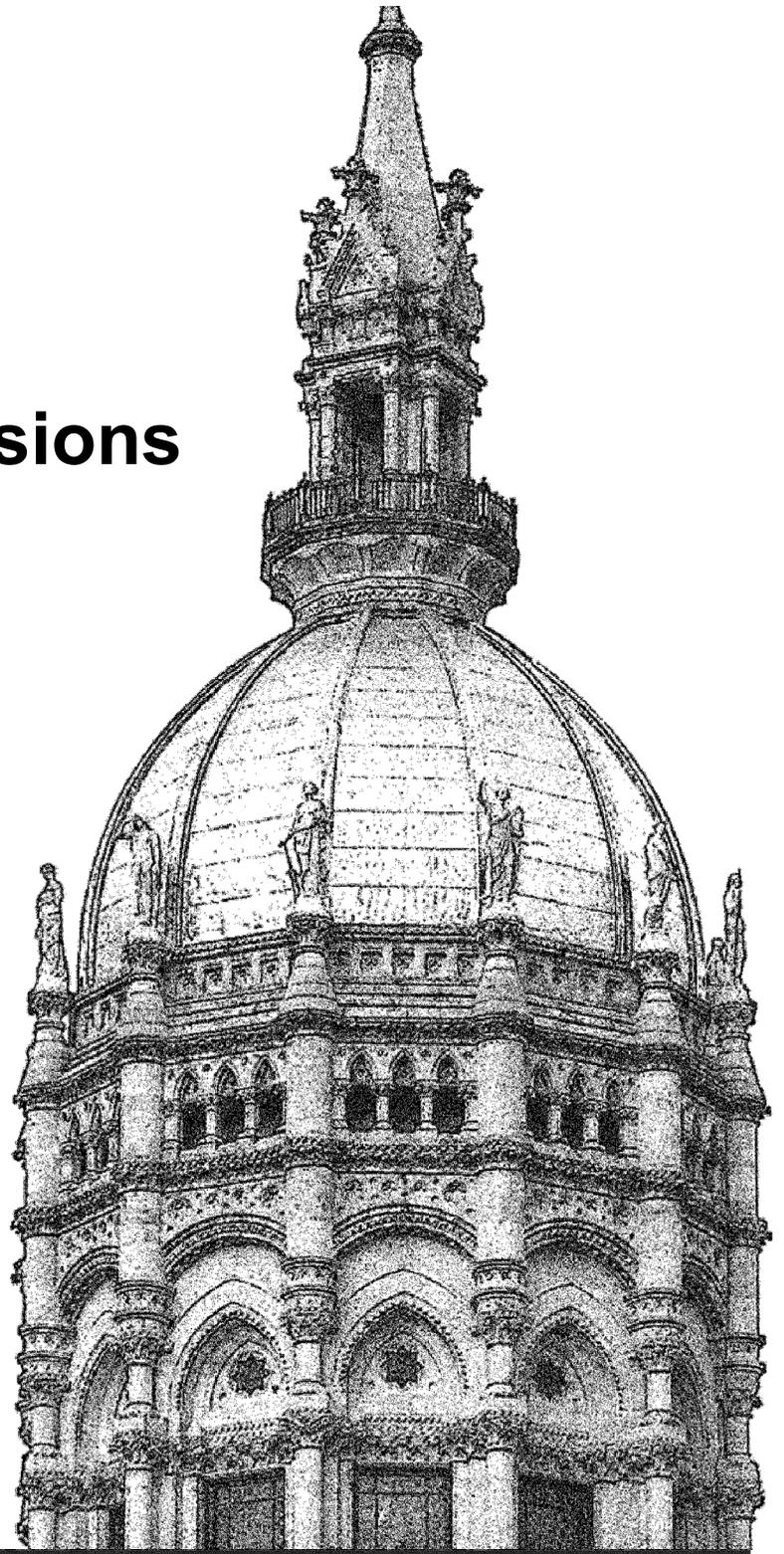


Scope of Practice Determination for Health Care Professions

DECEMBER 2009



PRI

**Legislative Program Review and
Investigations Committee**

Connecticut General Assembly

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the Senate, the Senate minority leader, the speaker of the house, and the House minority leader each appoint three members.

2008-2009 Committee Members

Senate

John A. Kissel
Co-Chair
Donald J. DeFronzo
John W. Fonfara
Scott L. Frantz
Anthony Guglielmo
Andrew M. Maynard

House

Mary M. Mushinsky
Co-Chair
Vincent J. Candelora
Mary Ann Carson
Marilyn Giuliano
Brendan Sharkey
Diana S. Urban

Committee Staff

Carrie Vibert, Director
Catherine M. Conlin, Chief Analyst
Jill Jensen, Chief Analyst
Brian R. Beisel, Principal Analyst
Michelle Castillo, Principal Analyst
Maryellen Duffy, Principal Analyst
Miriam P. Kluger, Principal Analyst
Scott M. Simoneau, Principal Analyst
Janelle Stevens, Associate Analyst
Michelle Riordan-Nold, Associate Analyst
Eric Michael Gray, Legislative Analyst II
Bonnine T. Labbadia, Executive Secretary

Project Staff

Brian Beisel

STATE CAPITOL ROOM 506
Email: pri@cga.ct.gov

HARTFORD, CT 06106

(860) 240-0300

www.cga.ct.gov/pri/index.asp

LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

**Scope of Practice Determination
for Health Care Professions**

DECEMBER 2009

[Blank Page]

Table of Contents

SCOPE OF PRACTICE DETERMINATION FOR HEALTH CARE PROFESSIONS

EXECUTIVE SUMMARY	i
INTRODUCTION	1
Study Focus.....	1
Methodology	1
Report Organization.....	2
I. BACKGROUND	5
History of Scopes of Practice in Connecticut	5
Health Care Professions Regulated by Scope of Practice Laws	6
II. SCOPE OF PRACTICE DETERMINATION PROCESS	9
Stakeholders.....	9
Process Changes	11
State Oversight of Scopes of Practice	15
Department of Public Health	15
Professional Boards and Commissions	17
III. OTHER STATES	21
Arizona	21
Hawaii.....	23
Iowa	23
Minnesota	25
New Mexico	25
Oregon	26
Texas.....	27
Virginia.....	28
New England States.....	29
National Model Practice Acts.....	32
Nurse Licensure Compact	32

Table of Contents

IV. FINDINGS and RECOMMENDATIONS..... 33

- Guideline Questions..... 33
- Scope of Practice Legislation 35
- Selected Professions..... 36
- Outputs and Outcomes..... 49
- Stakeholders..... 52
- Department of Public Health 57
- Best Practices 57
- Recommendations..... 61
- Scope of Practice and Current Health Care Reform 66

APPENDICES

- A. Licensed Health Professions Scope of Practice Profiles
- B. DPH Quality Factors for Practitioner Groups Regarding Scopes of Practice
- C. Declaratory Rulings for Health Care Professions
- D. Connecticut Nursing Board: Scope of Practice Decision Model
- E. Program Review Committee Staff Data Base: Data Elements
- F. Sample Collaborative Practice Agreements
- G. Overview of Nurse Practitioner Scopes of Practice in United States
- H. Program Review Committee: Public Health Committee Survey
- I. Program Review Committee Proposed Scope of Practice Process: Timeline
- J. Agency Response

Executive Summary

Scope of Practice Determination for Health Care Professions

Health care providers in Connecticut must be licensed by the state to practice their professions. Licensing requirements generally include meeting certain education, experience, and competency standards. “Scope of practice” is the term for the procedures, actions, and processes that a health care practitioner, once licensed, is permitted to perform.¹ In Connecticut, scopes of practice for licensed health care professions are established in state statute, as are the underlying licensing requirements.

Defining scopes of practice for health care professions in statute provides the state with public policy control over the range of services licensed health care professions may provide. Legislative interest, however, has been raised about whether the state’s process for creating and modifying scopes of practice for health care professions via the legislative process is the most useful and effective process or, if not, whether the scope of practice development process should be revised in any way. Moreover, often scope of practice issues before the legislature are technical in nature and require considerable background knowledge before lawmakers can make truly informed policy decisions. Even with such information, legislators may not feel adequately prepared to make fully informed decisions involving complex scope of practice issues based on their experiences.

The program review committee initiated this study in May 2009. The 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. The study specifically examined 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.

As the education, training, and technology within health care professions advance and become more sophisticated, and practitioners become more competent as a result, scopes of practice may need to be amended to reflect those changes (along with the corresponding licensing requirements). In Connecticut, for example, as the training and education for nurse practitioners and physician assistants progressed over time, their scopes of practice changed to the point where the two professions currently perform many responsibilities previously reserved for medical doctors. Similarly, the practice scopes for other professions such as dental hygienists and podiatrists expanded over time as a result of increased education and training, allowing the professions to practice a wider range of duties. This is not to suggest that certain health care professions should or will assume the full range of responsibilities historically reserved for other

¹ See: “Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety,” Federation of State Medical Boards, p. 19, which more broadly defines scope of practice as the “definition of the rules, the regulations, and the 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.”

professions, but as the education, training, experience, and overall competency of practitioners expand, so can their scopes of practice.

Although potential benefits may result from expanding existing health professions' scopes of practice, or introducing new ones, such as increased access to health care by consumers, any expansion must balance potential benefits with protecting public safety and the overall quality of care – two key components of governmental regulation. A change in a profession's scope of practice viewed as a benefit by one profession may be seen by others as a risk to public safety or access to care, or interpreted as an infringement on the business of another profession. As such, it would seem that scope of practice changes should be based on sound information and careful consideration by policymakers, with particular attention to how a scope change would affect the professions seeking the change, other health care professions, and the broader health care system.

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 changes.

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 (including provider competency), access to health 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 some public health committee members was that overall, there is difficulty fully evaluating scope of practice information when it involves complex medical topics, based on members' 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 some other states. Combined with information collected from stakeholders, the program review committee 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. A few national documents provide guidelines for states to use when determining practice scopes. Although Connecticut's process incorporates some of those guidelines, it is difficult to provide a full assessment of 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 the differences between professions over scope of practices issues were acutely protracted, the professions turned to a neutral mediator to help resolve their differences. The general consensus among some of the stakeholders involved in the mediation process was that it 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 mostly point to no severe deficiencies in the outcomes of the scope development process. What raises questions, however, is the information collected through interviews with various stakeholders, including public health committee members. This information 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, the committee's recommendations provided below 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;
- 2) create a process whereby knowledgeable, objective professionals in the relevant 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 best practices, 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, positive starting point from which scope of practice issues can be considered and policy decisions made.

RECOMMENDATIONS

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 five 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 as include 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.**
- **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.**

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.”² The process to determine scopes of practice in Connecticut is the legislative process. 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

The program review committee’s study focused on the *process* used in Connecticut to develop scopes of practice for health care professions and how the state reconciles differences when scope of practice issues arise.³ The study examined whether changes to the process are necessary to make it more useful to legislators and other stakeholders when making scope of practice decisions.

Specific areas identified for review by the committee included evaluating whether a different model, or changes to the state’s current model, for determining and amending scopes of practice for health professions would enhance the process, and assessing the potential impact of a new or revised scope of practice process on the organization, resources, and coordination of the state’s regulatory entities responsible for overseeing health care professions. The study did not examine whether changes to the existing scopes of practice of any health care profession specified in statute are necessary, or how well the Department of Public Health (DPH) regulates health care professions.

Methodology

Various sources of information were used to prepare this report. At the outset of the study, committee staff met with the commissioner of the Department of Public Health, and also conducted in-depth interviews with DPH licensing program personnel and practitioner members of health care professional associations.⁴ State statutes and regulations and national literature were reviewed. A data base was developed tracking legislation for several professions through the scope of practice determination process. The actual process and outcomes of scope of practice

² *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards, 2005.

³ The term health care profession encompasses a broad range of professions. As used in this report, the term is defined as those professions licensed by the Department of Public Health that provide physical and mental health care-related services to Connecticut’s residents. A more detailed summary and profile of the health care-related professions covered in this study is provided in Appendix A of the report.

⁴ Fourteen professions accounting for two-thirds of the total number of licensed health care professionals in Connecticut as of June 2009.

legislation in Connecticut were examined for several health professions in order to compare what actually happens in this state with identifiable “best practices.” Information about scope of practice processes used in other states was also collected and 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. Committee 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. 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 scopes of practice issues and processes were discussed with a national scholar on scopes of practice for health care professions.

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

The state’s scope of practice process was analyzed 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 an in-depth knowledge of what has occurred at the public health committee level regarding scopes of practice. As a broad measure of the outputs and outcomes of the scope process, the current scope of practice for a specific profession was compared with the scopes used in all other states for that 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.

Report Organization

Chapter I of the report provides background information on the history of Connecticut’s practice acts for health care professions. Chapter II is an overview of the state’s current process for developing and amending scopes of practice for health care professions, as well as a description of the state’s regulatory entities responsible for overseeing health care professions governed by scopes of practice. This chapter also examines the roles of nongovernmental entities (e.g., professional associations) in the scope of practice development process. Chapter III describes models used by several other states to establish or modify scopes of practice. Chapter IV provides the committee’s overall findings and recommendations, which are organized according to: 1) guideline questions; 2) scope of practice legislation analysis; 3) process outcomes; 4) stakeholders; 5) public health department; 6) other states; 7) best practices; and 8) current health care reform initiatives. The following appendices are included in the report:

- Appendix A: Summary and profile of the health care professions for which legislatively-defined scopes of practice exist in statute and are included in this study.
- Appendix B: List of questions the public health department uses to collect information during discussions about proposed scope of practice changes.
- Appendix C: Declaratory rulings made by health care professional boards in Connecticut since 1985.
- Appendix D: Matrix used by the state Board of Nursing Examiners to help guide the board in determining whether a provider is not working within a profession's scope of practice.
- Appendix E: Data elements contained in the committee staff's data base regarding scope of practice legislation.
- Appendix F: Examples of written collaborative agreements between Advanced Practice Registered Nurses (APRNs) and physicians.
- Appendix G: 50-state comparison of the scopes of practice for APRNs.
- Appendix H: Copy of the survey committee staff sent to public health committee members.
- Appendix I: Proposed scope of practice process timeline.
- Appendix J: Agency Response

[Blank Page]

Background

History of Scopes of Practice in Connecticut

In Connecticut, scopes of practice for licensed health care professions (i.e., what they are allowed to do) are established in state statute, as are the underlying licensing requirements. Scopes of practice for the various health care professions are often included within what are referred to as practice acts, comprehensive statutes that set out any number of provisions related to the individual health care profession in question. Such provisions may include, in addition to the scope of practice, procedures to discipline licensed providers, requirements for liability insurance, and requirements for professional boards. Practice acts in Connecticut for some professions specifically use the term “scope of practice” within the act, while others set out the permissible authority of the profession without specifically referring to “scope of practice.” Across the country, state practice acts share similar contours, yet their detail and operation vary widely among states.⁵

States have the authority to regulate health care professions via Article X of the federal constitution, which provides that all powers not explicitly reserved to the federal government or pre-empted by federal law are states’ rights. From this, regulation of health care professions is conducted at the state level. State legislatures have the authority to enact laws related to health care practice and then delegate the enforcement of those laws to a state regulatory agency, board, or commission.

Other activities can affect the parameters within which health care providers may practice. As with any statute, questions of interpretation arise about what a scope of practice does or does not allow a practitioner to do. For professions with separate professional boards handling license enforcement, those boards may make declaratory rulings on their own initiative or upon a filing. These rulings do not have the force of law, and may be appealed to the superior court. Also, attorney general opinions may be sought on scope of practice questions, which are more advisory than binding.

In Connecticut, health care professions have developed over time, and so have their statutory scopes of practice. In 1893, the legislature established professional practice parameters for physicians through the practice act for medicine and surgery. The law required that: “No person... shall for compensation, gain, or reward, received or expected, treat, operate, or prescribe for any injury, deformity, ailment, or disease, actual or imaginary, of another person, nor practice surgery or midwifery, unless or until he has obtained a certificate of registration...”⁶ The act further required that anyone wishing to be registered to practice medicine or surgery in Connecticut must successfully complete an examination developed by a committee of physicians

⁵ *State Practice Acts of Licensed Health Professions: Scope of Practice*, DePaul Journal of Health Care Law, James W. Hilliard and Marjorie E. Johnson, Fall 2004, p.247.

⁶ Connecticut Public Acts Summary, Chapter CLVIII, *An Act Concerning the Practice of Medicine, Surgery, and Midwifery*, Substitute for House Bill 186, 1893.

appointed by the State Board of Health in existence at that time. State registration, and thus the ability to legally practice medicine, would only be provided upon successful completion of the exam.

The state's original physician practice act gave the profession an unrestricted scope of practice in the field of medicine and surgery, which continues to exist. This law served as the basis for formal practice acts in Connecticut. It is within the context of the unrestricted scope of practice for physicians and surgeons that other health care professions are generally judged when wanting either to establish or expand their scopes of practice.

As the education, training, experience, and overall competence of health care practitioners have advanced over time, the distinctions between many health care professions in terms of their abilities to perform particular health care procedures have lessened or been eliminated. At the same time, health care professions in Connecticut have resisted the expansion of other professions' scopes of practice when they view such expansion as an encroachment on their own scope of practice, which often equates to an infringement on their livelihoods. It is within this dynamic that most health care professions have had to work to develop and evolve their particular scopes of practice in Connecticut.

The degree of specificity of Connecticut's scopes of practice also differs among health care professions. For example, while the statutory scope of practice language for physicians and surgeons is broad in terms of the parameters within which the profession is allowed to practice; the statutory language for optometrists details in much more specificity exactly what an optometrist may and may not do within the practice of optometry. Some view the level of specificity as the direct result of the "first in time, first in right" paradigm of the physicians' practice act.⁷

The process of what some professions consider as having to "carve out" their individual scopes of practice from the physicians' practice act, in particular, but from other professions as well, has led to increased contention across professions over time. The result for the legislature has been an ever-growing set of complex scope of practice issues to consider and resolve. With these issues often come very diverse positions and conflicting information, which policymakers must absorb and sort through as they consider scope of practice matters within the legislative context. Connecticut, however, is not alone in this regard. Other state legislatures have been grappling with similar issues, and several states have tried to add an additional information gathering process than is generally used in the legislative process with the intent of: 1) better informing the legislative decision making process; and 2) obtaining objective information, advice, and recommendations from persons knowledgeable about health care professions.

Health Care Professions Regulated by Scope of Practice Laws

Since the original scope of practice was established for physicians over a century ago, scopes of practice have been created in statute for an additional 28 physical and mental health care professions within the scope of this study (see Appendix A for a detailed summary of each

⁷ *Closing the Gap Between Can and May in Health-Care Providers' Scope of Practice: A Primer for Policymakers*, Barbara J. Safriet, Yale Journal on Regulation, Summer 2002, p.331.

profession). Table I-1 shows the years when scopes of practice for individual health care professions regulated by DPH appeared in statute.

Table I-1. Scopes of Practice Established in CT Law: Dates of Origin		
Health Care Profession	Date of Original SOP	Statutory Cite
Medicine and Surgery	1893	Sec. 20-9
Optometry	1913	Sec. 20-127
Dental Hygienist	1915	Sec. 20-126l
Dentist	1915	Sec. 20-123
Podiatry	1915	Sec. 20-50*
Chiropractor	1917	Sec. 20-28
Natureopathy	1923	Sec. 20-34
Opticians	1935	Sec. 20-145
Nurse**	1939	Sec. 20-87a
Physical Therapy	1941	Sec. 20-66
Psychologist	1969	Sec. 20-187a
Speech and Language Pathologist and Audiologist	1973	Sec. 20-408
Paramedic	1977	Sec. 20-266jj
Occupational Therapist	1978	Sec. 20-74a
Occupational Therapy Assistant	1978	Sec. 20-74a
Marital and Family Therapist	1983	Sec. 20-195a
Nurse-Midwife***	1983	Sec. 20-86b
Clinical Social Worker	1985	Sec. 20-195m
Respiratory Care Practitioner	1986	Sec. 20-162n
Massage Therapist	1988	Sec. 20-206a
Physical Therapy Assistant	1989	Sec. 20-66
Radiographer and Radiologic Technologist	1993	Sec. 20-74bb
Dietitian-Nutritionist	1994	Sec. 20-206m
Acupuncturist	1995	Sec. 20-266aa
Alcohol and Drug Counselor	1997	Sec. 20-74s
Professional Counselor	1997	Sec. 20-195aa
Athletic Trainer	2000	Sec. 20-65f
Physician Assistant	2003	Sec. 20-12d
Perfusionist	2005	Sec. 20-162aa
* Also see: Sec. 20-54(b)		
** The profession of nursing has long been regulated in Connecticut, although nurses were dependent upon the supervision of a licensed physician or dentist according to their scope of practice. Public Act 75-166 changed the scope of practice for nurses allowing nurses to practice certain aspects of the profession independent of a physician/dentist's supervision. The act also made the distinction between "registered nurse" and "licensed practical nurse." Public Act 89-107 defined Advanced Practice Registered Nurse.		
*** Public Act 83-441 repealed certain statutes regulating midwives and established new state licensure for nurse-midwives, which included the scope of practice for nurse-midwives.		
Source: PRI staff analysis.		

As the table shows, scopes of practice for 10 professions were codified in statute prior to 1950. Since then, scopes of practice for another 19 health care professions have been legislatively defined.

Licensed providers under scopes of practice. According to the public health department, 130,280 health care professionals were licensed as of April 2009.⁸ Table I-2 lists

⁸ Health care practitioners accounted for almost two-thirds of the 197,307 professionals in all occupations licensed by DPH as of April 2009.

each licensed health care profession and the total number of licensees within the profession. Each license is connected to a scope of practice identified in Table I-1.

Table I-2. Health Care Professionals Licensed by Department of Public Health: As of April 2009		
Profession	Total Practitioners Licensed (n=130,280)	Percent of Total
Registered Nurse (RN)*	53,476	41.0%
Physician/Surgeon**	16,355	12.6%
Licensed Practical Nurse (LPN)	12,293	9.4%
Clinical Social Worker	5,082	3.9%
Physical Therapist	4,302	3.3%
Massage Therapist	4,027	3.1%
Radiographer	3,969	3.0%
Dental Hygienist	3,495	2.7%
Dentist***	3,331	2.6%
Advanced Practice Registered Nurse (APRN)	3,096	2.4%
Speech and Language Pathologist	2,320	1.8%
Paramedic	1,945	1.5%
Occupational Therapist	1,930	1.5%
Psychologist	1,769	1.4%
Respiratory Care Practitioner	1,671	1.3%
Physician Assistant	1,610	1.2%
Professional Counselor	1,578	1.2%
Chiropractor	1,019	0.8%
Alcohol and Drug Counselors****	1,002	0.8%
Marital and Family Therapist	954	0.7%
Optician	687	0.5%
Optometrist	662	0.5%
Dietitian/Nutritionist	657	0.5%
Occupational Therapy Assistant	615	0.5%
Physical Therapist Assistant	543	0.4%
Athletic Trainer	515	0.4%
Acupuncturist	319	0.2%
Podiatrist	310	0.2%
Audiologist	243	0.2%
Naturopathic Physician	235	0.2%
Licensed Nurse-Midwife	212	0.2%
Perfusionist	58	0.1%

Notes: The “physician/surgeon” category includes all medical doctors (e.g., general practitioners and specialists); Public Act 09-232 created a separate license (via a new practice act) for audiology, which was previously combined within the speech and language pathologist practice act.
 * Does not include licensed nurses who are retired: APRNs (26), LPNs (387), RNs (2,884).
 ** Includes 12 licensed Homeopathic Physicians
 ***Includes 132 dentists who have been granted the required permit (on top of a dental license) for administering conscious sedation and general anesthesia and 16 dentists who are permitted to use conscious sedation only.
 **** Includes 302 certified alcohol and drug counselors
 Source: PRI staff analysis of DPH data.

Registered nurses (RNs) accounted for 41 percent of the health care professionals licensed by DPH, the largest percentage of any licensed health care profession. Physicians/surgeons, as a group, were the next highest percentage of licensees, with just under 13 percent, followed by licensed practical nurses (LPNs) (9 percent), and clinical social workers (3 percent). Combined, these professions accounted for almost two-thirds of the licensed health care professionals in Connecticut as of April 2009.

Scope of Practice Determination Process

Given the diverse backgrounds and experiences lawmakers bring to the legislature and the breadth of policy issues they address, it is likely legislators are confronted with subjects of which they have limited or no prior knowledge. The amount of information needed to be processed regarding specific legislative matters and the divergent positions often taken by advocates on either side of an issue, add to the complexity of the legislative decision-making process.

Policy matters dealing with scopes of practice for health care professions are no different. In fact, some may argue that scope of practice issues involving health care professions can be among the most involved and time-consuming issues legislators perennially face. This may be particularly true for members of the public health committee, as the legislature's committee of cognizance with initial jurisdiction over matters involving the process to determine health care professions' scopes of practice.

Figure II-1 illustrates Connecticut's typical process for determining and modifying scopes of practice for health care professions, which is, simply put, the standard legislative process. At times, as discussed later in this chapter, the legislature has stepped outside the legislative process and established ad hoc committees of professionals and public members to deal with scope of practice issues and present recommendations to the legislature. In addition to ad hoc committees, the legislature recently required several health professions to use an independent arbiter to help resolve a scope of practice dispute. Although mediation is not a new dispute resolution concept, this was the first time the legislature required its use by health professions in dealing with a scope of practice issue.

Scopes of practice were first included in statute over a century ago, as discussed in Chapter I. For the past three decades, state law has required that any request for regulation of emerging health care professions or occupations⁹ first be received by the legislature's public health committee.¹⁰ 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."¹¹

Stakeholders

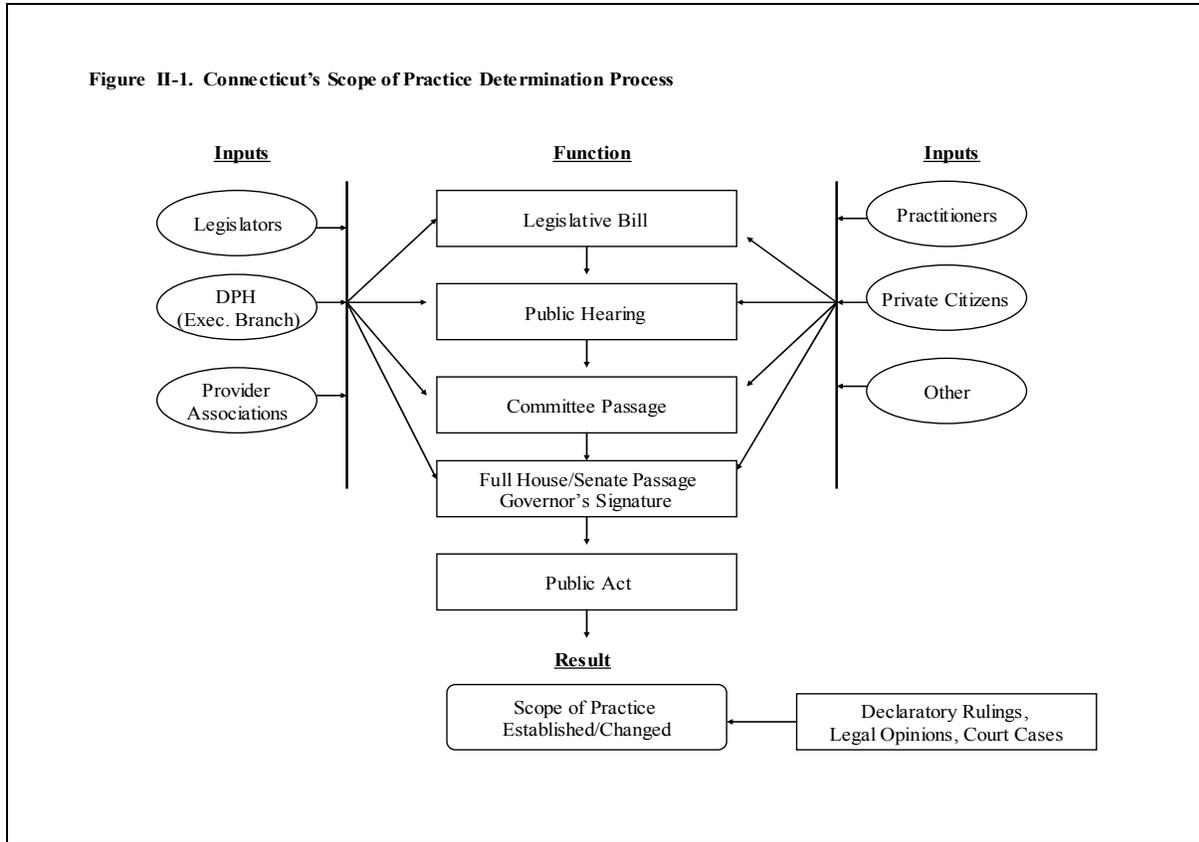
Input to determine the scopes of practice for health care professions can come from a range of stakeholders. Legislators, provider associations, individual practitioners, the public health department, professional boards and commissions, attorney general opinions, court cases, and the general public all may contribute to shaping a profession's scope of practice in some capacity.

⁹ 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.

¹⁰ C.G.S. Sec. 19a-16.

¹¹ Ibid.

Figure II-1. Connecticut's Scope of Practice Determination Process



Professional associations. The main impetus for developing a new scope of practice for a profession or amending a profession's current practice scope comes from professional associations. The associations typically recommend amending scopes of practice to ensure their professions' permissible activities be expanded to remain current with practitioners' increased education, training, and professional competencies. A broader scope of practice allowing professions to perform a wider range of services may also have other advantages, including higher job satisfaction and increased revenue for practitioners.

Department of Public Health. In addition to professional associations, the Department of Public Health contributes to the process by helping shape scopes of practice for health care professions. As noted later in this chapter, DPH testifies before the public health committee about proposed scope of practice legislation. Over the past decade, the department has also been meeting with professional groups more frequently to discuss potential scope of practice requests prior to legislative submission. DPH staff indicate, though, the department has no specific policy requiring any profession wanting changes in its scope of practice to first meet with the department to discuss the request. The health care professions interviewed by committee staff, however, believe it is a pragmatic strategy to meet with the department prior to coming to the legislature to request a scope of practice change. Meeting with the department early in the process allows professions to get a sense of DPH's concerns about any proposed scope change.

The public health department has said the agency is available to provide feedback to health care professions about whether or not a particular scope of practice change is implementable from a regulatory and resource perspective. The department also offers its guidance to any profession as to whether it believes the profession has adequate information to support the scope change, including if the requisite education and training exists among providers within the profession, or would need to be increased through a licensing change. DPH has a list of 13 questions it uses as a basis to collect information during its discussions with practitioner groups about proposed scope of practice changes or the development of a new scope of practice. The information helps DPH formulate its feedback and guidance to the groups. (Appendix B contains the list of questions.)

Other. Statutory scopes of practice are important, but not the only, determinants of professional practice authority, because like all other statutes, interpretation disputes may arise. Individual interpretations of practice scopes are affected by declaratory rulings,¹² attorney general legal opinions, and court decisions. Such interpretations can determine how health care professionals practice within individual states, including Connecticut. For example, a practice act with a relatively narrow scope of practice can be balanced by an attorney general's lenient application of the statutes.¹³

Another factor for consideration when determining scopes of practice is model practice acts developed by national associations. Some national associations have created model practice acts as guidelines for the range of services their member professionals have the educational and professional ability to perform. The acts are developed to help states with the scope of practice decision-making process and to standardize scopes of practice across states. Examples of professions with national model practice acts include the American Association of Physician Assistants and the American Dietetic Association.¹⁴

Process Changes

What is seen as advancement and evolution in the scope of practice for one profession may often be viewed as encroachment on the scope of practice of another profession. One profession may argue that any increased expertise on the part of providers within that profession should allow those providers to practice within a broader practice scope and changes to the profession's practice scope should occur. At the same time, another profession's practice scope may already allow it to perform the function(s) another profession is trying to acquire and will typically view the requested change as an infringement on its scope of practice.¹⁵ Although professions may use a

¹² Declaratory rulings are made by professional boards when boards are asked to provide their interpretation of whether or not a certain practice is within a profession's particular scope of practice. Declaratory rulings do not hold the force of law, but provide guidance to health care practitioners. Declaratory rulings are part of the state's Uniform Administrative Procedure Act (C.G.S. Sec. 4-166 et seq.)

¹³ *Promising Scopes of Practice Models for Health Professions*, Catherine Dower, JD, Sharon Christian, JD and Edward O'Neil, PhD, MPA, FAAN, Center for the Health Professions, University of California, San Francisco, 2007, p. 10.

¹⁴ See: <http://www.aapa.org/advocacy-and-practice-resources/state-government-and-licensing/issues/scope-of-practice/490>; <http://www.eatright.org/ada/files/ScopeofPractice.pdf>, accessed August 21, 2009.

¹⁵ Examples include: giving dental hygienists the ability to provide local anesthesia, which only dentists could administer (changed per Public Act 05-213); and allowing physical therapists the ability to receive patients without a physician's referral, even though physicians claimed physical therapists would be making medical diagnoses without the proper medical background (changed per Public Act 06-125).

myriad of arguments against other professions' attempts to expand scopes of practice, the reasons for opposing scope changes generally include increased risk to public safety, a decrease in access to health care provided by competent professionals, or lack of proper education or training on part of practitioners within the profession wanting the scope change. It is at this stage that friction often occurs between professions around changing a scope of practice and the issue ends up before the legislature for resolution.¹⁶

Because Connecticut's process to establish or modify scopes of practice for health care professions rests with the state legislature as the final decision maker, the fundamental framework for determining scopes of practice – the legislative process – has not changed over time. The legislature has, on occasion, directed that additional information about scope of practice changes be collected prior to the legislative process through alternative methods (e.g., an ad hoc committee and on one occasion, an arbitrator). The Department of Public Health also notes that it has become more involved over the past decade in trying to bring opposing professions together outside of the legislative environment to gain mutual resolution to scopes of practice differences between professions.

Ad hoc study committees and mediation. Several attempts have recently been made by the legislature and the public health department to facilitate resolution of scope of practice disputes outside the realm of the legislative process. Chief among those efforts were to help settle disputes between dentists and oral and maxillofacial surgeons, and podiatrists and orthopedic surgeons.

Dentists/Oral Surgeons. A scope of practice issue between dentists and oral and maxillofacial surgeons about the appropriate definition of dentistry and the permitted scope of oral surgery for dentists came before the legislature in 2004. The change sought would have permitted dentists to practice certain types of surgery, a change opposed by oral maxillofacial surgeons based on the respective professions' scopes of practice.

The issue was initially presented in a petition filed with DPH in 2002 by oral and maxillofacial surgeons claiming dentists were practicing outside their scope of practice by performing oral surgery, a practice reserved for oral surgeons. A subsequent declaratory ruling by the State Dental Commission sided with the surgeons.¹⁷ The state dental association appealed the commission's ruling in superior court. Before the court ruled on the lawsuit, however, the legislature passed Special Act 04-7. The act required the public health department to establish an ad hoc committee for the broader purpose of examining and evaluating possible statutory changes that would improve: 1) access to oral health care, particularly by persons underinsured, uninsured, or on Medicaid; and 2) the quality of oral health care. Part of the ad hoc committee's focus was to examine statutory changes to address the issue of whether dentists should be allowed by their scope of practice to perform oral surgery.

Special Act 04-7 required the DPH commissioner to appoint the members of the ad hoc committee. Membership included a DPH representative, dentists, a maxillofacial surgeon, dental hygienists, and a representative from a college or university offering a program for dental

¹⁶ Some states have attempted to address scope of practice changes using various methods outside of the legislative forum. Examples of models used by several states are discussed in Chapter III.

¹⁷ State Dental Commission, Declaratory Ruling, June 8, 2004 (subsequently withdrawn November 28, 2005).

assistants. Commissioners from the Departments of Public Health and Social Services were ex-officio members, and committee membership could be expanded by the public health commissioner. A report detailing the results of the committee's examination along with recommendations for statutory changes was due to the legislature's public health committee by the end of 2004.¹⁸

Knowing that nothing in state law precluded the public health department from using mediation to reach a compromise between health care professions involved in a scope of practice dispute, the DPH commissioner initiated the use of a third-party, neutral facilitator to help mediate an agreement between the dentists and the oral maxillofacial surgeons. The parties agreed to the process, a mediator was selected through the American Arbitration Association,¹⁹ and the issue between the dentists and oral surgeons was removed from the ad hoc committee's agenda prior to the committee's final report.

Ten mediation sessions were held between the parties over the course of seven months from June through December 2004.²⁰ One licensed practitioner was permitted to represent each of the parties. Prior to the start of mediation, specific ground rules were established to conduct the mediation, including allowing lobbyists and association representatives to attend some sessions, but only to silently observe.

Key among the department's concerns during the mediation was the issue of public health and safety and the adequacy of staff resources to implement any scope of practice changes (DPH said it did not have adequate resources to regulate a new licensure category,²¹ and any resolution to the issue found during mediation should consider this issue). The agreement reached by the parties through mediation was an impetus in the passage of Public Act 05-213. Among other changes, the act redefined the scope of practice for dentistry to allow oral surgery.

Podiatrists/Orthopedic Surgeons. A dispute in Connecticut involving podiatrists and orthopedic surgeons is another example of when the state has used alternative dispute resolution to resolve a scope of practice issue. The long-standing conflict between the two groups was over whether the ankle was considered part of the foot and, if so, could podiatrists perform ankle surgery. At hand was a 20-year old declaratory ruling by the Connecticut Board of Examiners for Podiatry stating that the ankle was part of the foot and podiatrists could treat the ankle, but only non-surgically. The state medical society appealed the declaratory ruling in court, and the superior

¹⁸ See: Department of Public Health, *Report to the General Assembly. An Act Concerning Oral Health Care*, December 1, 2004.

¹⁹ The American Arbitration Association provides neutral, third-party mediation and arbitration services through mediator and arbitrator panels to resolve interest and grievance conflicts among disputing parties and is a world-wide, not-for-profit organization.

²⁰ Committee membership included the following professional groups: CT State Medical Society, CT State Dental Commission; CT Society of Plastic and Reconstructive Surgery; CT Society of Eye Physicians; CT Society of Dermatologists; and CT Society of Oral Maxillofacial Surgeons.

²¹ *Mediating Regulatory Disputes Involving Licensed Professionals: The Connecticut Department of Public Health's Experiment*, Susan C. Zuckerman, *Dispute Resolution Journal*, February/April 2007.

court eventually sustained the medical society's appeal, noting the declaratory ruling was in contrast to the plain language of the statute regarding definition of the term "foot."²²

In 2005, podiatrists approached the legislature to get a change to their scope of scope to allow them to perform ankle surgery. By this time, according to DPH, at least 40 states had modified their practice acts allowing the practice. The legislature, with the passage of Special Act 05-12, created an ad hoc committee to study the issue (similar to the one created the previous year for the dentistry issue). The ad hoc committee was to assist the public health commissioner to examine and evaluate the definition of podiatry. The eight-member committee consisted of two DPH employees, three podiatrists, and three orthopedists, and was to make a report with its findings and recommendations to the legislature by February 1, 2006.²³

The department formed the committee, which was tasked with determining whether the podiatric scope of practice should include surgical and nonsurgical treatment of the ankle. In its final analysis, the committee reached agreement on issues regarding definition of the term "ankle" and acknowledged that podiatrists with appropriate education, training, and experience could be permitted to treat the ankle and perform ankle surgery, but the committee did not reach consensus on the appropriate level of training to perform ankle surgery.²⁴

In 2006, the legislature passed Public Act 06-160. The act called for DPH to convene a panel to "develop a protocol and recommendations permitting qualified practitioners of podiatric medicine...to perform surgery on the ankle." The panel was to at least include a representative from DPH, an arbitrator selected by DPH, and two representatives each of the CT Podiatric Medical Association and the CT Orthopedic Society. The act specified that the arbitrator direct and advise the panel in its deliberations, with the cost of the arbitrator split by the two associations. A report of the panel's findings and recommendations was due to the legislature by January 1, 2007.²⁵

The panel ultimately reached an agreement following sessions during late 2006. The groups found common ground on how to expand the scope of practice for podiatrists regarding surgical treatment of the ankle, with an overall emphasis on public safety through increased training. Using the compromise, the legislature passed Public Act 07-252 expanding the scope of practice for podiatrists.

The two scenarios described above are recent examples of how the legislature has directed the use of methods outside the traditional legislative process to reach agreement on scope of practice issues. A more dated example of how scopes of practice issues have been examined outside of the legislative process to find solutions includes a task force created in 1989, which studied expanding the practice scope of nurse practitioners to allow them to prescribe medication.

²² *Connecticut State Medical Society, et. al. v. Connecticut Board of Examiners in Podiatry and Department of Health Services, et. al.*, Connecticut Superior Court, District of New Haven, October 1987.

²³ See: Department of Public Health, *Report to the General Assembly, An Act Concerning the Practice of Podiatric Medicine*, February 2006.

²⁴ *Mediating Regulatory Disputes Involving Licensed Professionals: The Connecticut Department of Public Health's Experiment*, Susan C. Zuckerman, *Dispute Resolution Journal*, February/April 2007, p.5.

²⁵ See: Department of Public Health, *Report to the General Assembly, An Act Concerning Podiatric Medicine*, January 2007.

State Oversight of Scopes of Practice

The development of systematic processes for defining scopes of practice and credentialing health care professions is essential to ensuring the safety and quality of services delivered in the public health sector. These processes can help make certain that health care providers have the requisite educational background and training to deliver competent care in a safe manner. The processes also aim to ensure health care practitioners in any setting provide skilled services consistent with a strong public safety component. However, all the effort that goes into establishing scopes of practice and the accompanying license requirements through statute, with the main goal of protecting public health and safety, is diminished if administrative oversight does not exist to ensure the statutory requirements are being met.

Although an evaluation of the state's administrative oversight of licensed health care providers is not part of this study, a brief description of DPH's role in overseeing health care professions, and ensuring practitioners only provide the services they are legally permitted to provide within their scopes of practice, is provided below. In addition to DPH, various professional regulatory boards and commissions also have the responsibility of regulating health care practitioners, primarily through disciplinary actions against licensed providers.

Department of Public Health

Chief among the entities regulating health care professions in Connecticut is the Department of Public Health. The department is responsible for the regulatory oversight of various occupations impacting public health.

Specifically, the department's Practitioner Licensing and Investigation Section (PLIS) oversees the licensing and investigation functions of health care professions. As noted in Table II-1, over 130,000 health care professionals are licensed by DPH (the department oversees an additional 65,000 licensees in other non-health care-related professions, such as barbers and funeral home directors).

Organization and resources. The Practitioner Licensing and Inspection Section consists of two units: 1) the Practitioner Licensure and Certification Unit; and 2) the Practitioner Investigations Unit. Among the section's responsibilities is to receive, review, and make decisions on applications for licensure, certification, or registration, and administer licensure exams. Currently, 25 staff support the section's health profession licensing component, and an additional 18 staff members conduct investigations of complaints filed with the department about health care professionals.²⁶ The investigations unit does not conduct random investigations of providers and only investigates when a complaint is received. The unit works closely with the department's legal office to seek disciplinary action against regulated professions, also via any relevant professional boards and commissions.

Budget resources are not available by individual program function because of how the department's budgeting system is designed, meaning expenditure data for the health profession licensing/inspection function are not available. License revenue data are available, and show the

²⁶ The section is headed by a section chief who is supported by an administrative assistant; two additional staff members are responsible for the nurse aide registry.

health care practitioner licensing function has averaged approximately \$18.6 million in annual revenue from licensing fees over the past two fiscal years. The revenue is transferred to the state's general fund.

Scope of practice questions. The licensing unit answers general questions from providers regarding scopes of practice. The department notes that questions typically are about the type of services a profession can provide and whether certain procedures fall within its scope of practice and asking DPH to conduct investigations licensed providers believed to be working outside their scopes of practice. The unit will refer more detailed questions to the department's legal unit if they require an interpretation of the statutes or to the professional board if one exists for that profession.

License applications and issuance. All applications for health care profession licenses are received and processed by the licensing unit. Applicants are responsible for ensuring all required documentation is submitted. The unit does not routinely notify applicants of incomplete documentation.

Once all application materials are received, professional staff reviews the applications and make eligibility determinations. This review is supposed to be conducted within 10 business days from the time the application is deemed complete. The applicant is notified in writing of the results.

The process for issuing a license begins at the time an applicant is determined eligible for licensure. Licensees receive written verification of their license numbers and the effective dates of their licenses. Fees for initial licensure cover the administrative costs of determining eligibility, and are separate from application renewal fees. Licenses are renewed either every one or two years during the licensee's birth month.²⁷ The full renewal fee is required regardless of the date of initial licensure.

Licensure requirements. Licensure requirements are subject to change as a result of new legislation or regulations adopted by the department, where appropriate, in cooperation with various boards and commissions. Applicants must meet current licensure requirements and proof must be submitted. (See Appendix A for a description of the licensure requirements for health care professions licensed by DPH.)

License renewal. Licensees receive a renewal application approximately two months prior to the expiration of their current license, with a final notice of license renewal 30 days after expiration. There is no inactive status for licenses and a licensee needs to keep his/her license current. If a licensee wants to reactivate a license, the licensee needs to apply for and meet the requirements for reinstatement specific to the profession. State law provides licensees a 90-day grace period following expiration during which time a licensee may continue to practice and renew the license. If not renewed, the license becomes void and the licensee must apply for reinstatement.

²⁷ Licenses for occupational therapists are renewed every two years per C.G.S. Sec. 20-74h.

DPH is moving toward an on-line license renewal system. Currently, physicians/surgeons, dentists, and nurses (APRNs, RNs, and LPNs) have the ability to renew their licenses as part of the department's on-line system. DPH is working on adding other health care professions to the system.

Notification of changes. If there are changes to a profession's scope of practice, DPH sends out a notice of the changes when a provider renews his/her license. Health care providers also learn about practice act changes from other sources, including their professional associations.

Complaints and investigations. As noted above, license enforcement by DPH is complaint driven – meaning the department does not conduct random, on-site investigations to ensure health care providers are practicing within their legal scopes of practice. The department only becomes aware of practitioners working outside of their respective practice scopes when a complaint is received.

Complaint investigations include obtaining all relevant records, conducting interviews, and receiving opinions from experts. The unit forwards the complaint to the hearing phase of the process only upon the determination that sufficient evidence exists that a license holder has committed an infraction against licensure requirements; otherwise the case is dismissed. Cases warranting disciplinary action are referred to the department's legal office, which presents charges to the pertinent professional board for discipline. If no professional board exists, the department handles the disciplinary actions against a licensee.

Professional Boards and Commissions

Professional boards and commissions oversee certain health care-related professions.²⁸ The key duties of the professional boards are to oversee and make final decisions regarding licensure disciplinary matters (e.g., suspensions and revocations) and to issue declaratory rulings. Boards receive advice from the attorney general's office and from the DPH legal department.

Boards for health care professions have been in existence for decades. Boards previously were responsible for licensing responsibilities, until the function was transferred to the department effective in 1979, per Public Act 77-614, a major government reorganization act.

Not all health care professions regulated in Connecticut have professional boards, as shown in Table II-1. Of the 29 licensed health professions included within the scope of this study, 10 have professional boards, while the remaining 19 professions do not. The boards and commissions are within the Department of Public Health for administrative purposes.

²⁸ See C.G.S. Sec. 19a-14.

Table II-1. Professional Health Care Boards and Commissions	
Health Care Professions <i>With</i> Professional Board	Health Care Professions <i>Without</i> Professional Board
Chiropractic <i>State Board of Chiropractic Examiners</i>	Accupuncturists
Dentistry <i>State Dental Commission</i>	Athletic Training
Medicine/Surgery <i>Connecticut Medical Examining Board</i> <i>Connecticut Homeopathic Medical Examining Board</i>	Audiologists
	Clinical Social Workers
Natureopathy <i>State Board of Natureopathic Examiners</i>	Dental Hygienists
Nursing <i>State Board of Examiners for Nursing</i>	Dieticians/Nutritionists
Physical Therapists <i>Board of Examiners for Physical Therapists*</i>	Marital and Family Therapists
Podiatry <i>Board of Examiners in Podiatry</i>	Message Therapists
Psychologists <i>Board of Examiners for Psychology</i>	Midwifery
Opticians <i>Board of Examiners for Opticians</i>	Occupational Therapists**
Optometry <i>Board of Examiners for Optometrists</i>	Paramedics
	Perfusionists
	Professional Counselors
	Radiographers/Radiologic Technologists
	Respiratory Care Practitioners
	Speech and Language Pathologists
	Alcohol and Drug Counselors
*Includes physical therapy assistants; **Includes occupational therapy assistants Source: C.G.S. Sec. 19a-14.	

Declaratory rulings. State law specifies “any person may petition an agency, or an agency on its own motion initiate a proceeding, for a declaratory ruling as to the validity of any regulation, or the applicability to specified circumstance of a provision of the general statutes, a regulation, or a final decision on a matter within the jurisdiction of the agency”.²⁹ The statute further provides that the agency has discretion in deciding whether or not to hold a hearing prior to issuing a ruling. If the agency issues a ruling adverse to a party, the remedy for that aggrieved party is an action for declaratory judgment, as defined in statute. If the agency conducted a hearing for the

²⁹ Uniform Administrative Procedures Act, C.G.S., Sec. 4-176(a).

purpose of finding facts as a basis for its ruling, the remedy is an appeal to Superior Court. For the health care professions with professional boards, it is the board which will issue declaratory rulings; DPH issues rulings when no professional board exists. Table II-2 lists the professions with declaratory rulings issued by professional boards and DPH since 1985 that relate to scope of practice issues. (A more detailed description of the rulings is provided in Appendix C.)

Table II-2. Declaratory Rulings by Professions: 1987 to Present.		
Profession	Ruling Determined by Board or DPH	Number of Declaratory Rulings
Alcohol and Drug Counselors	DPH	1
Chiropractors	Board	3
Dentists	Board (Commission)	1
Dental Hygienists	DPH	1
Massage Therapy	DPH	1
Physicians	Board	1
Naturepaths	Board	1
Nursing	Board	4
Opticians	Board	1
Optometry	Board	1
Physical Therapy	Board	2
Podiatry	Board	3
Psychology	Board	1
Source of data: Public Health Hearing Office, Department of Public Health.		

Declaratory rulings do not hold the force of law, and thus parties are not mandated to follow a board’s decision. As discussed above, there have been times when a board’s ruling has been challenged by a party (e.g., dentists) arguing a board went beyond its authority in its declaratory ruling. Moreover, at least one board, the nursing board, has developed a formal framework (i.e., scope of practice decision tree) from which the board uses in its process of deciding whether a particular issue is or is not within the scope of practice for nursing if such questions arise (see Appendix D).

[Blank Page]

Other States

Part of the program review committee's purpose 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. The committee expressed specific interest in models used in two other states: Arizona and Iowa. In total, processes used in 14 states have been examined.

The processes used by other states to establish or amend scopes of practice for health care professions are generally comparable to Connecticut's. States typically use their respective legislative process to develop and revise scope of practice.

Changes to scopes of practice occur for many reasons, including increasing public safety and expanding access to quality care. At the same time, lawmakers' possible frustration over the complexity of the issues and the amount of time it takes to fully understand the positions taken by proponents and opponents of the changes are challenges within the legislative process when dealing with scopes of practice. Recognizing these challenges, several states have attempted to implement alternative ways of addressing scope of practice matters. Such methods have included working on scope issues outside of the legislative forum or within the legislative process, but according to specific criteria. The discussion below highlights these models.

Arizona

As a matter of public policy, Arizona law establishes two principles regarding scope of practice: first, regulation will not be imposed on any unregulated health profession except for the exclusive purpose of protecting the public interest; second, if the legislature finds that it is necessary to regulate a health profession not previously regulated by law, the least restrictive alternative method of regulation must be implemented.³⁰ Within this context, the state has outlined in statute a process to be followed when regulation of a health care profession is initially proposed or a request is made for changing an existing scope of practice.

Since 1985, Arizona state government has operated under statutorily-defined "sunrise" reporting requirements.³¹ 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.

Any report about the proposed regulation of a previously unregulated profession must contain the following elements (additional information is required within each of the elements listed):

³⁰ Arizona Revised Statutes Sec. 32-3103.

³¹ 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.

- a definition of the problem and why regulation is necessary;
- the efforts made to address the problem;
- the alternatives considered;
- the benefit to the public if regulation is granted;
- the extent to which regulation might harm the public;
- the maintenance of standards;
- a description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in Arizona, an estimate of the number of practitioners in each group and whether the groups represent different levels of practice; and
- the expected costs of regulation.

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. In which legislation will be proposed. The audit committee assigns the report to the appropriate committee of reference for review.³² The committee of reference decides whether to put forth legislation incorporating the scope of practice proposal.

Prior to proposing any scope of practice change in legislation, committee of reference members may use the sunrise reports 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 profession proposes to expand its scope of practice, copies of the report must be sent to the

³² 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.

regulatory board of the health profession for review and comment. If applicable, the board may make its own recommendations based on the report submitted by the health care profession seeking expansion to its scope of practice.

Hawaii

Over the course of several years, the Hawaii legislature considered multiple scopes of practice bills regarding psychologists' ability to prescribe drugs to their patients. In 1990, as a way to help resolve the ongoing issue between psychiatrists and psychologists, the legislature used the state's Center for Alternative Dispute Resolution as a neutral, third party facilitator to help resolve the dispute.³³ The Center was asked to put together a report with information legislators would need to help form their policy decisions, including arguments, data, citations, and sources from testimony offered by those for and against the issue. Three roundtable sessions over a six-month period were convened to elicit testimony and feedback from the public. Using the report submitted by the Center, the legislature determined that psychologists had not proven their competence to prescribe drugs and the proposed legislation failed. Although this model was used on an ad hoc basis, it provides an example of how scope of practice disputes can be addressed not entirely within the legislative process.

Iowa

In 1997, based on the recommendations of a task force on health regulation, the Iowa legislature created a pilot project establishing scope of practice review committees.³⁴ Scope of practice review committees were developed to assess proposed scope of practice changes based on objective, technical criteria outlined in regulation, including whether health professionals had the requisite knowledge, training, and experience to provide the care proposed in the scope of practice request.

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: 1) requests from practitioners seeking to become newly licensed health professionals or to establish their own licensure boards; 2) requests from health professionals seeking to expand or narrow the scope of practice of a health profession; and 3) unresolved administrative rulemaking disputes between licensure boards.

Specifically, the following standards were to be evaluated by the review committees: 1) the proposed scope of practice change does not pose a significant new danger to the public; 2) enacting the proposed change will benefit the health, safety, or welfare of the public; and 3) the public cannot be effectively protected by other more cost-effective means. The public health department director, the legislature, the state's administrative rules committee, and state licensure boards determined the topics subject to the scope of practice review. After their evaluations, the

³³ *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, Taskforce on Health Care Workforce Regulation: Pew Health Care Commission, October 1998, p. 31.

³⁴ 1997 Iowa Acts, Chapter 203 (Appropriations: Health and Human Rights, Sec. 6).

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.)

Each scope of practice review committee consisted of five members: one member representing the profession seeking a change in scope of practice, licensure, or a new board; one member of the health profession directly impacted by, or opposed to, the proposed change; one impartial health professional who was not directly or indirectly affected by the proposed change; and two impartial members of the general public. The law did not designate who the appointing authority was to select the committee members, although the department was required to adopt administrative rules to implement the law.

The original act establishing the review committee pilot program required the Iowa public health department to evaluate the pilot program to determine its overall benefit.³⁵ A survey of stakeholders was conducted after the program was implemented. Respondents mostly indicated the program had a positive impact on health care policy and should be continued. A second evaluation was conducted in 2002 and revealed a number of key benefits of the program, including the ability to: impartially review health care issues outside of the legislative process, establish a formal resolution mechanism for constituencies to debate their differences, and provide legitimate public policy recommendations to the legislature in a cost effective manner.

Between 1997 and 2002, the review committee pilot project reviewed four scopes of practice proposals, two each from the legislature and the state's public health department.³⁶ The pilot project was originally scheduled to terminate in 2000, but was extended several more times through legislation. The Iowa legislature ultimately repealed the review committee program in 2007.

Since the repeal of the pilot program, at least one attempt has been made to have an outside body objectively examine scope of practice changes. A bill before the Iowa legislature in 2009 would have required the state's public health department to create a scope of practice review committee to study the issue of state licensure for professional midwives.³⁷ The bill, which ultimately failed, would have required the department to submit a report to the legislature with its findings and recommendations by January 2010.

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.

³⁵ Ibid.

³⁶ *Scope of Practice Laws in Health Care: Exploring New Approaches for California*, Issue Brief, California Healthcare Foundation, March 2008.

³⁷ *An Act to Establish a Scope of Practice Review Committee Relating to the Licensing of Midwives*, House File 781, 2009.

Minnesota

Comparable to Arizona, Minnesota's state policy is not to regulate occupations, including health professions, unless required for the public safety and well being.³⁸ The following factors must be considered in evaluating whether an occupation shall be regulated: 1) whether the unregulated practice of an occupation may harm or endanger the health, safety, and welfare of citizens of the state and whether the potential for harm is recognizable and not remote; 2) whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability; 3) whether the citizens of this state are or may be effectively protected by other means; and 4) whether the overall cost effectiveness and economic impact would be positive for citizens of the state.

The state has a Council of Health Boards made up of members of individual licensure boards. The chair of a standing committee in either house of the legislature may request information from the council on proposals relating to the regulation of health occupations. The council follows specific guidelines to objectively review proposals for expanded scopes of practice. In addition, the Minnesota Health Occupation Program, within the state's public health department, is responsible for providing policy analysis, reviewing applications for regulation from unregulated human service occupations, and reporting its recommendations to the legislature.

For all bills proposing new or expanded health profession regulation, proponents must submit a report to the legislature and to the state's Council of Health Boards within 15 days of when the bill was introduced. The report is to address specific issues about the proposed change, including why the change is requested, what potential harm is there to the public if the change was implemented, the functions typically performed by members of health profession and whether they are identical or similar to those performed by another occupational group(s), education and experience requirements, and the expected impact of the proposed change on the supply of practitioners of the occupation and on the cost of services or goods provided by the occupation. Upon review of the information, the council makes a report to the legislature with its recommendations.

New Mexico

New Mexico has made several attempts in the last few years to modify its scope of practice determination process. In 2007, the New Mexico legislature passed a joint memorial to study the scope of practice determination process for health care providers.³⁹ The legislature was seeking a way to obtain objective information regarding proposals submitted to either establish or modify scopes of practice. The memorial states the primary factors when determining scopes of practice are: 1) promoting better consumer care; 2) improving consumers' access to care; and 3) recognizing that the scopes of practice for health professions inevitably overlap.

The memorial directed the legislature's Health and Human Service Committee to "study and recommend to the legislature an unbiased and fair process to review proposed changes to scopes of practice of licensed health professions and new health professions requesting licensure". As part of its review process, the committee heard testimony from a panel of presenters on the

³⁸ Minnesota State Statutes, Sec. 214.001

³⁹ New Mexico House Joint Memorial 71, 2007.

topic in September 2008. The panel, which offered recommendations, included the state medical society, dentists, dental hygienists, advanced practice nurses, nurses and chiropractors. The status of the recommendations at this point is unclear, and no official final report has been published.

In 2009, two bills were introduced in the New Mexico legislature proposing alternative methods for addressing scope of practice issues.⁴⁰ Although neither bill was ultimately passed, they each attempted to create coordinated procedures for reviewing scope of practice changes for health care professions.

The first initiative would have established a mechanism whereby any proposed scope of practice change would first be reviewed as part of a public hearing process by the pertinent professional licensing board. The board would then report its findings and recommendations to the legislature and governor. A second process would be established for reviewing proposals to create any new licensed health profession as part of a public hearing process by the state's licensure and regulation department (also with a report to the legislature and governor outlining the department's findings and recommendations). Both procedures were to examine: 1) the impact on public health and safety; 2) the economic impact on overall health care delivery; 3) whether the potential benefits of the proposal outweigh any potential harm; and 4) the extent to which the proposal would affect the availability, accessibility, delivery and quality of health care in the state.

The second bill would have required any state licensing board, upon receipt of request for a hearing concerning a proposed change in a scope of practice, to notify the state's Health Policy Commission of the request. The board would be required to collect data, assess whether the proposed change was in the profession's current scope of practice, and report its conclusions and recommendations to the commission. The policy commission would then appoint an ad-hoc review panel to review and make recommendations on the proposed change. The panel's process would be public, including hearing testimony from persons with particular knowledge in the field.

The review panel's assessment would determine any positive or negative impact the proposed change would have on public health and safety and the overall benefit of the change. An annual report on each scope of practice change request, including any legislative recommendations by the review panel, would be required.

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.

⁴⁰ Senate Bill 174 and House Bill 585, First Session, 2009.

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.⁴¹ 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.

Texas

In 1995, Texas established an Ad Hoc Committee on Collaborative Practice to provide a forum for nurses, physician assistants, and physicians to discuss scope of practice and delivery system issues and develop a collaborative legislative and regulatory agenda.⁴² The committee's work and recommendations from 1995-2003 have been credited for having helped resolve scope of practice issues among health care professions making passage of legislation an easier process.⁴³ For example, several health care professions, through mediation facilitated by the ad hoc committee, agreed to a moratorium on any further expansions in scope of practice through the 2007 legislative session, with some exceptions, which presumably gave the parties additional time to work on compromises.

⁴¹ See Oregon 2009 Laws Chapter 558.

⁴² Coalition for Nurses in Advanced Practice, http://www.cnaptexas.org/displaycommon.cfm?an=1&subarticlenbr=5#Ad_Hoc

⁴³ American College of Physicians, Texas Chapter, <http://www.taim.org/i4a/pages/index.cfm?pageid=768>, accessed August 12, 2009.

Since the dissolution of the ad hoc committee, several attempts have been made to revamp the state's scope of practice determination process. In 2007 (and previously in 2005), a bill came before the legislature to establish a procedure for objective and balanced review of proposed changes in the scope of practice of health professionals licensed in the state. The bill created the Health Professions Scope of Practice Review Commission to review scope requests and provide information to the legislature to use when considering scope of practice changes.⁴⁴

Although the legislation did not pass, it would have authorized the nine-member review commission to create subcommittees, workgroups, or advisory panels as needed to evaluate the proposed scope of practice change (legislators could direct the commission to analyze any scope change for health care professions). Reviews by the commission were to determine: 1) whether the proposed change could potentially harm the public health, safety, or welfare; 2) whether the proposed change will benefit the public health, safety, or welfare; 3) the extent to which the proposed change would affect the availability, accessibility, delivery, and quality of health care in this state; and 4) the quality and quantity of the training provided by health care professional degree curricula and postgraduate training programs for health care professionals in active practice with regard to the increased scope of practice proposed. As part of its review process, the commission was required to collect public testimony, analyze practices in other states, assess any statutory changes needed to implement the change, and identify the overall effects of the change.

The commission was to report its findings and recommendations on a biennial basis. The bill further authorized the commission to perform ongoing research on scope of practice issues and provide any other assistance to the legislature regarding scope of practice changes.

Virginia

The Virginia Board of Health Professions is an 18-member board with representatives from each of the state's 13 health regulatory boards and five citizen members from across the state. One of the board's chief responsibilities is to examine scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts.⁴⁵

The legislature has directed the board to issue reports on scope of practice matters on specific occasions. For example, in 2000, the board evaluated the appropriate level of regulation for certified occupational therapy assistants within the state. As part of its analysis, the board: 1) surveyed all states that regulated occupational therapists, showing aggregate numbers of complaints, disciplinary actions, and malpractice claims over a two-year period; 2) surveyed occupational therapists in the state to collect information on supervision and delegation patterns or a variety of activities; and 3) held a public hearing on the topic. Based on the board's findings, the legislature decided no additional regulatory oversight was necessary at that time.⁴⁶

⁴⁴ See: H.B. 2706 (2005) and HB 3950 (2007).

⁴⁵ Code of Virginia, Sec. 54.1-2510

⁴⁶ *Promising Scopes of Practice Models for Health Professions*, Catherine Dower, JD, Sharon Christian, JD and Edward O'Neil, PhD, MPA, FAAN, Center for the Health Professions, University of California, San Francisco, 2007.

New England States

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

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 moved 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.

In 2007, the state implemented Vermont Act 71, implemented. The act required the public health commissioner and the Board of Nursing to establish a work group to study and make recommendations on the advisability of eliminating the requirement for an advance practice nurse to work in a collaborative practice with a licensed physician. The goal of the taskforce was to evaluate whether advance practice nurses might serve a greater role as primary care providers who provide essential chronic care management.

The work group's membership was to include a representative of the Vermont Nurse Practitioner Association and a representative of the medical practice board. The group was required to make its recommendations in a report to the legislature and the commission on health care reform by January 15, 2008.

The taskforce considered the following criteria in making its recommendations:⁴⁷

- public safety and protection;
- challenges and barriers to providers of necessary APRN care;
- cost;
- access to primary care and the relationship to the Vermont Blueprint for Health Care;
- potential effects of increased APRN independent practice; and
- assuring continued collaboration.

Ultimately, a majority of the taskforce recommended the Vermont Nursing Board eliminate its requirement for APRNs to have written/signed collaborative agreements with physicians.

Summary of findings: other states. The 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.*

⁴⁷ Taskforce on Advanced Practice Registered Nurses as Primary Care Providers (Act 71), Final Report, January 15, 2008.

National Model Practice Acts

Several professions have moved toward nationally uniform scopes of practice through the development of model practice acts, as discussed earlier. The model acts, usually created by professional associations, are designed in part to provide a framework for state legislatures to consider when establishing or expanding scopes of practice for professions within their own state. The Pew Commission Taskforce on Health Care Workforce Regulation noted in its report that states might look to these models when considering standardizing their own statutory and regulatory scope of practice language as a way for providing more uniform scopes of practice across states.⁴⁸ The taskforce also recommended in another report that Congress should establish a national policy advisory body to research, develop, and public national scopes of practice and continuing competency standards for states to implement.⁴⁹

Nurse Licensure Compact

The National Council of State Boards of Nursing developed the Nurse Licensure Compact in 1996. Viewed as an example of helping bridge non-uniformity of practice acts across states, the compact allows a nurse to have one license (in the nurse's state of residency) and to practice in other states, as long as that individual acknowledges that he or she is subject to each state's practice laws and discipline permits. As of July 2008, 23 states have signed on to the compact, including the New England states of New Hampshire and Rhode Island, and agreement from one other state is pending.⁵⁰ A similar compact was developed for APRNs in 2000. Like the Nurse Licensure Compact, the APRN Compact offers states a mechanism for mutually recognizing APRN licenses. Although no date has been set for the implementation of the APRN Compact, Iowa, Texas, and Utah have passed laws to join the compact.⁵¹

⁴⁸ *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, Report of the Taskforce on Health Care Workforce Regulation, Pew Health Professions Commission, December 1995, p.3.

⁴⁹ *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, Taskforce on Health Care Workforce Regulation, October 1998, pp. 11, 27, and 29..

⁵⁰ National Council of State Boards of Nursing, <https://www.ncsbn.org/158.htm>

⁵¹ Ibid.

Findings and Recommendations

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 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.

Debates among health care professions over scopes of practice occur and can be contentious, long-lasting, and influenced by a variety of factors, including public safety, training and education, disparities in access to health care services, economic incentives, and consumer demand. Requests to create or modify a profession's scope of practice should be supported by a verifiable need for such action, with public safety as the ultimate goal when evaluating the rationale for such changes.⁵² Connecticut, through its statutory scopes of practice and licensing of health care providers, has determined as a matter of state policy that public safety and health care provided by competent professionals are key components of health care in the state.

Legislators often are presented with contrasting information when health care professions seek changes to scopes of practice. Although public safety should be the primary consideration when making scope of practice policy decisions, other factors are important to consider within the practice scope determination process. Moreover, since scopes of practice for health care professions are developed within the legislative process, other political factors undoubtedly affect the overall policy-making decision process.

The areas discussed in this chapter include: 1) guideline questions; 2) scope of practice legislation analysis; 3) process outcomes; 4) stakeholders; 5) public health department; 6) other states; 7) best practices; and 8) current health care reform initiatives. The overall goal of the findings and recommendations presented below is to create a more structured process for reviewing scope of practice requests based on more standardized criteria than currently exist.

Guideline Questions

Through a review of national literature, the requirements of other states, and the factors used by DPH to acquire information from health care professions when discussing changes to scopes of practice, a set of common questions that policymakers should consider when establishing or modifying any health profession scope of practice became evident. Answers to those questions could serve as a basis from which legislators obtain the necessary background

⁵² *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards, Section I, undated.

information they need to make informed policy decisions regarding scopes of practice. Any rationale for creating or modifying a scope of practice, however, must first support the ultimate goal of public safety. A sampling of the key questions by main category is provided in Table IV-1.

Table IV-1. Guideline Questions for Determining Scopes of Practice	
Public Safety	<ul style="list-style-type: none"> • Is public safety adequately protected by the proposed change? • Are practitioners sufficiently competent through their education and training to support the establishment or modification of a scope of practice? • 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? • Are there training programs within the profession for obtaining a new skill or technique and are there adequate standards in place for such programs?
Access to Care	<ul style="list-style-type: none"> • Will consumers’ access to care by qualified practitioners be increased or decreased by the scope change? • How will the new or proposed scope change benefit public health?
Regulatory Oversight	<ul style="list-style-type: none"> • Is there an established history of the profession requesting the change and is the profession currently/adequately regulated (i.e., licensed by state)? • Is there a national exam and/or national certification associated with the license as a measurement to assess competency?
Other States	<ul style="list-style-type: none"> • Do other states allow this practice and what are their requirements? • What has the history been in other states of professions with the same scope of practice regarding consumer complaints, malpractice claims, investigations, etc.?
General	<ul style="list-style-type: none"> • Has a problem been identified for why a scope change is necessary, including the extent to which consumers need and will benefit from practitioners with this scope of practice? • Has anything changed in the profession to warrant a change in the profession’s scope of practice? • What are the economic implications to the state, general public, and practitioners of implementing the proposed scope of practice? • Will the proposed change in scope affect other health care providers and in what way(s)? • How many practitioners will be impacted? • 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? • Has the profession discussed the proposal with individual legislators and/or representatives from the legislature, specifically, the members of the Public Health Committee?
<p>Sources: See: <i>Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations</i>. 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. Undated; <i>Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety</i>, Federation of State Medical Boards, Section I, undated; Arizona Revised Statutes Sec. 32-3103; and Department of Public Health Scope of Practice Criteria (see Appendix A of this report).</p>	

Scope of Practice Legislation

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 IV-2 shows the results.

Table IV-2. 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.*

The program review committee 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 the analysis is the frequency of scope of practice ideas brought to the public health committee members or the Department of Public Health 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).

Selected Professions: Public Hearing Testimony Analysis

Oral Testimony

Connecticut's scope of practice determination process was examined to determine how the process actually works and how it compares with identifiable "best practices." Specifically, the analysis is designed to gain insight into: 1) who presents the information to the legislature about scopes of practice; 2) the types of information presented; 3) the legislature's response to the information; and 4) the final outcomes of scope of practice legislation, with the overall intent of more fully understanding the scope of practice determination process.

Committee staff's analysis focused on the scope of practice legislation affecting three licensed health care professions from 1999-2009: 1) nurses (including advanced practice registered nurses); 2) physical therapists; and 3) and dental hygienists.⁵³ Within each of the three professions, data were collected about the professions' scope of practice legislation (e.g., bill content, public hearing testimony, final disposition of bill). The information was then reviewed in relation to the following key questions that should be asked, as noted above and outlined in Table IV-1: 1) impact on public safety; 2) consumers' access to competent care; and 3) whether other states have implemented the same or similar scope of practice changes.

⁵³ The professions selected accounted for 76,662 (59 percent) of the 130,280 licensed health care professionals in Connecticut as of April 2009 (see Table I-2). Further, each of the professions had at least two statutory changes to their scopes of practice over the period analyzed.

All the bills associated with each of the three professions for the period analyzed as the initial step in determining which bills pertained to scopes of practice were first identified. Once the bills containing scopes of practice changes were identified, data were collected from various parts of the scope of practice determination process with emphasis on the actions of the public health committee. Namely, public hearing testimony before the committee was reviewed as a way to gauge the scope determination process from the perspective of the committee. The information was then compiled into a data base to analyze in more depth the scope of practice issues for the three professions from a process perspective and to help quantify what is typically a qualitative process.

The data base contains 36 data elements pertaining to the legislative process as it relates to establishing or modifying scopes of practice (see Appendix E for a list of the data elements).⁵⁴ Chief among the information collected is: 1) how the change affects the profession’s scope of practice; 2) relevant information from public hearing testimony, including support for or opposition to the scope change, arguments presented to support both positions, and questions from policymakers as a way to provide context and support of the change; and 3) final disposition of the legislation. The data base provides a starting point for analyzing the state’s scope of practice determination process.

Table IV-3 gives an overview of the quantity of bills analyzed by different categories. A total of 186 bills pertaining to the three professions were either introduced by, or initially referred to, the public health committee over the period analyzed. Of those bills, 28 (15 percent) involved a scope of practice change, and 15 (54 percent) of those ultimately enacted.

Table IV-3. Scope of Practice Legislation: Selected Professions (1999-2009)			
Profession	Total # of Bills (Introduced/Initially Referred to Public Health Committee)	Bills with SOP Changes	Resulting Public Acts (Of the SOP bills)
Dental Hygienist	24	6 (25%)	3
Nursing	128	14 (11%)	10
Physical Therapy	34	8 (24%)	2
Totals	186	28 (15%)	15
Note: percents are rounded Source: PRI staff analysis.			

Nurses. Fourteen bills involving scope of practice issues for nurses came before the public health committee between 1999 and 2009. Ten (71 percent) of the bills were enacted into public acts.

The topics of the bills varied, ranging from removing the requirement for direct physician *supervision* of APRNs allowing them to function as appropriate within their scope of practice in *collaboration* with licensed physicians, to allowing APRNs to issue a written certificate

⁵⁴ The information used to develop the scope of practice data base was collected from public sources. Information from private meetings or conversations used by legislators to make scope of practice policy decisions is not available to committee staff and thus not included in the data base.

authorizing and directing a person be taken to a hospital for medical examination based on psychiatric disabilities. For purposes of this preliminary analysis, committee staff focused on the scope of practice bills involving advanced practice nurses and the APRN/physician collaborative agreement requirement. The issue at hand is the degree to which APRNs should be required by state law to formally collaborate with physicians. This topic is an oft-debated scope of practice issue for the nursing and physician professions over the past decade.

Public Act 99-168 permitted nurse practitioners to “collaborate” with physicians rather than “work under the direction of” a physician, as the law required at that time.⁵⁵ The act further required written protocols/agreements relative to the exercise of prescriptive authority regarding the level of controlled substances nurse practitioners may prescribe,⁵⁶ and for a method of physician review of patient outcomes, including the review of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures an APRN may prescribe, dispense and administer. The three subsequent bills before the public health committee on this topic attempted to eliminate the collaborative agreement requirements.⁵⁷

Public hearing participants and testimony. The public health committee conducted hearings on three of the four bills dealing with the collaborative agreement subject over the 11-year span examined. Only one of the bills was part of a multi-topic bill, while the others pertained only to the collaboration issue.

Oral public hearing testimony on the bills was primarily provided by various provider associations and practitioners (including nurses and physicians), as indicated in Table IV-4. The Department of Public Health also testified on several of the bills. As the table shows, different testimony was provided by different participants, depending on which side of the collaborative agreement issue they supported.

Table IV-4. Scope of Practice Legislation (Nursing): Public Hearing Participants			
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	N	N	N
Source: PRI staff analysis.			

Committee staff also reviewed the types of arguments used either to support or oppose the collaborative agreement scope of practice legislation. Information was collected about whether testimony was provided for any of three key factors: public safety, access to care, or practices used in other states. Table IV-5 shows testimony before the public health committee on this issue both to support and oppose the legislation included reference to public safety, access to care, and

⁵⁵ 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.

⁵⁶ Schedule II and III drugs per the U.S. Controlled Substances Act.

⁵⁷ See HB 7161 (2007), HB 5243 (2009), and HB 6674 (2009).

whether other states have similar requirements. The only factor not used in any of the testimony was the use of practices in other states to oppose the legislation.

Testimony from DPH was provided for the bills, although the department did not testify on original 1999 legislation allowing collaborative agreements. The department took a neutral position on each bill. In its testimony, DPH summarized the bills and suggested changes it would like to have considered should the bills move forward in the legislative process.

Table IV-5. Scope of Practice Legislation (Nursing): 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	N

Source: PRI staff analysis.

The primary arguments put forth by proponents (i.e., APRN professional groups and practitioners) of the bills focused on increased access to care and public safety. Specifically, by allowing APRNs to practice without a collaborative agreement, any potential problems associated with the agreements (e.g., what happens to an APRN’s patients if the collaborative agreement with her/his participating physician ceased) would be eliminated, thus maintaining the public’s access to competent, safe care. Testimony was also provided indicating APRNs would – within the normal practice of their profession – collaborate with physicians to maintain public safety, and a statutory requirement to do so was unnecessary. Opponents (i.e., physicians and physician associations), on the other hand, testified that public safety would be at risk because nurse practitioners are not as well-trained as physicians. As such, a requirement that APRNs collaborate with physicians and function under the required written agreement provisions should remain in place as a way to protect public safety. Testimony was also presented indicating no direct impact on access to care would result without the collaborative agreement requirement.

Public health committee members asked questions relevant to public safety, access to care, and other states, except in the case of the original bill in 1999, presumably because the bill’s basis was a compromise between the involved parties. The committee also queried those who testified about how the collaborative agreement process worked, and about the number of nurse practitioners having difficulty securing such agreements (the number was not known by those testifying, but anecdotal information suggested it was an issue).

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, one bill did not receive a public hearing before the public health committee, one was not voted on by the committee after a public hearing was held, and the other bill was reported out of the public health committee on a vote of 19-8, and made it to the house calendar, but was never taken up for a vote.

Physical therapists. Of the eight scopes of practice bills for physical therapists before the public health committee since 1999, seven involved changing the law to allow the profession to treat patients without a referral from a licensed physician (i.e., direct access). The committee held public hearings for five of those bills in 2000, 2001, 2003, 2005, and 2006.⁵⁸ The scope of practice law for physical therapists was ultimately changed by Public Act 06-125 to allow direct access to physical therapy services under most conditions.⁵⁹ Each of the bills was a single-topic bill; none was included in any broader bill covering multiple topics. For its analysis, committee staff analyzed the bills as a group given they covered the subject of direct access to physical therapy services.

Public hearing participants and testimony. Table IV-6 shows public hearing testimony was made by a cross-section of participants. Similar to nursing scope of practice bills, the bulk of the testimony was made by professional groups and practitioners (including physical therapists and physicians), who testified according to their respective positions on the bills. The public health department maintained a neutral position on the two bills for which it provided testimony. The department’s testimony summarized the provisions of the bills. Testimony was also made by a state representative who supported direct access and a patient who utilized physical therapy services.

Table IV-6. Scope of Practice Legislation (Physical Therapists): Public Hearing Participants			
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	N	N
*DPH provided testimony for two of the five bills. Source: PRI staff analysis.			

Table IV-7 shows whether testimony before the public health committee on this issue referenced public safety, access to care, or if other states have similar requirements. The general arguments in support of and opposition to the scope change were relatively consistent for the various bills: those in favor of direct access testified that the overall education and training of physical therapists is sufficient to support the change, public safety would be maintained, consumers would have quicker access to care, and other states allow the practice. Those opposing the bills generally testified that allowing direct access to physical therapy services without a physician’s referral would result in physical therapists making medical diagnoses, which only licensed physicians are properly trained to make. Moreover, testimony was provided that making direct comparisons with other states is not appropriate because of the various limitations many states place on the practice of direct access.

⁵⁸ Public hearing transcripts were not available for HB 6453 (2003) due to a blank hearing tape; only written testimony was available for analysis.

⁵⁹ A physician’s referral is required for any person seeking physical therapy services if the treatment requires a Grade V spinal manipulation or involves a worker’s compensation injury.

According to hearing testimony, public health committee members asked specific questions about public safety issues and practices used in other states. Program review staff did not find any questioning from committee members about the impact the scope of practice change would have on consumers’ access to care. The various public health committees hearing the bills were more focused in their questions regarding public safety and other states.

Table IV-7 Scope of Practice Legislation (Physical Therapists): 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
Source: PRI staff analysis.		

Outcome of bills. In 2000 and 2003, two bills did not garner enough votes to pass the public health committee. In 2001 and 2005, two of the bills made it to the house, but were not voted on. Ultimately, in 2006, Public Act 06-125 was passed.

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

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.

Public hearing participants and testimony. The public health committee held hearings for four of the five bills dealing with the scope of practice for dental hygienists. Only one of the bills was a single-topic bill and not included in broader bills covering non-scope related topics.

Table IV-8 shows who participated in the public hearings and the positions taken on the practice scope legislation. Testimony was provided by a cross-section of groups and individuals, including professional associations, individual practitioners (e.g., dental hygienists and dentists), DPH, and other parties (e.g., university representatives, dental hygiene students). The public health department testified both in support of and opposition to several of the bills. The department favored the bill to allow dental hygienists to administer local anesthesia. This change in practice scope was included in the bill resulting from the ad hoc committee established in 2005 to examine increasing consumers’ access to dental care, discussed above. The department testified

against the bill to create an advanced dental hygiene practitioner, mainly because of the additional resources necessary for the department to implement the change. And the department noted in neutral testimony that expanding the types of facilities in which dental hygienists could practice independent of a dentist was a technical change.

Table IV-8. Scope of Practice Legislation (Dental Hygienists): Public Hearing Participants			
Participant	Provided Testimony For Bill	Provided Testimony Against Bill	Provided Neutral Testimony
Provider Associations	Y	Y	Y
Practitioners	Y	Y	N
DPH	Y	Y	Y
Other	Y	N	N
Source: PRI staff analysis.			

Table IV-9 highlights whether testimony on the dental hygienist practice scope legislation was based on any of the three key factors either to support or oppose any of the bills. In general, the testimony in support of the bills referenced: increased access to care, particularly for underserved consumers; lower costs; puts the state in line with the practices of other states; and better patient care. Opponents of the bills generally cited insufficient education and training requirements, increased costs, and no positive impact on access to care, as the main reasons for their opposition. Overall, public safety, access to care, and a comparison with other states were all used as part of testimony for and against the practice scope bills.

Table IV-9. 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
Source: PRI staff analysis.		

In contrast to the nurse and physical therapist bills, public health committee members were not as specific with their questions during the public hearing process. No questions centered on the public safety aspect of the bills, and few questions focused on the practices of other states. Committee members did raise questions for several of the bills about access to care.

Outcome of bills. As noted above, three bills became public acts in 1999, 2005, and 2009. One bill in 2003 did not receive a public hearing. The remaining two bills failed either at with the public health committee (2009) or on the house calendar (2007).

Summary

- Most of the testimony received by the public health committee addressed three key factors that should be examined as part of the scope of practice

determination process: public safety, access to competent care by consumers, and practices used by other states. Although various public health committees asked questions pertaining to these factors, members were ultimately faced with contrasting testimony from which to base their committee vote decisions (which is not uncommon in the legislative process) and questions were not uniformly asked.

- The written or oral testimony offered by the Department of Public Health on various practice scope bills could be classified as neutral, given the department did not take a formal stand on the bills; the department offered testimony for most of the bills reviewed, but not all.
- Most of the underlying topics of the scope of practice legislation reviewed by program review committee staff came before the public health committee several times over the period analyzed.

Written Testimony

Committee staff examined the written testimony for scope of practice bills for the same three professions within the same time period as the oral testimony. 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. Written public hearing testimony for the bills containing scope of practice changes for advanced practice registered nurses, particularly regarding the collaborative agreement requirement was evaluated. APRNs are required to collaborate with physicians and must have a written collaborative agreement with a physician to prescribe certain drugs.

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 IV-11, 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 IV-11. 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 IV-12 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 IV-12. Scope of Practice Legislation (APRNs): Key Factors Addressed		
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.

Upon additional review of public hearing transcripts, 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.⁶⁰

Written testimony. Table IV-13 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 IV-13. 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 IV-14 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 IV-14. 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.		

⁶⁰ 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 IV-15 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 IV-15. 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 IV-16 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 IV-16. Scope of Practice Legislation (Dental Hygienists): 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	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. Although it is difficult to fully quantify public hearing testimony and public health committee members' reaction to it, several conclusions are made based on committee staff's 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.⁶¹ 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. Program review 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 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 IV-2, 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, the committee 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 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*

⁶¹ 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.

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 an indicator 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.⁶² 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 prescribe⁶³ and required a method of physician review of patient outcomes⁶⁴ (see Appendix F 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.⁶⁵

Table IV-17 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 G 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 physicians 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 (excluding Connecticut) require written practice protocols between APRNs and physicians. Under the category "authority to practice," APRNs in 44 states, including Connecticut, have explicit

⁶² 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.

⁶³ Schedule II and III drugs per the U.S. Controlled Substances Act.

⁶⁴ This is to include a review of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures an APRN may prescribe, dispense and administer.

⁶⁵ See HB 7161 (2007), HB 5243 (2009), and HB 6674 (2009).

statutory authority to make diagnoses.⁶⁶ 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 IV-17. 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 that *Connecticut's process to determine practice scope policies for APRNs has produced a scope of practice that is comparable with scopes in many other states.*

This scope of practice issue is used 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 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

⁶⁶ 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.

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. DPH data on the numbers of complaints made against licensed health care professions were examined 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.⁶⁷ 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.

The number of complaints were compared 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? This could infer 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 IV-18 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 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

⁶⁷ 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.

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 IV-18. 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.⁶⁸ Staff also interviewed six current and former leaders of the public health committee, in addition to obtaining members' opinions of the process through a program review 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.
- 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.

⁶⁸ Based on DPH licensing statistics as of June 2009.

- 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 information on the scope of practice determination process to be gathered from a cross-section of public health committee members (see Appendix H 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). The response rate is somewhat low, and thus no conclusive findings or recommendations may be based 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 interest of the program review committee was 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, survey results also indicate economic factors motivate requests to change scopes of practice. Based on interviews and survey results, the committee 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.⁶⁹

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

⁶⁹ 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.

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 the pertinent scope of practice questions (discussed earlier) are positive. The questions serve as a solid foundation to collect information and are in accordance with current best practices (see Appendix B 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. The analysis presented above also does not point to any significant deficiencies within the process in broad terms. What raises questions, are the opinions of the many stakeholders and public health committee members interviewed during the committee study 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, *the committee 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.*

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.⁷⁰

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*⁷¹ (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”).⁷² 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

⁷⁰ *Demystifying Occupational and Professional Regulation*, Kara Schmitt and Benjamin Shimberg, Council on Licensure, Enforcement and Regulation, 1996.

⁷¹ *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.

⁷² *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards, 2005.

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 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.

The committee 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. The committee is unaware of any other state using mediation as part of its scope of practice determination process.

Recommendations

Although the findings based on the 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 during the study through 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.

The committee'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. (Appendix I provides a schematic of the proposed scope of practice process, including timelines.)

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 five 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 as include 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 occupations⁷³ 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."^{74/75} 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. The program review committee'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.⁷⁶

The committee 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

⁷³ 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.

⁷⁴ C.G.S. Sec. 19a-16.

⁷⁵ Ibid.

⁷⁶ 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.

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.”⁷⁷ The committee 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, the committee 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.**

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.

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.

⁷⁷ See https://www.fsbpt.org/ForFaculty/Newsletter/Vol5_No4/index.asp#ScopeOfPractice, accessed November 4, 2009.

As such, the committee 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. The committee 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. The committee 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.⁷⁸ Nationally, the U.S. Congress is working on legislative proposals that would overhaul health care.⁷⁹

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.

⁷⁸ 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 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 are either not insured or underinsured is to begin in 2012, and full implementation of the program is scheduled for 2014.

⁷⁹ 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

Acupuncturist	
<i>Scope of Practice</i>	Means the treating, by means of mechanical, thermal or electrical stimulation effected by the insertion of needles or by the application of heat, pressure or electrical stimulation at a point or combination of points on the surface of the body predetermined on the basis of the theory of physiological interrelationship of body organs with an associated point or combination of points for diseases, disorders and dysfunctions of the body for the purpose of achieving a therapeutic or prophylactic effect but shall not include the practice of physical therapy.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-206aa
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial Certificate: 2 years • Renewal Certificate: 2 years
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$200 • Renewal: \$250
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Completed sixty semester hours, or its equivalent, of post-secondary study in a properly accredited institution • Completed a course of study in acupuncture in a properly accredited program, which included a minimum of 1,350 hours of didactic and clinical training, 500 of which were clinical • Passed state exam • Completed a course in clean needle technique prescribed by the department. • Any person successfully completing the education, examination or training requirements of this section in a language other than English shall be deemed to have satisfied the requirement completed in that language. • Certain provisions exist for which licensure exempted <p>Renewal license</p> <ul style="list-style-type: none"> • Not referenced
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • An applicant for licensure as an acupuncturist by endorsement shall present satisfactory evidence of licensure or certification as a person entitled to perform similar services under a different designation, in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state and that there are no disciplinary actions or unresolved complaints pending.
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • No

Alcohol and Drug Abuse Counselor	
<i>Scope of Practice</i>	The practice of alcohol and drug counseling means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or groups' interest, abilities, and needs as affected by alcohol and/or drug dependency problems.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-74s
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$190 • Renewal: \$190
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Master's degree from accredited institution with a minimum of 18 graduate semester hours in counseling or counseling-related subjects, except that certification by the Certification Board, Inc. as a certified clinical supervisor may be substituted for degree requirement • Separate requirements exist for "certified alcohol and drug counselor" <p>Renewal license</p> <ul style="list-style-type: none"> • Earn at least 20 hours of continuing education each registration period related to individual's practice after first renewal
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • May issue alcohol and drug counselor licensure by endorsement of an out-of-state license provided the applicant holds a current, valid license in good standing in another state or territory of the United States and the state or territory of current licensure maintains licensing standards equal to or higher than Connecticut's requirements.
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes
<i>Other</i>	<ul style="list-style-type: none"> • Practice act does not apply to certain licensed health care professions, religious personnel, Department of Correction counselors, and certain substance abuse treatment groups (e.g., Alcohol Anonymous)

Athletic Trainer	
<i>Scope of Practice</i>	Athletic training means the application or provision, with the consent and under the direction of a health care provider, of (A) principles, methods and procedures of evaluation, prevention, treatment and rehabilitation of athletic injuries sustained by athletes, (B) appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, light massage, water, electric stimulation, sound, exercise and exercise equipment, (C) the organization and administration of athletic training programs, and (D) education and counseling to athletes, coaches, medical personnel and athletic communities in the area of the prevention and care of athletic injuries.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-65f
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$190 • Renewal: \$200
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Bachelor's degree from an approved college/university • Athletic trainer certification by the Board of Certification, Inc. • 120-day temporary permit may be issued after completion of the required course of study in athletic training if board certification not obtained <p>Renewal license</p> <ul style="list-style-type: none"> • Not indicated
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Evidence of licensure/certification and practicing in accordance with requirements from state with substantially similar or higher requirements than Connecticut's; no disciplinary action or pending unresolved complaint against applicant
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Chiropractic	
<i>Scope of Practice</i>	<ul style="list-style-type: none"> • Practice of the healing arts consisting of the science of adjustment, manipulation, and treatment of the human body in which the vertebral, and other malpositioned articulations and structures, that may interfere with the normal generational, transmission, and expression of nerve impulse between the brain, organs, and tissue cells of the body which may be the cause of disease, are adjusted, manipulated, or treated. • Upon successful completion of licensure requirements, any chiropractor may practice chiropractic but not prescribe or administer any medicine or drug, except vitamins, or perform any surgery or practice obstetrics or osteopathy. • Examine, analyze, diagnose the human living body and its diseases and use x-rays and other methods for diagnosis and analysis • Treat the body using manual, mechanical, electrical, or natural methods, including acupuncture or by use of physical means (e.g., light, heat, water) • Administer first aid, and incidental to the care of the sick, advise and instruct patients in all matter pertaining to hygiene and sanitary measures as taught and approved by recognized chiropractic schools and colleges • May not prescribe for or administer to any person any medicine or drug included in the materia medica, except vitamins, or perform any surgery or practice obstetrics or osteopathy
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-24 and Sec. 20-28
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$565 • Renewal: \$565
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • High school diploma and graduated from an accredited and approved college of chiropractic with degree of doctor of chiropractic • Pass state exam and completion of at least two years (60 semester hours) leading to a bachelor's degree • Graduated from a college of chiropractic accredited, at the time of graduation, by Council on Chiropractic Education; • Completed Parts I, II, III, IV, and the Physiotherapy examinations administered by the National Board of Chiropractic Examiners • Pass state exam (certain exemptions apply, including national board certified) <p>Renewal license</p> <ul style="list-style-type: none"> • 48 contact hours of a continuing education during CE monitoring period beginning in an odd-numbered year and consisting of two consecutive registration periods (1 contact hour=50 minutes of continuing ed. activity). CE programs must meet specific standards.

Chiropractic (cont.)	
<i>Professional Board</i>	<p><i>State Board of Chiropractic Examiners</i></p> <ul style="list-style-type: none"> • 7-member body appointed by governor (4 practicing chiropractors in state for at least 3 years; 3 public members) • Responsible for hearing and deciding matter concerning suspension/revocation of licensure, and impose sanctions where appropriate
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • May grant licensure without examination if currently practicing in another state have license requirements substantially similar to or higher than Connecticut's
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • Yes
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Clinical Social Worker	
<i>Scope of Practice</i>	Clinical social work means the application, by persons trained in social work, of established principles of psychosocial development, behavior, psychopathology, unconscious motivation, interpersonal relationships and environmental stress to the evaluation, assessment, diagnosis and treatment of biopsychosocial dysfunction, disability and impairment, including mental, emotional, behavioral, developmental and addictive disorders, of individuals, couples, families or groups. Clinical social work includes, but is not limited to, counseling, psychotherapy, behavior modification and mental health consultation.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Secs. 20-195m
<i>Length of License</i>	<ul style="list-style-type: none"> • One year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$315 • Renewal: \$190
<i>Licensure Requirements</i>	<ul style="list-style-type: none"> • Pay application fee of \$250 • Hold a doctorate or master's degree from a social work program accredited by the Council on Social Work Education or, if educated outside the United States or its territories, have completed an educational program deemed equivalent by said council; • Have three thousand hours post-master's social work experience which shall include not less than one hundred hours of work under professional supervision by a licensed clinical or certified independent social worker; and • Pass clinical level examination of the American Association of State Social Work Boards or any other examination prescribed by the commissioner. • On and after October 1, 1995, any person certified as an independent social worker prior to October 1, 1995, shall be deemed licensed as a clinical social worker pursuant to this section, except a person certified as an independent social worker on and after October 1, 1990, shall not be deemed licensed as a clinical social worker pursuant to this chapter unless such person has passed the clinical level examination of the American Association of State Social Work Boards or any other examination prescribed by the commissioner. • The commissioner may grant a license by endorsement to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a clinical social worker in good standing in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state, and (2) has successfully completed the clinical level examination of the Association of Social Work Boards, or its successor organization. • The commissioner may issue a license without examination, prior to January 1, 1998, to any applicant who offers proof to the satisfaction of the commissioner that he met the certain requirements and was an employee of the federal government with not less than three thousand hours postmaster's social work exp. prior to October 1, 1986.

Clinical Social Worker	
	Renewal license <ul style="list-style-type: none"> • Complete 15 hours of continuing education during preceding registration period (one contact hour = minimum of fifty (50) minutes of continuing education activity)
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under the purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • License may be granted by endorsement to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a clinical social worker in good standing in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state, and (2) has successfully completed the clinical level examination of the Association of Social Work Boards, or its successor organization. No license shall be issued under this subsection to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint. Not referenced
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Dental Hygienists	
<i>Scope of Practice</i>	The practice of dental hygiene means the performance of educational, preventative, and therapeutic services, including: complete prophylaxis; removal of calcerous deposits; accretions and stains from supragingival and subgingival surfaces of the teeth by scaling, root planing and polishing; the application of pit and fissure sealants and topical solutions to exposed portions of the teeth; dental hygiene exams and the charting of oral conditions; dental hygiene assessments, treatment planning, and evaluation; the administration of local anesthesia according to specific statutory requirements; and collaboration in the implementation of oral health care regimen.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-126l
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$150 • Renewal: \$100
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Diploma or certificate from dental hygiene program (at least two academic years of higher education in an accredited program); foreign school conditions apply • Written exam by Joint Commission on National Dental Examinations or comparable national exam accepted in lieu of state practical exam; no person engaged as a dental hygienist or working as a licensed dental hygienist for at least two years or has dental license • Must practice under the general supervision of a license dentist <p>Renewal license</p> <ul style="list-style-type: none"> • Earn at least 16 credit hours of continuing education within proceeding two years (1 credit hour=50 minutes of continuing ed. activity). CE programs must meet specific standards.
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under the purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • No exam necessary if licensed in another state with substantially similar or higher requirements than Connecticut's
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • Yes
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Dentists	
<i>Scope of Practice</i>	The practice of dentistry or dental medicine is defined as the diagnosis, evaluation, prevention, or treatment by surgical or other means, of an injury, deformity, disease, or condition of the oral cavity or its contents, or the jaws or the associated structures of the jaws. The practice of dentistry does not include: 1) treatment of dermatologic diseases/disorders of the skin or face; 2) performance of microvascular free tissue transfer; 3) treatment of eye diseases/conditions; 4) ocular procedures; 5) performing cosmetic surgery or other cosmetic procedures other than those related to the oral cavity, its contents, or the jaws; 6) nasal or sinus surgery, other than that related to the oral cavity, its contents, or jaws. Licensed dentists with post-doctoral training may perform other specific procedures or practice specialty areas of dentistry.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-123
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$565 • Renewal: \$565
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Diploma (or other certificate) from dental school as deemed reputable by the State Dental Commission with consent of DPH; specific requirements exist for foreign-trained dentists • Successfully pass professional knowledge and skill exam administered by DPH; results of Joint Commission on National Dental Examinations may be accepted in lieu of state dental exam as will successful completion of at least one year of graduate dental training as a resident dentist in a program accredited by Commission on Dental Accreditation under certain circumstances. <p>Renewal license</p> <ul style="list-style-type: none"> • Earn at least 25 contact hours of specific continuing education every two years
<i>Professional Board</i>	<p><i>State Dental Commission</i></p> <p>9-member body appointed by governor according to specific guidelines; provides advice/assistance to DPH regarding regulations; hear/decide licensure disciplinary matters and adjudicate complaints</p>
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • State may issue license to dentists licensed from another state with substantially similar or higher requirements than Connecticut's
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • Yes
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes
<i>Other</i>	<ul style="list-style-type: none"> • State permit required if dentist uses general anesthesia or conscious sedation (\$160 annual renewal fee) or to participate in advanced dental education program conducted by a dental or medical school or approved hospital.

Dietician-Nutritionist	
<i>Scope of Practice</i>	Dietetics or nutrition practice means the integration and application of the principles derived from the sciences of nutrition, biochemistry, food, physiology, and behavioral and social sciences to provide nutrition services that include: (A) Nutrition assessment; (B) the establishment of priorities, goals, and objectives that meet nutrition needs; (C) the provision of nutrition counseling in health and disease; (D) the development, implementation and management of nutrition care plans; and (E) the evaluation and maintenance of appropriate standards of quality in food and nutrition. The term "dietetics or nutrition practice" does not include the administration of nutrition by any route other than oral administration and does not include the issuance of orders for laboratory or other diagnostic tests or orders intended to be implemented by any person licensed pursuant to statute. Nutrition assessment means the evaluation of the nutrition needs of individuals and groups based upon appropriate biochemical, physical, and dietary data to determine nutrient needs and recommend appropriate nutrition intake including enteral and parental nutrition. Nutrition counseling means advising and assisting individuals or groups on appropriate nutrition intake by integrating information from the nutrition assessment.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-206m
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial Certificate: 1 year • Renewal Certificate: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$190 • Renewal: \$190
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Applicants holding current certification as a Registered Dietitian by the Commission on Dietetic Registration (CDR) may obtain CT certification by submitting a completed, notarized application with photograph; or (2) such applicant has (A) successfully passed a written examination prescribed by the commissioner, and (B) received a master's degree or doctoral degree, from a properly accredited institution of higher education, with a major course of study focused primarily on human nutrition or dietetics and which included a minimum of thirty graduate semester credits, twenty-one of which are in not fewer than five of the following content areas: (i) Human nutrition or nutrition in the life cycle, (ii) nutrition biochemistry, (iii) nutrition assessment, (iv) food composition or food science, (v) health education or nutrition counseling, (vi) nutrition in health and disease, and (vii) community nutrition or public health nutrition; written verification of registration sent directly from CDR to DPH <p>Renewal license</p> <ul style="list-style-type: none"> • Fee
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Not indicated
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Marital and Family Therapists	
<i>Scope of Practice</i>	Marital and family therapy means the evaluation, assessment, counseling and management of emotional disorders, whether cognitive, affective or behavioral, within the context of marriage and family systems, through the professional application of individual psychotherapeutic and family-systems theories and techniques in the delivery of services to individuals, couples and families.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-195a
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$315 • Renewal: \$315
<i>Licensure Requirements</i>	<ul style="list-style-type: none"> • Passed state exam • Graduate degree in a program specializing in marital and family therapy from a regionally accredited college or university or an accredited postgraduate clinical training program approved by the Commission on Accreditation for Marriage and Family Therapy Education and recognized by the United States Department of Education • Completed a supervised practicum or internship with emphasis in marital and family therapy supervised by the program granting the requisite degree or by an accredited postgraduate clinical training program, approved by the Commission on Accreditation for Marriage and Family Therapy Education recognized by the United States Department of Education in which the student received a minimum of five hundred direct clinical hours that included one hundred hours of clinical supervision • Completed a minimum of twelve months of relevant postgraduate experience, including at least (A) one thousand hours of direct client contact offering marital and family therapy services subsequent to being awarded a master's degree or doctorate or subsequent to the training year specified in subdivision (2) of this subsection, and (B) one hundred hours of postgraduate clinical supervision provided by a licensed marital and family therapist who is not directly compensated by such applicant for providing such supervision <p>Renewal license</p> <ul style="list-style-type: none"> • Complete 15 hours of qualifying continuing education during every license renewal period
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under the purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Licensure may be granted without examination, subject to certain requirements, to any applicant who is currently licensed or certified in another state as a marital or marriage and family therapist on the basis of standards which, in the opinion of DPH, are substantially similar to or higher than those of this state.
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No

Marital and Family Therapists (cont.)

<i>Title Protection</i>	<ul style="list-style-type: none">• No
<i>Other</i>	No license as a marital and family therapist shall be required of a: <ul style="list-style-type: none">• student pursuing a course of study in an educational institution meeting the requirements of section 20-195c if such activities constitute a part of his supervised course of study;• faculty member within an institution of higher learning performing duties consistent with his position;• person holding a graduate degree in marriage and family therapy or a certificate of completion of a post-degree program for marriage and family therapy education, provided such activities and services constitute a part of his supervised work experience required for licensure; or• person licensed or certified in this state in a field other than marital and family therapy practicing within the scope of such license or certification.• person practicing marriage and family therapy in accordance with statute may advertise or present himself as practicing marriage and family therapy provided he clearly sets forth, in his advertisement or presentation, the type of license pursuant to which he is practicing.

Massage Therapist	
<i>Scope of Practice</i>	Massage therapy means the systematic and scientific manipulation and treatment of the soft tissues of the body, by use of pressure, friction, stroking, percussion, kneading, vibration by manual or mechanical means, range of motion and nonspecific stretching. Massage therapy may include the use of oil, ice, hot and cold packs, tub, shower, steam, dry heat, or cabinet baths, for the purpose of, but not limited to, maintaining good health and establishing and maintaining good physical and mental condition. Massage therapy does not encompass diagnosis, the prescribing of drugs or medicines, spinal or other joint manipulations, nor any service or procedure for which a license to practice medicine, chiropractic, natureopathy, physical therapy, or podiatry is required by law
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-206a
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 2 years • Renewal: 2 years
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$375 • Renewal: \$250
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Graduation from a properly accredited school of massage therapy offering a course of study of not less than five hundred (500) classroom hours (on-line instruction is not acceptable towards meeting the 500 classroom hours) <p>Renewal license</p> <ul style="list-style-type: none"> • 24 hours of qualifying continuing education every four years
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • License may be issued to an out-of-state applicant who submits evidence of either: 1) a current license to practice therapeutic massage from another state or jurisdiction; 2) documentation of practice for at least one year immediately preceding application; and 3) successful completion of the National Certification Examination for Therapeutic Massage and Bodywork; or 1) graduation from a school of massage therapy offering a course of study of not less than five hundred classroom hours, with the instructor present, and, at the time of the applicant's graduation, was either (i) accredited by an agency recognized by the United States Department of Education or by a state board of postsecondary technical trade and business schools, or (ii) accredited by the Commission on Massage Therapy Accreditation, and 2) successful completion of the National Certification Examination for Therapeutic Massage and Bodywork
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Medicine and Surgery (Physician/Homeopathic Physician)	
Scope of Practice	No person for compensation or reward shall diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease of another person nor practice surgery, until a license is obtained from the public health department and then only in the kind of practice or branch stated in the license (Homeopathic physician prescribes the single remedy in the minimum dose in potentized form, selected from the law of similars)
Statutory Reference	<ul style="list-style-type: none"> • C.G.S. Sec. 20-9
Length of License	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
Fees (initial/renewal)	<ul style="list-style-type: none"> • Initial: \$565 • Renewal: \$565
Licensure Requirements	<p>Initial license</p> <ul style="list-style-type: none"> • graduate from accredited medical school in US or Canada • graduate from accredited medical school outside US or Canada and receive degree of doctor of medicine, osteopathic medicine (or equivalent) and satisfy all pursuant CT educational regulations and requirements • successfully complete at least two years of progressive graduate medical training as a resident physician in an accredited program • pass state exam (certain exemptions apply, including national board certified) <p>Renewal license</p> <ul style="list-style-type: none"> • earn at least 50 contact hours of continuing education within proceeding two years (1 contact hour=50 minutes of continuing ed. activity). CE must meet specific criteria <p>Homeopathic physician (C.G.S. Sec 20-12n):</p> <ul style="list-style-type: none"> • obtain DPH license to practice medicine or surgery (except a graduate of any school or institution giving instruction in healing arts who is completing post-graduate medical training in homeopathy • successfully completed no less than 120 hours of post-graduate medical training in homeopathy under direct supervision of licensed homeopath physician consisting of 30 hours of theory and 90 hours of clinical practice
Oversight Board / Certifying Body	<p><i>State Medical Board</i></p> <ul style="list-style-type: none"> • 15-member body appointed by governor • Responsible for: hearing and deciding matters concerning license suspension and revocation; adjudicating complaints filed with board and issuing sanctions, and providing advice and consent to DPH regarding physician/surgeon examinations for licensure <p><i>Homeopathic Medical Examining Board</i></p> <ul style="list-style-type: none"> • 3 physicians/surgeons, 2 public members, appointed by governor • hear and decide matters concerning suspension or revocation of licensure; adjudicate complaints against practitioners; and impose sanctions where appropriate

Medicine and Surgery (cont.)

<p><i>Reciprocity with other states</i></p>	<p>CT requirements <i>do not</i> apply to:</p> <ul style="list-style-type: none"> • non-resident physicians employed in another state to render temporary assistance or to consult with any physician or surgeon licensed in Connecticut • non-resident physician or surgeon holding a current out-of-state license employed to offer care to suffering patients in CT provided the physician/surgeon may only practice in CT without a CT license no longer than 30 consecutive days • non-resident physician who consults 1) on an irregular basis with a licensed CT physician or 2) with a CT medical school for education or medical training purposes • any individual who provides services to a short-term acute care general hospital, licensed by DPH, pursuant to any arrangement provide the arrangement/agreement was entered into prior to February 1, 1996 and in effect as of October 1, 1996 <p>CT requirements <i>do</i> apply to:</p> <ul style="list-style-type: none"> • resident and non-resident physicians/surgeons whose practice includes providing diagnostic or treatment services (including primary diagnosis of pathology specimens, slides, or images) to in-state residents through electronic communications or interstate commerce • non-resident physicians providing official written reports of electronic transmissions of radiographic images through ongoing, regular, or contractual arrangement with physicians or patients in CT
<p><i>Liability Insurance Required for Licensure</i></p>	<ul style="list-style-type: none"> • Yes
<p><i>Title Protection</i></p>	<ul style="list-style-type: none"> • Not referenced

Midwifery	
<i>Scope of Practice</i>	Midwifery means the management of women's health needs, focusing primarily on family planning and gynecological needs of women, pregnancy, childbirth, the post-partum period, and the care of newborns, occurring with a health care team and in collaboration with qualified obstetrician-gynecologists. Each nurse-midwife shall provide patients with information, or referral, to other providers, when care requested is not within the nurse-midwife's scope of practice. Signs birth certificates for infants delivered by nurse-midwives. Nurse-midwifery must be consistent with standards of care established by the American College of Nurse-Midwives (ACNM). May make actual determination of and pronouncement of death under certain circumstances.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-86a and 20-86b
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$100 • Renewal: \$120
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • License required if applicant eligible for registered nurse license, holds/maintains current certification for ACNM, completed 30 hours of education in pharmacology for nurse-midwifery; no pending disciplinary action or unresolved complaints • Graduates of ACNM-approved programs may practice for up to 90 days without a license under certain circumstances <p>Renewal license</p> <ul style="list-style-type: none"> • Not indicated
<i>Professional Board</i>	<ul style="list-style-type: none"> • 3-member advisory body appointed by governor of licensed nurse-midwives must provide advice and assistance to DPH in the administration of nurse-midwife program. • DPH handles disciplinary matters
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Not indicated
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Natureopathy	
<i>Scope of Practice: General Description</i>	The practice of natureopathy means the science, art, and practice of healing by approved natural methods, and shall include: counseling and the practice of mechanical (e.g., articular, manipulation, physiotherapy) and natural sciences (e.g., dietetics, phytotherapy)
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-34
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$565 • Renewal: \$565
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • High school diploma • Graduated from a school of naturopathy approved by the Connecticut State Board of Naturopathic Examiners and Department of Public Health, with award of the Doctor of Naturopathy degree. • Successfully completed both the Basic Sciences (Part I) and Clinical Sciences Examination (Part II) of the Naturopathic Physician Licensing Examination At least 64 weeks in college or scientific school; • Successfully completed the Connecticut jurisprudence examination for naturopathic physician licensing <p>Renewal license</p> <ul style="list-style-type: none"> • 15 contact hours of a continuing education within proceeding year (1 contact hour=50 minutes of continuing ed. activity). CE programs must meet specific standards.
<i>Professional Board</i>	<p><i>State Board of Naturopathic Examiners</i></p> <ul style="list-style-type: none"> • 3-member body appointed by governor (2 practicing natureopathic in state and 1 public member) • Responsible for hearing/deciding matters of licensure suspension/revocation; adjudicate complaints against practitioners; impose appropriate sanctions
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Licensure may be granted to out-of-state licensed/certified natureopathic physician (or comparable) from state with substantially similar or higher requirements than Connecticut's.
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • Yes
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Nursing	
<i>Scope of Practice: General Description</i>	The practice of nursing means the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching; case finding and referral, collaborating in the implementation of the total health care regimen and executing medical regimen under the direction of a licensed physician or advance practical registered nurse. Advanced nursing practice means advanced level nursing practice that may be performed by an APRN by virtue of post-basic specialized education and experience; performs diagnoses and treatment; collaborates wit CT licensed physician; may prescribe, dispense, and administer medical therapeutics and corrective measures, including controlled substances; may request, sign for, receive, dispense drugs (profession samples only); specific conditions apply for APRNs assisting in surgery. RNs and APRNs may make determination and pronouncement of death of a patient under certain circumstances and must sign the death certificate within 24 hours. APRNs who are nationally certified nurse anesthetists have prescriptive authority within certain requirements. Licensed practical nurse (LPN) means performing selected tasks and sharing responsibility under the direction of an RN or APRN within the framework of nursing.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-87a
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$100/APRN; \$90/RN; \$75 LPN • Renewal: \$120/APRN; \$100/RN; \$60 LPN
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • State exam (RN, LPN) • To take state exam, need degree, diploma, certificate from approved nursing program at an accredited college/university (LPN certificate from approved nursing program); may issue 120-day license exemption to graduates who have yet to take exam • APRNs: 1) maintain RN license; 2) hold and maintain current certification as nurse practitioner, clinical nurse specialist or nurse anesthetist from one of several national certifying bodies certifying advanced practice nurses; 30 hours of education in pharmacology for advanced-nursing practice; master’s degree (if nationally certified past December 31, 1994 in nursing) <p>Renewal license</p> <ul style="list-style-type: none"> • Not indicated

Nursing (cont.)	
<i>Professional Board</i>	<p><i>State Board of Nursing Examiners</i> 12-member body appointed by governor, based on specific criteria; provides advice and consent to DPH on adopting regulations, approving nursing courses, and state nursing license exam; keep list of all nursing programs and training programs for LPNs approved by board and consult with nationally recognized accrediting agencies when approving schools; hear and decide licensure disciplinary matters and adjudicate complaints.</p>
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Appropriately licensed RN in another state may be exempt from taking CT licensure exam if licensing requirements from state substantially similar or higher requirements than Connecticut's.
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • APRN: Yes
<i>Title Protection</i>	<ul style="list-style-type: none"> • APRN, RN, LPN: Yes
<i>Other</i>	<p>Collaboration means a mutually agreed upon relationship between an APRN and a licensed physician who is educated and trained, or has relevant experience that is related to work of the APRN and addresses a reasonable and appropriate level of consultation and referral, patient coverage in the absence of the APRN, and methods to review patient outcomes and provide disclosure to the patient of the relationship. Relative to the exercise of prescriptive authority, collaboration between an APRN and a physician must be in writing and address the level of schedule II and III controlled substances that the APRN may prescribe and provide a method to review patient outcomes, including but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that the APRN may prescribe, dispense, and administer.</p>

Occupational Therapist	
<i>Scope of Practice</i>	Occupational therapy means the evaluation, planning and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities, or anticipated disfunction, using A) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual, B) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped, C) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance and treatment techniques for physical capabilities for work activities. Such techniques are applied in the treatment of individual patients or clients, in groups or through social systems.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-74a
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 2 year • Renewal: 2 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$200 • Renewal: \$200
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Bachelor's degree from educational program accredited by American Occupational Therapy Association (or a program deemed equivalent by DPH) • Satisfactorily completed at least 24 weeks of supervised field work experience at a recognized educational institution or approved training program • Pass state licensing exam; 120-day temporary permit may be issued to a graduate of an occupational therapy program who has not yet taken the state licensing exam <p>Renewal license</p> <ul style="list-style-type: none"> • Earn at least 12 continued competency units within proceeding two years
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under purview of DPH

Occupational Therapist (cont.)	
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • State may grant a license to an otherwise licensed occupational therapist from another state provided there is sufficient evidence presented to DPH, unless professional disciplinary action is pending or complaint unresolved
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes
<i>Other</i>	<ul style="list-style-type: none"> • Therapists licensed in another state may consult or teach in CT without a license for a maximum of up to 30 days per year

Optician	
<i>Scope of Practice</i>	One having a knowledge of optics and skilled in the technique of producing and reproducing ophthalmic lenses and kindred products and mounting the same to supporting materials and the fitting of the same to the eyes.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-145
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$200 • Renewal: \$200
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Hold an associates degree in ophthalmic dispensing approved by the Connecticut Board of Examiners for Opticians OR have completed at least 4 years and 8,000 hours of apprenticeship training under the supervision of a licensed optician. Apprenticeship training completed in Connecticut will be accepted provided the applicant was duly registered as an optician apprentice by the public health department • Successful completion of the following examinations: The American Board of Opticianry's National Opticianry Competency Examination and the National Contact Lens Examination, and state practical exam and jurisprudence exam <p>Renewal license</p> <ul style="list-style-type: none"> • Earn at least 7 contact hours of continuing education annually. CE programs must meet specific standards.
<i>Professional Board</i>	<p><i>Board of Examiners for Opticians</i></p> <ul style="list-style-type: none"> • 3-member board appointed by governor: 2 practicing, licensed opticians; 1 public member • Provides advice and assistance to DPH regarding development and enforcement of regulations; revokes/suspends licenses; adjudicates complaints filed against practitioners; imposes sanctions where appropriate
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Not indicated
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Optometry

<i>Scope of Practice:</i>	<ul style="list-style-type: none"> • Practice of Advanced Optometric Care means any one or more of the following practices and procedures: (A) measuring, examining, diagnosing, preventing, enhancing, managing or treating visual functions, defects of vision, muscular functions or anomalies, or other conditions or diseases of the visual system, the eye and ocular adnexae; (B) the prescribing, supplying, adjusting, fitting or adapting of ophthalmic devices and lenses, spectacles, prisms, orthoptic therapy, visual therapy, visual rehabilitation, oculomotor therapy, tinted lenses, filters, contact lenses, diagnosing, preventing, enhancing, managing, treating or relieving visual functions, defects of vision, muscular functions or anomalies, or diseases of the visual system, the eye and ocular adnexae; (C) the administration or prescription of any pharmaceutical agents related to the diagnosis and treatment of conditions and diseases of the eye and ocular adnexae, excluding nonemergency oral glaucoma agents but including controlled substances under schedules II, III, IV and V in accordance with statute, subject to certain limitations relating to quantities dispensed, performance or ordering of procedures or laboratory tests related to the diagnosis and treatment of conditions and diseases of the eye and ocular adnexae; these procedures include, but are not limited to, removal of superficial foreign bodies of the corneal epithelium that have not perforated bowman's membrane, ultrasound and topical, oral or injectable medication to counteract anaphylaxis or anaphylactic reaction; (D) the nonsurgical treatment of glaucoma; or (E) the use of punctal plugs. The practice of advanced optometric care does not include surgical treatment of glaucoma, treatment of ocular cancer, treatment of infectious diseases of the retina, diagnosis and treatment of systemic diseases, use of therapeutic lasers, use of injectable medications other than to counteract anaphylaxis or anaphylactic reaction, surgical procedures other than noninvasive procedures, use of general anesthesia, use of intravenous injections, procedures that require the cutting or opening of the globe, enucleation of the eye, extraocular muscle surgery or any invasive procedure performed on the human body other than noninvasive procedures performed on the eye or ocular adnexae. • Practice of Optometry means any one or more of the following practices and procedures: A) the examination of the human eye and the eyelid for the purpose of diagnosis, treatment excluding the lacrimal drainage system and lacrimal gland or referral for consultation, as authorized by this section or, where appropriate, referral to an ophthalmologist; B) the use of tests, instruments, devices, ocular agents-D, ocular agents-T and noninvasive procedures for the purpose of investigation, examination, diagnosis, treatment excluding the lacrimal drainage system and lacrimal gland, or correction, as authorized by this section, of visual defects, abnormal conditions or diseases of the human eye and eyelid; C) the prescription and application of ophthalmic lenses, prisms, filters, devices containing lenses or prisms or filters or any combination thereof, orthoptics, vision training, ocular agents-D for the purpose of diagnosing visual defects, abnormal conditions or diseases of the human eye and eyelid, ocular agents-T and noninvasive procedures for the purpose of correction, alleviation or treatment, as authorized by this section, of visual defects, abnormal conditions or diseases of the human eye and eyelid excluding the lacrimal drainage system, lacrimal gland and structures posterior to the iris but including the treatment of iritis; D) the examination of the human eye for purposes of prescribing, fitting or insertion of contact lenses to the human eye. The practice of optometry does not include the use of surgery, xray, photocoagulation or ionizing radiation, or the treatment of glaucoma.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-127

Optometry (cont.)	
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$565 • Renewal: \$375
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Graduated from an approved school of optometry • Graduated from a school or college of optometry accredited by the Council on Optometric Education of the American Optometric Association; and successfully completed Part I Basic Science, Part II Clinical Science and all three components of the Part III Patient Care and the Treatment and Management of Ocular Disease (TMOD) Examinations of the National Board of Examiners in Optometry • • Specific requirements exist for optometrists first licensed prior to April 1, 1985, if acquiring and using ocular agents-D topically in the practice of optometry and for optometrists first licensed prior to January 1, 1991, if acquiring, administering, dispensing, and prescribing ocular agents-T in the practice of optometry, and for the practice of advanced optometric care; may delegate the use or application of any ocular agent to an optometric assistant, optometric technician, or appropriately trained person as defined in statute may not delegate the authority to prescribe any ocular agent; post January 1, 2005, no initial license to engage in optometry will be issued unless applicant meets the requirements to practice advanced optometry care. <p>Renewal license</p> <ul style="list-style-type: none"> • Earn at least 14 contact hours of continuing education annually; no more than 4 hours may be in the content area of practice management
<i>Professional Board</i>	<p><i>Connecticut Board of Examiners for Optometrists</i></p> <ul style="list-style-type: none"> • 7-member body appointed by governor (4 licensed optometrists, 3 public members); offers advice and assistance to DPH to make and enforce regulations; revoke or suspend licenses for cause; adjudicate complaints/impose sanctions
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • May issue license to 1) competent practitioners licensed in another state with substantially similar or higher requirements than Connecticut's; or 2) upon certification by the Council on Endorsed Licensure Mobility for Optometrists
<i>Liability Required for Licensure</i>	<ul style="list-style-type: none"> • Yes

Optometry (cont.)

<i>Title Protection</i>	<ul style="list-style-type: none"> • No
<i>Other</i>	<ul style="list-style-type: none"> • Licensure requirements not applicable to physicians, surgeons, or anyone who sells eyeglasses or spectacles on prescription of any physician or surgeon; cannot use the title doctor unless appends to name the words indicating applicant is an optometrist • Optometrists first licensed prior to April 1, 1985, are permitted to acquire and use ocular agents-D topically in the practice of optometry only after they have completed a course which 1) consists of a minimum of forty-five classroom hours and fifteen clinic hours, 2) is conducted by an accredited institution or approved by the National Commission on Accrediting or the federal government, and 3) is approved by DPH, and have passed a state exam in optometry, in pharmacology as it applies to optometry, with a particular emphasis on the topical application of ocular agents-D to the eye for the purpose of examination of the human eye and the analysis of ocular functions. Optometrists licensed on and after April 1, 1985, shall not be required to take a course or pass an examination in order to acquire and use said agents topically in the practice of optometry. • Optometrists first licensed prior to January 1, 1991, are permitted to acquire, administer, dispense and prescribe ocular agents-T in the practice of optometry only after they have 1) successfully completed a minimum of ninety-six classroom hours and fourteen clinical hours in the didactic and clinical use of ocular agents-T for the purposes of treating deficiencies, deformities, diseases or abnormalities of the human eye, including the removal of foreign bodies from the eye and adnexae, conducted by a duly accredited school or college of optometry or medical school, and have passed an examination as administered by the accredited school or college of optometry or medical school which conducted the course of study, and 2) successfully completed a course in cardiopulmonary resuscitation offered by an accredited hospital, the American Heart Association or a comparable institution or organization. Proof of successful completion of the courses required must be reported to the Department of Consumer Protection. Optometrists licensed on and after January 1, 1991, and who have graduated from an accredited school or college of optometry on or after January 1, 1991, are not required to take either a course in the didactic and clinical use of ocular agents-T or a course in cardiopulmonary resuscitation or pass an examination in order to acquire, administer, dispense and prescribe such ocular agents-T. • Optometrists are permitted to engage in the practice of advanced optometric care only after they have 1) successfully completed a minimum of seventy-five classroom hours and fifty-one clinical hours in the study of advanced optometric care that includes the treatment of deficiencies, deformities, diseases or abnormalities of the human eye, including anterior segment disease, lacrimology and glaucoma conducted by a duly accredited school or college of optometry or medical school, 2) passed an examination as administered by the accredited school or college of optometry or medical school that conducted the course of study, and 3) met the requirements that permit them to acquire and use ocular agents-D and to acquire, administer, dispense and prescribe ocular agents-T pursuant to statute.

Paramedic	
Scope of Practice	Paramedicine means the carrying out of: 1) all phases of cardiopulmonary resuscitation and defibrillation; 2) the administration of drugs and intravenous solutions under written or oral authorization from a licensed physician; and 3) the administration of controlled substances, as defined in statute, in accordance with written protocols or standing orders of a licensed physician.
Statutory Reference	<ul style="list-style-type: none"> • C.G.S. Sec. 20-206jj
Length of License	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
Fees (initial/renewal)	<ul style="list-style-type: none"> • Initial: \$75 • Renewal: \$75
Licensure Requirements	<p>Initial license</p> <ul style="list-style-type: none"> • Successfully 1) completed a mobile intensive care training program approved by the commissioner, and 2) passed state exam • Any person certified as an emergency medical technician-paramedic by the Department of Public Health on October 1, 1997, is deemed a licensed paramedic. <p>Renewal license</p> <ul style="list-style-type: none"> • Fee
Professional Board	<ul style="list-style-type: none"> • Under purview of DPH
Reciprocity with other states	<ul style="list-style-type: none"> • Applicant for licensure by endorsement shall present evidence the applicant: 1) is licensed or certified as a paramedic in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of CT, and the applicant has no pending disciplinary action or unresolved complaint against him or her; or 2) is currently licensed or certified as a paramedic in good standing in any New England state, New York or New Jersey, has completed an initial training program consistent with the United States Department of Transportation, National Highway Traffic Safety Administration paramedic curriculum, and has no pending disciplinary action or unresolved complaint against him or her.
Liability Insurance Required for Licensure	<ul style="list-style-type: none"> • No
Title Protection	<ul style="list-style-type: none"> • Yes
Other	<ul style="list-style-type: none"> • No license as a paramedic shall be required of: 1) a person performing services within the scope of practice for which he is licensed or certified by any agency of this state; or 2) a student, intern or trainee pursuing a course of study in paramedicine in an accredited institution of education or within a state-approved emergency medical services program, provided the activities that would otherwise require a license as a paramedic are performed under supervision and constitute a part of a supervised course of study.

Perfusionist	
<i>Scope of Practice: General Description</i>	<p>Perfusion means the functions necessary to support, treat, measure, or supplement the cardiovascular, circulatory, or respiratory system or other organs, or a combination of such activities, and to ensure the safe management of physiologic functions by monitoring and analyzing the parameters of the systems <i>under an order and under the supervision of a licensed physician</i>, including, but not limited to:</p> <ul style="list-style-type: none"> a) the use of extracorporeal circulation (i.e., diversion of a patient’s blood through a heart-lung machine or similar device that assumes the functions of the heart, lungs, kidney, liver, or other organs), long-term cardiopulmonary support techniques including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation and associated therapeutic and diagnostic technologies; b) counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support and isolated limb perfusion; c) the use of techniques involving blood management, advanced life support and other related functions; and d) in the performance of the following activities: <ul style="list-style-type: none"> i) the administration of pharmacological and therapeutic agents, or blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line <i>as ordered by a physician</i>; (ii) the performance and use of anticoagulation monitoring and analysis; physiologic monitoring and analysis; blood gas and chemistry monitoring and analysis; hematologic monitoring and analysis; hypothermia; hyperthermia; hemoconcentration and hemodilution; or modified extracorporeal circulatory hemodialysis; or (iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Secs. 20-162aa
<i>Length of License</i>	<ul style="list-style-type: none"> • Annual
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • \$250 initial • \$315 renewal
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Successfully completed a perfusion education program with standards established by the Accreditation Committee for Perfusion Education and approved by the Commission on Accreditation of Allied Health Education Programs • Completed a minimum of fifty cases after graduating from a perfusion education program accredited or approved by the above mentioned Commission • After completing the minimum of 50 cases after graduating requirement, successfully completed the certification

Perfusionist	
	<p>examination offered by the American Board of Cardiovascular Perfusion, or its successor. In lieu of the above requirements, the DPH commissioner <i>may</i> grant a license to anyone who:</p> <ul style="list-style-type: none"> • is currently certified by the American Board of Cardiovascular Perfusion; • has worked as a perfusionist in a licensed health care facility in another state for a period of not less than five years; and • has had no lapse in active practice as perfusionist greater than twenty-four months at the time of filing a licensure application in Connecticut. <p>Renewal</p> <ul style="list-style-type: none"> • Fee
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under the purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Not indicated
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • No

Physical Therapist	
Scope of Practice	Physical therapy means the evaluation and treatment of any person using physical measures, therapeutic exercises and rehabilitative procedures with or without assistive devices to prevent, correct, or alleviate physical or mental disability. Does not include surgery, prescribing drugs, making medical diagnosis, using cauterization or Roentgen rays or radium or diagnostic or therapeutic purposes.
Statutory Reference	<ul style="list-style-type: none"> • C.G.S. Sec. 20-66
Length of License	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
Fees (initial/renewal)	<ul style="list-style-type: none"> • Initial: \$285 • Renewal: \$100
Licensure Requirements	<p>Initial license</p> <ul style="list-style-type: none"> • Successfully complete requirements of approved school of physical therapy and pass state exam • Graduate of approved physical therapy school and working under direct supervision of licensed physical therapist, may receive 120-day temporary license prior to taking state exam; may take exam as many times as necessary to pass • Successful completion of National Physical Therapy Examination <p>Renewal license</p> <ul style="list-style-type: none"> • Complete at least 20 hours of specific continuing education for each registration period after first renewal
Professional Board	<p><i>Board of Examiners for Physical Therapists</i></p> <ul style="list-style-type: none"> • 5-member body appointed by governor (1 physician, 2 physical therapists, 2 public members) • Provide advice to DPH on adopting bylaws and regulations; keep list of all approved physical therapy schools; has jurisdiction over licenses not confirming with statutory requirements and may take action against licensees.
Reciprocity with other states	<ul style="list-style-type: none"> • May practice without exam if: 1) fee paid; and 2) is a registered/license physical therapist in another state or Canada with at least similar requirements as Connecticut • Any physical therapist from another state who has graduated from an approved school but not licensed in CT may practice on a six-month temporary basis which may be extended in the person is not licensed in another state and application for licensure is filed within six months after starting such practice
Liability Insurance Required for Licensure	<ul style="list-style-type: none"> • Yes
Title Protection	<ul style="list-style-type: none"> • Yes
Other	<ul style="list-style-type: none"> • Cannot use the term chiropractic adjustment or chiropractic manipulations within practice or practice medicine or surgery • Referral from physician for physical therapy services not necessary as long as physical therapist meets certain requirements; referral needed for Grade V spinal manipulations (along with other defined injuries)

Physician Assistant	
Scope of Practice: General Description	Physician assistants may perform medical functions delegated by a supervising physician. Functions must be within the scope of the supervising physician's license, competence, and normal scope of actual practice. Delegated functions must be implemented according to written protocols established by supervising physician. All orders written by physician assistant must be signed by the physician assistant and printed name of supervising physician. Physician assistants, within scope of supervising physician's practice may: 1) prescribe and administer drugs, including controlled substances in schedule IV and V; 2) renew prescriptions for controlled substances in schedule II, III, IV, and V; 3) prescribe and administer controlled substances in schedule II or III, provided supervising physician documents approval in patient's medical record within one day; 4) prescribe and approve use of durable medical equipment; and 5) may request, sign for, receive, and dispense drugs to patients using professional samples. Physician assistants may make actual determination and pronouncement of death of a patient under certain circumstances; physician assistants may <i>not</i> engage in the independent practice of medicine, represent himself as a licensed physician, or use the title of doctor.
Statutory Reference	<ul style="list-style-type: none"> • C.G.S. Sec. 20-12d
Length of License	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
Fees (initial/renewal)	<ul style="list-style-type: none"> • Initial: \$150 • Temporary permit: \$75 • Renewal: \$0
Licensure Requirements	<p>Initial license</p> <ul style="list-style-type: none"> • Bachelor's degree • Graduated from accredited physician assistant program • Passed certification exam of the national commission • Satisfied mandatory continuing education requirements of national commission • Completed at least 60 hours of didactic instruction in pharmacology for physician assistant practice
Oversight Board / Certifying Body	<p><i>Connecticut Medical Examining Board</i> - Same as physicians/surgeons</p>
Reciprocity with other states	<ul style="list-style-type: none"> • Not indicated
Liability Insurance Required for Licensure	<ul style="list-style-type: none"> • No
Title Protection	<ul style="list-style-type: none"> • Yes

Podiatry	
Scope of Practice	Podiatric medicine is the diagnosis and treatment, including medical and surgical treatment, of ailments of the foot and the anatomical structures of the foot and the administration and prescription of drugs. Includes treatment of diseases of the foot. A licensed doctor of podiatric medicine may prescribe, administer, and dispense drugs and controlled substances in Schedule II-V in connection with podiatry. Podiatric surgery does not include amputation of the leg or foot other than from the transmetatarsal level to the toes.
Statutory Reference	<ul style="list-style-type: none"> • C.G.S. Sec. 20-50
Length of License	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
Fees (initial/renewal)	<ul style="list-style-type: none"> • Initial: \$565 • Renewal: \$565
Licensure Requirements	<p>Initial license</p> <ul style="list-style-type: none"> • Two (2) years of post-secondary education which includes coursework in chemistry, physics or mathematics and biology; • Graduation from a program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association with the D.P.M. degree; • Successful completion of the examinations administered by the National Board of Podiatric Medical Examiners; • Completion of the PMLexis III examination. <p>Renewal license</p> <ul style="list-style-type: none"> • Not indicated
Professional Board	<p><i>Connecticut Board of Examiners in Podiatry</i></p> <ul style="list-style-type: none"> • 5-member body appointed by governor (3 practicing state residents and graduates of approved chiropody or podiatry colleges or schools; 2 public members) • Responsible for hearing/deciding matters of licensure suspension/revocation; adjudicate complaints against practitioners; impose appropriate sanctions
Reciprocity with other states	<ul style="list-style-type: none"> • DPH may accept a certificate issued by the National Board of Podiatry Examiners or the license of any state board of podiatry examiners or duly authorized licensing agency of any state or District of Columbia, in lieu of required written examination, if the applicant graduated from a chiropody or podiatry school or college recognized by the Connecticut Board of Examiners in Podiatry and that such other state board or licensing agency maintains standards for licensure equal to or higher than those of CT
Liability Insurance Required for Licensure	<ul style="list-style-type: none"> • Yes
Title Protection	<ul style="list-style-type: none"> • Yes

Podiatry (cont.)

Other

- A licensed podiatrist who is board qualified or certified may engage in the medical and nonsurgical treatment of the ankle and the anatomical structures of the ankle (and prescribe/administer prescription drugs incidental thereto) and the nonsurgical treatment of systemic diseases as they appear on the ankle. Such licensed podiatrist shall restrict treatment of displaced ankle fractures to the initial diagnosis and the initial attempt at closed reduction at the time of presentation and shall not treat tibial pilon fractures. "Ankle" means the distal metaphysis and epiphysis of the tibia and fibula, the articular cartilage of the distal tibia and distal fibula, the ligaments that connect the distal metaphysis and epiphysis of the tibia and fibula and the talus, and the portions of skin, subcutaneous tissue, fascia, muscles, tendons and nerves at or below the level of the myotendinous junction of the triceps surae.
- Must obtain a permit from DPH to independently engage in the surgical treatment of the ankle, including the surgical treatment of the anatomical structures of the ankle, and the administration and prescription of drugs incidental thereto. "Surgical treatment of the ankle" does not include the performance of total ankle replacements or the treatment of tibial pilon fractures. The permit may be issued to podiatrists who meet certain requirements, including: graduating from a three-year residency program in podiatric medicine and surgery accredited by the Council on Podiatric Medical Education, and holding/maintaining current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery.

Professional Counselor	
<i>Scope of Practice</i>	Professional counseling means the application, by persons trained in counseling, of established principles of psycho-social development and behavioral science to the evaluation, assessment, analysis and treatment of emotional, behavioral or interpersonal dysfunction or difficulties that interfere with mental health and human development. Professional counseling includes, but is not limited to, individual, group, marriage and family counseling, functional assessments for persons adjusting to a disability, appraisal, crisis intervention and consultation with individuals or groups.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-195aa
<i>Length of License</i>	<ul style="list-style-type: none"> • Annual
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Application Fee: \$315 • License Renewal: \$190
<i>Licensure Requirements</i>	<ul style="list-style-type: none"> • Each licensed professional counselor applying for license renewal shall furnish evidence satisfactory to the commissioner of having participated in continuing education programs, for which by adopting regulations DPH is to define basic requirements of continuing education programs, delineate qualifying programs, establish a system of control and reporting, and provide for waiver of the continuing education requirement for good cause
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under the purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Not referenced
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes

Psychologists	
<i>Scope of Practice</i>	<p>Psychology means the rendering of professional services under any title or description of services incorporating the words psychologist, psychological or psychology, to the public or to any public or private organization for a fee or other remuneration. Professional psychological services means:</p> <ul style="list-style-type: none"> • the application, by persons trained in psychology, of established principles of learning, motivation, perception, thinking and emotional relationships to the assessment, diagnosis, prevention, treatment and amelioration of psychological problems or emotional or mental disorders of individuals or groups, including but not limited to counseling, guidance, psychotherapy, behavior modification and personnel evaluation, with persons or groups in the areas of work, family, school, marriage and personal relationships; • measuring and testing of personality, intelligence, aptitudes, emotions, public opinion, attitudes and skills; and • research relating to human behavior
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Secs. 20-187a
<i>Length of License</i>	<ul style="list-style-type: none"> • Annual
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$565 • Renewal:\$565
<i>Licensure Requirements</i>	<ul style="list-style-type: none"> • Pass state exam • Graduate from an education program approved by the board with the consent of DPH • Received doctoral degree based on a program of studies whose content was primarily psychological from an educational institution approved in accordance with section 20-189; • Possess at least one year's experience that meets the requirements established in regulations adopted by DPH in consultation with the board. • Any certificate granted by the board of examiners prior to June 24, 1969, shall be deemed a valid license permitting continuance of profession subject to the provisions of this chapter <p>Applicant for licensure by endorsement may occur if:</p> <ul style="list-style-type: none"> • the applicant is a currently practicing, competent practitioner • at the time of application, the applicant is licensed or certified by a similar board of another state whose standards, in the opinion of the department, are substantially similar to, or higher than, those of this state, or that the applicant holds a current certificate of professional qualification in psychology from the Association of State and Provincial Psychology Boards. • The department may waive the examination for any person holding a diploma from a nationally recognized board or agency approved by the department, with the consent of the board of examiners. • The department may require such applicant to provide satisfactory evidence that the applicant understands Connecticut laws and regulations relating to the practice of psychology.

Psychologists (cont.)	
	<ul style="list-style-type: none"> • The department shall inform the board annually of the number of applications it receives for licensure by endorsement under this section. • No additional requirements for license renewal, including continuing education requirements.
Professional Board	<p><i>Board of Examiners of Psychologists</i></p> <ul style="list-style-type: none"> • 5- member body appointed by governor, 3 practicing psychologists and 2 public members • Responsible for: hearing and deciding matters concerning suspension or revocation of licensure, (2) adjudicating complaints filed against practitioners licensed under this chapter and (3) imposing sanctions where appropriate.
Reciprocity with other states	<ul style="list-style-type: none"> • See licensure requirements above
Liability Insurance Required for Licensure	<ul style="list-style-type: none"> • No
Title Protection	<ul style="list-style-type: none"> • Yes
Other	<p>Any hospital or health care facility may allow a psychologist, licensed pursuant to this chapter, full staff privileges in accordance with the standards of the Joint Commission on Accreditation of Health Care Organizations if the criteria that has been set forth by the hospital or health care facility is met.</p> <p>Allowed:</p> <ul style="list-style-type: none"> • activities and services of a graduate student, intern or resident in psychology, pursuing a course of study in an educational institution under the provisions of section 20-189, if such activities constitute a part of a supervised course of study. • No license as a psychologist shall be required of a person holding a doctoral degree based on a program of studies whose content was primarily psychological from an educational institution approved under the provisions of section 20-189, provided such activities and services are necessary to satisfy the work experience as required by section 20-188

Radiographer and Radiologic Technologist	
<i>Scope of Practice</i>	No person shall operate a medical x-ray system unless licensed and under the supervision and upon written or verbal order by a license physician; may perform venipuncture and administer medication for diagnostic procedures
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-74bb
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$200 • Renewal: \$100
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Complete course of study in radiologic technology in a program accredited by Committee on Allied Health Education Accreditation of the American Medical Association or comparable program • Pass state exam; 120-day temporary permit available to students upon graduation before licensure exam <p>Renewal license</p> <ul style="list-style-type: none"> • 24 contact hours of qualifying continuing education every two years after first renewal
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Not indicated
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • Yes
<i>Other</i>	<ul style="list-style-type: none"> • Other licensed professions (e.g., dentists, dental hygienists, physicians) exempt from radiographer licensure requirements

Respiratory Care Practitioner	
<i>Scope of Practice</i>	Respiratory care means health care under the direction of a licensed physician and in accordance with written protocols developed by the physician, employed in the therapy, management, rehabilitation, diagnostic evaluation and care of patients with deficiencies and abnormalities that affect the cardiopulmonary system and associated aspects of other system functions and that includes the following: (1) The therapeutic and diagnostic use of medical gases, administering apparatus, humidification and aerosols, administration of drugs and medications to the cardiorespiratory systems, ventilatory assistance and ventilatory control, postural drainage, chest physiotherapy and breathing exercises, respiratory rehabilitation, cardiopulmonary resuscitation and maintenance of natural airways as well as the insertion and maintenance of artificial airways, (2) the specific testing techniques employed in respiratory therapy to assist in diagnosis, monitoring, treatment and research, including the measurement of ventilatory volumes, pressures and flows, specimen collection of blood and other materials, pulmonary function testing and hemodynamic and other related physiological monitoring of cardiopulmonary systems, (3) performance of a purified protein derivative test to identify exposure to tuberculosis, and (4) patient education in self-care procedures as part of the ongoing program of respiratory care of such patient. The practice of respiratory therapy is not limited to the hospital setting.
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-162n
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$190 • Renewal: \$100
<i>Licensure Requirements</i>	<p>Initial license</p> <p>Route 1: Completion of an accredited educational program for Respiratory Therapists or Respiratory Therapy Technicians; successful completion of the Entry Level or Advanced Practitioner Respiratory Care examination administered by the National Board for Respiratory Care, Inc.; currently credentialed by the National Board for Respiratory Care as a Certified Respiratory Therapy Technician or Registered Respiratory Therapist.</p> <p>Route 2: was credentialed by the NBRC as a Certified Respiratory Therapy Technician not later than June 30, 1978; or was credentialed by the NBRC as a Registered Respiratory Therapist not later than June 30, 1971; and successfully completed Entry Level or Advanced Practitioner Respiratory Care Examination administered by the NBRC; and currently credentialed by the NBRC as a Certified Respiratory Therapy Technician or Registered Respiratory Therapist.</p> <p>Route 3: Registered as a Respiratory Therapist by the Canadian Society of Respiratory Therapists; passed the Clinical Simulation Examination of the NBRC; and is currently credentialed by the NBRC as a Registered Respiratory Therapist.</p> <p>Renewal license</p> <ul style="list-style-type: none"> • 6 contact hours of qualifying continuing education for each registration period

Speech and Language Pathologist and Audiologist	
<i>Scope of Practice</i>	<p>"The practice of speech and language pathology" means the application of principles, methods and procedures for the measurement, testing, diagnosis, prediction, counseling or instruction relating to the development and disorders of speech, voice or language or feeding and swallowing or other upper aerodigestive functions for the purpose of diagnosing, preventing, treating, ameliorating or modifying such disorders and conditions in individuals or groups of individuals.</p> <p>"The practice of audiology" means the application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and the determination and use of appropriate amplification related to hearing and disorders of hearing, including the fitting or selling of hearing aids, for the purpose of modifying communicative disorders involving speech, language, auditory function or other aberrant behavior related to hearing loss.</p>
<i>Statutory Reference</i>	<ul style="list-style-type: none"> • C.G.S. Sec. 20-408
<i>Length of License</i>	<ul style="list-style-type: none"> • Initial: 1 year • Renewal: 1 year
<i>Fees (initial/renewal)</i>	<ul style="list-style-type: none"> • Initial: \$75 • Renewal: \$75
<i>Licensure Requirements</i>	<p>Initial license</p> <ul style="list-style-type: none"> • Passed written state examination and is of good professional character • Master's or doctorate degree in speech and language pathology or audiology or has completed an integrated educational program which • Has had a minimum of thirty-six weeks and 1,080 hours of full-time or a minimum of 48 weeks and 1,440 hours of part-time professional employment in speech and language pathology or audiology under the supervision of a licensed or certified speech and language pathologist or audiologist <p>Renewal license</p> <ul style="list-style-type: none"> • Fee
<i>Professional Board</i>	<ul style="list-style-type: none"> • Under purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none"> • Written examination may be waived for any person who is licensed as a speech and language pathologist or audiologist in another state and such state has licensing requirements at least equivalent to the requirements in this state or holds a certificate from a national professional organization in speech and language pathology or audiology.
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none"> • No
<i>Title Protection</i>	<ul style="list-style-type: none"> • No
<i>Other</i>	<ul style="list-style-type: none"> • Public Act 09-232 established separate licenses for speech and language pathologists and audiologists

Speech and Language Pathologists and Audiologists (cont.)

<i>Professional Board</i>	<ul style="list-style-type: none">• Under purview of DPH
<i>Reciprocity with other states</i>	<ul style="list-style-type: none">• Not indicated
<i>Liability Insurance Required for Licensure</i>	<ul style="list-style-type: none">• No
<i>Title Protection</i>	<ul style="list-style-type: none">• Yes

APPENDIX B

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.

APPENDIX C

Declaratory Rulings for Health Care Professions

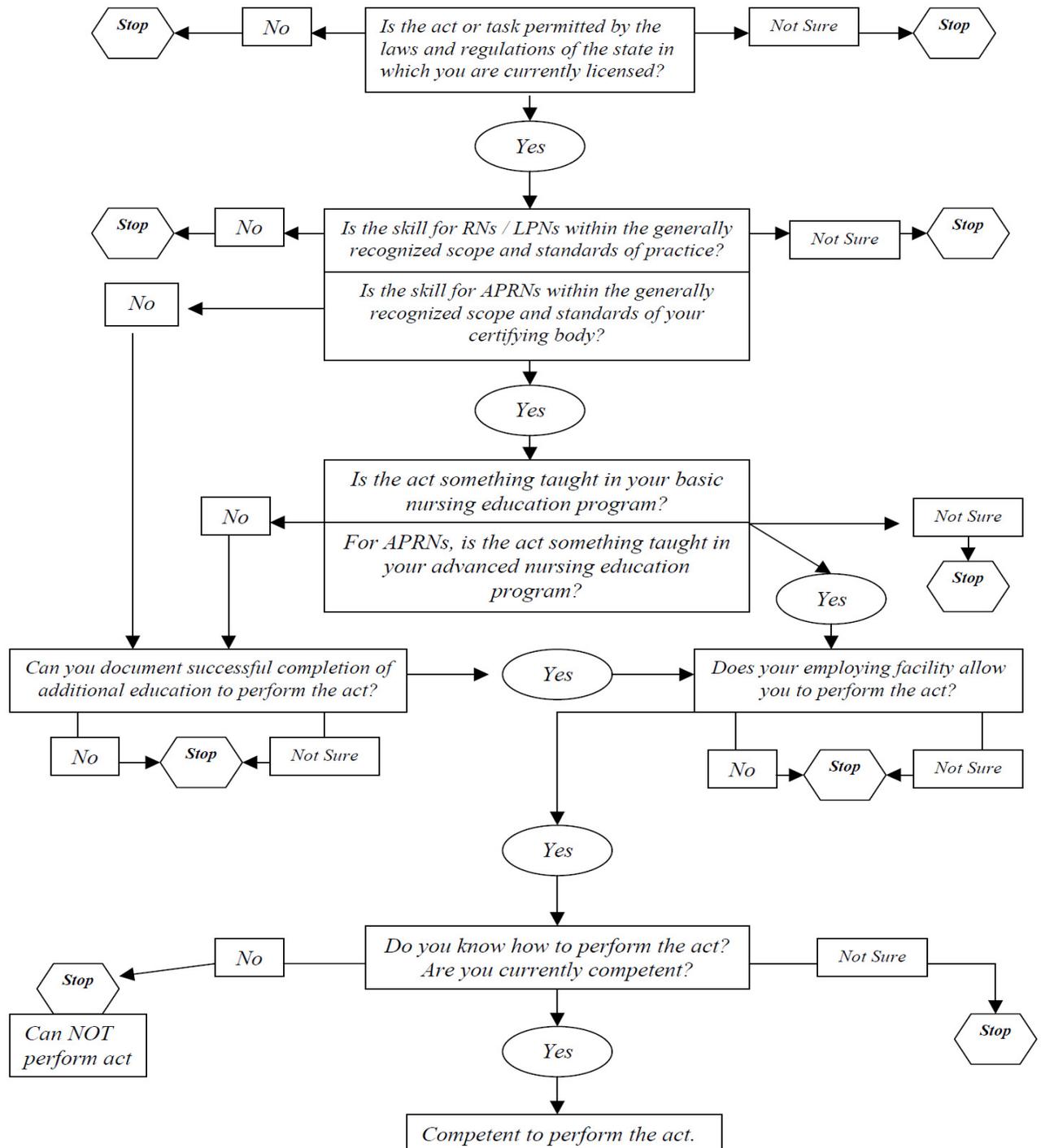
CASE NAME	DECISION	RULING DATE
DEPARTMENT OF PUBLIC HEALTH		
ALCOHOL DRUG COUNSELORS		
Petition by Practitioner	Ruling on Request for Dec. Ruling	10/31/07
DENTAL HYGIENISTS		
Declaratory Ruling Proceeding Regarding whether a dental hygienist is a provider required to maintain professional liability insurance	Declaratory Ruling	06/13/1997
MASSAGE THERAPY		
Declaratory Ruling Proceeding Concerning the Licensure of Massage Therapists	Declaratory Ruling	06/28/2004
STATE BD OF CHIROPRACTIC EXAMINERS		
Petition by Practitioner	Declaratory Ruling	5/25/89
Petition by Practitioner Re: (1) Whether Chiropractors May Provide Exercise Therapy in Conjunction With Adjustment Therapy, and (2) If So, Whether There is any Particular Time Period Within Which Exercise Therapy Must Be Performed By Chiropractors in Preparation for Chiropractic Adjustment or Manipulation	Declaratory Ruling	5/11/98
Use of Lasers in Chiropractic Practice	Declaratory Ruling	8/23/07
CT STATE DENTAL COMMISSION		
Declaratory Ruling Proceeding Regarding the Scope of Practice of Oral and Maxillofacial Surgeons	Declaratory Ruling	6/8/2004 (Withdrawn 11/28/05)

CASE NAME	DECISION	RULING DATE
CT MEDICAL EXAMINING BOARD		
Petition Submitted by President of the American Electrology Association, on use of Lasers for Hair Removal by Health Care Providers Other Than Licensed Physicians	Declaratory Ruling	3/1/98
STATE BD OF NATUREOPATHIC EXAMINERS		
Whether a Natureopathic Physician Licensed in Connecticut is Authorized to Perform Diagnostic Procedures Utilizing Substances Other Than Natural Substances as Defined by Connecticut General Statutes Sec. 20-343(b)	Declaratory Ruling	9/26/00
STATE BOARD OF EXAMINERS FOR NURSING		
Declaratory Ruling Regarding the Registered Nurse in Advanced Practice	Memorandum of Decision	6/25/87
Declaratory Ruling on Registered Nurses as First Assistant in the Operating Room	Declaratory Ruling	11/7/88
Declaratory Ruling to Clarify the Role of the Licensed Practical Nurse	Memorandum of Decision	2/7/89
Declaratory Ruling – Delegation by Licensed Nurses to Unlicensed Assistive Personnel	Memorandum of Decision	4/5/95
BOARD OF EXAMINERS FOR OPTICIANS		
Petition for declaratory ruling concerning the sale of contact lenses	Declaratory Ruling	6/24/03
BOARD OF EXAMINERS FOR OPTOMETRISTS		
Under what set if circumstances would an Optometrist be considered to be practicing his profession “as an employee of any unlicensed person, firm or organization” as that phrase is used in Connecticut General Statute Sec. 20-133a.	Declaratory Ruling	5/1/02

CASE NAME	DECISION	RULING DATE
BD OF EXAMINERS FOR PHYSICAL THERAPY		
Declaratory Ruling regarding appropriate medical record documentation for practitioners licensed to practice physical therapy in Connecticut, as defined in Connecticut General Statutes Sec. 20-66(2)	Declaratory Ruling	6/25/96
Declaratory Ruling concerning authorization by a physician for physical therapy services on the Individualized Family Service Plan form.	Declaratory Ruling	2/5/97
BOARD OF EXAMINERS IN PODIATRY		
Declaratory Ruling on Malpractice Insurance for Podiatrists Practicing in Federal Facilities	Declaratory Ruling	3/22/95
Declaratory Ruling – Noninvasive Vascular Testing of the Lower Extremity	Declaratory Ruling	9/05/2007
Declaratory Ruling – Hyperbaric Oxygen Therapy	Declaratory Ruling	6/03/2009
BOARD OF EXAMINERS IN PSYCHOLOGY		
Declaratory Ruling re: Clarification, by the Board, of the phrase "...is not qualified" as used under the provisions of Conn. Gen. Stat. Sec. 20-192	Memorandum of Decision	1/28/85
Source of data: Public Health Hearing Office, Department of Public Health		

APPENDIX D

Connecticut Board of Examiners For Nursing Nursing Competency / Scope of Practice Decision - Making Model



APPENDIX E

Program Review Committee Staff Data Base: Data Elements

- 1 Profession
- 2 Year
- 3 How SOP Affected
- 4 PHC Public Hearing
- 5 SOP change part of larger bill?
- 6 # Testifying on Specific SOP
- 7 # For
- 8 # Against
- 9 # Neutral
- 10 Testimony From
- 11 Agency Testimony For
- 12 Agency Testimony Against
- 13 Agency Testimony Neutral
- 14 Assoc Testimony For
- 15 Assoc Testimony Against
- 16 Practitioner Testimony For
- 17 Practitioner Testimony Against
- 18 Citizen Testimony For
- 19 Citizen Testimony Against
- 20 General Arguments For
- 21 General Arguments Against
- 22 Public Safety For: testimony was provided saying change would INCREASE public safety
- 23 Public Safety Against: testimony was provided saying change would HARM public safety
- 24 Access For: testimony was provided saying change would INCREASE access
- 25 Access Against: testimony was provided saying change would HARM access
- 26 Other States For: testimony regarding other states was provided to SUPPORT change
- 27 Other States Against: testimony using other states was provided to OPPOSE change
- 28 Public Safety: Committee asked questions about public safety
- 29 Access: Committee asked questions about access
- 30 Other States: Committee asked questions about other states
- 31 Notes: Public Hearing
- 32 Final Status
- 33 Comm Vote
- 34 House and Senate Votes

APPENDIX F

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

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 _____

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

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

© 2007 UCSF Center for the Health Professions. All materials subject to this copyright may be reproduced for non-commercial purposes of scientific or educational advancement.



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
HEALTHCARE
FOUNDATION

This project is supported by grant from the California HealthCare Foundation. Celebrating its tenth year, the California HealthCare Foundation (CHCF), based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems.

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			Nat'l Certif. Req'd	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		
Alabama ⁶			X	X	X	X	X	X	X	X	X ³	X
Alaska ⁷	X				X			X				X
Arizona ⁷	X				X	X	X	X				X
Arkansas ¹⁰			X ¹¹		X	X		X	X ¹⁷	X	X	X
California ¹³			X ¹⁴	X				X	X ¹⁵	X	X	X
Colorado ⁶					X			X	X	X	X	X
Connecticut ⁷					X			X	X	X	X	X
Delaware ⁸			X		X ¹⁹	X	X ²⁰	X	X	X	X	X
District of Columbia ⁴¹	X				X			X	X	X	X	X
Florida ²²		X	X ²⁴		X	X		X	X	X	X	X
Georgia ³³					X			X	X	X	X	X ²⁵
Hawaii ³⁶					X			X	X	X	X ²⁷	X ²⁸
Idaho ²⁹	X				X			X	X	X	X	X ³⁰
Illinois ³¹			X		X	X		X	X	X	X	X
Indiana ³¹			X		X	X		X	X	X	X	X ³³
Iowa ³⁴	X				X	X	X ³⁵	X	X	X	X	X
Kansas ³⁶					X ³⁷	X		X	X	X	X	X
Kentucky ³⁸					X ³⁹	X		X	X	X	X	X
Louisiana ⁴¹			X	X ⁴²	X ⁴³	X		X	X	X	X ⁴⁴	X
Maine ⁴⁵	X ⁴⁶				X ⁴⁷	X		X	X	X	X	X
Maryland ⁴⁸		X		X	X	X		X	X	X	X	X
Massachusetts ⁴⁹			X	X	X			X	X ⁵¹	X	X ⁵²	X
Michigan ⁵⁰									X	X	X	X
Minnesota ⁵³			X		X	X		X	X	X	X	X ⁵⁴
Mississippi ⁵⁵			X	X	X	X		X	X	X	X	X
Missouri ⁵⁶			X	X	X ⁵⁷	X		X	X	X	X	X
Montana ⁵⁸	X ⁵⁹				X	X		X	X	X	X	X
Nebraska ⁶⁰		X ⁶¹	X		X	X		X	X	X	X	X
Nevada ⁶²			X	X	X	X		X	X	X	X	X
New Hampshire ⁶³	X				X	X		X	X	X	X	X
New Jersey ⁶⁴					X	X		X	X	X	X	X ⁶⁵
New Mexico ⁶⁶	X							X	X	X	X	X
New York ⁶⁷			X	X	X ⁶⁸	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
Ohio ⁷²			X					X	X	X	X	X
Oklahoma ⁷³		X ⁷⁴			X	X		X	X	X	X	X ⁷⁵
Oregon ⁷⁶	X				X	X		X	X	X	X	X

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 ⁵	Authority to Prescribe Controlled Substances ⁶	
Pennsylvania ⁷		X	X		X			X	X		X	X
Rhode Island ⁸									X		X	X
South Carolina ⁹		X		X				X	X		X	X
South Dakota ⁹			X		X			X	X		X	X
Tennessee ³								X	X		X	X
Texas ⁸		X	X	X	X			X	X		X	X
Utah ⁵					X			X	X		X	X
Vermont ⁶			X	X	X			X	X		X	X
Virginia ⁹		X	X	X	X			X	X		X	X
Washington ⁸	X				X	X		X	X		X	X
West Virginia ⁹					X			X	X		X	X
Wisconsin ¹⁰		X		X	X			X	X		X	X
Wyoming ¹¹			X	X	X			X	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 <http://www.abn.state.al.us/main/downloads/admin-code/Chapter%20610-X-2.pdf>; Ala. Admin. Code r. 610-X-5, <http://www.abn.state.al.us/main/downloads/admin-code/Chapter%20610-X-5.pdf>.

⁸ 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>.

⁹ 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.

¹⁰ 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.arsn.gov/documents/nps/LINKED-RULES_JUNE%202007_WEB.pdf.

¹¹ 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.arsn.org/pdfs/practice_act/NURSEPRACTICEACT_2007_5.pdf; Position Statement: Scopes of Practice, http://www.arsn.org/position_statement_095_1.pdf; Difference between Advanced Nurse Practitioners and Registered Nurse Practitioners, <http://www.arsn.org/pdfs/arnp&rnbroch.pdf>; Advanced Nurse Practitioner, <http://www.arsn.org/pdfs/arnbroch.pdf>; Four Categories of Advanced Practice Licensure, <http://www.arsn.org/pdfs/4categories.pdf>.

¹² 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.

- 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>;
- ¹⁸ Advanced Practice Registered Nurse Licensure, <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389400>.
- ¹⁹ Del. Code Ann. tit. 24 §1902, <http://delcode.delaware.gov/title24/c019/index.shtml>;
- ²⁰ Del. Register of Regs. tit. 24 §§8.0-8.18, <http://regulations.delaware.gov/AdminCode/title24/1900%20Board%20of%20Nursing.shtm#TopOfPage>.
- ²¹ In Delaware, an NP may only refer patients to other providers if authorized under a written collaborative agreement with a physician. Del. Register of Regs. tit. 24 §§6.2.14.
- ²² D.C. Mun. Regs. tit. 17, Ch. 59, http://hpla.doh.dc.gov/hpla/frames.asp?doc=/hpla/hpla/prof_license/services/pdf/nurse_practitioner_chap_59_regs_8-10-05.pdf;
- ²³ D.C. Code Ann. §§3-1201.02, 3-1206.01, 3-1206.04, 3-1206.08.
- ²⁴ 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/info_Legisummaries.pdf.
- ²⁵ Ga. Comp. R. & Regs. §410-12-.03, <http://sos.georgia.gov/acrobau/PLB/Rules/chap410.pdf>; Ga. Code Ann. §§43-26-3, 43-34-26.1, 43-34-26.3, <http://www.lexis-nexis.com/hottopics/gacode/default.asp>.
- ²⁶ 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.
- ²⁷ 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).
- ²⁸ Haw. Rev. Stat. §§457-8.5, 457-8.6, <http://www.hawaii.gov/dcca/areas/pvl/main/hrs/>; Haw. Admin. R. §§16-89, 16-89C, <http://www.hawaii.gov/dcca/areas/pvl/main/haar/>.
- ²⁹ 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_ia_exc_apru.pdf; www.hawaii.gov/dcca/areas/pvl/main/reports/pvl_legislature_reports/JFAC_2004_Legislature_Report.pdf.
- ³⁰ 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.
- ³¹ Idaho Code §54-1402(1)(c), <http://www3.state.id.us/cgi-bin/newidst?scid=540140002.K>;
- ³² Idaho Admin. Proc. Act §§23.01.01.271, 23.01.01.280, 23.01.01.315, <http://www.adm.idaho.gov/adminrules/rules/tdapa23/0101.pdf>.
- ³³ 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>.
- ³⁴ 225 Ill. Comp. Stat. 65/15-5, 65/15-10, 65/15-15, 65/15-20.
- ³⁵ <http://ilga.gov/legislation/files/ies3.asp?ActID=1312&ChapAct=225%26nbsp%3BILCS%26nbsp%3B65%2F&ChapterID=24&ChapterName=PROFESSIONS+AND+OCCUPATIONS&ActName=Nursing+and+Advanced+Practice+Nursing+Act%2E>.
- ³⁶ Ill. Admin. Code tit. 68 §§1305.30, 1305.35, 1305.40, <http://www.ilga.gov/commission/jear/admincode/068/06801305sections.html>.
- ³⁷ 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/bandof/sbn/nursing_compilation.pdf.
- ³⁸ 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)).
- ³⁹ Iowa Admin. Code §655-7.1(152), <http://www.legis.state.ia.us/Rules/Current/iac/655/6557.pdf>;
- ⁴⁰ Iowa Code §147.107, [http://www.legis.state.ia.us/nxt/gateway.dll?templates&fn=default.htm](http://nxtsearch.legis.state.ia.us/nxt/gateway.dll?templates&fn=default.htm); Iowa Board of Nursing, http://www.state.ia.us/nursing/nursing_practice/arnp.html.
- ⁴¹ In Iowa, ARNPs may prescribe independently. NPs, however, may not prescribe medications. Pearson, *supra*, note 1 (citing Iowa Admin. Code §655-7.1(152)).
- ⁴² Kan. Stat. Ann. §§65-1113 to 65-1134, Kan. Admin. Regs. §§60-3-101; 60-11-101 to 60-11-119, <http://www.ksbm.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/314-00/042.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/practurm.pdf>.
⁴⁰ Kentucky law distinguishes between "medical diagnoses" and "nursing diagnoses." Ky. Rev. Stat. Ann. §314.011(4)(a).
⁴¹ In Kentucky, APRNs 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.lsbn.state.la.us/documents/rules/full-rules.pdf>;
⁴³ La. Stat. Ann. §37:913(3), La. Admin. Code §46:XLVII, Ch. 45 §4513, <http://www.lsbn.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/rca/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. §§10.27.07.00 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. §§4.05, 4.22, 4.26(2), <http://www.mass.gov/Eeoohs2/docs/dph/regs/244cmr004.pdf>;
⁵² Mass. Gen. Laws, Ch. 112 §80B, <http://www.mass.gov/legis/laws/mgl/112-80b.htm>; Mass. Gen. Laws, Ch. 112 §80E, <http://www.mass.gov/legis/laws/mgl/112-80e.htm>.
⁵³ Mich. Comp. Laws §333.16215, [http://www.legislature.mi.gov/\(S\(zizokq55mxsoo5jghfvcjv\)\)/mileg.aspx?page=getobject&objectname=mcl-333-16215](http://www.legislature.mi.gov/(S(zizokq55mxsoo5jghfvcjv))/mileg.aspx?page=getobject&objectname=mcl-333-16215);
⁵⁴ Mich. Comp. Laws §333.17212, [http://www.legislature.mi.gov/\(S\(kzhfca2uiyvfdewnerousi\)\)/documents/mcl/pdf/mcl-333-17212.pdf](http://www.legislature.mi.gov/(S(kzhfca2uiyvfdewnerousi))/documents/mcl/pdf/mcl-333-17212.pdf);
⁵⁵ Mich. Admin. Code R 338.10404, http://www.state.mi.us/ort/emi/admincode.asp?AdminCode=Single&Admin_Num=33810101&Dpt=CH&RngHigh=;
⁵⁶ Board of Nursing, <http://www.michigancenterfornursing.org/minimages/bfn/nursing.pdf>; http://www.michigan.gov/mdch/0,1607,7-132-27417_27529_27542-59003--,00.html.
⁵⁷ In Michigan, physicians may delegate the authority to prescribe medications under protocols. Mich. Comp. Laws §333.17212.
⁵⁸ In Michigan, NPs must prescribe controlled substances under a "Delegation of Prescriptive Authority Agreement" signed by their supervising physician. Pearson, *supra*, note 1.
⁵⁹ Minnesota Nurse Practice Act, http://www.state.mn.us/portal/mm/psp/content.do?rc_layout=bottom&subchannel=null&programid=536898782&sc3=null&sc2=null&id=536882405&agency=NursingBoard; Minn. Stat. §148.235, <http://www.revisor.leg.state.mn.us/bin/getpub.php?type=s&year=current&num=148.235>;
⁶⁰ Minn. Stat. §148.284, <http://www.revisor.leg.state.mn.us/bin/getpub.php?type=s&year=current&num=148.284>;
⁶¹ Advanced Practice Registered Nursing Information, http://www.state.mn.us/portal/mm/psp/content.do?rc_layout=bottom&subchannel=536882458&programid=536898474&sc3=null&sc2=null&id=536882404&agency=NursingBoard.
⁶² 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.
⁶³ 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>.
⁶⁴ 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/c300-399/33400000104.htm>; Mo. Code Reg. Ann. §2200-4, <http://www.sos.mo.gov/adrules/csr/current/20csr/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>; Mont. Code Ann. §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/cfr/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>.
⁶³ N.H. Rev. Stat. Ann. §8326-B:9, 326-B:11, 326-B:18, <http://www.gencourt.state.nh.us/rsa/html/NHITOC/NHTOC-XXX-326-B.htm>.
⁶⁴ N.J. Stat. Ann. §§45:11-47, 45:11-49, <http://www.state.nj.us/ps/cslaws/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&f=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/nmpmpa.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/t43c121.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/oacl/4723-8>.
⁷³ Okla. Stat. tit. 59 §567.3a, 567.4a, <http://www.lsb.state.ok.us/OKStatutes/CompleteTitles/os59.rtf>; Okla. Admin. Code §§485:10-15-6(c), 485:10-16-3, http://www.our.state.ok.us/our/codedoc02.nsf/frmmMain?OpenFrameSet&Frame=Main&Src=75tm2shfdnm8pb4dthj0chedppmc8q8dummak31ctjuyrgcln50ob7ckj42ibkdt374obdcl400_.
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. §§51-050, <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 §821.251; 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/bpoa/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 to 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/TITLES/5-34/5-34-3.HTM>; R.I. Gen. Laws §5-34-39, <http://www.rilin.state.ri.us/Statutes/TITLES/5-34/5-34-39>.
⁸⁰ Basic Nursing Edu. Programs R5-34-NUR/ED 1.9; 9.0 - 9.3.1, <http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4666.pdf>.
⁸¹ S.C. Code Ann. §40-33, <http://www.scstatehouse.net/code/40c033.htm>.
⁸² S.D. Codified Laws §§36-9A-4, 36-9A-5, 36-9A-12, 36-9A-13.1, 36-9A-15, 36-9A-17.1, <http://legis.state.sd.us/statutes/DisplayStatute.aspx?Statute=36-9A&Type=Statute>; S.D. Admin. R. §20-62:02:04, <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/tennesse/lpext.dll?f=templates&f=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.bnc.state.tx.us/bnc-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://vtprofessionals.org/opr1/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%20pres%20auth%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%202009%2020-%20204%20B-%202020%201%2020.htm>; W. Va. Code §16-30-3(c), <http://www.legis.state.wv.us/WVCODE/16/WVC%2016%2020-%202030%2020-%20203%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/esrdocs/worddocs/19-08.doc>; W. Va. Code §30-7-15(a), <http://www.legis.state.wv.us/WVCODE/30/WVC%2030%2020-%20207%2020-%202015%20B.htm>.
- ⁹⁰ Wis. Stat. §255.06(d), <http://www.legis.state.wi.us/statutes/Stat0255.pdf>; Wis. Stat. §§41.001(4), 441.16, <http://www.legis.state.wi.us/statutes/Stat0441.pdf>.
- ⁹¹ Wyo. Stat. Ann. §33-21-120, <http://nursing.state.wy.us/NPA/TITLE%202022%20CHAPTER%202021%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>.

APPENDIX H

**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

APPENDIX I

<p>By September 1 (of year preceding legislative session)</p>	<p>Health care profession seeking change/creation of SOP submits written SOP request to DPH, addressing established criteria</p> <p>DPH informs Public Health Committee of scope request; posts on website (within 5 business days)</p>
<p>By September 15</p>	<p>Any health care profession that might oppose the submitted request, as determined by DPH, must receive a copy of scope request</p>
<p>By October 1</p>	<p>Any opposing health care profession may submit written response to the SOP request, addressing same criteria, and include areas of agreement, to DPH</p>
<p>By October 15</p>	<p>Profession making request must submit written response to any opposing response; include areas of agreement</p> <p>DPH commissioner appoints a scope of practice review committee to analyze and evaluate SOP requests, including responses</p>
<p>By February 1 (of year of legislative session)</p>	<p>Scope of practice review committee provides written assessment and recommendations to the Public Health Committee</p>



STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

February 11, 2010

Senator John Kissel, Co-Chair
Representative Mary M. Mushinsky, Co-Chair
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Senator Kissel and Representative Mushinsky:

Thank you for providing the Department of Public Health with the opportunity to comment on the Legislative Program Review and Investigations Committee findings and recommendations on Scope of Practice Determination for Health Care Professions.

The Department of Public Health acknowledges the General Assembly's interest in resolving the issues surrounding scope of practice discussions and compliments the committee for undertaking the difficult task of assembling information from major stakeholders to evaluate the current system and develop recommendations to address the issues raised by various stakeholders. In particular, the Department appreciates the effort Carrie Vibert and Brian Beisel invested in trying to understand the process and the opportunity provided to my staff to comment on the draft report. Toward achieving our mission of protecting the health and safety of the people of Connecticut, the Department fully embraces the premise that only those health professionals who are adequately educated, trained and competent should provide care and services.

Although the Department does not believe that there are significant deficiencies in the outcomes of the existing scope of practice determination process, we do recognize the potential benefits of a more formal process that is focused on public health and safety and based on standardized criteria, and can also be used to gather, analyze and evaluate information from stakeholders. Ultimately, decisions as to whether a particular scope of practice should be modified or whether a new scope should be established reside with the legislature.

Department staff shares the frustration of health care practitioners and members of the Public Health Committee that the scope of practice review process is complex, resource-intensive and time consuming, and while committee staff believes the Legislature should more fully use the Department for information about scope of practice issues, it is not realistic to assume that the Department knows all there is to know about the scopes of practice for all of the individual health care professions we regulate. Within our limited resources, we too must depend on the regulated professions to provide us with relevant information.

Phone:



Telephone Device for the Deaf: (860) 509-7191

410 Capitol Avenue - MS # _____

P.O. Box 340308 Hartford, CT 06134

Affirmative Action / An Equal Opportunity Employer

To the extent that we are unable to identify any public health and safety concerns with a scope of practice proposal, our position is generally neutral because we have no vested interest in the proposed change. Obviously our position may change if a proposal impacts on Department resources. While there is no formal structure for dialogue between professions when differences occur within the legislative process, we have functioned as a neutral party in attempting to facilitate agreements among professional groups during scope of practice disputes on many occasions.

The Department agrees that scope of practice decisions should be based on the most complete, objective information possible and that finding common areas of agreement can provide a solid foundation for scope of practice discussions. The Department supports the development of specific criteria that would provide common standards to be applied in submitting a scope of practice request to the legislature. The Department is willing to continue to informally meet with professions to discuss scope of practice issues. However, we do not have the necessary resources to support the recommended scope of practice review committee model and respectfully disagree with committee staff that no additional resources would be necessary to support these activities. In addition to making sure that the process operates smoothly and participating in committee meetings as an ex-officio member, the Department would clearly be responsible for providing administrative direction and support to the scope of practice review committees. The Department cannot absorb the costs associated with this process within our current budget allotment.

Committee staff report that 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, however it is not evident that the proposed process would ensure that only the most objective, factual information is collected, assessed and made available to policy makers. While a more structured process may be beneficial and could alleviate some of the internal pressures experienced by the Public Health Committee, it does not appear that the recommended process is designed to evaluate the accuracy and validity of information that would be provided, and instead would shift the burden of determining which stakeholder has the most credible argument from the legislature to an outside panel who would not necessarily have any more expertise than the legislature. Should this proposal move forward, the Department would welcome the opportunity to provide more specific comments concerning the proposed scope of practice review committee process and structure for your review and consideration.

Thank you for providing the Department with the opportunity to comment on this report. Please do not hesitate to contact my staff if you have any questions concerning our comments.

Sincerely,



J. Robert Galvin, M.D., M.P.H., M.B.A.
Commissioner