



**Written Testimony
In Opposition to
SB 36, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO
HEALTH CARE
Committee on Public Health**

February 28, 2014

Senator Gerratana, Representative Johnson and members of the Public Health Committee, on behalf of the more than 250 orthopaedic surgeons of the Connecticut Orthopaedic Society, thank you for the opportunity to submit written testimony in opposition to SB 36, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE.

The Connecticut Orthopaedic Society appreciates efforts to improve access to healthcare in our state but we also appreciate that increased access to care does not always equate to increased quality of care. Our members have had longstanding collaborative relationships with APRNs in our state, which are highly valued and which the Society wants to continue. Working together with physicians, APRNs are important members of the healthcare team and they add value in the delivery of healthcare. With that said, the overwhelming sense among the public is that nurses work under the direction of physicians, and passage of this legislation would decouple that relationship, with patients treated by APRNs losing the safeguard of having a physician collaborating in their care, and in many cases those patients may be completely unaware.

APRNs are qualified to provide care that is predicated on their education and clinical training and that traditionally involves disease management and care coordination, not diagnosing and treating complex medical problems, which is a core competency for physicians developed during the average 3,200 hours of their highly standardized and supervised medical training. Collaboration combines the competencies of diagnoses and treatment plans developed by physicians with disease management and care coordination provided by APRNs. Without the commitment to ongoing collaboration, many physicians

Written Testimony Submitted by the Connecticut Orthopaedic Society – Oppose SB 36

would not continue to provide APRNs with post-graduate supervision that would serve as a precursor to independent practice, free of any of any additional oversight from the medical community.

As physicians we view APRNs as a valuable part of a clinical team and welcome them as an important partner in delivering care to our patients. However, it is important to note the limits of any practitioner's training and education allowing APRNs to practice independently with only three years of collaboration with no mechanism in place to demonstrate competency after the three years puts patients at potential risk. Again, in the absence of an ongoing collaborative arrangement that works to ensure the continuous delivery of high quality medical care, the Society believes requiring three years of collaborative practice at the beginning of an APRNs clinical practice does not meaningfully serve the interests of patients in the state of Connecticut, and may provide a false sense of security around their qualifications as clinicians.

As this proposed legislation is essentially providing for the "practice of medicine" by APRNs by allowing independent access to patients, the ability to formulate medical diagnoses, to prescribe medications and treatments, and to order and interpret diagnostic tests, it is the opinion of the society that APRNs be held to the same rigorous standards of continuing medical education and board certification requirement of physicians with similar practice demographics, and furthermore be held to the same standards of care and liability coverage limits as physicians.

SB 36 is being portrayed as an attempt to improve primary care access to patients in Connecticut. However, independent practice does not increase the number of APRNs in Connecticut. An APRN collaborating with a medical doctor can see as many if not more patients than an independent practicing APRN, particularly a less experienced one. Collaboration does not prevent an APRN from using his or her education, training, or experience, but allows the patient to also benefit from the collaborating physician. The goal should be to increase the number of APRNs practicing in Connecticut, which can be done via increased training programs and positions and making it easier for collaborating APRNs to take care of more patients, particularly underserved one. A good model is the Virginia House Bill 346 <http://lis.virginia.gov/cgi-bin/legp604.exe?121+sum+HB346>, which was legislation developed in

Written Testimony Submitted by the Connecticut Orthopaedic Society – Oppose SB 36

collaboration with both physicians and APRNs and improved patient access without risking patient safety.

Furthermore, AMA data shows that in 2010 only 47% of APRNs in Connecticut practiced primary care and that APRNs tend to be no more concentrated in rural and underserved areas than primary care physicians. SB 36 does not restrict APRNs to independent practice of primary care. The COS does not believe that current and previous APRN training 3 years of collaboration, particularly if the three years is with a primary care physician and/ or grandfathered, adequately prepares APRNs to independently practice specialty care such as cardiology or orthopaedic surgery that typically requires for medical physicians longer residency or additional fellowship training programs.

In a 2010 Truth in Advertising Survey, completed by the American Medical Association (<http://www.ama-assn.org/resources/doc/arc/tia-survey-2008-2012.pdf>), 98% of respondents agreed that physicians and nurses need to work in a coordinated manner to ensure that patients get the care they need and 88% agreed that while nurse practitioners are essential to the healthcare team, they should assist the physician, who should take the lead role in determining the type and level of care administered. Of those responding, 78% of all respondents indicated that physicians, rather than nurse practitioners, should diagnose medical conditions and 79% indicated that nurse practitioners should not be able to practice independently of physicians, without physician supervision, collaboration or oversight.

Connecticut, as one of 21 states that currently requires a collaborative agreement, should continue to safeguard its' citizens with the current mechanism put in place by the legislature and the Department of Public Health.

With respect to the recommendations of the 2010 Institute of Medicine Report that is being used to support SB 36, it must be remembered that the report is derived from the Robert Wood Johnson Foundation Initiative on the Future of Nursing and like many foundations whose work is used to promote political advocacy its work did not appropriately reflect the facts on both sides of the issue.

Written Testimony Submitted by the Connecticut Orthopaedic Society – Oppose SB 36

Thank you for your time and consideration of the orthopaedic community's concerns regarding the serious patient safety issues of this bill. The Connecticut Orthopaedic Society strongly urges this Committee to maintain the current model in place for APRNs in our state and oppose SB 36.

The orthopaedic community looks forward to working together to safeguard patients and to ensure quality and appropriate patient care.

Submitted by:

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Truth in Advertising survey results

Education and training matters when it comes to who provides your health care, but do most patients know the qualifications of their health care provider? A 2008 survey found that while patients strongly support a physician-led health care team, many are confused about the level of education and training of their health care provider.¹ Follow-up surveys conducted in 2010² and 2012³ confirmed that patients want a physician to lead the health care team. The surveys also underscored that patient confusion remains high. Key findings include:

- ▶ Ninety-one percent of respondents said that a physician's years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency.¹
- ▶ Eighty-six percent of respondents said that patients with one or more chronic diseases benefit when a physician leads the primary health care team.²
- ▶ Eighty-four percent of respondents said that they prefer a physician to have primary responsibility for the diagnosis and management of their health care.¹

Truth in Advertising legislation can help provide the clarity and transparency necessary for patients to have the information they need to make informed decisions about their health care.

Patients are not sure who is—and who is not—a medical doctor

Is this person a medical doctor?	Yes (%)		No (%)		Not sure (%)	
	2008	2010	2008	2010	2008	2010
Orthopaedic surgeon/Orthopaedist	94	84	3	12	3	4
Obstetrician/Gynecologist	92	93	5	4	3	3
Primary care physician*	n/a	91	n/a	7	n/a	2
General or family practitioner	88	88	8	9	3	4
Dermatologist*	n/a	84	n/a	12	n/a	4
Dentist	77	69	20	29	3	2
Anesthesiologist	76	78	16	19	8	3
Psychiatrist	74	75	20	21	6	4
Ophthalmologist	69	71	14	16	17	13
Podiatrist	67	68	22	21	11	11
Optometrist	54	54	36	38	10	8
Psychologist	49	41	44	53	8	6
Chiropractor	38	31	53	61	9	6
Doctor of nursing practice	38	35	37	46	25	19
Audiologist	33	30	40	47	27	23
Otolaryngologist/ENT ⁵	32	43	13	33	55	24
Nurse Practitioner	29	26	63	69	7	5
Physical Therapist	26	19	68	78	6	3
Midwife	11	7	82	86	7	7

Continued on page 2.

Additional findings from the “Truth in Advertising” surveys

Patients strongly prefer physicians to lead the health care team

Should only a medical doctor be allowed to perform the following procedures or should other health care professionals be allowed to perform this specific activity?	Only a medical doctor (%)			Other health care professional (%)			Both equally/ either one (%)			Don't know (%)		
	2008	2010	2012	2008	2010	2012	2008	2010	2012	2008	2010	2012
Amputations of the foot?	93	93	92	5	5	5	n/a	n/a	2	2	2	2
Diagnose and treat heart conditions?	n/a	n/a	92	n/a	n/a	4	n/a	n/a	3	n/a	n/a	1
Surgical procedures on the eye that require the use of a scalpel?	92	91	90	6	4	5	n/a	n/a	2	2	2	3
Treat emergency or trauma medical conditions, which may be life threatening?	n/a	n/a	90	n/a	n/a	4	n/a	n/a	5	n/a	n/a	2
Facial surgery such as nose shaping and face lifts?	90	89	83	8	8	7	n/a	n/a	3	3	3	6
Write prescriptions for complex drugs, including those that carry a risk of abuse or dependence	82	75	83	16	23	10	n/a	n/a	5	2	3	2
Diagnose and treat chronic diseases like diabetes?	n/a	n/a	78	n/a	n/a	15	n/a	n/a	6	n/a	n/a	5
Write prescriptions for medication to treat mental health conditions such as schizophrenia and bi-polar disorder?	80	75	77	17	22	12	n/a	n/a	6	3	3	4
Administer and monitor anesthesia levels and patient condition before and during surgery?	71	70	77	27	23	15	n/a	n/a	6	3	7	2
Write prescriptions for common conditions like sinus infections?	n/a	n/a	34	n/a	n/a	44	n/a	n/a	20	n/a	n/a	2

Patients want their health care professional to clearly designate their education and training

Do you agree or disagree with the following?	Agree (%)			Disagree (%)			Don't know (%)		
	2008	2010	2012	2008	2010	2012	2008	2010	2012
Only licensed medical doctors should be able to use the title of “physician.”	91	93	92	7	6	6	2	1	2
It is easy to identify who is a licensed medical doctor and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials?	46	51	n/a	51	44	n/a	3	3	n/a
Would you support or oppose legislation in your state to require all health care advertising materials to clearly designate the level of education, skills and training of all health care professionals promoting their services?	Support (%)			Oppose (%)			Don't know (%)		
	2008	2010	2012	2008	2010	2012	2008	2010	2012
	93	87		6	10		1		3

1. Global Strategy Group conducted a telephone survey on behalf of the AMA Scope of Practice Partnership between August 13–18, 2008. Global Strategy Group surveyed 850 adults nationwide. The overall margin of error is +/- 3.4 percent at the 95 percent confidence level.
2. Baseline & Associates conducted a telephone survey on behalf of the AMA Scope of Practice Partnership between November 4–8, 2010. Baseline & Associates surveyed 850 adults nationwide. The overall margin of error is +/- 3.4 percent at the 95 percent level.
3. Baseline & Associates conducted a telephone survey on behalf of the AMA Scope of Practice Partnership between March 8–12, 2012. Baseline & Associates surveyed 801 adults nationwide. The overall margin of error is +/- 3.5 percent at the 95 percent level.
4. The physician professions “primary care physician” and “dermatologist” were not referenced in the 2008 survey.
5. The abbreviation for ear, nose and throat—“ENT”—was not referenced in the 2008 survey.



Bill Summary: Virginia House Bill 346

Background

Physician organizations and nurse practitioner organizations often find themselves on opposing sides of legislative scope of practice battles. But in Virginia, both sides worked together to craft a law that outlines how they will partner to provide team-based care. The Medical Society of Virginia and Virginia Council Nurse Practitioners collaborated for nearly two years through a dialogue designed to explore solutions that address systematic challenges to access to care. Virginia House Bill 346 (HB 346) was the product of this two-year dialogue. The bill was signed into law (Chapter 213) on March 10, 2012.

Definitions

Collaboration

The communication and decision-making process among members of the patient care team related to the treatment and care of a patient, including: (i) communication of data and information about the treatment and care of a patient, including clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

Consultation

The communicating of data and information, exchanging of clinical observations and assessments, accessing and assessing of additional resources and expertise, problem-solving, and arranging for referrals, testing, or studies.

Patient care team

A multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering care to a patient or group of patients.

Patient care team physician

A physician actively licensed to practice medicine in Virginia who provides management and leadership in the care of patients as part of a patient care team

Other

The law supports consultation and collaboration among physicians and NPs while preserving physician leadership and management of patient care teams. Specific provisions include:

- Nurse practitioners must practice as part of a patient care team, which includes maintaining appropriate collaboration and consultation with at least one patient care team physician

- Prescriptive authority – The law grants nurse practitioners the authority to prescribe Schedule II through Schedule VI controlled substances and devices, pursuant to a practice agreement with a physician that clearly states the nurse practitioner’s prescriptive authority.
- This collaboration and consultation can take place through telemedicine, allowing NPs to work in locations separate from their team physician (e.g., nursing homes, free clinics in medically underserved areas). Before the law, NPs had to work under direct supervision of a physician in the same location.
- For NPs providing care to patients within a hospital or health care system, the requirement for a practice agreement may be satisfied by evidence of the credentialing document for that NP working in the hospital or health care system.
- Each member of the patient care team must have specific responsibilities related to the care of the patient(s)
- The law expands to six the number of NPs a physician can partner with. Before the law, physicians could partner with only four NPs.
- Practice agreements can be submitted electronically. Before the law, practice agreements had to be maintained in paper form.