

# Connecticut Coalition of Advanced Practice Nurses

American College of Nurse-Midwives (ACNM), Region I, Chapter 2  
Connecticut Advanced Practice Registered Nurse Society (CT APRNS)  
Connecticut Association of Nurse Anesthetists (CANA)  
Connecticut Nurses' Association (CNA)  
Connecticut Chapter, American Psychiatric Nurses Association (APNA - CT)  
National Association of Pediatric Nurse Practitioners (NAPNAP), Connecticut Chapter  
The Northwest Nurse Practitioner Group

February 25, 2010 JOINT HEARING OF THE COMMITTEES ON PUBLIC HEALTH  
AND PROGRAM REVIEW AND INVESTIGATION

## **OPPOSITION to Raised Bill No. 5258, AA Implementing the Recommendations of the Program Review and Investigations Committee Concerning Scope of Practice Determinations for Health Care Professions**

Distinguished Chairs and Members of the Committee:

The Connecticut Coalition for Advanced Practice Nursing thanks the two committees for the opportunity to address the concepts presented in HB 5258, AA Implementing the Recommendations of the Program Review and Investigations Committee Concerning Scope of Practice Determinations for Health Care Professions. This testimony is submitted by Lynn Price and Mary Moller, representing the Connecticut Coalition for Advanced Practice Nursing, referenced henceforth as the APRN Coalition in the interest of brevity.

The APRN Coalition realizes that Public Health Committee members seek a more rational method to address scope of practice issues. We agree this is needed. The current proposal does not present a rational process.

PRI "staff," which in fact was one person, did a monumental job in meeting with the groups representing the majority of licensees under the Public Health Committee purview. From our own collective experience and anecdotally from others, these meetings took on average four hours per specialty group. In addition this sole staff member spoke for several hours with a national expert in scope of practice legislative and administrative issues regarding nursing and other recognized health professions. In short, the data collection is commendable, even extraordinary.

The report issuing from this exemplary data collection does not reflect what we believe these data suggest. And equally concerning, the current bill, which relies on that report and the data collected, does not reflect best practice regarding scope of practice procedures. In fact, the current proposal appears to rest on a legislative template designed by the American Medical Association (AMA) in 2008, entitled "Creation of State-based Scope-of-Practice Review Committees".<sup>1</sup> While we support and commend our physician colleagues in attempting to rationalize scope of practice issues, we also note that the AMA's interest in such affairs commenced in 2006 with the creation of the

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<sup>1</sup> AMA, Scope of Practice Campaign Advocacy Resource Center. (2008). *Creation of State-based Scope-of-Practice Review Committees, Legislative Template.*

Scope of Practice Partnership (SOPP), which clearly identified a desire to resist any expansion of practice and to reclaim those that have been expanded:

- H-160.949 – Practicing Medicine by Non-Physicians. H-160.949 states that “[o]ur AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; **(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;** (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; and (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine. (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00)”<sup>2</sup> (bolding added).

The APRN community asks that members of these two committees recognize the "turf" wars explicit in the AMA statement stated above. We ask the committees to require the medical community to substantiate the public health risk it invokes in seeking to control non-physician practice. And we note that the composition and management of any review committee must be carefully balanced, to avoid any one profession from dominating the discussion or determining the outcome. We believe the current bill "institutionalizes" opposition from the medical community, as physicians are currently the only profession with no limit to their scope of practice, and thus would never be requesting a change.

Our colleagues will speak in more detail about the flaws in the process described in this bill. We would like to speak directly to the examples cited in the AMA template - New Mexico and Texas, as states actively contemplating such review; and Arizona and Nebraska, as states having implemented some sort of "review" process for scope of practice requests. And we would like to explicitly put before the committee the fundamental criteria recognized by the experts in healthcare profession regulation as inherent to crafting any scope of practice process.

New Mexico and Texas are easily addressed. The 2008 AMA document states that these states in each of the last several years have contemplated legislation proposing a review

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<sup>2</sup> American Medical Association. (2006). Board of Trustees Report # 24-A-06. Limited Licensure Health Care Provider Training and Certification Standards (D.M. Cady, Chair).

process to handle actual or potential scope of practice "requests".<sup>3</sup> True enough. Equally true is that these proposals have originated persistently, and only, from the state medical societies for New Mexico and Texas, not from the Executive or Legislative branches, nor from the health professions.

As to states alleged to have a good process, Arizona is noted in the 2008 AMA Legislative Template document to have "experienced much success" in its process, though no evidence, or metrics for that claim are cited.<sup>4</sup> Nonetheless, the APRN Coalition will assume that such claim does represent the facts. We draw the Committees' attention to substantive differences between what exists in Connecticut at present, and what exists in Arizona.

The Arizona Governor's Regulatory Review Council (GRRC) was implemented in 1981, by Executive Order.<sup>5</sup> This committee, appointed by the governor, is considered "the final step in the rule-making process" for most agency rules, and is not a legislative advisory body.<sup>6</sup> The GRRC meets at least monthly to consider ANY proposed change to rules, not only matters actually or potentially related to scope of practice for health professionals. The members represent the public and the business community.<sup>7</sup> Executive agencies, through professional boards, bring any scope of practice requests to the committee.

The APRN Coalition notes that Arizona has maintained a vital Board of Nursing Examiners, with an Executive Director and staff, as well as an APRN advisory committee. In contrast, Connecticut eliminated the Executive Director for the State Board of Examiners of Nursing long ago. One position of twelve belongs to APRNs on the Connecticut Board. Although the Boards in Arizona and Connecticut each consider disciplinary issues, Arizona's Board also is mandated and sufficiently staffed to consider requests to expand practice scope, and to bring its recommendations to Arizona's GRRC via the equivalent of the Department of Public Health, which is not the case in Connecticut. APRNs in Arizona practice without mandated physician involvement.<sup>8</sup>

Nebraska, as the 2008 AMA Legislative Template notes, has experienced "more tempered" success than has Arizona, and again does not define this.<sup>9</sup> The "committee" is actually a regulatory board for APRNs, with physician membership; this perhaps explains why the AMA template offers it as an example. As it models not an advisory committee in fact but a professional board, Nebraska's process does not pertain to the issues for which the two committees hearing commentary about Bill 5258 seek solution.

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<sup>3</sup> AMA Scope of Practice Campaign Advocacy Center, *op. cit.*, p 2, 5.

<sup>4</sup> AMA Scope of Practice Campaign Advocacy Center, *op. cit.*, p. 2.

<sup>5</sup> Governor's Regulatory Review Council, available at <http://www.grrc.state.az.us/>

<sup>6</sup> Governor's Regulatory Review Council, *ibid.*

<sup>7</sup> Governor's Regulatory Review Council, *ibid.*

<sup>8</sup> Arizona State Board of Nursing, Nurse Practice Act, available at <http://www.azbn.gov/NursePracticeAct.aspx>

<sup>9</sup> AMA Scope of Practice Campaign Advocacy Center, *op. cit.*, p. 2.

Of interest, the PRI Report on which this bill rests, however, also references a consensus document issued in 2007 from the national regulatory board associations for six of the major health professions: social work, physical therapy, **medicine**, pharmacy, occupational therapy, and nursing.<sup>10</sup> This consensus statement does not envision any particular process for weighing requests to change scope of practice authority, nor does it advocate for a "state professional board approach" over a "legislative" one. Instead, it speaks directly to the four concerns any decision-making body should consider when evaluating changes to health professions' scope of practice: history and evolution of the profession at hand, education and training of the profession, evidence that the proposed change will increase access to quality care, and the regulatory environment. The document sets out specific questions under each of these four principles for decision-makers to consider. This consensus document from the experts in professional regulation recognizes that we are long past a time where one profession can claim to own any particular scope, as there is much overlap. Therefore, **"the criteria related to who is qualified to perform functions safely.... are the only justifiable conditions for defining scope of practice."**<sup>11</sup>

The APRN Coalition seeks, as do the two committees and our colleagues in the other professions, a balanced and fair process. Bill 5258 does not provide this. However, we are very interested in coming to the table to continue the discussion, and look forward to doing so.

Thank you,

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Connecticut Coalition for Advanced Practice Nurses

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<sup>10</sup> National Council of State Boards of Nursing. Changes in health care professions' scope of practice: Legislative considerations. Available at <https://www.ncsbn.org/ScopeofPractice.pdf>

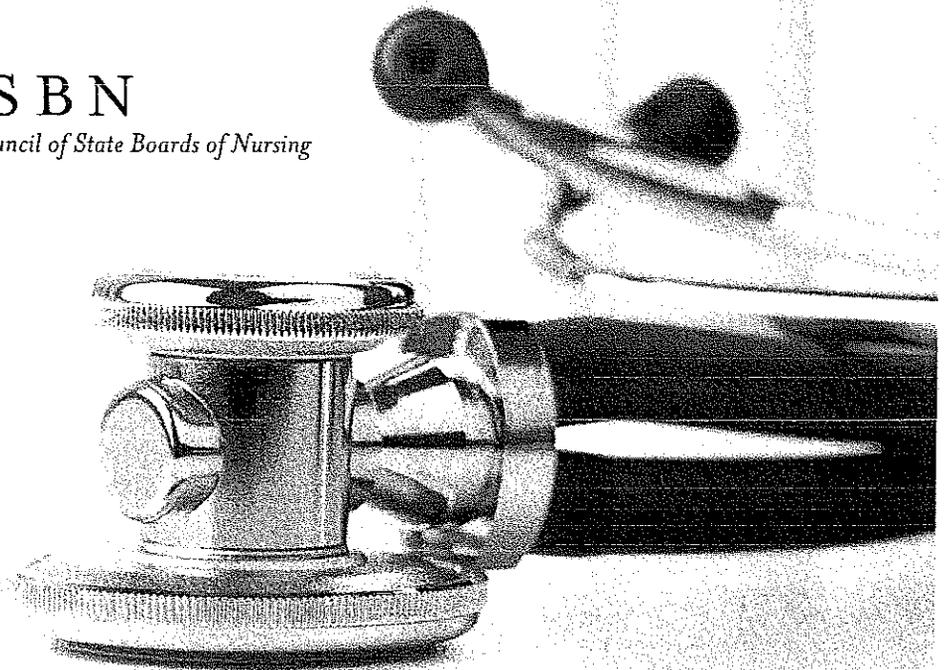
<sup>11</sup> *ibid.* p. 15.

Changes In  
Healthcare Professions'  
Scope of Practice:  
Legislative Considerations



**NCSBN**

*National Council of State Boards of Nursing*



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In 2009, a new era of healthcare reform is sweeping state and federal government in the U.S. During these difficult economic times policymakers are faced with many challenges, not the least of which are legislative and regulatory debates on how to maximize the use of all healthcare practitioners and the debate among healthcare practitioners, regarding the continuous evolution of scopes of practice. Law and rule makers charged with consumer protection will find this document helpful in guiding discussions on how the most effective and efficient care can be delivered to the American public in an era of continuous changes in healthcare.



## Executive Summary

This document is a result of a collaborative effort in 2006 by representatives from six healthcare regulatory organizations. It has been developed to assist legislators and regulatory bodies with making decisions about changes to healthcare professions' scopes of practice.

Proposed changes to a healthcare professions' scope of practice often elicit strongly worded comments from several professional interest groups. Typically, these debates are perceived as turf battles between two or more professions, with the common refrain of "this is part of my practice so it can't be part of yours." Often lost among the competing arguments and assertions are the most important issues of whether this proposed change will better protect the public and enhance consumers' access to competent healthcare services.

Healthcare education and practice have developed in such a way that most professions today share some skills or procedures with other professions. It is no longer reasonable to expect each profession to have a completely unique scope of practice, exclusive of all others. We believe that scope of practice changes should reflect the evolution of abilities of each healthcare discipline, and we therefore have attempted to develop a rational and useful way to make decisions when considering practice act changes.

Based on reports from the Institute of Medicine<sup>1</sup> and the Pew Healthcare Commission<sup>2</sup> we propose a process for addressing scope of practice, which is focused on patient safety. The question that healthcare professionals must answer today is whether their profession can provide this proposed service in a safe and effective manner. If an issue does not address this question, it has no relevance to the discussion.

This process gets to the heart of regulation which, according to Schmitt and Shimberg, is intended to:

1. "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners";
2. "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner"; and
3. "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses."<sup>3</sup>

The argument for scope of practice changes should have a foundational basis within four areas: 1) an established history of the practice scope within the profession, 2) education and training, 3) supporting evidence, and 4) appropriate regulatory environment. If a profession can provide support evidence in these areas, the proposed changes in scope of practice are likely to be in the public's best interest.

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<sup>1</sup> *Crossing the Quality Chasm: A New Health System for the 21st Century*, The Institute of Medicine, National Academy Press, 2001.

<sup>2</sup> *Reforming Healthcare Workforce Regulation: Policy Considerations for the 21st Century*, Report of the Pew Health Professions Commission's Taskforce on Healthcare Workforce Regulation, December 1995, ix.

<sup>3</sup> *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*, Schmitt, K. and Shimberg, B., Council on Licensure, Enforcement and Regulation, 1996.

## D. Introduction

The scope of practice of a licensed healthcare profession is statutorily defined in each state's laws in the form of a practice act. State legislatures have the authority to adopt or modify practice acts and therefore adopt or modify a particular scope of practice of a healthcare profession. Sometimes such modifications of practice acts are just the formalization of changes already occurring in education or practice within a profession, due to the results of research, advances in technology, and changes in societal healthcare demands, among other things.

This process sometimes pits one profession against another before the state legislature. As an example, one profession may perceive another profession as "encroaching" into their area of practice. The profession may be economically or otherwise threatened and therefore opposes the other profession's legislative effort to change scope of practice. Proposed changes in scopes of practice that are supported by one profession but opposed by other professions may be perceived by legislators and the public as "turf battles." These turf battles are often costly and time consuming for the regulatory bodies, the professions and the legislators involved.<sup>4</sup> Aside from guidance on scope of practice issues, this document may assist in preventing costly legislative battles; promote better consumer care and collaboration among regulatory bodies, the professions and between competent providers; and improve access to care.

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<sup>4</sup> *Strengthening Consumer Protection: Priorities for Healthcare Workforce Regulation*, Report from Pew Health Professions Commission, 1998.



# The Purpose of Regulation

Before providing information regarding scope of practice decisions, we must ask the very basic question, "What is the purpose of regulation?" According to Schmitt and Shimberg, regulation is intended to:

1. "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners";
2. "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner"; and
3. "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses."<sup>5</sup>

## A. Defining Scope of Practice

A 2005 Federation of State Medical Boards report defined 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."<sup>6</sup>

## B. Assumptions Related to Scope of Practice

In attempting to provide a framework for scope of practice decisions, basic assumptions can be made:

- 1. The purpose of regulation — public protection — should have top priority in scope of practice decisions, rather than professional self-interest.** This encompasses the belief that the public should have access to providers who practice safely and competently.
- 2. Changes in scope of practice are inherent in our current healthcare system.** Healthcare and its delivery are necessarily evolving. These changes relate to demographic changes (such as the aging of the "baby boomers"); advances in technology; decreasing healthcare dollars; advances in evidence-based healthcare procedures, practices and techniques; and many other societal and environmental factors. Healthcare practice acts also need to evolve as healthcare demands and capabilities change.
- 3. Collaboration between healthcare providers should be the professional norm.** Inherent in this statement is the concept that competent providers will refer to other providers when faced with issues or situations beyond the original provider's own practice competence, or where greater competence or specialty care is determined as necessary or even helpful to the consumer's condition.

- 4. Overlap among professions is necessary.** No one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is within one profession's skill set does not mean another profession cannot and should not include it in its own scope of practice.
- 5. Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service.** No professional has enough skills or knowledge to perform all aspects of the profession's scope of practice. For instance, physicians' scope of practice is "medicine," but no physician has the skill and knowledge to perform every aspect of medical care. In addition, all healthcare providers' scopes of practice include advanced skills that are not learned in entry-level education programs, and would not be appropriate for an entry-level practitioner to perform. As professions evolve, new techniques are developed; not all practitioners are competent to perform these new techniques.

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<sup>5</sup> *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*, Schmitt, K. and Shimberg, B., Council on Licensure, Enforcement and Regulation, 1996.

<sup>6</sup> *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards, 2005.

# The Basis for Decisions Related to Changes in Scope of Practice

Arguments for scope of practice changes should have a foundational basis within four areas: 1) an established history of the practice scope within the profession, 2) education and training, 3) supportive evidence, and 4) appropriate regulatory environment. This foundation should provide the framework for analyzing and determining if a change in statutory scope of practice is warranted in a particular situation. If a profession can provide supporting evidence in these areas, the proposed changes in scope of practice should be adopted.

## A. Historical Basis

The first of these relates to the history and evolution of the profession and its practice. This historical framework provides the basis for the essentials of the profession, including its theoretical basis, how it developed over the years and how it is presently defined. Changes in statutory scope of practice should fit within the historical, evolutionary and present practice context for the profession.

Questions to be considered in this area include:

1. Has there been an evolution of the profession towards the addition of the new skill or service?
2. What is the evidence of this evolution?
3. How does the new skill or service fit within or enhance a current area of expertise?

## B. Education and Training

Tasks added to scopes of practice are often initially performed by professionals as advanced skills. Over time, as these new skills and techniques are utilized by a sufficient cohort of practitioners, they become entry-level skills and are taught as such in entry-level curricula. It is not realistic to require a skill or activity to be taught in an entry-level program before it becomes part of a profession's scope of practice. If this were the standard, there would be few, if any, increases in scope of practice. However, the entry-level training program and its accompanying accrediting standards should provide the framework, including the basic knowledge and skills needed, to acquire the new skill once out in the field. There should be appropriate accredited post-professional training programs and competence assessment tools that indicate whether the practitioner is competent to perform the advanced skill safely.

Questions to be considered in this area include:

1. Does current entry-level education prepare practitioners to perform this skill as their experience increases?
2. If the change in scope is an advanced skill that would not be tested on the entry-level licensure examination, how is competence in the new technique assured?



3. What competence measures are available and what is the validity of these measures?
4. Are there training programs within the profession for obtaining the new skill or technique?
5. Are standards and criteria established for these programs?
6. Who develops these standards?
7. How and by whom are these programs evaluated against these standards?

### **C. Evidence**

There should be evidence that the new skill or technique, as used by these practitioners, will promote access to quality healthcare. The base of evidence should include the best available clinical evidence, clinical expertise and research. Other forms of evidence include evolving concepts of disease/disability management, quality improvement and risk data, standards of care, infection control data, cost-effectiveness analysis and benchmarking data. Available evidence should be presented in an easy-to-understand format and in an objective and transparent manner.

**Questions to be considered in this area include:**

1. Is there evidence within the profession related to the particular procedures and skills involved in the changes in scope?
2. Is there evidence that the procedure or skill is beneficial to public health?

### **D. Regulatory Environment**

A consideration in proposing changes in scope of practice is the regulatory environment. Often, it is the professional association that promotes and lobbies for scope of practice changes. The regulatory board should be involved in the process and be prepared to deal with the regulatory issues related to the proposed changes.

**Questions to be considered in this area include:**

1. Is the regulatory board authorized to develop rules related to a changed or expanded scope?
2. Is the board able to determine the assessment mechanisms for determining if an individual professional is competent to perform the task?
3. Is the board able to determine the standards that training programs should be based on?
4. Does the board have sufficient authority to discipline any practitioner who performs the task or skill incorrectly or might likely harm a patient?
5. Have standards of practice been developed for the new task or skill?
6. How has the education, training and assessment within the profession expanded to include the knowledge base, skill set and judgments required to perform the tasks and skills?
7. What measures will be in place to assure competence?

## Basis for Legislative Decision Making

Although the areas for decision making listed above do not specifically mention public protection, supplying documentation in historical basis, education and training, evidence and the regulatory environment is likely to ensure that the public will be protected when these changes are made.

Potential for harm to the consumer is difficult to prove or disprove relative to scope of practice. It is the very fact that there is potential for harm that necessitates regulation. If a strong basis for the redefined scope is demonstrated as described above, this basis will be rooted in public protection.

This paper rests on the premise that the only factors relevant to scope of practice decision making are those designed to ensure that all licensed practitioners be capable of providing competent care.

## Conclusion

This paper presents important issues for consideration by legislators and regulatory bodies when establishing or modifying a profession's scope of practice. The primary focus of this paper is public protection. When defining a profession's scope of practice, the goal of public protection can be realized when legislative and/or regulatory bodies include the following critical factors in their decision-making process:

- **Historical basis** for the profession, especially the evolution of the profession advocating a scope of practice change,
- Relationship of **education and training** of practitioners to scope of practice,
- **Evidence** related to how the new or revised scope of practice benefits the public, and
- The **capacity of the regulatory agency** involved to effectively manage modifications to scope of practice changes.

Overlapping scopes of practice are a reality in a rapidly changing healthcare environment. The criteria related to who is qualified to perform functions safely without risk of harm to the public are the only justifiable conditions for defining scopes of practice.

Testimony on Bill No. 192      LCO No. 983

An Act Concerning Advanced Practice Registered Nurses and Primary Care Providers for Individual and Group Health Insurance Policies

February 25, 2010

Committee on Insurance and Real Estate

This is testimony in support of Bill No. 192      LCO No. 983

My name is Mary Leahy, FNP-NC, APRN. I have been a practicing family nurse practitioner/APRN for the last 15 years. For the last 5 years, I have been the owner and primary care provider of Roaring Brook Family Practice, in Avon, Connecticut. I currently care for over 4000 patients.

Senator Crisco and Representative Fontana:

Thank you for hearing this Bill. I speak in support of proposed Bill No. 192. The problem this Bill will address is an individual's choice of competent primary care providers. In addition, this Bill will allow me to continue to practice responsibly and accountably. Please allow me to give you a few specifics.

Access to a preferred primary care provider has always been desirable in our health care system. I currently accept (and am therefore credentialed by) most major health care insurances, including some State insurance plans.

I have been the sole primary care provider for the majority of my patients for more than 5 years; and in some cases more than 10 years. When an individual enters my office, they provide in depth confidential information. We develop a long-term working relationship based on mutual understanding. If a patient cannot find me on the insurance companies' lists of approved providers, they may assume I am not credentialed or covered. This can create stress. It may also cause them to seek an alternative provider despite not wanting to leave my practice.

When I went into an independent practice setting, I did so with the intention of meeting the needs of a unique population. I am a niche primary care provider. I provide APRN based primary care within an ever changing and somewhat pressured health care environment. I engage individuals as active participants in the health care process. I see adults, their children, their parents, and their grandparents.

Please understand that this Bill is not economic. I will never sacrifice the quality of care that I provide for quantity of patients seen. I will never get rich doing what I do. However, I do provide good care, and I sleep well at night. Granted, the majority of my patients are referred by word-of-mouth from existing patients. In fact, I don't know of anyone who would just pick an arbitrary name off a listing or panel of providers. However, once individuals are given my name, most persons are going to want to "check me out". They will go to the internet and look at my ratings, and then they will go to their insurance site to see if I am listed. Who can afford a provider out-of-pocket? Very few of us can. If I am not listed, then I

do not exist. That may be the end of the search and the end of a potentially therapeutic relationship-before it even started.

Also, as a business owner who is looking out for my employees and self, I am well aware of the decision-making process, including the comparison of costs and benefits of different employer-provided health insurance plans. In order to make ends meet, I review proposals from a variety of health insurance companies on a yearly basis. Based on these yearly assessments, I (as with most large and small businesses) may decide to change our insurance company or plan. One of the first things an employee will do, in response to this change, is to check to see if his/her current preferred health care provider is listed under the new plan or policy. The majority of the time I am not listed as a primary care provider by these major health insurance plans, or my name is found in some obscure place like "other" or "nurse". I am difficult to find, if I can be found at all, despite being fully credentialed by the health insurance companies.

I am compelled to also discuss the impact of Bill No. 192 on referral to specialists; and vice versa, referrals from specialists back to my practice. I have worked diligently and have obtained an excellent reputation as a competent primary care provider with most area specialists. They are often asked their opinion on who provides primary care in the area. The same circumstance holds true. If the specialist looks at the patient's provider panel list and I am not listed, I am not accessible.

I have discussed just a few of the issues related to access to care, and I want to spend the remainder of my time talking about responsibility, accountability, and liability.

Let me give you one specific example. An 83 year old patient fell in her assisted living facility, striking her head but not losing consciousness. I was never notified of the fall. Four days later, a fax notifying me of the fall and asking whether or not I wanted to do a head CT scan was hand carried to my office. It turns out, despite being asked to notify me directly, the Director of the facility-notified the "physician of record" instead. She did not know that he had never met the patient and knew nothing about the patient's history, nor was she aware that his office was closed for those 4 days and no one checked the fax machine. Luckily, nothing serious happened to this woman, but this situation could have been disastrous.

Commonly, because of insurance issues, radiology reports inadvertently end up addressed to and delivered to a physician's office instead of mine. If I order a radiographic study, I am usually concerned about something that I cannot see with the naked eye or I am waiting for that report to make further decisions regarding care. If these reports end up in the wrong place, there are delays in answers and treatment. It can create undue stress and allow conditions to simmer longer than necessary. The chances of a mistake or lost results are enormous.

Outside consultants work under the same constraints. Often policies exist within organizations that require "physician of record" identification, usually to simplify insurance processing for incoming patients. The problem then is that these consult reports again are addressed to a physician who is not the primary care provider and are not directly received by my office. These results and recommendations are essentially unavailable to me. I refer to specialists when a patient's problem is

beyond my scope of practice as an APRN and/or because I am concerned about something more serious occurring and want to expedite a specialist evaluation. I need this information.

As technology advances, and EMR becomes the record keeping method of choice, it will be even more difficult to track what has and has not been received. Paper reports will eventually vanish. If these reports end up in a physician's computer or in his office-there is no possible method to avoid delay or know if I will ever receive the results at all.

I am sure, at this time, you have other thoughts of your own "worst case scenarios" given the current circumstances. I reiterate my goal is to provide the best possible primary care available from an APRN within the current health care system. Please allow me and other APRNs to continue to do this by removing barriers to access to quality care and barriers to information needed to provide safe thorough care. Thank you for your time and attention.