth during public hearings, although probably not intentionally; some professions acknowledge they do not have necessary data to support their scope of practice proposals.
- There needs to be a uniform set of standards to frame scope of practice issues for proper debate to occur; such a system would help ensure transparency in the process and give policymakers a base of knowledge.
- Having specific criteria would provide for some common standards to be applied before a scope of practice request is submitted to legislature and could provide a way for legislature to get objective information.
- The downtime between legislative sessions should be used to resolve differences between professions regarding scope of practice issues.
- There should be more time to collect information for public hearings; additional information would provide the committee with a greater context of the scope of practice issues.
- A neutral panel could be responsible for hearing from parties involved in any scope of practice changes. Using a particular set of standards or criteria, the panel would decide whether the changes warranted legislative action and forward recommendations to the legislature.
- There needs to be proof that any change in scope of practice would make a difference, particularly in terms of access to care.

- Scope of practice debates are often influenced by national associations.
- Financial motivation is the primary factor behind supporting or opposing changes to scopes of practice.
- Legislators need to get clear, objective information through a standardized process.

Public health committee survey. Program review committee staff surveyed each member of the public health committee serving on the committee since 2005. The survey was used to more fully understand members’ experiences with scope of practice issues during their service on the public health committee. The survey also allowed program review staff to obtain information on the scope of practice determination process from a cross-section of public health committee members (see Appendix C for a copy of the survey).

A total of 87 members served on the public health committee at any point since 2005. Surveys were mailed to 51 unduplicated members (one member’s survey was returned without a forwarding address, leaving a total of 50 members surveyed). Thirty-nine members currently serve in the legislature, while the remaining 12 surveys were sent to former legislators. Fifty-five percent of the surveys were sent to members serving on the committee for one term, 25 percent serving for all three terms, and 20 percent serving for two terms since 2005.

A total of 12 surveys were received (24 percent). Program review staff believes the response rate is somewhat low, and does not base any conclusive findings or recommendations solely on the survey results. At the same time, the results provide insight into public health committee members’ opinions on the process to determine scopes of practice, and help support program review staff’s other findings and recommendations. Some of the more relevant results of the survey are:

- public health committee members unanimously said the process to changes scopes of practice for health care professions needs to improve;
- members most often chose the following ways to improve the process: 1) the public health committee should receive more standardized and comprehensive information; 2) DPH should provide more input about scope of practice changes, including recommendations, to the public health committee; 3) professional boards should make recommendations to the public health committee on scope of practice changes;
- just under half of the members said they “seldom” had enough information to vote as knowledgeably as they would have liked on scope of practice bills
- three-fourths of the members said they received conflicting factual information from parties regarding legislation to change scopes of practice;
- “economic gain” was the most frequent response by members when asked to rate what motivates health care professions to support a scope change; “economic loss” was the

most frequent response for what motivates professions to oppose scope of practice changes;

- just over half of the members thought input from the public health department in the process to determine scopes of practice was “not enough;” and
- almost an equal number of members thought the public health committee spent “too much time” as “not enough time” on scope of practice issues in relation to other committee matters.

Motivating factors. A key request of the program review committee was for committee staff to examine the reasons behind health care professions either seeking or opposing changes in scopes of practice. This question is somewhat difficult to answer solely based on the public hearing record, since professions may or may not present their full intentions regarding scope of practice issues in public. While testimony presented to the public health committee provided some insight into the reasons why professions seek (or oppose) scope of practice legislation, committee staff could not obtain a complete understanding of professions’ motivations from the testimony.

Although public hearing testimony shows professions usually testified to several important components regarding scope of practice issues, including public safety, what is telling of professions’ motivation behind scope of practice requests is information obtained from interviews with health care professions. Professions were forthright in their discussions about economics being the primary factor for seeking or opposing scope of practice legislation. As noted above, committee staff’s survey results also indicate economic factors motivate requests to change scopes of practice. Based on its interviews and survey results, committee staff finds that *although public health and safety, including provider competence, and consumers’ access to care were key factors cited publicly about scope of practice proposals, financial gain or loss are commonly shared reasons why health care professions either support or oppose scope of practice proposals.* Moreover, national literature on this topic also cites economics as a key motivating factor behind scope of practice legislation.¹¹

National efforts. National associations want to ensure the interests of their professions are protected at the state level when it comes to scope of practice legislation. National associations are known to utilize their state-level groups to help protect/advance their interests when it comes to scopes of practice for health care professions.

As an example, efforts by at least one national association show the level to which the group is organized to inform state legislators of its positions regarding scopes of practice for health care professions and to provide legislators with information and data analyses in support of those positions. Concerned with the expansion of allied health care professions’ scopes of practice over time in states nationwide, the American Medical Association (AMA) created the Scope of Practice Partnership (SOPP) in 2005. The Scope of Practice Partnership is a cooperative effort between select physicians’ groups to study the qualifications, education,

¹¹ See for example: Overview of Nurse Practitioner Scopes of Practice in the United States – Discussion, Sharon Christian, JD, Catherine Dower, JD, and Ed O’Neil, Ph.D., Center for the Health Professions, University of California, San Francisco, 1997, pp.5, 22.

academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes and peer review of health care providers who are not physicians.

The results of the SOPP's work are starting to emerge. For example, in mid-2008, the partnership developed a written module (i.e., guide) on nurse practitioners. The module is one of 10 for specific professions that are proposing scope changes that the AMA deems may be harmful to the public. Collectively known as the Scope of Practice Data Series, the modules provide extensive background information and data for each profession. The modules are seen as resources for lawmakers to help understand, in part, the various qualifications of the respective professions. Legislators can use this information when making policy decisions on scopes of practice for health care professions.

The above example is but one profession's effort to provide legislators with information regarding scope of practice proposals. Along with other professions, the medical association has a particular position it is trying to advance and thus is presenting information to lawmakers in support of that position. *Without a more standardized process for collecting information based on specific criteria in a uniform manner, information to lawmakers from professions seeking or opposing scope of practice changes will continue to be provided on an ad hoc basis.* Moreover, committee staff's discussions with stakeholders, including public health committee members, indicates a more formalized process to collect objective information based on standardized criteria for lawmakers to use when determining scopes of practice is needed in Connecticut.

Department of Public Health

The Department of Public Health plays several roles within the scope of practice determination process beyond its main regulatory functions of licensing health care providers and enforcing licensing requirements. *The department currently offers professions the opportunity to meet with department staff to discuss their proposals to establish new scopes of practice or modify existing scopes of practice – the process, however, is not mandatory. DPH also provides information to the public health committee about scopes of practice, although on an ad hoc basis.* The information is offered within the context of either the public hearing process or outside of the public hearing forum, typically upon request by the committee leadership.

There is also no requirement for DPH – or any other state entity, including professional boards – to independently collect, verify, or analyze information from stakeholders proposing changes to an existing scope of practice or requesting new scopes of practice, as there is in other states. Professional associations with scope of practice proposals are not required to submit any type of formal information to DPH (as the state's regulatory agency for health care practitioners) based on specific standards prior to scope of practice matters going to the legislature.

The department's willingness to meet with professions to discuss scopes of practice proposals and its use of pertinent questions in those discussions (as discussed in committee staff's briefing report) are positive. The questions serve as a solid foundation to collect information and are in accordance with current best practices (see Appendix D for the department's questions). The meetings, however, are not mandatory and the information relayed back to the public health committee is not part of any structured interaction between DPH and the committee, but based more on the decision of the committee leadership to request the information. *The current ad hoc*

process within the executive branch to collect, review, and analyze information regarding scopes of practice for health care professions leaves important medical issues impacting public health and safety and consumers' access to quality health care mainly within the context of the legislative process for analysis and solution.

Several constituencies noted to committee staff that there is nothing inherently “wrong” with the current process to determine scopes of practice, given it is the democratic process. Committee staff’s analysis presented above also does not point to any significant deficiencies within the process in broad terms. What cannot be ignored, however, are the opinions of the many stakeholders and public health committee members interviewed by program review staff who stressed a more structured process based standardized criteria would provide more uniform factual information, and is viewed as more beneficial than the current process.

As discussed below, scope of practice processes in other states highlight instances where scope decisions are based on standardized criteria to ensure the most objective, factual information is collected, assessed, and made available to policy makers in a structured, systematic way. If nothing else, *committee staff believes such a process could alleviate some of the internal pressures experienced by the public health department and the public health committee members regarding scope of practice issues without compromising stakeholders' ability to present their positions to the legislature; such positions would simply be presented under a different format.*

Scope of Practice Determination Processes: Other States

Part of the committee staff’s charge within this study was to review how other states determine scopes of practice, including whether any state is modifying its scope of practice determination process. A preliminary summary of models used in several other states was included in staff’s earlier briefing report. The program review committee expressed specific interest in two of the models summarized in the report, Arizona and Iowa, and asked for additional information on those states. Information about the processes used in Oregon plus the five New England states has been collected. In total, processes used in 14 states have been examined by committee staff.

Arizona and Iowa. Additional information about the processes used to determine scopes of practice for health care professions in Arizona and Iowa was obtained for this report. Committee staff contacted both states to gain a greater understanding of each state’s process.

Arizona. Since 1985, Arizona state government has operated under statutorily-defined “sunrise” reporting requirements.¹² Sunrise reports are a tool for policymakers to systematically assess proposals to expand the scope of practice of a regulated profession or to establish new regulatory requirements for a previously unregulated profession. The purpose of sunrise reports is to analyze whether the proposed regulation is necessary at all to protect the health, safety, and welfare of the public.

¹² According to the Council on Licensure, Enforcement, and Regulation (CLEAR), 13 states have active “Sunrise” reporting requirements. See: <http://www.clearhq.org/sunset.htm>, accessed on November 10, 2009.

Sunrise provisions in Arizona require any group proposing regulation of a previously unregulated profession, or requesting an increase in a current scope of practice of a health care profession, to submit a report to the legislature prior to the start of the legislative session in which legislation will be proposed. Once submitted, the report is assigned to the appropriate committee of reference for review.¹³ The committee decides whether to put forth legislation incorporating the scope of practice proposal.

Any sunrise report about the proposed regulation of a previously unregulated profession must contain the specific elements as defined in statute. The factors include: 1) a definition of the problem sought to be remedied through the new regulated profession; 2) why regulation is necessary; 3) how the proposal will benefit the public; and 4) whether any alternatives to regulation have been considered. A new health profession will only be regulated by the state if the: 1) unregulated practice can clearly harm or endanger the public health, safety, or welfare and the potential for harm is easily recognizable; 2) public needs, and can reasonably be expected to benefit from, an assurance of initial and continuing professional ability; and 3) public cannot be protected by other means in a more cost-beneficial manner.

Any profession seeking to modify its current scope of practice also must address certain statutorily prescribed criteria in its sunrise report. Specifically, the report must contain the following factors:

- a definition of the problem and why a change in scope of practice is necessary, including the extent to which consumers need and will benefit from practitioners with this scope of practice;
- the extent to which the public can be confident that qualified practitioners are competent;
- the extent to which an increase in the scope of practice may harm the public, including the extent to which the change will restrict entry into practice; and
- the economic implications to the state and to the general public of implementing the proposed increase in scope of practice.

Sunrise reports are submitted to the legislature's Joint Legislative Audit Committee by September 1 of each year preceding the legislative session. The audit committee assigns the report to the relevant committee of reference for review.

Prior to proposing any scope of practice change in legislation, committee of reference members may use the report to assist them in their information collection and decision-making processes. The committee of reference is required to examine the sunrise report and may hold a public hearing(s) on the scope proposal.

By December 1 of each year, the committee of reference is to deliver its recommendations to the legislative audit committee, the Governor, legislative leaders, and the applicant group. If a

¹³ Each standing committee of the legislature creates a "committee of reference" (i.e., subcommittee) from its membership. The committee of reference is intended to act as a proxy for the standing committee, and has certain responsibilities, including receiving sunrise reports, conducting hearings, and evaluating/recommending regulation or increased scope of practice.

profession proposes to expand its scope of practice, copies of the report must be sent to the regulatory board of the health profession for review and comment. The board may make its own recommendations based on the report submitted by the health care profession seeking expansion to its scope of practice.

Iowa. The state created a pilot program in 1997 establishing scope of practice review committees.¹⁴ The review committees were designed to evaluate requests for changes to health professions' scope of practice. Under this process, professions seeking changes were required to first submit their scope request to the public health department. The department designated the members of the committees according to certain guidelines (e.g., representatives supporting/opposing the request, an impartial health care provider, and members of the general public). The committees were required to make recommendations to the legislature and the appropriate licensure boards on the following:

- requests from practitioners seeking to become newly licensed health professionals or to establish their own licensure boards;
- requests from health professionals seeking to expand or narrow the scope of practice of a health profession; and
- unresolved administrative rulemaking disputes between licensure boards.

Scope of practice review committees assessed proposed scope changes based on objective, technical criteria outlined in regulation. After their evaluations, the committees would make recommendations based on their findings using specific standards (e.g., the proposed scope of practice change does not pose a significant new danger to the public and enacting the proposed change will benefit the health, safety, or welfare of the public.)

The law establishing the review committee pilot program required the Iowa public health department to evaluate the pilot program to determine its overall benefit. The evaluation revealed a number of key program benefits, including the ability to: 1) impartially review health care issues outside of the legislative process; 2) establish a formal resolution mechanism for constituencies to debate their differences; and 3) provide legitimate public policy recommendations to the legislature in a cost-effective manner. The program was extended several times by the legislature, but was eliminated in 2007 mainly due to political reasons, according to the Iowa public health department.

Despite ending the review committee process, Iowa is still examining how best to determine scopes of practice for health care professions. Currently, scope changes are made via the legislative process on an ad hoc basis and not according to any standardized criteria. The public health department told committee staff it understands this is not the most effective or efficient process to determine scopes of practice, some form of structured process based on standardized criteria is necessary, and that it is continuing to examine ways to change the process.

¹⁴ 1997 Iowa Acts, Chapter 203 (Appropriations: Health and Human Rights, Sec. 6).

Oregon. Oregon is another state facing dilemmas with its scope of practice determination process and provides a key example of a state currently examining its scope of practice process. In response to interest from the legislature's Senate and House health care committees regarding Oregon's lack of a clear process for vetting scope of practice issues and resolving conflicts among differing professions, the Oregon Consensus Program – within the National Policy Consensus Center at Portland State University – was retained to examine the issue. The Oregon Consensus Program convened a group of stakeholders in mid-2008 to develop recommendations to improve the state's process for resolving scope of practice issues. The group, referred to as the Process Advisory Group, met to develop recommendations to establish a formal process to evaluate future scope of practice requests. The advisory group was led by an outside facilitator.

In early 2009, the advisory group prepared a report containing recommendations for formalizing Oregon's scope of practice determination process. The report was submitted to the chairmen of the public health committees and key among its recommendations was to pilot a standardized process for reviewing scope of practice bills in the upcoming legislative session. Professions would submit their proposals according to specific criteria, including a statement of the problem the change is trying to correct and the overall benefit to public health resulting from the change, the impact on health care access, and the availability of education, testing, and regulation. All piloted scope of practice changes required each request to be based on a template that uniformly articulates the issues for consideration. A neutral entity would review the proposal and submit a summary report to the legislature. The scope issues for study would be selected by the chairs of the Senate and House health care committees. Within six months of the legislative session, pilot participants, and the advisory group would report to the legislature regarding the pilot's effectiveness and the validity of any long-term process.

Staff from the Oregon Consensus Program told program review staff several scope of practice bills were reviewed during the recent legislative session. The professions supporting and opposing the bills submitted reports to the health care committees according to the recommended template. Due to budget cuts, however, the use of neutral parties to review the proposals was not implemented. As such, the full recommended process did not come to fruition, and the formal evaluation of the pilot has yet to occur.

In 2009, the Oregon legislation also passed legislation creating a seven-member work group to examine whether psychologists in the state should have the ability to prescribe medications for the treatment of mental illness and develop recommendations for legislation to change current statutes.¹⁵ The work group must be facilitated by a mediator. The Oregon Consensus Program is following the progress of the work group and is anticipated to evaluate the group's process upon completion in early 2010.

New England states. Committee staff collected information on the processes used in the other New England states in addition to the models discussed above and the several states discussed in the staff briefing report. The information helps provides an understanding of the scope of practice processes used by the Northeastern states in comparison with Connecticut's process.

¹⁵ See Oregon 2009 Laws Chapter 558.

Maine. Comparable to Arizona, Maine has sunrise requirements for health care professions either proposing a new scope of practice or modifying an existing scope of practice. Maine law requires a sunrise review be undertaken whenever proposed legislation would license or otherwise regulate an occupation or profession (e.g., health care) that is not currently regulated to determine whether such regulation is necessary to protect the health, safety, and welfare of the public.

The commissioner of the state's Department of Professional and Financial Regulation is responsible for appointing a seven-member sunrise review technical committee to examine and investigate each proposal. Committee membership consists of representatives from both the professions proposing and opposing the scope change, a designee of the commissioner, and two public members without a professional or personal interest in the scope change.

The technical committee is responsible for collecting and analyzing information from the professions according to criteria specified in statute (similar to Arizona's criteria), including whether the proposed change is necessary to protect public health and safety. The committee may also use information received through public input or through its own research or investigation. Additional information may be requested by the committee if necessary.

The commissioner is responsible for submitting a report to the legislature following the technical committee's review of the information. The report must include a summary of the material presented to the committee regarding the scope proposal, the department's assessment of the information, and the commissioner's recommendations, if any, based on the technical committee's review.

Massachusetts. Each regulated health care profession in Massachusetts has a professional board. The boards are responsible for interpreting the statutory scopes of practice when questions arise. Board membership consists of practitioners and members from the general public, which is comparable to the membership structure of professional boards in Connecticut.

The executive agency under which the individual boards are located provides administrative and legal support to the boards, similar to Connecticut. Boards rely on executive staff for research and guidance regarding scopes of practice. For example, if a profession has a question about whether a particular practice or procedure is within its scope of practice (e.g., podiatrists' ability to work on the ankle), it will ask its respective board for an interpretation of the statutory scope and a decision will be made by the board. Boards generally rely on the executive agency staff to provide background research and to develop policy statements for boards to vote on. If a profession does not agree with the board's interpretation of the statutes, it may file suit against the board's ruling.

Boards, if asked by the legislature, will provide the legislature advice and/or recommendations on scope of practice issues. All recommendations to the legislature from the boards must first be approved through the governor's office. Massachusetts has no current plans to change its process to determine scopes of practice for health care professions.

New Hampshire. Health professions in New Hampshire are regulated through individual professional boards. Such boards function through the state's department of health and human

services, but are self-funded through licensing fees collected from regulated professions. The boards' main responsibilities include licensing professions, conducting investigations, and handling disciplinary matters. This was how Connecticut regulated health care professions until 1978, when the responsibility was move to DPH.

Committee staff contacted the New Hampshire nursing board for information on how scopes of practice are determined in the state. The board reported that to date, no major problems have arisen within the process, although stakeholders frequently are concerned about the amount of work and resources that go into the scope of practice determination process. The board noted that if a scope of practice change was necessary, the legislature would be petitioned to draft a bill proposing the change. Information would be provided to the legislature through the public hearing process; there are no formal reporting requirements for professions to provide information. Whenever a change in scope is proposed, the key factors addressed in the process are public safety and whether competency requirements are sufficient to support the change.

Rhode Island. According to the Rhode Island Office of Health Professionals Regulation, the state tries to the extent possible to handle less controversial scope of practice decisions within the authority of professional boards or through state regulation. Boards are established for health professions and part of their responsibilities is to answer questions from providers about whether certain practices fall within the purview of their scopes of practice (professional boards in Connecticut make similar decisions.)

For more complex scope of practice issues to expand scopes of practice, the legislative process is used to consider such changes. The state's health department is frequently asked by the legislature to submit a formal written report stating its position on a scope of practice issue (i.e., fiscal impact, etc.). Information used to develop the report usually comes from professional associations, educational programs, and other sources, including professional boards. The legislature will use the report in its consideration of scope of practice legislation.

Vermont. Comparable to Arizona and Maine, Vermont has sunrise requirements for health care professions that mandate any profession wanting to create or modify the regulation of a health care profession must submit a sunrise report to the Office of Professional Regulation within the Vermont Secretary of State's Office. The reports are reviewed by the director of the professional regulation office, with recommendations made to the legislature regarding the scope of practice proposal. In addition, as in other New England states, individual professional boards exist and have the authority to regulate health care professions, including interpreting statutory scopes of practice.

Summary of findings: other states. The results of committee staff's examination of selected other states shows:

- *States use various methods to collect scope of practice information from professions, but issues are ultimately resolved by legislature, as in Connecticut.*
- *Several states collect information from stakeholders regarding scopes of practice based on a structured process outside the traditional legislative*

process. The information is based in response to formal criteria specified in statute.

- *Trying to identify ways to make the process for determining scopes of practice for health care professions as objective and transparent as possible is not unique to Connecticut; other states are grappling with similar issues and trying various alternatives as solutions.*

Best Practices

There is limited information from a national perspective on best practices for determining scopes of practice for health care professions. Moreover, according to the Council on Licensure, Enforcement, and Regulation (CLEAR), there is no “best” way to assess requests for regulation.¹⁶

Two recent reports in the national literature help provide some perspective on best practices for determining scopes of practice: *Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations*¹⁷ (referred to below as the “Legislative Considerations report”) and *Federation of State Medical Boards - Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety* (referred to below as the “FSMB report”).¹⁸ Combined, the reports offer a framework for states to use when considering scope of practice changes. The reports provide information and important factors for helping guide policymakers when considering changes to scopes of practice for health care professions. The documents build on previous national research and present the most current ideas for addressing scopes of practice issues through a structured approach.

The FSMB report, developed in 2005, offers a set of guidelines that should be considered by lawmakers and regulatory boards when considering scope of practice proposals for health care professions. The guide states that any request to create, change, or expand scope of practice should be supported by a verifiable need for the proposed change. Patient safety and public protection must be the primary objectives when evaluating these requests.

The Legislative Considerations report was developed in 2006-07. The report was produced through the collaboration of representatives from six healthcare professions: medicine, nursing, occupational therapy, pharmacy, physical therapy, and social work. Its purpose is to assist legislators and regulatory bodies with making decisions about changes to healthcare professions’ scopes of practice. The report also attempts to develop a rational and useful method for examining scope of practice changes, within the primary context of patient safety. Specifically, the report discusses the purpose of regulation, a definition of scope of practice, a

¹⁶ *Demystifying Occupational and Professional Regulation*, Kara Schmitt and Benjamin Shimberg, Council on Licensure, Enforcement and Regulation, 1996.

¹⁷ *Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations*, Developed in conjunction by the Association of Social Work Boards, Federation of State Boards of Physical Therapy, Federation of State Medical Boards, National Board for Certification in Occupational Therapy, National Council of State Boards of Nursing, and National Association of Boards of Pharmacy, 2007.

¹⁸ *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards, 2005.

framework of common assumptions within which scope of practice changes should be considered, and key factors to base scope of practice decisions. Taken together, these points help provide a set of best practices for policymakers to use when determining scopes of practice for health care professions.

Purpose of regulation. The Legislative Considerations report states that if a scope of practice change is not rooted to protect public safety, it is not relevant to the scope of practice discussion. Within that context, the report identifies the protection of public safety as the main purpose of the regulation of health care professions. The report further uses CLEAR's work to define the intent of regulation, which is to:

- ensure that the public is protected from unscrupulous, incompetent and unethical practitioners;
- offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner; and
- provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses.

Definition of scope of practice. The Legislative Considerations report uses the FSMB definition of scope of practice, which defines scope of practice as: "the rules, regulations, and boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability."

Scope of practice framework. The Legislative Considerations report identifies five common assumptions that provide a basic framework for making scope of practice decisions. During its interviews, committee staff asked stakeholders about the five factors, and most agreed that the factors are an important part of scope of practice determination process. The basic assumptions identified in the literature are:

- 1) the purpose of regulation – public protection – should have top priority in scope of practice decisions, rather than professional self-interest;
- 2) changes in scope of practice are inherent in our current health care system;
- 3) collaboration between health care providers should be the professional norm;
- 4) overlap among professions is necessary; and
- 5) practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service.

Foundational basis for making scope of practice changes. Building on the above scope of practice framework, the report focuses on specific areas that should serve as the basis for health care professions when seeking a scope of practice change. Lawmakers also should have information in these areas to analyze scope of practice changes and determine whether changes are warranted, with the ultimate goal of protecting public safety. Specifically, the four areas include:

- 1) *established history of the practice scope within the profession* – provides the basis for the profession, including how it has developed over time and how it is presently defined;
- 2) *education and training* – as health care professions inherently evolve, education and training must remain the key components to health care professionals providing competent care and protecting public safety;
- 3) *evidence* – professions need to provide supporting evidence how the proposed scope of practice change benefits the public, including providing greater access to competent care; and
- 4) *appropriate regulatory environment* – a proper mechanism must exist to effectively oversee the implementation of the scope of practice change and deal with the regulatory issues associated with the proposed change.

Committee staff finds *Connecticut's process to determine scopes of practice for health care professions is not fully developed in accordance with the best practices framework presented above. Although the public safety component of scope of practice issues is generally discussed in public hearings, the breadth of scope of practice issues are not addressed in relation to any structured framework or standardized criteria.*

Alternative Dispute Resolution Processes

Despite not being specifically mentioned as a “best practice” in the national literature, the use of alternative dispute resolution processes, namely mediation, to resolve scope of practice disputes between professions may be considered a beneficial practice within the scope of practice determination process. Connecticut’s recent experiences with mediation to address issues for two scopes of practice disputes were considered positive methods for getting stakeholders to discuss their differences. The process resulted in scope of practice changes mutually agreed upon by the parties and passed by the legislature. As discussed above, Oregon is currently using mediation to help resolve a scope of practice issue, the results of which have yet to be determined. Committee staff is unaware of any other state using mediation as part of its scope of practice determination process.

Recommendations

Although the findings based on committee staff’s quantitative analysis of legislation and complaint information presented above do not point to any severe deficiencies regarding the outcomes of the practice scope process, the qualitative information collected by staff through its

numerous interviews with various stakeholders, including public health committee members, suggests the process to determine scopes of practice should be changed. *Stakeholders clearly specify the process should be more structured so important information regarding scope proposals is presented to the legislature in a systematic way and according to specific criteria.*

Scope of practice decisions may affect the provision of quality health care and consumers' access to competent care and should be based on the most complete, objective information possible. The information presented to the public health committee regarding scopes of practice is not done in accordance with any formal, standardized criteria and so the types of information actually presented varies in comprehensiveness and indeed sometimes conflicts. This does not minimize the importance and role public hearings play in the overall process, or the fact the ultimate policy decisions about scopes of practice should rest with the legislature. It suggests, however, the legislature and other stakeholders may benefit from a different process to ensure policy makers receive the most complete, objective, and factual information possible from stakeholders based on common, specific criteria.

Committee staff's recommendations presented below are designed to achieve three goals for enhancing the state's process to determine scopes of practice for health care professions:

- 1) create a more formal, standardized, and concise process for information gathering;
- 2) create a process whereby knowledgeable, objective professionals in the area of health care review and assess the information prior to any action by the public health committee; and
- 3) allow a body of professionals to make recommendations to the public health committee based on formal evaluation of pertinent information and discussions with stakeholders.

In addition, the overall process to determine scopes of practice should be considered in accordance with current best practices to the extent possible. Within such process, an important part of the scope of practice determination process should be to have stakeholders find common areas of agreement on as many factors as possible about scope issues. Such agreement can provide an initial starting point from which scope of practice issues can be considered and policy decisions made.

Scope of Practice Request

- **By September 1 of the year preceding the pertinent regular legislative session, any health care profession seeking a change in its statutory scope of practice or the creation of a new scope of practice in the regular legislative session shall submit a written scope of practice request to the Department of Public Health.**

- Each scope of practice request shall include information addressing the following criteria:
 - a. A plain language description of the scope of practice request
 - b. How public health and safety will be protected if the request is implemented, or harmed if the request is not implemented
 - c. Ways in which the scope of practice request will benefit the public health needs of Connecticut's citizens, including its impact on the public's access to care
 - d. Summary of current state laws and regulations governing the profession
 - e. Current education and training requirements for the profession
 - f. Current level of state regulatory oversight of the profession and whether the request will alter this oversight
 - g. History of scope of practice changes requested and/or enacted for the profession
 - h. Information regarding numbers and types of complaints, licensure actions, and malpractice claims against the profession
 - i. Economic impact on the profession if the scope request is made or not made
 - j. Regional and national trends in the profession, and a summary of relevant practices in other states
 - k. A listing of any potential profession in opposition to the request; also include a history of any interaction between the profession seeking the request and the profession(s) opposing the request to discuss the proposed scope of practice request; also include a summary of all areas of agreement between the professions

- The Department of Public Health shall inform the legislature's public health committee of each scope of practice proposal received by the department within 5 business days after timely receipt of the request. If the request is not made by the September 1 deadline, it shall not be considered during the next legislative session. All requests shall also be posted on the DPH website.

Scope of Practice Reports

- By September 15 of each year, any profession that might oppose the filed practice scope request as determined by the Department of Public Health, must receive a copy of the scope of practice request originally filed with the department.

- By October 1 of each year, any such opposing profession(s) may submit a written response to the original scope of practice request to the public health department. The opposing profession's response shall indicate the reasons for opposing the scope request based on the specific criteria reference above.

The response shall also identify any areas of agreement with the original scope of practice request.

- By October 15, the profession filing the original scope of practice request must submit a written response to the opposing profession's response to the public health department. The response shall rebut any areas of disagreement with the opposing profession's response, as well include as any areas of agreement between the professions.

Scope of Practice Review Committee

- For each scope of practice request submitted to the public health department, there shall be a scope of practice review committee established. The purpose of the committee shall be to analyze and evaluate the scope of practice request, any subsequent responses, and any other information the committee deems applicable to the request. In its function, the committee may seek input on the scope request from pertinent stakeholders, including the Department of Public Health, as determined by the committee.
- Upon its review of the scope request and other relevant information, the committee, through its chairperson, shall provide written assessment and recommendations, including the basis for its recommendations, on the scope request to the public health committee. The report shall be submitted no later than February 1, immediately following the September 1 scope of practice request submittal date.

Scope of Practice Review Committee: Membership

- Each Scope of Practice Review Committee convened shall be appointed by the commissioner of the Department of Public Health by October 15 of each year a scope of practice request is submitted.
- Committee membership consists of the following five members:
 - one member representing the profession for which the scope of practice change is requested (if a state professional board exists, such member shall be selected from the board);
 - one member representing the health profession most directly opposed to the proposed change (if a state professional board exists, such member shall be selected from the board);
 - two impartial licensed health care professionals not having a professional or personal interest in the scope request; and

- **one impartial member representing the general public not having a professional or personal interest in the scope request.**
 - **the public health department commissioner or his/her designee shall serve on each committee in an ex-officio capacity.**
- **The scope of practice review committee shall select a chairperson from its impartial members. Each scope of practice review committee shall disband upon submitting its written report to the public health committee. The members shall serve without compensation.**

For the past three decades, state law has required that any request for regulation of emerging health care professions or occupations¹⁹ first be received by the legislature’s public health committee. The stated purpose of this requirement is to “provide a systematic and uniform legislative review process to limit the proliferation of additional regulatory entities and programs.”^{20/21} The recommendations presented above will not change this requirement. Instead, a key goal anticipated from these recommendations is to enhance and standardize the type of information presented to the legislature for scope of practice issues.

As long as the legislature is involved in deciding the scopes of practice for health care professions, legislators, especially those serving on the public health committee, will need to be versed in scope practice issues to make the most informed policy decisions possible. At present, it seems an unrealistic premise that legislators have a full knowledge of the technical medical issues that may accompany scope of practice legislation. Program review committee staff’s recommendations try to balance lawmakers’ responsibility for understanding scope of practice issues, with developing a way of providing them with relevant, synthesized, and more complete information they need to make the most informed decisions possible on scopes of practice issues.

The process recommended above provides policy makers with a framework for considering information based on formal criteria within a more structured process than currently exists. The revised scope of practice determination process should help alleviate, or at least make more concise and comprehensive, the ad hoc way legislators receive information when considering scope of practice legislation. The scope of practice review committees also should help provide the legislature with recommendations on scope issues based on the review and evaluation by professionals of the information. The committees also have the ability to request additional information from professions to help in their overall decision making capacity.²²

¹⁹ C.G.S. Sec. 19a-13 defines emerging occupation or profession as a group of health care providers whose actual or proposed duties, responsibilities and services include functions which are not presently regulated or licensed or which are presently performed within the scope of practice of an existing licensed/regulated health occupation or profession.

²⁰ C.G.S. Sec. 19a-16.

²¹ Ibid.

²² The American Medical Association, in its publication *Creation of State-Based Scope of Practice Review Committees, Legislative Template*, 2008, has indicated scope of practice review committees at the state level may provide a procedure for objective review of proposed scope of practice changes.

Committee staff further anticipates the new process to resolve some of the differences between opposing professions regarding scope of practice issues. Specific criteria must be addressed in the original scope of practice request and subsequent reports from the professions in an effort to help make the information received as part of the process more standardized and transparent. Professions also need to identify any areas where they agree with the opposing profession, which serves as a positive starting point for considering scope requests. Arguments for either supporting or opposing a scope proposal also would have to include quantifiable information to the extent possible.

With the recommended reporting requirements plus requiring professions submit information according to specific criteria, the potential for misinformation or misleading information should be reduced. As noted by the Federation of State Boards of Physical Therapy, efforts by the states to evaluate scope of practice changes primarily based on “criteria related to who is qualified to perform functions safely without risk of harm to the public have worth and should be supported rather than just the passionate arguments of the supporters and challengers.”²³ Committee staff believes the recommendations presented above achieve this goal.

Process review. Given the state’s present fiscal condition, as well as federal and state health care reform efforts (discussed below), it is difficult to determine the impact such fiscal and programmatic realities may have on the full implementation of the committee staff’s recommendations. As such, committee staff recommends **the Department of Public Health shall evaluate the state’s process to determine scopes of practice for health care professions within three years after the recommended model is implemented. The department should report its findings to the public health committee upon completion of its evaluation.**

Committee staff believes a three-year period to implement the new scope of practice model provides a solid basis upon which to evaluate how well the model works, especially in relation to intended and unintended consequences. Based on the evaluation, the legislature will decide as to whether the process meets its intended objective – providing a more structured method for information collection and review of proposals to create or modify scopes of practice for health care professions – and if it should be continued, modified, or abolished. A formal review of the process at the three-year mark also should give stakeholders enough time to develop a sense as to whether or not changes should be made and provide input to the legislature regarding such changes.

Legislature’s role. During committee staff’s interviews with stakeholders, the question was asked about whether the legislature should be the final arbiter of scope of practice issues or if some alternative process should be implemented. Stakeholders agreed the legislature should have the final policy decisions regarding scopes of practice. At the same time, stakeholders agreed the statutory scopes of practice process should not become too prescriptive. Scopes should be based on education, training, and skill competencies, thus allowing enough latitude to ensure as many health care professionals as possible can safely practice under the scope within their skills and abilities while accounting for advancements in health care without having to frequently “re-open” scope of practice statutes for debate.

²³ See https://www.fsbpt.org/ForFaculty/Newsletter/Vol5_No4/index.asp#ScopeOfPractice, accessed November 4, 2009.

The legislative process also adds an inherent check on scopes of practice and maintains a mechanism that is open to input from all stakeholders if they so choose. Without some type of formal method for policy makers to consider the views of various constituencies, the process becomes insular and without adequate opportunity for the thoughts of all stakeholders to be expressed.

As such, committee staff does not recommend the scope of practice determination process be removed from legislative control. As new technologies emerge allowing health care providers to better perform services within a given scope of practice, it is in the public's interest to have an open process for identifying such procedures and recognizing providers who have the knowledge and skills to perform the procedures. Committee staff believes its recommendations accomplish this goal, while maintaining the scope of practice determination process within the legislature's purview.

The scope of practice model recommended in this report is intended ultimately to assist and inform legislators and other stakeholders in a technical area by having each scope of practice proposal brought before the legislature assessed in a standardized way based on credible and tested information pertinent to the protection of public health and safety and consumers' access to health care. Committee staff recognizes other considerations may come into play during the legislative process, such as a need to compromise between interested parties, but having objective information can only improve the ultimate outcome.

DPH resources. The program review committee requested staff to assess the potential impact of a new or revised process to determine scopes of practice on the organization and resources of the Department of Public Health. Two staff from the department's licensing and government relations units have the bulk of the responsibility within the department for scope of practice matters within their current duties.

The department expends resources as part of the scope of practice process, particularly when it interacts with various stakeholders. Committee staff does not foresee the need for additional staff resources to implement these recommendations. Additional work will be necessary to ensure the scope of practice review committee process operates smoothly, but committee staff believes such responsibility can be completed within current resources.

Scopes of Practice and Current Health Care Reform Initiatives

Committee staff was asked to provide information about current initiatives to reform health care and their possible effect on scopes of practice for health care professions in Connecticut. At present, health care reform efforts are occurring at both the state and national levels. In Connecticut, the legislature established the Sustinet health insurance plan in 2009, scheduled for a 2011 launch.²⁴ Nationally, the U.S. Congress is working on legislative proposals that would overhaul health care.²⁵

²⁴ The Sustinet plan is designed specifically for Connecticut in an attempt to increase access to health insurance by residents who are either uninsured or underinsured, control health care costs, and ensure quality health care services. In general, Sustinet creates a large insurance pool consisting of state employees/retirees, residents currently in the state's Medicaid and general assistance programs, businesses, and individual residents who are either underinsured or

SustiNet is guided by a board of directors. Within the board, five advisory committees have been created to make recommendations to the board on more fully developing the SustiNet health care model. According to the Universal Health Care Foundation, which facilitated the original process to design SustiNet, there is the possibility of discussions about scopes of practice for health care professions within two of the advisory committees (i.e., Medical Care Home Committee and Provider Advisory/Quality Committee). At the time of this report, however, no substantive discussions have taken place either by the board or advisory committees about scopes of practice and their possible impact on the implementation of SustiNet.

Two initiatives have been established in Connecticut to monitor federal health care reform. The SustiNet board of directors is currently monitoring federal reform and its effect on the SustiNet health insurance model. The governor, through Executive Order 30, also formed the Connecticut Health Care Advisory Board in July 2009. The board is to evaluate federal health care reform from a statewide perspective and prepare a set of proposed health care policies in response to federal reforms. The board must also evaluate current state health care policies and the health care industry in this state and consider changes. The state comptroller currently co-chairs the SustiNet board of directors and is a member of the governor's health care advisory board, which should help provide coordination between the two oversight bodies. In addition, both initiatives will be monitoring if, and how, scopes of practice for health care professions within Connecticut will be affected by federal health care reform.

Health care reform efforts at both the state and federal levels may eventually involve changes to the scopes of practice for various health care professions as one way to help more fully develop the overall capacity of primary care within the current health care infrastructure. Given the state and national health care reform efforts have not been fully implemented at the time, it is too early to determine whether, or what, changes to professions' scopes of practice may be necessary as part of health care reform.

not insured. Based on the size of the pool, favorable negotiated rates for health care services and prescription drugs are anticipated. An 11-member public/private board of directors is responsible for overseeing the insurance pool, making recommendations for change, and reporting to the legislature. SustiNet is scheduled to begin enrolling state employees and retirees by 2011; enrollment of residents who either are not insured or underinsured is to begin in 2012, and full implementation of the program is scheduled for 2014.

²⁵ As of October 29, 2009. See http://www.kff.org/healthreform/upload/healthreform_tri_full.pdf for a summary of the Senate Finance Committee America's Healthy Future Act of 2009, the Senate HELP Committee Affordable Health Choices Act (S. 1679), and the House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200).

Appendix A

SAMPLE COLLABORATIVE PRACTICE AGREEMENTS

I, _____, and _____ agree to enter into a collaborative practice agreement in the provision of health care.

Coverage for patients during non-office hours and vacations will be arranged as per standard office procedure.

Schedule II through V medication may be prescribed for the acute and chronic physical conditions requiring their use as related to current practice standards of care.

Consultation and referral shall be on a case by case basis as warranted by patient condition and level of expertise of the advanced practice registered nurse.

Patient outcomes will be measured by clinical response and/or laboratory data, as per standard office procedure.

Disclosure of physician-APRN collaboration will be either verbal or written declaration to the patient.

Signed,

Advanced Practice Registered Nurse

Physician

Source: Connecticut Coalition of Advanced Practice Nursing

CONNECTICUT SOCIETY OF NURSE PSYCHOTHERAPISTS

Example 1

**ADVANCED PRACTICE REGISTERED NURSE (A.P.R.N.) COLLABORATIVE AGREEMENT
FOR THE OUTPATIENT SETTING**

THIS FORM IS PROPOSED AS A GUIDELINE FOR ADVANCED PRACTICE REGISTERED NURSES IN DEVELOPING A COLLABORATIVE AGREEMENT FOR THEIR PRESCRIBING PRACTICES. IT IS NOT AN AUTHORIZED STANDARD OF PRACTICE NOR IS IT A LEGAL DOCUMENT. THE CONNECTICUT SOCIETY OF NURSE PSYCHOTHERAPISTS BEARS NO RESPONSIBILITY FOR ITS USE.

The following mutually agreed upon collaborative agreement shall form the basis of a prescribing relationship between _____, A.P.R.N. and _____, M.D. wherein the A.P.R.N. may prescribe and administer medical therapeutics and corrective measures and may dispense drugs in the form of professional samples.

1. The categories of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures, which may be prescribed, dispensed or administered by the Advanced Practice Registered Nurse (A.P.R.N.) are:
 - a) Medications, which may include but are not limited to antidepressants, antipsychotics, anxiolytics/hypnotics, mood stabilizers, antihistamines, and antiparkinsonian drugs.
 - b) Laboratory tests, medical therapeutics, diagnostic procedures and treatment that are commonly performed in the assessment and treatment of psychiatric disorders.
2. Periodically, the A.P.R.N. will randomly select cases for review with the collaborating physician. The purpose will be to review patient outcomes including a review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that may be prescribed, dispensed and administered by the A.P.R.N.
3. Schedule II and III drugs may be prescribed by the A.P.R.N. Patients receiving these medications will be reviewed in the same manner as in section 2.
4. A registered nurse may take orders for medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures from an A.P.R.N. under the supervision of a collaborating physician.

_____, A.P.R.N. Date _____

_____, M.D. Date _____

Example 2 (optional language added)

ADVANCED PRACTICE REGISTERED NURSE (A.P.R.N.) COLLABORATIVE AGREEMENT
FOR THE OUTPATIENT SETTING

THIS FORM IS PROPOSED AS A GUIDELINE FOR ADVANCED PRACTICE REGISTERED NURSES IN DEVELOPING A COLLABORATIVE AGREEMENT FOR THEIR PRESCRIBING PRACTICES. IT IS NOT AN AUTHORIZED STANDARD OF PRACTICE NOR IS IT A LEGAL DOCUMENT. THE CONNECTICUT SOCIETY OF NURSE PSYCHOTHERAPISTS BEARS NO RESPONSIBILITY FOR ITS USE.

The following mutually agreed upon collaborative agreement shall form the basis of a prescribing relationship between _____, A.P.R.N. and _____, M.D. wherein the A.P.R.N. may prescribe and administer medical therapeutics and corrective measures and may dispense drugs in the form of professional samples.

1. The categories of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures, which may be prescribed, dispensed or administered by the Advanced Practice Registered Nurse (A.P.R.N.) are:
 - a) Medications, which may include but are not limited to antidepressants, antipsychotics, anxiolytics/hypnotics, mood stabilizers, antihistamines, and antiparkinsonian drugs.
 - b) Laboratory tests, medical therapeutics, diagnostic procedures and treatment that are commonly performed in the assessment and treatment of psychiatric disorders.
2. Periodically, the A.P.R.N. will randomly select cases for review with the collaborating physician. The purpose will be to review patient outcomes including a review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that may be prescribed, dispensed and administered by the A.P.R.N.
3. Schedule II and III drugs may be prescribed by the A.P.R.N. Patients receiving these medications will be reviewed in the same manner as in section 2.
4. A registered nurse may take orders for medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures from an A.P.R.N. under the supervision of a collaborating physician.
5. Consultation and referral shall be on a case by case basis as deemed appropriate by the A.P.R.N.
6. Coverage for patients during non-office hours and vacations will be arranged by the A.P.R.N.
7. There will be a method of disclosure to the patient of the M.D.-A.P.R.N. collaboration.

_____, A.P.R.N. Date _____

_____, M.D. Date _____

APPENDIX B

**Chart Overview of Nurse Practitioner Scopes of Practice
in the United States**

Sharon Christian, JD, Catherine Dower, JD, Edward O'Neil, PhD, MPA, FAAN

Center for the Health Professions
University of California, San Francisco

2007

Chart Overview of Nurse Practitioner Scopes of Practice in the United States

Sharon Christian, JD, Catherine Dower, JD, Edward O'Neil, PhD, MPA, FAAN

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THE CENTER
FOR THE HEALTH PROFESSIONS
University of California, San Francisco

The mission of the Center for the Health Professions is to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care workforce capable of improving the health and well being of people and their communities.

The Center is committed to the idea that the nation's health will be improved if the public is better informed about the work of health professionals.



**CALIFORNIA
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Notes: The following Chart provides summary information regarding legal scopes of practice for nurse practitioners. For additional discussion about the Chart, please see *Overview of Nurse Practitioner Scopes of Practice in the United States – Discussion (2007)* available at <http://futurehealth.ucsf.edu>. The information contained in this chart is intended to be informative for professionals and policy makers. Efforts have been made to ensure accuracy at the time of publication. However, laws, regulations and interpretations of such often change and may no longer be current. In addition, nothing in this document should be interpreted as legal advice.

Chart Overview of Nurse Practitioner Scopes of Practice in the United States (the "Chart")¹
UCSF Center for the Health Professions, Fall 2007

	Oversight Requirements				Practice Authorities ²				Prescriptive Authorities				Joint BoN/BoM ⁴ Authority
	No MD Involvement Req'd	MD Supervision Req'd	MD Collaboration Req'd	Written Practice Protocol Req'd	Explicit Authority to Diagnose	Explicit Authority to Order Tests	Explicit Authority to Refer	Authority to Prescribe w/o MD Involvement	Authority to Prescribe w/ MD Collaboration	Written Protocol Req'd to Prescribe	Authority to Prescribe Controlled Substances	Nat'l Certif. Req'd	
Alabama ⁶					X	X	X	X	X	X	X	X	X
Alaska ⁷	X				X	X	X	X	X	X	X	X	X
Arizona ⁸	X				X	X	X	X	X	X	X	X	X
Arkansas ⁹			X ¹¹		X	X	X	X	X ¹²	X	X	X	X
California ¹³			X ¹⁴						X ¹⁵	X	X	X	X
Colorado ¹⁶				X	X	X	X	X	X	X	X	X	X
Connecticut ¹⁷					X	X	X	X	X	X	X	X	X
District of Columbia ²¹	X				X ¹⁹	X ²⁰	X	X	X	X	X	X	X
Delaware ¹⁸					X	X	X	X	X	X	X	X	X
Florida ²²		X	X ²⁴		X	X	X	X	X	X	X	X	X
Georgia ²³				X	X	X	X	X	X	X	X	X	X
Hawaii ²⁶					X	X	X	X	X	X	X	X	X
Idaho ²⁹	X				X	X	X	X	X	X	X	X	X
Illinois ³¹				X	X	X	X	X	X	X	X	X	X
Indiana ³²			X		X	X	X	X	X	X	X	X	X
Iowa ³⁴	X				X	X	X	X	X ³⁵	X	X	X	X
Kansas ³⁶					X ³⁷	X	X	X	X	X	X	X	X
Kentucky ³⁸					X ³⁹	X	X	X	X	X	X	X	X
Louisiana ⁴¹			X		X ⁴²	X	X	X	X	X	X	X	X
Maine ⁴³					X ⁴⁴	X	X	X	X	X	X	X	X
Maryland ⁴⁶	X				X	X	X	X	X	X	X	X	X
Massachusetts ⁴⁹		X			X	X	X	X	X	X	X	X	X
Michigan ⁵⁰									X ⁵¹	X	X	X	X
Minnesota ⁵³			X		X	X	X	X	X	X	X	X	X
Mississippi ⁵⁵			X		X	X	X	X	X	X	X	X	X
Missouri ⁵⁶			X		X ⁵⁷	X	X	X	X	X	X	X	X
Montana ⁵⁸	X ⁵⁹				X	X	X	X	X	X	X	X	X
Nebraska ⁶⁰		X ⁶¹			X	X	X	X	X	X	X	X	X
Nevada ⁶²			X		X	X	X	X	X	X	X	X	X
New Hampshire ⁶³	X				X	X	X	X	X	X	X	X	X
New Jersey ⁶⁴					X	X	X	X	X	X	X	X	X
New Mexico ⁶⁶	X				X	X	X	X	X	X	X	X	X
New York ⁶⁹			X		X ⁶⁸	X	X	X	X	X	X	X	X
North Carolina ⁶⁹		X			X	X	X	X	X	X	X	X	X
North Dakota ⁷⁰					X ⁷¹	X	X	X	X	X	X	X	X
Ohio ⁷²			X		X	X	X	X	X	X	X	X	X
Oklahoma ⁷³		X ⁷⁴			X	X	X	X	X	X	X	X	X
Oregon ⁷⁵	X				X	X	X	X	X	X	X	X	X

	Oversight Requirements				Practice Authorities ¹			Prescriptive Authorities			Natl' Certif. Req'd	Joint BoB/BoM ² Authority
	No MD Involvement Req'd	MD Supervision Req'd	MD Collaboration Req'd	Written Practice Protocol Req'd	Explicit Authority to Diagnose	Explicit Authority to Order Tests	Explicit Authority to Refer	Authority to Prescribe w/o MD Involvement	Authority to Prescribe w/ MD Collaboration	Written Protocol Req'd to Prescribe		
Pennsylvania ⁷		X			X				X		X	
Rhode Island ⁹									X		X	
South Carolina ⁸		X			X				X		X	
South Dakota ⁴¹							X				X	
Tennessee ⁶									X		X	
Texas ⁴		X			X				X		X	
Utah ⁸					X				X		X	
Vermont ⁶		X			X				X		X	
Virginia ⁷					X				X		X	
Washington ⁸	X				X				X		X	
West Virginia ⁹							X				X	
Wisconsin ⁹		X			X				X		X	
Wyoming ⁹					X				X		X	
TOTALS	11	10	27	21	44	20	33	11	40	34	48	42

¹ References: 1) Linda Pearson, "The Pearson Report," The American Journal for Nurse Practitioners (February 2007), http://www.webnp.net/images/ajnp_feb07.pdf; 2) Carolyn Buppert, *Nurse Practitioner's Business Practice and Legal Guide* (Third Edition; Jones and Bartlett 2008); "Joint Regulation of Advanced Nursing Practice," U.S. Federal Trade Commission (2007), <http://www.ftc.gov/os/comments/healthcarecomments2/carsondoc1.pdf>. Data updated by UCSF Center for the Health Professions in September 2007.
² **Important:** The Chart is designed to be referenced from left to right. Thus, if the Chart indicates that physician supervision or collaboration is required, then NPs may not diagnose, order tests or refer patients without physician supervision or collaboration.

³ Board of Nursing.
⁴ Board of Medicine.
⁵ Absent explicit statutory or regulatory language requiring a separate written agreement, the Chart does not indicate that a written prescriptive protocol is required in states that already require NPs to establish written practice protocols with physicians. See, for example, Maryland, Massachusetts and Ohio.
⁶ Ala. Code §§34-21-80, 34-21-81, 34-21-86, <http://www.abn.state.al.us/main/nurse-practice-act/ARTICLE-5.pdf>; Ala. Admin. Code r. 610-X-2-.05, <http://www.abn.state.al.us/main/downloads/admin-code/Chapter%20610-X-5.pdf>.
⁷ Alaska Stat. §08.68.410(1), 12 Alaska Admin. Code tit. 12 §§44.430, 44.440, 44.445, <http://www.commerce.state.ak.us/occ/pub/NursingStatutes.pdf>.
⁸ In Alaska, ANPs (advanced nurse practitioners) must have five years of experience in prescribing before they may apply for authority to prescribe controlled substances. 12 Alaska Admin. Code tit. 12 §44.445.
⁹ Ariz. Rev. Stat. §32-1601.15, <http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/32/01601.htm&Title=32&DocType=ARS>;
Ariz. Admin. Code §§R4-19-402, R4-19-508, R4-19-511, R4-19-512, http://www.azbn.gov/documents/npa/LINKED-RULES_JUNE%202007_WEB.pdf.
¹⁰ Arkansas law distinguishes between RNPs and ANPs. The Chart delineates the ANP's scope of practice. Ark. Code Ann. §§17-87-102, 17-87-302, 17-87-310, http://www.arsbn.org/pdfs/practice_act/NURSEPRACTICEACT_2007_5.pdf; Position Statement: Scopes of Practice, http://www.arsbn.org/position_statement_095_1.pdf; Difference between Advanced Nurse Practitioners and Registered Nurse Practitioners, <http://www.arsbn.org/pdfs/anp&rnbroch.pdf>; Advanced Nurse Practitioner, <http://www.arsbn.org/pdfs/ambroch.pdf>; Four Categories of Advanced Practice Licensure, <http://www.arsbn.org/pdfs/4categories.pdf>.
¹¹ In Arkansas, RNPs must practice "in collaboration with and under the direction of a licensed physician or under the direction of protocols developed with a physician." ANPs with prescriptive authority must have a collaborative practice agreement with a physician. Ark. Code Ann. §17-87-310.
¹² In Arkansas, RNPs may not prescribe medications.

- ¹³ Cal. Code of Regs. tit. 16 §§1480(a), 1485, <http://www.rm.ca.gov/regulations/title16.shtml>; Cal. Bus. & Prof. Code §§2725, 2725.1, 2836.1, <http://www.rm.ca.gov/regulations/bpc.shtml>.
- ¹⁴ In California, the standardized procedure (SP) is the legal mechanism for APRNs and NPs to perform functions that would otherwise be considered the practice of medicine. SPs must be developed collaboratively by the nursing, medicine and administrative departments of the healthcare system where they will be used. Once an SP has been signed by the nurse, physician and facility, the practice is considered independent. SPs basically cover diagnoses, referrals, prescriptions and procedures that involve penetration of tissue functions. Pearson, *supra*, note 1.
- ¹⁵ In California, NPs may "furnish" or "order" drugs. However, they may not "prescribe" drugs. Cal. Bus. & Prof. Code §2836.1.
- ¹⁶ Col. Rev. Stat. §§12-38-103, 12-38-111.5, 12-38-111.6, <http://www.dora.state.co.us/NURSING/statutes/NursePracticeAct.pdf>.
- ¹⁷ Conn. Gen. Stat. §§20-87a, 20-94a, <http://www.cga.ct.gov/2007/pub/Chap378.htm>;
- Advanced Practice Registered Nurse Licensure, <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389400>.
- ¹⁸ Del. Code Ann. tit. 24 §1902, <http://delcode.delaware.gov/title24/e019/index.shtml>;
- ¹⁹ Del. Register of Regs. tit. 24 §§8.0-8.18, <http://regulations.delaware.gov/AdminCode/title24/1900%20Board%20of%20Nursing.shtml#TopOfPage>.
- ²⁰ Delaware law distinguishes between "medical diagnoses" and "nursing diagnoses." Del. Code Ann. tit. 24 §1902.
- ²¹ D.C. Mun. Regs. tit. 17, Ch. 59, http://hpla.doh.dc.gov/hpla/frames.asp?doc=/hpla/lib/hpla/prof_license/services/pd/ffile/nursing/nurse_practitioner_chap_59_regs_8-10-05.pdf;
- ²² Fla. Stat. §§464.003, 464.012, Fla. Admin. Code Ann. 64B9, http://www.doh.state.fl.us/mqa/nursing/info_PracticeAct.pdf; Frequently Asked Questions, http://www.doh.state.fl.us/mqa/nursing/nur_faq.html#ARNP; 2006 Legislative Changes for Nursing, http://www.doh.state.fl.us/mqa/nursing/info_legisupdates.pdf.
- ²³ Ga. Comp. R. & Regs. §410-12-03, <http://sos.georgia.gov/acrobat/PLB/Rules/chapt410.pdf>; Ga. Code Ann. §§43-26-3, 43-34-26.1, 43-34-26.3, <http://www.lexis-nexis.com/hottopics/gacode/default.asp>.
- ²⁴ In Georgia, a physician may delegate the authority to perform certain medical acts under a nurse protocol agreement. Ga. Code Ann. §43-34-26.3.
- ²⁵ In Georgia, the Board of Medical Examiners promulgates the rules and regulations for the nurse protocol agreement. Ga. Code Ann. §43-34-26.1(c).
- ²⁶ Haw. Rev. Stat. §§457-8.5, 457-8.6, <http://www.hawaii.gov/dcca/areas/pvl/main/hns/>; Haw. Admin. R. §§16-89, 16-89C, <http://www.hawaii.gov/dcca/areas/pvl/main/har/>.
- ²⁷ The rules to implement NP authority to prescribe controlled substances are currently being drafted. See, www.hawaii.gov/dcca/areas/pvl/main/press_releases/nursing_announcements/pvl_ja_exec_apra.pdf; www.hawaii.gov/dcca/areas/pvl/main/reports/pvl_legislature_reports/JFAC_2004_Legislature_Report.pdf.
- ²⁸ In Hawaii, the Board of Medical Examiners has joint rule-making authority with the Board of Nursing over prescriptive matters only. Haw. Rev. Stat. §§457-8.6.
- ²⁹ Idaho Code §54-1402(1)(c), <http://www3.state.id.us/cgi-bin/newidst?scid=540140002.K>;
- ³⁰ Idaho Admin. Proc. Act §§23.01.01.271, 23.01.01.280, 23.01.01.315, <http://www.adm.idaho.gov/adminrules/rules/ida23/0101.pdf>.
- ³¹ In Idaho, an Advisory Committee to the Board of Nursing addresses issues related to the practice of NPs and other APPNs. The Committee consists of two APPNs appointed by the Board of Nursing, two physicians nominated by the Board of Medicine and appointed by the Board of Nursing and one pharmacist nominated by the Board of Pharmacy. The Board of Nursing cannot expand the scope of practice or prescriptive authority of an APPN beyond that recommended by the Committee. Idaho Code §54-1417, <http://www3.state.id.us/cgi-bin/newidst?scid=540140017.K>.
- ³² 225 Ill. Comp. Stat. 65/15-5, 65/15-10, 65/15-15, 65/15-20, <http://ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1312&ChapAct=225%26nbsp%3B65%2F&ChapterID=24&ChapterName=PROFESSIONS+AND+OCCUPATIONS&ActName=Nursing+and+Advanced+Practice+Nursing+Act%2E>;
- ³³ Ill. Admin. Code tit. 68 §§1305.30, 1305.35, 1305.40, <http://www.ilga.gov/commission/jcar/admincode/0680/06801305sections.html>;
- ³⁴ Ind. Code §§25-23-1-19.4 to 25-23-1-19.6; 848 Ind. Admin. Code §§ 4-1-3, 4-1-4, 4-2-1, 5-1-1, http://www.in.gov/pla/bande/isbn/nursing_compilation.pdf.
- ³⁵ In Indiana, Board of Nursing decisions regarding requirements for initial and renewed prescriptive authority must be approved by the Board of Medicine. Pearson, *supra*, note 1 (citing Ind. Code §§25-23-1-7(B), 25-23-1-7(C)).
- ³⁶ Iowa Admin. Code §655-7.1(152), <http://www.legis.state.ia.us/CurrentIac/655/6557/6557.pdf>;
- ³⁷ Iowa Code §147.107, <http://nxtsearch.legis.state.ia.us/nxt/gateway.dll?f=templates&fn=default.htm; Iowa Board of Nursing>;
- ³⁸ http://www.state.ia.us/nursing/nursing_practice/arnp.html.
- ³⁹ In Iowa, ARNPs may prescribe independently. Pearson, *supra*, note 1 (citing Iowa Admin. Code §655-7.1(152)).
- ⁴⁰ Kan. Stat. Ann. §§ 65-1113 to 65-1134, Kan. Admin. Regs. §§60-3-101; 60-11-101 to 60-11-119, <http://www.kssbn.org/npa/npa.pdf>.

- ³⁷ Kansas law distinguishes between "medical diagnoses" and "nursing diagnoses." Kan. Stat. Ann. §65-1113(b).
- ³⁸ Ky. Rev. Stat. Ann. §314.011, <http://162.114.4.13/KRS/314-00011.PDF>; Ky. Rev. Stat. Ann. §314.042, <http://www.lrc.ky.gov/KRS/314-00042.PDF>;
- ³⁹ 201 Ky. Admin. Regs. §20-056, <http://www.lrc.state.ky.us/kar/201020/056.htm>; 201 Ky. Admin. Regs. §20-057, <http://www.lrc.state.ky.us/kar/201020/057.htm>; 201 Ky. Admin. Regs. §20-059, <http://www.lrc.state.ky.us/kar/201020/059.htm>; Scope of Practice Determination Guidelines, <http://kbn.ky.gov/NR/rdonlyres/74A5FF75-543D-4E12-8839-720B7623DA87/0/pracdtrm.pdf>.
- ⁴⁰ Kentucky law distinguishes between "medical diagnoses" and "nursing diagnoses." Ky. Rev. Stat. Ann. §314.011(4)(a).
- ⁴¹ In Kentucky, ARNPs must be registered to practice for at least one year before entering into a written collaborative practice agreement with a physician to prescribe controlled substances. Ky. Rev. Stat. Ann. §314.042.
- ⁴² La. Admin. Code §46:XLVII, Ch. 45, <http://www.lsb.state.la.us/documents/rules/fullrules.pdf>.
- ⁴³ La. Stat. Ann. §37:913(3), La. Admin. Code §46:XLVII, Ch. 45 §4513, <http://www.lsb.state.la.us/Documents/scope/apscope.pdf>.
- ⁴⁴ In Louisiana, APRNs who "engage in medical diagnosis and management shall have a collaborative practice agreement." APRNs practicing solely in their nursing scope of practice, on the other hand, are not required to have a collaborative practice agreement. Pearson, *supra*, note 1 (citing La. Admin. Code §46:XLVII, Ch. 45 §4513).
- ⁴⁵ In Louisiana, APRNs may diagnose only if they are authorized under a collaborative practice agreement. La. Admin. Code §46:XLVII, Ch. 45 §4513.
- ⁴⁶ In Louisiana, APRNs must have experience prescribing medications in collaboration with a physician for 500 hours before applying for authority to prescribe controlled substances. La. Admin. Code §46:XLVII Ch. 45, §4513.
- ⁴⁷ Code Me. R. tit. 32 §2102, <http://janus.state.me.us/legis/statutes/32/title32sec2102.pdf>; Code Me. R. tit. 32 §2201-A, <http://janus.state.me.us/legis/statutes/32/title32sec2201-A.pdf>; Code Me. R. tit. 32 §2205-B, <http://janus.state.me.us/legis/statutes/32/title32sec2205-B.pdf>; Code Me. R. tit. 32 §2102, <http://janus.state.me.us/legis/statutes/32/title32sec2102.pdf>; 02-373 Me. ADC, Ch. 3, <http://www.maine.gov/sos/cec/rules/02/373/373c003.doc>; 02-380 Me. ADC, Ch. 8, <http://ftp.state.me.us/pub/sos/cec/rn/apa/02/380/380c008.doc>.
- ⁴⁸ In Maine, physician supervision is required for at least the first two years of NP practice, after which independent practice is authorized. Code Me. R. tit. 32 §2102, 2-A.
- ⁴⁹ Maine law distinguishes between "medical diagnoses" and "nursing diagnoses." Code Me. R. tit. 32 §2102(2)(A)(1).
- ⁵⁰ Md. Code Ann. §810.27.07.00 to 10.27.07.08, <http://www.dsd.state.md.us/comar/10/10.27.07.01.htm>; <http://www.dsd.state.md.us/comar/10/10.27.07.02.htm>; <http://www.dsd.state.md.us/comar/10/10.27.07.03.htm>; <http://www.dsd.state.md.us/comar/10/10.27.07.05.htm>; <http://www.dsd.state.md.us/comar/10/10.27.07.08.htm>.
- ⁵¹ 244 Code Mass. Regs. §84.05, 4.22, 4.26(2), <http://www.mass.gov/EcoHhs2/docs/dph/regs/244cmr004.pdf>;
- ⁵² Mich. Comp. Laws §333.16215, [http://www.legislature.mi.gov/\(S:zizokq5mxus0055jghfcvjb\)/mleg.aspx?page=getobject&objectname=mcl-333-16215](http://www.legislature.mi.gov/(S:zizokq5mxus0055jghfcvjb)/mleg.aspx?page=getobject&objectname=mcl-333-16215);
- ⁵³ Mich. Comp. Laws §333.17212, [http://www.legislature.mi.gov/\(S:kzhfca2uuyvfdewnerous1\)/documents/mcl/pdf/mcl-333-17212.pdf](http://www.legislature.mi.gov/(S:kzhfca2uuyvfdewnerous1)/documents/mcl/pdf/mcl-333-17212.pdf);
- ⁵⁴ Mich. Admin. Code R 338.10404, http://www.state.mi.us/ort/emi/admincode.asp?AdminCode=Single&Admin_Num=33810101&Dpt=CH&RugHigh=;BoardofNursing, <http://www.michigancenterfornursing.org/mimages/bofnursing.pdf>; http://www.michigan.gov/mdch/0,1607,7-132-27417_27529_27542-59003--,00.html.
- ⁵⁵ In Michigan, physicians may delegate the authority to prescribe medications under protocols. Mich. Comp. Laws §333.17212.
- ⁵⁶ Minnesota Nurse Practice Act, http://www.state.mn.us/portal/mm/jsp/content.do?rc_layout=bottom&subchannel=null&programid=536898782&sc3=null&sc2=null&id=536882405&agency=NursingBoard; Minn. Stat. §148.171, <http://www.revisor.leg.state.mn.us/bin/getpub.php?type=s&year=current&num=148.171>;
- ⁵⁷ Minn. Stat. §148.235, <http://www.revisor.leg.state.mn.us/bin/getpub.php?type=s&year=2006§ion=148.235>;
- ⁵⁸ Advanced Practice Registered Nursing Information, http://www.state.mn.us/portal/mm/jsp/content.do?rc_layout=bottom&subchannel=536882458&programid=536898474&sc3=null&sc2=null&id=536882404&agency=NursingBoard.
- ⁵⁹ In Minnesota, NPs may only prescribe medications under a written agreement with a physician based on standards jointly established by the Minnesota Nurses Association and the Minnesota Medical Association. Minn. Stat. §148.235.
- ⁶⁰ Miss. Code Ann., Ch. IV, VII, <http://www.msbn.state.ms.us/pdf/nursingpracticelaw2007.pdf>; Miss. Board of Nursing Rules & Regs. §73-15, <http://www.msbn.state.ms.us/pdf/rulesandregulations2007.pdf>.
- ⁶¹ Mo. Rev. Stat. §335.016, <http://www.moga.mo.gov/statutes/C300-399/3350000016.HTM>; Mo. Rev. Stat. §334.104.2, <http://www.moga.mo.gov/statutes/C300-399/3340000104.htm>; Mo. Code Reg. Ann. §2200-4, <http://www.sos.mo.gov/admlcs/csr/current/20c2200-4.pdf>; Nursing & Collaborative Practice, <http://pr.mo.gov/nursing-advanced-practice-nursing-collaborative.asp>.

- ⁵⁷ Missouri law distinguishes between "medical diagnoses" and "nursing diagnoses." Mo. Rev. Stat. §335.016(10)(b).
- ⁵⁸ Admin. R. Mont. §24.159.1401, <http://arm.sos.mt.gov/24/24-16651.htm>; Admin. R. Mont. §24.159.1470, <http://arm.sos.mt.gov/24/24-16692.htm>; Admin. R. Mont. §24.159.1461, <http://arm.sos.mt.gov/24/24-16685.htm>; Admin. R. Mont. §24.159.1465, 24.159.1466, <http://arm.sos.mt.gov/24/24-16689.htm>; Admin. R. Mont. §37-8-102, <http://data.opi.state.mt.us/bills/mca/37/8/37-8-409.htm>; Admin. R. Mont. §24.159.1463, <http://arm.sos.mt.gov/24/24-16687.htm>; Admin. R. Mont. §24.159.1464, <http://arm.sos.mt.gov/24/24-16688.htm>.
- ⁵⁹ In Montana, physicians must review a percentage of each NP's chart as part of a quality assurance plan. Admin. R. Mont. §24.159.1466.
- ⁶⁰ Neb. Rev. Stat. §§71-1704 to 71-1726.02, <http://www.hhs.ne.gov/cr/statutes/nurspractitioneract.pdf>; 172 Neb. Admin. Code, Ch. 100 §001 (not publicly available online).
- ⁶¹ In Nebraska, NPs must first complete 2000 hours of practice under physician supervision. Neb. Rev. Stat. §71-1723.02.
- ⁶² Nev. Rev. Stat. §632, <http://www.leg.state.nv.us/NRS/NRS-632.html>; Nev. Admin. Code §632, <http://www.leg.state.nv.us/NAC/NAC-632.html>.
- ⁶³ N.H. Rev. Stat. Ann. §§326-B:9, 326-B:11, 326-B:18, <http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXX-326-B.htm>.
- ⁶⁴ N.J. Stat. Ann. §§45:11-47, 45:11-49, <http://www.state.nj.us/ps/cs/laws/nursinglaws.pdf>; N.J. Admin. Code §§13:37-6.3, 13:37-7.1, 13:37-7.7, <http://www.njconsumeraffairs.gov/laws/nursingregs.pdf>.
- ⁶⁵ In New Jersey, joint protocols on prescriptive authority must conform to standards developed by the Board of Nursing and the Board of Medicine. N.J. Stat. Ann. §45:11-47.
- ⁶⁶ N.M. Stat. Ann. §61-3-23.2, N.M. Admin. Code §16.12.2, <http://www.conwaygreene.com/nmsu/lpext.dll?f=templates&fn=main-h.htm&2.0>.
- ⁶⁷ N.Y. Edu. Law tit. VIII, Art. 139, §§6900-6910, <http://www.op.nysed.gov/article139.htm>; N.Y. Comp. Codes R. & Regs. tit. 8 §§64.4-64.6, <http://www.op.nysed.gov/part64.htm>.
- ⁶⁸ New York law distinguishes between "medical diagnoses" and "nursing diagnoses." N.Y. Edu. Law tit. VIII, Art. 139, §6901(1).
- ⁶⁹ N.C. Gen. Stat. §§90-18.2, 90-18.3, <http://www.ncmedboard.org/Clients/NCBOM/Public/PhysicianExtenders/nnpa.pdf>; 21 N.C. Admin. Code §36, <http://www.ncbon.com/content.aspx?id=654&linkidentifier=id&itemid=654>.
- ⁷⁰ N.D. Admin. Code §54-05-03.1, <http://www.legis.nd.gov/information/acdata/pdf/54-05-03.1.pdf>; N.D. Cent. Code §43-12.1, <http://www.legis.nd.gov/cencode/43c12.1.pdf>.
- ⁷¹ North Dakota law distinguishes between "medical diagnoses" and "nursing diagnoses." N.D. Cent. Code §43-12.10-02(5)(b).
- ⁷² Ohio Rev. Code Ann. §§4723.43(C), 4723.431, 4723.50, 4723.10, 4723.481, <http://www.nursing.ohio.gov/PDFs/NewLawRules/CH4723Andersons0207.pdf>; Ohio Admin. Code §4723-8, <http://codes.ohio.gov/oac/4723-8>.
- ⁷³ Okla. Stat. tit. 59 §§567.3a, 567.4a, <http://www.lsb.state.ok.us/OKStatutes/CompleteTitles/oss9.rtf>; Okla. Admin. Code §§485:10-15-6(c), 485:10-16-3, http://www.oar.state.ok.us/oar/codedoc02.nsf/frmMain?OpenFrameSet&Frame=Main&Src=75mm2shfcdnm8pb4dtj0chedppmcbq8dtmmak31ctjjujrgeln50ob7ekj42bbkdt374obdclt00_.
- ⁷⁴ In Oklahoma, physician supervision is required only for prescribing ARNPs.
- ⁷⁵ In Oklahoma, the Formulary Advisory Council, partially composed of physicians appointed by the Oklahoma State Medical Association, has power to select drugs for the formulary. The Board of Nursing may accept or reject the Council's recommendations. However, the Board of Nursing may not amend the formulary without the approval of the Council. Pearson, *supra*, note 1 (citing Okla. Stat. tit. 59 §567.4a).
- ⁷⁶ Or. Rev. Stat. §851-050, <http://www.oregon.gov/OSBN/pdfs/npa/Div50.pdf>; Or. Rev. Stat. §851-056, <http://www.oregon.gov/OSBN/pdfs/npa/Div56.pdf>.
- ⁷⁷ 49 Pa. Code §§21.251; 21.283 to 21.287; 21.291 to 21.294; 21.311, http://www.pacode.com/secure/data/049/chapter21/049_0021.pdf; Pa. Prof. Nursing Law §2(13), http://www.dos.state.pa.us/npoa/lib/bpoa/20/nurs_board/nurseact.pdf.
- ⁷⁸ In Pennsylvania, Schedule II prescriptions by CRNPs are limited to 72-hour supplies. Schedules III-IV prescriptions are limited 30-day supplies. Pearson, *supra*, note 1 (citing 49 Pa. Code §21.284).
- ⁷⁹ R.I. Gen. Laws §5-34-3, <http://www.rilin.state.ri.us/Statutes/TITLE5/5-34/5-34-3.HTM>; R.I. Gen. Laws §5-34-39, <http://www.rilin.state.ri.us/Statutes/TITLE5/5-34/5-34-39.HTM>; R.I. Gen. Laws §5-34-35, <http://www.rilin.state.ri.us/Statutes/TITLE5/5-34/5-34-35.HTM>; Rules & Regs. for the Licensing of Nurses and Standards for the Approval of Basic Nursing Edu. Programs R5-34-NUR/ED 1.9; 9.0 - 9.3.1, <http://www.sctatehouse.net/code/140c033.htm>.
- ⁸⁰ S.C. Code Ann. §40-33, <http://www.sctatehouse.net/code/140c033.htm>.
- ⁸¹ S.D. Codified Laws §§36-9A-4, 36-9A-5, 36-9A-12, 36-9A-13.1, 36-9A-15, 36-9A-17, 36-9A-17.1, <http://legis.state.sd.us/rules/DisplayRule.aspx?Rule=20:62:03>.
- ⁸² S.D. Codified Laws §§36-9A-4, 36-9A-5, 36-9A-12, 36-9A-13.1, 36-9A-15, 36-9A-17, 36-9A-17.1, <http://legis.state.sd.us/rules/DisplayRule.aspx?Rule=20:62:03>.
- ⁸³ In South Dakota, NPs may prescribe Schedule II controlled substances for a period of not more than 30 days. S.D. Codified Laws §36-9A-12.
- ⁸⁴ Tenn. Code Ann. §§63-7-103, 63-7-126, 63-7-123, <http://michie.lexisnexis.com/tennessee/lpext.dll?f=templates&fn=main-h.htm&cp=>, Rules of Tenn. Board of Nursing 1000-4, <http://www.state.tn.us/sos/rules/1000/1000-04.pdf>.

- ⁸⁴ 22 Tex. Admin. Code §§221, 222, <ftp://www.bne.state.tx.us/bne-rr-0607.pdf>.
- ⁸⁵ Utah Code Ann. §58-31b, <http://dopl.utah.gov/laws/58-31b.pdf>; Utah Admin. Code R156-31b-702, <http://dopl.utah.gov/laws/R156-31b.pdf>; Utah Code Ann. §58-31d, <http://dopl.utah.gov/laws/58-31d.pdf>.
- ⁸⁶ 26 Vt. Stat. Ann. §1572, <http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=26&Chapter=028&Section=01572>; Code Vt. R., Ch. 4, Subch. 8, <http://viprofessionals.org/oprt1/nurses/forms/nursingrules.pdf>.
- ⁸⁷ Code of Va. §§54.1-2957, 54.1-2957.01, http://www.dhp.state.va.us/nursing/leg/MedicalPracticeAct_Nursing.doc; 18 Va. Admin. Code §90-30-10 et. seq., <http://www.dhp.virginia.gov/nursing/leg/Nurse%20practitioners%2011-29-07.doc>; 18 Va. Admin. Code §90-40-10 et. seq., <http://www.dhp.virginia.gov/nursing/leg/Nurse%20prac%20press%20autit%203-21-07.doc>.
- ⁸⁸ Wash. Admin. Code §246-840-300, <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-300>; Wash. Rev. Code §18.79.250, <http://apps.leg.wa.gov/RWCW/default.aspx?cite=18.79.255>; Wash. Admin. Code §246-840-420, <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-420>; Wash. Admin. Code §246-840-400, <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-400>.
- ⁸⁹ W. Va. Code §9-4B-1(c), <http://www.legis.state.wv.us/WVCODE/09/WVC%20209%2020-%20%204%20B-%20%20201%20%2020.htm>; W. Va. Code §16-30-3(c), <http://www.legis.state.wv.us/WVCODE/16/WVC%2016%2020-%2030%2020-%2030%2020-%2030%2020.htm>; W. Va. Code §19-7, <http://www.wvsos.com/csrdocs/worddocs/19-07.doc>; W. Va. Code §19-10, <http://www.wvsos.com/csrdocs/worddocs/19-10.doc>; W. Va. Code §19-8, <http://www.wvsos.com/csrdocs/worddocs/19-08.doc>; W. Va. Code §30-7-15(a), <http://www.legis.state.wv.us/WVCODE/30/WVC%2030%2020-%207%2020-%207%2020-%207%2020-%207%2020.htm>.
- ⁹⁰ Wis. Stat. §255.06(d), <http://www.legis.state.wi.us/statutes/Stat0255.pdf>; Wis. Stat. §§441.001(4), 441.16, <http://www.legis.state.wi.us/statutes/Stat0441.pdf>.
- ⁹¹ Wyo. Stat. Ann. §33-21-120, <http://www.legis.state.wy.us/rsb/code/n/n008.pdf>.
- Wyo. Stat. Ann. §33-21-120, <http://nursing.state.wy.us/NP/TITLE%2022%20CHAPTER%2021%20-%20NURSES.htm>;
- Wyo. State Board of Nursing, Rules & Regs., Ch. IV, Advanced Practitioners of Nursing, <http://nursing.state.wy.us/rules/pdfdocs/Ch4-Apr01.pdf>.

**Legislative Program Review and Investigations Committee
Scope of Practice Determination Process for Health Care Professions
Survey of Public Health Committee Members**

*** Please answer the following questions based on your tenure on the Public Health Committee since 2005 ***

1. Overall, how much time did the *public health committee* spend on issues involving scope of practice changes for health care professions in relation to other matters before the committee:
 - a. Too much (5)
 - b. Right amount (2)
 - c. Not enough (4)
 - d. No opinion (1)

2. Overall, how much time did *you* spend on issues involving scope of practice changes for health care professions compared with the rest of the matters before the public health committee?
 - a. Too much (5)
 - b. Right amount (2)
 - c. Not enough (5)
 - d. No opinion (0)

3. Overall, how often did you have enough information to vote as knowledgeably as you would have liked on bills before the public health committee involving scope of practice changes for health care professions?
 - a. Always (1)
 - b. Usually (4)
 - c. Seldom (5)
 - d. Never (0)
 - e. No opinion (0)

4. Did you ever receive conflicting *factual* information from parties regarding legislation changing scopes of practice for health care professions?
 - a. Yes (9)
 - b. No (1)
 - c. Do not recall (2)

5. Overall, how would you rate the *usefulness* of the information from the following sources in helping you make informed votes on bills before the public health committee changing scopes of practice for health care professions? (Please mark one response per category)

<i>Source of Information</i>	Very Useful	Useful	Somewhat Useful	Not Useful	None Provided
a. Practitioners, professional practitioner associations, and lobbyists <u>supporting</u> legislation changing scopes of practice	2	8	2	-	-
b. Practitioners, professional associations, and lobbyists <u>opposing</u> legislation changing scopes of practice	1	9	2	-	-
c. Department of Public Health (DPH)	1	5	3	2	1
d. Health care consumers or their representatives	1	5	2	1	2
e. Health insurance companies	-	-	7	-	3
f. Other:	-	-	1	-	1

PLEASE CONTINUE ON BACK



6. Please *rank order* the following factors that in your opinion motivate health care professions to seek scope of practice changes (1 = most influential motivating factor; 6 = least influential motivating factor):

- | | |
|--|---|
| <u>5</u> Increased public safety | <u>1</u> Economic gain for the profession <i>seeking</i> change |
| <u>3</u> Increased access to care | <u>4</u> Taking direction from profession's national assoc. |
| <u>2</u> Sufficient education and training on part of the profession <i>seeking</i> the scope of practice change | <u>5</u> Other: _____ |

7. Please *rank order* the following factors that in your opinion motivate health care professions to oppose scope of practice changes (1 = most influential motivating factor; 6 = least influential motivating factor):

- | | |
|--|--|
| <u>4</u> Decreased public safety | <u>1</u> Economic loss for the profession <i>opposing</i> change |
| <u>5</u> Decreased access to care | <u>2</u> Taking direction from profession's national assoc. |
| <u>3</u> Insufficient education and training on part of the profession <i>seeking</i> the scope of practice change | <u>6</u> Other: _____ |

8. How would you describe the Department of Public Health's overall level of input in the process to change scopes of practice for health care professions?

- a. Too much (1) b. Right amount (3) c. Not enough (7) d. No opinion (1)

9. If you chose either "a" or "c" to Question 8, please explain your main reason why: _____

10. How often did DPH provide you with its recommendations on proposals to change scopes of practice for health care professions outside of the public health committee's public hearing process?

- a. Always (1) b. Usually (3) c. Seldom (5) d. Never (2)

11. Does the process to change scopes of practice for health care professions need to improve?

- a. Yes (12) b. No (0) c. Not sure (0)

12. If you answered "yes" to Question 11, how do you think the process to change scopes of practice for health care professions should improve? (circle all that apply)

- a. Public health committee members should receive more standardized and comprehensive information (10)
- b. The Department of Public Health should provide more input, including its recommendations, to public health committee members for all scope of practice changes (9)
- c. Establish an outside, objective entity to make recommendations to the public health committee (6)
- d. For any health care profession with a state board, the board should make recommendations to the public health committee (9)
- e. Protracted scope of practice differences should be resolved using formal alternative dispute resolution methods, such as mediation (5)
- f. Other: (0)
- g. No opinion (0)

Thank you for completing this survey and returning it by November 20, 2009

DPH Quality Factors for Practitioner Groups Regarding Scopes of Practice

When approached by practitioner groups to discuss issues regarding new licensure categories or changes/expansions in scopes of practice, DPH tries to elicit as much information as possible to assist the department in determining its position on the proposal should the legislature decide to move it forward. In these discussions, the department also tries to highlight for the profession the types of information it must be prepared to provide legislators and other interested parties. Below are the most frequently asked questions/issues (in no particular order) the department inquires about in any of the scope of practice meetings with health care professions.

- Why is the profession seeking the change/why is the change necessary?
- What has changed in the practice of the profession to cause it to seek this change?
- Do other states allow for this practice and, if so, what are the requirements?
- How many practitioners will be impacted?
- What is the education and training to prepare a practitioner to engage in this practice?
- How is competency to engage in this practice assessed? (i.e., is there a national exam and/or national certification associated with the credential?)
- How does a practitioner maintain competence in this practice area?
- How will practitioners who are already licensed, and who may have been licensed for a number of years, be educated, trained, and assessed to ensure they are competent to engage in this practice?
- How will consumers benefit from the proposed change? (Discussion of DPH's role in the protection of patient safety - try to identify any concerns DPH has regarding patient safety.)
- Has the profession discussed the proposed changes with representatives from other professions that may be impacted by the change?
- Does this practice infringe on the scope of practice of other professions? (Department tries to identify overlaps if it is aware of them, and encourage profession to engage in discussions with other groups.)
- Has the profession discussed the proposal with individual legislators and/or representatives from the Public Health Committee? (DPH explains that such proposals must be raised and enacted by the legislature - not the department.)
- DPH identifies if it believes there will be costs to the state to implement their proposal.