



**Connecticut State Medical Society Testimony in Opposition to
Senate Bill 36 An Act Concerning the Governor's Recommendations to Improve
Access to Health Care
Presented to the Public Health Committee
February 28, 2014**

Senator Gerratana, Representative Johnson and members of the Public Health Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS), we present this testimony to you today in strong opposition to Senate Bill 36 An Act Concerning the Governor's Recommendations to Improve Access to Health Care. Although the title refers to attempts to improve access to healthcare, this legislation would grant advanced practice registered nurses (APRN) the authority to independently practice within a rather broad and vaguely-defined scope of what is now considered the licensed practice of medicine in Connecticut after completing three years of an equally broad and vague collaborative agreement.

Current statute requires a critical bond between the APRN and collaborating physician to ensure that the patient receives the right care for the right reason at the right time. These functions have been mutually identified by the two parties: the physician has assessed the abilities and talents of the APRN, and there is an assurance the physician is willing to assume responsibility for the APRN's delivery of medically necessary services and treatment based on a set of previously-established protocols.

By removing the requirement for collaboration with a physician, the APRN alone would make all treatment decisions, whether the APRN is working with a patient with a single episode of care or with a patient who has multiple co-morbidities involving complex and often varied treatment modalities. If passed, this bill would allow APRNs to open their own practices to evaluate, diagnose, and provide treatment for potentially complex and life-threatening diseases. It would further allow APRNs to independently prescribe, administer, and dispense medications to patients, including controlled substances that require the development of patient treatment plans. All of this would take place without the benefit of oversight from a licensed physician with years of clinical training and practice.

At both the state and national level, our healthcare systems are increasingly adopting a team-based approach to the delivery of integrated care. The Patient Centered Medical Home (PCMH), Advanced Medical Homes (AMH) as proposed in the State Innovation Model (SIM), and other models of care are based on this team concept, with physicians, nurses and other care providers actively collaborating to ensure quality patient care, improve patient safety and control costs. Removal of collaboration requirements, such as is proposed in Senate Bill 36, are inconsistent with this team approach, inhibiting care coordination and severely hampering the connectivity between care team participants.

APRNs are valuable care extension resources, but they are not a substitute for a trained and licensed physician. Throughout discussions and debate on this issue we have clearly demonstrated a difference in education and training between physicians and APRNs. The differences cannot be overlooked. The average physician completes 3,200 hours of clinical training in medical school and 9,000 hours during residency. This extensive education and training provides physicians with the skills and experience to diagnose and treat complex medical problems. Depending on specialty, physicians are required to complete additional hours of accredited Continuing Medical Education (CME) to receive and maintain board certification. This is significantly greater than CME requirements of 50 hours over a two-year period contained in state statutes.

Conversely, the average APRN completes 500 hours of clinical training prior to practice. APRN education and training focuses on competencies such as health promotion, disease management and care coordination. These APRN skills are an important component of positive patient health outcomes, but not equivalent to those of a physician and should be considered when the determination is made whether or not to provide complete independence without the need for any involvement with a physician.

There is no substitute for the education, training and skills of a physician. Patients will not be well-served if APRNs are allowed to practice and prescribe independently, without appropriate physician direction, knowledge and involvement. Every patient deserves the confidence of knowing that a fully-trained physician is involved in the course of his or her medical care.

Should a majority of legislators support a move toward the independence of APRNs, a significant number of issues across a broad spectrum of concerns must be understood and addressed to ensure quality and protect patients as much as possible:

Education, clinical standards, continuing education requirements and oversight

Senate Bill 36 contains no language regarding these areas. APRNs practicing independently must be required to meet the same educational and clinical standards as physicians, as well as the same standards for continuing medical education. Three years of a very loosely defined collaboration prior to complete independence is unacceptable. Collaboration is not a substitute for the intensive, highly supervised minimum of three years of residency and additional years of specialty training prior obtaining any ability to practice with autonomy. Physicians in collaboration are not direct supervisors.

Regarding oversight, APRNs practicing independently in the same manner as physicians should submit to the Medical Examining Board and not the Board of Examiners for Nursing. In addition, a profiling system through the Department of Public Health (DPH) website must be established for APRNs exactly as it is for physicians. Patients seeking care have a right to know the qualifications of the person providing care including discipline actions, liability claims, education and training. Additional standards should be considered to require any APRN practicing independently to delineate his/her independence and clearly identify him/herself as an APRN.

The removal of the need for collaboration also brings with it the ability of complete and unlimited prescriptive authority for APRNs. We offer that there is a significant difference in the pharmacology education obtained during formal clinical education, as well the amount received by physicians during comprehensive residency programs. Any APRN practicing independently and granted prescriptive authority should be provided an established, limited formulary for prescribing, be required to obtain continuing clinical training and education related to pharmaceuticals and prescribing, and formally demonstrate competency on a regular basis.

Quality Assessment

As previously mentioned, Senate Bill 36 only requires the completion of a very vaguely defined collaboration establishing no requirements for the intensity or comprehensiveness of the collaboration. It is possible for an APRN within the drafted language to practice part time, or even in a role in which no hands-on patient care is delivered and still be eligible for independent practice of three years of holding a license. Of even greater concern is the fact there is no requirement for the demonstration of competency, as there is in physician residency programs, and there is no ability for a collaborating physician to affirm or question competency of the APRN to practice independently.

Continuum of Care/Delivery of Care

Physicians must meet high standards in terms of coverage responsibilities, hospital admission privileges, and involvement with patients across the entire continuum of care. While it is uncertain how or if legislation can address the issue of hospital admissions, APRN coverage requirements must be identical to those required for physicians in terms of referral and consultation plans, and plans for patient coverage in the absence of APRN availability. Included must also be the development and implementation of methods to incorporate services and treatment provided by the APRN into medical records for purposes of quality control, documentation, reporting, billing and liability. Full compliance with CMS rules regarding collaboration and caring for Medicare patients must be met and documented.

Network Adequacy/Stratification

Advocates for the independence of APRNs state that their intent is not to replace physicians with APRNs. However, we raise significant concerns over how such a change in statute would be approached by insurers or other payers. Many of you know the recent issues we have identified regarding network adequacy requirements of commercial insurers within the state. We feel that while many meet inappropriately low standards contained in our statutes, the networks provided do not provide adequate numbers of physicians in many specialties and many regions. Should SB 36 move ahead, it is imperative that associated statutes regarding network adequacy be amended to require insurers to demonstrate adequate numbers of physicians within their network. APRNs must not be used as substitutes for physicians in regards to network adequacy, nor should insurers be provided the ability to indicate that network adequacy standards have been met through the use of APRNs.

Also, government programs such as our state's Medicaid program do acknowledge the difference in training and abilities between APRNs and physicians through differences in reimbursement levels. We caution against the stratification of access to care, and against

the intentional or de facto establishment of a tiered system differentiating between patients with and without private paying insurance. Within the Medicaid program, our Department of Social Services (DSS) must be required to maintain an adequate network as physicians and not rely on APRNs as a less expensive alternate.

Contained in this testimony are real and serious concerns that must be addressed should the policy decision be made to allow for APRN independence. Clearly, the volume and significance of these concerns illustrate the complexity of removing the need for physician collaboration. This is not simply a “minor amendment” to state statute. More issues will need to be addressed, including those related to liability and the definition of nursing versus medicine. Again, this is not a change to be undertaken lightly.

To be clear, we are concerned first and foremost about the medical care received by the patients of Connecticut. We believe that licensed and well-trained physicians are the best able to identify, diagnose, treat and monitor patient illness and disease, and when necessary and clinically appropriate, provide the medical and surgical procedures necessary for quality patient outcomes. At a time when quality care demands more stringent standards, this bill would lower the standards of care and therefore the clinical quality provided to Connecticut patients.

Please oppose Senate Bill 36.

CT Academy of Family Physicians
CT College of Emergency Physicians
CT Council of Child & Adolescent Psychiatry
CT Dermatology & Dermatologic Surgery Society
CT ENT Society
CT Infectious Disease Society
CT Society of Eye Physicians
CT Society of Urology
CT State Medical Society
CT Chapter American Academy of Pediatrics
CT Chapter, American College of Physicians
CT Chapter, American College of Surgeons
CT Chapter, American Congress of Obstetricians & Gynecologists
CT Orthopaedic Society
CT Pain Society
CT Psychiatric Society
CT Society of Plastic & Reconstructive Surgeons
CT State Society of Anesthesiologists
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Middlesex County Medical Association
Radiological Society of CT
Tolland County Medical Association
Waterbury Medical Association
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