

PA 14-12

SB36

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**CONNECTICUT
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On page 15 of today's calendar, House Calendar 310, favorable report of the joint standing committee on Public Health. Substitute Senate Bill 36, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE.

SPEAKER SHARKEY:

Representative Sayers.

REP. SAYERS (60th):

Thank you, Mr. Speaker.

This bill eliminates the written collaborative agree --

SPEAKER SHARKEY:

Could you move acceptance, Madam?

REP. SAYERS (60th):

I move acceptance of the joint committee's favorable report and passage of the bill in concurrence with the Senate.

SPEAKER SHARKEY:

Question before the Chamber is acceptance of the joint committee's favorable report and passage of the bill in concurrence with the Senate.

Will you remark, Madam?

REP. SAYERS (60th):

Thank you, Mr. Speaker.

This bill eliminates the written collaborative agreement required by an APRN after three years of practice. The Senate adopted an Amendment LCO Number 3475. Will the Clerk please call Senate Amendment "A" and I be permitted to summarize?

SPEAKER SHARKEY:

Will the Clerk please call LCO 4454, which has been previously designated Senate Amendment "A."

THE CLERK:

Senate Amendment "A," LCO 3475, introduced by Senator Looney, et al.

SPEAKER SHARKEY:

I'm sorry. I actually called LCO 4454. Which was the number you were calling, Representative?

REP. SAYERS (60th):

LCO Number 3475.

SPEAKER SHARKEY:

Three four seven five. Thank you. So if the record could be corrected. I am calling -- I'm not calling LCO 4454, I'm calling LCO 3475, which has been previously designated Senate "A."

THE CLERK:

That's correct, Mr. Speaker.

SPEAKER SHARKEY:

Thank you, Mr. Clerk.

Gentlewoman has sought leave of the Chamber to summarize. Is there objections?

Seeing none, you may proceed with summarization, Madam.

REP. SAYERS (60th):

Thank you, Mr. Speaker.

This amendment requires the APRN to have practiced in collaboration with a physician for three years, not just been licensed for three years. And the APRN when applying for license renewal to have earned a minimum of 50 contact hours of continuing education within the proceeding 24 month period. These ECU's must be in an area relevant to the practice of Advanced Practice Nursing.

It also requires manufacturers to report the same information required by federal law to be reported for payments or transfers of value to physicians or teaching hospitals also to APRNs. This is the federal law known as the Physician's Payment Sunshine Act. I move adoption.

SPEAKER SHARKEY:

Question before the Chamber is adoption of Senate Amendment "A."

Will you remark? Will you remark?

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

Good afternoon, Mr. Speaker.

SPEAKER SHARKEY:

Good afternoon, sir.

REP. SRINIVASAN (31st):

I'm indeed privileged to have the deputy speaker bring out this bill, a person for whom I have the greatest regard, the greatest respect and I definitely feel honored today to have this opportunity to debate this bill with our Deputy Speaker.

Through you, Mr. Speaker, on these contact hours which is what the amendment is talking about, currently what is their requirement for the APRNs, through you, Mr. Speaker?

SPEAKER SHARKEY:

Representative Sayers.

REP. SAYERS (60th):

I'm sorry, I didn't -- what was the requirement -- the requirement today for the APRN is they actually have to have 150 contact hours in a five year period which is approximately 30 contact hours a year.

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SPEAKER SHARKEY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, then it is my understanding that the 30 hours of contact hours per year is now 50 hours per year, through you, Mr. Speaker?

SPEAKER SHARKEY:

Representative Sayers.

REP. SAYERS (60th):

No, it is not the 50 hours per year. Its 50 hours for a 24 month period is what the amendment says which is 25 CEUs per year.

SPEAKER SHARKEY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, so just to be clear, we are now from 30 hours per year, we are now reducing the contract hours to 25, through you, Mr. Speaker?

SPEAKER SHARKEY:

Representative Sayers.

REP. SAYERS (60th):

Although the legislation indicates that they must have a minimum of 50 contact hours, their

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certification process still requires that they have 150 contact hours over a five year period. So that would still require them to have the minimum of 30 contact hours per year.

SPEAKER SHARKEY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, then what does this amendment do if they still need to maintain the 150 hours and you're now switching it to 50 hours over a 24 month period, then what does this amendment try to do, through you, Mr. Speaker?

SPEAKER SHARKEY:

Representative Sayers.

REP. SAYERS (60th):

The requirement for contact hours is not in statute other than in statute it requires the APRN to maintain that certification which as I had indicated requires the 150 contact hours. So this amendment requires the 50 contact hours in a two-year period which is the same as physicians are required to have in a two year period.

SPEAKER SHARKEY:

Representative Srinivasan.

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REP. SRINIVASAN (31st):

Through you, Mr. Speaker.

Does this amendment address also the special areas that the nurses need to have contact hours in, that the APRNs' need to have contact in, through you, Mr. Speaker?

SPEAKER SHARKEY:

Representative Sayers.

REP. SAYERS (60th):

No, it does not. It just indicates that it has to be in the -- a relevant area to Advanced Practice Nursing. However, because the Senate did not indicate -- put that information in this bill. However, because we have heard that there are concerns around this, we have put those individual things the same as the physician is required to have in the Public Health Tech Revisions Bill.

SPEAKER SHARKEY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

I do appreciate that. Our concerns were addressed and they are being included in the Public Health Bill. Thank you, Mr. Speaker.

SPEAKER SHARKEY:

Thank you, sir.

Would you care to remark? Would you care to remark further on Senate Amendment "A"?

If not, let me try your minds. All those in favor of Senate Amendment "A," please signify by saying aye.

REPRESENTATIVES:

Aye.

SPEAKER SHARKEY:

Those opposed, nay.

The ayes have it, the amendment is adopted.

Would you care to remark on the bill as amended? Would you care to remark on the bill as amended? The distinguished ranking member of the Public Health Committee, Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

The face of medicine has changed. This face is changing very rapidly and it is up to us, each and every one of us here in this Assembly, to address these changes and try to keep pace with what changes occur in the practice of medicine.

The good old Norman Rockwell painting that I'm

sure a lot of us are very familiar with where you have a very authoritative, a very dictatorial doctor, talking down, talking to, but actually talking down to the mother of the child instructing her what to do. That's a painting we're all very familiar with and many of us even probably have it in our homes. I definitely do.

Things have changed. Health care has changed and it is no longer a one person show. It is a team effort and together, together all of us try to do the best that we can to serve our patients, to serve our constituents right here in the Assembly so that health care delivery is more effective and health care delivery is more cost effective as well. That is our goal. That is our common goal.

With the passage of the affordable care act, we know we have challenges that we have to face and we here in Connecticut can definitely be proud that we were once step ahead, we were very proactive in what needed to be done and are the envy of the nation for how prepared we are when the affordable care act (inaudible) all of its delays is finally implemented for one and all.

So we are aware of the changing landscape in

medicine, a paradigm shift from a single person calling all the shots, calling all the orders to a team effort -- a team effort comprising of the MD, the APRN, the PA and of course a whole long list of other health care providers as well. That is how medicine is delivered today. And of course we don't know this changing face in the decade or the decades to come.

So with this changing landscape that we all have to face with, we realized that this collaborative agreement that exists between the physician and the APRN, a very loose collaborative agreement passed back in the 1989, if I remember correctly. That agreement, that collaborative agreement, is not a tight one. It is very open, it is very loose ended. We heard that - - I heard that for the first time in the public hearings last year as to how lose some of these arrangements are and we heard it again this year a same repeat performance of the concerns that the APRNs had with regards to their collaborative agreement.

Is the present collaborative agreement perfect? Is it what it should be? The answer is absolutely no. But two wrongs do not make it right and that is my concern on Senate Bill 36 here today.

Yes, we do not have a collaborative agreement

that is effective. So do we go the other extreme, 180 degrees and then say, we do not need the collaborative agreement at all. I think for us to look at this bill, to look at the changing face of medicine, to look where we are and what our requirements are, is to look at this collaboration to make it meaningful, to make it work. Let us not go from one end of the spectrum to the other. That is definitely not the right way to go.

We are all here to do the right thing. I know we will all do the right thing. This is not a republican issue, this is not an issue for the democrats, this is not about MDs, this is not about APRNs. They are not what the center stage is all about. The center stage is patient care; the center stage is access and the center stage is to make sure that these patients are treated in an appropriate way and we do not end up in different tiers of care, a first level care, and a second level care which is what my concern is if this bill were to pass.

So this bill is a good start; is a step in the right direction. That collaboration needs to be revisited, collaboration needs to be looked at and modified so that we have an effective way that we can

have this relationship between the MD and the APRN.
Eliminating the collaboration is not the answer and
through you, Mr. Speaker, I have a series of questions
to our Deputy Speaker, through you, Mr. Speaker.

SPEAKER SHARKEY:

Please proceed, sir.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker.

How many APRNs do we have currently practicing in
the State of Connecticut?

SPEAKER SHARKEY:

Representative Sayers.

REP. SAYERS (60th):

Through you, Mr. Speaker.

I'm not sure of the accurate number. I think
it's around -- it's either 3,000 or 6,000. I really
don't know.

SPEAKER SHARKEY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker.

It is my understanding it is about 4,000. So our
Representative was right there in the middle between
three and six as is my understanding. And through

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you, Madam Speaker, good afternoon, Through you, Madam Speaker, these APRNs that are currently in practice, in this collaboration, do we know how many of them are out on their own and have a collaborative agreement or how many of these APRNs whether it be 3,000, 6,000 somewhere in between, are working along, side by side in the medical offices, through you, Madam Speaker.

(Deputy Speaker Miller in the Chair.)

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

I do not know. The Department of Public Health only maintains the licensure; does not maintain that data.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

If the APRNs do not need a collaboration and the number of APRNs that we have anywhere from 3,000 to 6,000 they're already practicing either along, in

collaboration, or they're practicing in an office setting, they're already practicing; they're already doing what they are doing. So how does this Senate Bill 36 increase the access to our patients, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

It increases access because there was testimony at the public hearing that many of our APRNs had difficulty in obtaining a physician in which to collaborate with. In addition to that, anytime there was for some reason that the physician discontinued the collaborate agreement or perhaps died unexpectedly, they had difficulty in finding someone else in which to collaborate. And that presented a great difficulty for those APRNs because they would have to abandon their patients because legally without a written collaborative agreement, they could not continue to practice.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

Through you, Madam Speaker, the good deputy speaker talked about many APRNs in this position where they are not able to find a collaborative doctor or unfortunately as she said, the doctor dies and they do not know what to do and nobody here in this Chamber wants anyone to abandon their patients, absolutely not. It's just the opposite that they're here to do. Do we know how many, is many, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

There's really no accurate number on that and I actually have asked for that data in the past, but it's really not available and is very difficult to ascertain. Thank you.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

I, too, was present at the public hearings both last year and this year and I know very well those

public hearings lasted into the wee hours of the morning until they became tomorrow by the time the public hearings were done. And in these public hearings I did hear the concern that our good Representative Sayers has in terms of people not being able to find collaboration.

But I also heard over and over again, of a very good system where the APRN is working with a physician office in a group and has and will continue to do so regardless of how this bill passes one way or the other. Through you, Madam Speaker, did our deputy speaker also hear of APRNs that have a wonderful working relationship as it exists with their medical offices, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

I have actually spoken to APRNs that have a very good relationship that are in a situation that works very well. But that is not the concern. The National Institute of Medicine and the National Governor's Association both recommended that we work to remove barriers to practice and they identified agreements

such as our requirement for a written collaborative agreement as barriers to practice. So therefore this bill is before us.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

I do understand the concern about barriers. I do understand about the concerns about access, no question about that at all. But other than in those instances for which we have no number, we do not know how many unfortunately, because we don't have a system to track the numbers down.

My concern is that when we switch from one system to another, we are assuming -- assuming that the APRNs' practices are limited. In what way, I do not understand in the present system where there is a collaborator, where they are in a comfortable position working with whom they collaborate with. In what way are their expertise? In what way -- what they're capable of doing limited, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

The APRNs in their testimony identified that it was very problematic in terms of maintaining that collaborative agreement and they were the ones that came forward requesting this. It went through the scope of practice mediation process at the Department of Public Health and it was determined that it was safe to remove the collaborative agreement and in fact as a result of the recommendations from that collaborative agreement, there actually was no recommendations for the three years that is in this bill.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

I would like to into the training for an APRN before he or she is able to become and independent practitioner if this bill were to pass. Through you, Madam Speaker, after completing high school, what is the process, what is the time frame, what is the experience that an APRN gathers before he or she is capable of becoming independent, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

The training for an APRN is the four years of nursing to reach a BSN and during that time unlike a physician's first four years to obtain Bachelors, there is actually clinical practice involved in that. Then it requires that they have a master's in nursing and that may be either a 60 credit course and beyond that in order to become an APRN, there is an additional requirement for pharmacology as well as that they take an exam required for certification.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

I want to thank the good deputy leader for her answers. So as I understand it, at the completion of high school, we're talking about four and three to become an APRN, a total duration of seven years.

Through you, Madam Speaker, I want to make sure that that is the right number, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

It is approximately. It's definitely four years. The master's program that the nurse may go through may be a two year program or a three-year program depending on what school that they choose.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

We are now in this bill if amended, as amended, and the bill goes to the Governor's desk and signed, we will be looking at APRNs who at the end of three years of collaboration, will be able to do their work as an APRN, on their own. A physician, Madam Speaker, goes through four years of undergrad, after completing his high school and after that goes through a three-year program, the residency program, after completing medical school.

So it is a four and three -- four years of undergrad and four years of medical school and then three years as far as a residency is concerned. So we are talking about seven years after completing of high

school and here we're talking about four and four and three, we are talking about 11 years of training prior to become somebody who is able to practice on his own or her own.

And just for purposes of information, when a person goes through medical school and does those four years, I just want to make sure that we're all clear that those four years are not just pure text books that they are reading. The four years comprises of anatomy, physiology, extensive pharmacology, and pathology and the last two years its clinical rotation. So we are not even talking about going to residency, we're talking about medical school.

In the medical school itself in the last two years of their medical training, they go through clinical rotations where they get an opportunity to see the patient, examine -- take the history of the patient, examine the patient and of course, present it to their supervisor. The supervisor could be a resident, could be a chief resident and of course the attending.

Is this the kind of training that an APRN goes through where he or she has an opportunity to talk to the patient, take the history, examine the patient and

come with their assessment during their RN training, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

In the review for the scope of practice before the Department of Public Health, there was no evidence or data provided as part of the scope of practice review process to validate that removing the mandatory collaborative agreement would alter APRN patient care or place patients at risk or that patients are at risk or care has deteriorated in other states where there's no required collaborative practice agreement.

So, therefore, the other part of that is that when you look at the two areas of practice. One is training to become a physician and other is training to become a nurse. They are very different types of practice.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Chair.

I'm very thankful that Representative Sayers made

that distinction that the initial training, almost four years of training, is very different for an RN who is extremely important in our health care system. We need the RNs, we need the APRNs. The system would not work unless we had a team effort. As I said earlier in my opening remarks, gone are the days where a single person, the doctor alone was able to do it all. Far, far from that.

But the training as the good representative said, is very different. It's a training for nursing, which is very important for all of those of us who have gone through procedures and that and the other, we know how important the nurses are in our care. We know how comforting a nurse is when you have a problem or are in pain. No question about that at all. But the training of an RN is very different from the training that a doctor has in the medical school.

Through you, Madam Speaker, having made the differentiation in the training between nursing and to be a physician, in APRN training, whether it be two years or three years, what goes on in that training, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

The training -- if you're talking about the training for an RN, that is done in the first four years or two years, depending on which program that RN attends and at that time they take the nursing boards to become a registered nurse. They may go on to a master's program and have a master's in nursing. At that time they may or may not choose to become an APRN. If they choose to become an APRN, they would have to take -- go through the exam for the certification process that would prove that they have the knowledge they need to become an APRN.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

On an average, none of us are averages, but we talk about averages as a ballpark as to where we all are. On an average, what is the number of clinical hours in terms of training for an APRN, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

In the scope of practice issue it identified around 500 hours.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Madam Speaker, our APRNs clinical training is to the tune as we just heard of about 500 hours. And if you look at a residency training, a three-year residency training, and if you look at the training in a medical school, we're looking at somewhere in the ballpark of 3,200 hours in medical school, we're looking at 9,000 hours in a residency and that, Madam Speaker, is my concern.

When you look ultimately, training is critical, training is important. We all are what we are today because of what we learned in the education process. So that training of 3,000 hours on the one hand for medical school, 9,000 hours on the other hand as far as residency and here we have on the other side of the scale, 500 hours is what we have in clinical training for an APRN.

So to make that APRN at the end of 500 hours, yes

we have a collaborative agreement even in the bill as it is amended and I will get to that in a second, to me that is the concern. That here we are letting them go out, if the bill is passed, to be on their own. And in my opinion, the training is not adequate enough to be on their own.

An ideal setting would be a good collaborative agreement. I granted that right at the very beginning that our collaborative agreement is very weak and that is what we need to make sure does not happen. Strengthen a good collaborative agreement and it will be a win-win situation. Not for doctors, not for APRNs, but it will be for the patients that we all will be taking care of and that is very critical moving forward.

Through you, Madam Speaker, in the bill we talk about collaborating for three years after they've completed their APRN course. Could we elaborate, through you, Madam Speaker, to the good deputy speaker, on what that three years of collaboration means? Is it going to be open ended, is it going to be tight, what kind of a collaboration would the APRN, he or she will have with the collaborator, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Thank you, sir. Can we take conversations outside the chambers, please? Thank you.

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

The collaborative agreement that currently exists would be no different to the collaborative agreement that would exist once this bill is passed in that it requires that the physician and the nurse identify in a written agreement, those areas on which they would collaborate. And collaboration by definition is where they work together to help each other make decisions in the best interest of the patient. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

So at the completion of the APRN course and he or she goes in with a collaborator, will that collaboration be as it is right now, which is very loose, very open ended and we heard that over and over again in the public hearings. Not all the time, but

to some extent and of course we do not have any numbers by which we can say is it 10 percent that the collaboration does not exist or 20 percent, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

I'm not sure of the question. Could the doctor please present it again?

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Of course, it would be my pleasure to repeat it again, through you, Madam Speaker.

When the APRN now goes into collaboration with his or her collaborator, will that collaboration for the next three years before he or she becomes independent, if he or she chooses, I know nothing is mandating that, I'm well aware of that. This is just an option we're giving to the APRNs if they choose to do so. I would like to know in detail what that collaboration for three years would entail, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

The three years' collaboration would not change in any way from what the current collaborative agreement requirements are in law today. The thing that would change is at the end of that three years, if that nurse APRN determined that she would end the collaborative agreement, she would have to notify the Department of Public Health that she was doing so.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

In that case, this collaboration for the three years as I understand it, and the good deputy speaker said that twice and I appreciate that very much, is that this collaboration will be as we have it right now, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

That is correct.

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DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

We heard in public hearings, not once, on two different public hearings in two different years, that the collaboration is very weak, the collaboration is meaningless and is just a written signature on a piece of paper by the notice APRN and by the collaborator. So, are we suggesting that that same form of collaboration, a collaboration that is meaningless, a collaboration that's not worth even the paper in which it is signed is what we will continue for three years, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

The -- what would -- nothing would change. It would be up to the physician and the APRN as they sit down and determine what that collaborative agreement would consist of to come up with the information they need to either make that a very good collaboration where they share information with each other, or one

where they do not see each other that frequently.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

But that is the current system. We leave it between the APRN and the collaborator to decide how to collaborate, how frequent to collaborate and what is the nature of the collaboration. Is it by a phone call, is it a meeting once a month, is it a meeting once a year? All of the present pitfalls of the present collaboration that we have.

So am I to understand that the same collaborative agreement with all its deficiencies that we all have seen, they are there loud and clear no question about that, we cannot escape that. We in this Legislative body many years ago talked about a collaborative agreement but did not nail it down as to what the collaborative agreement should be, left it open ended and here we are in 2014 concerned about the collaborative agreement.

So through you, Madam Speaker, how could this collaborative agreement be more meaningful and more

effective than what it is right now, through you,
Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

I appreciate the good representative's concern,
but I like to look at outcomes and we know that in
terms of outcomes, there have not been problems
identified as a result of the current practice with a
collaborative agreement between APRNs and physicians.
I think that had there been negative outcomes or if we
had seen problems as part of it, we would have looked
at that in depth and perhaps made changes to it. But
because there were no negative outcomes, we did not.
Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

I look at it from a different angle all together.
We need to be proactive; we need to prevent a negative
outcome. And just because we did not have a negative
outcome over a period of time and I have my doubts on

that, but I will let that pass, but if we did not have it, that is not for me reason enough to continue to be status quo. What I would like to see in a changing face of medicine in health care where it is right now, is a tightening of the collaboration to make the collaboration more effective and not leave it as loose as it is. Through you, Madam Speaker, the Clerk is in possession of an amendment, its LCO 3811. I ask that it be called and I be granted leave to summarize.

DEPUTY SPEAKER MILLER:

Will the Chamber stand at ease.

(Chamber at ease.)

DEPUTY SPEAKER MILLER:

Will the Clerk please call LCO 3811, which will be designated House Amendment Schedule "A."

THE CLERK:

House Amendment "A," LCO 3811, introduced by Representative Srinivasan and Representative Carter.

DEPUTY SPEAKER MILLER:

The Representative seeks leave of Chamber to summarize the amendment. Is there objection to summarization? Is there objection to summarization?

Hearing none, Representative Srinivasan, you may proceed with summarization, sir.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

And I would request that when the roll is taken, that it be taken by individual roll call, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

The question before the Chamber is on a roll call vote. All those in favor of a roll call, please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER MILLER:

The ayes have it.

When the vote is taken it will be taken by roll call.

Any further remarks, sir?

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

What this amendment -- Amendment "A" 3811 does, basically makes this collaboration tight, it makes the collaboration effective. What we now have is a three-year collaboration between an APRN and the

collaborator. That, to me, as I'm sure would be to you as well, leaves a lot of openings. What if an APRN chooses to work one day a week so the end of one day a week, three years, he or she can now have an independent practice? What if an APRN chooses to work three days a week, not full time, because of other commitments, family commitments, decides to work three days a week.

When does the clock start, when does the clock stop? Is it number of years or is it the number of time, the number of hours that are spent in collaboration? In this three-year collaboration that we have in the bill in front of us, it is reality -- unfortunate, but reality, that the APRN could fall ill or need to take some time off. When do we stop the clock?

It is possible that a family member could fall ill and the APRN needs to take months off to take care of an elderly parent, to take care of an elderly relative. Once again, three years -- where does it begin and where does it stop? And, of course, rather than painting these dismal alternatives, what if the APRN becomes pregnant and in her pregnancy she obviously needs to take the time off and then come

back a little later maybe after the delivery.

Once again, to me my concern is all of that is not spelled, is not written, in this collaboration. This collaboration is loose, is open ended and what I wanted to do in this amendment is try to make it tighter. And what I'm asking for in this amendment is rather than using three years, convert those three years to 6,240 hours of collaboration. That is all I'm requesting in this. We all agreed that the outcomes were negative. I have seen that. APRNs are very effective at delivering their services. No questions about that at all.

It is the training that we are talking about and since they have less training before they come out and start their independent practice, it would be appropriate for them to have this many hours, 6,240 hours which is over a three-year period before they could start their independent practice. How did I come up with a number? I just didn't pull it off a hat. I looked at my residency program.

In my years of residency back in Brooklyn, New York, we worked 80 hours a week -- 80 hours a week for three years and that's how I completed by residency. I know because of fatigue, I know because of other

factors, the number of hours have been reduced. My son who just graduated about 10 years ago, he did 60 hours per week in his residency program. And what I'm doing here is converting the 80, the 60 and making it more realistic, even more realistic into 40 hours a week for the three years.

And that's how I come up with the 6,240 hours, Madam Speaker. So what I'm saying is, I'm accepting the fact that at the end of three years, they can be independent. But let us look into those three years and make it more effective, make it more meaningful, so that we continue in a proactive way to have better outcomes.

So that essentially is what the amendment does. Converts the three years, that all that it does, into number of working hours in collaboration and I've come up with 6,240 hours, Madam Speaker.

Madam Speaker, I would request to move adoption.

DEPUTY SPEAKER MILLER:

The question before the Chamber is adoption of House Amendment Schedule "A."

Will you remark further on the amendment?

Representative Carter.

REP. CARTER (2nd):

Thank you very much. Good afternoon, Madam Speaker.

DEPUTY SPEAKER MILLER:

Good afternoon, sir.

REP. CARTER (2nd):

I'd like to start with one question, through you, to the proponent of the amendment, please.

DEPUTY SPEAKER MILLER:

Representative Srinivasan, will you prepare yourself, sir?

Representative Carter.

REP. CARTER (2nd):

Thank you. Through you, Madam Speaker, you mentioned that the residency program that you went through and that your son went through we'll say was 60 to 80 hours. During that 60, 80 hours could you let me know a little bit more about what you did during residency like how was your average day I would say structured, and was it educational focused or were just working most of that time, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

Let me begin with my residency. I started my first year residency, got married and for one year, my wife didn't know who I was because I was never home. So that is what a residency does to you, it is hard, it is brutal, but it is necessary because that's how you get trained.

So in my three years of residency and I'm sure what it is right now, it's a very good combination of clinical -- you spend most of the time, I would say anywhere from 70 to 80 percent of the time in your clinical duties. You're taking the history, you're evaluating the patient, in the three years right from year one, presenting it to your mentors and the mentors would be the residents, your senior resident, the attending and that's how you learn through the patient at the patient's bedside.

That is most of where the training comes in. And of course, Madam Speaker, we have regular speeches -- lectures that we have to attend. Typically it would be one hour every day and the whole program would be rotated around so over the three-year period you cover every subject related to your residency and every Friday -- in my hospital it was Friday, we had our

grand rounds where some speaker would come across the country, it would be international speaker and give an in-depth analysis of that subject matter.

So clinical training was the most important part of our residency a good opportunity to learn at the bedside of the patient and of course we had our didactic sessions too. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Carter.

Would you excuse me, sir? Can you please take the conversations out into the hall? It's difficult for the proponents to hear. Thank you.

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

I thank the esteemed ranking member of the Public Health Committee for his answers because you did confirm what I knew to be true about residency programs and the nature of a residency program.

You know, you see, ladies and gentlemen, what has been asked for in this amendment goes a long way to clear up some of the concerns that I've had as this bill has come forward. The majority of that has been what happens during that three years of a

collaborative agreement? What kind of training does somebody receive?

You know, a residency program is an educational program. Not only are residents working at a hospital and being paid to work there and they've been accepted to this program, but it's heavily focused on training. And as the good ranking member mentioned, that those days are long and structured and include everything from being able to publish to actual clinical work dealing with multitudes of different patients, different kinds of rotations and ladies and gentlemen, this is after medical school.

So those folks have already -- these physicians have already had two years of clinical time and as he's mentioned, we're talking upwards of 12,000 to 16,000 hours of clinical time and I think that's important. So looking at what this amendment does, it doesn't make a lot of -- it's not a bad thing to ask at least if you're in a collaborative agreement, you work full time for three years.

That's all we're asking. We're not even -- we're asking that somebody who comes out with minimal training from APRN school of 500 clinical hours, has some sort of extra time actually being there instead

of just showing up for one day a week and what have been determined loosey-goosey arrangements of a collaborative agreement.

And the other reason I think this makes a lot of sense to me is that if you look back over the history of how the collaborative agreement even started, back in 1989 when we gave prescriptive rights to APRNs, at that time they were working directly under a doctor's supervision. And when we looked at that we said, okay, that makes sense, we'll give them more scope, they're doing it under a doctor's supervision so it makes sense to let them do that. We even put limits on it at that time. They went through and they said well you can only do it in institutions, you can only do it in clinics and we didn't open that up until 2006.

So in 1999 is when we finally came up with this collaborative agreement and we were still having some sort of control over those minimum hours that they were spending with a physician. So this makes a lot of sense to me that we have something structured in place during that three years of what a nurse practitioner should be doing besides just having a license. I mean just having a license isn't near

enough to say that you're qualified to do anything.

When those practitioners come out, obviously they have about 500 clinical hours and they're very good at diagnosing acute things. But where are they going to really get that good hands on experience of being able to do chronic disease and right now without having something in statute that says during that three years, I'm actually going to go to work for at least 40 hours a week or if I'm taking time off for family leave, I'm going to make up those hours somehow.

I think that just makes good common sense to have something in place because right now without this amendment, this becomes a real quality of health issue. So ladies and gentlemen, as you look at this amendment, I think it's a common sense amendment that you have something in place because going from having this collaborative agreement which we've said is weak to doing something that even the good chairwoman said, doesn't change what the agreement is. I mean it's a flawed agreement as it is; nothing's going to change it with this bill. At least this establishes something in statute that says, hey you're at least going to show up for work so you're going to have some sort of training.

So, ladies and gentlemen, I really urge my colleagues on this side, I urge colleagues on that side because this is not a partisan issue. This is a quality health issue for our state and I urge everybody to get behind this and at least have some sort of minimum on the books that nurse practitioners have to practice before they go out on their own. Thank you, ladies and gentlemen. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker.

I'd like to speak to this amendment and I have a question for the proponent of the amendment.

DEPUTY SPEAKER MILLER:

Representative Srinivasan, please prepare yourself to respond, sir.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

And I do have to say that you have been pronouncing my name so well and I want to thank you for the effort you've taken to make sure you're able to do that. I appreciate that very much.

DEPUTY SPEAKER MILLER:

I've been practicing for a week.

REP. SRINIVASAN (31st):

I can see that and I appreciate that very much.

Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker.

My question is the amount of hours that are in this amendment, it's 6,240 hours in a three-year period. Can you tell me how you arose at those numbers, through you Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

I definitely will. I thought I had alluded to that when I brought out the amendment. But it would be pleasure to talk about that again.

I looked at it as I said in the residency program. When somebody does 80 hours like I did, the old hack, the younger hack my son, did 60 hours a week for a three-year period and I thought let's bring it

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down to earth, let's be realistic here and therefore I converted 40 hours a week. So its 40 hours a week for three years and that is how we came up with that number. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker.

All right. I think the numbers I was coming up with was 43 hours so I wanted to clarify that. Is there vacation time built into that 6,240 hours, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

Absolutely, absolutely. It is so critical -- it is so critical like when Representative Carter asked me what was my residency program about. It was not just churning out patients. It was not just seeing patient, after patient, after patient. That was important because that's how you learned at the bedside. But equally important are the sessions where you go through the various subject matters, where you

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sit down not with the rush of having to see the next patient in the next five minutes, (inaudible) before we start your practice or at the end of the day, set aside a time which would be included in this 6,000 hours. Through you, Madam Chair.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker.

I'm standing here before you to ask my colleagues to vote this amendment down. I think we might be mixing up what we're doing here with the residency program and the nurse practitioners. When we're looking at the health care industry, health care you know, we can kind of look at it as apples and oranges, nursing and physicians. We're all still fruit but we all serve a different purpose and we're all good for you.

I think that's very important. So when we're talking about the scope of practice, that's not really in this bill. We already have that established in our statutes. Nurse practitioners already come out practiced to their full scope of practice to their education and to their board certification. That's

already done.

Nursing is a different profession than medical profession. And I think we all respect each other, we all work great in collaboration, but putting on this type of hours, I believe would be just be more of a barrier to nurse practitioners. Right now we have our neighboring states that are all practicing independently.

Twenty states in the United States are actually doing that now. So the last thing we need to do and I hear often is having businesses leave the state. We don't need nurse practitioners to lose -- go to our bordering states where they can right now practice to their full extend. And again, I'm just asking my colleagues to vote no on this amendment. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Smith.

REP. SMITH (108th):

Thank you, Madam Speaker.

A few questions to the proponent of the amendment, please?

DEPUTY SPEAKER MILLER:

Representative Srinivasan, please prepare

yourself to respond, sir.

REP. SMITH (108th):

Thank you, Madam Speaker.

Just I'm wondering under the current law what the number hours is that are required for the collaboration agreement if any, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

The good representative was absolutely right, there is none so far, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Smith.

REP. SMITH (108th):

And the amendment I guess that was called prior to this amendment, so the bill -- let's go back to the bill as proposed. Is there a certain number of hours that are required under the bill, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

I apologize, but I did not get the question right. If he could phrase it in a different way, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Smith.

REP. SMITH (108th):

I'll try to rephrase that. So I know under the amendment that we're talking about right now, there is 6,000 some odd number of hours that are proposed here in terms of the training period. I'm wondering under the bill itself that's been brought out, is there a similar or lesser number of hours in that bill, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

I want to thank the good representative for clarifying that for me. I appreciate that and the answer is no. In the current bill as amended, it is just a three-year time period and does not specify in any way how those three years should be spent and when the clock starts and when the clock is turned off,

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through you, Madam Chair.

DEPUTY SPEAKER MILLER:

Representative Smith.

REP. SMITH (108th):

Thank the good chair for that clarification and just one final question. To those states that have taken on a similar type of legislation, are there hourly requirements in those states, if the Chairman knows, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

That's an excellent question and I do not have an answer for that but I will definitely be able to get that. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Smith.

REP. SMITH (108th):

Thank you and I will look forward to that information and I'll continue to listen to the debate today and make a decision going forward. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Representative Adinolfi.

REP. ADINOLFI (103rd):

Thank you, Madam Speaker.

I just want to pass a few comments on this bill. Recently I've had the opportunity and I have been for many years, to visit an APRN. This APRN was in a doctor's office. In one case it was just a general practice and the APRN would perform the typical examinations as a nurse would do but in addition to that, she would go into the exact reason that you were visiting that doctor for. Whether it was pains in your back, pains in your head, whatever it was.

But in every case that that happened with me before I left the visit, I saw the doctor too and he went over what she did. If she prescribed me some medication or some physical therapy whatever it was, he would look it over and agree or disagree. And I'm concerned about that. If you get an APRN that is working in the orthopedics field, say specializes on shoulders and she recommends some medication for the pain you're going through with the recovery and some physical therapy for recovery and that's wrong because it wasn't agreed to by the doctor and you just went

down and exercised, bought the prescription and when for the physical therapy.

But if that prescription and PT was wrong, is she eligible to be sued for malpractice and I don't know that. And are they required to keep the same amount - - I should ask through you the question to the proponent on this next part. Through you, Madam Speaker, to the proponent of the bill, are they required to carry the same malpractice insurance as the doctor does if they're on their own? I don't know who the proponent is.

DEPUTY SPEAKER MILLER:

Is it the proponent of the bill or the amendment, sir?

REP. ADINOLFI (103rd):

I'm talking on the bill, I'm sorry.

DEPUTY SPEAKER MILLER:

I'm sorry?

REP. ADINOLFI (103rd):

But I think it fits.

DEPUTY SPEAKER MILLER:

I'm sorry, sir, I didn't hear you. Is the proponent --

REP. ADINOLFI (103rd):

I still think my question fits either on the amendment.

DEPUTY SPEAKER MILLER:

Okay, sir. So, Representative Sayers would you prepare yourself, Madam.

You may proceed, sir.

REP. ADINOLFI (103rd):

Is the APRN required to carry medical insurance at the same rate as the attending physician would?

REP. SAYERS (60th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER MILLER:

Representative Adinolfi.

REP. ADINOLFI (103rd):

Okay. That answers my question on that. I'm very -- I'll talk more on the bill when it comes up then. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Representative Carter for the second time.

REP. CARTER (2nd):

Thank you very much, Madam Speaker, and thank you for the second opportunity.

Through you, Madam Speaker, I'm wondering if I

could ask a question -- oops, looks like she left. I was going to ask for a question from the esteemed colleague from the 105th District. Is she still in the chamber?

DEPUTY SPEAKER MILLER:

She's not in the chamber, sir.

REP. CARTER (2nd):

All right. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative C. Davis -- I'm sorry, Representative Sayers.

REP. CARTER (2nd):

Madam Speaker, I'm asking if I can have a question with the colleague from the 105th District that would be Representative Conroy.

DEPUTY SPEAKER MILLER:

I'm sorry, sir. She is in the chambers.

Representative Conroy, would you prepare yourself, Madam.

You may proceed, Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

As we are in this Chamber we have the opportunity to bring a lot of our experience with us and I

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appreciate the experience of my colleagues. So I wanted to ask, through you, Madam Speaker, if she could enlighten me a little bit as to what the scope of practice is of an APRN that she was speaking of. She said when they graduate from I guess APRN certification and take the test, they have a certain scope of practice. Would she be able to just tell me basically what that is, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker. It's actually -- and I'm just looking this up, but it's actually defined in the state statutes for the APRN. It's nothing that comes out of the school itself. It is in our state statute, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

I guess what I'm hearing a lot of talk about what the scope of practice is and it's almost like a legal term. Everybody says, well I can graduate and I can practice through my scope of practice. But right now,

the scope of practice in Connecticut has always had some sort of physician connection or some kind of oversight. In this case it's the collaborative agreement. So I was hoping to learn more about that but I'll listen to the debate and I'll comment again later. Thank you and thank you to the good representative from the 105th.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Representative Davis, C. Davis.

REP. DAVIS (57th):

Thank you, Madam Speaker.

Through you to the proponent of the amendment, I have a question.

DEPUTY SPEAKER MILLER:

Representative Srinivasan, can you prepare yourself, sir, to respond?

You may proceed, sir.

REP. DAVIS (57th):

Thank you, Madam Speaker.

Through you to the proponent, in this amendment you discuss collaboration with the physician and ask that they do that for over 6,000 hours. Through you, Madam Speaker, what exactly would be this

collaboration with the physician? Thank you.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

Through you, Madam Speaker, this collaboration would be working as I see that, because we don't have it yet, because we have it so open ended and loose, but I'm envisioning would be the APRN working in the physician's office, working very closely with the physician so that just similar to any situation where you're in training you always have easy access to the mentor.

And this kind of collaboration may be the first year, would have to be pretty much on site so that you're able to be comfortable what you're doing day in and day out. They would definitely in my opinion would include some time of lectures whether they're done as I said earlier at lunch time, before we start the practice or the end of the day, so that the APRN has a wide range of knowledge because remember, when patients come in through the door, you do not know what they have and there may be times, periods of time you may be seeing the same repetitive kind of a

medical condition over and over again, but not have had the experience to deal with other situations.

But when you are on your own, you cannot once again pick and chose so what comes through the door is what you've got to deal with. And if that is not dealt with on a day to day basis because those patients are not there, then those become subjects of discussions. So that is how I envision that.

And as we move to year to two and year three, they do not need to be, as I see it, on site. They could be at a distance remote and at the same time check in on an on-going continual basis. Nothing loose, but very clear that at the end of the day, there is a sign in and a sign out of the patients that they have seen at this point in time independently, but under the umbrella, under the supervision of the collaborator.

DEPUTY SPEAKER MILLER:

Representative C. Davis.

REP. DAVIS (57th):

Thank you, Madam Speaker.

Through you, so in the collaboration that you just described, is that enumerated within this amendment or is it still open ended as it currently is

for the APRN to make that agreement with the doctor or perhaps later on down the road, have the Department of Health put in regulations that would require this type of collaboration, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

I want to thank you very much for that question because that has been on my mind all along as to how do we then put down what all of the requirements are and that I would say through DPH, through regulations, through regs, would how we would be able to establish that. What going forward, what this collaboration should include in terms of hours of training, and in terms of number of hours, in terms of lectures, would all have to be spelled out. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Davis.

REP. DAVIS (57th):

Thank you, Madam Speaker, and I thank the kind gentleman for his answers. From my discussion with the proponent of the amendment and in also reading the

amendment myself, I would stand in strong support of it because I think it is actually a compromise. I personally would rather see that information about what a collaboration is actually defined within the bill, but I think the proponent of the amendment has perhaps found a compromise where we are requiring that the hours be in there, but allow them to come to an agreement with either the physician that they're working under or perhaps have DPH come up with those regulations later on. So I stand in support of this amendment and I encourage the members of this chamber to support it as well. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Thank you. Thank you, Madam Speaker.

I stand here to ask my colleagues to oppose this amendment. When the Department of Public Health did the scope of practice mediation, they did not determine there was any need for maintaining a collaborative agreement even for the first three years. Last year, I did an amendment to a bill and because of some of the concerns that doctor -- Representative Srinivasan had, and I put in the three-

year collaborative agreement.

It doesn't come from anything other than a decision to try and help someone be more comfortable with this legislation. But it's not required and in other states that have eliminated written collaborative agreement, there has not been any problems and in fact in some cases, the outcomes of practice by nurses has been better than those by physicians.

Representative Smith asked questions about is there currently anything, and because that was a concern for a number of people in the tech revisions bill which is also on the calendar, we put that the three years of collaborative practice had to have as a minimum 2,000 hours, so we did address that. My concern about this amendment is that it would greatly increase the cost of health care without changing the quality of health care. When I see increased costs, I want to know that that's going to change the quality of health care.

This amendment does not do anything in terms of the quality. We have in the testimony that was given by physicians, none of the identified problems with the current way the collaborative agreement works. In

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fact, many of them testified that it worked extremely well and that they did not see it as a problem. So I would ask my colleagues to please oppose the amendment. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Would you care to remark further on the amendment?

Representative Ackert.

REP. ACKERT (8th):

Thank you, Madam Speaker.

I rise in support of this amendment and just to give you a little background as to why, when you start to think about time in a job. We understand that there's elaborative training that goes into an APRN, but nothing is more valuable than working in the profession and the time spent. So actually, experience and time is a value.

So when I look at -- just to give you an example, many, many occupational licenses called tradesman. Now these people are not diagnosing the human body, they're diagnosing a plumbing leak, they're diagnosing an electrical problem, they're looking at your HVAC -- have to just for their basic license, not to be able to practice on your own, for their basic license,

8,000 hours of training along with school. Think about that. We're talking 2,000 and collaboration.

I'm talking your first license for a tradesman to work on -- not your human body, but on a building. Is 8,000 hours -- that's just to get their first license. Now to practice on their own, they must get a letter from their employer that they worked for an additional 4,000 hours. Six years, ladies and gentleman, six years to be able to practice on their own because that is what the state department of occupational licensing says they need.

Six years of training to practice on their own, not on a human body, folks. So I rise in strong support of this legislation because I believe experience is everything. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative O'Dea.

REP. O'DEA (125th):

Thank you, Madam Speaker.

I rise also in support of this amendment and I come from a unique perspective, I believe, as my father is a general surgeon, retired and my mom is a practicing nurse with a four year degree in college. And if my mom is listening, I obviously love her very

much, but I would not let her diagnose and treat me for a medical problem that I would need a doctor for.

So I would ask people here to think about what we are doing with this legislation and I would ask that you support this amendment and have the APRNs have at least a minimum number of 6,240 hours of training which is less than as Representative Ackert just said, that you need as an electrician. So please I would ask that my colleagues please support this amendment when it comes time to vote. Thank you very much, Madam Speaker..

DEPUTY SPEAKER MILLER:

Will you remark further? Will you remark further on the amendment before us?

If not, will staff and guests please come to the well of the House. Members take your seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll.

The House of Representatives is voting by roll. Will members please return to the chamber immediately?

DEPUTY SPEAKER MILLER:

Have all members voted? Have all members voted? Will the members please check the board to determine

if your vote is properly cast?

If all members have voted, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally?

THE CLERK:

LCO 3811, House "A."

Total number voting	147
Necessary for passage	74
Those voting Yea	67
Those voting Nay	80
Those absent and not voting	4

DEPUTY SPEAKER MILLER:

The amendment fails.

Will you remark further on the bill? Will you remark further on the bill?

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

Madam Speaker, I rise for the purpose of an amendment.

DEPUTY SPEAKER MILLER:

You may proceed, sir.

REP. CARTER (2nd):

Thank you, Madam Speaker.

The Clerk has in his possession, LCO Number 4413. Will the Clerk please call the amendment and may I be allowed to summarize?

DEPUTY SPEAKER MILLER:

Will the Clerk please call LCO 4413, which will be designated House Amendment Schedule "B."

THE CLERK:

House Amendment "B", LCO 4413, as introduced by Representative Srinivasan and Representative Carter.

DEPUTY SPEAKER MILLER:

The Representative seeks leave of the Chamber to summarize the amendment. Is there objection to summarization? Is there objection?

Hearing none, Representative Carter, you may proceed with summarization, sir.

REP. CARTER (2nd):

Thank you, very much Madam Speaker.

Madam Speaker, this amendment to the bill would be a strike-all amendment but what it would do is it would establish the need for those nurse practitioners who do not want to practice in a collaborative agreement to be able to avail themselves of attending a two year accredited residency program. That's the amendment and when I asked -- when the vote is taken I

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ask that it be called by roll.

DEPUTY SPEAKER MILLER:

The question before the Chamber is on a roll call vote. All those in favor of a roll call vote, please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER MILLER:

The requisite 20 percent has been met. When the vote is taken, it will be taken by roll call.

You may proceed, sir.

REP. CARTER (2nd):

Yes, Madam Speaker, I also move adoption.

DEPUTY SPEAKER MILLER:

Stand at ease, please.

(Chamber at ease.)

DEPUTY SPEAKER MILLER:

The question before the Chamber is on adoption of Schedule -- I'm sorry, House Amendment Schedule "B."

Will you remark on the amendment, sir.

REP. CARTER (2nd):

Yes, Madam Speaker.

Ladies and gentlemen, a lot of the conversation over the last hour or two has been focused on the differences in training between physicians and advance practice registered nurses. And we've heard by people in our own Chamber about how very different those two are.

You know, somebody who is an advanced practice registered nurse, was first a registered nurse and in that program it was very focused on nursing. When they come out and get their master's and have a little more clinical hours which changes their -- I would say their focus a little bit, they have 500 clinical hours when they finish training and they take their test. When you look at the physician's side of the argument, unfortunately physicians have to go to school a very, very long time.

We've heard that after achieving their Bachelors degree and much of that is pre-medicine, obviously, chemistry and things like that. Then they go to medical school. And when they go to medical school, at least two years of that medical school is devoted to rotations and actual clinical work.

And ladies and gentlemen, the difference that we've even talked about today between nurses and

physicians is that physicians have a much deeper knowledge about systems; it's much more focused on diagnosis than what the nurse practitioners go through at that time.

Then after that of course, the physician goes off to a residency program. Now ladies and gentlemen, as we've heard about residency programs, residency programs as our own Representative -- the good ranking member of Public Health mentioned, are brutal. And when we say brutal it means that they're rigorous. That there's academic rigor, there's time rigor and it's all based around training.

It's about giving somebody real world experience and having somebody who's precepting or a mentor over them who's there to teach them around every corner. See in a collaborative agreement with nurses, they may have some of that collaboration. We know that the intent of the collaboration agreement was to have that; that was the intent.

And unfortunately, this thing has gotten away from some people perhaps, but by enlarge, the majority of nurse practitioners right now do practice with a physician in some sort of capacity, where they're working together. In fact, if you look at what we're

doing in the future, it's all about team based approach to health care.

It's about getting nurse practitioners, PAs, doctors, case workers, all together. That's why folks, we're going to the affordable care act and the accountable care organization model. So what I propose in this amendment to do, is at least make sure that those who want to practice with a collaborative agreement can.

If their choice is to go on and stay in a practice working for an endocrinologist and managing diabetes or whatever it is they're doing and they want to increase their ability and their knowledge, they can do that under a collaborative agreement. For those who do not want to have a collaborative agreement, this ladies and gentlemen, is a fantastic avenue to make that happen. Because what we would have is we would have a two year accredited residency program for nurse practitioners.

Now ladies and gentlemen, by the way, Connecticut is the place where that exists. Connecticut is the place that had the first nurse practitioner residency program, right here ladies and gentlemen, and right now across the country more and more people are

looking at nurse practitioner residencies as a way to evolve their scope of practice; to make them better; to make them stronger; to make them know more.

So ladies and gentlemen, if we were to adopt this amendment, not only would be handling the issue of what happens in that three-year period, we would actually making nurse practitioners stronger, better, caregivers and it would be focused on diagnosing problems. And I would feel much more comfortable that we would not have this question looming about the quality of health care in the future because by enlarge when we make these changes to health care and keep cutting back, eventually the quality suffers.

This is a way that the quality won't suffer and for that matter we're even creating a new environment where nurse practitioners can evolve and take teaching jobs in our state, clinical teaching jobs and of course many of them go on to doctorates and nurse practitioners. So I think this is a great idea, it's a great amendment, and I hope everybody in the chamber would support it. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Will you remark further on the amendment before us?

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

Madam Speaker, through you, a few questions to the proponent of the bill?

DEPUTY SPEAKER MILLER:

Representative Carter, please prepare --

REP. KLARIDES (114th):

Oh, you know, I apologize, Madam Speaker. I didn't realize we were still on the amendment. Sorry.

DEPUTY SPEAKER MILLER:

Okay. Thank you.

Will you remark further on the amendment before us?

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

I too rise this afternoon in strong support of the amendment. When we talked about the previous amendment, which obviously did not pass, but we talked about training, we talked about the number of hours that a person would have to be trained so that they -- he or she could then be an independent practitioner. Training is crucial and we in our state already have

such a training program for APRNs.

Granted this residency program that we have in our state is limited in terms of numbers, but that is definitely an avenue we need to explore and look at an option to the three years of collaboration. If at the end of a two year training program an APRN training program, the person can then become an independent provider because they've gone through that very rigorous program that may not be what we see in a collaborative agreement for a three-year period.

So as a good option to the three years of collaboration will definitely be this two year residency program which we need to develop in our state. We could be the leading state doing that. We already have a program. Several cities in our state could come up with such a program. It is a win-win situation because if you look at retaining APRNs, here we are bringing people into the program from across the country and then hopefully they will remain and stay in our state and practice.

I hope that members on both sides of the aisle will consider this amendment and help us pass that. Through you, thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker.

I have a question for the proponent of this amendment.

DEPUTY SPEAKER MILLER:

Representative Carter, please prepare yourself to respond, sir.

REP. CONROY (105th):

In speaking of these accredited nurse practitioner residency programs, can you tell me where these programs are right now in this state, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

Yes, Madam Speaker.

The one in the State of Connecticut is run through the Community Health Center, Incorporated. I'm not sure what year it was started, but they have them at a number of locations around the state including over in Middletown. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

And through you, Madam Speaker, can the proponent please tell me how many slots are available in this limited residency program, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

Thank you, Madam Speaker.

That's an excellent question because right now at this health center, there's eight slots available. But understand that we could have more slots available if we mandate this as a law in Connecticut we could have them at Yale New Haven, we could have them at Bridgeport, we could have them at St. V's, Waterbury at St. Mary's, Danbury at St. Raphael's. So the idea would be to have one at every clinic in the state. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker.

And can you please enlighten me to whom is doing the accreditation for these nurse residency programs

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in the state, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

In the amendment that we've put forth, we are looking for the accreditation to be from the American Association of College Nurse Practitioner -- excuse me, American Association of Colleges. And I believe that might be a misspelling in the amendment. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker.

And just to clarify, I'm not sure if he said they're looking for accreditation or if there is a program that's accredited, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

My understanding of the American Association of College of Nursing right now they're looking to accredit ate different programs around the country.

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Because this is not only happening in Connecticut as our colleagues have said, this residency program idea and the issues expanding scope of practice or having nurses practice without agreements, is sweeping the country as part of the affordable care act. So there are many nurse practitioner residency programs popping up and in fact it's been a big focus in health care reform moving forward. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Conroy.

REP. CONROY (105th):

Thank you, Madam Speaker.

I stand here in strong opposition to this amendment and urge my colleagues to also. As you heard there's only a couple of slots in one program in the State of Connecticut. That program happens to be one of our federally qualified health care places and Margaret Flinter who is the nurse that's responsible for this great program, actually came before the Public Health Committee at our public hearing and spoke in favor of having -- getting -- to rid the state of the written collaborative agreement and nowhere did she speak to saying that we need to have a residency program in place if we were to do away with

the written collaborative agreement.

So again, I urge my colleagues to vote against the amendment. This is not what the bill is about. The bill is about just getting rid of the written collaborative agreement and not changing the scope of nursing practice to become a residency program. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Thank you, Madam.

Representative Sayers.

REP. SAYERS (60th):

Thank you, Madam Speaker.

I too stand and ask my colleagues to vote -- to please oppose this amendment. Both the National Institute of Medicine and the National Governor's Association have recommended that we remove all barriers to practice for the APRN. And in the 20 states that have already done this, there have been -- there is actual documentation that outcomes have been very favorable and there have been no problems. So ask everyone to please oppose this amendment. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Will you remark further on the amendment before

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us? Will you remark further?

If not, will staff and guests please come to the well of the House? Will the members please take your seats? The machine will be on.

THE CLERK:

The House of Representatives is voting by roll.

The House of Representatives is voting by roll. Will members please return to the chamber immediately?

DEPUTY SPEAKER MILLER:

Have all members voted? Have all members voted? Will the members please check the board to determine if your vote is properly cast?

If all members have voted, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally?

THE CLERK:

LCO 4413, House "B."

Total number voting	143
Necessary for passage	72
Those voting Yea	52
Those voting Nay	91
Those absent and not voting	8

DEPUTY SPEAKER MILLER:

The amendment fails.

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Will you remark further on the bill? Will you remark further on the bill?

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

Madam Speaker, now finally through you, I would like to ask a few questions of the proponent of the underlying bill?

DEPUTY SPEAKER MILLER:

Representative Sayers, will you please prepare yourself, Madam, to respond.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

Through you, just for some general understanding, when a doctor and an APRN have this three-year collaboration, what occurs after the three years to allow the APRN to go out on their own, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

We have put information in the Department of Public Health tech revisions bill that actually requires that at the end of that three years if that

APRN determines not to continue the collaborative agreement and to go out on their own, that they must notify the Department of Public Health that they are doing that.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

And besides that, is there any written statement, oral statement or anything that needs to be done on the doctor's part to allow the Department of Public Health to know that this APRN has accomplished this goal, has done the necessary days and hours that he or she needs to do, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Other than the notification by the APRN, no.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

And in that three-year period I know that there is a, I believe its 2,000 hours, is that accurate,

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through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Through you, Madam Speaker.

Is it -- so it's my understanding from the previous answers from the Representative, that it is only the word of the APRN after that period of time that these hours, that these three years have been finished, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

So there's no verification, which I guess I don't understand, is on both parts. I would think that there would be verification. If the APRN says I

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worked X amount of hours in furtherance of my ability to go out on my own if I so choose after the three-year period, there's no verification whatsoever from the doctor, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

No, but the Department of Public Health could request an audit that would show -- where the APRN would have to show that she had accomplished the 2,000 hours. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

So the lady said that the Department of Public Health could do an audit. How many times is that done, maybe by percentage, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

Weill this would be new legislation unless there

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have been problems identified, the Department would not verify that there is a current collaborative agreement. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

So this is a new process we're going through I understand that. Is it written anywhere or is there any documentation that that's how it could go if there was question? I don't -- I guess I don't understand, I'm not in this field, so please bear with me, I don't understand how if APRN Sayers just finished her three-years and she decides she is going to go out on her own and she sends the Department of Public Health her documentation saying that I have now worked with Dr. Srinivasan for the past three years and the Department gets it and because this is all new, how would the Department of Public Health even think, you know I think we need to audit this because we're not sure, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

I suspect that the Department would not request an audit or any trail, paper trail, unless there was concerns about the APRNs' practice and right now any time there's ever concerns or a complaint has been made to the Department, the Department can go and investigate and follow up on that. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

Well, I have concerns about that particular issue because whether you supported the underlying bill or don't support it or somewhere in the middle, I would think that typically speaking if we have situation where there is somebody working with somebody and you need to accomplish a certain amount of hours or days or years or months or whatever unit we set up in legislation, that you would think there would be checks and balances not somebody just saying I've done this many hours, I've done this many years, so I'm ready to go.

I mean I understand we are where we are with the

bill, but I would think that there would be something where the doctor would have to say, you know, in agreement with it. So I guess I have a concern in that regard.

On another subject in regard to the hours, through you, Madam Speaker, I know it's a 2,000 hour time that the APRN needs to fulfill. Could that be one hour a week, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

It is 2,000 hours in conjunction with a three years of the collaborative agreement, so it would be very difficult to obtain that number in three years if you worked one hour a week. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

So if somebody worked, and I'm not going to do the math here because I'm not going to try this, but if somebody worked five hours a week, let's just say in a

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collaborative agreement with a doctor and they get to the three-year period and clearly we haven't reached the 2,000 hours, does that mean you start from the beginning on day one of your four as far as the totaling of the hours, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

No, there would be no reason to go back to the beginning. You could continue to add your minimum of 2,000 hours. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

I'm just a little confused with that answer because I guess the good representative said that it was 2,000 hours and three years. So I think did she mean 2,000 hours and -- I don't understand it. So it could be 2,000 hours and that could take 20 years, through you?

DEPUTY SPEAKER MILLER:

Representative Sayers.

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REP. SAYERS (60th):

Through you, Madam Speaker.

The way the amendment in the tech revisions reads that the three years of collaborative agreement must consist of a minimum of 2,000 hours. It doesn't identify if there's less than 2,000 hours how that would be handled. And through you, Madam Speaker, I would be happy to work with the Representative because that's in the tech revision bill and if she feels that there should be additional information, we certainly can look at that and work on that. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

And yes, I will take the Representative up on that. Thank you very much. I thank the good representative for her questions.

DEPUTY SPEAKER MILLER:

Thank you, Madam.

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

Through you, Madam Speaker, to the proponent of the bill amended as it is, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers, please prepare yourself to respond, Madam.

Representative Srinivasan, you have the floor, sir.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

What provision is there in this bill to make sure to ascertain that the minimum requirement as far as training is met other than the three years and maybe the 2,000 hours in the tech bill, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

When they present their license for renewal, they have to -- there is a questionnaire that requires them to give that information and when they are initially licensed, they have to also provide information.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

As I understand it in that case, it is this document that they have to present will say that they had a collaborative agreement for a, three years and b, they met the 2,000 hour requirement, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

Through you, Madam Speaker, what recourse is there if the supervising physician, he or she feels that this APRN, and it happens in programs all the time, under this collaborative agreement is not capable, is not competent enough to be in independent practice. That is the assessment of the collaborator. Three years have gone by, 2,000 hours have been put in; but unfortunately, that APRN is not competent in

the opinion of the collaborator. What then happens, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

As is current today, any time a physician feels that the practice of an APRN was incompetent, he has the ability to make that report to -- referral to the Department of Public Health with his complaints and there would be an investigation. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

Through you, there is a process as I understand where the collaborator, the physician can send to DPH that that particular APRN is not meeting the necessary clinical standards, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

When this bill or if this bill passes, the three-year supervision period, obviously it starts ticking from the date it is signed by the good Governor, but does that include retroactive time to the people who have already been in over three years of collaborative agreement, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

If somebody has obviously a license in our state for over three years, has had collaboration with a physician for 10 years as per the current statute, when this bill is passed, he or she is now qualified to be an independent APRN, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

If there are agreements, employment agreements, between the APRN and the doctor, the medical doctor, what happens to those agreements, through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

Because those agreements would be contracts, that they had entered into, they would have to maintain those contracts until the date of renewal of the contract or else renegotiate those contracts. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

When an APRN is in collaboration, is a physician and physician alone who can be the collaborator, through you, Madam Speaker, during these three years and for the 2,000 hours, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

Could the good representative please repeat the question? I'm not clear that I heard it accurately.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Definitely. Through you, Madam Speaker.

This collaboration between the APRN, can that collaboration for the three years and the 2,000 hours that we've talked about, can that collaboration be only with a physician, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

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REP. SRINIVASAN (31st):

Through you, Madam Speaker.

If an APRN has a collaborative agreement with another physician but the physician is in another state, our APRN does have a license to practice in Connecticut, so that requirement is met, but the collaboration so far has been with one of the neighboring states. Through you, Madam Speaker, in that case would that APRN -- can that APRN be an independent practitioner, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

If the APRN has been practicing with a collaborative agreement in Connecticut with a doctor that is licensed in Connecticut, then it would count. If they have not been practicing in Connecticut, when they entered Connecticut to begin their practice, it would be as they were newly licensed. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Madam Speaker, thank you very much for the clarification. But the scenario that I had in mind was the collaborating physician happens to be in a neighboring state. That's where the physician is and the APRN is practicing in Connecticut, obviously in a remote relationship with the collaborator and does have a license to practice in Connecticut as well. So only the collaborator happens to be out of state. What happens then when this bill is passed, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

The collaborative physician must be licensed in Connecticut in order for them to have a collaborative agreement. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

Yes, that physician also has, happens to practice in Massachusetts or Rhode Island, you know Springfield is not too far away from Enfield, so practices in

Massachusetts but does maintain a Connecticut license as well, but a primary practice is not in our state, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

That situation already exists in many of medic clinics the nurses have collaborative agreements with a physician who is licensed in Connecticut but may not reside in Connecticut. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker.

So in that scenario, that APRN even though the physician has a license in Connecticut, does not practice in our state, will be able to become an independent provider after the three years are up, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

If it has met all the essence of the collaborative agreement, yes.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you. Sorry for interrupting, I apologize. Through you, Madam Speaker.

By law nurse anesthetists must work under a physician's direction. Under current law, certified nurse anesthetists can prescribe and administer medication during surgery only if the physician is directing it medically. Will this bill when passed, have any impact on nurse anesthetists, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

No, this does not make any changes there at all. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

My final question, Through you, Madam Speaker, is

given the fact that our current APRNs and we can go anywhere in the numbers within 3,000 to 600, they are all employed to their full capacity, whether it be two days a week if that's what they choose, four days a week or six days a week. When this bill is passed, our present APRNs are already working to their capacity that is my understanding, that no APRN in our state is looking for a job and not finding a job and not having a job that is what I have observed with the APRNs in our state. Do you think, Madam Speaker, because of this collaborative agreement not being there, Connecticut will suddenly open up its flood gates and we'll have a whole slew of APRNs from other states coming to our state to get into a collaborative agreement, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

I suspect some of our APRNs will come home to practice because we know that they have left the state due to the fact that they see the collaborative agreement, written agreement as a barrier to practice. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

I want to take this opportunity to thank the very gracious Deputy Speaker. She as we all know is extremely knowledgeable and over and above being knowledgeable is always there to talk, to communicate and meet you more than halfway. And I'm very happy that I've had the opportunity on this bill, like many other bills, to work with her very closely. On this bill obviously we have our differences. We see things in different ways, but at the end of the day, our goal is very simple, our common goal whether it be that side of the aisle or this side of the aisle, is to make sure that health care in our state is available, health care is accessible and health care is going to be what it should be, deliver good quality health care. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker, yes.

Just a couple of questions through you, to the proponent of the bill, please?

DEPUTY SPEAKER MILLER:

Representative Sayers, please prepare yourself to respond, Madam.

Representative Carter, you may proceed, sir.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

Through you, Madam Speaker, it was said a couple of times that they were talking about no negative outcomes with respect to the collaborative agreements. I just want to make sure I fully understood what that -- what she was referencing at that point, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

I first want to thank Representative Srinivasan for his kind words. Representative Carter, there was a scope of practice mediation at the Department of Public Health. It is available for anyone to read. It's online on the Department of Public Health website and it goes into details. There were physicians

represented there as well as APRNs and a number of other health care practitioners and it talks about outcomes in other states, information that was presented and at the time, no information was presented that said any deterrents to getting rid of the collaborative agreement. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

Thank you very much and through you, Madam Speaker, then is there some plan in Connecticut or some means that we could actually track outcomes with respect to patients of APRNs versus patients of physicians, through you Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

One of the ways we are able to track health care outcomes because when there are errors or there are problems in someone's practice, through reports that are sent to the Department of Public Health, they are able to investigate and follow up on them and make

determinations it there's negative problems or outcomes within those practices. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

So if I understand this correctly, there are -- the patients are the ones who make complaints against a health care provider of any kind and these are not legal complaints, these are done through the Department of Public Health, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

That is correct. It could be patients, it could be family members, it could be someone else who is in practice with that person, it could be any number of people including anonymous complaints. The Department would follow up on an investigation. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

Through you, then is there anybody out there then who actually tracks clinical outcomes of nurse practitioners versus physicians? You know my question would be, is there somebody out there who says, okay there's more heart attacks in this population or more cancer versus more heart attacks and cancer found or actually prevented in the physician population, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

Actually when they did the review process, there was information provided that the studies found that APRN produce patient outcomes they were comparable to or in some instances exceeded those of physicians in areas such as patient health status, functional status, use of emergency departments and patient satisfaction. Additionally, evidence provided from practice experience in other states where there's no requirement for a physician collaborative agreement,

there was no evidence to refute any of those findings. There was no evidence or data provided as part of the scope of practice review to validate that removing the mandatory collaborative agreement would alter APRN patient care or place patients at risk or that patients are at risk of care -- the care has deteriorated in other states where there's no required agreement. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

I do thank the Representative for her answers to the questions and as our own Representative Srinivasan had mentioned, you know these battles are not personal; these battles are about something we may not agree on, but at the end of the day we're all colleagues and I appreciate the work that she's done with our side of the aisle and everybody in the chamber for that matter.

Madam Speaker, I guess where I was going with my line of questioning is, right now the way we look at patient care, there's nobody out there necessarily tracking outcomes from a practice specifically whether

they were an APRN patients or they were physician patients. Those kinds of things don't always exist. Now what our colleague alluded to is right on the point.

APRNs are a huge, huge part of our medical practices in this state. They've been used for years to lower costs, be more efficient. You know, nurses are especially adept at doing the education component in these practices which is why often they spend more time with their patients. In many instances nurse practitioners are the ones teaching about diabetes. So I don't there's a questions about the role of nurse practitioners or how important they are overall.

But we still have to go back -- we have to recognize that nurse practitioners and physicians are different. And this change or this ability to have a collaborative agreement has grown over time. You remember I think I mentioned earlier, back in 1989, actually prior to 1999, nurse practitioners in our state practiced under direct supervision of doctors. And what's interesting to me is that's exactly why we gave them prescriptive authority.

If you look back at the testimony, the testimony is all about making access to health care, making it

easier. And by the way, the doctors at that time wanted more nurse practitioners to have prescribing rights all over the state. Now we as a Legislature actually limited it and didn't fix that until many years later. But my point is, the whole reason we gave them prescriptive authority was they practiced under direct supervision of a doctor.

So fast forward to '99 we get rid of the -- the collaborative agreement comes around and lo and behold the collaborative agreement isn't very good. I've been in the industry for many years and I've known many nurse practitioners over the last 15 years and the majority of those folks actually practice very tightly with a physician or in some sort of group practice or some sort of clinic.

These people have come out now who have said that collaborative agreements are really bad and they're really loose. That is a vocal minority of what actually happens and I think what we should be doing is looking at finding a way to make those agreements better. Unfortunately this bill doesn't even address any of that.

I would agree with the concept that it's time we move forward with finding better ways to utilize nurse

practitioners and their skills in our state. There is no question about it; they are going to play a vital role moving forward in the way we treat patients.

But we've got to remember that there's a blend of the way we should be doing this and right now when you have somebody come out of school and they have a very limited scope of practice, that's going to cause a big concern for me because even though there's no evidence out there to refute it, these studies are all geared towards looking about how nurse practitioners effect practice and how they help the quality of care. And that's true.

But, most of those are actually in practices with other people. My overall concern is that -- you know, I went to a CVS yesterday and I saw -- at CVS they have a minute clinic. I'm really worried that we're going to have a lot of people going to the minute clinic for their health care. And at the end of the day, I don't think those folks are the best trained to see some of these chronic diseases that we face and at the end of the day we're not going to have outcomes to show whether they found them or not.

They're just -- people are just going to go untreated and I don't think it's any way to document

or find out if that's really happened or whether it was resolved at a minute clinic. So I look at this moving forward I think this is a bad idea right now. Especially not having anything additional in place to make sure that people have more training.

Right now with the collaborative agreement, the intent has always been to have some sort of oversight, some sort of check in. Not on top of the person, not checking everything they do -- remember we got rid of that in 1999. But we've had some sort of support to make sure that nurse practitioners were providing quality medicine. And without an additional board, without additional training, I'm worried that that's going to go the wrong way.

So I urge my colleagues to defeat this bill and I would be more than happy to come back and look at this in future years because I do think nurse practitioners should enjoy a greater autonomy. But there just needs to be a more rational way to do this than to just open the flood gate at this point. Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Representative Smith.

djp/mb/lgg/cd
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REP. SMITH (108th):

Madam Speaker, just a few short questions if I may to the proponent of the bill?

DEPUTY SPEAKER MILLER:

Representative Sayers, please prepare yourself to respond, Madam.

Representative Smith, you may proceed, sir.

REP. SMITH (108th):

Thank you, Madam Speaker.

Just this 2,000 hour figure that we've talked about today, I know it's supposed to be in a bill that's yet to come and I have a little bit of a concern with that because if the bill that it's supposed to be in doesn't get passed, I would assume then that that 2,000 hour requirement would not be part of this bill, is that fair to say, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

Through you, Madam Speaker.

In reply to Representative Smith, I will tell you that we have always passed the tech revisions bill. But I will tell you one year I can remember bringing

out the bill at five minutes to 12 on the last night of session and yet we still passed the bill. So it's one of those perennial bills that we always do. So I wouldn't tell you 100 percent but 99 and nine tenths percent, we're going to do that bill, sir. Thank you.

DEPUTY SPEAKER MILLER:

Representative Smith.

REP. SMITH (108th):

Well that representation is good enough for me. I do appreciate that from the good representative.

The 2,000 hours, I've been fooling with the math up here and I don't know, it's probably why I went to law school and not math school, but what does that really come out to if we did it on a weekly basis, through you, Madam Speaker?

DEPUTY SPEAKER MILLER:

Representative Sayers.

REP. SAYERS (60th):

I'm not even sure. My math skills are good in algebra and geometry for getting adding a column a figures. Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Smith.

REP. SMITH (108th):

All right. Well I've enjoyed the debate today and I thank the Chairwoman for her answers and thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Will you remark further on the bill as amended?
Will you remark further on the bill as amended?

If not, will staff and guests please come to the well of the House? Will all members please take your seats? The machine will be open.

THE CLERK:

The House of Representatives is voting by roll.

Members to the chamber please. The House of Representatives is voting by roll. Members to the chamber please?

DEPUTY SPEAKER MILLER:

Have all members voted? Have all members voted?
Representative Arce, for what purpose do you rise, sir?

REP. ARCE (4th):

For correction. I have voted by mistake for Representative Baker but it's corrected now.

DEPUTY SPEAKER MILLER:

Let the records reflect that the votes have been properly cast.

Have all members voted? Have all members voted?
Will the members please check the board to determine
if your vote is properly cast?

If all members have voted, the machine will be
locked and the Clerk will take a tally.

Will the Clerk please announce the tally?

THE CLERK:

Senate Bill 36 as amended by Senate "A."

Total number voting	145
Necessary for passage	73
Those voting Yea	110
Those voting Nay	35
Those absent and not voting	6

DEPUTY SPEAKER MILLER:

The bill passes in concurrence with the Senate.

Will the Clerk please call Calendar Number 137.

THE CLERK:

On page 40, House Calendar 137, favorable report
of the joint standing committee on Education,
substitute House Bill 5375, AN ACT IMPLEMENTING THE
RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND
INVESTIGATIONS COMMITTEE ON THE REEMPLOYMENT OF OLDER
WORKERS CONCERNING THE TECHNICAL HIGH SCHOOL SYSTEM.

DEPUTY SPEAKER MILLER:

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**CONNECTICUT
GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
2014**

**VOL. 57
PART 2
341 - 702**

Necessary for adoption	19
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The Consent Calendar passes. Senator Looney.

SENATOR LOONEY:

Yes, Madam President. Thank you. Madam President, would move that all of the bills referred to various Committees earlier in the Session, that those bills be immediately transmitted to the Committees to which they were referred.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you. Thank you, Madam President. Madam President, if the Clerk would now call an item that was marked passed temporarily earlier, and that was Calendar Page 9, Calendar 108, Senate Bill 36.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On Page 9, Calendar 108, Substitute for Senate Bill Number 36 AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTHCARE. Favorable Report of the Committee on Public Health, and there are amendments.

THE CHAIR:

Good evening, Senator Gerratana.

SENATOR GERRATANA:

Good evening, Madam President. Thank you. I move acceptance of the Joint Committee's Favorable Report and passage of the bill.

THE CHAIR:

Motion is on acceptance and passage. Will you remark, ma'am?

SENATOR GERRATANA:

Yes, Madam President. Thank you so much. This bill amends the Nurse Practice Act to say that nurse practitioners or APRNs who have maintained a license for at least three years in accordance with current law, may then practice alone or in collaboration with a physician.

Madam President, at this time, the Clerk has an amendment, and if he will call LCO Number 3475 and then may I allowed to summarize.

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO Number 3475, Senate "A" offered by Senators
Looney, Gerratana, et al.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Madam President, this bill --

THE CHAIR:

Motion to accept the Amendment.

SENATOR GERRATANA:

Oh, excuse me. I'm sorry. Motion for adoption.
Thank you, Madam President.

THE CHAIR:

Please proceed.

SENATOR GERRATANA:

Thank you. This bill is in three different parts. It amends the current language that we have regarding the new language for nurse practitioners and we strengthen it a little bit on Line 5 by saying engaged in the performance of advanced practice level nursing activity, in collaboration with a physician, so it is clear that a nurse practitioner would be working with that physician.

In Section, I believe it's 501, because of some concerns, we are also adding language that requires that nurse practitioners would have continuing medical education requirements.

And in Section 502, the last section of the bill, we are now going to also require that anyone who, any manufacturer that provides a payment or other transfer value to an advanced practice registered nurse who is practicing in the state, shall submit to the Commissioner of Public Health in a foreign manner prescribed, information about and disclosure of any sort of value or transfer value for certain items such as medical devices or pharmaceutical products. Thank you, Madam President.

THE CHAIR:

Will you, I'm sorry.

SENATOR GERRATANA:

Madam President, one other thing, if I may ask for a Roll Call Vote when the vote be taken.

THE CHAIR:

Absolutely. Will you remark? Senator Welch.

SENATOR WELCH:

Thank you, Madam President. If I may, a few questions to the proponent of the Amendment.

THE CHAIR:

Please proceed, sir.

SENATOR WELCH:

Thank you, Madam President. The underlying bill left me a little bit uncertain about what the requirement was that collaborate for three years being licensed relative to, let me stop there.

I understand from what you just stated that you're attempting to clear that up now. So, the initial confusion that I had stems from the underlying bill in, excuse me, in Lines 11 through 12, where we say that an advanced, an APRN shall for the first three years after having been issued such license, collaborate with a physician.

And I guess the question that I have from that is, what did we mean by collaborate there? Did we mean that we're having, you have to have a collaborative agreement and how does the underlying Amendment, or the Amendment that you just proposed address that issue? If I may, through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. The current language does talk about collaboration and what should be in that collaboration. That's current language, current law in our state. We felt the difference in this Amendment and the difference between the underlying bill as we are discussing here today is that we added in, as I said, those words, engaged in the performance of advanced practice level nurse activity.

We thought it would be important to indicate that an advanced practice nurse would be working with a physician and be employed if you will. Activities in this case would be whatever would be related to his or her job. Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. So then, would one be collaborating under the Amendment if they were working for, if an APRN was working at a hospital? Would that be considered collaboration? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Well, Madam President, through you, collaboration is currently with a physician. Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Okay, thank you, Madam President. So, I guess maybe to ask the question in another way. Or let me just state what I think I understand this Amendment does.

It will require an APRN to actually be collaborating with a physician under a collaborative agreement for three years before they can then go on their own, as it were. Is that correct? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Yes, that is the intent here, that there would be that three-year period of collaboration, then the APRN may choose to work either, continue that collaboration if he or she wishes, or work independently, as it goes on in the bill. Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. And then with respect to the timeframe of three years, what is expected with respect to a collaborate during those three years, Madam President, if I may, through you. Is there an expectation that they will be engaged in full-time employment during those three years, part-time employment, is there a certain hour requirement? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Currently, nurses, APRNs, I should say, or nurse practitioners who do collaborate, there is no requirement for the number of hours that they work.

However, I did go to the website, the DPH website to see how many APRNs around the state who have active status and most of them are working full time at this point.

So I think, I hope that answers your question that from what I could discern, that there, although we don't mention the number of hours per week that an APRN would work, most of them are working full time and that we do say, again, to strengthen just a little

bit, that there has to be that activity of being an advanced practice nurse activity.

So that would be related to an APRN working, being engaged in their practice. Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. And then, if I may, through you, Madam President, with respect to the CE credit requirement that is in the bill, I believe it says 20, excuse me, that's in the Amendment, I believe it says 25 contact hours of continued education within a year.

Is there a current CE requirement for APRNs? Through you, Madam President.

SENATOR GERRATANA:

Through you, Madam President. No, not that I'm aware of. There is, of course, requirements due, which is linked to their certification, but I believe this is all new language, Madam President. Yes, it is.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam Prèsidet. And I apologize because I am just kind of looking at this language for the first time, but would the CE requirement apply to all APRNs, if by that I mean those that are practicing on their own or say maybe those that are working in a hospital or somewhere else? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Yes. It would be all APRNS. That is my understanding.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. That's all the questions I have on the Amendment. I will be supporting it. Thank you.

THE CHAIR:

Thank you very much. Will you remark further? Will you remark further? Seeing none, at this time, Mr. Clerk, call for a Roll Call Vote on Senate "A". The machine will be opened.

THE CLERK:

An immediate Roll Call has been ordered in the Senate on Senate Amendment Schedule "A".

Immediate Roll Call is ordered in the Senate.

THE CHAIR:

All members have voted? All members voted? The machine will be closed. Mr. Clerk, will you call the tally, please.

THE CLERK:

Senate Amendment Schedule "A".

Total number voting	36
Necessary for adoption	19
Those voting Yea	32
Those voting Nay	4
Those absent and not voting	0

THE CHAIR:

Senate "A" passes. Will you remark? Senator
Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Madam President, I just want to talk a little bit about the underlying bill and what we are doing here.

I also wanted to clarify a little bit because I know there's been a lot of discussion and talk about nurse practitioners, not only what they do but also how they function in our state.

I want to say first of all, that nurse practitioners have had independent, independent practice for the last 15 years, since 1999. They gained that independence.

What we are doing here is making them independent of the collaboration, the term collaboration in our statute. So I just wanted to assure all the members here that this is not an establishment of an independent practice. They already have that. They already have prescription authority also, and they are able to treat patients as they can within their scope of practice currently.

I also wanted to reassure our members here that they do go through a baccalaureate program and then they do post-graduate education. They must do at least two years and most APRNs, excuse me, APRNs or nurse practitioners do at least four years.

Many that I have talked with in the state do a variety of work in clinical settings and they also, I've met many who are Ph.D. They go on and specialize in their area. Most APRNs like to hone their skills in the particular area that they work with.

And also, wanted everyone to know also that New York just passed legislation that grants autonomy, similar legislation to what we're discussing here today and that 19 other states also have full autonomy for their nurse practitioners to practice their particular medicine.

If you by any chance had a chance to see 60 Minutes this past weekend, you will know that APRNs fulfill a function both here in the state and in other parts of the country, in taking on indigent population. They are very happy to do so and we all acknowledge that Medicaid reimbursement can be very low, but they are happy to see the Medicaid population.

So I urge the Chamber to support the bill that we have before us. Thank you, Madam President.

THE CHAIR:

Will you remark? Senator Welch.

SENATOR WELCH:

Thank you, Madam President. I thank Senator Gerratana for her description of the bill and her work on bringing the bill forward. I do support the bill, but I do have a number of questions that I think will be beneficial for the Circle to hear so if I may, through you, Madam President.

THE CHAIR:

Please proceed, sir.

SENATOR WELCH:

Thank you, Madam President. The first question I have deals with nurse anesthetists and I notice in the OLR report that there is some confusion as to how this might apply to nurse anesthetists.

The OLR report states that by law, nurse anesthetists must work under a physician's direction. How does this bill impact that specialty? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Thank you, Senator Welch for that. I meant to mention that it does not. Nurse anesthetists do not want, nor will they have under this legislation, the ability to work independently. They are under the supervision of a physician and will remain so.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. Another area of concern I think that was raised during the public hearing process was actually by the Hospital Association. They presented testimony that DSS is not providing reimbursements for hospital-based services provided by APRNs, and obviously that's an agency decision. That's in the control of these bodies here and if I may, through you, Madam President, ask Senator Gerratana, are there plans to change that and allow for reimbursement? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, not that I'm aware of. I think that is something for the Human Services Committee to take up, perhaps. Thank you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. Another concern that was raised during the public hearing and frankly was a concern I shared. It had to do with profiling. Currently, doctors have profiles with the Department of Health where people can lodge a complaint and they're registered. I believe statute requires the

same profiling to be of APRNs, yet it doesn't sound like it's going because it's not being appropriated.

So if I may, through you, Madam President, how are APRNs going to be profiled, if they're going to be profiled? Through you.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Yes, we do have statutory referencing to profiling of physicians and others in the healing arts, including APRN. There is a requirement. It's 20-13j and it does require that there be disclosure.

Currently, we do do this for medical doctors. I did talk with the Department of Public Health. They are very amenable to going forth after this bill passes, and once it does pass and if it becomes law, to be able to profile APRNs in a very similar manner.

Of course it would have a fiscal impact in talking with them. That's another discussion, but it is already in statute that they are required to do this, and I believe it says within available appropriations, so. Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. Another concern that I've heard is, I guess I would kind of categorize it as truth in advertising, and I think the concern goes like this. Are people going to know when they see an APRN in practice, that one, that they're actually seeing an APRN as opposed to another medical provider, and two, that they are seeing an APRN? Do they have an understanding as to what type of collaboration that APRN is involved in?

And I don't know, through you, Madam President, to what extent Senator Gerratana can maybe even describe the process how it works now, how it's envisioned to change, if at all, through this legislation. Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Yes, there's a number of ways that APRNs are identified. Not long ago, I think a couple of years ago, we actually did legislation that medical personnel, particularly in facilities, be identified. I recall at that time, during, that there was testimony that employees, particularly in a hospital setting or other clinical settings, it was very hard to discern exactly what their profession or title is and we did do some legislation requiring badges or identification of those particular settings.

Most APRNs that I have met over the past year, I have talked to many, have either a badge or they have embroidered on their lab coats who they are and that they are APRNs and then any other degrees that they may have.

We also have a statute, Section 53-41 and I know there was some concern about APRNs perhaps purporting or holding themselves out to be doctors. That particular statute, which is in our Judiciary, or Judicial statutes, thoroughly prohibits this from happening and also attaches a fine to it, so an APRN could not and would not, I believe, purport to be anything other than what they are. Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. I think another concern that, frankly that I've had, has to do with prescriptive authority. As I understand it now, APRNs

can prescribe Schedule 2, 3, 4 and 5 drugs. As I understand under this legislation, that's the same schedule that they will be able to prescribe, but there are some changes.

So if I may, through you, Madam President, ask Senator Gerratana, would be the difference of their prescriptive authority as it stands today and as it would be under this legislation. Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Madam President, there would be no change. They can have prescriptive, they do have prescriptive authority, in fact. The only thing that changes is the decoupling, if you will, from the collaborative agreement. At this time there would be a written collaborative agreement that the nurse and the doctor would come to an agreement how, whatever that process is.

But what has been in practice over the last 15 years is that nurses prescribe. They prescribe independently. There's no co-signing on a prescription. The APRN signs the prescription, indeed, has his or her own prescription pad.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. And I think finally, a question that came up with some frequency during the debate in the public hearing process had to do with liability insurance.

I think there was a question as to whether or not APRNs were required to have liability insurance, and indeed they currently are required to have liability insurance.

Are there any changes in this legislation to APRNs' requirement to have essentially malpractice insurance? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, no. APRNs are required to have malpractice insurance and it's the same coverage, or I should say, the amount regarding the liability as MDs have. Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. And those are all the questions I have for Senator Gerratana. I thank you for your time.

This is a concept that I believe is something we need to move forward with and we need to move forward within a number of reasons.

First and foremost is the challenge that we have in providing primary care to certain parts of the State of Connecticut, and I see this as an opportunity to increase the penetration of primary care.

And unfortunately, I think as the Affordable Care Act moves forward and certain pressures are created because of that, it's going to be even harder to get primary care practitioners to practice here in the State of Connecticut.

So I think that there is a need now. I think that need is going to grow and I think this bill is at least a piece of meeting that need, so I will be supporting it. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark? Will you remark?
Senator Kane.

SENATOR KANE:

Thank you, Madam Chair, Madam President. Through you, I have a couple of questions to the proponent of the bill.

THE CHAIR:

Please proceed, sir.

SENATOR KANE:

Thank you, Madam President. I believe your conversation with Senator Welch spoke to a concern that many people have in regards to truth in advertising. Can you just reiterate that statement to me as well? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Certainly, Madam President. Thank you. As I said to Senator Kane, we did pass legislation, I think a number of years ago, requiring that employees, particularly in a hospital setting or a facility have identification that says who they are, what they do.

I also mentioned that in talking with and seeing APRNs that practice either in hospitals or even in other clinical settings, that they very often have a badge on, or they have on their coats, their lab coats, they have embroidered who they are and what they do, so it would be for instance, you know, Tom Smith, APRN, and any other degree.

I also mentioned that there was concern and talk about APRNs perhaps purporting to be doctors or something along that line. They cannot. I quoted a statutory reference where actually the term physician, surgeon, medical doctor, osteopath or doctor, the initials MD,

OD. I'm sorry, DO, or even DR are specific to medical doctors to MDs, who are licensed differently and there's also a penalty attached to that.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. I really wasn't referring to wearing a badge. I was more looking at the fact that if and when this legislation passes, APRNS are going to put up a shingle. Correct? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, they already do.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Well, thank you, Madam President. If they already do, then why do we need the bill? Through you.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

As I explained, Madam President, thank you, in the beginning they already have independent practice. But what this bill is removed what I consider to be an obstacle and that is to have the collaboration.

Collaboration in this case, we're just removing that so that they are independent of collaboration. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. Obstacle to what?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Well, Senator Kane, on Public Health Committee we heard testimony from our APRNs. Some of them have trouble finding and arranging to have a collaboration with an MD, and we also heard from APRNs who were from out of state who find it extremely difficult to find an MD to collaborate with. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. MDs from out of state? Why would we care about MDs from out of state? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

I'm sorry, if I misspoke. APRNs who come from out of state trying to find an MD in this state to collaborate with. We had testimony that they had difficulty finding an MD to collaborate with.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. So APRNs are coming from out of state for what reason? They're coming from out of state to Connecticut? Through you, Madam President, is that what you said?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, some do. Some of them are right here in our own state.

THE CHAIR:

Senator Kane.

SENATOR KANE:

And they, thank you, Madam President, and they came to testify in front of the Public Health Committee? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, no. I think one of them might be living if I recall from the testimony, was living in the state, but they had difficulty when they came into the state to live here, to find an MD to collaborate with.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. Well that's one. I think you said APRNs from out of state, as in plural, more

than one, multiple, many, are having difficulty when they're coming to the state. So my question was, are these APRNs coming from out of state to Connecticut? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Yes, there's that possibility.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. No, I'm not talking about possibilities. I'm asking if that is actually taking place right now, because I believe you said that that was taking place. So is that true? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Madam President, I said that I knew of at least one APRN who did testify, who when she came into the state had trouble finding someone to collaborate with, an MD.

There might have been more over the years, I think, since we've heard this bill a number of times. Whether there are this very minute APRNs coming into the state to work I do not have knowledge of that, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. Probably not, because we tax them too much.

You said there is an obstacle for them to collaborate with an MD. Why is that? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President. Some of the testimony, you can read it. It's on line, but some of the testimony as I recall and this is from my memory, is that many APRNs said that it was difficult to find and form a collaboration with an MD and they considered this to be an obstacle. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. No, I asked why is that? Why are they finding it difficult to collaborate with an MD? Through you.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Oh, sorry. Sorry, Madam President. It could be for a variety of reasons. Perhaps it's because of the, and I'm speculating here, because I just don't recall the exact words of the testimony, but the impression that I got was that trying to find an MD because it's perhaps an area that they want to themselves specialize in or have an interest in it and it was hard to find an MD in their area where they live that would be convenient.

But in general, I do recall that APRNs do find that establishing collaborative agreements or having to do so is just another step that they have to take in this state and therefore, the reason for the bill to remove that, and I'm using the term obstacle. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. Did the MDs testify that this obstacle exists? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

I'm sorry, Madam President. Did who? I didn't hear your term. Could you repeat the question.

THE CHAIR:

Senator Kane.

SENATOR KANE:

I think the term that you and I have both been using, MD, medical doctor, MD. Did the MDs, medical doctors, I think we've both been using that term, claim or testify that they believe that the same obstacle exists? Through you.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, not to my recollection that they, I don't think we asked them, or that they

volunteered that information. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

I guess that's where my confusion lies. So the medical doctors say there's no obstacle but the APRNs say they're, there is an obstacle to the same issue. I don't understand. Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

I think just, Madam President, for a clarification. I didn't say that the MDs find it to be an obstacle. I don't know that. I did say, however, that I read testimony where the APRNs found it to be difficult and an obstacle. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. Right. And what I said was, you as the Chair of the Public Health Committee had witnesses who were APRNs, who claim this was an obstacle, that collaboration with an MD was an obstacle.

Then you also stated that the MDs did not testify to that same effect. So if two parties are collaborating, how could there be this difference in the way they see the obstacle that's taking place between the very parties? Through you, Madam President.

SENATOR GERRATANA:

Through you, Madam President, I guess it depends if you're an MD or an APRN on how you perceive this. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Right. But this is what I'm trying to say. So the MDs say there's no obstacle, we are collaborating, but the APRNs say there is an obstacle for the same issue. That's what I don't get. That's what I'm trying to understand. Is there an obstacle or is there not an obstacle? How could we see it. It's like, you know, you and I saying well, I'm saying it's mostly cloudy and you saying it's partly sunny. I mean, is that what's taking place? Although we're both not seeing rain? I mean, you know, I guess I still don't understand the obstacle as we'll belabor the word, exists and that's what I'm trying to understand.

So because of this obstacle, are people not getting access to healthcare? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, I really don't see the link per se other than I know that APRNs in being able to decouple or at least work alone without the collaboration, it would be far easier for them to do so. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. So it would be easier for the APRNs to not have an agreement with the doctor, a collaborative agreement, but that doesn't necessarily

mean that we're gaining greater access, right? I think that's what you just said, because you said there's no concern about access. So why are we doing this? Just to give the APRNs their own business? Is that what it is? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Through you, I didn't say that it was an access problem or an obstacle, rather that for APRNs it would be a lot easier for them to provide services without having to go through and find an MD to set up a collaboration with.

And I do believe that that would mean that APRNs could more freely practice in the state. They already do, of course. As I mentioned, we have over 4,000 who are actively practicing in the state, but it would remove the requirement, the obstacle, the difficulty, whichever word you would like to use, to have that collaborative agreement with an MD. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. So then to whose benefit? If there's not an issue of access, then to whose benefit does this bill exist? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, I think to everyone's benefit. I had talked a little bit about how APRNs, nurse practitioners practice in our state and also

that they are more likely to see indigent and Medicaid patients, so if you're talking about access, to my way of thinking and belief, this would increase access for those patients. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Well, I'm really confused because a moment ago you said it wasn't about access. Now you're saying it would increase access. That's where you're losing me.

Are those individuals, the indigent population, are they not getting treatment now, are they not getting access now, through you, Madam President?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President. Well, I also serve on the MAPOC. Medical Assistance Program Oversight Council and I know that very often, and certainly I've seen articles about network adequacy and access to other health practitioners. This certainly knowing, and as I mentioned the 60 Minutes article that was on television this past weekend, that APRNs are more likely to take on practices and accept Medicaid patients and other indigent patients, so I do believe that at least in this case, that there would be better access. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. So having said that, does that assume that the doctors, MDs, are not seeing the Medicaid and indigent population? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. From my experience and from what I've heard and from what I know, that very often, doctors will not accept Medicaid patients by and large. Through you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Really? Thank you, Madam President. Do we have statistics that show that? I mean, do we have research data? Do we have some, really? Okay, thank you, Madam President. She's nodding her head. I'm assuming she has some information for me.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, I am very much aware that in many parts of our state, particularly rural parts of our state that access to, particularly for indigent people who do not have transportation or reliable transportation I should say, that there aren't enough MDs, if you will, to see these patients.

We've heard these reports on MAPOC at council meetings. We've seen reports, in fact there's a network adequacy report that I believe just came out and talks about, particularly in rural areas and some areas of our state where access to healthcare practitioners are difficult. Through you, Madam President, or whoever. Mr. President. I'm sorry.

THE CHAIR:

(Senator Duff in the Chair.)

I'm here. I'm here. Senator Kane.

SENATOR KANE:

Thank you, Mr. President, and back to Senator Gerratana, is there testimony in the Public Health Committee in regard to this bill stating that? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Mr. President. I would have to check. We can easily do that on our computers. There's, I think, dozens of testimony. As I say, I have heard of those through MAPOC, through you, Madam, Mr. President. I'm sorry.

THE CHAIR:

Thank you. Senator Kane.

SENATOR KANE:

Thank you, Mr. President. It almost sounds anecdotal, you know. I don't know if we have any data that backs that up, nor do we have data that backs up the fact that, because earlier you said, I speculate that people are coming from out of state more than, and looking for collaborate agreements and can't find it, so that seems without data as well.

Going back to my original question about truth in advertising, what I was referring to is, I've never personally gone to an APRN. You know, you went to the doctor, right? You're a kid, your mom took you to the pediatrician. As you got older, you went to the doctor. I don't know anyone who's gone or sought out an APRN.

That's not to say they don't provide good care, not to say they don't have education and great medical

knowledge, but I just don't understand that. So, my question in regard to truth and advertising is, and I asked you earlier, are they going to be putting up a shingle and you said no, they're already putting up a shingle and I said how were they able to put up a shingle, and you said, because they have to collaborate through the doctor.

And then I said, well why do we need this bill and you said so they don't have to collaborate to the doctor. So I said, well, what, well, how do, what will this change do for us then because who's going to go out and seek the APRN because people generally go to the doctor.

So now, my question is, how will that person, that APRN, differentiate themselves from a doctor, and that's where I get to the truth in advertising part. So how does this person know, John Q. Public, walks up to this door and sees, you know, a medical practice opens, how do they know that this person is an APRN and not a doctor? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Mr. President. Well, as I mentioned before, and I explained that we already have a statute in our Judicial statutes. There is a prohibition for anyone to call themselves a doctor. I think I named off surgeon, physician, medical doctor, osteopath doctor, MD, DO, or even the initials, or the abbreviation DR, except those who are licensed as medical doctors in our state.

I also mentioned that and certainly just from practice and experience in going and visiting doctors' offices, going to hospitals, and the labeling, if you will, or signage that is there, clearly states either on the person with a badge, or with some sort of identification on the lab coat, or if the person has a sign it says who this person is and their degree, their medical degree. Through you, Mr. President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I guess what I'm talking about, earlier today we did a bill from the General Law Committee that spoke to independent contractors, home builders, home improvement people and we made sure that these contractors were truthful in their pursuit of business, so we actually, the underlying bill wanted them to wear badges when they're working on a job site.

But, you know, certainly that was negotiated and now we're going to attach the certificate to the contract when these people make an agreement with a potential homeowner or something. That's a home improvement contractor.

This is medicine. This is life. This is someone diagnosing illness. I mean, this is life and death. So, I want to know how a person is going to differentiate between an APRN and a doctor when that so-called APRN puts up that shingle on the wall or puts an ad in the Yellow Pages or on Google or on Yelp or wherever they may be, you know, advertising. How does that person know, walking into that office, that this person is not a doctor? 'Just because they don't put, we all use, you know, I have a gentleman in my town who is a real estate agent who has CCIM, you know, all these different initials after his name. I don't know what that means.

So how do I know, or the average Joe Public know APRN versus MD versus PTS versus whatever. And those are just initials, you know, right? Look at anything. So how does that person know that they are seeing an APRN and not a doctor when the basic assumption for me and for many people is that you go to the doctor when you don't feel well? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Mr. President. I recall that bill, Senate Bill 205 and in that, the contractor has to produce their registration and again, we do regulate our APRNs and other health practitioners in our state. They all need licenses. Through you, Mr. President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Maybe I don't do a good job of framing my questions. Let me try again. I know that everyone gets a certification. I know that. What I'm asking you is, how does the general public know when they see an ad, when they go on Google, when they drive down Main Street, know that they are seeing a doctor or an APRN? How do they know that? Because, just because there's initials at the end of the name doesn't mean anything. I don't think. So how do they know? I mean, how are we protecting that individual so they know I'm seeing an MD versus an APRN? I know they're certified. I get that. They're licensed. I get all that. You could put all the badges on you want. I get all that.

What I need to understand is how that person, when they see that ad knows the difference between an APRN and an MD? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President. Again, according to the way that the department oversees APRNs and doctors and other practitioners is by their licensure and of course the requirements for that licensure.

How, I must ask you, Senator Kane, how do people know you are Senator Kane? Sometimes, you know, you may have a name tag on or something along that line.

But if you're concerned about safety or how people are identified in a healthcare setting, I went through that explanation a number of times, how they are identified in facilities, how they are identified in clinics and you know, other settings, that there's a variety of ways that they are identified.

And also, if you go to the Yellow Pages, very often if you look at ads for physicians or other health practitioners, it's also designated that way. APRNs, if they do advertise, could not call themselves doctors, so they would have to, if for nothing else because of what they do, would identify themselves as APRNs. Through you, Mr. President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I'm walking down the street in New Britain and I see Terry Gerratana, APRN and I go see the next door and it says John Kissel, MD. I don't know the difference because I don't know initials. I don't know what one stands for. I don't know what the other one stands for.

Is there any delineation, is there anything that says, you know, Terry Gerratana, APRN, Advanced Practice Registered Nurse. I can do this, this, this and this. Senator, I'm sorry, not Senator Kissel, Dr. Kissel, next to you can do this, this and this. Is there something that lays it out?

I mean, we have bills here that want to put you know, labeling on E cigarettes in a store. We want to label cell phones and the amount of radiation they put out. We label everything, right? I mean, we have put out bills on the most amazing things, but yet, I'm still trying to understand what the difference is so John Q. Public walking down the street sees your door and his door and knows the difference. Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, Senator Kissel MD and Senator Terry Gerratana, APRN are going to go into collaboration here, we decided.

But, Senator Kane, to answer your question, you know, I always talk about licensure because that defines, and we do have of course the law, state law that goes to licensure and describes what people do.

But you know, in a clinical setting, in any sort of medical setting, you usually and customarily make an appointment and you know, sometimes people can be referred to APRNs, but they are usually told that they're going to be seen by an APRN.

If they see a doctor, then they can request to see a doctor, and medical practitioners and medical professionals will talk to a patient, I think any good one, and will talk to a patient and explain who they are, what they do, you know, that sort of thing. This is very appropriate.

I know when I see my doctor, my doctor comes in. Of course, I know who she is and she explains of course, what she is going to do and that sort of thing, and this is usual and customary. You get to know your practitioner, whoever that practitioner is, and even if you see someone for the first time, they will introduce themselves.

Many times you go into that clinical setting and they'll say, I am Dr. Kissel, or I am APRN nurse practitioner Gerratana, and that is the way to identify and that's usual and customers. As I said, many are identified formally, not just with the link to their license, but also if they don't explain what they do, they should explain what they do. Good practitioners do that. But they also either have badges or other means of identification. Through you, Mr. President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I guess what I'm getting at is, I understand that there's a difference between an APRN and an MD. I understand that they both have to be certified and get licenses and they have different initials after their name.

What I'm saying is, the average Joe is not going to know the difference unless it's laid out, you know? Unless there's something on the wall that says, you are at an APRN, an APRN can do these things. You are at an MD. An MD can do these things. I think there's going to be confusion by the general public when this bill passes, and I think what's going to happen is, you're going to end up with people being referred to an MD anyway and which in turn may increase costs.

In fact, let me ask you about insurance rates. I've heard an argument that insurance carriers would most likely refer patients to an APRN because it will be cheaper than going to a doctor. Is that true? Have you heard that? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Mr. President. Usually insurance plans, beneficiary of an insurance plan, will look to see a provider panel and it's clearly listed in the provider panel that the physician or the APRN or even the physician assistant, and in many cases also physical therapists or other health practitioners that are listed that are covered or that are available under the plan and that are covered under the benefit. Through you, Mr. President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. Can I ask you about Senate Bill 459?

THE CHAIR:

I think we have to stay on the bill, Senator.

SENATOR KANE:

Well, yes, and I will stay on the bill. Senate Bill 459 was a bill that went to the Public Health Committee on AN ACT CONCERNING MEDICAL ASSISTANTS, and it was about expanding the scope of practice for medical assistants, and I'm bringing it back to this bill, Mr. President. I'm guessing, or I believe, that this bill expands the scope of practice for APRNs.

So if you're shaking your head. So if I may, if we're doing this, why are we not expanding medical, expanding scope of access or scope of practice for medical assistants as we stated we wanted to have greater access? And so, Mr. President, I appreciate the latitude.

I guess what I'm trying to get at, I don't care about the bill per se, but trying to bring up a point that if we're doing this type of bill, why aren't we doing it consistent along the whole scope of practice in this field? Through you, Mr. President.

THE CHAIR:

Senator Gerratana, do you care to respond?

SENATOR GERRATANA:

Through you, Mr. President, that particular bill died in the Public Health Committee as you probably know and we won't have it before us.

One of the reasons is because it wasn't really clear in talking to many of the people who were both opponents and proponents of the legislation exactly what or how we would go about changing the scope.

Medical assistants did go through our scope review as APRNs did. We took it up in Public Health Committee because we felt they had gone through the DPH scope review if memory serves here, and that it would be appropriate at least to hear the bill, but we didn't go farther with the bill. As I said, there were many challenges in it. Through you, Mr. President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. And I was just curious, because I believe there were APRNs that spoke against the bill. Is that true? Is that your recollection? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, I'd have to pull it up on my screen, but I believe --

SENATOR KANE:

That's okay.

SENATOR GERRATANA:

-- that the Connecticut Nurses Association testified against it, if memory serves. Through you, Mr. President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. And thank you to Senator Gerratana for answering my questions. I guess I find it a bit inconsistent that APRNs want to expand their scope of practice but didn't want medical assistants

to expand theirs by testifying against the bill. I just found that interesting.

I also am not sold on this truth in advertising question that I asked nor am I sold that this is about access, because I do believe we have access currently, and I don't know if this is going to solve that issue.

So I appreciate Senator Gerratana for entertaining my questions, and I'll be voting in opposition to the bill. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator. Will you remark further on the bill as amended? Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. Mr. President, while I think that this bill has some parts to it that are very good, I think the continuing education part of this bill is worthy. I also believe that the section dealing with the disclosure with respect to the dispensing of drugs that the federal guidelines as I understand it, apply to physician assistants and physicians. This covers that gap, and I think that's a good catch and it's very much appreciated.

However, I do have some questions for Senator Gerratana, if I may, through you, Mr. President.

THE CHAIR:

Please proceed.

SENATOR FASANO:

Thank you, Mr. President. Senator, as I understand the bill as written, the bill allows that an APRN, as long as they have three years of this collaborative agreement, after the three years they no longer need the collaborative agreement to continue on in the profession of an APRN. Is that basically an accurate statement? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, as I said earlier, they may then practice alone, or they can collaborate. They can continue to collaborate with the MD or even another APRN or, you know, they can continue to do so.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

So absent, I agree with you, nothing in this bill prohibits a continuing collaborative agreement. However, if an APRN didn't want to have a collaborative agreement, an APRN could venture off by themselves and continue to practice without the collaborative agreement. Is that correct? Through you, Mr. President.

THE CHAIR:

Senator Fasano, Senator Gerratana.

SENATOR GERRATANA:

Yes, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. And then I also understand that if an APRN is not engaged in an active professional practice for some period of time, they shall be exempt from continuing the educational requirements. That's on Line 64.

What would be that period of time where they would no longer be engaged? Is that years, months, what have you? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, as I understand it, this is usual and customary language that we include in our continuing medical education statutes. Not engaged in active professional practice, I'm just reading through the actual language here.

SENATOR FASANO:

Sure.

SENATOR GERRATANA:

To me would say that they are not active, that they are not engaging or working as an active professional. They could be retired or no longer working as an APRN. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Would that apply if an APRN decided to take a year off from being an APRN? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, I'm just reading. They would have to provide and submit to the department prior to the expiration of the registration period, a notarized application for exemption on a form prescribed by the department and other documentation.

So the department could then take into consideration why they would be going for non-active status. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Okay. So getting back to Lines 3 through 9 if I may, they have to maintain a license for a period not less than three years. They have to have a collaborative agreement for at least three years and then go off on their own.

If I were an APRN and I wanted, and I had a license and I had a collaborative agreement, however, I worked two days a week. After three years, would I be entitled to go off on my own?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, right now APRNs who have a collaborative agreement, it's not prescribed in there how many hours a week that they would work. Most of them as I said earlier in my presentation do work, they're active status. They do work full time. They are hard-working individuals with that collaboration, but we have not heretofore prescribed the number of hours and we don't do that under this legislation in this bill. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. And so it's a fair statement to say that if an APRN were to work for three years with a collaborative agreement but only work for example, two days a week, at the end of that

three-year period, they would be entitled to continue on full time as an APRN if they wanted to after the three years. Is that correct? Through you.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Mr. President, through you, yes, as it is now.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. So it seems to me why even bother having the three years if there's no requirement of the duration of work time in which to do it. Why even bother having that period of time of three years? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, I think the way the bill is designed is to infer that, and actually state that there would have to be that requirement once the nurse and RN actually got a license and then went on to become an APRN that they would do so under current language, of course, and then have the option after three years being in a collaboration to either work alone, or even continue working in a collaborative, you know, in a collaborative setting, or with a collaboration with an MD or other healthcare provider.

So again, it is the current practice right now that they work in collaboration with an MD and then going forward, it would be the three years, and I think your question is, well why continue that particular arrangement?

But if you look, and I'm just going to cursor down a little bit in existing language, you will see that in working in collaboration with a physician, I'm looking, collaboration means, and this is in the underlying bill, Line 27, means a mutually agreed upon relationship between an APRN and a physician and the physician is educated, trained or has relevant experience related to the work of the advanced practice registered nurse.

So my understanding is with APRN, that what they do is, they usually form a collaboration with someone, an MD in an area that they have expertise in and want to hone their skills. So keeping the three years in place has some value in my opinion, at this time, and it goes to their actual ability to work with a professional, if you will, in the particular area that they are trained in and interested in. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

So let me go back and break down your answer with my question. Nothing prohibits an APRN to enter into a voluntary collaborative agreement after the three years if they wanted to continue to hone in on some expertise. Nothing in this bill prohibits that? Is that correct? Yes or no?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, I'm sorry. I had a little problem hearing, but let's see if I could answer what you asked me. Right now, under this legislation an APRN would work three years with a collaborative agreement and then could go alone. Go ahead. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. Through you, and nothing would stop under this bill if it passes, nothing stops an APRN after three years to continue on with that collaborative agreement. Correct? Through you.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, yes. The APRN has the option of continuing on with the collaborative agreement or working independent, I shouldn't say independently, but working without the agreement. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

And then in your answer before you indicated to me that perhaps an APRN may want to have a collaborative agreement with the specialist in order to hone in on their skills and under this bill, after the three years, they could certainly continue on to hone in their skills with that doctor for that expertise.

The question that I posed to you, though is, if an APRN after three years, whether or not they worked full time, part time, one hour a week or whatever, could work by themselves, what is the point of the three years in this bill? What's the significance, other than expertise, which they could do either way. There's nothing that prohibits parties from entering into that.

So what is the point of the three years to be in this bill? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, the point is, and I think it's appropriate, is that instead of going right from in this particular practice, going from being in collaboration with, and you know, I want to say this. It's the nature of APRNs and other healthcare professionals to work in collaboration with each other, first of all.

Secondly, for an APRN or any other healthcare practitioner, and you know, my husband is an MD as you probably know, and I know that he worked with others to hone his skills, his skills as a physician and later as an orthopedic physician, and it's not inappropriate to say at this time to keep that in place as a formal way of an APRN working with another healthcare professional, in this case an MD.

This is usual and customary. Yes, it's true that other than going through an internship and residency, two years, if you will for a medical doctor, this is not the same thing, but it does give both practitioners the ability to work together in this kind of study. And I think it's important to keep the three years in at this time because it does reflect, in my opinion, the professionalism the healthcare professionals have, both MD and APRN. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

So in summing that up, and not putting words in your mouth, but as I understand your argument is the three years are in there to allow a new APRN, someone just out of nursing school to work in collaboration, get them to get in collaboration with the doctor so that they can hone their skills, get used to the standard of care of various practices, like anybody else coming

in to any of the new professions, sort of learning the real life of being an APRN in the medical world and giving care. Is that a correct policy reason for holding on to that three years? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA: Through you, Mr. President, I think it is appropriate to have this particular language. I think it is appropriate because from what I know with APRNs and other healthcare professionals, this is usual and customary and this is, and has been, a way for APRNs, you know, to share an interest.

They collaborate usually with an MD who has a special interest or skill that they are also interested in. so even though they are not under the supervision of the MD, they are working as I consider to be colleagues. They have a particular relationship and right now what anchors them is that collaborative agreement. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you. And I believe that, too, that an APRN going into practice should work in a collaborative union for a period of time while they get their feet wet and get used to their skill.

Let me ask you this, through you to Senator Gerratana, and it does a little bit deal with Senator Kane's question, how would I know when I visit an APRN, where could I go to look to determine if that APRN is still in a collaborative agreement or is no longer in a collaborative agreement, i.e., they're by themselves. That may make a difference to me as a patient. How would I know? Where could I go? Where would I find this information? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, currently the collaborative arrangements and the collaboration is linked to the licensure. DPH actually has the APRN fill out paperwork and in that they have to acknowledge and be compliant with the law that they are in a collaborative agreement, so it is tracked through the Department of Public Health. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you. So through you, Mr. President, if there was a collaborative agreement, that would be recorded with their license. They have a collaborative agreement. But then if the APRN went by themselves went off on their own; does the APRN notify Public Health, hey, I've done my three years, I am now by myself and I am notifying you, Public Health, for the purposes of your records, so if anybody calls, they know there's no longer a collaborative agreement. I am by myself. In your bill, is there anywhere that that indication is given the Department of Public Health? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, it is the way that the Department makes sure that they are in compliance with the law as currently written. That is my understanding in talking with the department. So unless there is some complaint, and in that case then it is investigated and that's in another way that they go through and find out if they have, indeed, been compliant. But they do track it.

My understanding is that again, it's linked to the licensure, and the licensure, when you do renew, you have to be compliant and have to indicate that you've been in collaboration.

Once you are not in collaboration and independent, then you don't indicate that, and that is, as I said, through my understanding in discussions with the department is tracked. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you. So number one, you would agree with me there's no regulations that have been written with respect to this collaborative agreement. There's no regulations that the state ever wrote with respect to that. Is that correct? Through you, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President, there currently is not regulation regarding this. It is the way, however that the department has promulgated the law. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

So there's no regulations, number one.

Number two, we're changing the law to say after three years you don't need a collaborative agreement, and there's nothing in this bill where it says you'll notify the Department of Public Health should you go off on your own without a collaborative agreement.

There's no language like that in this, forget about their policy is, there's no language like that in the statute. Correct?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President. I'm sorry, are you saying that there's no language currently under the law that says that the collaborative agreement must be --

THE CHAIR:

Senator Fasano.

SENATOR GERRATANA:

-- if you will.

SENATOR FASANO:

Through your Amendment, which is the bill in front of us, there is no language in there that says once you decide after three years you want to go off on your own that you notify a soul. There's nothing in this language that says you have to tell DPH, nobody that you have to tell. You just, at the end of three years say, I've done my three years. I'm hanging my shingle. Is that correct? Through you, Mr. President.

THE CHAIR:

Senator Gerratana,

SENATOR GERRATANA:

Through you, Mr. President. They can hang a shingle right now, as I said. I was trying to describe and maybe I don't describe as well as perhaps you would like, but this is, in my opinion, colleague to colleague, this is a way for an APRN to work with a physician and I use the term hone, his or her skills.

There is nothing in the legislation right now that delineates or lays out how it should be regulated or described that, but I, as I said, said to the Chamber here and I say to you that the department is promulgating a way and a tracking that they do if an APRN is in a collaborative agreement or not. That is linked to their license. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

But Senator, you're changing the law and you're allowing APRNs after three years, they can say, I no longer need a collaborative agreement. I've done my three years. I'm going off on my own. No collaborative agreement.

And the simple question I have for you, in this piece of legislation, do you require the APRN to notify DPH that they no longer have a collaborative agreement and they're going off on their own? Is that in your bill?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Mr. President. No. I am going through the existing language. I was trying to read to see if there was anything in existing law, but currently, no. I'm telling you how the department promulgates it. Through you, Mr. President.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President. I thank Senator Gerratana for the answer to my questions. And I think that Senator Gerratana was right. Look, what we have is, what we've done is, we said, you have a collaborative

agreement for three years, and I agree with Senator Gerratana. The purpose of that is to let your feet get used to the standard of care, know how to deal with patients, just like everybody else does in their profession, understand what it is to deal in a new environment. That's what the three years does do.

But the problem with that is, if the person works once a week versus the person who's working 40 hours, I would suggest the policy of training somebody to do the job is lost, because if they're only working once a month, they could work under this bill, they don't even have to work one day. They could get a license, have a collaborative agreement, not work one day or work part time as a fill in for three years and then walk out and say, I'm by myself now. No collaborative agreement.

The second thing is, there's no notice to the Department of Public Health. So if you wanted to find out if your APRN is someone who is off on their own and not subject to a collaborative agreement, APRNs are great. They're a definite need. No question about it.

But I may want to say, listen, I'd feel more comfortable if they had some collaborative agreement with the doctor. There's nowhere you can check.

Finally, I may add, we don't write bills for everyone who's good. We have to write bills for those who don't follow the law. Nothing stops other than being caught, nothing stops an APRN from being out there for two years and saying, they're never going to know I'm going off on my own. I can't find a doctor for the third year. I'm going to go off on my own, and nobody would catch it until there's a complaint.

So I ask the Clerk to call something. LCO 3475.

THE CHAIR:

(The President in the Chair.)

Mr. Clerk.

SENATOR FASANO:

That's not the right one.

SENATOR GERRATANA:

Madam President.

SENATOR FASANO:

I apologize. LCO 3518.

THE CHAIR:

Senator Fasano, would you repeat it one more time for them?

SENATOR FASANO:

Yeah, I apologize. LCO 3518.

THE CHAIR:

3508.

SENATOR FASANO:

18.

THE CHAIR:

18. Sorry.

THE CLERK:

LCO 3518, Senate "B", offered by Senator Fasano.

THE CHAIR:

Senator Fasano.

SENATOR FASANO:

Madam President, I move the Amendment and request permission to summarize.

THE CHAIR:

Motion is on adoption. Will you remark, sir?

SENATOR FASANO:

Thank you Madam President. Madam President, what this says is that the APRN has to either be there the three years or 3,000 hours, which really is a part time, 20 hours a week. That's what it does. So it says they have to be there three years or 3,000 hours, which gets around that APRN that's working once a month or once a year on a collaborative agreement, so we know if the purpose as Senator suggested, is to have the background and knowledge and experience. This guarantees that that background, knowledge and experience is fulfilled.

The second part about this Amendment says that they have to let Public Health know when they're going to go off on their own and they have to tell them who they had the collaborative agreements are for the three years so a file can be generated so everyone understands where and when the person went off on their own, not short of the time, there's some documentation that goes to Public Health, who they collaborated with, the patient's, I'm sorry, the physician's name, license number and the Commissioner just holds this information.

I'm not asking to investigate, just hold onto it so we have a paper trail, so if there is a problem, someone can look back and say yes, they fulfilled the obligations.

That's a minimum that we should do if we're going to put this bill forward.

One, we should make sure that during the period they do get the proper training by giving them minimum hours and two, that they do the minimum paperwork so that we have a paper trail so six years after they go off on their own, someone wouldn't have to reconstruct the file if there's a complaint. We could look at it and figure it out.

Madam President, this is, I understand what we want to do and before we get to the bill, I think all this does is strengthen the bill. It makes more sense. It

doesn't deny the APRN to want to do it, but it ensures if we're going to have a reason to do it, we back up the policy by the minimum number of hours and we have a paper trail. Thank you, Madam President.

I ask for a Roll Call Vote.

THE CHAIR:

A Roll Call Vote will be taken. Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Madam President, while I appreciate Senator Fasano's concern, I will reiterate again and say that currently, the compliance with the law is currently promulgated already with the Department of Public Health. They ensure that the current license and that the requirements that we have currently under law are even with the change of going from three years in a collaborative process or arrangement to no collaborative process is tracked. It's linked to the license.

We don't need additional legislation because at this point in time this legislation, which Senator Fasano has come forward with, basically I would have to be opposed to because already we know that there have been 15 years of APRNs who have been practicing and there have been at least from my knowledge, have not been an inordinate number of complaints about APRNs, or people putting forth complaints and asking if they are working in collaboration.

They can certainly do the work that they do under their scope and again, as I said, the Department has made sure that APRNs are compliant. So I would urge the Chamber to vote no on this Amendment. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark? Will you remark on Senate "B"? Senator McKinney.

SENATOR MCKINNEY:

Thank you, Madam President. I want to rise in support of the Amendment. I listened to both the support for the Amendment offered by Senator Fasano and the opposition laid out by Senator Gerratana and I didn't hear her address what I think is the most significant concern that this Amendment seeks to address, and that is the fact that you have to have a three-year collaborative agreement does not in any way, shape or form mean that you have to work a certain amount of time.

I think as Senator Fasano said, you might be able to work one day a week or one day a month and still go out and practice on your own independently without a collaborative agreement after three years. This would require a certain number of hours to be done.

I also got the impression from Senator Gerratana that well, you know, the department is handling some of these issues. Well, if there are things that this Amendment wants to do that the department's going to do, what's the objection to it?

But the bigger issue here is, you know, and I don't want to talk too much about the underlying bill because I want to address just the Amendment, but what I've heard is a real concern, is that it's difficult to find doctors to engage in collaborative agreement. That's what I've heard from some APRNs.

And I think it's fair to assume that the 15-year history that Senator Gerratana talks about has been protected by the fact that there has been required to be collaborative agreements that extend way beyond the three years.

To assume that there's not going to be a bad actor once we remove the requirement of a collaborative agreement is being foolish. Now, I don't stand here to assume that, you know, it's going to be an extraordinarily high number. But we're naïve to think that there are bad actors in every single profession, whether it's doctors or APRNs or politicians, or lawyers.

And so it is very possible to imagine a world where someone after three years can then go out on their own

or as Senator Fasano, maybe after two years because maybe the doctor retires and they can't find someone to have a collaborative agreement with. How do we know? How do we know? How is it possible that you as a consumer of healthcare wouldn't want to know?

Is this APRN out on their own or do they have a collaborative agreement with the doctor? And what's the fear of telling the patient that?

This is a very frustrating bill because it's been set up to be about doctors versus APRNs. That disgusts me. I've been in a hospital recently with a loved one. Guess what? Our system doesn't work without either of them. Doctors and APRNs, extraordinary people devoting years and years to education, to their profession, to their craft.

But this is at least, I mean, would you go hire a lawyer who's practiced one day a month for three years, versus a lawyer who's been working in the courtroom every day, five days a week for three years? Maybe you would, but I don't know.

If you wanted to have heart surgery, would you find out, hey doc, have you ever done this before? Well, I've done one. Maybe I'm going to go to the guy who's done 1,000.

And it's just said that if you're going to have a collaborative agreement for three years and only three years, and I think it's naïve to suggest that the world doesn't change when you take that disconnect, when you unplug the collaborative agreement. There will be a change.

And this simply says we're going to require a certain number of hours to be worked. I don't understand what the fear is with that, because my assumption is, based on the number of hours that almost everyone's going to meet this anyway.

So therefore, it truly only is in there to protect against those who may not do what is probably what most of the right way to do it is.

I don't know that there was a lot of work with our side of the aisle on negotiating this bill, and you know what? I guess if I pointed that out every time it was true, that probably would be part of almost every speech I give in this Circle.

But I would want to know, and I would think my loved ones would want to know, and I would want my loved ones to know, when you go see somebody, are you a doctor or not? Are you an APRN or not? Do you have a collaborative agreement or not?

Because the reality if they have to have a collaborative agreement for our system of healthcare to work. Doctors and APRNs have to work together.

So I'm disappointed that this Amendment is dismissed without really a logical explanation as to why it's harmful to the underlying bill, and I'm going to support the Amendment. Thank you.

THE CHAIR:

Thank you, Senator. Senator Guglielmo.

SENATOR GUGLIELMO:

Thank you. Thank you, Madam President. I'll be very brief. The hour is late, but I didn't really know too much about the bill before coming here tonight and I listened to the discussion but I think the Amendment makes a lot of sense.

I'm pretty surprised that there's no paper trail under the existing legislation. That would seem to be an oversight that we could correct with this Amendment. And the fact when the APRN goes out on his or her own, they don't have to notify anybody, that's a bit surprising.

When you compare that with the building trades, if you're going to be an apprentice I believe there are three journeymen for each apprentice. Those are strict regulations and they practice under strict supervision for a lot of years, and that's strictly enforced.

So it kind of surprised me that we would do these so, have such a good system in place for the building trades and what seems to be a pretty loose system in place for somebody who's dealing with the human body and human life, so I intend to support the Amendment. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark further? Will you remark further? Senator Frantz.

SENATOR FRANTZ:

Thank you, Madam President. I appreciate that. I stand in strong support of the Amendment, and the reason for that is that we're dealing with one of the most important, if not the most important subject areas that any of us can think of, and that is our own personal health when we're unfortunately in an institution looking for medical assistance.

It's a completely reasonable thing to ask for a minimum number of hours of experience before turning someone loose and becoming independent as essentially a medical doctor going forward.

If you look at all the other industries out there where you're dealing with safety or human health, there are requirements of a certain number of hours, minimum hours of experience before being turned loose.

If you look at the trucking industry, the major companies anyway, have minimum requirements in terms of numbers of hours or perhaps years behind the wheel of a truck.

If you look at the commercial aviation business, you work your way up through the system, you don't get hired unless you have 1,500 hours of flight time, you go in as a flight officer and you're not allowed to even be considered to be a captain of an aircraft until you have 2,500, depends on the airline, maybe 2,500 or 3,000 hours of experience under your belt.

So this is a completely reasonable request, given the things that can go wrong in the medical profession, so

I stand in strong support of it and thank you, Senator Fasano for introducing it. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark further? Will you remark further? If not, Mr. Clerk, will you please call for a Roll Call Vote on Senate "B". The machine will be opened.

THE CLERK:

An immediate Roll Call has been ordered in the Senate on Senate "B".

Roll Call ordered in the Senate.

THE CHAIR:

All members have voted? All members have voted? The machine will be closed. Mr. Clerk, will you please call for a tally.

THE CLERK:

On Senate Amendment Schedule "B".

Total number voting	36
Necessary for adoption	19
Those voting Yea	15
Those voting Nay	21
Those absent and not voting	0

THE CHAIR:

The Amendment fails. Will you remark? Will you remark? Will you remark? Senator Fasano.

SENATOR FASANO:

Thank you, Madam President. Madam President, I am not going to support the bill now before us, because I honestly believe that we should have a minimum requirement. I honestly believe we should have a paper trail.

I think the Department of Public Health should know when an APRN is going to jump up ending the three years under the agreement to going off on their own. There needs to be some record.

But one of the issues that was brought up was the fact that one of the reasons why we're doing this is because there's a lack of doctors and there's a lack of primary care medical people out in the real world. Let me take this opportunity to say I agree with that. I definitely agree with that.

But I think there's a lot of factors going on. I think the larger hospitals are squeezing every private medical practice out of business. I think every hospital out there, nonprofit hospital is sitting out there making extraordinarily difficult, if not impossible by design, by using their ER for referrals for only doctors associated with the major hospital, by using their ORs, to make it more difficult to schedule surgeries, by using computers like Epic, in which the referrals are only within its own system, which system you have to buy from one of the largest nonprofit hospitals.

We as a Legislature know what's going on. And we have a choice. We are either going to decide to do nothing and let others decide the fate of a medical practice in the State of Connecticut. Well, we are going to make a conscious decision, no matter what it is, whether we're going to let two hospitals be the primary care hospitals for the entire State of Connecticut, or we're going to say we like that, then let's endorse it and go forward.

Whether they're profit or nonprofit is not the issue that I'm rallying on today. I am suggesting that in a very short period of time private practices will not exist in the state.

I defy anybody to find a private oncologist in New Haven area. I defy anybody to find more than one private urologist in New Haven area. And in three years, I would defy anybody to find a private orthopedic in the New Haven area.

And it may sound grand now, but the economics flip, because when a hospital, private or nonprofit controls a monopoly, they dictate care and they dictate prices.

We're doing this so we have more medical professionals out there. Good. But there's a larger issue in the dark shadows. You can read all about it by reading all the different people writing in. But I'll tell you what the scariest part is, and I don't know about anybody in this Circle but I've gotten calls from private doctors who feel that they have no choice but to leave their practice. They have no choice because they're being run out of their practice.

When their patient goes to the emergency room, that patient cannot get to their physician. That patient can't get to their cardiologist. We created in 2009 or 5, I think it was 9, private foundations that allow nonprofit hospitals to hire doctors. I probably voted for it, as many of us did. Interesting. That is going to destroy our medical practice in this state. We see it happen.

It doesn't have much to do with this bill, but I felt that I'd take this opportunity since it was related to medical facilities to put that out there and I know there's going to be legislation.

I would ask the Circle to pay attention to what's happening. It's not a Republican issue. It's not a Democrat issue. It's an issue for all our constituents.

Because if any other business that acted the way some of these nonprofits act, particularly in the New Haven area, there would be anti-trust lawsuits flying left and right.

I know that the Attorney General has done a great job. Bob Clark has done a great job out of the AG's office. George Jepsen has done a great job in his office. I know the Governor's looking at some issues right now regarding this.

But we need as a group to figure out what we want to do and there's not much time. And with respect to

this bill, I cannot support it. Thank you, Madam President.

THE CHAIR:

Thank you, Senator. Will you remark? Senator Guglielmo.

SENATOR GUGLIELMO:

Thank you, Madam President. Just a couple of questions that cropped up during the discussion, for Senator Gerratana.

THE CHAIR:

Please proceed, sir.

SENATOR GUGLIELMO:

Thank you, Madam President. At one point I think you answered that the Nurses Association was opposed to this legislation? I just would like to ask why, if you could recall from the testimony?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President. No, that's not what I said.

SENATOR GUGLIELMO:

Oh, okay.

SENATOR GERRATANA:

Actually, it goes to a line of questioning that Senator Kane had on another piece of legislation regarding medical assistants, Senate Bill 459, which did not come out of Committee and he asked if the nurses testified against that bill. I think he used the term nurses, and I did mention that the Connecticut Nurse Association did have problems with

the bill, but not with this bill. He was talking about a different one. Through you, Madam President.

THE CHAIR:

Senator Guglielmo.

SENATOR GUGLIELMO:

Okay. Thank you. Thanks for the clarification. Another question, just because I'm not on the Public Health Committee.

Could you tell us just quickly, what is the difference between a nurse practitioner and an advanced practice registered nurse?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, I believe there is no difference to the term nurse practitioner and advance practice or APRN are the same. Through you.

SENATOR GUGLIELMO:

So that is the same thing. Okay. Now, just a final question and this is just, I received a call from a physician and Senator Kane talked about truth in advertising and you mentioned in your discussion back and forth about some of the APRNs having PhDs and is there, he had, they can get, through you, Madam President, they can get a PhD as an advanced, am I correct in that?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, yes, I have met APRNs, that are Ph.D.

SENATOR GUGLIELMO:

Okay. So in the, thank you. Through you, Madam President, in the case that the physician spoke to me about, there was an APRN who was, who did receive her PhD and she would wear on her shirt, and she would use the term doctor, which she technically is a doctor. She's not a medical doctor, but she's a doctor.

Is there anything in either the underlying bill or in this Amendment that would prevent that because I think that everyone here would have trouble differentiating between an MD and a PhD if they presented themselves in that way.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, I did mention before, Section 53-341 of the General Statutes and the uses of the word physician, surgeon, medical doctor, osteopath or doctor, or initials MD, DO or DR, DR period for doctor are protected and others who use those terms are subject to fines.

In my opinion, if the APRN was claiming to be an MD or a doctor, DR, then she was in violation of the law. Through you, Madam President.

THE CHAIR:

Senator Guglielmo.

SENATOR GUGLIELMO:

Thank you, Madam President. Thank you, Senator.

THE CHAIR:

Thank you. Are there any other comments? Senator Kelly.

SENATOR KELLY:

Thank you, Madam President. Through you to the proponent of the bill. I have a few questions.

THE CHAIR:

Please proceed, sir.

SENATOR KELLY:

Thank you very much. Not being on Public Health, I did have the opportunity to look at some of the information pertinent to the public hearing and I just had a couple of questions to clarify what happened and if you would be able to provide that information I'd be appreciative.

There is some testimony that talks about lowering the cost of emergency room and emergency department hospital costs. Could you explain how this would reduce that? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, I'm not sure. You'd have to direct me to the testimony. I just don't recall offhand. Through you, Madam President.

THE CHAIR:

Senator Kelly.

SENATOR KELLEY:

Thank you, Madam President. The person that testified, or provided this information was Lynn Rapsilber who is Chair of the Connecticut Coalition of Advanced Practice Nurses, and what she talked about was that there was a DPH report specifically refers to documentation of cost savings including lower drug costs, lower per-patient costs, lower visit costs and lower costs associated with lower rates of emergency department referrals.

So I wanted to know how this would actually impact emergency departments and what type of referrals we're talking about. Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, actually, I did pull up her testimony, but she might have had more than one, but it is her testimony, and it is her word. Of course, when people come before our Committee and, I think, I'm going to, you know, speculate and say that I think what she was referring to is that if there's access to a primary care practitioner, that that does reduce the cost of people going to the emergency room.

I think, Senator Kelly, I believe you're very familiar and you know that very often when we talk about people, particularly individuals who may not be able to see a doctor; get to see a doctor because of the transportation issues or even many other issues. Scheduling is another barrier, very often.

I had mentioned before that APRNs as family practice practitioners can see patients and therefore prevent them from going to the emergency room to have care there, and that of course, in my opinion, would probably save money and also be better for the patient. Through you, Madam President.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President. And to follow up on that, so is the role or vision of the APRN to be more of a community-based provider of services as opposed to institutional? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President. I think having APRNs as they currently practice, do, and are able to provide, particularly in the family practice APRNs in the community setting, that the accessibility is there. From my understanding they are there and available if you will. Through you, Madam President.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President. Would the, as you mentioned the family practice, would this just be limited, or is the APRN limited more in scope to family practice, or would it be a span of life practice that would also encounter say children and seniors. Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, APRNs can be certified in family practice. They go for the education and training in that. All APRNs when they go for their training and their education are trained as primary care practitioners. There are APRNs that do have specialties and actually go for certification and training in those specialty areas. Through you, Madam President.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President, and that leads me to actually a nice segue into one of the areas I'd like to pursue on this, and that is, is there any specialty

or focus on Alzheimer's? Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President, from my understanding, I do know that there is, and there are APRNs who do pursue practices in gerontology, in geriatrics, from what I understand. I'm not familiar with what kind of didactic or clinical training they go through, you know, regarding Alzheimer's specifically, but I do know that they go for certification in those particular areas. Through you, Madam President.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President, and I do thank Senator Gerratana for her answers to the questions that I've posed.

At this time, Madam President, the Clerk has an amendment, LCO Number 3520. Will the Clerk please call the amendment?

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO Number 3520, Senate "C", offered by Senator Kelly.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Madam President, I move adoption by Roll Call and seek leave to summarize.

THE CHAIR:

Motion is on adoption and Roll Call will be called. Please proceed, sir.

SENATOR KELLY:

Thank you very much. The Amendment that we now have on the Floor, seeks to amend the bill to include training, education for and in the area of diagnosis and treatment of Alzheimer's.

And I believe that this is an important component to this area for a number of reasons. First and foremost, last fall there was a Task Force on Alzheimer's and we have Senate Bill 179 that is on the Calendar and that really focuses a number of different areas of our healthcare system on dealing with the issue of Alzheimer's.

We know that currently in Connecticut there's about 14 percent of our population over the age of 65 and in the past two years, baby boomers have moved into retirement. In other words, they've attained the age of 65 and in Connecticut, one-third of our population is a baby boomer.

So we have a significant amount of our population moving into this area and what we need to do is start to look at ways to make sure that we provide healthcare that they need at a fraction of the cost, because if we continue to provide institutional care, it's going to significantly increase the cost to our budget, a cost that right now we're having difficulty meeting.

And so, this is something that's important that we need to look at. I noted in the Amendment that we passed earlier to change the underlying bill, that we included 50 contact hours of continuing legal education, or not legal, continuing education, but it didn't include any training on Alzheimer's, and that was one of the big things that came out of the Alzheimer's Task Force and requires, in Senate Bill

179 that we look to nursing homes, residential care homes, police officers, probate courts, we look across the spectrum of those people who come in contact with our seniors to start to do training so that they become more attuned with what individuals are experiencing and so that they get the proper diagnosis and care.

An APRN is going to be uniquely situated to deal with those individuals. The Amendment before us will include that training in the underlying bill, so I think it's something that we need to focus on with both the demographic that's happening, coupled with the financial cost to the State of Connecticut and further, the fiscal note on this Amendment is zero, so there's no fiscal impact to make that change.

So I think this is a good Amendment to the bill. I think it's something that I'm going to say Connecticut citizens and in particular, the seniors, need and I would urge its adoption.

THE CHAIR:

Thank you. Will you remark? Will you remark?
Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Senator Kelly, I have to say I understand your concern that APRNs should be trained specifically in Alzheimer's disease. I think that's very laudable, but both your Amendment and the Amendment we adopted earlier does say that such continuing education shall be in the area of advanced practice registered nurse's practice, and I did also say that there are APRNs that also focus in this particular area.

So although you are delineating out continuing education in Alzheimer's disease, I think it's appropriate to go by the original parameters of the bill. We don't have to specifically delineate what they would have their hours of training in.

Although I appreciate your Amendment, I would have to speak in opposition to it. Madam President, when the roll is called, thank you.

THE CHAIR:

It's already been called for. Will you remark?
Senator Kane.

SENATOR KANE:

Thank you, Madam President. I rise in favor of the Amendment. Not too long ago, maybe three or four years ago I remember sharing a stage with Senator Prague as she and I both received an award from the Alzheimer's Association for our work on the Respite Care Program, and I remember having a long conversation with Senator Prague about the need for more education in Alzheimer's and the effects and the way this tragic disease affects so many people, and I appreciate Senator Kelly who is the Ranking Member on the Aging Committee for bringing this forward because I think this is something that truly is, should have bipartisan support, especially seeing the type of history that both sides of the aisle have witnessed in working on this subject and I look forward to passage of the Amendment. Thank you.

THE CHAIR:

Thank you. Will you remark? Will you remark? If not, Mr. Clerk, would you please call for a Roll Call Vote on Senate "C", and the machine will be opened.

THE CLERK:

An immediate Roll Call has been ordered in the Senate on Senate Schedule "C".

Immediate Roll Call has been ordered in the Senate.

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed. Mr. Clerk, will you please call a tally.

THE CLERK:

On Senate Amendment "C".

Total number voting	36
Necessary for adoption	19
Those voting Yea	14
Those voting Nay	22
Those absent and not voting	0

THE CHAIR:

The Amendment fails. Will you remark? Will you remark? Senator Boucher. Senator Boucher.

SENATOR BOUCHER:

Thank you, Madam President. Speaking on the bill now before us, and I don't see another amendment coming forward at the moment, I have to say that I really appreciated the comments by the good Senator from North Haven, Senator Fasano, when he talked about the changing landscape of the medical profession and the doctors in our state that we should all recognize that Connecticut has become not just one of the worst states to retire in, but also if not the worst state to practice medicine.

Too many of our doctors' practices are closing up or they're being taken over by larger hospital concerns. My own family doctor's sons actually went into medicine and their father suggested that they might want to set up their practices elsewhere where it was more friendly to run a practice, not unlike some of our businesses that are experiencing the very same thing.

And this bill, as was very well articulated, really for the doctors, another encouragement in what they do.

But I rise to actually oppose this bill for a medical reason. The reason I think is the most compelling to not move forward with this particular bill. Just like a medical technician in a dentist's office may be very expert at many of the things that dentists in the past did, there are other areas, particularly in the area

of diagnosis that really needs to be in the hands of someone that has had many more years of education, many more years of experience, many more years of exposure to many different types of things that can happen.

And that happened personally to one of my children who actually, we found that there was a growth in the back of their throat that wasn't caught by the technician that was cleaning her teeth in a rudimentary physical and cleaning, but in fact when the dentist took that last look and saw that there was something there and it, you know, caused us great concern until we found that it was a benign growth and could easily be taken out by a surgeon that the dentist recommended, and that was very helpful.

I don't know how many other countless situations like that occur, but I also had a situation just much more recently to someone much closer to me in my own home when they went and had a very serious medical procedure and there was follow up that needed to be taken care of and there was a nurse, an advanced nurse in one of the best hospitals in America, in fact.

And on his record it said, do not do this rudimentary procedure as you normally would, you must have the doctor come in and do it instead. And the nurse did see that. She saw that instruction and when I inquired after sitting in the waiting room for a long period of time that gave me some concern, she came running out to say well, you know, something has sort of gone wrong and they had to call the doctor in who was, at that point furious about what had occurred and she admitted she saw that it had instructions that the doctor should do this normal procedure that was done by this nurse and she didn't do it. She thought she could handle it. She'd done it a hundred time before. Of course, she could handle it.

Well, she couldn't handle it and the outcome was another hospitalization, a horrible infection that went through the blood stream and it was touch and go for three days.

And it just brought home the fact that sometimes, you can't be certain that you can handle all of those

situations and you have to know where to leave off and sometimes that's not quite clear.

And in our family, I'm proud to say that we had one of the first 100 nurse anesthesiologists come through the Connecticut program. I think there were 99 of them in that first class of 100, and she has been practicing in that arena for the last five years and is sought after all over the country.

She admits herself, she says, it's not something I would do alone. The doctor has to be there, because in all of the cases, she handles most of them, but there are cases that go beyond her scope of practice and it's really important to have the doctor be there.

And in this case as well. Many tout the fact that we need more access to good healthcare, but even if a nurse is doing a normal physical, there are things that could happen and that may be missed, and serious things that could be missed that could be life threatening where a doctor's oversight is necessary.

You cannot compare, no matter how many times we look at the various credentials there, you cannot stack that up against the pre-med programs, the four years of medical school, the years upon years as an internist and now they're even requiring fellowships to go even further. It could be up to 12 years. Think of the costs. Think of the exposure. Think of the different specialties that they encounter that make them a little bit more seasoned and educated enough to pick up on things that might be overlooked and cost someone's life.

I think we're going too far now, and as I said, it was very well articulated by our good Senator from North Branford and others that expressed some concern about this.

I think, although I respect the profession tremendously, and my own mother-in-law practiced as a delivery room nurse and later on as a midwife and then a Hospice nurse who went, who could deliver as many babies and probably did in the wee hours in the night after 25 years of working the 11-7 shift at St. Mary's

Hospital. She was extremely competent and I have tremendous regard for that profession.

But I also think we should be really cautious about this and as a result, really, and speaking from a direct personal experience just very recently, why this bill should not go through this evening. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark? Will you remark? If not, Mr. Clerk, will you call for a Roll Call Vote on the bill and the machine will be opened.

THE CLERK:

Immediate Roll Call has been ordered in the Senate.
Senators please return to the Chamber.

Immediate Roll Call has been ordered in the Senate.

THE CHAIR:

Have all members voted? All members voted? The machine will be closed. Mr. Clerk, will you please call a tally.

THE CLERK:

On Senate Bill Number 36 as amended by Senate "A".

Total number voting	36
Necessary for passage	19
Those voting Yea	25
Those voting Nay	11
Those absent and not voting	0

THE CHAIR:

The bill passes. Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. That will conclude our business for today's Session, but before wrapping things up would yield the Floor for announcements of

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televisions that we have in the office and follow along the testimony there. That is very convenient and also allows us to address other matters if necessary.

So with that, my co-chair, Representative Johnson is on her way, and I think what we'll do is -- Madame Administrator, can we start our hearing, do you think it's appropriate? Then, we will do so and our first speaker is the commissioner of the Department of Public Health, Dr. Jewel Mullen.

Welcome, welcome. You have your coffee, I have my tea. Cheers.

COMMISSIONER MULLEN: You and I have been seeing a lot of each other. Good morning.

SENATOR GERRATANA: Yes, good morning.

COMMISSIONER MULLEN: I think you know I'm only testifying on one Bill this morning, so I'll start.

SENATOR GERRATANA: Yes, I do.

COMMISSIONER MULLEN: So.

SENATOR GERRATANA: Senate Bill 36, I believe.

COMMISSIONER MULLEN: Yes. Good morning, Senator Gerratana and Public Health Committee Members.

I'm Commissioner Jewel Mullen of the Department of Public Health and I am here today to testify in support of the Governor's Bill Number 36, an ACT CONCERNING THE GOVERNOR'S RECOMMENDATION TO IMPROVE ACCESS TO HEALTHCARE.

The Governor's proposal upholds the requirement for an advanced practitioner, which -- I actually should have written this advanced as advanced

practice registered nurse, to maintain a collaborative practice agreement with the position during his or her first three years of practice, after which the requirement for a collaborative practice agreement is eliminated.

Specifically, section one requires that an APRN collaborate with a physician for the first three years after having been issued a license.

Thereafter, the APRN would be authorized to practice alone or in collaboration with the physician or other healthcare provider and may perform acts of diagnosis and treatment of alterations and health status and prescribe, dispense, and administer medical therapeutics, corrective measures, and drugs, including in the form of professional samples.

Section two amends the portion of the medical practice facts that references APRN to remove the language that currently requires them to have a collaborative practice agreement.

The language properly references the new requirement, the collaboration that's required for the APRN's first three years of practice.

To help resources and services administration of United States Department of Health and Human Services project the shortage of 20,400 primary care physicians nationwide by the year 2020. Other organizations set that projection much higher.

Analyses conducted by the DPH Office of Healthcare Access revealed that although the availability of primary care providers in our state is somewhat better than the national average, geography distribution of and access to primary care providers is uneven. Moreover, access is particularly challenging for

un and underinsured individuals.

Implementation of the Affordable Care Act will increase demands for services among the newly insured.

Our commitment to ensuring they receive care is the basis for the Governor's proposal.

I have stated publicly in the past and want to reiterate now that this proposal does not turn nurse practitioners into physicians.

Moreover, it does not intend to diminish the medical profession, nor does it reflect an inflated perspective on the capabilities of nurse practitioners.

The Governor's proposal will allow APRN independent practice aligned with similar recommendations of esteemed organizations, such as the Institute of Medicine, the National Governors Association, and the Robert Wood Johnson Foundation, all of whom view APRN independents as the means of improving access to primary care.

The DPH scope of practice review process was established by Public Act 11-209, an ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S OVERSIGHT RESPONSIBILITY RELATING TO SCOPE OF PRACTICE DETERMINATIONS FOR HEALTHCARE PROFESSIONALS.

DPH had brought this legislation three years ago to formalize the process for submission and review of scope of practice requests.

The provisions established guidelines for all petitioners to follow and required a committee vetting process, which is transparent, objective, and inclusive.

The domain's DPH review will include impact on public health and safety, effect on public access to healthcare, economic impact on the healthcare delivery system, and the relationship of the request to a healthcare professional's ability to practice for the full extent of their training.

In accordance with Public Act 209, DPH submits the formal scope report to the Public Health Committee, but we do not approve or deny any request. That is the role of the Legislature.

The details of the APRN scope process are summarized in the Scope of Practice Review Committee report on advanced practice registered nurses, which we submitted to the Public Health Committee on February 1, 2014.

Along with the 27-page report, our numerous appendices, supporting documents provided by the Connecticut Advanced Practice Nurse Society, and the submitted written impact statement from 21 other individuals and organizations related to the scope of practice request.

And I'll just comment that I'm told that the committee that vetted this was comprised of 42 individuals.

Being sensitive to time and anticipating that you have questions, I will conclude with a short list of salient points from the report.

One, processing APRN increased access to care, particularly in underserved areas.

Two, research support that there is a range of conditions and functions that APRNs can and do perform without evidence that patient safety suffers.

Three, within that range of conditions and functions, NPs produce outcomes that mirror those produced by many physicians.

Many of those conditions and functions are at the core of APRN practice, evaluations, naming, history taking, and physical examination, and management of a number of routine medical conditions, such as hypertension, diabetes, asthma, and patient functional status.

APRN patient satisfaction, of course, is comparable to or higher than those of physicians, in part due to the time they can spend with their patients and their emphasis on holistic care.

Hospitalization rates are similar among patients treated by APRNs and those treated by physicians. Mortality rates also are similar.

The DPH scope review process did not uncover any evidence that the care APRNs provide is unsafe, and no such evidence was presented to the Committee.

And then, finally, residency training programs for new APRN graduates will strengthen their preparation for independent practice. And maybe I should add here as well that there's -- there's starting to be people writing now that for nurse practitioners who want to sub-specialize, perhaps a fellowship could be considered.

Additionally, the Department respectfully requests the following language be added at the technical amendment.

Section three, subsection 2094B of the general statutes is repealed, and the following is substituted in lieu thereof.

An advanced practice registered nurse licensed

pursuant to section 2094A, and maintaining current certification from the American Association of Nurse Anesthetists, may prescribe, dispense, and administer drugs, precluding controlled substances in Schedule 2, 3, 4, or 5.

An advanced practice registered nurse licensed pursuant to the same section who does not maintain current certification from the American Association of Nurse Anesthetists may prescribe, dispense, and administer drugs precluding controlled substances in Schedule 2, 3, and 4, or 5, except that such an advanced practice registered nurse may also prescribe controlled substances in schedule 2 or 3 that are expressly specified.

Don't listen to me; just read this part.

In written collaborative agreement, pursuant to the subsection B of section 20-87, as amended by section one.

Thank you for hearing my testimony in support of the Governor's proposal. I would be happy to take your questions.

SENATOR GERRATANA: Thank you, Commissioner.

Actually, just have one, and that is number eight in the point that you talked about.

Residency training programs renew APRN and then graduates will strengthen their preparation for independent practice.

Is there a new requirement for residency training or?

COMMISSIONER MULLEN: There's -- there's not a requirement for residency training, and this is not -- these are points that were highlighted in

the scope report. So this is isn't a recommendation, but it's acknowledged that -- and the way this -- the Governor's Bill is written, really accommodates the time necessary to have experience prior to independence. So the -- this proposal requires a collaborative agreement for the first three years.

The first -- actually, the first residency program for nurse practitioners was started by a nurse practitioner in Connecticut. I don't see here in the room today, Margaret Flinter.

And -- and the one that -- she has created and is in a number of sites now have a particular focus on working with patients in (inaudible) health centers.

But in general, what this is about is approving petition experience to be able to really go out and practice to the full scope.

SENATOR GERRATANA: Thank you so much.

I'm sure there are people who have questions. One -- Representative Conroy. Good morning.

REP. CONROY: Good morning. Thank you, Madame Chair. And I -- I'm sorry. I have a little bit of a voice left.

Thank you for all the hard work that you're -- DPH did on the scope of practice. I really appreciate that.

I was just hoping you can clarify the technical change for us and just explain to the Committee what those different schedule drugs mean that we're looking at.

COMMISSIONER MULLEN: So the Drug Enforcement Administration categorizes five classes of

controlled -- controlled substances, one through five, based on their -- their strength, degree of harm that they could cause, and their addictive potential. All the way from drugs that are illegal, LSD, cocaine, in one, down to relatively less harmful drugs in schedule five. That might be cough medicines with codeine added. And there's a section in between where, depending on, say, the strength of -- of a medication like Oxycodone, might be in a -- a schedule two drug versus a schedule three drug.

So it's -- it's range of potential harm and addictive potential.

REP. CONROY: Thank you very much.

COMMISSIONER MULLEN: Okay.

REP. CONROY: Thank you. Representative Srinivasan.

REP. SRINIVASAN: Good morning, Commissioner. Good to see you here again, and I want to thank you, as my counterpart representative said. Thank you for all the hard work that you put in and come up with the scope recommendations. We all appreciate that very much.

Just a few questions, if you don't mind.

The first one is, this collaboration of three years at the APRN after graduating, getting the certificate, his or hers, will have with the physician, is that collaboration -- does it have to be in the State of Connecticut? Or they could be -- have the collaboration somewhere else for the first three years and then move to Connecticut, will the clock start all over again?

COMMISSIONER MULLEN: I don't believe that detail was in the bill. I think that's from -- in -- in a number of other situations where we have -- an

individual coming into the state seeking a license to practice in the state, then we would look at the qualifications that they bring to them. And I believe that's one of the -- that's one of the points that we would have to examine further.

In general, the notion is the three years of experience as opposed to starting the clock over again. Okay?

REP. SRINIVASAN: So if this APRN, so that I'm clear, comes with the recommendations and all of those appropriate paperwork to you, as -- as DPH, and you review that and you find that that's qualified enough for them to practice in Connecticut now without a collaboration? Is that true?

COMMISSIONER MULLEN: Correct.

REP. SRINIVASAN: Thank you.

The other question I have is in residency programs, obviously you have been through one, as -- as I have been through. We are all rated as to how good a resident we are and it doesn't happen very frequently. But infrequently it can happen and, as it did in my residency with my colleagues, they were not allowed to go to the next step because they were deficient, they, you know, did this that, and the other.

What is the safety measure here if the -- in the three years of collaboration, the physician finds that this person has not been up to par? Is there a safety precaution where he or she, the collaborative physician, can say excuse me, but you have not done your work well enough. I think you need another year or you need the two years. What -- will they approach you, DPH, with those recommendations?

COMMISSIONER MULLEN: That's a great question because it actually gets to the crux of how physicians even monitor one another's practice.

Technically, I think we both know that even in -- in working with residents now, the -- the degree to which there is consistent or a standard mechanism, an objective one, by which individual performance is graded and the individual is allowed to pass on to the next level, is -- is sometimes hard to fully capture.

And in a circumstance like this, I think more importantly than thinking about a collaborative relationship as one of just assessing the capability of an individual, I actually like to think about the collaborative relationship as the mindset that people are actually working together as team.

And -- and that, I think is probably a bigger challenge to get people to talk about around this proposed legislation than -- than staying in a debate about whether or not this bill should go forward, which, you know, I imagine a few people are going to have something to say something about today.

So it's a -- a really good question. Now, what nurse -- I've worked with nurse practitioners since I was in medical school in the seventies. and -- and what I've always heard from them is that collaboration is -- is part of what they're trained to do.

Now, I mean, part of what we're talking about here is how we advance the profession of medicine and -- and focus it on patients as opposed to turf. At the same time, that we incorporate in that conversation the ways in which our -- the training of doctors and nurse practitioners

should improve the care of people, rather than have us think that somebody is going to suffer.

So getting back to the points around collaboration, in any collaborative practice agreement, it's really imperative for the physician to be -- to -- to be available to that nurse practitioner.

One -- another challenge in Connecticut is that the spirit of collaboration, I think is inherent to settings where there are teams and multiple practitioners working.

Another thing we're overcoming in the state, another reality, is that we have a lot of small practices, one, two, or three physician practices.

It's a lot harder to have that team environment when we have more small practices here and HMOs and other centers, not just sites for the un and underinsured, where teams more readily come together. I think it's much more natural for people to collaborate, and they don't do it because of what -- a signature on a piece of paper. And individuals don't just talk to each other because there is a signed agreement between two people; they talk as team members.

So, you know, as I look around the room, you know, part of what -- what I wonder is what -- what the capacity of the professionals here, who are here, interested in this bill, is to develop that collaboration in Connecticut.

But I don't think I'm the only person to answer that question.

REP. SRINIVASAN: Thank you, Commissioner, for the -- for the -- and as you said, as -- as the day progresses, I'm sure we'll be hearing a lot more

of the subject matter, too. But I do appreciate your thoughts and your comments on that thing that has been at the back of my mind.

And my final question to you is that, as we see this bill, the Governor's Bill, progressing through -- wherever it progresses, in your opinion, is it -- is it -- where does the three-year process start? Is it are we grandfathering people that -- or have already done a three-year collaborative? Are we starting -- that was part I was a little bit confused about.

As if somebody has been an APRN in the state and -- and has been there, you know, for -- you know, for a period of time, obviously, at the present time, under collaboration already, but does that mean that the person will have to begin a three-year process? Or if anybody has had a collaboration for what -- of a period, if it's more than three, then can, if they choose to, be independent, number one?

And the next one is -- my last part of the same question is, that in what capacity will be -- they able to practice?

You know, be talking about primary care, which is what they're trained for, and the thoughts that - - that I've heard and concerns that have been raised is that will the APRN be practicing primary care, OB-GYN? Will it be internal medicine? Will it be family medicine? Or will it be specialties, other forms of medicine as well?

And I'm not sure what requirement they would need to be able to do that, including primarily psychiatric, which I know is the bulk of where the need is in our state.

COMMISSIONER MULLEN: Those are great questions, which

I believe are the basis -- some of the details that get worked out as this proposal is refined.

And this -- undoubtedly the case that you're going to hear a number of opinions about all of that.

The issue around grandfathering, for example, and the -- the questions about specialization, the sub-specialization.

Now, the -- the bill does not specify primary care or specialization. So I -- I believe that's something else that still has to be considered.

I know you're going to hear different opinions on that issue. What I presented to you from the report, based on a lot of the research presented in a number of the documents that are in the appendix, and from my own reading, is that a lot of the information that's been provided, and the evidence provided around quality, basically patient satisfaction, et cetera, are based on the -- the core practice of -- of nurse practitioners in the functions which I outlined in my testimony.

When I outlined it that way, I didn't mean to imply that -- that that's all there is. But I -- but once again, we go to the core, and that's where we also have to think about some of those other questions that you raised around collaboration.

Now, I have met with nurse practitioners in the past couple of years who have had an interest in -- in being specialists. And given that we have areas in the state where patients don't have access to specialists, and in our little State of Connecticut, there are places that are considering tele-medicine to get that access for their patients, I hope that the conversation can

be, even with a proposal like this, how we reconcile those differences to figure out how to gain access.

The institute of medicine and other organizations, having knowledge to that, as time goes on, and we have models from 17 states to look at, there's the potential to do more -- more research to look at more detail around outcomes for some of those other conditions.

You know, there is -- anybody -- you know, I'm an internist. Any physician, you know, even any sub-specialist, at a certain point hits a point where they want to talk to a colleague about a patient, either because they feel like they're -- they're in over their head, or because they want another opinion.

That's -- I mean, that's one of the essential roles that we need to continue as medical professions, that always need to be there.

So conversations that are around sub-specialization should incorporate questions such as what's the access to that?

One of my biggest concerns here would be crafting and finalizing a proposal at the same time that we can create a spirit of collaboration in the state.

Because a spirit of collaboration, or lack -- or -- doesn't have -- a spirit of collaboration needs to exist even if there's no mandate for a collaborative practice agreement. Does that make sense?

REP. SRINIVASAN: It sure does. Yeah. And thank you very much, Commissioner, for your answers. I appreciate that.

And thank you, Madame Chair.

COMMISSIONER MULLEN: You are welcome.

SENATOR GERRATANA: Representative Johnson.

REP. JOHNSON: Thank you, Madame Chair, and thank you, Commissioner and -- for your great testimony and -- and your work on this very important issue for the Committee and for the State of Connecticut.

I just -- reading some of -- reading some of the reports that you made and listening to your testimony, in hearing some things from the medical profession, in particular doctors, there has been some concern that there is -- there is somehow an -- a usurping, perhaps, or interference with what doctors do and what the APRNs do.

And I just was hoping maybe you could give us a little of a briefing on the differences between the -- what the -- what the doctors are supposed to do and why the APRN profession isn't in -- in a position to -- to become medical doctors. Does that make sense?

COMMISSIONER MULLEN: It does. Some of my staff apparently drew a Venn diagram last week to try to say nurse practitioner-doctor overlapping. I -- it's helpful in a way, but on the other hand, it's not so concrete.

One of the things that I would say is that practices -- physicians, offices, and practices wouldn't hire nurse practitioners most likely if they couldn't do some of what doctors do.

The report and -- and what I testified about refers to some of the -- the more routine -- and I -- and I don't use that word in a demeaning way, primary care conditions around prevention and screening, management of upper respiratory,

urinary tract infections, stable medical conditions, like hypertension, asthma.

Sometimes, some destabilization of those conditions, because when you're trained to collaborate, you're going to reach out for help in those situations, and guidance.

So -- so it's that kind of a realm. And -- and within the primary care, nurse practitioners, you have some that focus more on pediatrics. Maybe some that focus more on geriatrics; taking care of adults or -- or a little bit of both. Family nurse practitioners.

And, you know, I know there are a lot of nurse practitioners in the room and they might be sitting here thinking I'm horribly misrepresenting their profession, but they can write me later. I hope I'm not. But -- I'll hear about it.

But on the other hand, you've heard of working as a team is also in the -- in a really well functioning practice where providers can be satisfied about what they do together as a team, if the capacity to have somebody take care of some of the -- the less complicated conditions so that you can take care of some of the more complicated ones, and everybody can still learn in that process, and that's -- I mean, that's what I mean about a spirit of collaboration that isn't linked to a bill or a mandate for a condition.

I feel like Dr. (inaudible) could come sit next to me and help describe what it looks like when it works in an office.

Have I answered enough of your question of that?

REP. JOHNSON: Certainly. I -- I don't mean to put

you on the spot, but -- but on the other hand, from -- for people who don't practice in that -- in medicine, it's -- it's good to hear that, you know, some of what your vision is when you did the scope of practice and when the people were on the Committee did the scope of practice.

Because I think that we need to understand that there are things that doctors will be doing that the APRNs will not be doing. And -- and in terms of other -- how our -- our whole configuration of laws work together, we need to perhaps understand how that all fits together.

There are a number of different areas that I look at in terms of, you know, treating physician rules, established case law, all those kinds of things that come together that aren't necessarily part of the practice, but are part of the law. That it creates a situation where people are able to obtain their Medicare and Medicaid coverage or try to obtain insurance coverage.

Those are all practical applications of what will become -- that will have to be adjusted or will have to be reviewed in terms of how we -- how we, you know, get payments to people.

And so, to understand that there's differences and where -- where those are and how that works in terms of a collaborative agreement with the doctors for the three years, or whatever we finally do determine.

Those are things that we have to have some understanding of, because it's not just this narrow focus on -- on removal of the collaborative agreement. There are other -- other types of things that may come into play, that maybe they won't.

But I think that that's what some of the talk is

about. So any clarification you can give in that regard is -- is going to be very helpful.

COMMISSIONER MULLEN: So part of what's going to be really important in -- in the conversations is focus and not being distracted by things that aren't going to happen.

So nurse practitioners are not going to do hip replacements. Right? There -- there are certain things they're just not going to do.

I didn't even know there were nurse practitioners sitting behind me.

So it will be -- and -- and at -- at DPH every year, with this go process, we get to review the requests for a lot of people who want to do things that we say wow. Perhaps they should have gone to medical school.

And -- and I don't mean -- I'm not trying to sound derogatory with that. It's that part of what our role is is to really look at the practice and -- and training and make sure they're -- they're aligned.

So as we look at the scope review, we're not -- we're also not saying okay. Let's just make believe nurse practitioners went to medical school.

Now, if -- if a conversation that goes forward only exists in the realm of uncertainty, I mean, we can talk into Memorial Day, but session will be over and nothing will have happened.

So it's really going to take the commitment to say what are the practical elements that need to be worked out here?

And -- and for, you know, I -- I have utter

respect and understanding for -- for my physician colleagues, who don't -- don't -- and -- and rightfully don't want to worry about more complicated patient conditions being left to people who are not doctors, if doctors should be treated those conditions.

But we wouldn't be responsible if we created a law that put nurse practitioners in that position either. And that's the kind of thought that -- that -- that goes into this.

So if along the way, part of the consideration is, okay, maybe in Connecticut we start with where we know there's more research around primary care. That could be a consideration.

But with that, I still am going to say, because I understand what's happened in other states, the conversation then should not shift to this is a gimmick to give second-class care to poor people. Because that's been done in other places and that's not what this is about either and I know that because most places where I've worked with nurse practitioners have -- have not been places that are treating the underserved, the underinsured.

So we don't -- we don't want to do that either because we have the responsibility to convey to Connecticut residents that we're improving their access to good care, not to any old care for some people.

You really don't want me to sit here for too long. I don't want to preach, but, I mean, these are really important considerations and -- and you have the report. I -- I'd give my staff a lot of credit.

I think -- I don't know. We're probably going to end up talking to you about this PSA taskforce.

Maybe that was also very good.

But this -- a -- a committee of 42 people, where sometimes the standoff is just yes and no, to come out with a product that I feel very proud about. I think they did an excellent job and I think it's a testament to everybody that contributed to it that we could get to that point.

It's time now to say with this investment, and -- and the nurse practitioners can tell you, we didn't take up their scope requests last year because we didn't think they had presented enough evidence that I would sit here and -- and this is -- the Governor didn't have a bill, where I would just say they've given up enough to say we want to go forward with this.

This is -- I think it's a fantastic challenge. It's not easy. And it's on us to figure out whether or not we can work through details that make sense.

REP. JOHNSON: That -- that's wonderful. And thank you very, very much for your work and I can't tell you how much we all appreciate your work on creating the scope for us. We were -- we really needed to have you do that because we really want to move forward on this.

But also, we need to really understand what we're doing. So thank you very much for your work and your testimony.

Thank you, Madame Chair.

SENATOR GERRATANA: Thank you, Representative Johnson.

And I know there are many APRNs that are signed up to do testimony today and I would urge them also to explain how they collaborate with their physician and what they actually do when they

practice. That is just a -- a request, if possible.

Are there any other questions or comments? If not -- I'm sorry. Representative Sayers.

REP. SAYERS: Thank you. Good morning, Commissioner.

One of the questions that the physicians brought to my attention, and I came in late so you may have already addressed it, was that the part in the bill as it stands that has for the three years, where it would have the written collaborative practice. And if a physician found that there were any problems as a result of that three years, it doesn't appear that there's anything there that says what they need to do in response to that.

COMMISSIONER MULLEN: Well, then, what -- you make me think of that. Perhaps in the original legislation, there also wasn't anything there.

So what we probably also need to find out from physicians, since they work within -- with collaborative practice agreements now, is how they handle it now and -- and whether or not there are some suggestions that they have about how it should be handled going forward.

Because the practice with the collaborative agreement has been the rule.

REP. SAYERS: Thank you. And that's really a very, very important point. Have there been a lot of complaints from physician in terms of the nurses that they have a collaborative agreement with?

COMMISSIONER MULLEN: Not that I am aware of. I can go back to our healthcare quality staff to find out. But, you know, what -- what you didn't hear -- you might not have heard me say, as well as

this gets to the -- the crux of some of our medical professionalism, even, you know, medical students, residents, nursing students, you know, in certain ways, we are self-policing professions.

And when you work at the Department of Public Health, part of what -- and when you have our goal, part of what we get to answer sometimes is why, you know, why are you only doing something now?

People have to decide what they want to bring to us.

REP. SAYERS: Thank you.

SENATOR GERRATANA: Thank you, Representative, and thank you, Commissioner. Thank you for your testimony today.

Next --

COMMISSIONER MULLEN: Excuse me. Try to have fun with this.

SENATOR GERRATANA: Thank you. I -- I spent -- I came in here about an hour earlier this morning reading over that Practice Act. So yes. I understand.

Next is Commissioner Patricia Rehmer from the Department of Mental Health and Addiction Services.

She is testifying on -- testifying on House Bill 5145. Welcome, Commissioner.

COMMISSIONER REHMER: Good morning, Senator Gerratana, Representative Johnson, and distinguished members of the Public Health Committee.

for RAP certificates for section eight who we will no longer be able to house. And that will really impact many of the individuals that we serve.

The last change we are requesting will give individuals served in our system the ability to choose where they receive services. And again, this has been our policy, but we believe that it's important that -- that it's codified.

And I will say before I close and ask for questions that I do support also Senate Bill 36 regarding the scope of practice for APRNs.

I am a nurse with a master's in psychiatric nursing. I do not hold an APRN license. My career has taken me into another path.

But in our system, we do employ APRNs, clearly under the current statute with collaborative relationships, and they are a critical component of our service system delivery and especially in the area of medication management, where we have some ongoing access issues.

This would very helpful for us and I -- I want to reinforce what Commissioner Mullen said. It's a collaboration with -- whether there is a written expectation or not.

APRNs work in the context of multidisciplinary teams, and I have yet to see an APRN in our system where there's a difficult pharmacological issue not request a consult, perhaps, from a physician who has more experience in that situation.

So I just want to add my -- I know it's not my written testimony, but hearing, I need to my support for that bill. So.

SENATOR GERRATANA: Thank you, Commissioner.

COMMISSIONER REHMER: Thank you for time and attention and I'll be happy to answer any questions you may have.

SENATOR GERRATANA: Certainly. Thank you.

Is there any questions of the Commissioner?
Okay. If not, Representative Johnson.

REP. JOHNSON: Thank you so much, Commissioner, for your testimony and -- and your remarks about the APRN legislation as well.

I -- I just -- I wanted you to go into a little more detail about the rental assistance programs and not having the districts, because it's my understanding that people are having some difficulty moving from one part of the state to the other, where they might have an opportunity for a job, and that creates, perhaps, an unemployment issue, or something like that, where they could move, they can't because they can't get -- they can't get the rental assistance in any other part of the state, because they have to cross those invisible barriers.

If you could just tell us a little bit more about some of that, it would be quite helpful.

REP. REHMER: Let me just clarify that the part of the legislation where we are asking that individuals be allowed to receive treatment in any part of the state is really more related to, in some ways, the ACA, and then any willing provider issue. So that's one issue.

The housing assistance is really, again, a fund that we use to cover gaps in housing assistance that's available for the individuals that we serve.

MICHAEL SAFFIR: Sure. Dr. Michael Saffir. Physician and president of the Connecticut Medical Society.

Senator Gerrantana, Representative Johnson, members of the Public Health Committee, on behalf of the physicians and physicians in training for the -- part of the Connecticut Medical Society, I want to introduce myself.

I'm a podiatrist, Mike Saffir from Bethany. Current president, as I noted.

I want to thank you for the opportunity to present this testimony and I'm asking for your strong opposition to Senate Bill 36, an ACT CONCERNING THE GOVERNOR'S RECOMMENDATION TO IMPROVE ACCESS TO CARE.

Although the title refers to attempts to improve access to healthcare, this legislation would grant advanced practice registered nurses the authority to practice independently within a rather broad and vaguely defined scope of practice.

What is now considered the licensed practice of medicine in the State of Connecticut, and this would be after completing only three years of an equally broad and vague collaborative agreement, the basis of which is unclear.

As such, this legislation is not right and requires further work and a joint effort and we ask you to oppose it. I'd like to take a minute not to -- not to brag about myself, but to outline what my training was in terms of the amount of time I spent going to school.

I did four years in undergraduate, as many people who have gone to college have done, and then I did four years of medical school, which is

obviously additional training.

After that, I spent a year in an -- in an internship and another three years in residency and another fourth and fifth year in fellowship. Those five years on top of the other eight, for a total of 13 years of training beyond high school.

I also have maintained my certifications both in my specialty in physical medicine and rehabilitation, having first come here to Gaylord Hospital 20 years ago, but I'm also Board certified in pain medicine and Board certified in sports medicine.

I have to recertify and take those Boards every ten years and maintain an adequate level of continuing medical education in order to practice medicine with the high professional standard, which we have come to accept in this state.

We have provided you today with written testimony raising significant questions regarding the language before you across the wide spectrum of issues.

APRNs are valuable care extenders and participants in the team of practice of medicine. But to practice independently is not a substitute for what a physician provides for you.

At both the state and national level, our healthcare system is increasingly adopting a team-based approach to delivery of integrated care, patient-centered medical home model, as proposed in the state innovation models that we're developing here in Connecticut, and other models are based on this concept. This independent practice is not consistent with that team process. There are clear differences in education and training for physicians and APRNs, as I outlined.

The average physician completes 33 -- excuse me, 3,200 hours of clinical training in medical school and another 9,000 hours during residency.

The average APRN training program has five hours of clinical training prior to practice. 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. Three years of very loosely defined collaboration prior to completing this practice is unacceptable.

APRNs practicing independently in the same manner as physicians should be or have some oversight by the Board of Medicine, which oversees the practice of medicine.

The Board of Nursing is present and is currently set up to address the practice of standard nursing across the state, but it's not the practice of medicine.

Additionally, the transparency for physicians and for nurses and for patients who are seeing them to know are am I seeing a nurse practitioner? Am I seeing an MD? Who is it that's providing my care? And we think that it is important that the language includes that identification.

We spoke to Governor Malloy and believed that that would be part of this legislation. Any independent prescriptive authority should have some type of guidelines in terms of ongoing training. As I mentioned, you know, we have to be certified in order to get our drug prescribing licenses.

Our own Matt Katz has been a leader on study that

was done with UCONN that showed the distinct variations in practice and prescriptive patterns between APRNs and psychiatrists and primary care physicians. And those differences are significant.

The best option to address that is unclear yet at this point, but it's evidence of further work that needs to be done. Quality assessment.

As drafted, Senate Bill 36 would make it possible for an APRN to practice part-time or even in a no hands-on role, depending upon what the three years of collaboration meant. And it's not clear what that means, and that's a big gap in the bill.

The Department of Public Health, as part of their scope of practice review, looked at the concept of nurse residency, and I outlined what my residency was. But unfortunately, the collaboration is all we have in terms of identifying what nurse residency training would be.

REP. JOHNSON: Did you see the testimony?

MICHAEL SAFFIR: Yes, we did.

REP. JOHNSON: Okay. I -- because I haven't seen it on the online at this point in time. But in any event, could you please summarize?

MICHAEL SAFFIR: Summarize?

So in terms of providing the -- the appropriate specifics for a bill, this current Bill is unacceptable.

We are concerned about, as you know here in state, with network issues, with the united layoffs of people. We think this could have an impact that we are concerned about and these

issues need to be addressed as well.

I think it's in the interest of the patients in Connecticut that they are aware of what's being put into law and what the impact on them will be.

And somebody needs to be accountable for those changes and we're asking you to -- to work with us on this bill to see if we can -- if we can do something better for the future.

This bill is currently not it. Thank you.

REP. JOHNSON: Thank you. And I -- please submit your testimony and any recommendations for language.

Are there any questions?

Representative Srinivasan.

REP. SRINIVASAN: Thank you for your testimony and thank you for being here this afternoon with us.

The issue of malpractice liability.

MICHAEL SAFFIR: Yes.

REP. SRINIVASAN: If you can just give us an idea as to when, you know, in a lot of our practices, we do have PAs and APRNs working with us. And since they are part of a practice, they structure their rate as whatever it is, and obviously, different from that of a physician.

But when they are on a -- by alone and there are no collaborative agreement, and if they were to be on the stand alone, can you give us an idea as to what their malpractice or liability would look like?

MICHAEL SAFFIR: Well, if I was an attorney, I'd be having a field day at this legislation, because

it would just be a -- a new target to go after.

And -- and again, the open-ended question of standards means that you would have people say, well, there was some malpractice occurred and -- and they were at -- they were not necessarily doing the same level.

We know this as physicians because we have a liability crisis that we are addressing here in the state.

When we practice in teams with APRNs with physician assistants, with regular nurses, we, as members of that team, are held responsible, and our malpractice bills reflect that.

If people are going to practice independently, then there are going to be liability risks, and -- and we think that needs to be clear as well.

REP. SRINIVASAN: Do you have any idea as to what that amount could be in comparison to when they are in a group practice with us?

MICHAEL SAFFIR: Well, the -- the clear answer is that when you're part of a regular practice, those numbers are -- are not -- are not very -- are not very large in comparison to what you have as an independent physician.

I would expect, and I can't give you numbers off the top of my head, it does vary across specialties so that the amount that you would be liable for depends upon what you practice.

Again, this bill doesn't specify what type of nurse specialties you would have, so would be -- would an APRN be a cardiologic APRN? Would she be a paid medicine APRN? Would she be doing procedures and interventions and injections? All of those are factors with liability risks, which

are not clearly outline in this bill at all.

Again, it just -- it's just a field day in terms of what could happen with this.

REP. SRINIVASAN: Thank you very much.

Thank you, Madame Chair.

SENATOR GERRATANA: Thank you.

Any additional questions?

Senator Musto.

SENATOR MUSTO: Thank you, Madame Chair. Good afternoon.

I'm trying to figure out, other than the requirement -- well, first of all, let's -- let's back up a little bit.

A nurse, a registered nurse, can do certain things in the scope of practice.

Maybe you don't know the answer to this, so we'll not, but what's the difference between that and what an APRN does generally?

What -- what can an APRN do that a registered nurse cannot, currently, under the current law?

MICHAEL SAFFIR: All right. I -- I won't -- I won't say that I'm an expert on this, but obviously, a clinical nurse, and there are a number of different subspecialties, even for just clinical nursing, in terms of the education and training that they provide to patients and fellow practitioners.

There are clinical nurse specialists, there are nurses who are clinically -- who are on the wards

providing direct hands on care. They may be in clinics providing care.

The advanced practice component deals with where the -- the nursing specialty starts to overlap and do stuff with a physician team.

So they would be, for example, able to -- if we are talking care of you as a patient and you called in, they would be able to say, okay. This medication is appropriate. We have you on file as a patient. We know what's going on. We may need to adjust your medication. But it's part of a team effort.

So that -- the -- the APRN would be making those types of decisions and it's very similar to what a physician assistant does.

A physician assistant is somebody who's trained to work with a physician and -- and provide clinical assessments and feedback to the team, the physician and -- and the other team members, about what changes or appropriate treatments might be applied. And again, it's usually done in a team effort.

The concern that we have -- that we have is the collaborative concept, which is outlined in this bill.

The previous practice act had been moved from practicing under direct supervision a number of years ago, which is what we do with physician assistants, to collaboration, which is a looser term and was felt to give the advanced practice nurses a little bit more independence to practice.

The concept of what that means now is -- is very unclear because what would you do to collaborate for three years and then what impact would that

have going into the future?

I, personally, would not want to be responsible for having a three-year collaboration with an advanced practice nurse practitioner.

I'd love to work with her, but I wouldn't want to be the person that said she collaborated with you and then, when a case went bad, the attorney -- well, the malpractice attorney, looks at me and says, hey. You were the one she collaborated for three years. You know, don't you think that, you know, she could have had some better issues or couldn't you have identified this problem? We want to hold you responsible.

And so, my answer would be no thank you.

Did I answer your question?

SENATOR MUSTO: I don't think so.

MICHAEL SAFFIR: I go that. So again, I won't specify all the details and I -- I'm sure you will have some input and testimony in what some of the additional specifics are in terms of practice and training from some of the other people testifying.

And advanced practice nurse has -- has a greater degree of training and does more clinical decision-making, rather than just following orders.

SENATOR MUSTO: Okay. And -- I'm trying to (inaudible). I tried pulling up some of the statutes about nurses. You know, what their scope of practice is and -- and it seems like one of the current things that a registered nurse can do is to diagnose human responses to actual potential health problems.

And I'm frankly not sure what that means under current law. Providing health counseling, teaching. Providing supportive and restorative care.

But the process of diagnosing human response as to actual potential health problems, that's something a registered nurse is able to do now, regardless of the APRN rules.

MICHAEL SAFFIR: Sure. I'm -- I'm interpreting. And again, this is my interpretation. I'm interpreting the -- excuse me. Monitoring responses is being -- looking at blood pressure, looking at temperature, fever, somebody who is on antibiotics.

So you're looking at an intervention, whether it's a blood pressure med or a wound care treatment, and you're saying we've implemented this wound care, we've implemented this blood pressure medication, we've implemented these antibiotics, and the vital signs and -- and the -- the healing response to the wound, those are the responses that we're looking at that are showing clinical improvement.

So in order to make that assessment -- by the same token, if you -- if you implement an antibiotic course and the fevers are going higher or the wound isn't healing, you need to be able to make that assessment and communicate it to other members of the team and say the treatment plan we have in place is not succeeding. We need to change it.

SENATOR MUSTO: Okay. And then, the APRNs currently, it's seems like the only change to the bill would really be the independent practice part of it. Is that fair?

MICHAEL SAFFIR: That's -- that's probably the main

aspect of it, because it is independent. Yes.

SENATOR MUSTO: Okay. Is there another part of the bill that I'm missing that you're concerned about other than the independent practice part?

MICHAEL SAFFIR: Well, I mean, I think if you started to look at that level of performance, the increasing demands that we are seeing in terms of liability, in terms of continuing medical education requirements, I think that that should be carried over to all the healthcare professionals.

So there are aspects to our discussions points, which you will get if you haven't gotten them, in terms of what would be necessary to maintain this high level.

So APRNs do have the highest level of clinical care, higher than an RN, as you and I pointed out, and there needs to be standards for training and education that go on with that.

Now, that being said, here in Connecticut, the Connecticut Bar Association has battled with the idea of continuing legal education requirements. So whether they should have to sit and take the bar exam a second time, or whether it's good for life.

So those kinds of ongoing training questions are the core of what a profession is and -- and need to be addressed.

So part of our -- our concerns are that these continuing education requirements to truly be a professional, whether you are a doctor, a nurse, or an attorney, needs to have a fairly high level if you truly are a professional.

SENATOR MUSTO: Okay. And as far as different types

of APRNs. Are there different disciplines within
--

MICHAEL SAFFIR: Yes.

SENATOR MUSTO: Okay. Do you -- how many? Do you
know or is it --

MICHAEL SAFFIR: You have -- you have certified -- you
have certified registered nurse anesthetist,
which is probably the -- the technically highest
level of skill because you're having them
administer anesthesia under the direct
supervision of a physician.

So I -- I think the technology, the assessment of
the vital signs, the effect of the anesthesia,
that is probably one of the more complex skill
sets that you would have to do.

And under the current bill, I believe that is
exempted. That is not included in terms of
allowing independent practice.

You have psychiatric nurse practitioners who have
a specialized interest and this an area where
there are a large number of psychiatric nurse
practitioners.

And -- and we've looked at some of the
psychiatric prescribing issues and some of the
collaborative agreements that we currently have,
because it is a -- mental health is a clearly
important area for healthcare today.

So that's the type of healthcare. You can have -
- I believe you can have geriatric advanced nurse
practitioners who specialize in the elderly, just
like we have internal medicine docs who have
specialization in geriatrics.

Again, I -- I had actually done some of my

research in looking into this as part of looking at the bill to understand where the different scopes would be, but I don't have all the different specialties at my fingertips.

Certainly could use this or we could certainly ask additional testimony, possibly in some of those areas that -- that may be relevant.

SENATOR MUSTO: And in your estimation, are there any particular specialties, APRN specialties, that are more or less on a -- on a continuum, more or less able, for lack of a better word, to practice in --

MICHAEL SAFFIR: I think -- I think conceptually, most people perceive this -- particularly even the Governor's approach to access to care, is a primary care issue.

So I think whether you're talking about geriatrics primary care, pediatrics primary care, the question is -- is will these team models allow better access to primary care?

We built a new medical school down at Quinnipiac that the focus is primary care. Now, they -- they have a team approach. They have physical therapists, occupational therapists and nurses.

I'm going to be addressing the medical students tomorrow up at UCONN and some of the Quinnipiac students, and the question is -- is what am I doing? Does it make a difference that I'm in this Quinnipiac medical school or should I just get a degree in nursing?

I think the -- the degree of specialization is important. Now obviously, we have training pathways to do geriatrics, to do sports medicine, to do pain medicine, which I'm certified in.

But let's say somebody comes and -- and work with my colleague Dr. Woolson, who's a cardiologist, and spent three years with him, and then says you know what? I want to go out and do pain medicine.

The question is -- is does those three years of training, if he decides to collaborate with her in cardiology and internal medicine, does that make her fully trained to practice independent cardiology, or -- or he?

Does it make him qualified to practice pain medicine? Should he be able to say I've done my three years and now I decided that I don't like cardiology, but I've gotten my three years under my belt. I'm going to do pain medicine.

So I -- I think these open-ended questions in terms of specialization are -- are important. And the practice of nursing has some areas defined. Like I said, clinical nurse specialist, APRNs, CRNAs, nurse midwives is another area that I didn't mention earlier.

So they've already started to define some special areas there, but -- but not practicing independently.

SENATOR MUSTO: All right. Thank you.

Thank you, Madame Chair.

SENATOR GERRATANA: Thank you, Senator Musto.

Are there any other questions?

Oh, Representative Conroy.

REP. CONROY: Thank you, Madame Chair, and thank you Dr. Saffir for being here today.

MICHAEL SAFFIR: Good to see you again.

REP. CONROY: Thank you. I just have a couple questions.

Was the Connecticut State Medical Society a part of the scope of practice review that was done this past year?

MICHAEL SAFFIR: Yes.

REP. CONROY: Okay. Because I heard there was 42 different people on there and I just wanted to make sure you -- your opportunity to speak there.

How were these concerns addressed during that review period?

MICHAEL SAFFIR: I wasn't actually, myself, part of the process. I know that there were extensive discussions about some of these particular issues.

Unfortunately, I think they were left open-ended. You know, they -- so therefore, if I made recommendations that there should be a higher level of training, that they weren't addressed.

If there should be some degree of certification by the Medical Board, that wasn't included.

So those are examples of my insights into key areas that I ask questions about personally. But I can't speak to that directly.

We could certainly have some of our administrative staff who work through that process, you know, give you information.

I will tell you that John Foley, who is my predecessor as president of the Medical Society, has been a key vocal physician on this issue, but

he is actually a nurse.

His original training was as a nurse and he went back and felt he needed to do the additional training to go to medical school to allow him to do the kind of practice he's doing.

And so, he's been one of the strongest voices saying, listen. I know. I've been a nurse. I know what's involved. If you want to be a doctor, you should go to medical school.

But to simply -- it certainly is easier to legislate right here than to spend the 13 years I spent. If I had known this head of time, I might have gotten a bill and --

REP. CONROY: I think you're kind of digressing, because I don't think we're talking about going to medical school. I think nursing and -- and medical schools are two different professions that we have heard from before.

MICHAEL SAFFIR: Sure.

REP. CONROY: Do you have a nurse practitioner in your --

MICHAEL SAFFIR: Practice? No.

REP. CONROY: You don't?

MICHAEL SAFFIR: I have practiced with them in the past, though.

REP. CONROY: Okay. And what kind of setting was that in?

MICHAEL SAFFIR: Actually, it was in a hospital setting. I practiced with somebody up at Mount Sinai St Francis, where I was. And it's been so long, but I believe at Gaylord Hospital as well.

REP. CONROY: Okay. And I just want to follow up on a question Senator Musto had.

MICHAEL SAFFIR: Sure.

REP. CONROY: About liability insurance. You were saying about -- who is going to want to do it for the three years, for the malpractice.

MICHAEL SAFFIR: Well, I think -- I think the concern would be, if I'm a good trial lawyer and -- and you were -- you spent your three years with -- with Senator Musto and you did your training and then there was some type of catastrophic event in a case that you were managing independently, I would -- as -- as a claimant's attorney, I would file against you.

And then, I'd say who trained you? Who did you spend the three years with? And they say, oh, Senator Musto. And I'd add him to my complaint (inaudible).

REP. CONROY: Now, isn't that true, then, that that could be happening right now with the written collaborative agreement, that the two of us would be together in --

MICHAEL SAFFIR: Well, in fact, I mean, the -- if you have a written collaborative agreement, that's an ongoing issue.

So in fact, you are working with that doctor all the time and he does have some oversight, ostensibly, of what you're doing, and -- and that would be clear responsibility as well.

I -- I would -- wouldn't even ask my question. I would say, listen. If it's three years with me and then you're out and I don't know what you're doing anymore, it would be particularly

frustrating for me to get pulled into a suit because a smart trial lawyer got me on the stand and said didn't you work with her five years ago and train her for three years, or ten years ago and train her for three years?

Wasn't that her, you know, advanced training under the law? Sure.

REP. CONROY: Yeah. I just -- I guess I'm looking at a different perspective, that will actually free up the medical physicians from having the liability being onto their name also.

MICHAEL SAFFIR: Well, a good trial lawyer tries to get as many people on the hook as they can.

REP. CONROY: Right. But if there's no longer that written collaborative agreement, then, going forward, it just won't have that.

MICHAEL SAFFIR: Right. They'll -- they'll point to it historically. They'll say that it was there by history, that you let this person out onto the street.

REP. CONROY: No. That's another place, another discussion, if that ever happens.

But thank you for your time in answering the questions.

SENATOR GERRATANA: Thank you.

Are there any other questions? If not, thank you very much for your testimony.

MICHAEL SAFFIR: You're welcome. Thanks.

SENATOR GERRATANA: Next is Dr. Steve Wolfson, followed by Lynn Rapsilber.

STEVEN WOLFSON: Good -- good afternoon --

SENATOR GERRATANA: Good afternoon.

STEVEN WOLFSON: -- Senator Gerratana, members of the Committee, long suffering audience.

I am a cardiologist in New Haven and vice-chair of the Council of the State Medical Society.

Regretfully, I am here today to oppose passage of Senate Bill 36.

I say this with regret because I have seen the benefits of APRNs and physicians training together and then working together collaboratively over long periods of time.

One Saturday a --a month, I volunteer as a faculty adviser to the free clinic in Fair Haven, Connecticut.

Here, medical students, nursing students, physician assistant students work together to serve uninsured patients under the supervision of physicians and of the superb APRNs who have worked collaboratively at the Fair Haven Clinic for years.

It is a yeasty mix and I must say that as the cardiologist, I have much to offer here. But I have also learned from the experienced APRNs who have matured in the collaborative setting at the Fair Haven Clinic.

Without exception, they are caring, committed, and wise clinicians. It is clear that they have benefitted from a setting where they have interacted with physicians over the years, often sharing the same patients.

The concept of independent practice concerns me.

I doubt many physicians will be willing to collaborate with an APRN, share exposure to their patients, and then see the APRN leave the practice and set up his or her own office nearby.

It is not realistic to expect this. We will be competitors, not collaborators.

And so, the inevitable progression will be that the APRNs will establish their own training and experience settings.

The disciplines will drift apart. Their pride in their accomplishments will further this divide, naturally, and we will all lose from this.

In a time when integrated shared team approaches to healthcare are being fostered at the national and local level to establish a separate tract of clinical practice is not wise.

Thank you.

SENATOR GERRATANA: Thank you so much, Dr. Wolfson.

Are there any questions?

Yes, Representative Perillo.

REP. PERILLO: Senator, thank you very much.

Just to get to one of the points you made concerning the potential for future competition and whether a physician would want to collaborate and work within their own practice an APRN with the possibility that that APRN could become a competitor down the road.

Right now what do physician practices do when they take in a new associate, a new MD, and work with that individual and collaborate with that individual?

What would happen if after, you know, three months that individual says I met a bunch of patients. I'm going to open up shop next door. What happens now?

STEVEN WOLFSON: Not -- not good. But these physicians are already trained. They're not at a -- you're not offering training to these young physicians. They have already completed medical school, internship, residency, sometimes fellowships, and they are fully qualified practitioners when they join your practice.

Again, the interaction between the disciplines of physician and lawyers is -- is delicate here.

Many physicians join a group practice having signed an exclusive covenant saying that they won't just go down the street and set up practice for at least a -- a certain period of time. So there is some -- some protection in that.

But I think the -- the principal thing is that you are asking physicians to -- to basically do - - allow an APRN to do an internship in their practice and then set up competitively, potentially.

I -- I -- it -- it doesn't fit what -- what I understand to be human nature.

REP. PERILLO: Understood and I can see where, perhaps a physician might not want to take the active role in training their future competition, although, you know, in a society where -- where academic medical education is a pretty big deal, essentially physicians -- physical educators are doing that every day.

But you mentioned, though, situations where perhaps there would be a non-compete if a

physician joined a practice so that, indeed, they could not open up a practice next door after three months, a year, three years.

Would there be anything stopping a physician from bringing an APRN to their practice and setting up a similar non-compete?

STEVEN WOLFSON: No. I think that, though, with the years and with the shortages in clinical practice, it has become more and more difficult to enforce that exclusive covenant or arrangement.

I'm -- I'm not a lawyer, but that's -- that's what I have been told.

REP. PERILLO: So -- so you're saying that non-competes right now, as they exist in the medical community, are very, very difficult to enforce?

STEVEN WOLFSON: Correct.

REP. PERILLO: But, you know, physicians still bring in new physicians to their practices as associates and work with them --

STEVEN WOLFSON: Again --

REP. PERILLO: Those physicians in the practice help generate revenue for the practice, just as an APRN would help generate revenue for the practice. Is that correct?

STEVEN WOLFSON: Again, fully trained physicians, and we also bring in advanced practice registered nurses, who may go to another practice. But they are fully trained in their discipline and a -- a breach of work within a collaborative agreement.

It's the independent practice that I think raises concerns here.

REP. PERILLO: I -- I can appreciate that. And -- and we sort of operate on the assumption that any APRN coming into a physician practice would need to be trained, and if not already fully trained, I would imagine that there are a number of APRNs, in fact probably the majority of APRNs, at least in -- in the Connecticut medical community, that are already fully trained.

They've gone through their nursing education, their, you know, master's level nursing education. They've worked in a hospital facility setting, or otherwise. They've done their time and they've learned and they've kept up with their continuing medical education.

STEVEN WOLFSON: And I've already -- I've already testified --

REP. PERILLO: And -- and I -- I heard that, so we're kind of coming full circle now, don't we?

STEVEN WOLFSON: I have appreciated working with them and I -- and I have learned from them when we work in the clinic.

I'm fully capable of teaching them cardiology, but they have previously taught me general principles of medicine.

REP. PERILLO: Well, thank you. I'm sure everybody appreciates those kind words.

I -- I don't know. I feel as though we're -- we're sort of talking in circles here.

You originally expressed concern that, you know, a physician wouldn't want to bring a potential competitor into their practice, yet we then established that there are non-competes out there that protect, you know, to the best extent that

the law allows, to protect from future competition from someone you bring into your practice.

Then, we discussed the fact that -- you discussed the fact that, you know, many APRNs coming into a practice will need to be trained and the physician wouldn't necessarily want to train their future competition.

Yet in the same breath, we also said that many APRNs who move from one practice to another, or a hospital setting to a practice, already have that initial training.

So again, we're sort -- there's a little bit of incongruity between our concerns versus the reality.

And then, I sort of still come back to that same central feature of American medicine that is based in medical education and residencies and fellowships and -- and that's how we train people.

And essentially, we have a medical community, you know, of -- of physicians who understands that a part, a key part, of what they do as clinicians also entails a significant educational component.

To suggest that perhaps physicians are no longer going to embrace that educational component, because of the risk of future competition, I -- I don't know that I understand. I don't know that I am certain that would be true.

As you said, you know, a physician may not want to take in an APRN and -- and train them and send them on their way and, you know, have them hang a shingle next door.

That's the basis of American medicine. That's

how we improve and -- I don't know.

I -- I think your concerns are -- are understandable from your side of this table. I'm a little skeptical as to whether or not they are as legitimate as perhaps some might think they would be. My personal opinion.

STEVEN WOLFSON: I respect that.

REP. PERILLO: Thank you.

SENATOR GERRATANA: Thank you. Are there any other comments or -- okay. Representative Srinivasan, followed by Representative Conroy.

REP. SRINIVASAN: Thank you, Madame Chair. Thank you very much for your -- for your testimony today.

Elaborating on what Representative Perillo just said, do you feel that in the years to come, if this were to be -- be pulled into law, passed into law, signed into law, that the physician community would not embrace the APRN community in the three years of their training period here in Connecticut?

Is that -- is that one of the concerns that you have? Yes, they could have a training, but realistically, there's nobody out to train them that has been at practice or in a hospital setting?

STEVEN WOLFSON: I think that the bill, as it is currently written, has not undertaken an analysis of that problem.

I don't know what the future will hold. As I -- as -- as I look at the -- the bare bones, an advanced practice registered nurse will complete his or her basic education.

Now, they will -- and -- now, they will enter a practice in a training setting for three years.

At the end of that time, what evaluation process will go on to establish that they have been trained adequately?

Will the physician who has trained them be able to say I did my best, but this is not an adequate clinician. I can't grant him or her the certification that they need in order to practice.

Will the advanced practice registered nurse, having completed three years, be held to the same standards that apply to physicians?

Coverage for 24 hours, seven days a week, 365 days a year. Advanced continued education. Recertification from time to time. None of those -- none of those are in the bill.

I think it needs more thought.

REP. SRINIVASAN: Thank you very much. In fact, you brought up a -- a question I had had earlier in the day, earlier in the morning. We're going back to 10:30 now, to -- to Commissioner Mullen, when she came here to present on this bill.

And one of my questions to her was exactly what you said, that in this training process, of a three-year collaboration, if the physician, he or she is not convinced that the adequate skills, adequate clinical skills, had been established, but they're supposing to go out on her own or his own, then what kind of safety guards do we have?

And she thanked me for the interesting question and said that is something that we need to work on and that's exactly what you said.

And those are some of the concerns, not the concept of the -- of the clinical skills, but being on their own without supervision, and the rule that the three-year collaboration provider, the responsibility and the liability both ways, of the person who is certifying that this person is now adequately trained, like we do in our residency training.

I mean, no different than the residency training, where every resident that goes to the training program has not ultimately become an -- become a resident, there are -- they have asked to stay another year or say things have to move or you're better off in another field, and internal decisions can be made.

So that is what we had in the medical field. I'm not sure how we will be able to replicate here given the fact that we may have some people that may not add up at the end of the three years of collaboration.

And thank you for sharing that, because that was one of my concerns. And I think we need to work on that moving forward. Thank you.

Thank you, Madame Chair.

SENATOR GERRATANA: You're welcome.

Representative Conroy.

REP. CONROY: Thank you, Madame Chair, and thank you, Dr. Wolfson for being here, and thanks for all your community and volunteer service out in Fair Haven. I'm sure that's much needed and appreciate there.

I just want to follow up on the question about the concerns about the collaborative three years.

You brought up that you thought, you know, what physician would want to do that for the three years and that -- that's what you did say, right?

STEVEN WOLFSON: As -- as an educator, as a member of the faculty of the Yale School of Medicine, I'm happy to educate anyone. As a practicing physician, I also know that I need to pay my bank. I need to -- to pay the nurses and APRNs whom I hire and whose work I'm responsible for.

I would have doubts that -- that it would be wise for me to bring in a trainee, expose that trainee to my patients, and then assume that they will leave in three years and go elsewhere.

None of the other hires I have have an expected term. I assume they'll stay with me forever.

If their families call them to -- to move to California, if they hate me and leave after some period of time, I can understand that can happen. But as I'm taking them on initially, I assume that this like a marriage.

REP. CONROY: So how do you see that we can make sure that we do enact this legislation, that there will be doctors out there would be willing to have APRNs for that three-year period?

STEVEN WOLFSON: I think let's not have this bill and let's continue that the requirement for collaborative care and let's continue that relationship, which is essentially for the team-based approach that both federal law and the -- the needs of -- of the healthcare delivery system are increasingly fostering.

REP. CONROY: Yeah. I'm just a little concerned when you're saying that, you know, we might not find these doctors, because I come from a stance that if we're saying that nurse practitioners after

three years can independently practice, maybe we should be looking at -- then at this point. Maybe after three years, they can take on newly licensed APRNs.

If it's going to be a problem finding the medical profession to this, it might just be another option we'll have to look at on our side.

And then, a couple of things you were just saying. You were talking about the evaluation process and training.

Now, maybe you're looking at the bill a little bit different than I am. I'm not really seeing that part of training and I'm just seeing that we're getting rid of that written collaboration.

I don't think that the practice of APRNs in a -- a medical profession, collaboration, is going to change at all. Do you see it differently than I am?

STEVEN WOLFSON: If it's not doing the change, then why introduce the bill?

The Bill specifically states that APRNs will be entitled to have an independent practice. The whole thrust of the changes in healthcare now is toward increasing collaboration. We're going in opposite directions.

REP. CONROY: But right now, we have the collaborative agreement.

STEVEN WOLFSON: Correct.

REP. CONROY: And how is the evaluation practice going now? If you had a APRN -- do you work with APRNs?

STEVEN WOLFSON: In -- in my practice, we work with

physician assistants.

REP. CONROY: Okay. So you don't have APRNs.

STEVEN WOLFSON: I don't have APRNs.

REP. CONROY: Well, if there's somebody else that you know speaking on the Medical Society that I -- that are for me to ask that question.

STEVEN WOLFSON: Dr. Stone, a pediatrician in private practice has a number of APRNs in her practice and I'm sure she would be happy to speak to that.

REP. CONROY: And I know you're also, just when you were speaking to Dr. Srinivasan, about CEUs and recertification. You were -- you were discussing that with, you know, you're -- you're responsible for and with the APRNs.

I'm not quite sure where all that testimony was coming from.

STEVEN WOLFSON: It was just suggesting that physicians are held to pretty high standards, appropriately so. Sometimes, it's (inaudible). We have a specific 50-hour requirement every two years to do continuing medical education.

Every ten years, we're required to recertify in our specialty. I've seen nothing in the bill that will hold APRNs to the same standards and I think that if the decision is made to go ahead with the bill, that those standards should be in place.

REP. CONROY: Do you know what the requirements are currently for APRNs to be certified?

STEVEN WOLFSON: I -- I don't.

REP. CONROY: You don't have that. All right.

Hopefully, someone later I can ask that question to.

That's it. Thank you for your time in answering my questions.

STEVEN WOLFSON: Thank you, Madame Chair.

SENATOR GERRATANA: Certainly. Thank you.
Representative Johnson.

REP. JOHNSON: Thank you, Madame Chair, and thank you for your testimony today.

Just as -- I'm going to ask the similar question to what I asked the Commissioner, and that was, you know, what is the difference in terms of what the -- what the doctor does and what the nurse does?

Because for people who are not doctors or nurses, there's a hard -- it may be hard for people to know when you go into the -- the -- to the doctor's office and the APRN is there and they do the examination and all that.

What type of oversight is occurring there? And where -- where is the line drawn in, say, the primary care delivery system or the -- or in some other, you know, more focused practice, like mental health services?

STEVEN WOLFSON: I think that Dr. Stone can -- can speak to that specifically -- but from her experience. Are you asking about what a -- are you asking specifically about an APRN or a registered nurse?

REP. JOHNSON: We are speaking only of, I mean, from my perspective, only APRNs. This is where we're getting -- we're removing the collaborative agreement requirement.

So what we're looking at is what does that actually mean? So in terms of when someone goes to the doctor's office or -- or practices are established.

Certainly if someone is in the doctor's office and the doctor is in the office, whether you have a collaborative agreement or not, it's -- I would suspect that the doctor wouldn't be contracting with the APRN. The doctor would have the APRN as an employee.

So that changes the dynamic completely. So when you look at the collaborative agreement, in terms of how the -- how -- how that would work if you had, say, a group practice of APRNs contracting with medical doctors, you know.

And I just -- so that has a possibility. Then how is -- how would something like that look in terms of how -- how you would perhaps hire somebody or contract with a group of -- of APRNs to -- to help you work with your practice if you were supposed to have -- if we're looking at person-centered medical homes or medical neighborhoods?

Would, I mean, it's foreseeable that down the road that something like that could occur.

REP. JOHNSON: I think you -- I think you're asking all the questions that should be asked while drafting the bill.

The -- I -- the answer is it's going to require some thought. Given a collaborative agreement, the -- the doctors and the APRNs will be working very closely and there will be a lot of back and forth in terms of difficult questions.

As -- as I've worked in -- in the -- in the --

the Fair Haven Clinic, we -- we frequently see complicated situations where I'm asking the APRN what their -- what their feeling is about the -- the -- gastroenterologic aspect of -- of this issue and they're asking me about the cardiologic aspect.

There's -- there's a lot of back and forth and again, that Dr. Stone can speak -- can speak to that specifically because she does that every day, not just -- just -- not just one thing.

But -- but I -- I urge you to consider that, looking forward, we're all going to need to be working together for the care of the patient. Hillary Clinton said it takes a village to raise a child. It takes a village to take care of patients, particularly over the long course of -- of their -- of their lives.

And the more that we encourage the -- the different practitioners who impact the care of patients to work together collaboratively, to share information, and to counsel together, the better off we will all be.

REP. JOHNSON: Thank you so much for your testimony and all the work that you do, Dr. Wolfson. Much appreciated.

STEVEN WOLFSON: Thank you. I gain more from doing that work than -- than the patients do.

SENATOR MUSTO: Madame Chair?

SENATOR GERRATANA: Hold on, Dr. Wolfson. I'm sorry, Senator Musto had a question for you.

SENATOR MUSTO: Thank you.

SENATOR GERRATANA: Thank you, Sir.

SENATOR MUSTO: Thank you, Doctor. Excuse me for being -- jumping on a little late.

There was testimony earlier about the training doctors go through and you testified as to some continuing education.

Just -- I'm not quite sure where the Boards come in -- in the training. You have college and medical school and residency and -- and what's the progression and where -- where do you actually take your test, whatever the test is, and what is it -- what does the test grant when you -- should you obviously pass it? What does it -- what does it do?

STEVEN WOLFSON: I -- I did pass (inaudible). At each stage of the game, there -- there's -- there's a test.

After -- after graduating from -- from medical school, I took exams and passed them. After completing an internship, I was approved not on the basis of an exam to proceed to my -- my residency after completing.

Along the way, I had to take the Board's internal medicine, which was a -- a large written examination. Then, I had to take the Boards in cardiovascular diseases. At that time, we traveled to another city so that people wouldn't know us and we -- we were asked to see patients under the oversight of the examining physicians and we -- we examined them.

We then prescribed for them and we were asked a number of questions about the particular discipline. We sat down with the pathologist who handed us hearts and we were asked to -- what pathology the hearts represented.

And every -- every ten years, we're asked to take

an extensive written examination that requires months of preparation in -- in order to continue to be -- to be certified.

It -- it's a -- it's a very formal and a very intensive and a very expensive process. And -- and I -- I'm glad for the sake of my patients that we have been put through this. It ensures that -- it -- it doesn't ensure that we're good doctors, but it ensures that we have at least read the books and have a knowledge base to work from.

SENATOR MUSTO: And you mentioned internal medicine. You're -- cardiology is part of internal medicine?

STEVEN WOLFSON: It -- it is. That's correct. Cardiovascular disease is a subspecialty of internal medicine.

SENATOR MUSTO: Okay. And the internal medicine test or the cardiology test that you take, whatever -- whatever you take every ten years, that only allows you to practice internal medicine. You do not -- there are other types of medicine, obviously, that you -- you don't have the ability to practice? Orthopedics, perhaps, or pediatrics? I'm not sure.

What -- what does the test permit you to do?

STEVEN WOLFSON: It permits to advertise myself, put myself forward, as a Board certified cardiologist.

I don't think within the law, that there's anything to proscribe my doing almost anything in medicine. But I know that if I try to walk into the operating room, I'd be asked to demonstrate my Board certification in surgery.

If I tried to go on to a pediatrics floor, the nurses would refuse to let me -- what are medications for an infant, because I'm obviously not -- not qualified to do that.

SENATOR MUSTO: Do you -- do you believe, though, that you would be able to do that legally? It's just that there might be some other --

STEVEN WOLFSON: We -- we have built in faculty protection for patients that ensure that people are adequately trained in their specialty before they will practice those specialties.

SENATOR MUSTO: And currently, there is the distinctions -- and -- and I'm not sure we all know what they are, but the Chairwoman asked about what nurses do, what doctors do, et cetera.

What is the concern about a well-trained APRN diagnosing and treating certain things? What -- what could one do versus what a doctor could do?

STEVEN WOLFSON: I have no concern about a well qualified experienced APRN practicing his or her trade, evaluating patients, making a diagnosis, and then treating.

I am concerned that he or she not have ready access to consultation with a physician who has much more training and much more experience.

I believe Dr. Saffir went into some of the numbers. Physicians, during medical school, put -- put in about 3,200 hours of training. And then, during residency, including the nights they're on call, another 9,000 hours. And the requirement for certification as an APRN is about 500 hours.

SENATOR MUSTO: You know, I think a lot of the concern here is that if you're working with an APRN and

the APRN decides to get up and leave the state and go somewhere else, that doesn't really affect your ability to practice.

But if the opposite is true and the APRN is working with you for 20 years or whatnot and then you decide to retire, go leave the state, that the APRN is then proscribed to (inaudible).

STEVEN WOLFSON: I'm sorry. I don't -- I don't understand.

SENATOR MUSTO: Well, if -- if you a collaborative agreement with an APRN, for example, and you retire, that APRN is then required to go out and find another physician who will collaborate with the APRN. Is that correct?

STEVEN WOLFSON: That -- that is correct. But if I'm retiring and have a responsibility to my patients, I've made arrangements for that practice.

Usually, I will hire other physicians who will be working within my practice and will continue that collaborative agreement.

Absent that, I would have made arrangements for my patients to be -- to be undertaken by other practices and I would -- would urge them to make the collaborative agreement with an APRN who has worked with me for years.

I would also try to get them to -- to hire my secretary and the other people in my office, because a practice is -- is organic. All the people contribute to the care of the patient.

I remember some years ago, we took into my practice a -- a very senior physician whose old practice had -- had broken up.

It became very clear to us that the person who was important for us to hire was perhaps less that physician, his secretary.

The patients all loved her and communicated with her. She was the face of his practice and if she wasn't coming, they weren't interested. We hired his secretary.

SENATOR MUSTO: All right. Thank you, Doctor, for your testimony. Thank you, Madame Chair.

SENATOR GERRATANA: Certainly. Okay. Can we let Dr. Wolfson go now?

STEVEN WOLFSON: I'm fine. You're staying here a long time.

SENATOR GERRATANA: It's our lot in life.

STEVEN WOLFSON: Right.

SENATOR GERRATANA: Thank you, Dr. Wolfson for your testimony.

Okay. Next is Lynn Rapsilber, followed by Sheryl Marinone.

Good afternoon.

LYNN RAPSILBER: Good afternoon. Senator Gerratana, Representative Johnson, and members of the Public Health Committee, my name is Lynn Rapsilber and I am an APRN. I am also the chair of the Coalition for Advanced Practice Nurses. I am here to support this bill 36.

Last year, 78 legislators signed onto a bill that was similar to this.

The Connecticut Advanced Practice Registered Nurse Society requested a scope review last

August.

This brought to the table over 40 individuals and organizations, both in support and opposition, to discuss the merits of the request.

These are the binders of the information that we submitted for the scope request. We discussed quality, over 40 studies demonstrating the outcomes from APRNs that we are as good or better than physicians, and many of the studies were cited in our report.

We discussed safety. There is no data to support that any harm to the public by removing the agreement was documented, and DPH agreed with us.

We discussed education. Yes, we are trained differently from physicians. APRNs are population-focused, competency-based, with a holistic approach to education and training.

APRNs are health promotion and disease prevention focused. APRNs, we have national standards of certification and education.

APRN scope of practice is defined by training specific to a very defined certification, and students' educational time is 100 percent concentrated in that clinical area.

The best test of the better education is through the outcomes data that we provided.

We also discussed cost. Data show that we can reduce cost in disease management as part of a nurse-led patient-centered medical home.

We can also document cost savings in lowering drug costs, cost per patient costs, lower visit costs, and lower costs associated with lower emergency room department referrals. And lastly,

we need to talk about access.

We discussed that there is provider shortage areas in primary care and behavioral health in all counties in Connecticut.

We take care of the most vulnerable populations; the elderly, the mentally ill, the uninsured, the underinsured, and the homeless.

APRN practices are going to close, unable to grow, and not able to open due to this mandated outdated agreement.

The issues were thoroughly discussed by the scope review process.

I refer to the document Changes in Healthcare Profession Scope of Practice Legislative Consideration.

In a collaborative effort of six healthcare regulatory organizations, including the Federation of State Medical Boards, which, quote, states that healthcare education and practice has evolved where most professions share skills or procedures with other professions.

It is no longer reasonable to expect that each profession can have a completely unique scope of practice exclusive of all others.

The question that the health profession must answer today is whether the profession can provide this service in a state in an effective manner.

If an issue cannot address this concern, it has no relevance to the discussion, quote.

That is the essence of the scope review and that question has been answered with an abundance of

data.

And we support this bill. We hope that Connecticut will be in line with other New England states for APRN practice.

This bill does not grant APRNs any new authority and will remove the barriers that prevent practices from opening and prevent practices from closing.

Thank you.

SENATOR GERRATANA: Thank you, Lynn.

Lynn, what other states in our region have independent practice of APRNs?

LYNN RAPSILBER: Rhode Island, Maine, Vermont, New Hampshire.

SENATOR GERRATANA: Thank you. Now, I have been looking at Oregon and Colorado and their statutes. It seems as though, with the practice of independent APRNs, that in their nurse practice act, they actually specify the different specialties, such as midwife.

I'm looking at Colorado right now and they have a variety of descriptions and also designations according to the specialty and the profession and the work that the APRN does.

It also looks like they have their own board and that board certifies that they are -- have gone through specialized training in these particular areas, and they name the organizations around the country that do that kind of training.

I'm sorry. I can't pull it up right now. I'm all over the place here. But, you know, basically, they do name the accredited entities

that do the specialized training.

Once the nurse goes through the APRN courses and that specialized training, then she or he is designated, for instance, as a -- an APRN midwife, for instance.

And that's not what our statutes do. I'd like you to comment on that.

LYNN RAPSILBER: Actually, you are talking about certification and education. And actually, there is somebody who is going to be testifying extensively on that question. So I'll defer to her.

SENATOR GERRATANA: Thank you. Thank you very much. I appreciate that.

Does anyone have any questions or -- Representative Zoni.

REP. ZONI: Typically, when an APRN signs a collaborative agreement with a physician, is it - - is it just an agreement that we will collaborate together? Or is there a financial component to this collaborative agreement, much like a contract?

LYNN RAPSILBER: What we presented in our scope review process is that there has been some financial ties to signing the new agreement for certain APRNs. That has been discussed and has been presented in the scope review.

REP. ZONI: Do you know what percentage of APRNs have a financial agreement as a result of their collaborative agreements?

LYNN RAPSILBER: It's hard to know that. I don't have the answer for that. All I know is the folks that did come forward and talk about what their

relationships were, that there were several that said they did have to pay for collaboration.

REP. ZONI: Thank you very much.

SENATOR GERRATANA: Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madame Chair.

Thank you very much for your testimony this afternoon.

A couple of questions for you. The -- Dr. Wolfson talked about the years of training to become an independent person going out and real life and taking care of patients, which is what you do and which is what we all do as physicians as well.

My question is that, I mean, if you look at the training for -- to become an internal medicine. We're not talking about a cardiologist or a super specialist.

If 11 years for training from high school; four years undergrad, four years of medical school, and then, on an average, minimum average is three years of residency, and by and large, it is typically nowadays is four, but in my days, it was only three.

So in 11 years, I -- I am out there trained, qualified for the appropriate certification, passing the exams, and so on and so forth. Could you tell me for an APRN, what is the number of years of training? And my concern is to match up and be, you know, be out there taking care of patients, which I know you all do extremely well. I have an APRN in my practice. We -- we work famously well together.

And my concern is that -- the three years is a

concern to me. You know, three years of collaboration, because it doesn't match up to the 11 years of training to be an independent provider.

Because now, in the presence system, you are always in a collaboration, which is a different story. But if you want to be an independent provider, which is, I know, the goal of this bill, is the three years of the collaborative agreement.

Could you comment on that?

LYNN RAPSILBER: First of all, I wanted to address your issue of independent.

I am fully licensed to take care of my patients. I am an independent provider of care right now for my patients.

The collaborative agreement doesn't guarantee that I am going to collaborate with my physician. I may collaborate with somebody else of the healthcare team. It might be a cardiologist, it might be a nutritionist.

So I am also totally responsible for my patient care, every aspect of it.

With regards to your question on education and the requirement, again, I want to defer you to somebody that's going to be coming up and specifically focusing on education because I'm sure there is going to be more questions besides that that she can answer for you.

REP. SRINIVASAN: Thank you very much and I look forward to the person coming after you to address that issue.

And my question, I'm not sure if it's your other

person or somebody else coming after you, is to talk about give -- give us -- give the Committee kind of an oversight of what the -- the coverage would be in this independent practice, non-collaborative practice, past 5 o'clock on a Friday, 5, 6 o'clock on a regular weekday, and if you could tell us how that could work. Thank you.

LYNN RAPSILBER: My personal opinion is that I am in a specialty practice, so I don't have to have anybody cover the physicians that I work with to cover that group. If a nurse practitioner has their own practice, they would have to seek coverage for that window of time, and whatever that would be.

And I do know that somebody coming up also can answer that question for you who has their own primary practice.

REP. SRINIVASAN: Thank you very much. Thank you, Madame Chair.

SENATOR GERRATANA: Oh, okay. Okay. Representative Conroy again.

REP. CONROY: Thank you, Madame Chair.

I -- this is a first time on this one.

SENATOR GERRATANA: Yes. So thank you. Absolutely.

REP. CONROY: Thank you, Lynn, for coming today.

You were a part of the scope of practice review?

LYNN RAPSILBER: Yes, I was.

REP. CONROY: How many meetings were there for the scope review?

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LYNN RAPSILBER: We had five meetings altogether.

REP. CONROY: Five meetings. And were you at all of them?

LYNN RAPSILBER: I was at every one.

REP. CONROY: Thank you. Because I know we're getting, you know, some -- the medical side is having some concerns and I -- I just asked earlier if they were there because it's concerning that we're getting questions now at this junction of where this bill is after going through a scope of practice.

Were they -- there -- they were there at all the meetings also?

LYNN RAPSILBER: The physicians present in the room were specialty representatives from ears, nose, and throat, otolaryngology. There was eye and urology, were represented. Oh, and psych. Yeah.

REP. CONROY: Thank you.

Another question is what evaluation process that's in place now? We keep hearing now with this -- this new format of bill that there's going to be an evaluation process of three years.

Is there an evaluation process currently with the collaborative agreement?

LYNN RAPSILBER: No.

REP. CONROY: So there is nothing going on?

LYNN RAPSILBER: No evaluation process. We just have to be in possession of the agreement.

REP. CONROY: All right. And I'm not sure if this is for you, because I know you were talking about

the testing and recertification. But can you -- or unless there's someone else.

The recertification process for nurse practitioners, can you tell us how that goes?

LYNN RAPSILBER: I actually just recertified and I am an adult nurse practitioner. My requirements are for five years, I have to have 150 continuing education units.

That can be all continuing education, or I can do 75 continuing education units and 75 from other areas.

I actually, in my recertification, did 275 continuing education units in five years. I precepted 180 hours of my APRN student colleagues. I presented at over 20 conferences. I wrote an article for the clinical advisor on hepatitis C. And I also wrote a chapter in a book on coding and reimbursement.

So that was my five years of recertification requirements that I submitted.

REP. CONROY: And you also have to have your APRN license? And in Connecticut, an RN license also? Two licenses?

LYNN RAPSILBER: Yes. We have to possess both licenses.

REP. CONROY: How about other licensing do the State - - is there anything other --

LYNN RAPSILBER: We have to do a controlled substance license as well and we have to possess the DEA for prescribing.

REP. CONROY: So there -- there's several pieces of documents for credentialing?

LYNN RAPSILBER: Right.

REP. CONROY: All right. Thank you. Thank you very much. Thank you, Madame Chair.

SENATOR GERRATANA: Absolutely. Did you -- Representative Johnson, did you have any questions?

REP. JOHNSON: No. No.

SENATOR GERRATANA: Okay. Thank you so much for coming today and testifying.

LYNN RAPSILBER: Thank you. I appreciate it.

SENATOR GERRATANA: Next is Sheryl Marinone, followed by Mary Jane Williams.

Good afternoon.

SHERYL MARINONE: Good afternoon, Senator Gerrantana, Representative Johnson, and members of the Committee.

I am Sheri Marinone. I am an APRN and I am support of Bill 36.

I am in private practice. I have been APRN for over 17 years and I have been in my private practice for over 12 years. I do have a collaborative agreement, but I collaborate with many physicians that I deem appropriate for my patients as -- as their problems come up throughout the course of the day.

As far as this collaborative agreement goes, the healthcare culture has changed substantially over the 12 years that I have been practicing. It was pretty easy to get a collaborative agreement back 12 years ago.

My first one had left the state to practice in California, so I had to get another one, and that seemed to be pretty seamless. But as he was aging, I was getting concerned about him retiring, which I don't think he's ever going to do. But I needed to be mindful of that.

So I went in search of another collaborative agreement a couple of years ago, and that took 18 months to do. It took 18 months, and during that time I had gone to several other physicians that I collaborate with all the time and respect and respect me also.

And the answers that I got is that there are -- they had asked their liability carriers, insurance carriers, and they said that the liability was too high and they had recommended that they don't do it.

They had asked their attorneys, and their attorneys had recommended that the liability is too high and they recommended that we don't do it. One unfortunately was killed in a car accident, and that could happen at any time in my practice, is those things happen. They could -- we had lost a physician a few years ago to breast cancer and she would have been another one I was going to ask. So I could be without a collaborative physician just like that.

In the meantime, I did ask one. He had asked for \$10,000 a year. I can't afford that. I was lucky to get one without asking for any stipend. She's great and we do have a year-by-year contract. Our contract will be up in May. She will probably resign, but she doesn't have to. She could say she doesn't want to and I would be back searching again.

And as you can see from now to May doesn't

constitute 18 months. So I could be in a big -- big problem. It could leave me in a huge problem in not having a collaborative agreement and having to close my practice, but also having not given my patients 120 days to establish care, which is also illegal to do.

SENATOR GERRATANA: Thank you so much. Could you please summarize for us?

SHERYL MARIONE: That's the summary. I did want to mention Dr., I believe it was Saffir, had mentioned something about liability insurance. And we are -- we have the same liability.

SENATOR GERRATANA: You're required.

SHERYL MARIONE: Yeah.

SENATOR GERRATANA: I know. I did that law.

SHERYL MARIONE: All right.

SENATOR GERRATANA: I'm well aware. Good. Yes.

Representative Johnson actually has a question for you.

REP. JOHNSON: Thank you, Madame Chair.

Thank you for your testimony today.

You said that you are in private practice. I was wondering, do you specialize in a particular area? In what type of a practice is it? If you wouldn't mind sharing that with us.

SHERYL MARIONE: Okay. I am Board certified as a family nurse practitioner, but because I went into private practice, I don't see anyone under the age of 18 just because it was just too complicated being by myself.

I can't secure other nurse practitioners because they can't get a physician to sign to go in practice with me. So the coverage gets a little more difficult.

I have an agreement with my collaborative physician that we cover each other when we're off so that we do get that time off.

But all of, my -- all of my patients, even though I'm not necessarily a specialist, they all manage their -- they all keep their primary care providers, and that's one of the rules that I have with that.

And that's the other reason I want a nurse practitioner in my practice to do the primary care piece so that we can all be working together.

REP. JOHNSON: So your collaborative agreements are with other family practitioners?

SHERYL MARIONE: My collaborative physician is really the family practitioner.

REP. JOHNSON: Thank you so much. Thank you so much for being here and thank you for your testimony. Thank you, Madame Chair.

SHERYL MARIONE: You're welcome.

SENATOR GERRATANA: Thank you.

Mary Jane Williams and then Pauline Consebido.

MARY JANE WILLIAMS: Good afternoon, Senator Gerrantana and Representative Johnson.

I speak -- I'm Mary Jane Williams, chair of Government Relations for the Connecticut Nurse

Association.

I have practiced nursing in the State actively for 49 years, did critical care nursing for 32 years, and now my arena is practice of policy.

In 1997, 1998, 1999, I was the nurse that was relegated to sit at the table and write the compromise language with the Medical Society for the previous Nurse Practice Act.

It was the consensus at that meeting that this -- this would move to independent practice within five years.

Since 1999, when the legislation became law, the environment for change has become oppressive while the need for qualified primary providers has increased ten-fold.

I am going to jump to the end of my testimony because I think this is a question that we need to answer.

The scope of practice for physicians, APRNs, physicians' assistants, and others is controversial to say the least.

In all groups, a question arises. where will the expansion of scope of practice stop or will all groups eventually want to do all things?

There is actually a scientific methodology to the evolution of professional scope of practice. When a new skill, technique, or intervention is first contemplated, it must always come to us through human subject research.

From that point, if it is safe for the public and produces the desired outcomes, it becomes a research innovation.

When that occurs, a wired group begins to learn about it and how to participate with it to the benefit of the patient. Then, it becomes taught formally to a much wider group and is considered to be an emerging practice.

Boards of nursing, as in the case with other boards, receive requests to consider whether or not the professionals they regulate can perform the new skill, technique, or intervention within their scope of practice.

The group at the National Council State Board of Nursing refers -- reviews all emerging practices and assembles an expert panel to create guidance around it. Then, it is disseminated to the surrounding boards.

Once incorporated into professional scope, outcome measures are the feedback loop. The practice is stable and safe and produces a desired result.

The idea is that a thoughtful progress always includes public protections, just as graduate education for APRNs is a progression of professional standards, inclusion, and required clinical hours and the master's essentials are maintained.

A certification and a professional of job analysis to experts who write the tests and tests the APRNS to make sure that they are competent and have a competency actually necessary to practice.

And I have one other comment. When I started practicing in 1964, the practice of nursing has changed dramatically since then.

And nurses, if they continue to practice, all have to participate in continuing education.

They have to do on the job training. They have to be involved so that their practice stay current, or they would become unsafe practitioner and we would have untoward outcomes.

And when I did my master's, my second master's, at the University of Connecticut in cardiovascular nursing, in order to become competent and to practice cardiovascular nursing, I actually was mentored by one of Dr. Wolfson's colleagues and partners in his practice until I was competent to do a cardiovascular assessment.

I didn't get paid for it. He didn't get paid for it. But we worked together as colleagues in a profession.

And so, I urge you to support this Senate 36 to allow nurse practitioners to practice to the full extent of their education, as recommended by the accrediting agencies and the ION. Thank you.

SENATOR GERRATANA: Thank you, Mary Jane.

Mary Jane, I do have a question. Are there currently continuing education units for APRNs?

MARY JANE WILLIAMS: Absolutely. Nurse practitioners have to -- have to be involved in ongoing continuing education and clinical hours, which they have to provide to their accrediting agency in order to be recertified.

An APRN cannot carry a license in the State of Connecticut unless they are certified by their certifying agencies. And those agencies, although not clearly delineated, are clearly -- are -- are well known to all of the (inaudible).

SENATOR GERRATANA: Right. I've been reading the Colorado statutes and I know they delineate in the statute -- well, I like their set up as a

nurse practice act and they also delineate the hours of education that an APRN would need in certain specialties and so forth.

I don't think we have anything like that in our statute.

MARY JANE WILLIAMS: We -- and I know that one of my colleagues who is coming is going to speak to that.

That is part of the -- a new program that is being set up by the National State Board of Nurse Examiners and it's a -- a compact. And they would like to see all states eventually move to that, but we have many issues to deal with here at another level before we can move to that level.

SENATOR GERRATANA: Right. It would be helpful, I think, for the Committee members to understand that when there is that accreditation, the education, accreditation, and whatever other certification, whatever sort of validation, if you will, and proof, that the work has been done. That when we cite in our statutes, which are very lean and thin, if you will, there's not a lot of, you know, we -- we say it pretty straight out.

There's not a lot of what I'd call the feely touchy stuff in our statutes. And it would be helpful if perhaps you could provide to Committee members what that means in terms of education.

I made an enquiry to find out if there are any, excuse me, regulations that were adopted to our Practice Act. There is not, at least for APRNs.

So it would be helpful if we could look at and see what it means if you are certified, if you are given the APRN designation, through what authority, and how that is done.

So I'm going to the nuts and bolts of becoming an APRN.

MARY JANE WILLIAMS: I -- I think that we can provide that. I'm sure that can be provided.

SENATOR GERRATANA: Thank you.

MARY JANE WILLIAMS: And I will -- I will say this. When we did the last scope of practice related to APRNs, they -- we cleaned up with that. Everybody seemed to have a master's degree.

SENATOR GERRATANA: Right.

MARY JANE WILLIAMS: Appropriate certifying agency and it is a global, but I think we can give you the specifics without a --

SENATOR GERRATANA: Thank you. Thank you very much. Does anyone else have any questions or comments?

Senator -- well, Senator Musto, and then Representative Srinivasan.

SENATOR MUSTO: Thank you, Madame Chair. Regarding the scope of practice and I'm just not as familiar, obviously, as you are. That's why you're here and I'm over here.

So I'd like to ask you, there is clearly certain things that when the bill passes or not, physicians would be able to do that APRNs would not.

And I'm sure that that's also current, because, really what the bill does is mostly, as I see it -- let me -- well, let me ask you that first.

Other than removing the collaborative part of it, or reducing it to three years, I should say, what

-- is there some other part of the bill we should be talking about or is that really the thrust of the bill?

MARY JANE WILLIAMS: This bill only deals with removal of the written agreement. It will absolutely not affect a nurse practitioner's collaborative endeavors.

We all -- I'm an RN. I am not an APRN. But I collaborate with physicians all the time.

If someone calls me, I will make a -- and I'll tell them. I think you need to, you know, referral, and I give them three physicians.. I never say one, because that's what we do.

APRNs, if they have a question or an issue, are going to appropriately collaborate with the expert in their field to get the knowledge and the validation that they need for a diagnosis that they're making before they start a treatment plan.

And I believe that during the scope review, which I sat at the table for, there was literature that was brought forward that demonstrated that nurse practitioners make referrals for consultation.

And some people thought that they need too many referrals, but I ensure and think that it's always better to make more referrals than less referrals, because you're acknowledging that you question this and you want it validated.

So the written agreement is not going to change practice. It's just going to allow nurse practitioners to practice to the full extent of what they are educated for, understanding that a nurse practitioner can only practice in their specific specialty area.

So as Lynn Rapsilber said, she is an adult nurse practitioner with a specialty. That is her practice area.

So -- and that's what we're certified for. When we certify nurses, we only certify them for a specialty or an -- an age group within that -- within that specialty.

So a pediatric nurse practitioner can only take care of pediatric clients.

SENATOR MUSTO: I am not sure. That doesn't change under the bill.

MARY JANE WILLIAMS: That will not change.

SENATOR MUSTO: Okay. So -- and you -- right now, there's a requirement that there be a collaboration.

MARY JANE WILLIAMS: A written collaborative agreement.

SENATOR MUSTO: Okay.

MARY JANE WILLIAMS: Not a -- you don't -- can't mandate collaboration.

Actually, I pulled out a couple of things because I did education for a few years.

We have -- the American Nurse Association has a code of ethics for nursing and I also have a publication called Social Policy Statement, which mandates all nurses, as part of their professional responsibilities, to collaborate and ethically to seek other opinions.

And that's part of how we are educated in our -- our professional education.

SENATOR MUSTO: I'm not sure I'm -- I'm looking at the bill and I'm not sure I'm finding -- could you point me to the part about the written collaboration?

It -- it -- current law says the advanced practice registered nurse performs acts of diagnosing, treatment, of alterations in health status, as described in section A, and shall collaborate with the physician licensed to practice medicine in this state.

It -- it says you shall collaborate with the physician licensed to practice.

MARY JANE WILLIAMS: Right. Right.

SENATOR MUSTO: So this bill would change that so that the -- the collaboration requirement would only be three years. Am I missing something there?

MARY JANE WILLIAMS: The collaborative would only be three years. Yes. You're not missing anything.

SENATOR MUSTO: Okay. So, I mean, whether it's written or not, I assume, in most instances, it is, because --

MARY JANE WILLIAMS: Yes.

SENATOR MUSTO: -- you want to know what you're -- what the terms of your agreement are.

MARY JANE WILLIAMS: Currently --

SENATOR MUSTO: Currently.

MARY JANE WILLIAMS: -- as written, because that's the requirement of the law.

SENATOR MUSTO: Okay. I'll take your word for it, rather than trying to read this whole thing.

But collaboration is required right --

MARY JANE WILLIAMS: Yes.

SENATOR MUSTO: -- on a permanent basis.

MARY JANE WILLIAMS: Yes.

SENATOR MUSTO: Okay. And this would -- that is the main thrust of this bill, is to remove the requirement of collaboration. Not just the writing, but any --

MARY JANE WILLIAMS: No. It's just to remove the agreement. Collaboration is what we do. We collaborate.

Like, you collaborate with your colleagues. You might ask Representative Conley to explain something to you. You don't have to have an agreement to do that. You do that because that's part of how you -- you work professionally.

You're a lawyer. If you have a question related to law that you're not an expert in, you would seek out the expert in that -- that lawyer so that you could bounce those things off of that lawyer.

That's collaboration.

The agreement is -- is a -- a mechanism that was utilized back in 1998 and 1999 to move from under direction, and it was too much of a leap at that time for anybody to go from under direction to independence.

So we went with a written collaborative agreement with the -- the impetus to move to independence after five years, and it's been 14.

SENATOR MUSTO: Okay. All right. Thank you, Madame Chair.

REP. JOHNSON: Thank you, Senator Musto.

I have a question, and that is -- so you -- you drew a comparison to what lawyers do.

Lawyers have a requirement in the law, an ethical requirement, which is law; it's written into law, that if they are unfamiliar with a particular area that they're going to work in, that they become informed, whether it's true taking additional courses or through a collaboration.

But that -- that's -- so what would you recommend to do something similarly in this circumstance?

There's nothing in the law that does that here.

MARY JANE WILLIAMS: Well, that's general law, if you're doing general law. But I just said before, and -- and maybe that wasn't the perfect analogy.

But a nurse is only -- who is certified as an APRN can only practice in their specialty area.

So the question that they would have would be related to their specialty area. They would seek out somebody in their specialty area for that validation and they are getting continuing education and recertification in their specialty area.

So it's actually covered, it's implicit in the educational process and the certification process. So it's already implicit in what is written.

REP. JOHNSON: But it's not so stated in the law anywhere.

MARY JANE WILLIAMS: You're required to be certified, to be licensed. In order to be certified, you have to meet certain competencies and educational requirements, and that's -- that's implicit.

And so, I think to what Senator Gerratana said, we will provide the Committee with all of that information so you know exactly what is being taught, what is being examined, and what people are certified for so we can make it more implicit for you as a reader.

REP. JOHNSON: I'd prefer it to be explicit.

MARY JANE WILLIAMS: Explicit. Okay. More explicit. Not if I can help it.

REP. JOHNSON: Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madame Chair. Thank you very much for your testimony. You are extremely eloquent and you bring years of experience at -- for the (inaudible).

MARY JANE WILLIAMS: Thank you.

REP. SRINIVASAN: A few years of experience in the -- and you have seen medicine through different landscapes.

I would like you to comment on where we are today, in 2013 -- 2014, where independent private practices for physicians, or one-man or a one-woman practice, two-person practice, it's practically a thing of the past and more and more, the physicians, for multiple reasons, you know, are actually becoming a part of a hospital system.

You know, the hospitals are acquiring them. They work for a hospital. They are -- they are

forming groups by themselves so that they are efficient, mainly part sufficient by the number of people that work in that particular practice.

Given that the landscape that's happening here, in the physician community, I'm kind of surprised that the APRN community is ready to go out on their own and just put up, you know these, you know, private practices, one-person, two-person, whatever the practices are, because our experience in that world is that world as -- is -- is way behind us and group practices, hospital practices, is what the wave is in -- in the -- in the years to come.

Could you comment on the disparity between the two sets of practices?

MARY JANE WILLIAMS: I will say this. I -- I think that people assume that when you remove this written collaborative agreement, that nurse practitioners are going to run out and start their own practices.

And I don't really -- and I only -- this is hypothetical. I don't think that that's what is going to happen.

But I think what it does is it -- it allows nurse practitioners, whether they are -- no matter what practice setting they're in, to work at a -- in a collegial, equal relation with the other individuals that they practice with. And it becomes truly, then a collaborative practice.

I just think that you -- you hear some people who in independent practice, and I know Sheryl Marinone has an site practice that's independent, but she is not -- it's -- that's not the norm.

I don't -- and I don't picture that nurse practitioners who are in physicians' offices are

also going to run out and start their own practices.

But I -- I think it becomes just of equal field at that point, where we're recognized for our ability and our capability. And one of the things that I've always felt that the nursing profession has not done is they have not, as a profession, been recognized for what they bring to the table as -- as a healthcare provider. And -- and that's our fault.

Individual nurses are recognized for their abilities, for their competence, for the knowledge that they have. But as a group, that's not so.

And the -- the essence of it is, if you walk into a provider setting today, it's the nurses who are there 24/7 who are the ones who are dictating, you know, what is going on, and people are then providing orders for that.

So I -- I don't think you're going to see the big changes that you expect with the State of Connecticut.

REP. SRINIVASAN: Thank you very much. And I fully agree with you on that, that I don't think, as you correctly said, that APRNs who are working in physicians' offices, you know, in a very congenial manner, and are not the ones that just want to get out of there.

But in a good relationship, have no plans at all of moving on regardless the status of Senate Bill 36.

I, myself, have an APRN working with me. We have a fabulous relationship and last year I asked her, hey, by the way, if this becomes law, what do you think you're going to do?

She said no. I'm not going to do anything. I'm going to stay where I am because we have a wonderful relationship. And that's what life is all about.

I definitely agree with you on that.

MARY JANE WILLIAMS: That's great.

REP. SRINIVASAN: If you can just ask one more question, and you brought up this very important point, and it has been said in the media, said by, you know, a lot of people, that when the care is designated to an APRN, the cost of medicine, the cost of program medicine, will go down because, obviously, we know the reimbursement rates are different for a physician as compared to an APRN.

And that is the general myth, or just a general fact, that is being -- that's being talked about.

And you raised a very important point, and which is our -- our concern in the medical community, is that it is just the opposite is going to happen.

Because dependency, when you're on on your own and don't have that collaborative agreement of somebody sitting next to you. Hey, what shall I do with this? Or what shall I do with that?

It will end up in a referral and that referral, whether it be a physician or a procedure, whether it be X-ray, CAT scan, blood test, whatever it is.

At the end of the day, it would be very interesting for us to see that -- has the cost of medicine actually gone down because we have people that are providing these services, quote unquote, at a lower cost to begin with. But when

you add it all up, from A to Z, is it as cost efficient as we think it will be?

What is your comment and take on that?

REP. JOHNSON: Well, I think there will be some cost savings, and the reason I think that is because nursing practice looks at the -- we look at the holistic individual. We look at the total person and we are geared at preventive health and education.

And so, when -- when we see clients, and -- and I have actually APRNs come to me and tell me that they've left their jobs because they've been told they have to see a patient every 15 minutes or every ten minutes, and if they don't do that, they're either going to have their salaries decreased, or -- or they can't practice in those settings. And so, they leave.

We are -- we are really good as nurses at educating people about how to take care of themselves and how to become more and how to adapt to their healthcare regime.

And so we -- I see that that decreases recidivism into hospitals. It gives you better management of things like congestive heart failure, with patients who have multisystem failures.

And so I think if we collect the data, that we're going to find that there will be cost savings when you have nurse practitioners providing care in collaboration with other healthcare providers, just because of the body of knowledge that we bring to that setting as -- as people who provide total care to the clients.

And I can say from my own personal experience, I had a very ill father who was a multisystem failure. I had wonderful physicians that I

worked with, but my father only went to the hospital when he needed open heart surgery and when he needed carotid endarterectomy. And the nurses would say to him, well, how you haven't been in the hospital? He said, I have my daughter.

And he never, I mean, he -- if he went into congestive failure, I went to the house. I took care of him.

It saves the healthcare -- when you have nurses at that level managing -- the case management is, you know, one of the best things that we can do for patients, you know these patients really well, and you know how to prevent all of these incidents where people keep running into urgent care centers or emergency rooms.

REP. SRINIVASAN: Thank you very much. Your -- your father is a very fortunate man.

MARY JANE WILLIAMS: Yes, he was. Thank you.

REP. SRINIVASAN: Thank you, Madame Chair.

SENATOR GERRATANA: Representative Maroney.

REP. MARONEY: Thank you very much for taking the time to come here and testify today.

I have a -- a question again back to the -- to the CMEs, or the continuing medical education.

MARY JANE WILLIAMS: Right.

REP. MARONEY: I understand that, you know, to maintain your certification, you are required to have a certain number of -- of CMEs.

And it's my understanding that doctors also, you know, for their Board certification, need to

maintain a -- a certain number of CMEs.

However, we also do codify the CMEs for doctors. So is there any reason not to treat it the -- the same, to -- to codify the CMEs for nurse practitioners?

MARY JANE WILLIAMS: I don't see why there isn't (inaudible). And they do. My -- one of my colleagues behind me was saying we do it.

REP. MARONEY: No. I understand. But if you're --

REP. JOHNSON: Oh, please. You're going to have to -- excuse me. You really have to -- have to come to forefront here and make sure you're signed up before you give testimony.

Please continue, Representative Maroney.

MARY JANE WILLIAMS: So I think that that's -- that's not a problem.

REP. MARONEY: Okay.

MARY JANE WILLIAMS: That would work.

REP. MARONEY: Thank you.

MARY JANE WILLIAMS: You're welcome.

REP. JOHNSON: Thank you so much for your most excellent testimony and your willingness to work with us. We so much appreciate it very much.

MARY JANE WILLIAMS: Thank you.

REP. JOHNSON: The next speaker we have signed up is Mary Jane Williams followed by Pauline Consebido.

That was Mary Jane Williams. Okay. She wasn't -

- all right. Pauline Consebido. Sorry if I'm mangling your name, Pauline, and Mary Moller. And please say your name for the record.

PAULINE CONSEBIDO: Pauline Consebido.
Good afternoon, Representative Johnson, Representative Srinivasan, and members of the Public Health Committee.

Thank you for the opportunity to testify on Senate Bill Number 36, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE.

My name is Pauline Consebido. I am a certified registered nurse anesthetist, Government Relations Committee co-chair, immediate past president of the Connecticut Association of Nurse anesthetists, and a member of the APRN Scope Review Committee.

I am also a licensed advanced practice registered nurse.

I am here today on behalf of the members of the Connecticut Association of Nurse Anesthetists in support of Senate Bill Number 36.

Nurse Anesthetists, or CRNAs, are a part of Connecticut's approximately 4,000 licensed advanced practice registered nurses.

There are more than 45,000 nurse anesthetists across the United States. CRNAs have been providing anesthesia care to patients for 150 years.

We provide anesthesia in every setting in which anesthesia care is delivered, including hospitals, obstetrical units, ambulatory surgical centers, office-based settings, the U.S. military, and the Department of Veterans Affairs.

healthcare facilities.

The Connecticut Association of Nurse Anesthetists are not seeking a legislative change to our section of the statute.

Anesthesia delivery provided by nurse anesthetists serve our patients, the citizens of Connecticut, well.

At this time, Connecticut CRNAs do not experience similar concerns with access to healthcare as our APRN colleagues.

However, came in support to our fellow APRNs in their effort to increase access to quality healthcare for the citizens of Connecticut as the number of insured individuals and families is expected to increase with full implementation of the Affordable Care Act.

Educational standards for -- that APRNs must achieve ensures public safety, and this is supported by a national data.

APRNs are a part of the solution to the concern of access to healthcare.

This -- this legislation does just that, promoting greater access to quality healthcare.

I thank you for the opportunity to address the Committee regarding this important legislation.

I am happy to answer any questions you may have at this time.

REP. JOHNSON: Thank you so much for your testimony.

Are there any questions?

Thank you so much for taking the time.

Representative Maroney?

Hold on, please. Come back. We have a delayed response here.

REP. MARONEY: I'm sorry. And I apologize if this question had been asked before. I believe you said were part of the Scope of Review Committee?

PAULINE CONSEBIDO: Yes.

REP. MARONEY: Now, I know when (inaudible) the doctors who were on the Scope of Review Committee, it sounded like there were not any primary care physicians, and -- and you may not be able to answer this question for me.

But if we're looking at an access to care issue, healthcare issue, as, you know, with the Affordable Care Act, assuming more people are going down to church, more people -- I'm just wondering why they weren't included. Why it was only specialists, and that may not --

PAULINE CONSEBIDO: From my understanding, from the Scope of Review Committee process, with the Department of Public Health, the Committee Association of Nurse Anesthetists has actually been a part of it for the past few years that it's been -- that we've tried to get it picked up by the DPH to see if it can get reviewed.

But I can't answer your, I mean, from my understanding, it's open to any organization that would like to have a seat at the table to -- to voice our concerns and fact finding type of thing.

REP. MARONEY: Okay. Thank you. I was just curious.

PAULINE CONSEBIDO: Okay.

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REP. MARONEY: Thanks.

REP. JOHNSON: Thank you so much.

PAULINE CONSEBIDO: Thank you.

REP. JOHNSON: Mary Moller, followed by Jill Heidel.

Welcome and please state your name for the record.

MARY MOLLER: Hello. My name is Mary Moller and I would like to say hello to Senator Gerratana, Representative, Johnson, and members of the Committee. And thank you for hearing my testimony.

I am here in support of Senate Bill Number 36.

So to those of you who have heard previous testimony, nice to see you again. Those who are new, I'm looking forward to sharing this.

Since January of 2009, I have been director of the Psychiatric Mental Health Nurse Practitioner Specialty at the Yale University School of Nursing.

I'm dually certified as a clinical specialist in adult psychiatric mental health nursing and as a certified psychiatric rehabilitation practitioner.

From 1992 through 2008, I was the owner of the first independent APRN owned and operated rural psychiatric outpatient clinic in the United States. That clinic was in eastern Washington State.

Since 1978, Washington State has been an independent practice state for all APRNs. It was the third state to have complete autonomous

authority for APRNs.

That means there's no mandatory requirement of any kind to physician oversight or approval of our practice.

I remain licensed in that state and continue to provide care via Telehealth to those patients who could find a psychiatric provider when I left.

In that capacity, physicians and APRNs work side by side consulting and collaborating and referring to one another in a most collegial manner.

It is an equilateral, mutual understanding of each other's skill sets and knowledge base. It is not hierarchical. It is not paternalistic.

We were always collaborating and I continue to consult, collaborate, and refer to other physicians in that state in obtaining the care needed for patients that are beyond what I can provide.

When I moved here, I was literally shocked at the oppressive nature of APRN practice as restricted by physicians who either refuse to sign an agreement or, if they do, are restrictive in the APRN's ability to exercise their full scope of practice.

When I first came here, I was going to have a physician colleague who's licensed in Connecticut but doesn't live here be my collaborator, but he was going to charge \$6,000 because he said that is what his malpractice would go up to take me on.

It took me two years to find someone, and that only occurred because I was a local CHC and the administration worked it out with a psychiatrist

who was there four hours a month.

I met him once and never saw him again, but he signed the agreement that allowed me to practice, and that's what the agreement is. It allows us to practice.

I called him once because the psychiatrist was supposed to sign an evaluation for Medicare disability that I had conducted, completed, and filled out, and he was upset and asked me to have one of the docs at CHC do it because he didn't want to be bothered.

I collaborated daily with other physicians and providers at that clinic and certainly didn't have a practice agreement with each of them.

The mandatory collaborative agreement has nothing to do with the daily practice of collaboration, but rather with proving that an APRN can indeed practice.

I've been saddened and disheartened at the time, negative energy, and resources that have been expended to continue to prohibit independent practice for APRNs in Connecticut.

In Washington State, I developed a program that reduced psychiatric rehospitalization for patients with schizophrenia by 93.5 percent.

Those results have been published and replicated in the United States and internationally. However, I'm not in a practice situation in which I could bring those protocols to Connecticut.

We literally saved the state of Washington millions upon millions of dollars. It would be wonderful for the citizens of Connecticut to have access to that.

I would like to stress, we are not physicians and we don't want to practice medicine. If we did, we would have gone to medical school. We practice nursing, which is health promotion, disease prevention, and education to promote recovery.

Within that frame, we conduct assessments, diagnose, order and interpret tests, implement treatments, prescribe medications in a tightly regulated and monitored scope of practice based on licensure accreditation, certification, and education.

As an NP program coordinator and former president of the American Psychiatric Nurses Association, I have been in on the ground floor of the national consensus document on the regulations governing advanced practice registered nurses, which was adopted in 2008, and goes into effect January 1, 2015 across the United States.

All aspects of APRN license or accreditation certification and education are tightly regulated and monitored by numerous different national and state bodies in order to ensure standardization and consistency across and between programs, which I can elaborate upon later.

As an educator, I am seeing more and more of our Yale graduates leave the State to neighboring New England states that have independent practice for the APRN.

I'm concerned that, as the National Council State Boards of Nursing moves forward with the interstate compact for APRNs, that Connecticut will be excluded from participating due to the restrictions of the current physician approval form.

I'm asking you to help us bring Connecticut into

the 21st century and to recognize that NP status means a new paradigm in access to healthcare in Connecticut.

Thank you.

REP. JOHNSON: Thank you so much for your testimony. That's very interesting.

Something that you raised was the consensus document that you worked on in 2008. Could you give a little bit of a discussion on that and what it means and what the implementation will be? What it will look like, rather, in 2015?

MARY MOLLER: I would be glad to.

Actually, we're going on it since 1996.

So there was a move to -- by over 70 different nursing educations, universities, all specialties, to bring consensus and consistency amongst and between programs. And we have an acronym that was developed called LACE, which stands for Licensure, Accreditation, Certification, and Education.

This document was originally put forth by the National Council of State Boards of Nursing, and then grew legs and had all these other organizations.

So what this document says is that currently, there's a number of certifications, and -- and they proliferated it as knowledge base, expanded it, and people interests grew.

So it's -- it's going to be honed in and there will be six different populations is all. And that is what the master's prepared -- excuse me, APRN will -- recertification. I'll explain those.

Post-certification, then specialization will occur. Specialization will be governed by the various professional organizations.

So for instance, the American Psychiatric Nurses Association will be establishing certifications in adult, child, adolescent, gero, substance abuse, forensics, etc.

The NAPNAP, the National Association of Pediatric Nurse Practitioners, will do the same, et cetera, et cetera, et cetera. So the six populations that an APRN will certified in, we're speaking specifically to nurse practitioners and clinical nurse specialists.

The CRNAs and certified nurse midwives are also advanced practice registered nurses, but they typically have their own practice guidelines in the State. So I'm speaking to CNSes and NPs.

So those six populations will be adult and adult-gero; family and individual across the lifespan; pediatric, and that's broken into acute and pediatric primary care; psychiatry; women's health; and gender issues, and neonatal.

So as of January 1, there will be those six population areas to which a person may be certified. All NP education across the United States is now set up for that. It was set up in 2008 to be implemented in 2015. So that has given all universities and colleges of nursing ample time to ramp up their programs and many of the old kinds of programs are closed so that we're focusing on these populations.

The regulatory body, so for licensure, that involves what's going on in your state. In Connecticut, we have to have two licenses, our RN and our APRN. It's the same thing I carry in

Washington State. I have an RN and an APRN. We answer to the State Board of Nursing in Washington and here in Connecticut.

The American Nurses Association establishes scope and standards of practice for registered nurses and for APRNs. Each of the specialty organizations then establish a subset of scope and standards, which we are legally held to in a court of law.

I do periodic legal review and that's what we always look at. So the American Psychiatric Nurses Association has established scope and standards for psychiatric RNs and psychiatric APRNs. All of the other specialties have done the same thing.

The National Organization of Nurse Practitioner faculty, NONP, establishes competencies for populations. They have revised all the population competencies and they are -- they're numerous.

We submitted all of these regulatory guidelines in scope of practice review, the process of which I was a part. The American Association of Colleges of Nursing have a certification, a credentialing board that accredits universities and programs of nursing.

So Yale, for instance, we're accredited by CCNE. That is the Commission on Collegiate Nursing Education. That's the certification accreditation arm of the American Association of Colleges and Nursing.

They ensure that we, indeed, follow the competencies established by the National Organization of Nurse Practitioner faculty.

Then, the National Organization of Nurse

Practitioner faculty is collaborating with all of the specialties to make sure the competencies are sound, current, and up to date, and they're continually under review.

So then, the specialty organizations, as I said, establish specialty criteria. So those are our major regulatory bodies that govern our practice; very tightly regulated. We have to answer all kinds of people.

REP. JOHNSON: Very, very good. That's really good information for us to have and I think it will really help us with our process.

MARY MOLLER: Good.

REP. JOHNSON: Are there any questions?
Representative Cook.

REP. COOK: Mary, thank you much for your very informative testimony.

As we sit here, and obviously, this isn't the first time that we've discussed this very topic in the legislative body, but part of my question, and you were touching on education and -- and the process and I look at your testimony.

You have all these cute little, you know, letters behind your name, which goes to show me that you are a very well educated individual.

What is the difference between the education that you have received and the education that a regular physician would have received?

Can you give me the difference, please?

MARY MOLLER: Yes. We're -- my -- I have a bachelor's degree in nursing, a BSN, so four-year college education for that.

And then, I had a -- I have a master's degree in psychiatric mental health nursing with a minor in nursing administration from the University of Nebraska Medical Center (inaudible) nursing, where I was living at the time.

And that was a three-year program and after that, in order to be certified, I had to have 1,000 supervised hours, and then I was able to sit for certification.

As -- and we didn't have as many clinical hours in the programs then. That was done post-master's.

As the evolution of education and certification has occurred, we've built those hours now into the master's programs so that certification can occur immediately upon graduation and not have to wait for long.

And then, I have a doctorate in nursing practice in clinical leadership from Case Western Reserve University. And then, I -- those are -- my others are my certifications, and then the -- I'm a fellow in the American Academy of Nursing.

REP. COOK: So to compare your certifications, all of them, to a -- a doctor who is going to become certified to be a doctor, if you will, what are -- where is the -- where is the difference in the years of residency or education as whole? What is the difference for you to them?

MARY MOLLER: Well, physicians are -- they have medical school and then they have their residency in whatever is going to be their specialty. So that's what a physician does.

An APRN has exactly what I just explained earlier. So we have our trajectory, but it's a

very narrow scope. So in my understanding, a physician can graduate from medical school and hang out a shingle and practice and an RN can do that.

An APRN would have -- we have this very tightly -
- tight scope. So all of my education was in psychiatry so that -- and if somebody's a pediatric NP, it's all focused in your population of choice.

So it's -- it's a very -- it's very compressed.

REP. COOK: Thank you. I'm a mother of a psychiatric nurse and so I appreciate what you're doing, and thank you for the clarification.

MARY MOLLER: You're welcome.

REP. JOHNSON: Thank you. Any additional questions?
Oh, Representative Conroy.

REP. CONROY: Thank you, Madame Chair.

REP. JOHNSON: And followed by Representative --

REP. CONROY: And thank you for your testimony.

I -- you teach at Yale?

MARY MOLLER: I do.

REP. CONROY: Okay. That's one -- how would you rate that program to other programs throughout the United States? I'm sure it's got to be right up there.

MARY MOLLER: Our program is -- is tied for number one with UCSF. We each go back and forth between the two.

REP. CONROY: And how long have you been teaching for

them?

MARY MOLLER: I've been at Yale since January 2009.

REP. CONROY: Okay. Thank you.

I know you're testifying earlier than some of the other testifiers that will be coming later.

So I reviewed all the written testimony. I just have a couple of questions on some testifiers that might come up later and I'm reading their testimony. I think you might be the one that might be able to answer it.

The Connecticut State Medical Society has submitted some testimony here saying that they're looking at how child psychiatrists and APRNs prescribe for children with mental illness.

And they're finding -- they're doing a study right now and don't have the data for it, but they're showing that the nurse practitioners are prescribing more medications that have more side effects than physicians.

Do you have any information on that or are you aware of this study that's being done?

MARY MOLLER: That -- that's -- that's pretty strange, because we prescribe out of the same medication formularies.

So, I mean, a medication, if they have a side effect, for a physician to prescribe it, it's going to be side effect for an APRN to prescribe it.

REP. CONROY: All right. Well, this -- that's why I just thought maybe you might be able to answer some of this. But I'll just wait to ask my questions then when they go to testify.

MARY MOLLER: Okay.

REP. CONROY: Thank you.

MARY MOLLER: Okay.

REP. CONROY: Thank you, Madame Chair.

REP. JOHNSON: Certainly. Representative Ziobron.

REP. ZIOBRON: Thank you, Madame Chair, and thank you for your testimony.

I wanted to follow up with Representative Cook. She talked -- asked you about your qualifications, and they seem to be, in a way, above and beyond.

But my question is, you know, are you an unusual example of somebody who is extremely highly educated in the APRN field? Are you an average person? Are you an above average person, based on the amount of school you've had?

And the reason I ask that is because I have -- as well as Representative Conroy, I'm reading other testimony and the testimony I'm reading is from the Connecticut Society of Eye Physicians and four other specialty practices.

And then, their testimony, their -- one of their reasons for opposing the bill is they're concerned about the amount of schooling, much to what Representative Cook was asking.

So if you explain to me, is your level of expertise, you know, where does it fall into the range? That might be helpful to me to understand. Thank you.

MARY MOLLER: I've been an APRN for 22 years, so when

I left Nebraska and moved to Washington State in 1992, I had my master's degree.

And I had taught in various schools of nursing and, you know, had worked in state hospitals and -- and communal health center.

And I was frustrated because I couldn't deliver the kind of care that I wanted to do with what I had been trained with my master's degree.

And when I learned about the Nurse Practice Act in Washington State, I went wow. I think I'll -- I'll go set up my own clinic.

I didn't know how to do that, I went to the Yellow Pages, but I just felt like this was something that I was supposed to do. The first thing I did when I moved there was talk to some other APRNs and I wanted to find a physician that had gone to either Creighton Medical Center, a college of medicine, or University of Nebraska.

Because I knew I would be needing to establish someone, first of all, who would provide the medical care for psychiatric patients, and I knew that we would have a similar philosophy, you know, being educated in the same area.

So I developed the cadre of referral sources that I was able to develop before I ever, you know, hung out the shingle. And then, you know, went over to Olympia and figured out how to get all of my provider numbers and just carved this out.

We ended up with four APRNs, child-adolescent therapists, social work. I always maintained a adjunct faculty at the Washington University. And then, we had graduate students with us.

So I -- I have a skill set, but I don't have all of the skills. So you have to find people that

you can then help get those for the patient.

REP. ZIOBRON: Yeah. I appreciate the information, but I think -- I don't think you understood my question, and maybe I didn't ask it correctly.

My question is -- is I clearly -- you have a very high level in your field. That's very clear to me. But I'd like to know what the average -- what the average APRN looks like, what the below average APRN looks like, compared to you.

I'm assuming that you're at the top of your field and I just don't want to make that assumption. So I'm hoping you can explain to me what the differences are.

I'm -- I'm assuming not every APRN has a master's degree.

SENATOR GERRATANA: If I can interject here, I think we're talking about different levels of practice or maybe specialties perhaps?

MARY MOLLER: No. You know, it's a good question. All of my extra stuff happened after I went into independent practice.

I had my master's degree and, you know, basic master's level experiences teaching and working as a clinical specialist.

So after I -- and that was in 1992. So as I encountered patients that had disorders that I wasn't confident in, I had to go get training. I found other people to refer those patients to who needed that, until I was able to establish competency in my ability.

So it's all about the continuing education, growth, and development. So the APRNs coming out now have far more background actually, coming out

now, in 2014, than I did. I got my master's in 1982, and then I went into independent practice in 1992.

So the -- it's been so revamped that much of what I had to get as continuing education is now built into the APRN education.

SENATOR GERRATANA: Helpful to me, too. Thank you very much. Senator Musto.

SENATOR MUSTO: Thank you, Madame Chair. Hi.

MARY MOLLER: Hi.

SENATOR MUSTO: Good afternoon. You mentioned in your testimony that you weren't a doctor and you didn't want to be a doctor, you would have gone to medical school. Is that -- that was your, right? It's been a while.

MARY MOLLER: That I -- I'm sorry. I didn't hear you.

SENATOR MUSTO: That -- that's something you said in your testimony, that was you, correct?

MARY MOLLER: That I said? I didn't hear what you said.

SENATOR MUSTO: You didn't want -- you weren't a doctor.

MARY MOLLER: Right.

SENATOR MUSTO: Okay.

MARY MOLLER: I'm not a medical doctor.

SENATOR MUSTO: Because I think some of the things we're doing here, and it sounds like a lot of this has been done outside of this bill, is drawing lines about who, you know, scope of

practice, where one ends, where one begins, et cetera.

And what I don't know, it's not in the bill, and -- and I'm not as -- obviously as familiar with it as you are is what -- what does that really mean in -- on the ground? You know, that you're not a doctor.

What -- what are you limited from doing as an APRN that a doctor can do, especially in the area -- well, let's limit it to your area, because, you know, maybe with pediatrics or anesthesiology, you're not as familiar with that. But certainly, in the psychiatric area, it seems like that's where your expertise lies.

So what's really the difference between what you do and what a physician does? If you were independent, what could you not do, for example?

MARY MOLLER: Well, I will give you the answer that I give to patients when they ask me that question.

Okay? We -- we get asked that question a lot.

We have very overlapping scopes in the area of the ability to assess, diagnose, develop a treatment plan, order medications, and, you know, conduct the groups, provide education, that kind of thing.

What I can't do that a physician can do is I don't have admitting privileges to a hospital. I would not give electroconvulsive therapy. I would not be able to do invasive procedures.

But I can certainly assess, diagnose, order medications, monitor treatment. And that is an overlapping scope.

But I would not be able to order maybe a -- a

psychiatrist may have gotten training in endocrinology and may be able to add extra medications or extra treatment for patients that have had endocrinology disorders, for instance.

So if I had a patient that I identified through labs that needed physician care, I would refer that patient for that physician care.

I don't know if that answered your question.

SENATOR MUSTO: No. I -- I think -- I think so. So endocrinology, could you tell us, for those of us who aren't doctors, maybe --

MARY MOLLER: So for instance, like if somebody has a severe thyroid disorder. That's a very common (inaudible) in psychiatry.

I have gotten a lot of training in that I am competent and safe to handle hypothyroidism, but I would not treat hyperthyroidism that was happening.

We certainly know that (inaudible) mood disorders, bipolar disorder in particular, blood sugar for people who with diabetes, and thyroid levels for people who have thyroid disorders greatly impacts the ability to stabilize a psychiatric illness.

So I would not -- I would not manage the blood sugar for that patient with the diabetes. A physician may do that, if that was -- if they were trained to do that. They may refer that out to another specialist as well.

SENATOR MUSTO: All right. Thank you. Thank you, Madame Chair.

SENATOR GERRATANA: Thank you. Are there any other questions? If not, thank you so much for coming today and answering our questions, too, and

giving your testimony.

Next is Kathy Null, followed by Elsa Stone.

Good afternoon.

KATHY NULL: Hi. Good afternoon, Senator Gerratana and Representative Johnson and members of the Public Health Committee.

My name is Kathy Null. I'm an AARP advocacy volunteer from Bridgewater, Connecticut. I'm here in support of Senate Bill number 36 and I am also here to cover for Jill Heidel, who was originally going to speak. She had to leave for a family matter, so, as an associate of mine, I am speaking for her.

Jill is a retired RN. She's also an AARP advocacy volunteer from Bethel, Connecticut, and she served on AARP's -- as a AARP Representative on the Department of Public Health's Scope of Practice Review Committee.

AARP, as you know, is a membership organization of people 50 and older with 603,000 members in Connecticut and is pleased to have the opportunity to provide our comments.

We are committed to championing access to affordable, high quality health care for all generations, providing the tools needed to save for retirement, and serving as a reliable information source on issues critical to Americans age 50 plus.

Thus, we strongly encourage you to support Senate Bill 36. We support this bill because it will increase consumer access to healthcare and reduce unnecessary healthcare costs.

It would do this by removing outdated barriers

that prohibit advanced practice registered nurses, APRNs, from providing care to consumers to the full extent of their education and training.

These barriers often delay care to consumers, especially in rural and urban underserved areas where there is a lack of available physicians to supervise or collaborate with the APRN.

And when care is delayed, it does not only hurts consumers, it also places added stress on family caregivers, who are all too often overwhelmed with bearing the brunt of providing and overseeing the care of a loved one.

It can also add unnecessary costs by requiring payments to doctors for collaboration and take precious time away from patient care by making clinicians fill out unnecessary paperwork. Reducing barriers to full APRN practice is supported by leaders in policy and science.

A recent report from the National Governors Association titled *The Role of Nurse Practitioners in Meeting Increasing Demand For Primary Care*, documents the clear and convincing evidence that exists for nurse practitioners, which shows they provide high quality care with high patient satisfaction, and recommends that states consider removing barriers to practice for nurse practitioners, emphasizing their role in the growing demand for primary care.

This recommendation supports the 2011 Institute of Medicine evidence-based report titled *The Future of Nursing: Leading Change, Advancing Health*, which calls for changes at the state and federal levels to help increase consumer access to care by enabling APRNs to practice to the full extent of their education and training.

SENATOR GERRATANA: Ms. Null, could you please summarize? Thank you.

KATHY NULL: I just want to thank you, that we strongly feel that this support will really help people in -- in our state receive the care that they need.

As an aging population in this state, I can speak for personal concerns, and particularly living along the route seven corridor, where we have a high rural area and where there is definitely always the concern going on that we're going to lose our primary care physician.

I have to hope at the age of 68 that my physicians will outlive me. So of course, I'm always looking for good healthcare.

SENATOR GERRATANA: Thank you. And thank you for your advocacy and your testimony here today.

KATHY NULL: Thank you.

SENATOR GERRATANA: Representative Srinivasan has a question for you.

REP. SRINIVASAN: Thank you very much for coming here this afternoon. Thank you, Madame Chair.

This has been a little bit to before, and I just want to see what documentation or what report is out there, not necessarily in Connecticut, but in the other states where the cost of delivering medical care, when you compare apples and apples, where you're looking at services rendered by a primary care physician, MD, and a primary care APRN?

Do you have information, not necessarily you, but does the society --

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KATHY NULL: I'd be happy to see if we can get that information.

I have -- I would strongly suspect, since Jill did refer to these two reports, that there is that type of information in there.

REP. SRINIVASAN: Right. I do understand that. Because the -- because when I asked this question before, I was told that their approach to seeing patients is -- is a general holistic approach. They talk to patients more. They prevent their recurrence of, you know, various chronic conditions, and we understand all of that. All of that is understood.

But I want to see that in black and white, that the -- where is the report, not -- which was (inaudible) the number of states that are done, where it shows that at the end of the day, when you look at a year's report or two years' report, that the cost of delivering -- delivering medicine has actually gone down.

KATHY NULL: Okay. And I will -- I will refer that question to Jill Heidel and have her get back to you on that.

REP. SRINIVASAN: Right. If you can send that to the Committee, the Committee Chairs will then forward to all of us.

KATHY NULL: Okay.

REP. SRINIVASAN: And I appreciate that very much.

KATHY NULL: All right. Great. Thank you very much.

REP. SRINIVASAN: Thank you.

SENATOR GERRATANA: Thank you. Are there any other questions? If not, thank you very much.

Next is Elsa Stone, followed by Margaret Flinter.

ELSA STONE: Thank you, Senator Gerratana.

SENATOR GERRATANA: Good afternoon.

ELSA STONE: Good afternoon. My name is Dr. Elsa Stone. I'm a former president of the Connecticut chapter of the American Academy of Pediatrics.

I'm currently on the Board of Governors in the New Haven County Medical Association and I have been present in the medical staff and served on the board of trustees of New Haven Hospital.

But relevant to this Committee, I've also been on the board of the National Certification Board of Pediatric Nurse Practitioners. I've been a practicing pediatrician in North Haven for the past 36 years and have worked with advanced practice nurses in my practice for almost 30 years.

I speak today in opposition to Senate Bill 36. I am a strong advocate for advanced nurse practitioners working in collaboration with physicians as -- as they are required to do under the current law.

There are numerous studies that demonstrate that they can and do deliver high quality care to patients.

They are much better than many physicians in educating patients about their health problems and often spend more time with patients, resulting in greater patient satisfaction.

They can provide excellent preventative care services and manage many acute problems. However, they do not have the depth of education

and training to enable them to replace physicians without potentially jeopardizing patient care.

This shortcoming is compensated for by their working in association with other physicians. I have numerous examples from my own practice how important this collaboration is to prevent unnecessary referrals to the emergency room, for example.

As APRNs do not work independently in most states, most of the studies looking at the outcomes of nurse practitioners' care were conducted in settings where they were working shoulder to shoulder with other medical professionals.

Significant informal consultation and education occurs in those settings and is not controlled for in these studies. This bill is an act that would enable and potentially encourage APRNs to practice independently outside the settings in which they could continue to learn and collaborate with other medical practitioners.

It would do nothing to solve the anticipated shortage of primary care providers, as there are ample settings in which they can work collaboratively and have the benefit of being able to consult with a physician.

Even without this expansion of scope of practice, currently abuses are occurring under the existing system, which undermines the quality of care patients receive in Connecticut.

Retail clinics are eagerly hiring new APRN graduates to staff their clinics. The collaborating physician is available by phone somewhere in the state. The nurse practitioner is not instructed to have the patient return for follow up. There's no continuity of care.

As a practicing pediatrician, I appreciate that the patient sometimes is referred back to me, which gives me the opportunity to review their care, but it may mean a second visit for that patient.

And how does the nurse practitioner learn anything from that? Is that the quality coordinated care that we desire for our patients?

And invaluable part of medical education is following the course of an illness and seeing the results of your treatments.

Lastly, this bill runs counter to the latest developments in knowledge about the delivery of health -- of high quality patient-centered cost-effective healthcare -- healthcare teams.

Physicians, APRNs, RNs, community healthcare workers, social workers, and (inaudible) working together, capitalizing on each profession's strengths, can enhance care, reduce costs, and result in far better outcomes.

This bill would move us backwards in our quest to accessible, high quality, cost effective care.

SENATOR GERRATANA: Thank you.

ELSA STONE: One last sentence.

What we really need are greater incentives for the development of healthcare.

SENATOR GERRATANA: We -- we have your testimony in front of us, but thank you.

But I do -- I am curious. Could you explain to me, I'm -- I'm not sure what I -- that I understand your meaning -- meaning here in your

testimony.

As a practicing pediatrician, I appreciate that the patient is referred back to me for follow-up. I can try to make up for any mistakes that were made. But how does the practicing nurse -- nurse practitioner learn anything?

ELSA STONE: How does the nurse practitioner sitting in the retail clinic know anything about what she did --

SENATOR GERRATANA: Oh, I see.

ELSA STONE: -- because they never see what happens.

SENATOR GERRATANA: So you're inferring that they're employed.

ELSA STONE: Yeah. And -- and the retail clinic --

SENATOR GERRATANA: What is a retail clinic?

ELSA STONE: In a walk-in clinic.

SENATOR GERRATANA: Oh, walk-in, like urgent care or something along that line?

ELSA STONE: Yeah. You know, minute clinics or what -

SENATOR GERRATANA: Isn't that the nature, though, of an urgent care center, to -- no -- no.

ELSA STONE: But -- not. What I'm -- my -- my point is that they put inexperienced individuals in that position without having somebody on site who could help them learn.

Because the first years out of training --

SENATOR GERRATANA: I see.

ELSA STONE: You know.

SENATOR GERRATANA: Okay.

ELSA STONE: You -- what you know is what it is.

SENATOR GERRATANA: Thank you for that. Okay.
Representative Cook.

REP. COOK: Thank you, Madame Chair.

Thank you for your testimony.

You had mentioned about demonstrating the stakes or things that have happened, and you -- you've witnessed how an APRN might have made a mistake or caused some problems.

Could you explain or give some examples of what you're referring to?

ELSA STONE: Yeah. A couple of things, and I think it really just results from having more experience, seeing more things over time.

Recently, I was -- my office is next to a nurse practitioner who works with me and I was hearing her on the phone and a mother was clearly painting a portrait of a kid who was very sick and my nurse practitioner was very worried about the patient.

The mother was saying that he wasn't eating or drinking. He hadn't urinated in the last 12 hours. And my nurse practitioner got me and she said, well, I think you really ought to take him to the emergency room.

At which point, overhearing this, I -- I intervened and I said, wait a minute. Bring him in. Let's see him, you know, because I don't

ever want to send somebody to the emergency room that I don't really have a good assessment on.

And so she said -- she agreed completely and said to the mother, well, can you bring him down right now? Well, no, he's in school. You know, there's those things.

Another instance was where we had seen a kid with asthma who was borderline and he didn't clear on the first couple of treatments, but his oxygen level was fair. It wasn't great, but wasn't terrible, and they wanted to send him to the emergency room, and I said, let's hold on here. We've -- we've given him the steroids, we've given the treatment. Let's send him home for a couple hours and bring him back in and see him again so that we can do the assessment, which really would have been done similarly in the ER; see how he responds over time.

Again, they're not as versed in -- they haven't had to work in an emergency room, which is part of training we do. You can kind of see that course of these things and that happens over time and getting more and more experience.

REP. COOK: I'm not sure how that resonates with me for a couple of reasons. I mean, I think that everybody makes a mistake, regardless of the amount of training that somebody has. I mean, we hope and pray that it doesn't happen, but I do believe that there are mistakes made every day in the medical field.

ELSA STONE: Absolutely. But I'm speaking to the fact that working together helps to make sure that those mistakes don't actually impact the patient.

I'm not -- I'm not chastising her because -- for -- for that error. I think that we can all -- I think that working solo or working independently

is less good than working together, less good than being part of the team.

I think we can all put our heads together. We get great value out of that. I'm not disparaging that.

REP. COOK: I think my concern is that we have -- we have promoted primary care medical home in the State of Connecticut and have done an incredible job rolling it out over the last three-and-a-half years and I've been at the forefront of that.

So we are running into a jam to where there are not enough physicians that can care for the amount of people that we need care for.

So where do we go from here? If -- if we're afraid that people are going to make mistakes, we all have to learn by mistakes, and we hope that those mistakes are not great.

But at the same time, how do we bridge the gap of need-based in preventative care and the recidivism in a hospital and emergency room if we don't try something different? I'm just asking.

ELSA STONE: Well, I'm not sure that different would be having nurse practitioners set up practice independently. I think that's the only thing that I'm speaking to here.

I think that there really ought to be more incentives to have more patient-centered medical homes to perhaps get better -- into the rural areas where there is less penetrance.

You know, but I'm not sure that this addresses that.

REP. COOK: In the primary care medical home, we have a nurse or APRN, or whatever the title is in that

primary care office, that is the one that's on the forefront to return phone calls or try to walk -- I call it walking the parent off the cliff before they rush to the emergency room with a child who might not need to go to the emergency room.

So you're -- you're referring that -- what you had said was a parent -- that you had an APRN that was sending somebody to the emergency room and you would have left that person home for a couple of hours. Is that what I'm understanding? Part of your concern?

ELSA STONE: In -- in one -- you know, I think it hadn't occurred to the nurse practitioner to -- that it was okay to actually have the patient leave the office and come back, rather than -- because it wasn't a situation that would have to be watched to see what would evolve over time.

Having worked in a hospital, having watched patients with asthma and seeing what they do over time, I was more comfortable with doing that than I think she was. And I think that's just a matter of a different level of training.

So I think it didn't occur to her that just because this patient was borderline, it didn't mean they had to go and be observed in the ER. We could, in fact, continue to observe here, because we also happen to have a population of patients that we can keep in very close contact with and can rely on that they will be back with us.

You know, that's where the experience of a medical training, of internship and residency, really does change how you look at things.

Can nurse practitioners gain some of that over time? Of course, but it takes over time and

should not be three years of whatever this collaborative agreement is going to be. It's not that kind of time after they've had only three years of training to get that masters degree and only 500 clinical hours of seeing patients. Five hundred clinical hours compared with 9,000 hours is the difference.

REP. COOK: I recognize that. I'm just trying to figure out a way, if we're going to continue to get opposition from different people, how do we move our state into a healthier state if we continue to put the road blocks up and continue to find problems? This is what I'm trying to wrap my hand around and like I said earlier, I get that every makes --

ELSA STONE: I think we should embrace nurse practitioners, just not in independent practice, that's all.

REP. COOK: But if we don't have physician's enough to care for the people that we have, what is our solution? Regardless of independent or collaborative --

ELSA STONE: Have the nurse practitioners be working with the physicians. That could double or triple the extent of the care rendered by any given physician. Create teams, its teams that we need.

REP. COOK: Okay. Thank you. Thank you, Madame Chair.

SENATOR GERRATANA: Thank you. Representative Conroy.

REP. CONROY: Thank you, Madame Chair. Thank you for coming today. I heard you say that you had an APRN in your office. Do you have a collaborative agreement with an APRN?

ELSA STONE: I have three APRN's in my office and yes,

I have collaborative agreements with them.

REP. CONROY: Great. Can you walk us through and tell us what a collaborative -- written collaborative agreement is?

ELSA STONE: It covers what their responsibilities, what their duties are, how they will care for their patients -- basically outlines what we do. And let me say, that the nurse practitioners in my office do the very same things that I do. I have in addition to those three nurse practitioners, I have four part-time physicians who also work there and I would say we are all part of the team, we all do the same things and we all discuss our cases and share what we're doing with one another. Does that help you?

REP. CONROY: It does but then what makes that written collaborative agreement need to be in place if you say you're sharing that?

ELSA STONE: It needs to be in place because they are required to have a collaborative agreement. In point of fact, they are also my employees as are the physicians. So in that sense, there is certain control that I do have. But in terms of their independence to practice, they practice the same way I do. They have a panel of patients that are their own panel of patients and as I say, we all work together and in sharing that we all have fairly common ways of approaching problems and dealing with them and if any of us is having a problem with a case, we run it by somebody else who's in the office to try to come up with ideas of how better to handle it.

REP. CONROY: Okay. And how do you review their work? Is there an evaluation process that you have in place?

ELSA STONE: Mostly by discussing the cases with them

and by sometimes looking in the charts and seeing the patients that they -- I do periodically go through and look at the charting of the patients that they see and I also see how they handled it and what the patient's reactions are and so forth.

REP. CONROY: And how often do you look through the charts? I mean how many patients do you say review the APRN has in a month?

ELSA STONE: Maybe 10.

REP. CONROY: Maybe 10. And you give them feedback or are the charts fine, you don't find anything on there? Tell me how that process works.

ELSA STONE: Well, sometimes if I don't feel it was clear enough in how they charted something, I will ask them, you know, what really happened here because I really couldn't make it out from you note. Things like that. I might say, you know, gee why did you use that antibiotic so we can talk about what would be a choice of antibiotics. But quite frankly, I have to say, I have very experienced nurse practitioners with me and I rarely have much quarrel with anything that they do.

REP. CONROY: How many years of experience do they have, do you know?

ELSA STONE: I have one who has been working for 11 years, one who has been working for eight years and one who has been working for four years.

REP. CONROY: And do you feel that you still -- let's put it this way, you also said you employ physicians and you employ APRN's. Do you find that there's a difference between the physicians that you have to talk to about what choice for an antibiotic that you have from APRN's or is it

about the same mix?

ELSA STONE: I think it's pretty much at this point about the same mix. I think we all have questions. Part of practice is that you're practicing; you're trying to figure out the best way to do it.

REP. CONROY: Right. And I just want to speak to the other part in your written testimony. I'm just going to self-disclose that I do work in a retail clinic and I just found immensely in the state for that and I'm proud to be working there because we have quality indicators we're JCAHO accredited, we have very strict controls.

There are studies coming out showing the APRN's antibiotic usage -- we are actually down from other primary care providers because we don't go to antibiotics when patients come to us first line. We tell them you had a cold for a day -- you have the cold for a day, no you do not need the antibiotic. There's all these other things, so we talk about that holistic method. And I'm just a little concerned when you said you have to make clear from mistakes there's no quality of care of continuing of care.

Every patient that goes to these retail clinics get called back two days later to see how they're doing. Every one of them when they come in, you find out who their primary care provider is and their pediatrician. It's an electronic medical record that the doctor gets sent a report -- there's follow up plans in place.

So I just wanted to clear up that testimony that you have here because there are strict guidelines out there and there are crediting agencies looking at these. So I don't think they're going to go away and I think there's a real niche for them right now and especially when you say

they're hiring new APRN's. Yes, there are a lot of APRN's, but as an APRN when you certify, you're certifying as an entry level APRN that you have the basics.

We know with any experience as an RN they can come out of school -- we all know you learn from experience a lot of the different things. When you listen to a phone call, you have the experience behind you. Where someone else saying, well the person is having an asthma attack and having problems breathing, we don't want to mess around with that because it's a life crisis. But your experience has shown you that. I think we have to still look at entry level as being still able to provide for everyone. So I just wanted to comment on that and just clarify for others that were in the audience that there are stricter controls in place. Thank you.

SENATOR GERRATANA: Thank you, Representative.
Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madame Chair. Thank you very much for your testimony this afternoon. We heard this last year when we had a public hearing and we heard it again to some extent this year, not as much but I'm sure we will hear it later this evening, that APRN's find it extremely difficult and spend a lot of time, effort and energy, not necessarily in the urban areas, but in some of the remote areas of being able to find a collaborative physician, number one.

Number two, the charges that they've been asked to pay this physician to be a collaborative physician, not by enlarge, but there are cases after cases, are so exorbitant that they just can't afford it at all. And what we've didn't hear today so far but we heard last year quite extensively, is every time the APRN picks up the phone and talks to the collaborative doctor,

there is a charge, it's like talking to your lawyer, the clock starts to tick the moment you two connect.

So my question to you is, as a medical society, what has been done to make sure that these concerns that they have raised over and over again in terms of establishing a collaborative agreement with somebody, are met and that they're not, as we heard earlier today, 18 months it took her to get a collaborative position and now she's back in the same cycle come May as to not knowing what to do. What is the response of the medical society?

ELSA STONE: I don't think I can speak for the medical society in answering that. I think that's a really difficult problem and I can certainly appreciate the difficulties that the APRN's are experiencing. I would never consider collaborating with somebody I wasn't really working with because I think the idea is really be able to understand what's going on.

And it it's a two way street. I think that if somebody who I don't know how they're practicing calls me up, it would be an awkward situation. As I said, I really am a proponent of having or making sure there's some way of establishing practices that would have the whole team there because I think that will be best and I don't know what incentives would be most effective in accomplishing that. But I think that's the direction we need to go in rather than creating little independent silos.

REP. SRINIVASAN: Thank you. But on the same token unless we provide the APRN's the appropriate locations with the appropriate collaborations, they are -- and as you correctly said, you don't know the person, you don't know the background, you don't know how she or he practices, we all

practice medicine but we have our own style of doing things and we have fine tuned that to ourselves but with somebody else joining you in this collaborative kind of an agreement it becomes really difficult. And I can hear their concerns as to why they are finding it more and more harder to find a physician with whom they can collaborate and that's a need that we need to make sure that we address as well. I mean it's easy to say, let's continue with this collaborative agreement, I can understand your point of view being in opposition of this bill, but by the same token we do have to make sure that those needs and requirements are met as well and they are able to get a collaborative physician.

ELSA STONE: Well one of the things that when Medicaid starting reimbursing better, it went up to Medicare rates and when the DSS starting encouraging practices to become patients in the medical homes by also making the reimbursement rate, all of a sudden more physicians were doing it and so I think there are ways to kind of build in incentives. If there's a real need in an area, there ought to be ways to build in incentives that would encourage physicians to collaborate better, to expand their practices to take in a nurse practitioner. So I think those ought to be things to be looked at, because in fact, it becomes better care all around.

REP. SRINIVASAN: Thank you very much. I definitely agree as a whole team approach, it definitely is the better care. It's not the MD alone but it's the team approach, absolutely. But how to make it happen is obviously our challenge. Thank you. Thank you, Madame Chair.

SENATOR GERRATANA: Thank you, Representative. Representative Cook, you have a follow up question.

REP. COOK: I do, thank you, Madame Chair. I just have one quick question. We were discussing primary care medical homes -- can APRN's currently lead primary care homes in the State of Connecticut.

ELSA STONE: I don't have the answer to that question, but I think so. I think it doesn't -- nowhere does it say who has to be the team leader.

REP. COOK: Okay. Thank you.

SENATOR GERRATANA: Thank you so much for coming today and testifying. Thank you. Next is Margaret Flinter followed by Darren Anderson. Is Margaret here? I don't see her. Darren Anderson? That's not Darren, that's Fred. Okay. Dr. Carolyn Drazine -- oh, Drazinic, maybe? Draznic, sorry.

CAROLYN DRAZNIC: No problem. Everybody messes up my name.

SENATOR GERRATANA: They do mine too. I'm sorry. Welcome. Thank you.

CAROLYN DRAZNIC: You're welcome. Madame Chair, Senator Gerratana and Representative Johnson and all the respective members of this committee. Thank you for sticking around, I really appreciate it. Good afternoon, my name is Dr. Carolyn Draznic. I am a psychiatrist and President of the Connecticut Psychiatric Society representing almost 800 psychiatrists in the State of Connecticut. I also happen to be on the APRN's scope of practice committee, so I'm the first doctor here testifying today who is on that committee and I also want to mention there was an earlier question about whether there were any primary care physicians, there was Dr. Doug Olson from the American College of Physicians who was also a member of the committee.

I'm here today to express our opposition to the section of Bill Number 36, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO ACCESS TO HEALTH CARE. That would allow APRN's to work independently without collaboration with a physician. Our opposition to this bill has nothing to do with the value of nurses at any level. Psychiatrists work with nurses in teams in many kinds of institutions and practices. In my hospital, for example, I work in a team with APRN's as well as other mental health providers every day.

Our concern is that given nurse's training and the circumstances of clinical practice today, nurse practitioners who are practicing independently in the community, is not the best model for delivering care, medically or economically. In fact, the model of independent practice is not working for many physicians any more either, given all the direction of health care today.

Over the last few years nurse practitioners have asserted that they can't get collaborative agreements with physicians. So this causes us to ask the question, if they cannot find physicians to collaborate with them, how is the situation going to be improved once the collaborative agreement law is voided? The argument that a less trained nurse practitioner can be available to see simple problems and relieve the load that physicians bear, works safely in institutions where such referrals take place down the hall from the physicians. But it doesn't work that well in the community where nurse practitioners could work in complete isolation from physicians.

Allowing nurse practitioners to practice medicine independently of physician collaborative agreements seems like an easy solution but it is

fraught with problems that will become more obvious to everyone should this legislation be implemented. Thank you for this opportunity and I'll take any questions.

SENATOR GERRATANA: Thank you also. Does anyone have any questions? No, but I appreciate you coming here today and I have made note of your name too in case we need to talk on the phone.

Over the last few years nurse practitioners have asserted that they can't get collaborative agreements with physicians. So this causes us to ask the question, if they cannot find physicians to collaborate with them, how is the situation going to be improved once the collaborative agreement law is voided? The argument that a less trained nurse practitioner can be available to see simple problems and relieve the load that physicians bear, works safely in institutions where such referrals take place down the hall from the physicians. But it doesn't work that well in the community where nurse practitioners could work in complete isolation from physicians.

Allowing nurse practitioners to practice medicine independently of physician collaborative agreements seems like an easy solution but it is fraught with problems that will become more obvious to everyone should this legislation be implemented. Thank you for this opportunity and I'll take any questions.

SENATOR GERRATANA: Thank you also. Does anyone have any questions? No, but I appreciate you coming here today and I have made note of your name too, in case we need to talk on the phone. Thanks for coming.

CAROLYN DRAZNIC: Thank you very much.

SENATOR GERRATANA: Next is Dr. Stacy Taylor, followed

by Kathy Grimmel..

STACY TAYLOR: Good afternoon.

SENATOR GERRATANA: Good afternoon.

STACY TAYLOR: My name is Stacy Taylor and I am a past President of the Connecticut Academy of Family Physicians. I have been a primary care physician in Northwest Connecticut for over 16 years. I am here today on behalf of the members of the Connecticut Academy of Family Physicians and more importantly on behalf of my patients, in opposition to Senate Bill 36.

I have taken time off from my busy practice because of my concern about the threat to public health posed by this bill. In order to better illustrate my concerns, let me tell you a little story. Put yourself in the shoes of one of my patients. You are 21 and healthy. Unfortunately, you start to not feel well. You've had a cough for months. You go to your health care provider who is attentive, caring and knowledgeable. She reassures that you have a virus that should resolve. You trust her not only because of who she is but because you assume she has the training, experience and competence to hold your life in her hands. Your symptoms however, continue. At your next appointment your tonsils are enlarged. Throat cultures are negative. Again, you are told that this is viral. Your symptoms worsen. You return to the office. Because your usual provider is not available, you see a physician who is very concerned and orders additional tests. You find out that you have leukemia.

What went wrong? Your initial provider was an APRN who did not recognize the seriousness of your symptoms. Had you realized the APRN's credentials, you may have gone to a physician

initially, however you thought she was a doctor. Her clinical training which could have been negligible but in this case was excellent, was still more than four times less than the physician that you ultimately saw. Her limited training, lacking experience with severe illness, made her unprepared to handle both the breadth and depth required in primary care. In other words she did know what she did not know.

In this case this APRN was an essential part of my health care team. Collaboration was in place, however, as in this example, it does not necessarily ensure good health care. It is informal at best. It does not have the standards of a residency training program. Her collaborating physician not having had her training, was unable to understand or fill her gaps of knowledge adequately.

This story is true and is illustrative of why Bill 36 should not be passed. For those voting in favor of this bill, would you want your care to be provided by an APRN under these circumstances? If this bill is passed, there is certain essential points. There must be truth in advertising. Patients must know that they are being treated by an APRN and not a physician. APRN's must also keep medical malpractice limits on par with that of physicians and pay a comparable licensure fee. If this bill were to pass, APRN's would be practicing medicine and not nursing, thus they should go before the board of medicine, not the board of nursing. If APRN's were to practice without collaboration of a physician, they must be required to complete continuing medical education requirements equivalent to physicians. The Connecticut Academy --

SENATOR GERRATANA: Thank you, Doctor Taylor, can you summarize for us, please?

STACY TAYLOR: Sure. These are just a few of the components that need to be added to this bill. The Connecticut Academy of Family Physicians feels strongly that this bill is not good health policy and threatens public safety. We do not support this. Additional information is in the written testimony. Thank you. I would be happy to answer any questions.

SENATOR GERRATANA: Yes, I was reading along. But thank you for submitting it electronically.

STACY TAYLOR: You're welcome.

SENATOR GERRATANA: Oh, certainly, Representative Conroy.

REP. CONROY: Thank you. Was your organization at the scope of practice review?

STACY TAYLOR: My organization was there. We had two representatives.

REP. CONROY: Okay. So they did take part.

STACY TAYLOR: Yes, they did.

REP. CONROY: And have you read the scope of practice recommendations?

STACY TAYLOR: I have read the summary of the recommendations, correct.

REP. CONROY: Okay. And is there specific in here that you wanted to address?

STACY TAYLOR: Basically, my concern is ramping up the educational requirements for nurse practitioners; making sure patients understand they're seeing nurse practitioners instead of physicians. That's a very confusing point for most patients.

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And through training and through rigorous measurement of that training, ensuring patient safety.

REP. CONROY: And how do you do the -- how do you disclose it now? Do you have APRN's in your practice?

STACY TAYLOR: I do have APRN's.

REP. CONROY: How do you disclose that to the patient currently?

STACY TAYLOR: My APRN's that I work with currently, says that she is an APRN. Despite saying that, she is called doctor very often because I don't think many patients understand what an APRN is.

REP. CONROY: Okay. But you're employing them, right?

STACY TAYLOR: I am not employing them.

REP. CONROY: Oh, you're not the employer?

STACY TAYLOR: I am employed by a hospital in Torrington.

REP. CONROY: So do you have meetings as a group then, a team meeting?

STACY TAYLOR: We do have team meetings every week and the nurse practitioner over time has made it -- has clarified it more to patients.

REP. CONROY: Great. All right. That's good news, thank you.

STACY TAYLOR: You're welcome.

SENATOR GERRATANA: Representative Cook.

REP. COOK: Thank you, Madame Chair. Thank you for

your testimony and your work that you do for our great hospital over there.

STACY TAYLOR: Thank you.

REP. COOK: I have a really quick question, so if you have an APRN that's in a practice and then a physician and the APRN is actually the one that sees the patient, how is it that the patient is billed the physician rate and not an APRN rate? Could you explain the difference?

STACY TAYLOR: Excuse me, I'm sorry?

REP. COOK: So if I go to the doctor tomorrow and I see the APRN that's in my doctor's practice, I don't see the doctor --

STACY TAYLOR: You will not be billed the same rate as -- well, maybe -- I don't know what Charlotte Hungerford's going to do, but when I was in my own practice, the APRN actually was billed less to the insurers, to the payers, than I was. The payers would not reimburse us at the same rate.

REP. COOK: Right. But I know in some practices that if I go in and I see an APRN on the bill when it comes to my house and it was submitted to my insurance company, it reads as if the doctor was the one that was doing the visit, not the APRN.

STACY TAYLOR: That is -- in my practice currently, that's something I have no control over because I work for a hospital system. But when I was in practice for myself, the payer did not reimburse us for the nurse practitioner as much as it was reimbursed for me. Now, the reason why the doctor is showing up is when currently in the State of Connecticut, you must pick an MD as your primary care provider and not an APRN. And that probably places some kind of limitation on what happens on the back end.

REP. COOK: Okay. Thank you.

SENATOR GERRATANA: Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madame Chair. Thank you very much for your presentation. The second half of your presentation of your testimony where you came with a list of things that you would like seen if this bill moves forward and continues to come to the floors of both chambers, that's very reasonable, very fair and they are concerns a lot of people have and I'm sure the language can be drafted as we go along. My question to you is the first half of the presentation is the person who came with the viral infection on day one, on day two, unfortunately ended up with leukemia. What else would the primary care physician have done when somebody walks in with a fever and a sore throat and -- I mean, does not obviously look terrible, would a primary care not do the same thing? That's a part of your testimony that I'm a little confused with because we see viral infections all the time and we don't go through a whole litany of blood tests and x-rays and we say, hey, you'll get better in a couple of days and if they don't we will proceed further, obviously. So in what way was the quality of care different in your testimony?

STACY TAYLOR: In the interest of time I summarized greatly what actually went on. It was a 21 year old who actually had a cough for four months. That should light up some red flags for any person seeing that 21 year old. The nurse practitioner who saw her was great, by the way. But she didn't have the experience with serious illness to think of leukemia as part of the differential diagnosis.

REP. SRINIVASAN: Thank you. That makes a big difference. A four months cough puts it into a

different category all together and I thought it was just a one day, two day, that's why I couldn't comprehend your earlier part of the testimony. Thank you for clarifying.

STACY TAYLOR: You're welcome.

REP. SRINIVASAN: Thank you, Madame Chair.

SENATOR GERRATANA: Thank you. Are there any other questions?

REP. JOHNSON: Thank you so much for your testimony and taking the time to be with us today.

STACY TAYLOR: You're welcome. Thank you.

REP. JOHNSON: Kathy Grammond or Gramode and then Nan Alexander.

NAN ALEXANDER: Good afternoon. I'm Nan Alexander. Thank you for allowing me to testify. Because we've had so much testimony, I'm not going to read from my testimony. You should have gotten it electronically. So, since there's some role confusion, I'm just going to tell what I do my practice.

I am fortunate to practice with a great group of physicians. I am employed. I do have a written collaborative agreement. They are separate. So the employment agreement for me, my business is making money off of me, which they should because they pay the overhead and they guarantee my salary. So there is an implied payment for my collaborative agreement. So when we talk about collaborative agreements, I want to make it clear that some people that have their own business model have to pay separately. Some of us that are employed, we pay behind the scenes because we're employees and we are making them money. So we can't work without them so there is kind of an

implied payment system.

So just because you hear from the psyc APRN's that they have to pay a lot of money, there are some practices where you're employed where they reimbursement may be slightly different. So there still is a payment for the collaboration agreement. And that fee employment agreement and I signed it willingly. My guys are great. If this goes forward, I'm not leaving the practice. I've been there 16 years. I actually share some patients with Dr. Srinivasan and there are patients that never see my docs. They don't need to. I feel really bad for that patient, the 21 year old leukemia. On the reverse I had a patient that was seen by a physician several times, antibiotics, but lymph node. He had adenoceated tonsils. So bad things can happen to good providers and there's bad providers in both areas.

So we have to keep that in mind with these anecdotal stories that it goes both ways and sometimes you have 10 minutes, you have not enough time, we're all human. So I think that's an important part. And I didn't blame that other provider, I just happen to see it and it struck me that day. In my practice I have a lot of patients who chose to see me. In my exam rooms, it's just me. I am a doctorate nurse prepared. So as I tell my patients, I'm a nurse practitioner, so I'm a doctor nurse and that really kind of confuses them. I never represent myself as a physician. And they all know and they call me doc, not that I think they're confused, but because they think anyone that provides health care for them is a doctor. And I think it's a general term they tend to use. So, you can read my testimony and I'm happy to take any questions. I do work internal medicine and pulmonary and because I work in a specialty as well, I have gone forward, I've taken

certification courses in Asthma and COPD as well as a lot of continuing education in other areas. Thank you.

SENATOR GERRATANA: Thank you, Ms. Alexander. Thank you for coming to testify. Are there any questions? Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madame Chair. Thank you for your testimony today and more importantly, thank you for the wonderful service that you give all of your patients and I've always heard wonderful things about you, not just today or yesterday, for all the years you've taken care of them and we've been in touch over that. I appreciate the opportunity to thank you publicly.

NAN ANDERSON: Thank you.

REP. SRINIVASAN: Thank you.

NAN ANDERSON: And I assume, if the bill gets passed you'll still take my phone calls?

SENATOR GERRATANA: Now that's a nice collaboration. Okay. We have Dr. Rocco followed by Dr. Ken Yanagisawa.

ELIZABETH ROCCO: Good afternoon, Senator Gerratana, Representative Johnson and the remaining members of the Public Health Committee. I'm Elizabeth Rocco. I am an MD and I have worked for the past 30 years as a practicing ophthalmologist in Middletown, Connecticut. So I consider we're kind of the general picture. Somebody wanted to know high, middle and low, I think I represent the face of medicine but somewhat interesting, I'm a female and went into medicine when very few females did in 1975. In addition, I'm now an old doctor so I have watched at age 61, health care evolving.

Rather than read from my script, I'd like to emphasize three points that have just been touched briefly on. The first is that this is not the APRN bill, this is titled improving access to health care. We have finite number of health advanced APRN's. No matter how you cut the pie, it is still the same number right now. Although the issue is being touted as an access issue, it is not clear from any of the testimony at the public health hearings, how ending collaboration changes that number, if we replace it with independent practitioners. We are talking about the very same pool of APRN's. Very few, I think, of whom are unemployed. We know that the state medical society created approximately three years ago, a service to try to help APRN's who had found that the collaborating physicians had been lost and we have not found that that service has been used very much. It's been underused despite multiple efforts to make the APRN's aware that that service exists.

The second think I'd like to emphasize is the issue of responsibility. I think physicians very early on are taught to be responsible for life and death matters. Most APRN's will focus on specific areas of expertise and we've heard some of them speak here today. But physicians, even at a very early age, have to deal with problems that are complex and life threatening.

One quick example. Even though I'm an Ophthalmologist, I do look at the whole person and I do think of problems and I treat people from age 3 days to 101 year old yesterday. But yesterday, a troubled 19 year old came in with her parents. She had been sitting in her college class and suddenly found that she could not open her eyes. Her parents brought her to my office where she started my afternoon. The techs were puzzled. I work with five partners, an

osteopath, an optometrist, licensed opticians, but no APRN, so I don't speak from experience. But this young girl was clearly suffering not from an eye problem, but from a psychiatric problem or behavioral problem.

I called the pediatricians upstairs and the APRN had the week before started the psychotropic medication. She had also started the psychotropic medication six months prior. I felt that they were all related. I'm on the phone trying to get the APRN to see the patient from my office, send her upstairs. And there was a great relicense and thankfully she went and spoke to the physician who agreed to have the patient come upstairs.

SENATOR GERRATANA: Dr. Rocco, could you summarize for us, please. I hope the outcome was good.

ELIZABETH ROCCO: Um hm. I think this is a very good example of where an APRN has physically, immediately available a physician to take care of a rather serious problem that she had no experience with -- that patients were served.

The last issue is the quality that doctors prior have spoken about and it's very clear that when people call themselves doctors, that there is some confusion by patients. We have naturopathic physicians, we have doctors of psychology, we have now doctorates in advance practice nursing. I am most concerned that my elected officials represent their constituents and that there is true transparency of what somebody's background is and exactly what their name or title of doctor means and that is one of the things that should concern all of us.

SENATOR GERRATANA: Thank you very much. We appreciate that.

ELIZABETH ROCCO: Thank you for allowing me to testify.

SENATOR GERRATANA: Representative Sayers has a question for you.

REP. SAYERS: Thank you. I have a little more than a question. I'm a little bit upset what your testimony because I want you to know that all nurses are extremely responsible and actually we're the first line, we're the person that that patient will likely see, we'll know when there's a change of condition when we have to refer that or call someone else in. So for you to imply that nurses are not responsible, is extremely upsetting because that is simply not true.

ELIZABETH ROCCO: I said responsible in complex and life threatening situations.

REP. SAYERS: Absolutely. Nurses are also in those situations and frequently they are in those situations when they are caring for patients, whether it be an intensive care unit or it be an APRN that's out in practice.

ELIZABETH ROCCO: Well, I do apologize to you, but I have heard much testimony here stating that physicians don't care for their patients, that we're not holistic and we're not thinking of the big picture. We're thinking of the financial aspect. And I take issue --

REP. SAYERS: Two wrongs don't make a right.

ELIZABETH ROCCO: -- and I am insulted by that today but I don't choose to address that here. I came to address specific issues.

REP. SAYERS: And I will tell you something else. From working in the hospital, the patients are much more likely to confide problems to the nurse

than they are to the doctor. I can remember many a time patients telling me problems that they were having and the doctor comes into the room and asks how they're doing and they answer, fine doctor. And I have to remind them of problems that they had voiced just minutes earlier. So for you to imply that that is not the problem and that's not the issue that we're talking about today. And also, the thing of calling -- most nurses I have found are very proud to tell people that they are a nurse, whether it is a nurse, an RN as I am or an APRN, they're very proud of what they are and they will tell patients that. More likely if they're calling someone mistitled, it is the PA that will say that they are doctors.

ELIZABETH ROCCO: I'm concerned more with signage outside of offices and I alluded to an example in my town --

REP. SAYERS: And I've never seen that.

ELIZABETH ROCCO: -- from the naturopathic physicians.

REP. SAYERS: I think that is their title. So, I mean that is very upsetting to me to imply that they did not have responsibility. So thank you.

SENATOR GERRATANA: Thank you. Are there any other -- Representative Zoni.

REP. ZONI: Thank you for your testimony today. You alluded to a group that exists solely for the purpose of replacing a collaborative agreement and you indicated that they're under utilized. Are you implying that there is no problem for APRN's to enter into a collaborative agreement?

ELIZABETH ROCCO: I am alluding to a service that --

REP. ZONI: A service, that's correct.

ELIZABETH ROCCO: -- apparently the state medical society set up approximately three years ago. I was not involved in that. I was given this information today stating that this was specifically set up to address the need of APRN's who had lost their collaborative agreements. That is, I think, an example of where physicians have tried to reach out to help people if they are suddenly faced with retirement or loss of a job and I was told today that that service despite quote, multiple efforts to make APRN's aware of its availability, has rarely been used.

REP. ZONI: That would imply that they are not having problems finding a collaborative agreement, correct?

ELIZABETH ROCCO: That is what I read into it, but I did not write that part of this testimony.

REP. ZONI: One other question,, is there any limitation to the number of collaborative agreements that one physician can enter into?

ELIZABETH ROCCO: I have no knowledge of that, I'm sorry. But I suppose I could get you an answer. But I doubt it exists.

REP. ZONI: I'll find an answer somewhere.

SENATOR GERRATANA: I don't think it's addressed in statute, Representative Zoni.

REP. ZONI: Okay.

ELIZABETH ROCCO: One issue I did read the 25 page summary that Dr. Mullen had testified at 10:30 this morning and I caught the end of her testimony, but one other fact has not been promoted either in any of the bullets or what's been discussed here today. And that fact is that in 2013, there were 12 states that tried to pass

a similar bill and only Nevada passed the bill to get rid of the collaborative agreements. When you look at the states that stuck with Connecticut, they're states that are much more similar to ours and those states are New York, New Jersey, Pennsylvania, California, Illinois, Massachusetts, Michigan, and North Carolina. And it behooves me to ask the legislators here to find out why those states would not pass this bill that we're re-entertaining here today. And I'd like some feedback from all of you.

SENATOR GERRATANA: Well, I can say I think there are 16 states that have some form of independent practice but it does vary. Some have oversight on prescribing authority, some have absolutely no oversight. I think I mentioned Oregon and Washington.

ELIZABETH ROCCO: But I would love to know those state's reasons for not passing the law.

SENATOR GERRATANA: Sure. Actually, I had asked our OLR who is our Office of Legislative Research, professional to do that and he actually did and forwarded it on to me. But, I'd be happy to share that with you. Just leave your email if it isn't on your testimony without administrator.

ELIZABETH ROCCO: Okay. And then one other final closing statement or no?

SENATOR GERRATANA: Well, I think there are more questions for you here if you just have just a minute or so more. Oh, Representative Zoni you had another one. He has a follow up.

REP. ZONI: Just one more question, this is probably a DHP, Department of Public Health question, but I'll ask you. When you enter into a collaborative agreement with an APRN, are you required to file that agreement the Department of

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ELIZABETH ROCCO: I have no knowledge of that. I do not have a collaborative agreement.

REP. ZONI: Does anyone in the room have any knowledge?

SENATOR GERRATANA: No.

REP. ZONI: Thank you.

SENATOR GERRATANA: No, there isn't. But if you go online and enter in collaborative agreement APRN you will find that there are forms that are provided in other states actually, Minnesota is one, Louisiana is another that actually lays out the collaborative agreement. Representative Cook.

REP. COOK: Thank you, Madame Chair. Just -- you made a comment a little bit ago about how you were not appreciative that people were misled of the position or the role or the title that they might have, so somebody said that she was an APRN but her patients called her doc, just because they do.

ELIZABETH ROCCO: I'm okay with that. I'm okay with that. But I do think we've had trouble with other transparency issues, false advertising and everybody's made a big issue here about the difference in the level of training. My children have been seen by APRN's in the pediatrician's office. I have no complaints.

But I do think that it does need -- if somebody is having a problem and I was treated with stomach cancer last year, out of the blue, so I am a patient too. I've been in the halls of Smilow Cancer Hospital. Fortunately, I'm a success story because it was discovered early.

But it is confusing to me there to see all the blue outfits and people not clearly identified. So I think we can do a better job and that's what this is all about. That's what this bill is about. How can we do a better job.

REP. COOK: So to piggy back on what you just said, my concern is the fact that, that doesn't go both ways. So if I call my physicians office and I make an appointment to see my doctor, when I walk into the doctor's office and it's not the doctor that sees me, it's the APRN, the doctors not giving me the respect to say, oh I can't see you today but you're going to see my APRN. So if we're talking about making health care better, then I think it has to go both ways.

ELIZABETH ROCCO: Well I would be insulted the same as you if I make an appointment with a particular provider, I expect to see that provider. And you're dealing with practice issues and you should sit down with that practice manager and voice your concerns.

REP. COOK: I think I'm dealing with timing elements and lack of resource issues and I think that that's why the APRN is indirectly filling in for the doctor. Whether he's in or out of the building, I think that it has to go both ways and so I think that by casting stones, I think we're creating more problems and animosity than we are really trying to fix a problem. That's just all I have to say. Thank you.

SENATOR GERRATANA: Thank you, Representative. I don't think there are any other questions. So thank you Dr. Rocco and thank you for your testimony and we wish you well. Dr. Ken Yanaginsawa followed by Lynn Price. Good afternoon.

KEN YANAGINSAWA: Good afternoon, Senator, how are

you?

SENATOR GERRATANA: I am fine. How are you doing?

KEN YANAGISAWA: I am very pleased, Senator Gerratana, Representative Johnson and distinguished members of this public health committee that you have me here for testimony. My name is Ken Yanagisawa and I am a board certified Otolaryngologist practicing in New Haven, Hamden, Ansonia and Milford, Connecticut and also serve currently as the President of the Connecticut ENT society. I am offering you testimony opposing Governor's Bill 36. On behalf of more than 1,000 physicians in Otolaryngology, ophthalmology, dermatology and urology.

With the coming of the ACA, medicine faces a severe access challenge. This legislation, however, may not help with access. APRN's that are already in the state are already seeing patients now. Allowing them independent practice will not increase their number, nor expand the number of patients they may see in a day. Even if this act attracts a flood of new APRN's to the state, it may be years before any significant increase in capacity could be realized.

Further, you will lose the safety net currently provided by the collaborative agreements. I understand that the APRN's chafe at them, but as a legislator, what do you or your constituents gain by releasing this modest level of backup by practitioners with much more extensive training. Instead of a phone call or a walk down the hall, any uncertainties or questions will require a referral out to another provider to determine the correct course or worse, no action. This will lead to increased cost and perhaps delays in treatment.

Additionally, patients requiring hospital

admission will require referral or coverage by an admitting physician which will also create delays and could produce safety risks. Please do not trade quality of care for perceived access. We have heard testimony about the costs of a collaborative agreement. The costs cited have appeared exorbitant. However, the costs noted are stated without context. Many doctors provide more than oversight and review adding in overhead, materials, equipment, supplies, rent, education, liability coverage and the cost of their own increased liability for taking on the collaboration.

The economics of modern office based medical care may limit APRN expansion into more underserved areas as it has for physicians. Overhead increases for replacing the services and equipment that collaborators currently provide and for their likely increase in liability costs coupled with the low reimbursement provided by most underserved patients, will create enormous pressure to limit financial risks.

The economic pressures that limit physician expansion into these underserved areas may also limit APRN's. For these and many other reasons that you have heard stated today, we ask that you oppose Senate Bill 36 to better clarify some of the important issues and questions that have been raised today and maintain the very important team approach to quality medical care which we want to remain strong in Connecticut. Thank you very much.

SENATOR GERRATANA: Thank you very much for coming and giving your testimony. Representative Sayers has a question for you.

REP. SAYERS: Thank you. Are you aware, sir, that the current nurse practice act requires collaborative practice?

KEN YANAGISAWA: That it requires collaborative practice?

REP. SAYERS: Not a written collaborative agreement for APRN's but for an RN, it requires collaborative practice.

KEN YANAGISAWA: Okay. So noted.

REP. SAYERS: Okay. So that going forward, nothing would change because that is current language in the nurse practice act. And the other thing that you mentioned about admissions to a hospital?

KEN YANAGISAWA: Yes.

REP. SAYERS: Are you aware most hospitals, you're seen by the hospitalist and not your own private physician?

KEN YANAGISAWA: That's certainly an option. I just raise it as a question. If a nurse practitioner wishes to be the provider for a patient, the question simply is, we like continuity. And personally, I don't particularly like the concept of hospitalists because you lose that continuity of patient care and that's where hand offs, communication errors happen. It's fraught with problems. And so ideally, I would like to see providers as I do -- if I admit somebody, I want to know what's happening with my patient and I will admit this person and I will go each and every morning regardless of which of the six hospitals that I provide care at, to start my day to make sure that they see me and get the care so that I'm not relying on other people to fill in because that's unfortunately where a lot of these errors in medicine happen.

So to answer your question, yes, hospitalists, I'm very aware of their presence and what they do

and what they are. That's one of the sort of questions that I was eluding to in my testimony, what happens with these patients? And if that is the answer, then you know, so be it. But I think we need to define what we're trying to do.

REP. SAYERS: Thank you. And I would agree with you 100 percent, but hospitalists are a fact of life in today's world. In fact we looked at legislation here to require to make sure that when someone is seen in the hospital by the hospitalist, that that information does get back to their primary care provider because we feel that that continuity was very, very important. So I would agree with you. But in today's world it is the hospitalist for the most part, follows most patients in the hospital. They do not see their private provider as they once did in the past who knew them. So, thank you.

KEN YANAGISAWA: I'm old school and I still do that.

REP. SAYERS: And I would be very much in support of that, but that's not the way it is in general. So thank you.

SENATOR GERRATANA: Representative Cook followed by Representative Conroy.

REP. COOK: Thank you, doctor, for your testimony, I just have one quick question. Do you currently have APRN's in your practice?

KEN YANAGISAWA: I do not have APRN's. I certainly have considered having APRN's work in our practice. I'm an ear, nose and throat surgeon. It's a little bit of a different feel because as specialists, sort of as I believe you had eluded in the last testimony, if somebody is referring a patient to me as a specialist; are they going to be -- or my referring provider, going to be very pleased if it walks not me. I don't care who it

is, it could be even my partner or an APRN or a PA. So we've looked at this, we consider it, I know a couple of my colleagues do use APRN's with success. But again, because we're a little bit different from a primary care provider but with great oversight because of the need to -- we have a lot intricate things that we do in scoping people and nuances. So I think that if we were to do it, we would do it willingly and we would embrace it, but I think I would still need the collaboration as opposed to this independence.

REP. COOK: Thank you. Thank you for your information.

SENATOR GERRATANA: Thank you. Representative Conroy.

REP. CONROY: Thank you, Madame Chair and thank you for coming here today. Maybe I should just preface everyone of these questions I start off with. Were you familiar with the scope of practice review?

KEN YANAGISAWA: I am familiar with the scope of practice review.

REP. CONROY: Okay. Because I see here that the review committee membership was the Connecticut ENT society and that's what you're here today or no? Somebody else is waiving.

KEN YANAGISAWA: I am presiding, I don't know if Dr. Boisaneau is raising his hand behind me, but he is President elect. He actually did attend the scope of practice meetings.

REP. CONROY: Okay. So will he be testifying? Good, so I'll hold off.

KEN YANAGISAWA: Anxiously waiting. Maybe I'm just trying to get to the point is, a few years ago the public health committee came up with the

whole scope of practice review to help us as legislators with these difficult decisions and any changes to the scope or just working within your scope of practice to the full extend. And the point of having that law change back then to have this review process was so we wouldn't have what we're pretty much doing here today.

It seems like we haven't or at least I'm feeling it hasn't changed much since back in 2009 when this APRN bill came up we had physicians coming on one side, APRN's on the other. So I'm just kind of -- I want to just say I'm disappointed on how this going today because the scope of practice there was a lot of people over 40 different groups coming to the table to say, what's the safety issues? I think the bottom line is we want to make sure that Connecticut's a health state.

We want to make sure that everyone that needs a provider, has a provider and we want to make sure that everyone can practice to their full extent. So, I don't know if I'll be questioning anybody else that comes up here today because my feeling is, everyone had an opportunity to put input into this scope of practice and we have a report in front of us. So although I do appreciate everyone coming out who opposes or who's for it, I look at this document as something that I'm going to be using going forward because I think everyone and every group that's here testifying here today has already had an opportunity to put input into this and I thank all of you that have done that.

But you know, I think we could sit here for another three hours, another six hours and we're just going to be going back and forth. So I'll probably reserve my questions now until something really gets me. So thank -- although you might not know it, I do refer a lot of people to you

just on a personal level because you are such a great doctor. Thank you.

KEN YANAGISAWA: I appreciate your kind words, thank you.

SENATOR GERRATANA: Thank you, Representative Conroy. Representative Miller.

REP. PHILLIP MILLER: Thank you, Madame Chair. Thank you for your testimony, doctor. At the end of your testimony you made a reference to access and I think is what the intent of this bill is, is to get more people to have medical access. You suggested that the barriers to accessibility physicians now face could also be an issue for APRN's. Could you expand on that, please?

KEN YANAGISAWA: Well, I'm not -- from my standpoint the point of that statement was that there are reasons that some of us have trouble getting out to these more underserved areas. Be it economic reasons, be it as I eluded to, sometimes the reimbursement issues become very challenging and we in our practice actually do a lot of free care, project access care, et cetera, so we try to -- even though we don't open our offices into the remote areas which do have problems getting there, we try in our own way to provide this care to help our patients. So I think there are reasons that we're having troubles say, opening offices in some of these more rural areas. So I guess the point of my statement there was just that I hope that if we can gain this independence that we'll see a lot more service provided by this group but I'm not 100 percent sure that will happen.

SENATOR GERRATANA: Okay. Thank you very much and thank you for coming today and presenting your testimony. We do appreciate it very much. Next is Lynn Price followed by Dr. Henry Schneiderman.

LYNN PRICE: Thank you. My name is Lynn Price and I am a board certified family nurse practitioner. I'm going to depart from my remarks this afternoon which have been submitted electronically. I'd like to make myself open for questions but I did want to try and help the committee understand perhaps some of the points that have been raised recently about access and how you're not going to get more APRN's perhaps or we won't or whatever.

I can tell you anecdotally having been involved with the APRN society and this political process for the past 18 years, that we do have APRN's leaving the state because it is more attractive to practice elsewhere. And the difficulty in securing the collaborative agreement, although I am aware of the medical society's efforts on that part, I can also tell you that the APRN community did not find that useful. It does not indicate that there's not a problem securing collaboration. It indicates that it was a broken process from our stand point. We appreciate their efforts but it just -- it did not work.

What I would like to remind the committee is as representative Conroy has mentioned and Representative Sayers, that the scope of practice committee was evidence based and the report that issued out of that is based on what we know best. We submitted a number of studies and my testimony does list the 27 that are actual research based studies. There are currently 18 jurisdictions, one of which is the District of Columbia, that have fully independent practice with no mandatory physician involvement whatsoever and the points in my testimony will show you that it is safe and effective practice so that a lot of the concerns that have been expressed primarily by the medical community here, I think are answered if you actually look at the evidence.

What I would also like to say is that back in 1999 when we came out from underneath supervision into the collaborative agreement, we experienced as a state a tremendous amount of innovation in the way that APRN's and the settings in which APRN's were practicing. So mainly we were able to go into the prisons, we were able to go into long term care, we were able to go into some of the group homes. And what we are experiencing now is, I think if you have an innovative idea and you want to get together for instance as a nurse managed health center which would provide access to some of these rural areas, it's difficult because of some of the issues that have been raised, the concerns about liability and so on.

So removing the necessary agreement that currently exists, I think we don't know exactly what will come down the pike, but I think there's a lot of entrepreneurial innovative practice that is just waiting to happen and we're seeing it in some of the other states. Thank you.

SENATOR GERRATANA: Thank you so much for your testimony. Are there any questions?
Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madame Chair and thank you for your testimony. You know, the issue has been raised that because of this collaborative agreement that exists at this point and the difficulty in getting that collaborative agreement which I'm well aware of that you mentioned, that APRN's have been leaving the state. But that's an open ended sentence.

And I wonder now, a couple of question if you have or you can get back to us if you don't have the answer on this, is in your estimate or the society's estimate, the number of APRN's that you

feel who had licenses or were in the State of Connecticut are no long here, number one.

And number two, that if this collaborative agreement were to be removed, what is your projection of people who would start their independent practices in the State of Connecticut? Because the people that I have spoken to, the APRN's that I have spoken to including Nan Alexander who just came and testified before us just now, they all have told me over and over again, that this is not going to change their life one way or the other. They're going to be in a practice, they're very happy in the practice where they are and they will continue the same way with or without the collaborative agreement.

So my question is, that would it make a change? I mean I'm sure there are the people who are having a hard time getting collaborative agreement, they're going to be through, that now they can be stand alone, but is that number five, is it number 50 -- just for the committee to know as to what numbers are we talking about if you or the society can provide us, I would appreciate that.

LYNN PRICE: I don't have that data at hand right now, but I would certainly be glad to do that. And I also was looking through what we did submit. There is some of the -- you were asking earlier about some of the cost implications or savings, potential savings. I would happy to speak with you further about what would be helpful in terms of what it is you want to know. There are two studies that are currently -- I believe as part of the appendices with the scope committees report and I'd be happy to point you in that direction but if they are not answering what you are interested in, I'd be happy to try and find that information.

REP. SRINIVASAN: Thank you very much. I appreciate that. That way we can always get back to you if those questions are not answered in those reports you're going to send us. Thank you. I appreciate that.

SENATOR GERRATANA: Thank you and thank you for your testimony today. I appreciate all the citings also. I read the Pittman citing and I appreciate that. Dr. Henry Schneiderman followed by Dr. David Boisaneau. Ah, there you are. Thank you. Good afternoon. Schneiderman, sorry.

HENRY SCHNEIDERMAN: I'm a physician who stands with the APRN's and I want to tell this group why. I'm an internist geriatrician with 36 years experience. I head a group of four MD and three APRN providers at Hebrew Health Care which employs all of us. I'm not the employer. We have a collaborative practice agreement for which the nurse practitioners do not pay and the nurse practitioners do everything that the physicians do except admit to our medical hospital unit because that requires a physician by statute.

But everything else we do, this is an answer to Representative Musto's question from earlier, is done by the nurse practitioner and the physician and I believe that that is highly representative of the very large segment of practices that have a nurse practitioner and physician unless there are procedures for which the nurse practitioners are not trained and certified just as I am not trained and certified to perform the procedures that a surgeon performs. And in answer to a further earlier question and I'm deviating from testimony because it's been submitted electronically, I could go and do coronary bypass except that no hospital would credential me and no operating room would permit me and thank God.

Through long collaboration with nurse practitioners and by serving on this same scope of practice committee and I did attend every meeting and read every paper, I know that collaboration occurs continuously. Just as when a seasoned physician knows when to seek consultation, so does an APRN and if anything, APRN's bend over backwards to check with a colleague who may know more than they and that colleague may be another APRN. There's no ownership of skill and competency among physicians. The requirement for a written collaborative practice agreement is the only thing that we seek in asking passage of Senate Bill 36. That requirement becomes a barrier for nurse practitioner practice because often there are no physicians willing and available for collaboration. And in answer to Representative Srinivasan's question just to build on what Ms. Price said, literature has been submitted from the peer reviewed medical and health affairs literature along with the materials that Ms. Rapsilber referred to that covers explicitly the net out migration from states that still have such a requirement in place to states that do not. I can't give you the answer about numbers. Just as there is also literature among that material that is in the possession of your committee on cost savings.

The present undersupply of primary care physicians will worsen due to economic disincentives. Access issues are most striking in those specialties that lack reimbursable procedures since current fee structure undercompensates cognitive services, time spent with patients, meticulous physical examination, and bio-psycho-social skills. Yet those very elements of practice define good internal medicine, good mental health care, good pediatrics, good geriatrics. Four areas where APRN's shoulder a disproportionately large share

of clinical work. I have worked closely with geriatric and geropsychiatric nurse practitioners and I teach in Yale's APRN program and am very proud to be a professor of nursing.

My intense respect for APRN's embodies deep trust. We utilize written collaborative practice agreements to be in compliance, but our actual talking about patients is for the same reason that I talk with physician colleagues -- mutual regard and recognition that teamwork enhances patient care and that won't change one iota with or without this stupid piece of paper. Forgive me for revealing my bias.

The psycho-social skills of nurse practitioners and their hands on approach recall traits long highly prized in physicians, traits that have not eroded. APRN's provide a counterweight to runaway costs in health care. In the 17 states and districts which have empowered APRN's to practice independently, access is improved, costs have fallen, quality has been maintained. I critiqued two papers cited by those who assert otherwise in the course of the work of the scope of practice committee. My critiques have been submitted to the committee. My reviews show that the published data do not support the author's conclusions.

I respect the Connecticut state medical society and proudly belong to it but their reasons opposing this bill are in my judgment, erroneous and irrelevant. For example, APRN's readily acknowledge that their training is not nearly so lengthy as that of physicians but that training demonstrably produces excellent patient outcomes.

In summary, if there are limited dollars to cover out staggering health care costs as a state and a nation, why would we not welcome a solution that costs less, preserves quality, and enhances

access? Why would we not accept the verdict of those impartial researches not drawn from the physician camp or the nurse practitioner camp but from the health services research camp who have shown again and again, clearly in the literature that nurse practitioners are fully effective and capable in independent practice? Why would we not listen to the many states that have successfully walked this path ahead of us?

To achieve best health care for the population, we need a system that does not break the bank. APRN's are a large part of that solution. There is every reason to welcome their needed effective presence and no down side in my opinion. I urge you on behalf of the people we both serve, you as legislators and we as health care providers, to enact Senate Bill 36 and I'd be very happy to take any questions.

SENATOR GERRATANA: Thank you, Dr. Schneiderman. Thank you for coming and giving your testimony. Representative Sayers.

REP. SAYERS: I just also want to thank you and you're very well thought of at People Health Care. I know my daughter talks well of you. So thank you.

SENATOR GERRATANA: Thank you. I guess that's it. Dr. David Boisaneau followed by Margaret Flinter. Oh, there you are.

DAVID BOISANEAU: Hi there, thank you. It's getting late. I will be excruciatingly brief which is sort of a surgical skill. And representing surgeons I'm, as you said, I'm David Boisaneau. I am a board certified Otolaryngologist. I'm the executive for Connecticut State Ear, Nose and Throat Society and Representative Conroy, I was on the DPH Committee, one of the specialists on the committee, so feel free to ask me any

questions right now.

But basically what I've just heard over the last three hours is basically that entire review committee is everything that I've already heard so I really have very little to add. My testimony is in front of you, but all I really want to bring up and nobody's really discussed this up to this point yet, is the three year collaboration period that's been posed to be part of the statute. I have a close personal friend who is an APRN in my area of the state and she has been for the past 20 years. She's an excellent clinician and when we discussed this statute last week, her first statement to me was astonishment over only a three year collaboration period. She felt that is woefully inadequate to see the breadth of patient problems that can come in front of you to be allowed to be an independent practitioner and to be solely responsible for a human life.

So it's apples to oranges comparison between training internal medicine doctor or primary care physician as we know we've heard about that already and I just wanted to put on the record that I feel that if this is a training period, a residency period, it's not defined that way and I'm concerned over the ability of a person after only about 500 clinical hours to be able to be solely responsible for a human life. Thank you.

SENATOR GERRATANA: Thank you very much and thank you for your testimony. I think Representative Sayers has a question maybe.

REP. SAYERS: Actually more of a statement. The next speaker actually does a residency program for APRN's so it's someone you might want to talk to about that afterwards.

DAVID BOISANEAU: That's what we need to hear more

about, yeah.

REP. SAYERS: Thank you.

SENATOR GERRATANA: And Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madame Chair. Thank you for your testimony. You did mention the 500 hours of training which we heard about earlier in the day, but following the 500 in this three year collaboration, I mean the idea is that they're collaborating with the physician which kind is similar to a residency program. So how do you compare a residency program that you and I have gone through compared to this three year program collaboration that the physician and the APRN should have and as I had asked Commissioner early in the morning that if the physician who is the collaborative physician is unhappy or not satisfied with the progress of this APRN, what recourse does he or she have?

DAVID BOISANEAU: That's exactly my concern as well. You can't compare the two right now as written, as in the statute and that's what concerns me. The three year -- which I'm not, nobody's said how that time period was even brought up. I don't know where that came from. I don't know if that's supposed to mirror a traditional residency program for a primary care physician or not, but there is no comparison, there is nothing written about how many clinical hours they're supposed to have, there's no didactic program, there's no mandatory research, there's no certain amount of disorders that you need to be seen or be comfortable with.

So it's very loosely defined and that's what I'm very concerned about as well. I'm not sure how somebody can get an APRN degree and three years working with a physician in a particular office would feel comfortable enough to take care of

every need of a patient after that. And that's what my friend, my colleague said to me over dinner. She'd been doing this for 20 years, she feels pretty darn comfortable now doing it. But she said she certainly did not feel comfortable after three years and she doesn't understand where that came from and that was her concern as well.

REP. SRINIVASAN: Thank you. And yet earlier in the day when I had asked the representative from one of the societies of the APRN, comparing the training between the 11 years that a physician goes through, minimum 11 to 12, to become a practicing physician, not a specialist, but just to be a primary care provider, compared to the five and three that we have, the five years of the APRN goes through and the three years that they collaboration is to be still off by three years and I was told earlier in the day that somebody will be addressing that issue specifically but not yet, but hopefully we will get some answers to the comparable training and the number of years and the number of ours. Thank you.

SENATOR GERRATANA: Thank you very much for coming. Next is Margaret Flinter followed by Donna Monesi Enters.

MARGARET FLINTER: Good afternoon. It's wonderful to be with you especially after fighting my way up - 91 North this afternoon. Stay in this room, it's not worth getting on the highway.

SENATOR GERRATANA: We had an earlier accident on 84 I know. One of those days.

MARGARET FLINTER: It gridlocked around the capital. So thank you members of the Public Health Committee and good afternoon. I'm Dr. Margeret Flinter. I'm the Senior Vice President and the

Clinical Director of the Community Health Center, Inc., a statewide federally qualified health center serving more than 80,000 primarily low income individuals per year.

CHC was Connecticut's first health center to be a level three patient center medical home and employs today more than 30 advanced practice registered nurses to practice in our primary care centers, in our school based clinics, in our homeless shelters, in generalist and in specialty roles.

And as many of you know, especially Representative Sayer who is one of our early supporters, we also created the country's first post graduate formal nurse practitioner residency training program for new NP's who were committed to practice careers as APRN's in the setting of community health centers who really sought an intensive emergent experience and the kind of high performance health care with complex populations. That's the hallmark of our organization.

And I also speak as somebody who's held a continual license as a nurse for 40 years, hard to believe, in Connecticut and 34 of those -- I know, who can believe it -- and 34 of those have been as an advanced practice registered nurse. So I've been in this movement for a long time. I also want to bring the greetings and the testimony of Dr. Darren Anderson, our chief quality officer and a practicing internist who could not be here this afternoon.

Nurse practitioners practice in many different capacities at CHC. As I said, some are in our primary care centers, some are in our school based health centers, and some specialize in psychiatry, in HIV and in women's health. Most are primary care providers for a very diverse

panel of patients and meet their needs for prevention, health promotion,, the treatment of acute illness and the management of chronic disease. And in all of their care they bring the holistic, patient centered, integrated and coordinated approach that's the hallmark of excellence in all nursing care and it's coupled with the rigor of their education and clinical training at the graduate level that prepared them for licensure, for certification, for credentialing by their organizations, their practices, and the insurance companies.

In every situation they are fully vetted prior to hire. They are privileged, appointed, re-privileged and re-appointed only on the basis of high performance and the delivery of safe, high quality, effective care. And that is the standard to which we need to hold all of our licensed independent providers in health care throughout the state.

In today's practice environment, every primary care provider whether an APRN or an MD or a PA needs to consult and collaborate with other providers and disciplines. The care is simply too broad to limit it to any one person. This is the nature of practice today. And we do so by phone, by video, electronically or in person. But the requirement for a written collaborative agreement with a single provider, simply doesn't make sense in today's practice environment, nor does it make a meaningful contribution to either safety or quality.

In an environment like mine, I can make sure that an agreement is placed. I simply build it in to all the physicians' contracts that they will establish collaborative agreements as we need them to. But to what end? It does not contribute to high quality accessible safe care and that should be the criteria. And outside of

my community health center system it may in fact, prevent and I know you've heard stories of this today, extremely talented, extremely expert committed clinicians from doing what they were educated and trained to do and what they seek to do to provide expert health care to people who need that care.

I do applaud the intent of this bill which is to create a vehicle for removing onerous requirements for a collaborative practice in perpetuity and replacing it with a time limited requirement of three years. I would encourage further discussion and progress in the direction of a shorter period of one to two years and expanding the collaborative practice relationship to include other APRN's not just physicians. Again, I applaud the intent of this bill which is to move us forward while respecting that there are many and differing viewpoints among many constituents and I thank you so much for letting me testify later than my turn was assigned this afternoon.

SENATOR GERRATANA: Well, we know all about traffic. We come here every day. Thank you very much for your testimony. Are there any questions? No. Thank you so much. Next is Donna Montesi Enters followed by, I think its Karen Myrick.

DONNA MONTESI ENTERS: Hello Senator Gerratana and committee members. My name is Donna Montesi Enters. I am an adult nurse practitioner certified since 2002. I completed my doctorate of nursing practice last May and I am also wound care certified. I would like to make some comments based on our Public Health Commissioner's presentation this morning and Senator Gerratana's questions regarding how collaborative practice works.

I am lucky enough to be the practice manager for

32 nurse practitioners working in a large physician practice with 17 physicians. The MD's and APRN's work very well together. We've been doing this since 2008. Our practice is a level three medical home. We take care of patients in the office, in the nursing homes, in the home care setting and our physicians also go to the hospital. We cover -- the nurse practitioners cover the nursing homes 24/7. We also cover each other on the weekends and during vacation times. The APRN's deliver care solely in the nursing homes and the home care setting and we act as the house staff in the nursing home during the week and also on the weekends.

We sign a collaborative agreement initially on our employment with the practice but that's the only time this collaborative agreement is looked at. And we collaborate with all of the physicians and all of the nurse practitioners in our practice, not just the physicians who we sign our collaborative agreement with. Our physicians that we work with see the nurse practitioners as a way to decrease their liability by having the nurse practitioners taking care of the complex medical needs of the nursing home patients and eliminating phone calls and triaging over the phone.

APRN's deliver care in the nursing home setting in our practice managing chronic health conditions, acute changes in conditions, wound care, we educate the nursing staff and other staff in the facilities in hopes of improving care in the facility. The APRN's are the core member of the health care team in the nursing home which also can be considered a subspecialty. We collaborate with all doctors in the health care team not just our physicians. We've developed a network of specialists that we can collaborate with to enhance our patient care and hopefully keep our patients in the nursing home

and not have to send them out to outside appointments and to the hospital.

Our nurse practitioners also have developed a network of collaboration amongst each other in our own expertise and certification specialty areas. And we mentor our nurse practitioners that are newer nurse practitioners. We also help train new physicians that come into the practice into the nursing home setting to help them get on their feet and take care of the residents in the nursing home setting. We provide a cost savings just by the fact that nurse practitioners are reimbursed 85 percent of the physician rate for Medicare and the majority of our patients in the nursing homes are Medicare and Medicaid patients. Our goals are to decrease hospitalizations.

In summary, collaboration is inherent in what we do as health care providers. Collaboration is based on patients needs as no one provider is knowing of all. I ask your support in Bill Number 36 as we are independent nurse practitioners already since 1999 and the collaborative agreement removal will not change that. Thank you.

SENATOR GERRATANA: Thank you very much for your testimony also. I could not find it online. Had you submitted it -- oh, if it's possible it would be appropriate and I know you gave your name, but maybe you could also provide your contact information to our administrators over here. Thank you so much. Are there any -- before you go away -- Representative Srinivasan has a question for you.

REP. SRINIVASAN: Thank you, Madame Chair. Thank you very much for your presentation and your testimony this afternoon. I have just have one question for you and I want to make sure I heard this clearly, that in this model that you have

which is phenomenal, the APRN's, the physicians working so well with each other and so on and so forth, that this model has reduced the medical liability. That's what I thought I heard you say and I wasn't sure -- if you would be kind enough to elaborate. I do understand the medical costs, that part is understandable, but how the medical liability costs was reduced, I would like you to elaborate if you can. Thank you.

DONNA MONTESI ENTERS: So our physicians when we started this model, the goal was to decrease liability because our physicians had patients in the nursing homes and they were in the office and getting phone calls from the nurses in the nursing homes. Now we have a model that we have nurse practitioners based in the nursing homes generally Monday through Friday and taking care of the patients and seeing the patients, assessing them, ordering necessary testing and taking care of them to try to decrease hospitalizations and delivering care by the telephone.

REP. SRINIVASAN: Thank you. And that has resulted in dollars and cents reduction in your liability insurance was that what I gathered from your testimony?

DONNA MONTESI ENTERS: The reason our physicians wanted to put this model in place was by having nurse practitioners making appropriate assessments above that of an RN that that would decrease liability on their part because we had that assessment skill set to make those clinical decisions and order appropriate testing and medications that are needed for the patients.

REP. SRINIVASAN: Thank you for sharing that because I find that a little difficult to accept because being in practice myself, I mean our liability insurance never goes down, so that's why I didn't

understand when you said -- I mean hopefully it just remains the same or inches up marginally assuming that we are all practicing within the work we should be doing and so that's why I find that a little difficult to accept that. Yes; I love the idea that the nurse -- APRN is there at the nursing home and is able to take care of the patient right away and that will definitely reduce the costs, will definitely reduce the number of hospital visits, I can understand all of that. But the liability factor was the part that I was not able to comprehend and still am not able to.

DONNA MONTESI ENTERS: So just to try to clarify, by having an advance practice registered nurse making those clinical assessments based on our educational level versus a nurse, whether that be an RN or LPN calling the physician over the phone, that better assessment will then treat the patient appropriately versus what the nurses are assessing. So that's what we were getting at.

REP. SRINIVASAN: Thank you very much. Thank you for clarifying that. Thank you, Madame Chair.

SENATOR GERRATANA: Thank you, Representative and thank you for coming and giving your testimony today. Next is Karen Myrick followed by Ines Zemaitis.

LAUREL HALLORAN: Hello, my name is Dr. Laurel Halloran, full disclosure I'm a PhD doctor, not an MD doctor.

SENATOR GERRATANA: Oh, are you testifying for Karen -

LAUREL HALLORAN: I am testifying for my colleague, Dr. Karen Myrick.

SENATOR GERRATANA: Oh, okay, thank you.

LAUREL HALLORAN: Thank you. She did submit this testimony electronically, so I'm going to just summarize this, her high points for her.

Karen is a family nurse practitioner and a professor at Quinnipiac University. She is also a member of the Connecticut APRN Society, Government Relations Committee and she was on the scope of review committee. Karen has been a practitioner for 15 years and she attempted to create a practice that would fill and identify state health care needs, improve patient time to treatment and significantly improve access to care.

At this time an athlete with an injury may need to wait more than a month to be seen in her practice. This wait time is increased for a patient with Medicaid. Providers may have limitations that management imposes on scheduling patients with Medicaid. These limitations range from not accepting patients with Medicaid to only seeing two patients a day. With such limited access to care, patients are at risk for complications that can be avoided.

Realizing this limited access and the health care needs that this created, Karen contacted more than 20 orthopedic and sports medicine physicians so that she could open a clinic for patients with Medicaid or patients with low incomes and families who had poor health insurance who sustained sports medicine injuries. Not one would sign a collaborative agreement for this endeavor although all thought the practice would be highly beneficial and would be happy to take referrals and refer patients to her once they determined such a clinic was in existence.

The mandatory collaborative agreement often is posed as a scope of practice matter. The removal

of this agreement would not change Karen's APRN practice, yet it would allow access to care for a population where significant need was identified. Please support Bill 36 and eliminate the practice barrier to fulfill no public health policy purpose. But it does provide a barrier to access for appropriate health care.

SENATOR GERRATANA: Thank you.

LAUREL HALLORAN: If I have a few moments I will tell you that I am a professor of nursing at Western Connecticut State University. I also have been an advanced practice nurse, a family nurse practitioner for 20 years and I do maintain a clinical practice myself. As a faculty member and I do run the masters program, I am obligated to maintain a clinical practice because I'm obligated to maintain certification so that I can teach my own students. This requires me to basically have a second job and a part time job and a collaborating physician. I would happily take that time and serve underserved populations but in order to go into a practice, I need a collaborating physician. So I can't just go to a clinic or an Medicare or something like that because I would have to have a collaborating physician. Without a collaborative practice I could volunteer my time. I can't do it now.

SENATOR GERRATANA: Thank you. Are there any questions? No. Well, thank you for coming today and testifying on behalf of Ms. Myrick. We appreciate that.

LAUREL HALLORAN: Thank you very much.

SENATOR GERRATANA: Thank you. Next is Ines Zemaitis followed by Regina Cusson.

INES ZEMAITIS: Good afternoon, Committee. Thank you very much for coming here. I want to discuss an

issue in regards to some of the barriers and confusion that have been brought about me in regards to having a collaborative relationship. I have also submitted this directly electronically. I am a licensed board certified graduate of Yale University as an adult nurse practitioner. I am your direct access to the primary care, preventative care. Connecticut House Bill 36 is imperative to the evolutionary changes in health care for the protection and improvement of the health of the people of Connecticut.

The current public act 99-168 has increased health care costs and limits access to the public. In July, 2013, I performed a pre-operational physical on a patient who required extensive dental procedures at a dental location in Connecticut. The orthodontist refused to accept my signature on my examination study stating that I required a physician to supervise and sign my assessment, diagnosis, plan and recommendations for the surgery. I immediately directed the orthodontist to the public act 99-168 and reiterated that I am not in a supervised role directed by a physician.

The orthodontist refused my signature, demanded the Medicare patient to return to the office to have another pre-operational physical to be performed by a physician. Medicare then denied the claim for the pre-operational physical performed by the physician due to the fact that Medicare had already paid the claim that I had submitted earlier that week. The patient therefore had to pay an out of pocket expense because the orthodontist refused to accept that public current act 99-168 on the nurse practitioner's signature.

Another example is in November, 2012, the outpatient laboratory center at a Connecticut

hospital refused to accept my order because I am a nurse practitioner and not a physician. They stated that they could not process my laboratory orders due to not having an attending physician within this hospital. I spoke with the manager of the laboratory services in which she stated I needed a supervising physician to process the order which was outpatient. I explained that I do not practice with a supervising physician, that I have a collaborating relationship with a physician and the scriptive authority is given by a collaborating physician not by license.

The laboratory requisitions that were directly given by me with my signature continue to this day be placed as ordered by another physician. This has been a chronic and debilitating problem that has impacted negatively to the care and the safety of my patients, my primary care patients. Numerous times I have not received laboratory data due to the imputing technician placing my collaborator or past physician seen by this patient or random physicians as the order provider to the requisition that I ordered. This has chronically delayed care, jeopardized the proper health care for my patients.

There have been patients that have been contacted by other providers that were randomly inputted as the ordering provider and were either given more blood analysis to do or given other medications or told to have a follow up with them. Consequently these health care costs were processed that were not justified and were not clinically indicated. Furthermore, the lack of appropriate ordering provider was on the laboratory analysis.

This could have been a sentinel event due to the actions of this hospital and a complaint was made to the department of public health on March 15, 2013 and that is currently under investigation by

the department of public health. The cessation of this collaborative agreement of nurse practitioners with physicians will end the archaic relationship between these two health care groups. Continuing this law will increase risks to the public's mental and physical health such as the risks that were imposed by this hospital to my patients because of the confusion of the current law.

SENATOR GERRATANA: Ms. Zemaitis, could you please give us a summary of your testimony? Thank you.

INES ZEMAITIS: Absolutely. It is imperative that the autonomy of nurse practitioners, the level of education, the expertise, the cost effective care that is given and concurrently with the continued changes in this health care, that it is reflected within the laws of the State of Connecticut to remove this collaborative agreement. Thank you very much members of this committee. I thank you for your time and your commitment to us.

SENATOR GERRATANA: Thank you very much also. Any questions? No. Okay. Thank you for coming today. Next is Regina Cusson followed by Kathleen Sullivan-Conger.

REGINA CUSSON: Good afternoon. That's a nice way to pronounce it and it is the French way but in the United States people call us Cusson.

SENATOR GERRATANA: Cusson. Okay.

REGINA CUSSON: And I am Regina Cusson and I am the Dean of the UConn School of Nursing and I am here speaking in favor of Bill 36. I thank you very much allowing me to come and speak to you today, Senator Gerratana and other members of the Public Health Committee.

Fully 25 percent of the faculty at the University

of Connecticut are APRN's as I am myself. I am a neonatal nurse practitioner. I'm very proud of that fact. I got a post masters degree -- actually post doctoral degree from the University of Pennsylvania for that preparation. As you know, UConn is the largest state affiliated university and we have trained and educated nurse practitioners, APRN's for over 30 years. We probably provided about one third of the nurse practitioners who practice in the State of Connecticut and we are proud of the fact that our graduates passed the boards with high rates, they are sought after by employers, many of them have job offers before they graduate and they complete an important part of Connecticut's primary, specialty and acute health care work force providing care to patients in need.

There is a national trend throughout the country for full practice authority which already includes as you've heard many times before today, 17 states plus the District of Columbia, but I want to point out that is fully one third of the states in the United States. And four of those are our neighbors, so - Maine, New Hampshire, Vermont and Rhode Island, here in New England are attractive to nurse practitioners in this state and 12 other states have bills in their legislatures to follow suit. Four of those states, Massachusetts, New York, New Jersey and Pennsylvania are in close proximity. So even though they may not have passed the bills in previous years, there are bills before them again this year.

We face the very real possibility of losing our APRN providers and I am particularly concerned about our new graduates who will move to other states rather than staying in Connecticut which I think will be an incredible loss for our good state.

In fact, there are states throughout the United States that have less restrictive laws who are coming up with incentive plans to attract nurse practitioners who are experienced from other states and some of them are in very attractive areas in the west where I can tell you that the weather is much better than what we have experienced here in New England this winter.

So with over seven university level in-state nurse practitioner programs, the State of Connecticut invests heavily in educating APRN's and it would be so unfortunate if we were to lose this precious commodity to neighboring states that have more favorable practice environments.

There will be those who will say that we shouldn't do this just because others are doing it, just like your mother said don't tell me that you want to do this because everybody else is doing it. However, we are simply going to be having these status quo and ignoring the strong evidence that has been presented by our colleagues here earlier today with lots of references to support that. So in summary, I would just like to ask you to consider all of the evidence that has already been provided that clearly shows that this would be a bill that would be very beneficial to the state. It would improve the number of nurse practitioners that are available because the new graduates would remain in the state if they had a more practice requirement. So thank you and I'll be happy to answer any questions.

SENATOR GERRATANA: Thank you, Dr. Cusson. Thank you for giving your testimony today. Are there any questions or comments? No, ma'am. Thank you. Have a good weekend. Next is Kathleen Sullivan-Conger followed by Diadette Hernandez.

KATHLEEN SULLIVAN-CONGER: Good evening. I'm here to

support bill 36. My name is Kathleen Sullivan-Conger. I'm an advanced nurse practitioner, board certified in mental health, 13 years through the life span. As I reminder I testified last year and I expressed concern to the severe problem in Connecticut to obtain and maintain a collaborative psychiatrist. I had to leave a federally qualified community health center position due to the unmet health standards of the collaborative agreement.

I also expressed concern for the growing need for psychiatric providers to see children and teenagers in our community. Many parents and primary care doctors have voiced concern as to the lack of access to care for the specialty service and the lack of providers willing to take certain insurances, specifically state insurances and the United Health Plan leaving children, teenagers and their families without psychiatric care.

Last year I did not own my own practice and subsequently there were barriers to my professional choices of which insurance I would be a network with and I could not. I was no longer providing care to state insured and United Health Care insured families. In my opinion we can no longer allow for this barrier to the people and the children of our state. Connecticut state insurance covers those in need who may be laid off, suffering from illness or struggling with financial burdens. United Plan covered certain state insurance and is also the plan of choice for many Connecticut companies including General Dynamics, our work force of Connecticut who protects our nation.

My father worked at EB for 45 years, my brother 35. I thought how could this be that I cannot help these families unless they pay me cash and I do not use their hard earned insurance plans.

People are paying for their care out of their paycheck and charging their health care on cards because providers are not accepting insurance. The only way I could serve this population was to start my own practice and I had wanted to do that in Connecticut but it was too difficult to obtain a collaborative agreement in Connecticut and there was too high of a risk of it being invalidated if a doctor moves or dies.

My only choice was to leave the state and go where I'm allowed to practice without fear of losing my practice, where I can treat patients who are in great need of mental health care and may have insurance plans that other providers are not accepting. I was extremely frustrated that our bill was not passed last year and I felt I had to do something other than just wait and Connecticut had a very risky environment with the economy for me to practice here. I now own a private practice in Westerly, Rhode Island and I am pleased to be a network providing care for families who are on Connecticut Medicaid, HUSKY, United Health Care, Tri-Care Military Insurance, Rhode Island's Children's State Plan and many others.

I have started seeing the children and family of Connecticut. They drive to Rhode Island to see me. I have made and I'm still making collegial partnerships in the community and I've met many primary care doctors, nurse practitioners. I've recently met with an entire health center to facilitate access to mental health services. I have a vast network of collaborators in my field of practice. And I am starting a collaborative meeting group with these practitioners to address patient's health needs and trauma informed care.

I want to quote from many primary care doctors and nurses and parents that I have met with, thank God you are here. My question is, why did

I have to leave the state I was born in, where my family and friends live, where my community is, in order to give them what they need.

SENATOR GERRATANA: Thank you very much for your testimony. Are there any questions?
Representative Ziobron.

REP. ZIOBRON: Thank you. Thank you, Madame Chair and thank you so much for your testimony and I too I'm very sad to hear that you've had to go to another state. I'm curious if you think -- if this bill passes this year, do you see a large contingent of folks with your background and really interested in your specialty dealing with mental health of youth, do you see a lot of people filling that void here in the State of Connecticut?

KATHLEEN SULLIVAN-CONGER: I have several practitioner colleagues that would like to join in partnership with me, you know, I'm breaking new ground. They are waiting. I have colleagues all over the state waiting to see what will happen with this bill. I not only represent myself, I represent them as well.

REP. ZIOBRON: And do you -- would you foresee your colleagues really being all over Connecticut? You're talking about EB, I happen to represent an eastern Connecticut community and what I find that happens so often is the small rural communities are left, you know, kind of on their own devices. So, I'm just curious is your career path attractive to people to locate in all areas in Connecticut or are they -- do they tend to go where the community health center is or the hospital? I'm just curious on how they would be populated through the State of Connecticut if this bill were to pass just as your opinion. I'm sure I'm not looking for a scientific method.

KATHLEEN SULLIVAN-CONGER: I have a lot of colleagues, I've worked in various areas working for the State of Connecticut for 14 years in psychiatry prior going out into the community health centers. So I've been fortunate and then belonging to the nurse committee and partnering around the state, I've been fortunate to meet a lot of people in different areas.

So, yeah, absolutely there are people who want to start their own practices outside the City of Hartford, there's people who would like to come out where I am. Even though I'm in Westerly, I'm able to provide services to Pawcatuck which was in great need, North Stonington another great need.

I've been out to the high school because there was no one out that way who spend quality time with teenagers and the families. There's also people from Groton. I have military families driving to Westerly to see me because I take their insurance and because I take the time with them. And I know other practitioners who would come out that way.

REP. ZIOBRON: Thank you very much. Thank you, Madame Chair.

SENATOR GERRATANA: Your welcome and thank you very much and I wish you success in your practice. Sounds like you're busy.

KATHLEEN SULLIVAN-CONGER: Thank you. Yes, already.

SENATOR GERRATANA: Thank you. Next is Diadette Hernandez followed by Danielle Morgan and then Christine Zarb.

DANIELLE MORGAN: Good evening, Senator Gerratana.

SENATOR GERRATANA: Good evening.

DANIELLE MORGAN: Representative Johnson, members of the committee. My name is Danielle Morgan and I am here to provide testimony in support of Governor's Bill Number 36. I am a family psychiatric nurse practitioner and I have provided psychotherapeutic and psychopharmacologic services for persons living with mental illness in Connecticut since completing my nurse practitioner training at Yale University in 2000.

I have a private practice in New Haven where I treat approximately 500 patients and I have a collaborating physician. She is one of the many colleagues with whom I collaborate to manage my patients as they seek wellness and symptom relief. We have engaged in a fruitful relationship for the last 11 years. She is in fact the collaborating MD for most of the New Haven County APRN's. If she were to leave her Connecticut based practice, many thousands of mentally ill patients may be without care if we are unsuccessful in striking a mutually acceptable collaborative agreement with another psychiatrist.

I have had several disruptive and ill informed interactions with psychiatrists in the past as I have attempted to find a collaborator. Additionally, I am a member of the medical staff that serves two non-profit clinics offering psychiatric services primarily to our most indigent of mentally ill people. I also provide the psychiatric assessment and medication management for New Haven based mentally ill prisoners transitioning from their Department of Corrections sentences, back to their communities. In both settings I am part of a multidisciplinary team that offers a range of psychiatric and substance abuse services aimed at reducing relapse, maintaining a productive life with

mental illness and reducing recidivism.

Among all settings, we manage approximately 2,000 patients most with serious and persistent mental illness. My collaborating MD in these facilities is close to retirement and he brings years of wisdom, a health respect for my independent practice and a generous relationship with these financially challenged clinics. He has submitted a statement in support of Governor's Bill Number 36 that I have attached. When he retires over the next few years, the 2,000 patients that we serve may experience a break in these services given the current legislative mandate of collaborative agreements.

Collaboration is one of the many clinical and ethical mandates that all practitioners of medicine are encourage to employ in our quest for optimal patient care. It happens naturally as we consult with each other daily in providing care and relationships are formed among providers. We assume respect for colleagues in various specialty practice settings and ultimately refer patients back and forth as their medical needs change.

The process of mandating collaboration with regulatory statute distorts it's true spirit and provides a forum for great misuse of power, misassumption of patient responsibility and indentures APRN's to physicians for whom previously collegial relationships are forced to become parental.

Nothing changes in the day to day operations of my psychotherapy and medication management practice whether I have a written collaborative agreement with an MD or not, but the act of needing to have one constructs a barrier that can bring patient access to mental health care to a immediate and unnecessary halt.

I want to also thank the Department of Mental Health for establishing the forum for our most recent scope of practice review. It was an honor to serve on that committee and I am pleased that the evidence based outcomes that provide support for what Governor's Bill, Number 36 was attempting to achieve.

SENATOR GERRATANA: Thank you so much for your testimony. Are there any questions? No, but thank you for coming today and waiting this long. Next is Christine Zarb.

CHRISTINE ZARB: Hello. Good evening. Thank you for listening to me today. I'm a nurse practitioner and owner and operator of a small med spa in Wilton, Connecticut. I run my med spa four days a week and one day a week I work in my collaborating physician's office. I'm here to declare my strong support of Senate Bill 36 to remove the collaborative agreement mandate between physicians and advance practice registered nurses.

The current mandate for a collaborative agreement is a practice hardship for an APRN's in Connecticut. It impedes APRN's from opening independent practices. For those of us who have opened independent practices if our collaborating physician dies, retires or severs the agreement, it renders our practices illegal. We are then forced to close our business. I am constantly worried that one day my collaborating physician will sever our agreement or retire. This constant worrying inhibits me from growing my practice.

Supporting this bill not only improves access to care but it also supports small business growth in Connecticut. When the med spa bill almost passed last year, it was very sobering. I

stopped all growth until it was vetoed. After it was vetoed I felt a little more confident about the future, so I hired a Connecticut based contractor to expand my spa and I hired a Connecticut website designing to redesign my website. I spent more money on marketing and medical supplies, I added a medical device and got another certification to provide that service safely.

This year I'm starting to advertise using local media. I'm currently poised for more growth which would include hiring one employee, but I'm hesitant to bring on another individual when I am currently in a precarious position myself having to rely on another individual, my collaborator.

The mandate for the collaborative agreement is a huge disincentive to open or expand a small business in Connecticut and I feel that to support this bill is also to support small business in Connecticut and I think that needs to be said.

SENATOR GERRATANA: Thank you so much for coming and testifying. Are there any questions? No? Thank you. Have a good evening. Next is Carolyn Goodridge followed by Karen Caffrey.

CAROLYN GOODRIDGE: Good evening, Senator Gerratana and members of the committee. We're going to do a little switch with another bill. I'm here to support Bill Number 5144, an act providing certain adopted adults -- adult adopted persons with access to parental health information and a copy of their original birth certificate. I am a social worker and public policy advocate for the Connecticut Association of Foster and Adoptive Parents --

SENATOR GERRATANA: Excuse me, please. Could you identify yourself for us for the record?

The resolution also points to concerns that common ingredients in children's personal care products have been linked to cancer, birth defects, reproduction damage. When everyday products are incinerated in Hartford, the toxins are released into our air. These airborne toxins also contribute to the high rate of asthma and other problems in our neighborhoods. Thus, members of my family and communities suffer from exposure to these toxins by the air we breathe as well as the products we use. We should not take chances with the health of our children.

JED

We have the right to know what chemicals are in the products we buy for our children. S.B. 126 will inform us about the presence of chemicals in children's products and the risks these chemicals hold. Thank you.

SENATOR GERRATANA: Thank you very much and thank you for your patience too, Gladys for coming today and testifying on the bill.

GLADYS ELLIS: My pleasure. Anything for the children.

SENATOR GERRATANA: We feel the same way.

GLADYS ELLIS: They say they're our future, but I have to wonder sometimes. If you think hard on it you wonder what kind of future you're going to have.

SENATOR GERRATANA: Thank you, ma'am. Have a good evening. Representative Miller, do you want to take over here?

REP. PHILLIP MILLER. Okay. We're going to go -- take a step backwards: We have a few people who still have to testify on Senate Bill 36. So first is Elena Schjavland followed by Saja Jackson. Welcome, Elena.

SB36 ELENA SCHJAVLAND: Hello, good evening. Thanks, Mr. Chairman and the committee of the Public Health group. Thank you for the opportunity to speak in support of this bill, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATION TO IMPROVE ACCESS TO HEALTH CARE. My name is Elena Schjavland and I live in Mystic. I'm the sole provider for the private house call practice, called Keys to Memory. It is based in New London County. I'm a Connecticut licensed APRN, board certified as adult and geriatric and I have an individual collaborative agreement and contract with a Connecticut physician.

Without any disrespect to my collaborator, I give this bill my vigorous support. I'm actually a poster child for this legislation. In short, the contract requirement has severely limited patient's access to the care I can deliver. Access and provisional quality health care is a priority in 2014 and the present requirement causes me headaches, significant time loss, every week. It's because of billing glitches, excessive phone calls, credential inquiries. Sometimes I refer a family to a memory center one to two hours away because I can't resolve the red tape.

Turf challenges, legal issues and boundary questions arise from local Connecticut doctors, hospitals, insurance companies and nursing facilities. It's never my patients who erect road blocks. Clients and their families know I'm a nurse practitioner and clever as they are, they actually know the difference between a psychologist, a podiatrist, a nurse practitioner and a medical doctor. My care consent and my website clearly identify my practice as an NP. We need easier access to and more appointments with qualified APRN primary care providers, mental health and geriatric specialists, APRN's

who provide depression behavior therapy and APRN's who specialize in women, child and adolescent health.

I would be more productive, treat more patients and have more time to improve dementia care in the community if I didn't have this contract requirement. There are plenty of patients for all of us especially me considering one out of six people here are going to be diagnosed with Alzheimer's disease in their lifetime. So I am essentially a care provider who takes care of dementia, cognitively impaired, ADD clients. Youngest is age 44, oldest is age 98 and without this contract requirement, I'm telling you that we could do much better dementia care.

REP. PHILLIP MILLER: Thank you for your testimony. Are there questions from the legislators? All right. Thank you for your testimony. We'll now hear from Saja Jackson if she's here, she left, okay. How about Valentine Iamartino? I hope I pronounced that not too bad. Okay. Thank you. On deck we'll start hearing from the first person for Senate Bill 126 and that will be Andy Hackman followed by Eric Brown if they're still here. But right now, Valentine, you have the floor.

VALENTINE IAMARTINO: Distinguished members of the Public Health Committee, thank you for having me here tonight. My name is Valentine Iamartino. I'm from Thompson, Connecticut. I'm here today to support Raised Bill 5144, AN ACT CONCERNING ACCESS FOR BIRTH CERTIFICATES AND PARENTAL HEALTH INFORMATION FOR ADOPTIVE PERSONS. As a member of the American Adoption Congress, in particular Access Connecticut, I do not present myself as your typical adoption triad member. I come to you not as a birth mother, adoptive mother or adoptee, but as a researcher with a strong passion for family history.

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**Governor's Bill No. 36 AN ACT CONCERNING THE GOVERNOR'S
RECOMMENDATION TO IMPROVE ACCESS TO HEALTH CARE****PUBLIC HEALTH COMMITTEE**

Public Hearing February 28, 2014

Testimony IN SUPPORT**Senator Gerratana, Representative Johnson, and Members of the Committee:**

I am a Family Psychiatric Nurse Practitioner and I have provided psychotherapeutic and psychopharmacologic services for persons with mental illness in Connecticut since completing my nurse practitioner training at Yale University in 2000. I have a private practice in New Haven where I treat approximately 500 patients and I have a collaborating physician. She is one of the many colleagues with whom I collaborate to manage my patients as they seek wellness and symptom relief. We have engaged in a fruitful relationship for the last 11 years. She is the collaborating MD for most of the New Haven County APRNs. If she were to leave her CT-based practice, many thousands of mentally ill patients may be without care if we are unsuccessful in striking a mutually acceptable collaborative agreement with another psychiatrist. I have had disruptive and ill-informed interactions with psychiatrists in the past as I have attempted to find a collaborator

Additionally, I am a member of the medical staff that serves two not-for-profit clinics offering psychiatric services, primarily, to our most indigent of mentally ill people. I also provide the psychiatric assessment and medication management for New Haven based mentally ill prisoners transitioning from their DOC sentences back to their communities. In both settings, I am part of a multidisciplinary team that offers a range of psychiatric and substance abuse services aimed at reducing relapse, maintaining a productive life with mental illness, and reducing recidivism.

Among all settings, we manage approximately 2,000 patients, most with serious and persistent mental illness. My collaborating MD in these facilities is close to retirement. He brings years of wisdom, a healthy respect for my independent practice, and a generous relationship with these financially challenged clinics. He has submitted a statement in support of Governor's Bill No. 36 that I have attached. When he retires over the next few years, the 2,000 patients we serve may experience a break in those services given the current legislative mandate of collaboration

Collaboration is one of the many clinical and ethical mandates that all practitioners of medicine are encouraged to employ in our quest for optimal patient care. It happens naturally as we consult with each other daily in providing care and relationships are formed among providers. We assume respect for colleagues in various specialty practice settings and ultimately refer patients back and forth as their medical needs change.

The process of mandating collaboration with regulatory statute distorts its true spirit and provides a forum for great misuse of power, misassumption of patient responsibility, and indentures APRNs to physicians for whom previously collegial relationships are forced to become parental. As outlined in the *Medical Economics* article attached, it does offer great financial reward for physicians. However, if we are unable to find a reasonable and knowledgeable collaborating MD willing to sign this document, our practices close and patients are not able to access care. Nothing changes in the day to day operations of my psychotherapy and medication management practice whether I have a written agreement with an MD or not, but the act of needing to have one constructs a barrier that can bring patient access to mental health care to an immediate and unnecessary halt.

This current public health policy overtly restricts the establishment and maintenance of mental health services. At a time when this access to care needs to be most available to our most vulnerable population, I urge your support of this legislation to help reverse a proven bad policy.

I want to also thank the Department of Public Health for establishing the forum for our most recent Scope of Practice Review. It was an honor to serve on the committee and I am pleased at the evidenced-based outcomes that provide support for what Governor's Bill No. 36 is attempting to achieve.

Respectfully submitted,

Danielle Morgan, MSN, ANP, CNS, Family PMHNP, APRN-BC
Family Psychiatric Nurse Practitioner

Medical EconomicsSM

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How hiring a physician assistant or nurse practitioner could ease a physician's work load, increase take-home pay, and more

H. Christopher Zaenger, CHBC

Publish Date: NOV 10, 2013

If you are having trouble finding physicians to join your practice, dismayed by their demands or expectations at interviews, or concerned about their high cost or need to be a partner, hiring a physician assistant (PA) or nurse practitioner (NP) may be your answer.

Hiring midlevels can ease the physician's practice pressures, increase take home income, and increase patient satisfaction. A primary care entrepreneur can earn as much as a surgeon and more.

A real-life example

Enter Alfonso Alvarez (the names have been changed to protect confidentiality), a family physician and the sole owner of La Vida Health Center, S.C., a family medicine practice in Waukegan, Illinois.

When I began consulting Alvarez in 2010 he was already doing well. Statistics for 2009 from the National Association of Healthcare Business Consultants indicated that family practitioners were taking home \$184,382 (33%) on \$559,584 in receipts. The average practice had two physicians and about one-third of the practices used a midlevel provider. Alvarez would generate \$809,000 and retain 35% of it. He was earning \$100,000 more than the average using one full-time-equivalent PA.

So as an observer, I said: "If the meal is good why not go for seconds?"

Alvarez hired a second PA, the limit in Illinois at the time. Then a providential change in state law allowing the physician to supervise up to five PAs was passed. Cycle time to fully busy was less than 6 months. Then Alvarez decided to hire a third PA. His take home income in 2010 increased by 29%.

In 2012, I devised a productivity incentive program that resulted in a huge boost in the productivity of the midlevel support staff. His PAs will earn more than \$120,000 each this year while each will produce over \$400,000 in receipts. He just doubled his office space and expanded office hours. His operating expenses climbed by 34% since 2010, and he added debt due to a large expansion of his office footprint. His take home income in 2013 will be significantly more than twice what he earned in 2010.

Now with the passage of the Affordable Care Act (ACA) and the creation of the Patient Centered Medical Home, (PCMH) the practice is looking to the "community health" model. Alvarez is adding an NP to help with care coordination and management of the statistical reporting requirements and implementation of the PCMH tools within his electronic health record (EHR).

Alvarez is one of many physicians implementing this model with success. The bottom line is that midlevel providers, if productive, do not cost a practice anything and can actually increase revenue.

Should you hire a midlevel?

Remember, the new competitor in healthcare delivery may not be your local hospital. It may be the CVS or Walgreens on the corner or an entrepreneur building a high-access clinic down the street in states that allow them

Because of these competitive pressures, midlevels may be the best way to expand your practice, increase the amount of net income per square foot of space, and provide you with a lifestyle that creates more freedom of choice.

If you answer 'yes' to these questions, you may be the perfect candidate to hire a mid-level:

- Do you know your state law and limits?
- Is your practice fully busy?
- Do you have a full waiting room at times during the week?
- Do you have a day of the week that is "crazy?"
- Can you double book and keep up?
- (Are patient waiting times an issue?)
- Are you booking new patients more than 3 weeks out?
- Are you offering 30 hours of office clinic time per provider?
- Are you having trouble recruiting another physician?
- Can you spare an exam room
- or two and/or expand hours?
- Can you cover the first 4-5 months
- of salary for a midlevel?
- Can you filter for the hard worker
- in your interviews?

The American Academy of Physician Assistants credential verification service, offered in conjunction with the American Medical Association, is a great tool for verifying candidate credentials. Two certifications employers should look for are the Physician Assistant National Certifying Exam (PANCE) for recent graduates and the Physician Assistant National Recertifying Exam for PAs who have been practicing for more than 5 years.

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Marisa Brown SB 36

Dear Legislators,

As a concerned clinician I am writing to you in hopes that you will vote NO on Governor's Bill #36, the bill that would allow Advanced Practice Registered Nurses (APRN) independent practice. I have a unique inside view with regard to the mental health side and thus strongly encourage you to keep reading and ultimately consider the ramifications of these proposed changes.

I completed my doctorate degree in clinical psychology in 2009. Given the medically compromised patients with which I work, I decided to enhance my medical knowledge by seeking an additional master's degree. Thus, I am currently enrolled full-time in a psychiatric nurse practitioner program while I concurrently continue to practice as a licensed psychologist. As a student, I am experiencing first-hand the education and training that APRN's undergo. As a clinical psychologist, I have the knowledge and training to assess what is being taught, how well it is being taught, and the level at which these skills are put into practice. Notably, I not only sit through classes taught by APRNs, but am also paired with APRNs who are practicing in the community. I am in the room as they treat patients, I attend their staff meetings, I see their documentation and all other aspects of the care they implement. Unfortunately, I have been continuously saddened by the mediocre quality of care I have observed as well as the lack of depth and breadth of the education/training. Moreover, despite these apparent limitations I have rarely witnessed practitioners collaborating, consulting, asking questions, or making referrals to other professionals. Therefore, I am extremely concerned that if collaboration agreements are removed APRNs will not seek out support and guidance despite the very apparent limitations in their skills.

Certainly, I have witnessed APRNs accomplishing the basics of mental healthcare, but beyond this level I have seen APRNs across the board struggle. Deficits are most prominent with arriving at accurate diagnoses, how to conduct a therapy session and moreover how to design a treatment plan focused on actual symptom reduction. All skills that can directly affect healthcare spending.

It is disconcerting to me that I sit through lectures in which some concepts are covered by one PowerPoint slide and yet within only 2 years' time students from these programs will be asked to diagnose and prescribe medications for these issues. If I was witnessing exceptional care based on such few classes and clinical hours, I would gladly say that we need to re-assess the length of our educational programs. However, this has not been the case.

When I made the decision to add APRN to my list of titles, I did so knowing that when I would have to deal with medical problems and medications, I would have the guidance and support of an MD whose training would far exceed mine. I was happy for this provision knowing that with only 2 years of training I could still help patients, but would also have an expert nearby who would pick up where my skills would leave off. I never could have imagined that fellow APRNs would not recognize the limitations inherent in a two year program and would seek to practice without close proximity to a more expert clinician for support and guidance.

I believe APRNs are requesting independence in good faith that they are able to provide quality care. Unfortunately, this is an issue of not knowing what they do not know. Because there is so much information that is not covered or even brought up, many APRNs are unaware of the information they

are missing or feel the information they have is sufficient. A young math student will solve problems only using addition and subtracting until his eyes are opened to the concept of multiplication. Unless a math teacher introduces the idea of multiplication, the young math student continues to function under the guise that addition and subtraction are the only options available for solving a problem.

If we send the message that two years of training and a handful of clinical hours are adequate to treat patients, then we are also asserting that higher medical degrees and doctorate degrees have little purpose. There is certainly value to what mid-level practitioners offer, however we must be clear where those lines begin and end and recognize that clinical techniques are not equal in the level of skill they require. I once had an APRN lecturer who put down a physician who requested her assistance in reading a PPD test. She mocked him for not knowing this and praised her skill in doing so. However, later in the lecture a question from a student forced her to admit she did not know how to interpret a complicated X-Ray that was on display. Little did she realize, the reason that physician did not know how to read a PPD (a very simple skill that can be learned within a few minutes) was because he was spending his training learning higher level skills such as reading a complex X-Ray.

The solution to our doctor shortage and access to care challenges is not to relegate duties to lesser trained practitioners. Instead, we must keep incentives to pursue high levels of education in place by reserving tasks, skills, and responsibilities for those who are willing to extend their time and knowledge to the highest level. May I suggest that problems with our current healthcare programs are systemic. Again, merely shifting responsibilities to other practitioners with lesser training and who are not encouraged to collaborate will not dissolve the barriers to quality care that exist. We should instead be seeking to enhance our interactions by allocating clinicians to the areas that best fit their training within a team-based model. We must finally decide if we want our healthcare system carried forth on the shoulders of competence or expertise?

Dwight Ligham, MD

Governor's Bill No 36

Gentlemen:

I am strongly opposed to non-physician level providers being able to prescribe and dispense controlled substances independently without physician supervision.

As you know, the problem of prescription pain medication abuse and diversion is rampant in our society. In fact the level of surveillance and supervision required in order to ensure that controlled substances are used appropriately and not diverted is quite high. This level of infrastructure is rarely available in none specialty provider settings and I would suspect even less so in a non-physician provider practice. The standard of care for long-term opiate analgesic patient management demands the highest level of training and infrastructure in order to protect both the individual patient and society as a whole.

In fact it is my belief that certain limits should be set both on the amount and duration of opiate analgesic treatment provided to patients by not specialty pain physicians. This treatment provided by even physician level providers without specific training and certification in pain management should be restricted in terms of both dosage and duration. One might look towards Washington State's law that sets limits in terms of dosage and duration of this therapy in the setting of non-specialty physician providers and directs that patients who need long-term therapy with these medications be sent to physicians with specialty training and certification in pain management.

I think Governor's Bill No 36 sets a dangerous precedent and opens the door to even more prescription drug abuse, and harm to both individuals and society.

Respectfully,

Dwight Ligham, MD
Advanced Diagnostic Pain Treatment Centers, PC
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New Haven, CT 06511

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CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

TESTIMONY

Delivered by Tracy Wodatch, Vice President of Clinical and Regulatory Services
The Connecticut Association for Healthcare at Home

Before the Public Health Committee

February 28, 2014

Raised Bill SB 36

**AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE
ACCESS TO HEALTH CARE.**

**To implement the Governor's recommendations concerning
advanced nursing practice.**

Senator Gerratana, Representative Johnson and members of the Public Health Committee. My name is Tracy Wodatch, Vice President of Clinical and Regulatory Services at the Connecticut Association for Healthcare at Home. I am also an RN with 30 years experience in home health, hospice, long term and acute care.

The Association represents 60 Connecticut DPH licensed/Medicare certified home health and hospice agencies that foster cost-effective, person-centered healthcare in the setting people prefer most – their own home. Collectively, our agency providers deliver care to more CT residents each day than those housed in CT hospitals and nursing homes combined.

We are Connecticut's community-based safety net, ensuring that the chronic conditions of the frail elderly, disabled, and homebound are managed and their care coordinated across the healthcare continuum to avoid unnecessary and costly rehospitalization or institutional care.

It is unfortunate that we must oppose raised bill SB 36 An Act Concerning the the Governor's Recommendations to Improve Access to Health Care by allowing APRNs to practice independently.

The goal of this bill is to increase access to primary care by removing the requirement that advanced practice registered nurses practice in collaboration with a licensed physician. Although this may make good sense for most care settings, the federal regulations for home health and hospice require physician certification and physician approval of all plans of care. If APRNs were to work independently, they would not be able to sign any of the orders for their patients' care while receiving home health and hospice services. This would be a significant barrier to smooth transitions of care and optimal person-centered care.



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

The Medicare Condition of Participation for Home Health Agencies specific to Medical Supervision (§ 484.18) is as follows: *Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.*

This federal requirement has been a long-standing challenge for the home health and hospice providers as we are the only licensed and certified provider who cannot accept APRN or PA orders. Our Association in collaboration with our state partner associations, the National Association for Home Care and Hospice (NAHC) and the Visiting Nurse Association of America (VNAA) have been advocating at the national level to allow APRNs to sign home health and hospice orders most especially their certification and plans of care. To date, our many years of advocacy to relieve this regulation have fallen on deaf ears.

In addition, seventeen other states have implemented some level of APRN independent practice. Several of them report that it has directly impacted the home health and hospice referrals and has, in some instances, caused a greater rift in coordination of care. Physicians struggle with the burdensome federal requirements for home health and hospice on their own patients never mind having to sign even more orders for an APRN's patients that they don't even know.

Unfortunately, until the federal regulations for home health and hospice change to allow APRNs to certify and sign home health and hospice orders, passing this bill will backfire on the many chronically ill, frail elderly and disabled, homebound residents trying desperately to stay in their homes. At the same time, we will likely see a significant increase in the need for re-hospitalization or institutional care.

Should APRNs be allowed to practice independently? Yes, but not until the federal requirements also allow them to certify and sign home health and hospice orders.

Thank you and if you have any further questions, please contact me directly at Wodatch@cthealthcareathome.org or 203-774-4940.



**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
Hartford County Medical Association
Litchfield County Medical Association
New Haven County Medical Association
New London County Medical Association
Middlesex County Medical Association
Radiological Society of CT
Tolland County Medical Association
Waterbury Medical Association
Windham County Medical Association



Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

**Testimony of Victoria Veltri
State Healthcare Advocate
Before the Public Health Committee
In Support of SB 36
February 28, 2014**

Good afternoon, Representative Johnson, Senator Gerratana, Senator Welch, Representative Srinivasan, and members of the Public Health Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

Senate Bill 36, An Act Concerning the Governor's Recommendations to Improve Access to Health Care, addresses a very timely issue. With more than 125,000 new entrants into Connecticut's insurance marketplace and a greater understanding of the critical importance of early access to preventative screening and care, developing workforce capacity remains an important element in effective health reform efforts. SB 36 begins to address this issue by capitalizing on our state's existing clinical expertise and enabling Advanced Practice Registered Nurses (APRNs) to diagnose and treat to the full extent of their training and with full independence..

This expansion enhances medical doctor's ability to focus on more complex patients, while maximizing access to effective, quality and compassionate primary care for consumers with more routine healthcare needs. In addition, SB 36 can help to reduce healthcare expenditures by leveraging the expertise consistent with each provider's training and experience, create more equity in the quality of healthcare delivery.

Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.



Connecticut Department of Public Health

Testimony Presented before the Public Health Committee
February 28, 2014

Commissioner Jewel Mullen, MD, MPH, MPA
860-509-7101

**Governor's Bill 36: An Act Concerning The Governor's
Recommendations To Improve Access to Health Care**

Good morning Senator Gerratana, Representative Johnson, and distinguished members of the Public Health Committee. I am Commissioner Jewel Mullen of the Department of Public Health (DPH) and I am here today to testify in support of Governor's Bill No. 36, An Act Concerning the Governor's Recommendations to Improve Access to Health Care.

The Governor's proposal upholds the requirement for an advanced practice nurse practitioner (APRN) to maintain a collaborative practice agreement with a physician during his or her first three years of practice, after which the requirement for a collaborative practice agreement is eliminated.

Specifically, Section 1 requires that an APRN collaborate with a physician for the first 3 years after having been issued a license. Thereafter, the APRN would be authorized to practice alone or in collaboration with a physician or other health care provider and may perform acts of diagnosis and treatment of alterations in health statutes, and prescribe, dispense and administer medical therapeutics, corrective measures and drugs (including in the form of professional samples). Section 2 amends the portion of the medical practice act that references APRNs to remove the language that currently requires APRNs to have a collaborative agreement. The language properly references the new requirement that collaboration is required for the APRN's first 3 years of practice.

The Health Resources and Services Administration of the United States Department of Health and Human Services projects a shortage of 20,400 primary care physicians nationwide by 2020. Other organizations set that projection much higher. Analyses conducted by the DPH Office of Health Care Access reveal that although the availability of primary care providers in our state is somewhat better than the national average, geographic distribution of and access to primary care providers is uneven. Moreover, access is particularly challenging for un- and underinsured individuals. Implementation of the Affordable Care Act will increase demand for services among the newly insured. Our commitment to ensuring they receive care is the basis for the Governor's proposal.

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I have stated publicly in the past and want to reiterate now, that this proposal does not turn nurse practitioners into physicians. Moreover it does not intend to diminish the medical profession. Nor does it reflect an inflated perspective on the capabilities of nurse practitioners. The Governor's proposal to allow APRN independent practice aligns with similar recommendations of esteemed organizations such as the Institute of Medicine, the National Governor's Association, and the Robert Wood Johnson Foundation, all of whom view APRN independence as a means of improving access to primary care.

The DPH scope of practice review process was established by PA 11-209, *An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professionals*. DPH had sought this legislation 3 years ago to formalize a process for submission and review of scope of practice requests. The provisions established guidelines for all petitioners to follow, and required a committee vetting process which is transparent, objective, and inclusive. The domains DPH reviews include impact on public health and safety, effect on public access to health care, economic impact on the health care delivery system, and the relationship of the request to a health care professional's ability to practice to the full extent of their training.

In accordance with the PA 11-209, DPH submits a formal scope report to the Public Health Committee, but we do not approve or deny a request. That is the role of the legislature. The details of the APRN scope process are summarized in the *Scope of Practice Review Committee Report on Advanced Practice Registered Nurses* which we submitted to the Public Health Committee on February 1, 2014. Along with the 27-page report are numerous appendices, supporting documents provided by the Connecticut Advance Practice Nurse Society, and the submitted written impact statements of 21 other individuals and organizations related to this scope of practice request.

Being sensitive to time and anticipating that you have questions, I will conclude with a short list of salient points from the report:

1. Practicing APRNs increase access to care, particularly in underserved areas.
2. Research supports that there is a range of conditions and functions that APRNs can and do perform without evidence that patient safety suffers.
3. Within that range of conditions and functions, NP's produce outcomes that mirror those produced by MD's
4. Many of those conditions and functions are at the core of APRN practice: evaluation, screening, history taking, and physical examination; and management of a number of routine medical conditions such as hypertension, diabetes, asthma, and patient functional status.
5. APRN patient satisfaction scores are comparable to or higher than those of physicians, in part due to the time they can spend with their patients and their emphasis on holistic care.
6. Hospitalization rates are similar among patients treated by APRNs and those treated by physicians. Mortality rates also are similar.
7. The DPH scope review process did not uncover evidence that the care APRNs provide is unsafe, and no such evidence was presented to the committee.

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8. Residency training programs for new APRN graduates will strengthen their preparation for independent practice.

Additionally, the Department respectfully requests the following language be added as a technical amendment:

Sec. 3. Subsection 20-94b of the general statutes is repealed and the following is substituted in lieu thereof:

An advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists may prescribe, dispense and administer drugs, including controlled substances in schedule II, III, IV, or V. An advanced practice registered nurse licensed pursuant to section 20-94a who does not maintain current certification from the American Association of Nurse Anesthetists may prescribe, dispense, and administer drugs, including controlled substances in schedule [IV] II, III, IV or V, [except that such an advanced practice registered nurse may also prescribe controlled substances in schedule II or III that are expressly specified in written collaborative agreements pursuant to subsection (b) of] in accordance with section 20-87a as amended by section 1.

Thank you for hearing my testimony in support of the Governor's proposal. I would be happy to take your questions.

PUBLIC HEALTH COMMITTEE HEARING - FEBRUARY 28, 2014

GOVERNOR'S BILL No. 36 AAC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

Testimony of Kathleen Sullivan-Conger APRN

My name is Kathleen Sullivan-Conger, I am an advanced nurse practitioner board certified in mental health ages 13- through the life span. As a reminder I testified last year and expressed concern to the severe problem in Ct to obtain and maintain a collaborative psychiatrist. I had to leave a federally qualified community health center position due to the unmet health standards of the collaborative agreement. I also expressed concern for the growing need for psychiatric providers to see children and teenagers in our community. Many parents and primary care doctors have voiced concern as to the lack of access to care for this specialty service and the lack of providers willing to take certain insurances specifically state insurance and the United health plan leaving children, teenagers and their families without psychiatric care. I did not own my practice and subsequently there was a barrier to my professional choices of which insurances I could be in network with and I could not. I was no longer providing care to state insured and united health care insured families.

In my opinion we can no longer allow for this barrier to the people and children of our state. Ct state insurance covers those in need who may be layed off, suffering from illness, or struggling with financial burdens. United plan covers certain state insurance plans and is also the plan of choice for many Ct. companies including General Dynamics our work force of Ct who protects our nation. My father worked at EB for 45 years and my brother for 35 years. I thought how could this be that I cannot help these families unless they pay me cash and do not use their hard earned insurance plan. People are paying for their care out of their paycheck and charging their health care on cards **because providers are not accepting their insurances.**

The only way I could serve this population was to start my own practice and I had wanted to do that here in CT. but it is too difficult to obtain a collaborative agreement in Ct and there is too high a risk of it being invalidated if a doctor retires, moves or dies. My only choice was to leave the state and go where I am allowed to practice without fear of loosing my practice. Where I can treat patients who are in great need of mental health care and may have insurance plans that other providers do not accept.

I was extremely frustrated that our bill was not passed last year and felt that I had to do something other then wait. Ct has a risky business environment leaving NP's dependent on a letter and I could not afford to take this risk in our economy. I now own a private practice in Westerly RI and I am pleased to be in network providing care for families who are covered by Ct. Medicaid (Husky), United health care, Tricare military insurance and RI children's state plan (as well as many others). I have started seeing the children and families of Ct who travel to RI and I

have been making collaborative collegial partnerships in the community meeting with primary care doctors and NPs, pediatricians, and have recently met with a health center to facilitate access to quality mental health services. I have a vast network of collaborators in my field of practice and am starting a collaborative meeting group to address patient health needs and trauma informed care. The response has been inviting and I quote from primary care offices and parents "Thank god you are here" My question is why did I have to leave the state I was born in where my family and friends live, where my community is in order to provide what they need?

PUBLIC HEALTH COMMITTEE PUBLIC HEARING 2/28/2014

GOVERNOR'S RAISED BILL No. 36 AN ACT CONCERNING THE GOVERNOR'S
RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTHCARE

Testimony of Laima Karosas PhD, APRN

Senator Gerratana, Representative Johnson, members of the Committee

Thank you for raising this bill and issues surrounding the written collaborative agreement for APRNs.

As an APRN in CT for over 20 years, a nurse educator and Director of Nurse Practitioner Programs at Quinnipiac University, I have the unique perspective of understanding both APRN practice and education.

The current requirement for APRNs to have a collaborative agreement with a physician is restrictive and unnecessary. Health care has become more complex and it is a standard of practice to collaborate and consult with other health care providers. No other health care provider has a mandated collaborative agreement in order to practice in the state. As a consequence, the loss of a collaborating physician results in the loss of an APRN practice. The final result is that a large number of patients loses access to care.

This state cannot afford to have primary care providers who are unable to practice. More people will need providers as a result of the Affordable Care Act. APRNs provide safe, effective and efficient care to their patients. This has been widely documented in the literature and provided in the scope request to the Department of Public Health. APRNs will continue to provide effective care by working with others to ensure that patient care needs are met.

Respectfully I request that the Public Health Committee approach Governor's bill #36 favorably, keeping in mind how this bill will benefit residents of our state. Removal of the written collaborative agreement will not change how APRNs practice, but it will allow them to open, maintain and create innovative ways to care for the patients of Connecticut.

Thank you for considering this request and for the opportunity to raise my concerns.

Laima Karosas, PhD, APRN
Chair, Health Policy Committee
CT APRN Society

Nurse Practitioner with West Haven Medical Group, LLC, West Haven, CT.
Director of Nurse Practitioner Programs at Quinnipiac University, Hamden, CT.

Connecticut Society of Eye Physicians
Connecticut ENT Society
Connecticut Urology Society
The Connecticut Dermatology and Dermatologic Surgery Society

Before the Public Health Committee
On February 28, 2014

**Governor's Bill No 36 AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO
IMPROVE ACCESS TO HEALTH CARE**

Good Morning Senator Gerratana, Representative Johnson and distinguished members of the Public Health Committee, my name is Elizabeth Rocco, M.D. and I am a board certified ophthalmologist practicing in Middletown, Connecticut. I am offering you testimony opposing Governor's Bill 36: An Act Concerning The Governor's Recommendations to Improve Access to Health Care on behalf of more than 1000 physicians in Ophthalmology, Ear Nose and Throat, Dermatology, and Urology.

104 years ago there were no standards for medical education in the United States. Medical schools varied enormously in quality; many required little or no college preparatory work, taught no basic medical science, provided no hands on contact with patients and produced access in abundance; access to mediocrity. The Flexner Report changed that environment by establishing standards for medical education that created a revolution in quality, setting the stage for the golden era of medicine in America. Today we are poised and on the brink of reversing those hard earned achievements, and all in the name of access that is doubtful at very best.

Our current practice pairs APRN's with physicians in ways that complement each other's strengths³ to improve access, quality and continuity of care. Most APRN's focus on specific and narrow areas of expertise and are able to rely on their physician partners for help when issues become esoteric or complex, or when the routine becomes emergency and life threatening. Even in the loosest collaborative arrangements it is the physician who holds the final responsibility when patients call with emergencies, and it is the physician who is ultimately responsible when patients do poorly and who is liable when things go wrong. Physicians such as myself, who have spent years in medical school and internship developing broad medical skills, and then many more years in residency and fellowship focusing and refining our skills know that medical science and knowledge is just too complex for the few years of study that are encompassed by even the most advanced nursing degree.

Although the issue is being touted as an access issue, it is not clear from any of the testimony given at the public health hearings how ending collaboration and replacing it with independent practice will actually increase access since we are talking about the very same pool of nurses, very few of whom are unemployed. We know that the service created by the state medical society to

pair APRN's with collaborating physicians has been profoundly underused, despite multiple efforts to make APRN's aware of its availability. Ironically, this law may actually decrease access; access to family practitioners who have seen their practice battered mercilessly by rising malpractice costs, and to primary care physicians in general.

Trading quality for access is not the solution and it is not the vision of the Affordable Care Act that seeks to improve both quality and efficiency by teamwork and collaboration and not by scattering multiple access points of variable depth and quality. As a physician with a large investment in education and training and as a patient who has recently had to endure serious and life threatening illness and surgery I am very concerned about the misconceptions that educated and sophisticated people will have, let alone those who are not well versed in the increasingly complex health care system. With the expansion of programs that produce doctorate degrees in nursing there will be increasing and potentially dangerous truth in advertising issues where patients may be under the impression that they are in the hands of a physician trained through multiple years of medical school, internship, residency and fellowship, when in fact they are being cared for by a nurse with just a tiny fraction of that level and extent of training. I am concerned that nurses who work under an initial collaborative arrangement in one specialty area, will be able to pursue independent practice in another field in which they are not trained, let alone well-trained. I am concerned that in one fell swoop and without consideration for liability, continuing medical education, and responsible coverage this statute will create a second and lower quality level of "physician". I am concerned that health insurers may be tempted to employ this second quality health care provider on restricted panels to the exclusion of better-trained physicians. I am concerned that this process, once set in motion, will be very difficult to stop or reverse. I am concerned that the education and training that have made me feel proud to be a part of the health care system will be de-valued in the system we are building. In the end and in the final analysis I am concerned about quality. I ask, I beg, I beseech you; do not trade quality for access.

Thank you for allowing me this time to present this testimony.

Respectfully,

Elizabeth Rocco, M.D.

Prime HealthCare PC
Internal, Pulmonary, and Sleep Medicine
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PUBLIC HEALTH COMMITTEE
PUBLIC HEARING FEBUARY 28, 2014

**GOVERNOR'S RAISED BILL No. 36 AN ACT CONCERNING THE GOVERNER'S
RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTHCARE**

Testimony of Nanette Alexander IN SUPPORT OF RAISED BILL No. 36

Senator Gerratana, Representative Johnson, and members of the Committee

Thank you for raising this bill and providing an opportunity to speak on an important issue affecting nurse practitioner practice and improving access to healthcare providers in our state.

My name is Nanette Alexander and I'm testifying in support of Raised Bill No. 36_ -
I have been a nurse practitioner since 1995 and served as a primary care provider since then.
Patients have chosen me as a primary care provider, and I have functioned as a primary care
provider managing their care.

The Governor has raised this bill to remove the written collaborative agreement and to improve
access to APRNs as healthcare providers. The Department of Public Health has given a
favorable report to the scope of practice change. This change will allow for advanced practice
nurses to practice to their full scope of education and training.

I have had the privilege of serving my patients as a primary provider of healthcare. I have
guided my patients in both wellness and illness. During times of illness I have collaborated with
various healthcare providers. This is a standard of practice.

I have collaborated with my physician of record, as he also has collaborated with me when my
knowledge base meets his patient's needs. More frequently, I have collaborated with physicians
of specialties, or other healthcare disciplines. This is standard of practice and does not require
statuary language.

The safety of nurse practitioners has been well documented. The Institute of Medicine has
recommended the removal of statutory barriers to the practice of nurse practitioners. There is a
documented shortage of primary care providers, nurse practitioners can help provide primary
care. There is also a shortage of psychiatric providers; access to psychiatric nurse practitioners
has been hampered by this written collaborative agreement. If enacted, Connecticut will join 18
other states that have removed these barriers, furthering the health of our state and our nation.

Please consider supporting this important bill that increases healthcare access to the population
of Connecticut.

Nanette Alexander DNP APRN
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Moodus CT 06469

The Future of Nursing Leading Change, Advancing Health.//www.nap.edu/catalog/12956.html

David H. Gorski, MD, PhD, FACS
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February 27, 2014

RE: Governor's Bill #36: An Act Concerning the Governor's Recommendations to Improve Access to Health Care.

Dear Senator Gerrantana, Representative Johnson and members of the Public Health Committee:

I am writing to you to urge your support for Governor's Bill #36 An Act Concerning the Governor's Recommendations to Improve Access to Health Care.

Although the views described in this letter belong only to me and do not necessarily represent those of my hospital or university, describing why I support this bill requires that I briefly list my qualifications. I serve as the medical director of the Alexander J. Walt Comprehensive Breast Center at the Barbara Ann Karmanos Cancer Institute, as well as chief of the Breast Surgery Section in the Department of Surgery at the Wayne State University School of Medicine in Detroit. Prior to that, I served as an Associate Professor of Surgery at the Rutgers Cancer Institute of New Jersey. Ever since I completed my surgical oncology fellowship in 1999, I have collaborated with nurse practitioners, both in New Jersey and Michigan. As a result, I know that NPs when practicing in their scope of practice not only provide excellent care, but increase access to care for patients who might have difficulties obtaining appointments to see physicians and surgeons. Contrary to the misgivings expressed by many physicians that expanding the scope of practice of NPs will result in substandard care and potential patient harm, there is no evidence in the scientific literature that I have been able to locate to support such fears and solid evidence to support the conclusion that NPs can provide effective and high quality care. For example, a recent systematic review¹ of the medical literature found that the use of NPs "in acute care settings can reduce length of stay and cost of care for hospitalized patients" and APRNs "provide effective and high-quality patient care, have an important role in improving the quality of patient care in the United States, and could help to address concerns about whether care provided by APRNs can safely augment the physician supply to support reform efforts aimed at expanding access to care," while a Cochrane Systematic Review² found that "appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients."

It is for these reasons that I urge you to consider and support Governor's Bill #36

Sincerely,



David H. Gorski, MD, PhD, FACS, MD, PhD

REFERENCES:

- 1 Newhouse RP, J Stanik-Hutt, KM White, M Johantgen, EB Bass, G Zangaro, RF Wilson, L Fountain, DM Steinwachs, L Heindel, and JP Weiner (2011) Advanced practice nurse outcomes 1990-2008 a systematic review *Nurs Econ* 29 230-250, quiz 251 ID
- 2 Laurant M, D Reeves, R Hermens, J Braspenning, R Grol, and B Sibbald (2005). Substitution of doctors by nurses in primary care. *Cochrane Database Syst Rev* 10 1002/14651858 CD001271.pub2 CD001271 ID:

Eric D. Grahling MD SB 36

As President of the CT Pain Society, please let this serve as testimony of strong opposition towards SB 36. Said bill will endanger CT patients, expand the narcotic epidemic and increase the cost of care to us all. Pain management is an incredibly complicated field that takes many years of specific training to master and APRN's and CRNA's simply do not have that training. Most non-pain management physicians themselves even struggle with this aspect of patient care. CRNA's are not properly trained to perform any spinal injections for pain conditions (other than in OB anesthesia in the hospital perhaps) and if they are allowed to perform them, people will get hurt and the cost of health care will skyrocket with certain increased abuse and misuse. The number of narcotic prescriptions will increase surely and the epidemic of abuse will worsen. There is no access to care issue in CT as far as pain doctors go. The risks of said legislation far outweigh any potential benefits, of which we can see none.

Respectfully,

Eric D. Grahling MD
President of the CT Pain Society
CAC Member for pain management
Board Certified and Fellowship trained in pain management

--

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President - Connecticut Pain Society
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David Boisoeneau, M.D. SB 36

Connecticut ENT Society

Connecticut Dermatology and Dermatologic Surgery Society

Connecticut Urology Society &

Connecticut Society of Eye Physicians

Testimony Opposing

SB No 33 AAC the Governor's Recommendations to Improve Access to Healthcare

Before the Public Health Committee

On February 28, 2014

Good Afternoon, Senator Gerrantana, Representative Johnson and distinguished members of the Public Health Committee, my name is David Boisoeneau, M.D. I am a board certified otolaryngologist (ENT) practicing in Waterford and Mystic, Connecticut. I was for present the Department of Public Health Program Review hearings on APRN scope expansion. As a member of the Executive Committee of the CT State ENT Society, I represent over 1000 board-certified surgeons in this state, and we collectively urge you to OPPOSE SB 36 as currently written.

I will be as brief as possible. Many of the surgeons I represent have had and will continue to have very successful collaborative agreements with APRNs. Our APRNs are essential in helping us with the management of difficult problems such as oral cavity cancer, chronic sinus disease, and postoperative care and counseling. It is a collaborative effort and an arrangement that works best for the patient and provides for the highest level of care. Allowing an APRN to be independent after three years of "collaboration", rather than practicing in a team model appears to undermine the entire system. I am not suggesting that APRNs are intending to become ENT specialists or attempting to perform specialized surgical procedures, HOWEVER there is nothing in this statute that states otherwise.

Most APRNs in this state provide primary care level medical diagnosis and treatment, and by and large they do it very well in collaboration with a trained, licensed physician. Family medicine physicians, primary care internal medicine specialists, pediatricians, psychiatrists and emergency medicine doctors all have extensive post-graduate training, accomplished during a 3+ year residency program. This rigorous and well-monitored training can include up to 12,000 clinical patient hours, as well as didactic lectures and even medical research. This as AFTER the completion of 4 years of medical school. In contrast, after obtaining an RN, only 500 clinical hours is the average training for an APRN. Thus, by allowing APRNs to independently practice after a loosely defined, much less intensive "collaboration period" seems irresponsible at best, and potentially dangerous at the worst.

The field of Ear, Nose and Throat surgery is complex and varied, and in order for us to become experts we require 4 years of medical school followed by 5-6 years of intensive post-graduate training under strict, regulated supervision

I have a close friend who has been a primary care APRN for over 20 years. She knows more about treating primary care patients than many of the providers who refer patients to me. When told of the three year period, she expressed astonishment to me that any APRN could be deemed adequately trained to be an independent provider responsible for a human life in such a short period of time. She also stated that her biggest challenge in her practice is trying to reconcile medications that are prescribed to her patients specifically by psychiatric APRNs. This alone would have motivated me to come to Hartford to oppose this bill, even if I were not the president-elect of the CT ENT Society.

In summary, APRNs are essential members of the health care team. A team in which each individual brings unique talents and education in order to deliver the best health care possible. Let us not forget that there are levels to this delivery system, and simply empowering well trained nurses to the same level as physicians who are fully trained in a

tightly regulated system has the potential to dismantle the system and do more harm than good. Remember, *primum non nocere*.

"First, Do No Harm"

Respectfully submitted

David S. Boisoneau, M.D.

President-Elect CT State ENT Society

PUBLIC HEALTH COMMITTEE HEARING - FEBRUARY 28, 2014

GOVERNOR'S BILL No. 36 AAC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

Testimony of Kathleen Sullivan-Conger APRN

My name is Kathleen Sullivan-Conger, I am an advanced nurse practitioner board certified in mental health ages 13- through the life span. As a reminder I testified last year and expressed concern to the severe problem in Ct to obtain and maintain a collaborative psychiatrist. I had to leave a federally qualified community health center position due to the unmet health standards of the collaborative agreement. I also expressed concern for the growing need for psychiatric providers to see children and teenagers in our community. Many parents and primary care doctors have voiced concern as to the lack of access to care for this specialty service and the lack of providers willing to take certain insurances specifically state insurance and the United health plan leaving children, teenagers and their families without psychiatric care. I did not own my practice and subsequently there was a barrier to my professional choices of which insurances I could be in network with and I could not. I was no longer providing care to state insured and united health care insured families.

In my opinion we can no longer allow for this barrier to the people and children of our state. Ct state insurance covers those in need who may be layed off, suffering from illness, or struggling with financial burdens. United plan covers certain state insurance plans and is also the plan of choice for many Ct. companies including General Dynamics our work force of Ct who protects our nation. My father worked at EB for 45 years and my brother for 35 years. I thought how could this be that I cannot help these families unless they pay me cash and do not use their hard earned insurance plan. People are paying for their care out of their paycheck and charging their health care on cards **because providers are not accepting their insurances.**

The only way I could serve this population was to start my own practice and I had wanted to do that here in CT. but it is too difficult to obtain a collaborative agreement in Ct and there is too high a risk of it being invalidated if a doctor retires, moves or dies. My only choice was to leave the state and go where I am allowed to practice without fear of loosing my practice. Where I can treat patients who are in great need of mental health care and may have insurance plans that other providers do not accept.

I was extremely frustrated that our bill was not passed last year and felt that I had to do something other then wait. Ct has a risky business environment leaving NP's dependent on a letter and I could not afford to take this risk in our economy. I now own a private practice in Westerly RI and I am pleased to be in network providing care for families who are covered by Ct. Medicaid (Husky), United health care, Tricare military insurance and RI children's state plan (as well as many others). I have started seeing the children and families of Ct who travel to RI and I

have been making collaborative collegial partnerships in the community meeting with primary care doctors and NPs, pediatricians, and have recently met with a health center to facilitate access to quality mental health services. I have a vast network of collaborators in my field of practice and am starting a collaborative meeting group to address patient health needs and trauma informed care. The response has been inviting and I quote from primary care offices and parents "Thank god you are here" My question is why did I have to leave the state I was born in where my family and friends live, where my community is in order to provide what they need?



PUBLIC HEALTH COMMITTEE FEBRUARY 28, 2014

SENATE BILL #36: AAC THE GOVERNORS RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTHCARE

Testimony of Vanessa Pomarico, APRN, President of the Connecticut Advanced Practice Registered Nurse Society (CT APRN Society) IN SUPPORT OF Senate Bill #36

Senator Gerratana, Representative Johnson, and members of the Committee:

Thank you for raising this bill.

I am President of the Connecticut Advanced Practice Registered Nurse Society (CTAPRNS) and am asking for your support of this bill. It is the CT APRN Society that requested this scope of practice review from the Department of Public Health. I am a practicing APRN for the past 16 years in a private, internal medicine practice. Additionally, I serve as the Interim Director of the Family Nurse Practitioner Track at Southern Connecticut State University educating tomorrow's practitioners.

In 1999, the law passed granting independent practice to APRNs in CT. A collaborative agreement has been required of all APRNs to practice in this state since that time. I want to emphasize that it is inherent in our profession, both ethically as well as medically, to consult and collaborate with other providers when the need arises in the care of any patient. The collaborative agreement does not define how we practice or prohibit us from making sound medical decisions regarding our patient's health and well-being. Removal of the collaborative agreement will in no way jeopardize the safety of our patients. The collaborative agreement is a barrier to practice and more importantly, access to care.

My physician colleagues are nearing retirement age. Our office is one of the few internal medicine practices in our area that is not closed to new patients or insurances. With the Affordable Care Act now a reality, the loss of my two physicians will present a difficult decision upon their retirement as I will not be near retirement age but will be forced to close a practice I have spent building well over the past decade resulting in the loss of providers for a large number of patients.

I am well respected among the medical community of the Greater New Haven area with solid professional relationships with specialists in every aspect of medicine, many of whom request to consult with me in my area of expertise. I also am the healthcare provider for family members of many of these physician specialists who respect my profession but more importantly, my level of expertise. A collaborative agreement does not make APRNs good practitioners. Our knowledge and expertise makes us good practitioners. The collaborative agreement has no bearing on how we practice. It is simply a barrier to access to care.

APRNs have a long history of well documented patient safety and patient satisfaction. We make no fewer or no more referrals than our MD colleagues do to the emergency department or to a specialist. Removal of this agreement does not grant us any authority we do not already have in our practices but will allow us to remain in practice upon the retirement, relocation or death of our MD colleagues thus providing continued care to the citizens of Connecticut.

As our state is impacted by the influx of the newly insured, primary care providers are needed to absorb and offer outstanding healthcare. There is already a well-documented physician shortage. APRNs are not in competition with our physician colleagues. We are simply looking to be part of the solution to the benefit of Connecticut's residents.

I urge you to support this bill, prevent practices from closing and increase consumer access to care.

Ami Marshall SB 36
142 Scott Ave.
Watertown, CT 06795

I would to thank the members of the PHC for consideration of the Governor's bill #36. I am in strong support of this bill to remove the written collaborative agreement with a MD for APRN practice.

I have been an APRN for approximately 10 years and have been serving Litchfield County throughout my APRN career. For the past 7 years, I have been employed as a primary care provider in a Community Health Center, I have seen firsthand the effects of the Affordable Care Act and the increasing demand for healthcare among the newly insured. There is a desperate need for new primary care providers and Nurse Practitioners are ideal providers to meet this demand. I have had the privilege to work at the Community Health and Wellness Center of Greater Torrington which is a predominantly Nurse Practitioner run facility. Our CEO is an APRN and we presently employ 9 Nurse Practitioners. We have 2 physicians in our practice, one of whom was recently hired. These physicians are our colleagues and there is a mutual respect among all providers in this facility for the unique care each individual provides. Each provider in our practice consults and collaborates with each other when there is a medical issue of concern for one's patient. Collaboration is essentially consultation and this is what every ethical practitioner engages in; whether it be a nurse, physician, or physical therapist. Bill #36 does not impact any ethical standards of practice relating to collaboration and consultation. Nurse Practitioners already have full practice authority; this bill will allow APRNs to remain in practices and allow them to open practices which is necessary to meet the increasing demands of the newly insured. The Collaborative Practice Agreement has nothing to do with how Nurse Practitioners take care of patients. Patients need to have access to quality healthcare providers that are able to practice to their full education and training. By removing the need for a Collaborative Practice Agreement after 3 years of practice, this will allow APRNs to effectively provide this care.

Thank you,
Ami Marshall APRN



**Connecticut State Medical Society Testimony
CSMS Vice Chair Steven Wolfson, MD
Regarding Senate Bill 36 An Act Concerning the Governor's
Recommendations to Improve Access to Care**

**Public Health Committee
February 28, 2014**

Senator Gerratana, Representative Johnson, and members of the Public Health Committee, on behalf of the Connecticut State Medical Society and its over 6,000 physicians and physician in training members, thank you for the opportunity to testify today.

My name is Steven Wolfson, MD. I am a board-certified cardiologist in New Haven, and I currently serve as Vice Chair of the Connecticut State Medical Society.

Regretfully, I am here today to oppose passage of Senate Bill 36.

I say this with regret because I have seen the benefits of APRNs and physicians training together and then working together, collaboratively, over long periods of time.

One Saturday a month, I volunteer as a Faculty advisor to the Free Clinic in Fair Haven, CT. Here medical students, nursing students, and Physician Assistant students work together to serve uninsured patients under the supervision of physicians and of the superb APRNs who have worked collaboratively at the Fair Haven Clinic for years.

It is a yeasty mix. And I must say that as a cardiologist, I have much to offer here. But I have also learned from the experienced APRNs who have matured in a collaborative setting at the Fair Haven clinic. Without exception, they are caring, committed, and wise clinicians. It is clear that they have benefited from a setting where they have interacted with physicians over the years, often sharing the same patients.

The concept of independent practice concerns me. I doubt that many physicians will be willing to collaborate with an APRN, share exposure to their patients, share the benefits of our advanced training, and then see the APRN leave the practice and set up his or her own office nearby. It is not realistic to expect this. We will be competitors, not collaborators.

And so the inevitable progression will be that APRNs will establish their own training and experience settings. The disciplines will drift apart. Their pride in their accomplishments will further this divide, naturally. And we will all lose from this – especially our patients.

At a time when integrated, shared, team approaches to health care are being fostered at the national and local level, establishing a separate track to clinical practice is not wise.

Thank you again for the opportunity to speak today.

PUBLIC HEALTH COMMITTEE PUBLIC HEARING FEBRUARY 28, 2014**GOVERNOR'S BILL No 36****AAC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE****Ines M. Zemaitis APRN, BC IN SUPPORT OF BILL #36****Senator Gerratana, Representative Johnson, and Members of the Committee:**

I am a licensed, board certified, graduate of Yale University, as an Adult Health Nurse Practitioner. I am your direct access to primary care, preventative care, and your medical home. Connecticut House Bill 36 is imperative to the evolutionary changes in healthcare for the protection and improvement of the health of the people in Connecticut.

Public Act 99-168 has increased health care costs and limits access to the public. In July 2013, I performed a preoperational physical on a patient who required extensive dental procedures at a Dental location in Connecticut. The orthodontist refused to accept my signature on my examination stating that I required a physician to supervise and sign my assessment, diagnosis, plan and recommendations for the surgery. I immediately directed the orthodontist to Public Act 99-168 and reiterated that I am not in a supervised role directed by a physician. The orthodontist refused my signature, demanded the Medicare patient to return to the office to have another preoperational physical to be performed by a physician. Medicare denied the claim for the preoperational physical performed by the physician due to the fact that Medicare had already paid the claim for the preoperational physical that I had performed earlier that week. The patient, therefore, had to pay an out of pocket expense because the orthodontist refused to accept Public Act 99-168 on nurse practitioners signature.

In November 2012, the outpatient laboratory center at A CT Hospital refused to accept my order because I am a nurse practitioner and not a physician. They stated they cannot process my laboratory

orders due to not having an attending physician within the hospital. I spoke with the manager of laboratory services, in which she stated that I need a supervising physician to process the order. I explained that I do not practice with a supervising physician; that I have a collaborating relationship with a physician and that prescriptive authority is given by a collaborating physician, not my license.

Laboratory requisitions that were directly given by me with my signature *continue* to be placed as ordered by another physician. This has been a chronic and debilitating problem that has impacted negatively towards the care and the safety of my patients. Numerous times I have not received laboratory data due to the imputing technician placing my collaborator, and/or past physicians seen by the patient, and/or a random physician as the ordering provider. This has chronically delayed care, and jeopardized the proper health care for my patients.

There are patients that have been contacted by other providers that were at "randomly" imputed as the ordering provider and were either given more blood analysis to do, and/or given medication, and/or told to have a follow up. Consequently, health care costs were processed that were not justified nor were they clinically indicated. Furthermore, due to the lack of the appropriate ordering provider on the laboratory analysis, patients were receiving medications that were ordered by myself and then by another physician. This could have been a sentinel event due to actions from the Saint Mary's Hospital's Laboratory Services.

A complaint was made directly to the Department of Public Health on March 15, 2013 and is currently under investigation.

The cessation of the collaborative agreement of nurse practitioners with physicians will end the archaic relationship between these two healthcare groups. Continuing this law will increase risks to the public's mental and physical health, such as the risks that were imposed by Saint Mary's Hospital's confusion with this law.

"Mid-level" is not a term that is generated by the American Nurses Association for nurse practitioners. This is a term generated by the American Medical Association to Physician Assistants and then later grouped to nurse practitioners by the American Medical Association. However, the level of education of nurse practitioners is to practice within the scope of primary care and those of physician assistants are to practice as an extension of a physician.

It is imperative that the autonomy of nurse practitioners, the level of education, the expertise, the cost effective care that is given, and concurrently with the continued changes in healthcare, that it is reflected within the laws of the State of Connecticut to remove this collaborative agreement.

Members of the Legislative Committee, I thank you for your time and commitment

Sincerely,

Ines M. Zemaitis APRN, BC

Board Certified Adult Nurse Practitioner, American Nurses Credentialing Center

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**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 Gerrata, 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 regarding Senate Bill 36 An Act Concerning the Governor's Recommendations to Improve Access to Health Care. CSMS has submitted testimony on our opposition to this legislation. This testimony focuses on clinical concerns with the prescribing habits of APRNs.

A research study was recently completed by CSMS, investigating the differences in prescribing practices between physicians and APRNs who prescribe psychotropic medications in the state of Connecticut. Data was analyzed from IMS Health, the world's largest healthcare data source, representing more than 75% of all Connecticut-based prescriptions. The CSMS study results are used in a manuscript currently being prepared for publication in a peer-reviewed scientific journal.

The study found statistically significant differences in prescribing patterns between physicians of certain specialties, particularly child psychiatrists, and APRNs when prescribing for children with mental illness. Specifically, APRNs prescribe a significant number of antipsychotic medications to children in Connecticut. The main statistically significant differences had to do with the level of prescribing of antidepressants (SSRIs and SNRIs) to children age 4- 12 by child psychiatrists, pediatricians, and other physicians in Connecticut, compared to antipsychotic medications that were more often prescribed by APRNs. The antidepressant medications used by physicians generally have fewer side effects compared to the antipsychotic medications more often used by APRNs.

Logistic regression analysis showed that the differences in prescribing habits and medications prescribed to children are statistically significant. One possible explanation for these findings is the substantial difference in education and subsequent training for physicians and for APRNs. Connecticut APRNs in Connecticut are only required to receive *thirty hours* of pharmacology training to receive their Connecticut license. By contrast, physicians log thousands of hours in pharmacological training. Another possibility would be that there is substantially more marketing of antipsychotic medications than antidepressant medications, and we are concerned that lack of pharmacological training and experience by APRNs may lead them to tend towards the highly marketed medications.

We would be happy to provide the committee members with additional research details, as well as the manuscript in preparation and the data summary to support this testimony.



Connecticut State Society of Anesthesiologists
 127 Washington Avenue, East Building, 3rd Floor
 North Haven, CT 06473-1715

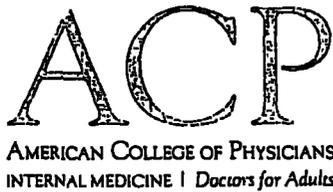
**Connecticut State Society of Anesthesiologists in Opposition to
 Senate Bill 36 An Act Concerning the Governor's Recommendations to Improve
 Access to Health Care
 Presented to the Public Health Committee
 February 28, 2014**

The Connecticut State Society of Anesthesiologists represents over 700 anesthesiologists in Connecticut, which includes practicing physicians, medical professors, and medical students. We write today in strong opposition to Senate Bill 36, An Act Concerning the Governor's Recommendations to Improve Access to Health Care. If passed, this bill would negatively impact the safety of patients in Connecticut by reducing the education and training requirements for practicing medicine by granting independent diagnostic and prescribing authority to Advanced Practice Registered Nurses (APRNs).

Granting APRNs independent practice authority would further fragment a health care system already fraught with overlapping, duplicative, and unnecessary services and providers, thus hurting rather than helping patient care. If SB 36 passes as it is written, APRNs will have complete, independent prescriptive authority after three years of collaboration, essentially allowing them to practice medicine without the benefit of a physician's educational background. Team-based, physician-led care results in better quality outcomes, higher patient satisfaction rates, and more cost-effective care. Moreover, a comprehensive analysis published by the Cochrane Library (a highly respected source of medical evidence) suggests that savings in cost, which are mostly due to differences in salary, are offset by the lower number of patients seen by APRNs.

The language in SB 36 is confusing. CSSA is concerned about CRNAs "not in a surgical setting" and their ability to practice independently. CSSA's hope is that the legislation does not apply to CRNAs "not in a surgical setting." However, clarification is needed in this area.

The Connecticut State Society of Anesthesiologists strongly opposes this legislation. Patients want - and deserve - to see a physician. When asked, four out of five patients preferred a physician to have primary responsibility for leading and coordinating their healthcare. To better ensure the safety of the patients in your community, we request that you also oppose SB 36.



Connecticut Chapter
www.acponline.org/chapters/ct

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**Connecticut Chapter of American College of Physicians
Testimony in Opposition to Senate Bill No. 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 internal medicine specialist and subspecialist physicians of the Connecticut Chapter of the American College of Physicians, we present this testimony to you today in strong opposition to Senate Bill No. 36, An Act Concerning the Governor's Recommendations to Improve Access to Health Care.

Our healthcare system needs to incorporate Advanced Practice Registered Nurses (APRNs) more effectively, and they should be allowed to practice within the scope of their training and education. But the limits of that training and education must be acknowledged. Those limitations should preclude the independent practice of APRNs in Connecticut. Innovations in Connecticut's healthcare system are already evolving to expand the role of APRNs in clinical care teams and do not require their independent practice. That should be our focus.

Our healthcare system needs to deliver better access to care of whatever sort is needed: routine preventive care, simple illness, management of complex multiple chronic conditions and specialist care. Sometimes a patient knows exactly which of these types of care is needed in a given situation, but that is not always the case.

Many have publicly stated that APRNs are adequately trained to practice independently in those areas of primary care that are within the scope of their training and education. But what does that really mean? The Institute of Medicine has defined "Primary Care" as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing the large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." A primary care clinician's practice should be the point of first contact for a medical problem or question. What "scope of training and education" is adequate to serve this role well?

It might be easy to determine that a given APRN or doctor cannot perform surgery because it is not within a certain scope, but primary care is more difficult to define since it spans a spectrum from simple illness to complex multi-system conditions, all with the same presenting symptoms. Exactly what "scope of practice" enables a clinician to differentiate a little sick from really sick? Does a clinician with just a couple of years of clinical training have the clinical judgment to adequately evaluate, diagnose, and treat a typical primary care problem like several weeks of cough in an elderly patient with multiple medical

problems like diabetes, a history of congestive heart failure, and chronic lung disease? That is potentially quite different from treating a healthy young adult with a cough from a couple weeks of a viral respiratory infection. Yet, these two situations have the same presenting symptoms and might erroneously get placed into the same protocols of management. That is not the good care we want to provide to our patients.

Without adequate clinical training and judgment, a clinician CANNOT know when he or she is beyond his/her scope of practice or expertise. The explosion of medical knowledge in recent decades requires that physicians have extensive education and training. A primary care doctor needs many years of basic science training and hands-on experience to develop the clinical judgment to become a good diagnostician and caregiver. Yes, certain aspects of straightforward mild illness and preventive care can be delivered just as well from an APRN as from a seasoned doctor. But does that warrant completely independent practice for APRNs in primary care without limitations?

A patient does not necessarily have the ability to determine that her symptom can be adequately managed by an APRN or needs the greater diagnostic acumen of a doctor. Therefore, APRNs must be practicing in situations where consultation is readily available. To ensure that different types of clinicians are able to practice effectively to the "top of their licenses," the concept of clinical teams has evolved

The physician community does not deny that APRNs have a valuable role to play in delivering excellent care to all our patients. We need to figure out how to better fit APRNs as well as physician assistants and other clinical colleagues into situations to deliver good patient care. That requires a better healthcare delivery AND payment system with teams of different professionals providing coordinated and efficient care. This strategy will improve access for patients. We must move forward to encourage the development of effective clinical care teams as ways to deliver the highest quality, most coordinated, and safest care for our patients.

Please oppose Senate Bill No. 36.

Respectfully,



Robert J. Nardino, MD, FACP
Governor, CT Chapter, American College of Physicians

Untitled Message

Page 1 of 1

Malcolm, Millicent

Sent: Wednesday, February 26, 2014 12:17 PM

To: Malcolm, Millicent

printing to include in our group testimony

From: Alexander, Ivy

Sent: Wednesday, February 26, 2014 12:00 PM

Dear Senator Gerrantana, Representative Johnson, and members of the Public Health Committee,

We, the undersigned faculty of and the students from the APRN programs at the University of Connecticut School of Nursing, provide this written testimony for the Public Health Committee Hearing being held on February 28, 2014 in support of Governor's Bill 36 to remove the mandated written collaborative agreement for APRNs. We believe this bill will increase access to care for Connecticut citizens by meeting the growing need for primary care providers and allowing all providers to practice to their full scope of education and training. Connecticut citizens had difficulty accessing primary care even before the influx of new patients expected with the Affordable Care Act. There are not enough NEW primary care doctors to handle this increased volume of patients. By keeping the mandated collaboration agreement in place, APRNs with practices, who cannot find collaborating physicians to sign the agreement, will close practices leaving patients without their health care provider. New APRN practices will not be opened due to the difficulty finding willing collaborating physicians to sign the agreement. Removing the mandate for the collaborative agreement, will enhance competition and allow patients a choice in health care providers, while allowing more APRNs to open practices to provide innovative health care delivery.

These measures will surely ease the shortage of primary and behavioral health care providers in areas of the state desperate for care. The IOM (Institute of Medicine), National Governors' Association and the FTC (Federal Trade Commission) all support removing barriers to APRN practice. We feel Connecticut must align itself with the 18 other states who have removed barriers to APRN practice including our neighboring states of Maine, Vermont, New Hampshire, and Rhode Island, with Massachusetts also pending a bill of their own. Please hear the voice of your APRN constituents this year, and help us to finally remove this barrier that only reduces our citizen's access to high quality care. This collaborative mandate serves no purpose other than to keep control of the APRN in a fiscal way, as we are required to collaborate with other health care providers as needed as part of our professional practice and in respect for our code of ethics as nurses---the most ethical profession voted year in and year out in public polls. Thank You.

Ivy M. Alexander, PhD, APRN, ANP-BC, FAAN
Clinical Professor and Director of Advanced Practice Programs
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Dear Senator Gerrantana, Representative Johnson, and members of the Public Health Committee,

We, the undersigned faculty of and the students from the APRN programs at the University of Connecticut School of Nursing, provide this written testimony for the Public Health Committee Hearing being held on February 28, 2014 in support of Governor's Bill 36 to remove the mandated written collaborative agreement for APRNs. We believe this bill will increase access to care for Connecticut citizens by meeting the growing need for primary care providers and allowing all providers to practice to their full scope of education and training. Connecticut citizens had difficulty accessing primary care even before the influx of new patients expected with the Affordable Care Act. There are not enough NEW primary care doctors to handle this increased volume of patients. By keeping the mandated collaboration agreement in place, APRNs with practices, who cannot find collaborating physicians to sign the agreement, will close practices leaving patients without their health care provider. New APRN practices will not be opened due to the difficulty finding willing collaborating physicians to sign the agreement. Removing the mandate for the collaborative agreement, will enhance competition and allow patients a choice in health care providers, while allowing more APRNs to open practices to provide innovative health care delivery. These measures will surely ease the shortage of primary and behavioral health care providers in areas of the state desperate for care.

The IOM (Institute of Medicine), National Governors' Association and the FTC (Federal Trade Commission) all support removing barriers to APRN practice. We feel Connecticut must align itself with the 18 other states who have removed barriers to APRN practice including our neighboring states of Maine, Vermont, New Hampshire, and Rhode Island, with Massachusetts also pending a bill of their own. Please hear the voice of your APRN constituents this year, and help us to finally remove this barrier that only reduces our citizen's access to high quality care. This collaborative mandate serves no purpose other than to keep control of the APRN in a fiscal way, as we are required to collaborate with other health care providers as needed as part of our professional practice and in respect for our code of ethics as nurses—the most ethical profession voted year in and year out in public polls. Thank You.

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Melissa Bohm-Hallenbede		5 CHARLES ST.	PUTNAM
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Agricia VARMA		30 Elm Hill Rd	East Lyme CT
Alexandra Venezia		9 Cranberry Lane	Glastonbury
Crista moggio		6 Beards Lane	Enfield, CT
Patricia Gramaglia		4 GAVO DR	East Hartford, CT
Kim Nayfeh		25 Tallwood Hollow	Avon CT
Vasnia Vee		53 Brookstone Dr	Sterling CT
Christina Greisler		535 Tollard Stage Rd	Tolland, CT
Annley P. Drey		21 HAZELWOOD DR.	SOUTHINGTON
Kristin Koidt		147 Admirer Rd	West Hartford, CT
Martha Stewart		115 Birdseye Rd	Farmington, CT
Emily Woods		79 Joan Circle	Manchester, CT
M. Nicole Malcolm		369 Baileyville Rd	Middletown, CT

Pant Name	Signature	Street Address	City or Town in CT
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Marina Creed	Marina Creed	87 Outlook Ave	West Hartford CT 06119
Emily Miesse	Emily Miesse	30 James Rd East	Jurman, CT 06422
Svetla Faldu	Svetla Faldu	6 Colde Rd	Windsor CT 06095
Caitlin Brunner	Caitlin Brunner	90 Pondmill Rd	Plantsville, CT 06479
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Shantay Wells	Shantay Wells	32 Bolton St.	Hartford, CT. 06114
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DANIELA LA ROSA	DANIELA LA ROSA	19 Kildgore Circle	Wethersfield, CT 06097
Shelvia Toffay	Shelvia Toffay	11 Colobs St. #200	Weymouth, MA 01967
Mackenzie Corbett	Mackenzie Corbett	430 Brewster Rd	Glastonbury, CT 06033
CHRISTINE NEEDHAM	CHRISTINE NEEDHAM	31 Plaza Way Apt 1017	Hartford CT 06114

Untitled Message

Page 1 of 2

Malcolm, Millicent

Sent: Wednesday, February 26, 2014 12:46 PM

To: Malcolm, Millicent

printed at the request of Paula McCauley and submitted with our group testimony

From: Mccauley, Paula**Sent:** Wednesday, February 26, 2014 12:37 PM

Dear Senator Gerrantana, Representative Johnson, and members of the Public Health Committee,

We, the undersigned faculty of and the students from the APRN programs at the University of Connecticut School of Nursing, provide this written testimony for the Public Health Committee Hearing being held on February 28, 2014 in support of Governor's Bill 36 to remove the mandated written collaborative agreement for APRNs. We believe this bill will increase access to care for Connecticut citizens by meeting the growing need for primary care providers and allowing all providers to practice to their full scope of education and training. Connecticut citizens had difficulty accessing primary care even before the influx of new patients expected with the Affordable Care Act. There are not enough NEW primary care doctors to handle this increased volume of patients. By keeping the mandated collaboration agreement in place, APRNs with practices, who cannot find collaborating physicians to sign the agreement, will close practices leaving patients without their health care provider. New APRN practices will not be opened due to the difficulty finding willing collaborating physicians to sign the agreement. Removing the mandate for the collaborative agreement, will enhance competition and allow patients a choice in health care providers, while allowing more APRNs to open practices to provide innovative health care delivery. These measures will surely ease the shortage of primary and behavioral health care providers in areas of the state desperate for care. The IOM (Institute of Medicine), National Governors' Association and the FTC (Federal Trade Commission) all support removing barriers to APRN practice. We feel Connecticut must align itself with the 18 other states who have removed barriers to APRN practice including our neighboring states of Maine, Vermont, New Hampshire, and Rhode Island, with Massachusetts also pending a bill of their own. Please hear the voice of your APRN constituents this year, and help us to finally remove this barrier that only reduces our citizen's access to high quality care. This collaborative mandate serves no purpose other than to keep control of the APRN in a fiscal way, as we are required to collaborate with other health care providers as needed as part of our professional practice and in respect for our code of ethics as nurses—the most ethical profession voted year in and year out in public polls. Thank You.

Paula McCauley DNP, APRN, ACNP-BC, CNE
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*A District Branch of the
American Psychiatric Association*

Connecticut Psychiatric Society

Good afternoon. My name is Carolyn Drazinic. I am a psychiatrist and President of the Connecticut Psychiatric Society, representing almost 800 psychiatrists in Connecticut. I am here today to express our opposition to the section of Bill Number 36, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE that will allow APRNs to work independently without collaboration with a physician.

Our opposition to this bill has nothing to do with the value of nurses at any level. Psychiatrists work with nurses in teams in many kinds of institutions and practices.

The concern is that given nurses' training models and the circumstance of clinical practice today, practicing independently in the community is not the best model for delivering care medically or economically. In fact, the model of independent practice is not working for many physicians any more either.

Over the last few years the nurses have asserted that they cannot get collaborative agreements with physicians. This causes us to ask the question: If they cannot find physicians to collaborate with them now, how is the situation going to be improved once the law is voided?

The argument that a less-trained practitioner can be available to see simple problems and relieve the load that physicians bear works well in institutions where such referrals take place down the hall, so to speak. It doesn't work that well in the community.

Allowing nurse practitioners to practice independently seems like an easy solution, but it is fraught with problems that will become more obvious to everyone should this legislation be implemented.

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**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

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

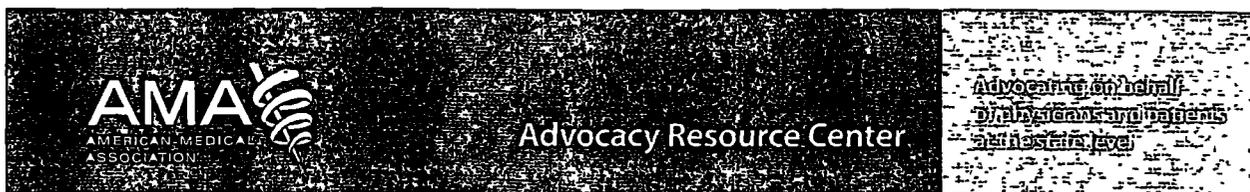
Thank you for your time and consideration of the orthopaedic community's concerns regarding the serious patient safety issues of this bill. The Connecticut Orthopaedic Society strongly urges this Committee to maintain the current model in place for APRNs in our state and oppose SB 36.

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

Submitted by:

Ross Benthien, MD

President-Connecticut Orthopaedic Society



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	2012	2008	2012	2008	2012
Orthopaedic surgeon/Orthopaedist	94	84	3	12	3	4
Obstetrician/Gynecologist	92	93	5	4	3	3
Primary care physician ¹	n/a	91	n/a	7	n/a	2
General or family practitioner	88	88	8	9	3	4
Dermatologist ⁴	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	64	9	6
Doctor of nursing practice	38	35	37	46	25	19
Audiologist	33	30	40	47	27	23
Otolaryngologist/ENT ³	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

Additional findings from the "Truth in Advertising" surveys

Patients strongly prefer physicians to lead the health care team

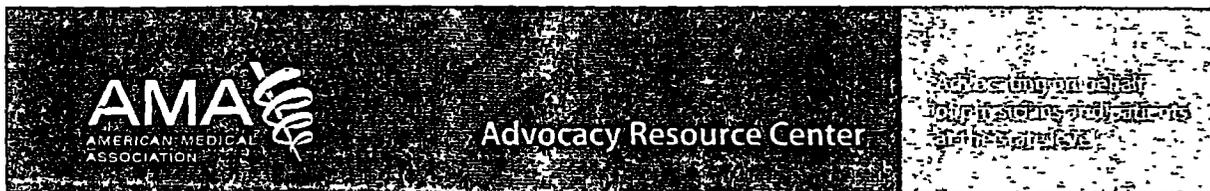
Should only a medical doctor be allowed to perform the following procedures or should other health care professionals be allowed to perform this specific activity?	Only a medical doctor (%)			Other health care professional (%)			Both equally/ either one (%)			Don't know (%)		
	2008	2010	2012	2008	2010	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	94	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	2008	2010	2008	2010
	93	87	6	10	1	3

- 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.
- Baselice & Associates conducted a telephone survey on behalf of the AMA Scope of Practice Partnership between November 4–8, 2010. Baselice & Associates surveyed 850 adults nationwide. The overall margin of error is +/- 3.4 percent at the 95 percent level.
- Baselice & Associates conducted a telephone survey on behalf of the AMA Scope of Practice Partnership between March 8–12, 2012. Baselice & Associates surveyed 801 adults nationwide. The overall margin of error is +/- 3.5 percent at the 95 percent level.
- The physician professions "primary care physician" and "dermatologist" were not referenced in the 2008 survey.
- 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.

CONNECTICUT HOLISTIC AND INTEGRATIVE MEDICINE

1057 Poquonnock Road * Groton, Connecticut * 06340 *

Office: (860) 445-2130 Fax: (866) 830-0472

Rebecca Murray APRN, FNP, CDE Medical Director

Jordan Goetz, MD Medical Consultant

February 27, 2014

Dear Senator Terry Gerratana,

I am writing this letter in regard to the Governor's Bill #36 concerning the ability of Advanced Practice Registered Nurses (APRNs) who have been in practice for many years to continue to practice WITHOUT the need to have an identified collaborative physician.

I joined the practice of CT Holistic and Integrative Medicine in 2001 and in 2009 I bought the practice from Dr Jordan Goetz as he moved onto a salaried position elsewhere in the state. He stayed on as my "collaborative physician". I am on the insurance panels and bill directly to them. I have saved so much money for the insurance companies as I practice "preventative medicine" and focus on keeping my patients healthy.

Dr. Goetz is considering retiring and moving to another state. Does this mean I have to close up my practice as when I have spoken to other physicians in the area, they are SO busy with their own practices that they do not want to take on "one more thing". That does not surprise me as with the extra time that is now needed in completing Electronic Medical Records and keeping up with all the changes in all the insurance plans and spending so much time in doing "prior-authorizations" etc, etc, etc, it is NO WONDER that they would say no. I respect their decision. I have not had to utilize the services of Dr. Goetz as I do what any dedicated practitioner would do for their patients and that is "collaborate" with a person who specializes in the area that correlates with the particular needs presenting by their patient.

If I, and other APRNs, find ourselves in the position that their identified collaborative physician retires, moves, or just decides that do not want to continue in that relationship, what are we to do? Close up our practice? Dismiss our patients? I already have patients come to me as there are NO openings for new patients in local practice groups. Are these patients to be denied care? Not have anyone to continue to treat their medical problems? I am certified in diabetes care. Should these patients be denied continuing prescriptions for their treatment of diabetes? Should they go to the Emergency Room to receive insulin when their blood sugars are in the 500 range, only to be told to follow-up with their "care provider" but they no longer have one? Should my patients who have high blood pressure suffer a stroke due to uncontrolled blood pressure because they no longer had access to prescriptions for their blood pressure? Should we fill up the Coronary Care Units of the hospital with patients experiencing a heart attack because they were denied access to their heart medications?

Will the doctors who oppose this bill take on ALL OF MY PATIENTS IMMEDIATELY to prevent the repercussions of "lack of access to medical care"?

Sincerely,
Rebecca Murray APRN

Dr. Regina Cusson and, as Dean of the School of Nursing at the University of Connecticut, SB36

Good Afternoon,

My name is Dr. Regina Cusson and, as Dean of the School of Nursing at the University of Connecticut, I would like to provide testimony in support of Governor's Senate Bill #36.

Thank you to Dr. Jewell Mullen and the members of the Public Health Committee for providing the opportunity to speak in favor of this legislation today.

UConn, Connecticut's largest state-affiliated university, has trained, and educated nurse practitioners – APRNs – for more than 30 years. We are proud of the fact that our graduates successfully pass the national board certification examinations in high numbers, are sought after by employers, and comprise an important part of Connecticut's primary, specialty, and acute healthcare workforce providing care to patients.

The national trend of states moving toward full practice authority already includes 17 states, plus the District of Columbia, fully one third of the nation. 4 of those states, Maine, New Hampshire, Vermont, and Rhode Island, are here in New England. At least 12 other states have bills in their legislatures to follow suit. 4 of those states, Massachusetts, New York, New Jersey, and Pennsylvania are in close proximity to our state. We face the very real possibility of losing our APRN providers to those nearby states where practice environments are more favorable than ours. As more states move to full practice authority for APRNs, restrictive states will fall behind. Already, governors of states where APRNs practice with full autonomy are proposing incentives to draw APRNs away from states like ours, with more restrictive laws. With 7 university level in-state nurse practitioner programs, Connecticut invests heavily in educating APRNs. How unfortunate will it be when we lose this precious commodity to neighboring states with more favorable practice environments?

There will be those who argue that simply changing a law because other states are doing so is not a good enough reason. However, that is simply advocating for the status quo, and ignores the strong evidence supporting this change. There is ample research to support passing Governor's Senate Bill #36. Quality outcome research studies on APRN practice are plentiful, all concluding that health care delivered by APRNs is safe, high quality, and cost-effective. Empowering APRNs to practice to the full extent of their training and education will support our health care infrastructure in Connecticut and increase healthcare access for patients. To those who would attempt to argue that passing this law would result in an end to inter-professional collaboration, nothing could be further from the truth. As an educator, I can assure you that inter-professional collaboration with all licensed health care providers is the hallmark and cornerstone of APRN training and education.

To conclude, all evidence supports passing the Governor's Senate Bill #36. I encourage our state legislators to support and vote in favor of this bill. Thank you so much for your time and attention.



Connecticut Association of Nurse Anesthetists

Written Testimony of
Pauleen Consebido MS, CRNA, APRN
Connecticut Association of Nurse Anesthetists

S.B. No.36
An Act Concerning the Governor's Recommendations to
Improve Access to Health Care

Friday, February 28, 2014
Connecticut General Assembly's Public Health Committee

Good day Senator Gerratana, Representative Johnson, Senator Welch, Representative Srinivasan and members of the Public Health Committee Thank you for this opportunity to testify on Senate Bill No. 36, "An Act Concerning the Governor's Recommendations to Improve Access to Health Care." My name is Pauleen Consebido and I am a Certified Registered Nurse Anesthetist (CRNA), Government Relations Committee Co-chair, Immediate Past President of the Connecticut Association of Nurse Anesthetists and a member of the APRN Scope Review Committee. I am also a licensed Advanced Practice Registered Nurse (APRN). I am here today on behalf of the members of the Connecticut Association of Nurse Anesthetists in support of Senate Bill No. 36.

Nurse anesthetists are a part of Connecticut's approximately 4,000 licensed Advanced Practice Registered Nurses. There are more than 45,000 nurse anesthetists across the United States. Nurse anesthetists have been providing anesthesia care to patients for 150 years. Nurse anesthetists provide anesthesia in every setting in which anesthesia care is delivered including hospitals, obstetric units, ambulatory surgical centers, office based practices, the U.S military and the Department of Veterans Affairs health care facilities.

The Connecticut Association of Nurse Anesthetists are not seeking a legislative change to our section of the statute. Anesthesia delivery provided by nurse anesthetists serve our patients, the citizens of Connecticut, well. At this time, Connecticut CRNAs do not experience similar concerns with access to health care as our APRN colleagues.

However, CANA supports our fellow APRNs in their effort to increase access to quality health care for the citizens of Connecticut as the number of insured individuals and families is expected to increase with full implementation of the Affordable Care Act. Educational standards that APRNs must achieve ensures public safety and this is supported by national data. APRNs are part of the solution to the concern of access to health care. This legislation does just that, promoting greater access to quality health care.

I thank you for the opportunity to address the committee regarding this important legislation.



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
Friday, February 28, 2014**

**SB 36, An Act Concerning The Governor's Recommendations To Improve
Access To Health Care**

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 36, An Act Concerning The Governor's Recommendations To Improve Access To Health Care**. CHA supports the bill as written.

Before commenting on the bill, it's important to detail the critical role hospitals play in the health and quality of life of our communities. All of our lives have, in some way, been touched by a hospital: through the birth of a child, a life saved by prompt action in an emergency room, or the compassionate end-of-life care for someone we love. Or perhaps our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay. In 2012, Connecticut hospitals provided nearly \$225 million in free services for those who could not afford to pay.

Connecticut hospitals are committed to initiatives that improve access to safe, equitable, high-quality care. They are ensuring that safety is reinforced as the most important focus—the foundation on which all hospital work is done. Connecticut hospitals launched the first statewide initiative in the country to become high reliability organizations, creating cultures with a relentless focus on safety and a goal to eliminate all preventable harm. This program is saving lives.

Providing culturally competent care, eliminating disparities, and achieving health equity are also priorities of Connecticut hospitals. The CHA Diversity Collaborative, a first-in-the-nation program to achieve these goals, has been recognized as a national model.

Generations of Connecticut families have trusted Connecticut hospitals to provide care we can count on.

As the Committee may know, the scope of practice for APRNs was reviewed during the recently completed Department of Public Health scope of practice review process. CHA was pleased to participate in the Review Committee and encourages the Public Health Committee to use the findings and conclusions identified within the Department's report, *An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to the Scope of Practice Determinations: Scope of Practice Review Committee Report on Advanced Practice Registered Nurses*.

SB 36 seeks to eliminate the requirement of a collaborative agreement for Advanced Practice Registered Nurses (APRNs) with three or more years of licensure. APRNs with less than three years of licensure would still be required to maintain a collaborative agreement with a licensed physician. During the Scope of Practice Review Committee process, numerous studies demonstrating that APRNs provide safe, high-quality care were reviewed. More importantly, evidence provided by other states indicates that the removal of the required collaborative agreement creates an environment in which APRNs are able to expand current practice and explore other options for delivering primary care services.

CHA supports the bill, as it facilitates flexibility in the access to and provision of care across the continuum. However, unless corresponding changes are made to the way in which the Medicaid program reimburses providers for the types of primary care services delivered by APRNs, the effect of the bill will be nullified. Currently, DSS refuses to reimburse hospital-based services provided by APRNs, including services provided in clinics, affiliated practices, and within the hospital itself, unless a collaborative agreement is in place and a physician specifically approves the services. Those limitations mean that without altering DSS policy, SB 36 will not change how APRNs are able to function in hospital-based settings.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

February 27, 2014

RSB #36 AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE DEALING WITH ADVANCED PRACTICE REGISTERED NURSES (APRNs)

Dear Senator Gerratana, Representative Johnson, and Members of the Public Health Committee,

This letter represents the experience of two psychiatric advanced practice registered nurses (APRNs) in private practice: **Mary Anne Zeh, APRN has been prescribing and providing therapy since 1996 and Kerry Williamson since 1987.** We are asking you to support RSB #36 which removes the mandated *written collaborative* agreement with a physician licensed to practice in the State of Connecticut that all APRNs must have in their possession to practice in this state. This bill is not a change in APRN's scope of practice.

The bill removes a very significant and real barrier to access to healthcare for people in the state of Connecticut and removes a barrier for APRNs to practice in this state.

As psychiatric APRNs we provide mental health treatment (therapy and medications) to some of our state's most vulnerable population. As we illustrate later, the written collaborative agreement actually creates a risk to our patients' safety because the sudden lack of a willing collaborating psychiatrist could shut down our practices instantaneously.

We were part of the Connecticut Society of Nurse Psychotherapists that helped to pass legislation to eliminate supervision of APRNs by physicians in 1999. At that time, *the legislature was heavily lobbied by physicians that it was "unsafe" to remove their supervision of APRN's.* Fifteen years later those claims prove unsubstantiated. Now the State Medical Society wants you to believe that APRNs cannot practice safely without the written collaborative agreement (again without substantial evidence). The physicians opposing this legislation have a vested financial incentive to have APRNs employed by them as it greatly increases their profits. *The written collaborative agreement binds professional APRNs' practices legally and therefore economically to the medical profession.*

We are solo practitioners and have provided care for thousands of patients (adults and children). We do not have a psychiatrist in our practices. Because many psychiatrists in Connecticut accept only cash-paying patients, psychiatric APRNs provide a much needed service to the rest of the Connecticut residents including children. We have the experience and competence to provide for their care safely. Patients are relieved to have someone who spends time with them.

- **Patients are often referred to us by their primary care physician for psychiatric care because they trust our ability to provide excellent psychotropic medication management and therapy to their patients.**
- **Patients come to us with undiagnosed underlying medical conditions such as thyroid problems, sleep apnea, vitamin d deficiency, Vitamin B12 deficiency, heart conditions, hormonal problems, dementia, etc. As nurses, we assess these problems and help our clients get all of the medical care they need.**
- **We have consulted with and referred our patients as appropriate to primary care providers, endocrinologists, neurologists, cardiologists, sleep centers, ob/gyns, maternal/fetal specialists, etc.**

We have experienced first-hand the real threat to our practices and livelihood the law requiring written collaborative agreements has created. This law ultimately threatens our patients' safety and access to care.

- *Finding a psychiatrist to collaborate is difficult at best – many psychiatrists are advised by their lawyers to avoid collaborating. Some want hundreds of dollars in fees plus coverage of their practices for free when they were on vacation. Some want us to work for them as a condition to collaborate.*
- *Mary Anne Zeh's first written collaboration was with a newly graduated resident that she helped mentor at the hospital where she worked at the time. Because the psychiatrist often failed to keep the monthly appointments, she decided to find someone else.*
- *We found a psychiatrist through some of our colleagues. We met with this psychiatrist as a group on a monthly basis for a fee (\$350 per hour). After a year or two that psychiatrist abruptly ended the written collaborative agreement. Each member of the group of psychiatric APRNs, each treating hundreds of patients in their respective private practices, had a month to find another psychiatrist for a written collaborative agreement or legally be required to shut down our practices.*
- *In one instance, to prevent closing our practices we accepted a written collaborative agreement with a psychiatrist who required a hefty fee. Early on it was clear that this psychiatrist's knowledge and practice regarding psychotropic medications was outdated as we were teaching him about new medications. We ended this written collaborative agreement as soon as we could find someone else who was more qualified and willing to work with us. This was a very difficult and lengthy process.*
- *We joined with a group of APRNs to have a written collaborative agreement with a psychiatrist who was unfamiliar to us. A year later, the Public Health Department suspended this psychiatrist's license. Each of us, again, had to find another psychiatrist for a written collaborative agreement or legally be required to shut down each of our practices.*
- *We now have a psychiatrist we meet with monthly for an hour and a half to discuss cases, mental health treatment and prescribing. However, we function independently with regard to prescribing medication.*

The current law places our practices and therefore our patients in a very precarious position. We are always at risk of being forced to close our practices because of the current law. If we cannot obtain a collaborating psychiatrist for the written agreement, we legally cannot treat our patients. This puts our patients at risk for abruptly losing access to vital mental health treatment. This is the real danger to patient safety.

Respectfully submitted,



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**TESTIMONY: Raised Governor's Bill No. 36 AN ACT CONCERNING THE GOVERNOR'S
RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE**

PUBLIC HEALTH COMMITTEE

February 28, 2014

Good Afternoon, Senator Gerratana, Representative Johnson and esteemed members of the Public Health Committee.

Thank-you for the opportunity to provide testimony on behalf of the Connecticut Nurses' Association (CNA) in respect to Raised Governor's Bill No. 36 AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE.

I am Mary Jane Williams Ph.D., RN current chairperson of Government Relations Committee for the Connecticut Nurses Association and professor emeritus from Central Connecticut State University. I speak in STRONG support of: Raised Governor's Bill No. 36 AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE.

In 1997/98 at the Connecticut Medical Society, the Coalition of Advanced Practice Registered Nurses met to develop compromise language related to the practice of the Advanced Practice Registered Nurse (APRN). I had the unique responsibility of being the

only Nurse at the table along with representatives from each organization. Senator Melodie Peters facilitated this process in collaboration with Representative Lenny Winkler. After negotiations were completed it was generally agreed that in five years we would revisit the language and move forward with "Independent Practice." Since 1999 when the legislation became law the environment for change has become oppressive while the need for the qualified primary providers has increased 10 fold. Buerhaus (2013) predicts an even more dramatic need for providers in the next decade. We have always known that access to care would become a major issue in the provision of primary care. Access is now an issue. This bill is timely, as the State needs to be prepared to provide primary care to growing numbers of individuals.

Connecticut is in a unique position. We are a small state and we have growing needs for providers of "Primary Care" in many areas of the State. We have vulnerable populations in many of our communities who have not had or who have had minimal access to health care. These individuals will now have health care and require providers. We have excellent community models of care that are led by APRNs. The community facilities provide access to safe, high quality care with excellent outcomes. This proposed legislation is essential to access.

I concur with the findings and conclusions of the Scope of Practice Review Committee Report on Advanced Practice Registered Nurse's. It is time for all health care providers to think proactively to address this growing issue of access. The implementation of the "Affordable Health Care Act" and the Implementation of "Access Health Connecticut" will increase the need for Primary Providers across the life span in all specialty areas of care. Passing this proposed legislation will allow fully qualified APRN's to provide care across the life span in their area of specialization is the right option at this time, during this current legislative session.

We need to heed the recommendations of The Robert Wood Johnson Study on the Future of Nursing in collaboration with the Institute of Medicine that reported:

- Nurses should practice to the full extent of their education and training.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States. (IOM)

Our goal should be to develop statewide infrastructure to address ongoing ever-changing health care needs of a growing number of patients who will need quality care in a timely manner. This proposed legislation provides us with a huge opportunity, at a very significant time in the professional evolution of Advanced Practice Nursing. We need to recognize that the Advanced Practice Registered Nurse is educated in a specific specialty. The specialty education in a specific practice area i.e. Gerontology, Pediatrics, Family, Mental Health etc in conjunction with National Certification determines their Scope of Practice. The Advanced Practice Registered Nurse Practice is defined by education and certification.

The Advance Practice Registered Nurse is not licensed as a generalist. The APRN is educated, certified and licensed within a specific specialty, which defines the extent of their clinical practice. The Scope of Practice of an Advanced Practice Registered Nurse is in fact determined by education and specialty certification. As an example, if I decided to become an APRN in Family Practice, my course of study would focus on life span, infants, children, adolescence young adulthood, adults and geriatric primary care. My practice would focus on life span and as would my clinical experiences and exams. The license to practice would be in the specialty area of Family Nursing Practice. My Scope of Practice is defined and limited by my education, clinical practice, certification (National) And License (State).

The scope of practice for physicians, APRNs, physician assistants, and others is controversial to say the least. In all groups the question arises – where will the expansion of scope of practice stop or will all groups eventually want to do all things?

There is a scientific methodology to the evolution of professional scope of practice. When a new skill, technique, or intervention is first contemplated it most always comes to us through human subject research. From that point, if it is safe for the public and produces the

desired outcomes, it becomes a research innovation. When that occurs a wider group begins to learn about it and how to participate with it to the benefit patients, then it becomes taught formally to a much wider group and is considered to be an emerging practice. Boards of nursing [as is the case with other Boards] receive requests to consider whether the professionals they regulate can perform the new skill, technique, or intervention within their scope of practice. We have a group at NCSBN that reviews emerging practices and assembles an expert panel to create guidance around it. Then we can disseminate the guidance to the Boards.

Once incorporated into the professional scope, outcomes measures are the feedback loop that the practice is stable and safe and produces the desired result. The idea is that it is a thoughtful progression that always includes public protections. Just as graduate education for APRNs is a progression of professional standards inclusion and required clinical hours and the Master's Essentials, and certification is a progression from job analysis to expert test writers, to a legally defensible exam.

What is most important is that legislators are informed that the scope changes being requested to align with "Consensus" do not represent new scope...these are practices already proven in study after study over a span of 20 or more years. (Cahill, Maureen Personal Communication)

This is an opportunity to recognize the evolution of nursing practice based on research evidence. In order to provide care for the citizens of Connecticut we need to seize the moment and move forward in an organized fashion as we create a seamless mechanism for patient access and continuity.

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.

This legislation does not increase risk to public safety. The current literature provided to the Department of Public Health in support of the Scope of Practice review supports full scope of practice for APRNs. However, by not utilizing all health care practitioners to their full extent of their education, we are potentially decreasing access to care and interfering with a patients' ability to move along the continuum of care. We as a State

need to focus on high quality, safe, cost effective care. We need to utilize all our providers to the full scope of their education as recommended by many groups and we need to promote integrated team based care that recognizes equally and respectfully all members of the health care team.

I urge you to support Raised Governor's Bill No. 36 AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE.

Thank you

Mary Jane M Williams

MIDDLESEX COUNTY MEDICAL ASSOCIATION

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Statement in opposition to**Governor's Senate Bill 36 – An Act Concerning the Governor's Recommendations
To Improve Access to Healthcare****Public Health Committee****February 28, 2014**

This testimony is being submitted on behalf of the members of the Middlesex County Medical Association in strong opposition to Governor's Senate Bill 36 – An Act Concerning the Governor's Recommendations to Improve Access to Healthcare.

The bill before you would remove the requirement that Advanced Practice Registered Nurses (APRNs) collaborate with physicians when providing medical care. There are real educational and training differences between APRNs and physicians that need to be taken into account when allowing APRNs to function independently. The depth of knowledge and training that a physician is exposed to and must complete before being allowed to independently practice is exhaustive and time-consuming and it cannot be matched. It is designed this way in order to make sure that patients receive the highest possible care with the maximum amount of safety. We must question why anyone would attend medical school or the grueling and intense training that follows when they can attend nursing school but still practice medicine.

APRNs are not our adversaries. They are integral parts of the health care team and are colleagues with whom we collaboratively practice. However, we have not been given any concrete reason why the removal of a collaborative arrangement or a supervisory arrangement is necessary and/or in patients' best interests. To completely remove this requirement with no real justification for doing so seems short sighted. We do not believe that given significant differences between physicians' training and education and that of an APRN that they are adequately prepared to safely and independently treat patients.

We respectfully request that you oppose Senate Bill 36.

Mark Schuman, Executive Director
860-243-3977



CONNECTICUT ACADEMY OF
FAMILY PHYSICIANS
 CARING FOR CONNECTICUT'S FAMILIES

Statement in Opposition to

**Governor's Senate Bill 36 – An Act Concerning the governor's Recommendations
 To Improve Access to Healthcare**

Public Health Committee

February 28, 2014

Good afternoon Senator Gerrantana, Representative Johnson, and members of the Public Health Committee. My name is Stacy Taylor and I am a Past President of the Connecticut Academy of Family Physicians. I have been a primary care physician in Connecticut for over 16 years. I am here today on behalf of the members of the Connecticut Academy of Family Physicians and, more importantly, on behalf my patients, in opposition to Governor's Senate Bill 36. I have taken time off from my busy practice because of my concern about the serious threat to public health posed by this bill. In order to better illustrate my concerns, let me tell you a little story:

Put yourself in the shoes of one of my patients. You are 21 and usually very healthy. Unfortunately, you start to become a bit tired and just don't feel well. You have had a slight cough for about 4 months. You go to your health care provider who is attentive, caring and knowledgeable. She reassures you that your illness is a virus and should resolve. You trust her, not only because of who she is, but because you assume she has the training, experience and competence to hold your life in her hands.

Your symptoms, however, continue. At a follow-up appointment, it is noted that your tonsils are enlarged. Throat cultures are done which are negative. Again, you are reassured that this is most likely viral. You continue to feel ill. Your fatigue has increased, and you have lost a little weight. You return to the office and, because your usual provider is not available, you see a physician who, upon hearing your story, becomes very concerned. After additional testing and evaluation, you are told that you have leukemia.

What went wrong?

Your initial provider was an APRN, who, though working well in collaboration with the physician, did not recognize the seriousness of your complaints.

- Her clinical training, which could have been negligible, but in this case was considered excellent for her credentials, was still four times less than the physician who you eventually saw.
- Her limited training, lacking experience with more severe illness, made her unprepared to handle both the breadth and the depth required in primary care. In other words, she did not know what she did not know.

- In this case, collaboration between the physician and APRN was in place, and the APRN was an essential part of the healthcare team, however, the APRN did not feel she needed the physician's guidance. Collaboration does not necessarily ensure good health care as it is an informal arrangement at best. Her collaborating physician, not having had experience with her training, was unable to understand or fill her gaps of knowledge.
- Had you had complete understanding of her credentials, you may have gone to the physician when first seeking a primary care provider, however you thought your APRN was a doctor.

This story is true and is illustrative of why Bill 36 should not be passed. For those voting in favor of this bill would you want your care provided by an APRN under these circumstances? But, if after hearing our testimony and pleas not to further fragment health care, you decide to pass this legislation, it must include the following:

- First, there must be truth in advertising and patients must know that they are being treated by an APRN and not a physician
- APRNs must also keep medical malpractice limits on par with that of a physician and pay a comparable licensure fee.
- If this Bill were to pass, the APRN's would be practicing medicine and not nursing; thus they should go before the board of medicine and not the board of nursing.
- If APRNs were to practice without the collaboration of a physician, APRNs must be required to complete increased continuing medical education requirements equivalent to physicians.

These are just a few components that need to be added to this bill. Please note that these requirements are not an exchange for support. The Connecticut Academy of Family Physicians feels strongly that this Bill is not good health policy. We are concerned about patient safety and do not support this bill. Additional information can be found in the submitted testimony. Thank-you for your attention.

I am happy to answer any questions.

We have come before you for many years to oppose independent practice for APRNs and this year is no different as we find it to be a fundamentally bad idea and poor patient care. It is the wrong approach and we do not support it. What we will do is fight for patient safety. In past years we have emphasized the differences in physician and APRN education and training and that has not changed. Physicians' education is standardized such that the didactics, training and experience are consistent throughout the country. The education of APRNs, on the other hand, may or may not include a bachelor's degree, a master's degree, or a doctorate, and the clinical training can be almost non-existent or even completed online. Physicians have four times the amount of clinical training as APRNs so we bring a broader and deeper expertise to the diagnosis and treatment of all health problems our patients face. It is ironic that many graduating medical students go into sub-specialty training because they are overwhelmed by the wide scope of primary care medicine and are concerned that they will not be able to be competent after four years of medical school and three years of residency training. It is difficult to fit in all the required core curriculum conferences within the three years of residency training never mind the much shorter programs designed to educate APRNs. This bill states that an APRN must have three years of collaboration with a practicing physician before becoming independent. Who will determine if the APRN is competent after that time? Is this the proper way to protect the public? Is three year's collaboration equivalent to a residency? Achieving independent practice through legislation rather than education is not the answer. One profession's education and training prepares for independent practice

while the other does not. It begs the question, why would anyone want to be a physician when becoming an APRN is quicker and easier yet affords all the same privileges. We already have a shortage of primary care physicians in this state, this bill will only make that worse.

A recent study conducted by a global market research company indicated that 72% of U.S. adults prefer physicians to non-physicians when it comes to healthcare. 90% of adults would choose a physician to lead their ideal medical team, and by greater than a two-to-one margin, adults see physicians as more knowledgeable, experienced, trusted and up-to-date on medical advances than non-physicians. I ask you, who do you choose to lead the healthcare for you and your family? Will you choose to ensure the safety of your family to an independently practicing APRN?

For more information, please contact:

Stacy Taylor, MD, Past President

860-496-6884

Mark Schuman, Executive Vice President

860-243-3977

Diana Greenia MSN, ANP, BC SB 36

My name is Diana Greenia and I am an Adult Nurse Practitioner. It would be a very effective decision to remove the collaborative agreement that Nurse Practitioners must have in order to practice in the state of Connecticut for the following reasons: it would remove several barriers that would give patients access to excellent healthcare services, it decrease the burden on the health care system from the perspective of lowering health care costs, decreases the number of unnecessary emergency room visits and hospitalizations, and give choices to the new patients that will be entering the health care system with the implementation of the Obama Health care

Cordially,
Diana Greenia MSN, ANP, BC



Building relationships that improve healthcare for everyone.

**Testimony in Support of Governor's Bill #36
February 28th, 2014**

To Whom It May Concern:

My name is Janet Carlson and I am Managing Director/Partner of the One Eleven Group, a 20 year old marketing agency that has focused primarily in healthcare arena. We have had the pleasure of working extensively for and with healthcare professionals, including APRNs. My husband and I are also the proud parents of 9 year old twins.

When I testified last year, I listened all day to each presenter. My take away from a day of testimony was.

1. That doctors and APRNs are truly yin and yang. Doctors are trained to find and treat **disease**. APRNs educate, prevent and promote **wellness**.
2. APRNs are ready, willing and able to go where physicians prefer not to tread: prisons, women's centers, clinics, disadvantaged neighborhoods, etc.
3. Everyone agreed that APRNs were fully capable, fully trained and had a different role from physicians.

My family's personal experience with APRNs has been top notch. The APRN in our pediatric practice not only cares for our children's physical well being, but asks how they eat, what food choices they make, how they handle bullying, etc. The APRN asks about hand washing and the importance of vaccinations.

It occurs to me that with the full launch of Affordable Care Act (ACA) and in the face of physician shortages, we would be very wise to enable APRNs as much as possible, since they tend to work in higher risk populations in less advantaged areas. And since APRNs as a nature of their training, support and promote wellness, our country will be a healthier place to begin with and physicians can focus on caring for the truly ill.

I stood up and testified last year and I stand with Connecticut's APRNs again. Please pass this bill, for the health and well being of our great State.

Respectfully,

Janet Carlson

Janet Carlson



One Eleven
G R O U P

Building relationships that improve healthcare for everyone.

Mary D Moller, DNP, PhD (hon), APRN, ARNP, PMHCNS-BC, CPRP, FAAN SB 36

Dear Members of the Public Health Committee,

To those of you I know from previous testimony I am saying hello and I thank you for your previous support of APRN attempts to remove the mandatory physician collaborative agreement. To those of you who I have not met, I would like to introduce myself and ask your support in moving Governor's Bill #36 out of committee. Since January of 2009 I have been the Director of the Psychiatric-Mental Health Nurse Practitioner Specialty at the Yale University School of Nursing. From 1992 through 2008 I was the owner of the first independent APRN-owned and operated rural psychiatric outpatient clinic in the United States. That clinic was Eastern Washington State. Since 1978 WA State has been an independent practice state for all APRNs. That means there is no mandatory requirement of any kind of physician oversight or approval of our practice. I remain licensed in that state and continue to provide care via telehealth to those patients who could not find a psychiatric provider when I left. In that capacity physicians and APRNs work side by side consulting and collaborating and referring to one another in a most collegial manner. It is an equilateral, mutual understanding of each other's skillsets and knowledge base. It is not hierarchical or paternalistic at all. We were always collaborating and I continue to consult, collaborate, and refer to other physicians in that state in obtaining the care needed for patients that are beyond what I can provide. When I moved here I was literally shocked at the oppressive nature of APRN practice as restricted by physicians who either refuse to sign an agreement or if they do are restrictive in the APRN's ability to exercise their full scope of practice. When I first came I was going to have a physician colleague who is licensed in CT but doesn't live here be my collaborator, but he was going to charge \$6000 because he said that is what his malpractice would go up to 'take me on'. It took me two years to find someone and that only occurred because I was at a local CHC and the administration worked it out with a psychiatrist who was there 4 hours/month. I met him once and never saw him again, but he signed the agreement that allowed me to practice. I called him once because a psychiatrist was supposed to sign an evaluation for Medicare disability (that I had conducted, completed, and filled out) and he was upset and asked me to have one of the docs at the CHC do it as he didn't want to be bothered. I collaborated daily with the other physicians and providers at that clinic and certainly didn't have a practice agreement with each of them! The mandatory collaborative agreement has nothing to do with the daily practice of collaboration, but rather with approving that an APRN can indeed practice! I have been saddened and disheartened at the time, negative energy, and resources that have been expended to continue to prohibit independent practice for APRNs in CT. In WA State I developed a program that reduced psychiatric re-hospitalization for patients with schizophrenia by 93.5%. Those results have been published and replicated in the US and internationally, however, I am not in a practice situation in which I can bring those protocols to CT. We literally saved the state of WA millions upon millions of dollars. It would be wonderful for the citizens of CT to have that same program available.

I would like to stress that we are not physicians and don't want to practice medicine, if we did we would have gone to medical school. We practice nursing which is health promotion, disease prevention, and education to promote recovery. Within that frame we conduct assessments, diagnose, order and interpret tests, implement treatments, and prescribe medications in a tightly regulated and monitored scope of practice based on licensure, accreditation, certification, and education.

As an NP Program coordinator and former President of the American Psychiatric Nurses association, I have been in on the ground floor of the national Consensus Document on the Regulations Governing Advanced Practice Registered Nurses which was adopted in 2008 and goes into effect January 1, 2015. All aspects of APRN licensure, accreditation, certification, and education are tightly regulated and monitored by several different national and state bodies in order to insure standardization and consistency across and between programs. As an educator, I am seeing more and more of our Yale graduates leave the state to neighboring New England states that have independent practice for the APRN. I am concerned that as The National Council of State Boards of Nursing moves forward with the interstate compact for APRNs that CT will be excluded from participating due to the restrictions of the current physician approval form. I am asking you to help us bring CT into the 21st century and to recognize that NP stands for a New Paradigm in access to health care in Connecticut.

Thank you.



Mary D Moller, DNP, PhD (hon), APRN, ARNP, PMHCNS-BC, CPRP, FAAN
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PUBLIC HEALTH COMMITTEE PUBLIC HEARING FEB. 28, 2014

GOVERNOR'S BILL No 36 AAC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

Nikki Rasmussen, RN – testimony IN SUPPORT OF #36

Senator Gerratana, Representative Johnson and Members of the Committee:

I write to urge you to give strong consideration is supporting SB36 "AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE." As a nurse and future Nurse Practitioner, it is in the public's best interest to rid Nurse Practitioners of the current requirement of maintaining a "collaborative agreement" with a Physician. As you are aware, collaboration does not assure quality of care delivered by Nurse Practitioners. Collaboration is something that healthcare providers do on an "as needed basis." Collaborative agreements have held some Nurse Practitioners hostage, resulting in Nurse Practitioners having to pay large sums of money for collaboration that would be sought otherwise, if needed.

In the past, individuals attempted to set up a system, by which Physician's would volunteer to be collaborators, thus there would be a "pool" of potential Physician collaborators. This attempt failed, as Physicians felt that they would be held liable, and still Nurse Practitioners would be required to pay them for their collaboration. Nurse Practitioners have had difficulty finding and maintaining collaborators and some have had to close their practices, if their collaborating Physician died or retired.

The supporting documentation provided by the Connecticut APRNs demonstrates that APRNs are qualified health care providers, with same, if not better outcomes than Physicians.

As a future Nurse Practitioner, I ask that you join the Nurse Practitioners and support SB36 which would allow APRNs to practice to the extent of their education. This will open the doors for those who need access to healthcare providers.

Sincere Regards,

Nikki Rasmussen, RN

1010 Village Walk
Guilford, CT 06437



Integrated Health Services, Inc.
 763 Burnside Avenue
 East Hartford, Connecticut 06108
 Telephone: 860-291-9787

Testimony in Support of Governor's Bill
 No. 36 LCO 249: An Act Concerning the Governor's Recommendations to Improve Access to Health Care.
 February 28, 2014

Senator Gerratana, Representative Johnson and members of the Public Health Committee: My name is Deborah Poerio, and I am President of Integrated Health Services, the non-profit organization that administers 7 School Based Health Centers in East Hartford, Connecticut. Most importantly, I have been a Nurse Practitioner for 29 years, of which most of that time has been providing services to underinsured children in Connecticut that had little access to them. That is why I am here today to testify in favor of the Governor's Bill No. 36:

An Act Concerning the Governor's Recommendations to Improve Access to Health Care by removing the collaborative agreement requirement that currently exists

- The agreement is a legal requirement only and does not affect scope of practice
- Collaboration is consultation and is what every ethical practitioner, all doctors, therapists, nurses, engage in - it is asking a question of a colleague on a medical issue of concern for one's patient. Doctors often do this with specialists as do social workers with psychiatrists, and dental hygienists with dentists.
- Bill #36 does not impact any ethical standards of practice relating to collaboration and consultation. It only removes the legal requirement that currently serves as a barrier to accessing care. Licensure, certification, and standards of care still exist to ensure that nurse practitioners are working within their licensed and certified scope of practice-just as dental hygienists, doctors, social workers, and registered nurses.
- APRNs already have full practice authority; this bill simply allows APRNs to open practices and remain in practice should their collaborating physician retire, move, or discontinue the collaborating agreement. It also enables those nurse practitioners that see large numbers of Medicaid children and families the ability to create medical homes, as there is insufficient practices that will accept these clients.
- Increasing the number of primary care providers is necessary to meet the needs of the newly insured.

The need to increase access and the number of providers, especially in the uninsured and underinsured population, is essential if we are to address the growing needs, and declining number of providers. Allowing Nurse Practitioners to practice without a collaborative agreement simply means that they must practice under the scope in which they are educated, licensed, and certified-the same as every licensed health care provider. It is time to equalize practice standards and allow nurse practitioners the ability to operate as all other licensed professionals practice-independent of a collaborative agreement. It is time to REMOVE barriers to care and enable qualified providers to address the tremendous health care needs that exist in Connecticut.

We are fortunate to have a Governor who has passed the nations' first mental health legislation for children, and continues to propose legislation that remove barriers to care. I applaud his, and the Public Health Committee's, goal to right this wrong and thank you very much for the opportunity to submit this testimony.

Sincerely,

Deborah Poerio, APRN, MS, FNP-BC
President/CEO, Integrated Health Services, Inc.

Public Health Committee Public Hearing – Governor’s Bill No. 36
AAC The Governor’s Recommendations to Improve Access To Health Care

Kathy Groff, APRN Testimony In Support of No 36
February 25, 2014

Senator Gerratana, Representative Johnson and Members of the Public Health Committee:

I am writing for the fifth year in a row to ask for your support in allowing advanced practice registered nurses to practice without a written collaborative agreement with a physician. I am confident that this is the year APRNs will be successful because your committee is now very familiar with the role of APRNs and with their safety record.

To attend to the demands of the added volume of patients seeking health care under the Affordable Care Act, there is a great need today for health care providers who can work at the highest level of their scope of practice without unnecessary restrictions. The nurse practitioner role emerged in the 1960s at another time when there was a potential shortage of health-care practitioners. APRNs started out treating people living in under-served areas, rural towns and inner-cities, where there was limited access to health care, and have since expanded into other primary- and specialty-care opportunities with equal success.

I know that, by removing the requirement for a collaborative agreement, patients will benefit. Not only will they continue to have the competent care they have come to expect from APRNs, they will also have continuity of care because their APRN will be able to continue to practice even if that APRN loses a collaborating physician through that doctor’s change of job, move out of state, or death.

During most my 16 years as an APRN, I have practiced in offices where there has been no or limited physician presence. My nurse practitioner training taught me to work within my scope of practice, to consult when necessary, and to accept ultimate responsibility for my diagnoses and treatments, regardless of whether I consult with other health care providers. I also know from personal experience what a wedge that mandated piece of paper can create. I worked for several months as RN, without the ability to prescribe medications, instead of as an APRN, because I had no collaborating physician. A physician colleague, unfamiliar with the nurse practitioner role, would not sign my collaborative agreement when she replaced another physician.

So, please, let’s do what makes sense and move forward to pass Governor’s Bill #36 to ensure that Connecticut patients get the care they need.

Thank you very much.

Sincerely,

S. Kathleen Groff APRN
Family Nurse Practitioner

PUBLIC HEARING FEBRUARY 28, 2014

GOVERNOR'S BILL #36ACC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

Testimony of Sheryl Marinone MSN, APRN, BC-FNP/CNS
IN SUPPORT OF #36

Senator Gerratana, Representative Johnson, and members of the Committee:

I have been a nurse practitioner for 17 years and in my own private practice for 12 years in Connecticut. I do not advertise. My practice has grown by word of mouth. I am extremely busy and need to add APRN staff. **I have tried to hire other APRNs but cannot get a physician to sign an agreement for new staff, preventing me from growing my practice to meet area needs and employing APRN providers.**

Also, recognizing my own collaborative physician is older and could retire, I recently sought to secure another physician.

This had become a very daunting task and disconcerting to say the least, as the health care environment changed considerably since I started my practice. Many doctors consulted with their malpractice insurance carriers who recommend they do not sign the agreement. Some had consulted with their attorneys and the response was similar due to the added presumed liability. I had one who offered to sign but at a cost of \$10,000. per year. This would be a pretty steep cost for my business to absorb given my much lower NP salary compared to MD salaries and my very high overhead costs. Another physician was killed suddenly in a car accident. **THIS ENVIRONMENT IS MAKING IT NEAR IMPOSSIBLE TO PRACTICE IN CT., SERIOUSLY.**

After 18 months of searching I was finally able to secure a collaborating physician who signed the agreement without asking for a financial stipend. This agreement is dated for 1 year and every year it will need to be re-negotiated. She could decide at the end of the term not to continue our agreement.

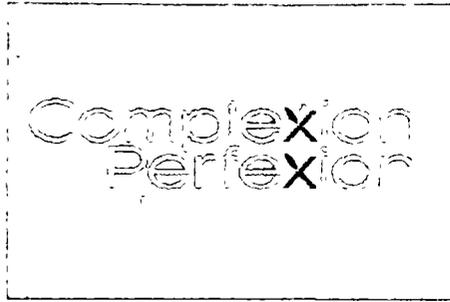
I FEEL AS THOUGH I AM ON A ROLLER COASTER, WITH MY PRACTICE OF 12 YEARS FLOURISHING YET IN JEOPARDY EVERY DAY OF CLOSING ON A DIME AND I FEAR ABANDONING 2,000 PATIENTS - I AM UNABLE TO GROW BECAUSE OF THIS LEGAL REQUIREMENT - UNABLE TO HIRE IN CT. BECAUSE OF THIS LEGAL REQUIREMENT. THESE ARE CONDITIONS TOTALLY UNACCEPTABLE AND NONEXISTENT FOR OTHER HEALTH PROFESSIONS.

MY PATIENTS DESERVE BETTER PUBLIC POLICY TO ACCESS AND SECURE HEALTH CARE.

THIS COLLABORATIVE AGREEMENT IS UNRELATED TO HEALTH CARE AND YET WE ARE ALLOWING IT TO CONTROL OUR SYSTEM TO DENY ACCESS.

With the changes in the health care system along with the primary care physician shortage, it is imperative the state of Connecticut become pro-active in its decision to remove the barriers that PREVENT nurse practitioners from practicing to their full scope AND ALLOW PATIENTS ACCESS TO CARE. THE TITLE OF THIS BILL IS ACCURATE.

Thank you for your consideration of this matter.
Sheryl Marinone, APRN



PUBLIC HEALTH COMMITTEE FEBRUARY 28, 2014

TESTIMONY RE: SB #36

SUBMITTED BY CHRISTINE ZARB, APRN-BC

OWNER/OPERATOR OF COMPLEXIONPERFECTION, LLC

Senator Gerratana, Representative Johnson, and Members of the Committee:

I am a Nurse Practitioner and owner/operator of a small boutique medspa in Wilton, CT. I run my medspa four days per week and one day per week I work in my collaborating physicians' office. I am writing to declare my strong support of Governor's Bill #36 to remove the collaborative agreement mandate between Physicians and Advanced Practice Registered Nurses (APRN's). The current mandate for a collaborative agreement is a practice hardship for APRN's in CT. It impedes APRN's from opening independent practices. For those of us who have opened independent practices, if our collaborating physician dies, retires, or severs the agreement it renders our practices illegal. We are then forced to close our business. For me specifically, I am constantly worried that one day my collaborating physician will sever our agreement or retire. This constant worry inhibits me from growing my practice.

Supporting this bill not only improves access to care, but it also supports small business growth in CT. When the medspa bill almost passed last year it was very sobering. I stopped all growth until it was vetoed, thankfully. After it was vetoed I felt a little more confident about the future, so I hired a CT based contractor to expand my spa, and hired a CT based website designer to redesign my website. I also spent more money on marketing and medical supplies. This year I am starting to advertise utilizing local media.

I am currently poised for more growth, which would include hiring one employee, but I am hesitant to bring on another individual when I am currently in a precarious position myself, having to rely on the whims of another individual (my collaborator). The mandate for the collaborative agreement is a huge disincentive to open or expand a small business in CT.

To support SB #36 is to support small business in CT!

PUBLIC HEALTH COMMITTEE

PUBLIC HEARING 2/28/14

Governor's Bill SB #36

Testimony of Catherine T. Milne MSN, APRN, BC-ANP/CNS, CWOCN

IN SUPPORT OF Governor's Bill SB #36

Dear Members of the Committee:

I am writing to support the removal of the mandated collaborative written agreement for Advanced Practice Nurses to practice in the State of Connecticut. I have been a licensed APRN in this state since 1995. During this time, I have been in an APRN nurse-owned private practice serving the needs of patients in long-term care, sub-acute and acute care settings. Additionally, I make house calls for the truly bed-bound patient. It is a practice set-up that most physicians do not choose to engage in. I have been fortunate to have found a collaborating physician in 1995, to whom I pay an annual fee.

However, I interact/collaborate mostly with the personal physicians of the patients I have been requested to see. More than 98% of the consultations I engage in are with physicians who are not my collaborating physician. It is inherent in the professional practice of medicine and advanced practice nursing, that one collaborates with others in the management of clinical care when in the best interest of the patient; one seeks more expertise for a given situation. Advanced practice nursing curriculum prepares us for this. It is expected and is part of standards of practice. All providers engage in consultation. It is the norm within our healthcare system.

My collaborating physician is approaching retirement. As such, and due to my subspecialty of wound and ostomy care, I will have great difficulty finding a physician who meets the collaborative agreement requirements and is willing. Many physicians have sold their practice to large groups or conglomerates. I would then be required to be an employee of that system to continue to practice. In addition, I fear the physician may ask for a large compensation as has been reported to me by other APRNs. The cost of "doing business" may be too prohibitive for me to continue practice. I urge you to SUPPORT this bill, removing the mandated written agreement. It serves no healthcare need, will add costs to healthcare, and is a severe barrier to patient access, APRN practice and patient need.

Best Regards,

Catherine T. Milne APRN (electronic signature)

Catherine T. Milne MSN, APRN, BC-ANP/CNS, CWOCN-AP



PUBLIC HEALTH COMMITTEE
PUBLIC HEARING FEBRUARY 28, 2014

Testimony IN SUPPORT of GOVERNORS BILL 36, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE.

Karen M. Myrick, DNP, APRN, FNP-BC, ANP-BC
February 25, 2014

Honorable Chairs and Members of the Public Health Committee:

Thank you for the opportunity to present testimony regarding Bill 36. My name is Karen Myrick. I am a family nurse practitioner, a Professor at Quinnipiac University, and a member of the Connecticut APRN Society's Government Relations Committee. I ask that you support this bill.

As a Nurse Practitioner for 15 years, I have attempted to create a practice that would fulfill an identified state health care need, improve patient time to treatment and significantly improve access to care. At this time, an athlete with an injury may need to wait more than a month to be seen. This wait time is increased for a patient with Medicaid. Providers may have limitations that management impose on scheduling patients with Medicaid. These limitations range from not accepting patients with Medicaid, to seeing only 2 a day. With such a limited access to care, patients are at risk for complications that could be avoided.

Realizing a limited access and a health care need, I contacted more than 20 orthopedic and sports medicine physicians so that I could open a clinic for patients with Medicaid or from low-income families, who sustained a sports medicine injury. Not one would sign a collaborative agreement for this endeavor.

The mandatory "collaborative" agreement is often posed as a scope of practice matter. The riddance of this agreement would not change my APRN practice, yet would allow access to care for a population where a significant need has been identified.

Please support Bill 36 to eliminate an impractical barrier that fulfills no public health policy purpose, but does provide a barrier to accessing appropriate health care.

Thank you,

Karen M. Myrick, DNP, APRN

PUBLIC HEALTH COMMITTEE PUBLIC HEARING FEB. 28, 2014

GOVERNOR'S BILL No. 36 AAC THE GOVERNOR'S RECOMMENDATIONS TO
IMPROVE ACCESS TO HEALTH CARE

Kathy Grimaud APRN, CEO
Community Health & Wellness Center
469 Migeon Avenue
Torrington, CT 06790

Senator Gerratana, Representative Johnson, and Members of the Committee:

I enthusiastically support the critical change in the nurse practice to remove the collaborative agreement requirement. This change is essential to improve patient access to health care, control the cost of health care and efficiently utilize of all types of health care providers available to us. With health care provider shortages and more than 45 million uninsured Americans, it becomes essential to look at all of our health care resources. APRNs are a vital part of the solution to CT and our country's healthcare challenges. Without APRNs, thousands of individuals in CT would not get health care.

Our community health center began in 1998 as a small service department of the local hospital with one Advanced Practice Registered Nurse (APRN) and a physician. Today we have grown to have a 2 physician and 8 APRNs providing quality cost effective health care to six thousand patients in northwestern CT. Our center provides quality health care and it has the lowest cost for care in the state. Prior to our services primary access to health care for the un/ under insured in Northwestern CT was in a Walk-In or Emergency Room setting. This health care was episodic and costly usually resulted in no major improvements in the individual's health.

In order to stay operating through the years it was critical that we considered all provider costs and issues to stay financially viable.

- The cost of hiring an APRN for us is 56% less than if we hired physicians.
- APRNs know how to care for 95-98% of what we see in primary care today. At our center, it is our APRNs that have the advanced knowledge to care for HIV/AIDS patients.
- Additionally APRNs at our center see as many and sometimes more patients that the physician.
- APRNs have the best training to support Patient Centered Medical Home requirements. The emphasis of education and self-care are core components of all nursing education.
- We have encountered difficulty maintaining MD collaboration through the years. Should our physicians decide to leave us, over 6,000 patients would be unable to get their health care due to the existing CT Statute that requires APRNs to have collaborative agreements.
- Our APRNs have a proven record of providing quality comprehensive health care. Additionally as **any professional**, APRNs, as any other professional, know when to seek collaboration regarding a patient's health care needs. For my most experienced APRNs it is usually a specialist that is needed.
- APRNs are independently responsible for their actions, regardless of whether physicians are involved.

- As a center that serves the underserved population, the need for more APRNs is critical and will continue to grow. APRNs work extremely well in our setting.
- As we move into person centered medical home, the skill set needed for these patients encompasses holistic care, understanding of psychosocial needs of the patients and the ability to educate & promote self-care behaviors. These abilities are the foundation of nursing education and training.

All health care providers need to work together, contributing our respective knowledge and expertise to meet the growing health care needs in our state and country. It is essential that the barriers of collaborative agreements be removed as we move toward health care as a right in CT and nationally.



PUBLIC HEALTH COMMITTEE
PUBLIC HEARING FEBRUARY 28, 2014

Testimony IN SUPPORT of Raised Bill 36 AAC THE GOVERNOR'S RECOMMENDATIONS
TO IMPROVE ACCESS TO HEALTH CARE

Lynn Price, JD, MSN, MPH
February 28, 2014

Senator Gerratana and Representative Johnson and Members of the Public Health Committee:

Thank you for the opportunity to present testimony in support of this bill. I am Lynn Price, a family nurse practitioner, Chair of the Graduate Nursing Program at Quinnipiac University, and a member of the Connecticut APRN Society

Some points to consider from all the testimony presented today:

1. Connecticut has an increased number of patients needing primary care and mental health services, especially among the most vulnerable of our residents.
2. Connecticut has a decreased number of physicians providing primary care and mental health services.
3. Connecticut has a well-qualified group of APRNS who can provide such services, including to the most vulnerable of our residents.
4. Current law in Connecticut, derived 15 years ago, presents untenable and unnecessary barriers to APRNs wishing to provide such needed patient services.
5. APRN practice is safe, effective, well-liked by patients, and extremely well-researched. Attached is a list of the 27 studies substantiating this (in the order in which they appear in the CTAPRNS Request submitted to DPH in August, 2013). Safe practice is well-established. Some highlights of recent research include:
 - a. States granting full practice authority to APRNs experience the greatest growth of nurse practitioners providing primary care, and thus growth in the numbers of patients receiving primary care.
 - b. APRNs practicing in "full scope" states are less likely to relocate out of the state.
 - c. Twenty jurisdictions have granted full scope of practice to APRNs, and in all of them, APRNs practice collaboratively with physicians and all other members of the health care team.
 - d. Prominent national groups have issued positive recommendations based on the evidence, including the Institute of Medicine and the National Governors' Association.

Thank you,

Lynn Price, JD, MSN, MPH

Attachment:

List of Research Studies on Nurse Practitioner Practice, Outcomes and Patient Satisfaction, from 1974 through 2013

1. Kuo et al.: States with the least restrictive regulations experienced the largest increase in patients seen by nurse practitioners. (2013)
2. Sekscenski et al.: State practice environments and the supply of physician assistants, nurse practitioners, and certified nurse-midwives (1994)
3. U.S. Department of Health and Human Services: A comparison of changes in the professional practice of nurse practitioners, physician assistants, and certified nurse midwives (2004)
4. Kalist et al.: The effect of state laws on the supply of advanced practice nurses (2004)
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9. Munding et al.: Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial (2000)
10. Lenz, et al. Primary care outcomes in patients treated by nurse practitioners or physicians: two-year follow-up (2004)
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15. Pearson: Annual Pearson Report NPDB & HIPDB State Ratios (2012)

16. Newhouse et al.: Policy implications for optimizing advanced practice registered nurse use nationally (2012)
17. Dill et al.: Survey shows consumers open to greater role for physician assistants and nurse practitioners (2013)
18. Kovner et al.: *Nurse Managed Health Centers*. Robert Wood Johnson Foundation Research Brief (2010)
19. American Academy of Nurse Practitioners: Nurse Practitioner Cost-Effectiveness (2010)
20. Paez et al.: Cost-effectiveness of nurse practitioner management of hypercholesterolemia following coronary revascularization (2006)
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22. Eibner et al. at RAND: Controlling health care spending in Massachusetts: an analysis of options (2009)
23. Traczynski et al.: Nurse practitioner independence, health care utilization, and health outcomes (2013)
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PUBLIC HEALTH COMMITTEE PUBLIC HEARING FEBRUARY 28, 2014

GOVERNOR'S BILL No. 36

AAC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

Rose Zmyslinski, MSN, APRN, PMHCNS-BC, PMHNP-BC, Geriatric CNS-BC IN SUPPORT OF #36

Senator Gerratana, Representative Johnson, Members of the committee:

As an experienced Advanced Practice Registered Nurse, who has three national certifications, I hold a highly responsible position within a community hospital setting. My job duties include outpatient medication management, admission and inpatient care and evaluation for discharge readiness for patients on the locked acute behavioral health unit. I also provide consultation to the medical doctors for appropriate mental health care and medication recommendations for patients on the medical units or in the emergency department. I function independently to provide high quality and cost effective psychiatric care to patients of this community general hospital.

It has come to my attention that my physician colleagues raise objections to the qualifications of an APRN to function in such a highly independent position. They rightly point out that my education included best practices to coordinate care and to work within a team format. However, they neglect to acknowledge the high level science courses, including advanced pathophysiology, pharmacology, psychopharmacology and advanced health assessment.

Given the limited health care resources in many high need areas of Connecticut the lack of independent APRN practice creates an unnecessary obstacle to access to mental health care for Connecticut residents. Although the current practice act requires me to have a collaborative practice agreement, I in fact work independently I am the sole provider for weekend, holiday and evening coverage for psychiatric services. When my physician colleagues take vacation or sick time, it is not unusual for me to be the only prescriber or attending practitioner to meet the care needs of our patients. This position was initially created in response to an acute need for a psychiatric provider due to a long vacant position. I dealt with many layers of resistance to a non-physician in this full scope of practice role. After several years of providing a highly valued service, my physician colleagues are now seeking to hire an additional APRN. As a physician coworker recently observed, "The experiment has worked. We need to hire another APRN" His words provide the essence of my testimony that the current requirement for practice restrictions is inconsistent with the level of care provided by this APRN.

Rose Zmyslinski, MSN, APRN, PMHCNS-BC, PMHNP-BC, Geriatric CNS-BC

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Waterbury Medical Association

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 Telephone (203) 753-4888 • Fax (860) 286-0787 • Email myokose@ssmgt.com

Statement in Opposition to

Governor's Senate Bill 36 – An Act Concerning the Governor's Recommendations to Improve Access to Healthcare

Public Health Committee

February 28, 2014

This statement is being submitted on behalf of the Waterbury Medical Association in strong opposition to Governor's Senate Bill 36 – An Act Concerning the Governor's Recommendations to Improve Access to Healthcare. We find the bill to be bad patient care.

The medical home concept is being recognized as a patient centered team approach to primary care. This is supported by the Affordable Care Act and integral to the development of Accountable Care Organizations. The team approach to care is more proactive in management of preventive health care and chronic disease management – reaching out to patients for improved care. It requires the organization to monitor the quality of care. Other innovations like group visits, email communication with patients and same day visits may help meet patient needs. One of the key principles of a patient centered medical home is that each member of the health care team has to work to the full extent of their license. For physicians, this means stepping back from the full control of each aspect of the medical care. For APRNs and other mid-level providers, this will include a larger role in wellness care and chronic disease management. To provide APRNs full independence would help undermine the patient centered team approach to care. A certain percentage of APRNs would divorce themselves from the team model to continue the current model of fractionation of care and increased use of specialists.

With 30 million Americans gaining insurance coverage, we need more primary health care providers - more nurses *and* more doctors - working together in coordinated, integrated health care teams. Providing care in underserved parts of our country requires us all to work together creatively to build and implement new and better models of team-based care. Each layer of the patient-centered medical team must build on each other, and not stand isolated. The physician-led, team-based approach ensures that the patient gets the right care from the right health care professional at the right time.

Several studies have established that having a regular source of care and continuous care with the same physician over time leads to better health outcomes as well as lower costs, and medical homes are designed to provide this type of care. A recent survey by the Commonwealth Fund concluded that adults who have medical homes have enhanced access to care and receive better quality care. The survey defined medical homes as regular health care providers that offer timely, well-organized care and enhanced access. Given the benefits of the medical home, we question if APRNs would have any interest in joining a medical home if they were in independent practice. There would be no reason for them to be part of such a type of care.

Many of us are teachers as well as physicians, so we recognize that what physicians do is not easy. On occasion, an intern has not been able to complete his or her residency because he or she just did not have what it takes to take care of patients independently. That is, despite the fact that they completed four years of college and four years of medical school and had more clinical training than an APRN would have when finished with all of their training, they just were not meant to practice independently. It is not

easy to recognize at the beginning stages of education and training who will be a competent practitioner later in the process. It takes years of hands on training backed up with a medical school education to become a competent independent practitioner. In order to provide the best possible health care and protect the public, we think it is essential that anyone practicing independently have the highest education and training. We do not believe that the educational and training requirements of an APRN are designed to allow for independent practice.

Physicians' education is standardized such that the didactics, training and experience are consistent throughout the country. The education of APNs, on the other hand, may or may not include a bachelor's degree, a master's degree, or a doctorate, and the clinical training can be almost non-existent or even online. Physicians have four times the amount of clinical training as APNs so bring a broader and deeper expertise to the diagnosis and treatment of all health problems our patients face. A physician cannot be simply replaced by another member of the team without creating different classes of care. While each member of the health care team has a role, they are not interchangeable. According to the American Association of Colleges of Nursing, there will 260,000 too few nurses by 2025. The primary care shortage is not resolved by fragmenting care with more independent groups.

It is ironic that many graduating medical students go into sub-specialty training because they are overwhelmed by the wide scope of primary care medicine and are concerned that they will not be able to be competent after four years of medical school and three years of residency training. It is difficult to fit in all the required core curriculum conferences within the three years of residency training never mind the much shorter programs designed to educate APRNs. When we have graduates of medical schools that are not quite as good as UCONN, we end up spending a lot of time going back over the basics. In addition, it takes a long time to develop the skill of knowing when and what you don't know. It can only be learned through experience and now that residents are restricted by the 80 hour work week, it is hard to ensure that they develop this skill (but impossible to ensure that graduating APRNs will have this skill).

Patients need to be able to trust that medical professionals are well trained and competent to practice in an independent setting.

For more information, please contact:

Ann Marie Conti-Kelly, M.D., President
Mary Yokose, Executive Director
(203) 753-4888

Rahul S. Anand, M.D. SB 36

Connecticut Pain & Wellness Center, LLC.

Pain management/medicine is a complex and critical field. There are serious risks of drug addiction for society and spinal paralysis of patients undergoing unsupervised and legitimate care. I am a dual certified anesthesiologist and pain medicine specialist. To allow a CRNA or APRN to provide opioids management or even spinal procedures is unheard of in any other country, and a public health risk. I would seriously consider the ongoing opioid epidemic and possible patient care sacrifice that will occur if you pass this NO. 36 bill. Use common sense and follow the lead of other countries. No nurse should be unsupervised in the OR, or a pain clinic, period.

Good day.

Rahul S. Anand, M.D.

Connecticut Pain & Wellness Center, LLC.

52 Beach Road, Suite 204

Fairfield, CT 06824

203-319-WELL (9355)

www.ctpainandwellness.com

Cate Moffett SB 36

I would like to support the removal of mandatory collaboration from the practice of APRNs in CT.

I have been a family nurse practitioner for over 30 years. I have worked in hospitals, corporations, community clinics and now in college health. I have worked independently, referring to physicians and specialists as needed. I have been fortunate in that most of my professional life I have been able to practice with collaborating physicians serving as consults, not supervisors. I find that the APRN culture of practice is a careful and collaborative one, collaborating not only with other specialists, but with the patients themselves. Perhaps that is part of the reason that our malpractice record is so good.

I strongly encourage the legislature to allow us to practice without the constraint of the mandatory collaborative practice agreement. Many of us are already practicing that way, with the "collaborative physician" in name only.

Thank you-

--

Cate Moffett, APRN
Director, Student Health Services
Connecticut College
270 Mohegan Avenue
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(860) 439-2275
(860) 439-5430 Fax

PUBLIC HEALTH COMMITTEE PUBLIC HEARING FEBRUARY 28, 2014

GOVERNOR'S BILL No. 36

AAC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

Rose Zmyslinski, MSN, APRN, PMHCNS-BC, PMHNP-BC, Geriatric CNS-BC IN SUPPORT OF #36

Senator Gerratana, Representative Johnson, Members of the committee:

As an experienced Advanced Practice Registered Nurse, who has three national certifications, I hold a highly responsible position within a community hospital setting. My job duties include outpatient medication management, admission and inpatient care and evaluation for discharge readiness for patients on the locked acute behavioral health unit. I also provide consultation to the medical doctors for appropriate mental health care and medication recommendations for patients on the medical units or in the emergency department. I function independently to provide high quality and cost effective psychiatric care to patients of this community general hospital.

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Given the limited health care resources in many high need areas of Connecticut the lack of independent APRN practice creates an unnecessary obstacle to access to mental health care for Connecticut residents. Although the current practice act requires me to have a collaborative practice agreement, I in fact work independently I am the sole provider for weekend, holiday and evening coverage for psychiatric services. When my physician colleagues take vacation or sick time, it is not unusual for me to be the only prescriber or attending practitioner to meet the care needs of our patients. This position was initially created in response to an acute need for a psychiatric provider due to a long vacant position. I dealt with many layers of resistance to a non-physician in this full scope of practice role. After several years of providing a highly valued service, my physician colleagues are now seeking to hire an additional APRN. As a physician coworker recently observed, "The experiment has worked. We need to hire another APRN". His words provide the essence of my testimony that the current requirement for practice restrictions is inconsistent with the level of care provided by this APRN.

Rose Zmyslinski, MSN, APRN, PMHCNS-BC, PMHNP-BC, Geriatric CNS-BC

The William W. Backus Hospital
326 Washington St
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860 889-8331 X7506.

Sarah Lavoie-Stamos SB 36

My mother is an APRN, practicing in Litchfield, CT. I fully support this bill.

Sarah Lavoie-Stamos

Haik Kavookjian, M.D. SB 36

To Whom This Will Concern:

I'm writing to voice my opposition of the proposed legislation which will allow APRNs to practice independently in Connecticut. based on my clinical experience APRNs do not have the education or training to provide quality care without physician supervision. Thank you for your attention.

Sincerely,

Haik Kavookjian, M.D.
555 Newfield Ave
Stamford, CT 06905

PUBLIC HEALTH COMMITTEE
PUBLIC HEARING FEB. 28, 2014

Governor's Bill No. 36 AAC The Governor's Recommendations
To Improve Access To Health Care

Elena Schjavland APRN In Support of Bill No. 36

To: Senator Gerratana, Representative Johnson,
and members of the Public Health Committee

Thank you for the opportunity to speak on this bill.

I am a Connecticut licensed APRN and a board certified Adult and Geriatric Nurse Practitioner. I have a DEA license and CT Controlled Substance license. I am self-employed as a Memory Disease and Dementia Specialist, and provide house calls to adults and seniors in Southeast CT. I diagnose and treat those diseases; prescribe and order tests including MRIs, complicated laboratory tests, and process DNA specimens; I help the patient, family and caregiver understand a mutually agreed upon dementia management plan, both present and future. I have an individual collaborative agreement and contract with a CT physician.

I testified last year, but actually, am more prepared NOW to address the Committee's concerns of health, safety, doctor issues and the economic implications of this bill. I have been in the field for the last 18 months dealing with the required APRN contract and its impact on my practice. In short, it has severely limited patient's access to the care I can deliver.

Access and provision of healthcare is the greatest issue in 2014. The present requirement and contract cause headaches and significant time loss for me every week. It is because of: billing glitches, excessive phone calls, and turf challenges. Sometimes I refer a family to a memory center 1-1¹/₂ hours away because I can't resolve the red tape.

We need easier access to, and more appointments with APRN Primary Care Providers, Mental Health APRNs, NPs who treat aging populations, APRNs who provide depression behavior therapy, and APRNs who specialize in woman, child and adolescent care.

Essentially, I would be more productive, treat more patients, and have more time to improve dementia care in our community under the new legislation. There are plenty of patients for all of us,.... especially me, considering one out of six people hearing this testimony will be diagnosed with Alzheimer's disease during their lives.

As healthcare consumers, we all demand **safe and competent medical visits**. The opinion by Dr. Jewell Mullen, along with the research outcomes studied by many multi-disciplinary and MD authorities demonstrate that APRNs have good healthcare outcomes.

I render care in a professional, competent and comprehensive manner. I provide for escalation of care, collaborate and refer to physicians as needed. I also collaborate and refer to: researchers, specialists, social workers, geneticists, counselors and home healthcare services. It is the same logical,

common sense approach among my colleagues in their first-rate NP primary care practices and house call services. With APRN autonomy, think of the quantity of care delivery, research and work on National Care Standards we can offer. The collaborative contract requirement is redundant; not so the physician collaboration we already integrate into our practice along with the entire health care team, patient and family.

I have personally encountered **physician's opposition** to my practice. Turf challenges, legal issues and boundary questions arise from local Connecticut doctors, hospitals and care facilities. It is never my patients who erect roadblocks. Clients and families know I am a nurse practitioner; and clever as they are, they know the difference between a psychologist, a chiropractor, podiatrist, Nurse Practitioner and a medical doctor.

It was hard for me to get that first signed contract, let alone convince another New London doctor to sign on that dotted line. I would consider relocating my practice to Rhode Island, Vermont, New Hampshire or Maine, where there is already independent practice for NPs, but I am closely tied to family and neighborhood. My practice will close if the current physician collaborator does not renew my contract, whether due to: physical inability, overwork, geographic move, loss of CT MD license, death or retirement. I, then can no longer see or support my patients and families. This uncertainty is the prime reason I am reluctant to hire additional staff I desperately need. If I can't see clients and be reimbursed, I can't afford the payroll.

APRNs are expertly educated and clinically competent; they pass certification boards, must have malpractice coverage, are periodically recertified, and require continuing education hours,

including meeting changing pharmacology standards. APRNs know practice boundaries. The same litigious culture that measures doctors, also judges NPs.

Allowing highly trained APRNs to more freely do their jobs will boost their productivity and improve care. It will benefit current local are **economics**.

I want to grow my business in Southeast CT. With independence, APRNs can develop new practices, especially in rural and ultra-urban areas. It will directly support access to care, local redevelopment and a real, *new jobs potential* from: office rental and custodial cleaning to professional nursing, legal, business and computer informatics trades. With independence I can hire APRNs, Registered Nurses, social workers and others.

To sum up my testimony, APRNs are nurses, the most trusted professionals in the United States. Consider that impact on honesty in healthcare. Remember too, APRNs are specifically educated in both medical and nursing models, care and cure, and wellness and holism. APRNs are especially nuanced to listen, a rare gift in healthcare today. Collectively, this provides the rubric for a valued service to CT healthcare consumers. I don't want the committee to pass on this opportunity.

Thank you.

Elena Schjavland Mystic. Keys2Memory.

Wednesday, February 26, 2014

Attention: Committee on Public Health, Connecticut Legislature

Re: Governor's Bill No. 36, LCO No. 249, An Act Concerning the Governor's Recommendations to Improve Access to Health Care

My name is Henry Schneiderman. I am an internist-geriatrician, and here offer my intense and unreserved support of Governor's Bill No. 36, LCO No. 249, An Act Concerning the Governor's Recommendations to Improve Access to Health Care. An essential feature of this bill removes the requirement that advance practice registered nurses (APRNs) have a written collaborative practice agreement with a licensed physician after a three-year period post training of such collaborative practice. Safe patient care does not require any such collaborative agreement nor the kind of consultation it stipulates, a kind of consultation that in fact is not universally practiced, typically because of failure by a physician to do so. By virtue of my own continuous collaboration with APRNs over the past 19 years, and by my serving on the Scope of Practice Committee of the CT Department of Public Health, whose report you will have seen, I recognize that collaboration occurs continuously between healthcare professionals. This is because we all seek insights from other professionals and consultants. The piece of paper that is the agreement does not ensure this essential function, and collaboration occurs without it, for instance, when I ask another MD, "What do you think about this presentation? Are there other diagnoses you'd consider, or other tests?"

APRNs have proven their efficacy and dedication for decades. They are highly vigilant to minimize patient risks. APRNs know when to consult: Just as I can take care of 95% of the kidney problems of my patients without a nephrologist, so too an APRN can render superb care, using her or his training and experience, for more than 95% of issues that ail her or his patients. Just as when a seasoned physician like myself knows well when to obtain consultation, so too does the APRN--if anything, and especially early in career, they will bend over backwards if in any doubt whatever, to check with someone who may know more--and that may be another APRN as well as an MD. The overlay of regulation burdens time and efficiency, and conveys inappropriate disrespect.

The requirement for a collaborative practice agreement becomes a major barrier for APRN practice because often there are no physicians willing and available for collaboration. Some doctors resist augmenting the scope of APRNs, viewing them as "unfair" economic competitors. That posture ignores the accepted reality that the present undersupply of primary care physicians will worsen sharply for decades to come, due to economic disincentives, overwork, lack of respect from hospitals, employers, insurers, pharmacies and the public, as experienced by every primary care practitioner. The care and health of human beings depend heavily on APRNs, and access to both primary and specialty care will require APRNs in an expanded role, to an increasing degree going forward. This reality is most striking in domains of medicine that lack reimbursable procedures, since current fee structure rewards procedures (including those of little or no benefit) and undercompensates cognitive services, time spent with patients, meticulous physical examination and a comprehensive approach to

the biopsychosocial needs of patient and patient-family unit. Yet those intense professional efforts define good primary care internal medicine, mental health care, primary care pediatrics, and my own area of specialization, geriatric care of frail elders whether in community or in a nursing home. Each of the above is an area where APRNs shoulder a disproportionately large share of the clinical workload, to their eternal credit.

Experience working daily with APRNs informs my opinion: I have collaborated closely in care of patients in long-term care and in hospital with both geriatric and geropsychiatric APRNs, and have long taught in Yale's APRN program. APRNs show consistent admirable willingness "to get their hands dirty" and to meet the patient where he or she lives – physically, medically, emotionally. My intense respect for APRNs includes a deep sense of trust. The APRNs at my workplace and I complete Collaborative Agreements per regulation, but we talk about patients together for the same reason that I talk with my physician colleagues: mutual regard, and recognition that insight flows in more than one direction. A cohesive team takes better care of a human being more effectively than any single individual, regardless of title.

I am proud to be a physician and feel confidence in my long training; but I'd be a fool to undervalue the post-training clinical experiences that mold any health care worker. The psychosocial skills of APRNs and their hands-on approach recall what used to be most highly prized in physicians; such skills have eroded among physicians to the detriment of patient care and of the prestige of physicians. APRNs represent a vital force in the reinstatement of best practices and values. They provide a counterweight to some runaway costs in health care (though medications, procedures and long-term care cost our society far more than all provider billings).

The research record is very clear in the 17 states (and the District of Columbia) which have long empowered APRNs to practice independently: access is improved, costs are lower, and quality is not diminished in the least. As part of my work on the Scope of Practice Committee, I very studiously critiqued two papers cited by those who assert to the contrary; my reviews, which I would be happy to share with you electronically if you like, revealed that the data in these papers did not support the conclusions drawn by their authors.

I respect the Connecticut State Medical Society and am proud to have been and to remain a member of it for three decades. But each of the specific reasons cited in their literature opposing this bill is unconvincing, erroneous or not relevant for example, APRNs acknowledge that their training is not as lengthy as that of physicians, but that training is demonstrably sufficient to support equal patient outcomes. If there are limited dollars to cover the staggering health costs of our population, why would we NOT welcome a solution that costs less, preserves quality, and enhances access? Why would we NOT accept the verdict of those impartial researchers who have shown, again and again in the health services journals, that nurse practitioners are fully up to independent practice? Why would we not listen to the many states that have successfully walked this path before us?

Our health-care system will operate more efficiently and effectively once we acknowledge, empower, license and support APRN practices that function without physician presence. Intense fiscal pressures on the health care system support this conclusion. So does the issue of provider supply: consider Massachusetts, and the impact of universal coverage without enough primary care providers; and the result when too many physicians refuse to enroll ill-remunerative patients on Medicaid. APRNs represent an indispensable element in achieving universal health care rather than a repellent two-tier health system. To realize any such noble vision, we need a system that does not break the bank of local, state and federal budgets; APRNs are a large part of the solution. There is every reason to welcome their needed and effective presence and practice to the full extent of their training and capacity, and no down side. I urge you on behalf not only of all health care workers in CT, but of our citizens and residents, to enact the Governor's Bill.

Sincerely and respectfully,

Henry Schneiderman MD FACP,
Vice-President for Medical Services and Physician-in-Chief, Hebrew Health Care;
and Clinical Professor, Nursing, Yale University
860-523-3854 FAX 860-523-3828 hschneiderman@hebrewhealthcare.org



Statement in opposition to

Governor's Senate Bill 36 – An Act Concerning the Governor's Recommendations to Improve Access to Healthcare

Public Health Committee

February 28, 2014

This statement is being submitted on behalf of the members of the New London County Medical Association in opposition to Governor's Senate Bill 36 – An Act Concerning the Governor's Recommendations to Improve Access to Healthcare. Each year that this bill or ones similar to it have been introduced we have come before this Committee and testified in person. Unfortunately times have changed and we are no longer able to both treat our patients and advocate for them. We now must do one or the other. Despite our strong feelings against this bill and the jeopardy that we believe this bill places our patients in, we are not able to testify before you today.

The bill before you would remove the requirement that Advanced Practice Registered Nurses (APRNs) collaborate with physicians when providing medical care. We feel that the removal of this requirement poses a significant health and safety risk to patients and it is for that reason we cannot support the bill.

We should begin by stating that APRNs are valuable members of the health care team. Through collaborative practice we have established working relationships that benefit the patient. In the past, we were told that APRNs have had difficulty finding a collaborative relationship. To help remedy this, the Connecticut State Medical Society (CSMS) established a referral service so that an APRN who could not find or establish a relationship could contact CSMS and CSMS would then help that APRN find a collaborative arrangement. Despite the widespread problem we were told APRNs were having finding such arrangements, very few took advantage of the program. Given that such a small number took advantage of the referral program, we were quite surprised to learn that the program was not working. We were even more surprised to learn that merely eliminating the collaborative requirement was the solution.

To completely remove a requirement for collaborative practice seems hasty, not to mention that it puts patients at considerable risk. We simply cannot support the removal of a requirement that was established to protect patients and assure that they receive the highest quality of care. We do not believe that given the differences between physicians' training and education and that of an APRN, that they are adequately prepared to safely and independently treat patients.

We respectfully request that you oppose the bill.

One Regency Drive
P.O. Box 30
Bloomfield, CT 06002
(860) 447-9408
Fax (860) 280-0787
Website www.nlcmo.org

Mahmoud Okasha, M.D., President
Mary Yokose, Executive Director
(860) 447-9408

Dr Carlesi SB 36

My name is Dr Carlesi and I oppose this bill because I am a interventionalist and O feel this would be a very dangerous decision to allow untrained non- physicans to perform these delicate and potentially life threatening procedures. If I was a patient I would not allow either of the two to touch me. Thank you.
Dr Carlesi

Sent from my iPhone

Mary Lou Graham, MSN, SB 36
Dear Public Health Committee Members,

I am Nurse Practitioner Mary Lou Graham and I am writing to urge you in the strongest of terms to support Bill Number 36.

Every Nurse Practitioner is Board Certified in a specialty area, we cannot practice without being certified. Our training is specialized right from the beginning of our education.

Good practice dictates accessing additional services/case review when the patient situation warrants so removing the requirement for collaboration will not alter how NP's practice. What it will do is allow practitioners like me to not worry that my 200+ patients would be left stranded without care if my elderly collaborator suddenly is no longer available to collaborate with me. Also I own my own practice, for 13 years as of June 1, and I am just about to commit to buying an office to house my practice and that of the other therapists I work with. I don't like uncertainty about my ability to stay in business and pay the mortgage and that is the situation I am currently in.

It is unfortunate that many in the physician community are uncomfortable with Nurse Practitioners and other Advanced Practice Nurses becoming more autonomous. There is now ample national experiences with just this paradigm and it has not been calamitous.

I would rather see unity in the provider community with a focus on caring for our patients who have so many unmet medical needs.

Lastly, our patients are not forced to use our services. Many people seek out our services and request to be treated by us. I turn away 3-4 patients for everyone I agree to take on. They seek our my care being fully knowledgeable about my academic credentials and licenses.

Thank you again and I would appreciate feedback about the results of your deliberations and if you need any further testimony from me.

Mary Lou Graham, MSN, APRN-BC, RN, LPC, MBA

Instructor
University of Saint Joseph West Hartford, CT

Owner, ML Therapies, LLC

Per Diem Nurse Practitioner :
Community Mental Health Affiliates New Britain, CT
The Hospital of Central Connecticut Outpatient Behavioral Health Clinic New Britain, CT

MARGARET PENEPEPENT
2 PIERSON GREEN
CROMWELL, CT 06416

Connecticut General Assembly
Public Health Committee Members
Room 3000
Legislative Office Building
Hartford, CT 06106

February 24, 2014

RE: RAISED BILL 36: AN ACT CONCERNING THE GOVERNOR'S
RECOMMENDATION TO IMPROVE ACCESS TO HEALTH CARE

Dear Committee Members:

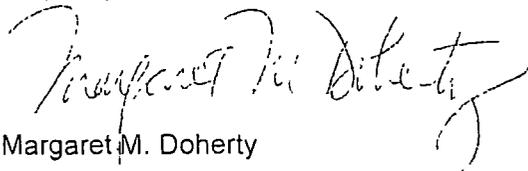
Please vote in favor of Raised Bill 36 permitting wider access to health care delivery by easing restrictions of Advance Practice Registered Nurses ("APRN")

Connecticut is leading the way in increasing access to health care insurance through our health exchanges. Connecticut needs to continue to increase access to health care delivery by expanding the scope of health care providers by fully utilizing the skills of APRNs.

Please vote to pro-actively expand access to health care delivery utilizing the skill of APRNs.

Thank you for your consideration of this important legislation

Very truly yours,



Margaret M. Doherty

Edward Volintesta

February 26, 2014

To: Public Health Committee

Re: S.B. No. 36: An Act Concerning The Governor's Recommendations To Improve Access To Health Care

I have been practicing primary care in Bethel for almost 40 years. I am submitting testimony in favor of S.B.No. 36.

The most common argument against granting APRNs independent status is that primary care MDs have more training. But this argument is misleading because primary care has undergone a radical transformation in the past twenty or so years. The forerunner of today's primary care doctor, the general practitioner (GP) did just about everything from delivering babies to taking out appendices. But the rapid expansion of medical science and new surgical techniques made it impossible for general practitioners to remain competent in so many areas.

Add to this the numerous regulations that insurers have placed on physicians and the excessive amount of time that doctors spend with paperwork and it is clear that the role of the primary care doctor has changed radically.

Today primary care physicians work mainly in the area of diagnosis and prevention; and coordination and maintenance of care. Many primary care doctors, who in the early years of their careers had treated a wide variety of illnesses, now find that their days are filled mostly with uncomplicated respiratory illnesses, some bone and joint problems, depression, maintenance of diabetes, stable heart disease, and hypertension.

Many only maintain an office practice and no longer take care of hospital patients or nursing home patients.

There are many important functions that APRNs can perform. In addition to some basic primary care services like treating upper respiratory infections, sore throats, and earaches, they could for example do insurance physicals, act as school nurses, make house calls, and do post-hospital follow-ups in patients' homes. These are just a few of the areas APRN s can make a difference in improving access to the health care system.

APRNs are endorsed by the Institute of Medicine (IOM) as qualified to practice independently within the limits of their education and training and because APRNs already are practicing independently in 20 states.

The Affordable Care Act will greatly increase the number of individuals seeking primary care services. In fact, experts predict that by 2020 there will be a shortage of about 60,000 primary care doctors.

Even though some medical schools are shortening their traditional four year programs by one year, it is impossible for them to fill the predicted need.

There is no doubt that one way to increase primary care access is to make greater use of advanced practice registered nurses (APRNs) by granting them independent status.

Sincerely,

Edward Volpintesta MD

Bethel, CT 06801

Sent: Tuesday, February 25, 2014 11:24 AM
To: PHC Testimony
Cc: lrapsiiber@optonline.net
Subject: testimony on Bill 36
Attachments: Testimony on APRN independent practice 2014 doc

Attached please find testimony on Bill 36: AAC The Governor's Recommendations to Improve Access to Health Care. We will not be testifying in person. This is for submission only.

Stephen A. Karp, MSW
Executive Director
NASW/CT
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Suite 205
Rocky Hill, CT 06067
860.257.8066



National Association of Social Workers / Connecticut Chapter

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Raymie H. Wayne, Ph.D., JD, MSW, President
Stephen A Karp, MSW, Executive Director
naswct@naswct.net

Testimony on Governor's Bill No. 36: AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

February 28, 2014

Submitted by: Stephen Karp, MSW

The National Association of Social Workers, CT Chapter, representing over 3000 social workers throughout Connecticut, supports the bill proposed by the governor titled AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE.

APRNs offer cost effective and quality health care services to the residents of our state. Of particular interest to NASW/CT is the access and delivery of mental health services. We estimate that two-thirds of all mental health services in Connecticut are provided by clinical social workers. These social workers provide services both within agency practice and private practice. In both settings we see an important role for the APRN that includes medication management. This bill will provide APRNs with the ability to practice fully independently and as such will increase the providers our members can consult with and collaborate with when the social worker's client is on a psychotropic medication.

There is a lack of sufficient psychiatrists and especially child and adolescent psychiatrists within Connecticut. This has made it difficult for individuals to access needed mental health services when medication management is necessary. Likewise, social service agencies often find it difficult to attain sufficient hours of consultation with a psychiatrist for their clients who are in need of medication management. This bill will significantly increase the accessibility of qualified providers who can provide consultation, oversight and direct care of individuals in need of mental health and physical health care.

Just as clinical social workers frequently work in collaboration with a psychiatrist seeking consultation when the social worker deems it necessary, we can expect that an APRN will do the same when appropriate. One of the common arguments against APRN's in independent practice is that they may not be properly educated or able to handle certain health issues that may be inflicting their patients. However, there are many general practitioners as well as social workers as noted above that initially see patients with problems that are outside their scope of trainings and these doctors/social workers refer their patients to a specialist who can properly treat the individual. This is exactly what APRNs would do. As professionals APRNs can be counted on to seek consultation when they need additional assistance however they should not be required to practice under physician consultation when not all cases need this added level of scrutiny. This bill recognizes the ability of an APRN to practice independently and by doing so will expand access to health care in a cost effective manner. APRN's are not trying to take patients away from doctors but rather to provide more options to patients.

Our members who work with APRNs consistently report on the positive relationship they have and on the quality of services the APRN provides. This feedback from our members was an important factor in NASW/CT offering our support for the Governor's Bill No. 36.

APRNs must complete a rigorous training regimen to earn the APRN. At a time when the Affordable Care Act is looking to expand healthcare access and services our state needs to be looking at how to assure that we have an adequate number of providers to offer that care. By removing the requirement that an APRN practice under a formal collaboration agreement with a physician is a sensible step toward expansion of health care services. It is also recognition of the qualifications of APRNs and the changing health care landscape that demands better ways of providing care.

In conclusion, the State Innovation Model (SIM) introduced recently promotes equal access to healthcare for everyone. Additionally, the Advanced Medical Homes that is the foundation of this initiative is designed to provide better access to primary care and to increase health care coordination. But I would ask you to consider the already long waits and high costs that often inhibit patients from scheduling regular visits with a primary care physician. Now within the state and in the country we are in uncharted territory as we implement the Affordable Care Act which provides health care access to millions of people who were once without it. How are we going to manage this influx of newly insured? One part of the solution needs to be allowing APRN's to take on more responsibility within their community thereby alleviating pressure on primary care physicians and most importantly providing patients with better access to quality care. NASW/CT believes by passing this bill and giving APRN's the chance to work freely within communities throughout Connecticut you will be addressing the growing need for qualified primary care providers.

From: Tabassum, Ali <Tali@wellmore.org>
Sent: Wednesday, February 26, 2014 2:55 PM
To: PHC Testimony
Subject: Testimony for SB 36
Attachments: GB 36 testimony.pdf

Attached is my testimony for SB 36. Please let me know if there is any difficulty in opening the attached document.

Thank you!

Taby Ali, APRN
Psychiatric-Mental Health Nurse Practitioner

Wellmore

Behavioral Health
Wellness for a lifetime

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Testimony Supporting Senate Bill No. 36: An Act Concerning the Governor's Bill to Improve Access to Healthcare

Senator Gerratana, Representative Johnson and Members of the Public Health Committee:

I am a recent graduate of Yale's School of Nursing and have been working within a community mental health center since July 2012. I am one of four medical providers at my agency who work to assess, diagnose and treat children with mental health needs. Our medical team consists of two nurse practitioners and two psychiatrists where collaboration is sought based on experience related to the clinical question rather than to which degree the individual holds. In practice, I assume primary responsibility for the assessment and treatment for my patients. I reach out for support, consultation, and collaboration internally and externally, as needed.

I write to share my strong support for the Senate Bill No. 36 as the proposed language meets our state and national government's shared goal of increasing access to healthcare for all. By allowing for independent practice among nurse practitioners (NPs), it is possible that more NPs would elect to create their own practices to meet the emerging demand for healthcare. As the law currently stands, NPs who have the experience and interest in creating private practice office are limited by their ability to seek, and sometimes pay for, a collaborative practice agreement with a physician. Furthermore, a collaborative practice agreement may become in jeopardy should the collaborating physician pass away, move, or retire. This could result in an entire cohort of patients losing their healthcare because a collaborative practice agreement is now void.

The collaborative practice agreement appears to more of a procedural barrier than one that truly insures quality patient care. All healthcare providers, regardless of their training, are held to a standard of providing clinically appropriate and ethical care to their patients. It would be negligent to believe that with more autonomy, NPs would stop appropriately consulting and collaborating with peers or other specialties, as needed. Furthermore, despite the preponderance of states with collaborative practice laws, there is little evidence to support that these legal agreements result in better health outcomes.¹ Indeed, studies have found that nurse practitioners perform as well as medical doctors within their specialty field.²

Since 1989, Connecticut has been adjusting its Nurse Practice Act to increase the independence of registered nurses and nurse practitioner so that we may practice to the full extent of our training and education. In 1999, Connecticut became one of the first states in the country to allow for nurse practitioners' current level of autonomy. I am hopeful that the work of nurse practitioners over the past 15 years has proven to our legislative body that we are capable of executing patient care safely.

¹ See Institute of Medicine's 2010 report: *The Future of Nursing: Leading Change, Advancing Health*.

² See Robert Wood Johnson's policy brief from October 25, 2012: *Health Affairs*, "Nurse Practitioners and Primary Care" which references an internally conducted meta-analysis of 26 studies on the consistency of healthcare outcomes between nurse practitioners and physicians.

As the state and federal government aim to prioritize increasing access to healthcare, it is important to identify systemic barriers, such as this state's current collaborative practice agreement requirement, and address it as the Governor's Bill proposes.

I thank you for your consideration into the matter.

Taby Ali, APRN
Family Psychiatric-Mental Health Nurse Practitioner

Frank Rector

I BEG you to support Governor's Senate Bill #36, which will eliminate the collaborative practice agreement for experienced APRNs. This bill is significant in that it will increase access to APRN-delivered health care, and improve the primary, and specialty health care workforce in Connecticut. Please do not be misled by self serving or even well meaning parties who seek to control our practice for reasons that are NOT related to the quality, efficacy and affordability of the care we provide.

This is not about turf battles or taking away physician's roles or incomes in health care. This is about an important and separate avenue to the access to efficient and affordable health care. We are not physicians and do not hope to replace them but to augment their impact on the health of our citizens, especially the most vulnerable and disenfranchised who live on the margins of society.

The track record of Nurse Practitioners across the country has proven that we have the training and experience to practice independently and that we provide quality services that improve health care access and delivery. Many of us choose to work in areas and with populations that are grossly underserved and where most physicians will not practice.

I am a Psychiatric and Addictions specialist, Nurse Practitioner, triple board certified, and have been in advanced practice for decades. My CT license number is # 000006 as I was the sixth licensed advanced practice nurse in CT. For the past 15 years I have been working with individuals who are chronically homeless and who suffer from grave mental health and addiction disorders that leave them inaccessible to traditional health care systems where they rely on extremely expensive emergency rooms for health care if any. I go into the community and into homeless shelters and under bridges, into encampments in the woods and even abandoned buildings to outreach and engage such people, gain their trust and provide health care that eventually allows them to connect them to mainstream preventative care, entitlements and eventually affordable housing. Right from the moment I meet them, I can provide prescriptive service to give them the desperately needed medications to begin their journeys of recovery, where they are and on their terms.

The "collaborative practice agreements" I have signed with some excellent psychiatrists who support my role have been nothing more than annual paper requirements, as they support my independent practice and sign the papers simply so I can practice. I collaborate with multiple specialists in providing the overall care to my clients like all physicians and nurse practitioners do, when needed, and not because of an outdated and misguided law.

I have been fortunate to have not been exploited by physicians due to this law like some of my colleagues, but it has clearly restricted my ability to provide the care I can to the patients I serve and I have had to fight to be able to do so. I have been fortunate to find reasonable and confident physicians who are not afraid of the independence in the

services I provide but there are many who want to control my practice for their own self serving or misguided ends.

Again, I BEG you to support Governor's Senate Bill #36

Frank Rector, APRN, CARN-AP
Psychiatric-Addictions Nurse Practitioner
Director of Homeless Services
Capitol Region Mental Health Center
500 Vine Street
Hartford, CT 06112
(860) 297-0936
frank.rector@po.state.ct.us

Julie Gombieski

Dear Committee Members,

I am writing as Family Psychiatric Nurse Practitioner and I had previously posted a testimony to the Public Health Committee Testimony in 3/20/2013. At that time I had started a private practice and had many failed attempts at obtaining a collaborating psychiatrist. The CT Psychiatric Society had put in a testimony that they would offer APRN's assistance in finding one but in the end it did not lead me to the collaborating psychiatrist that I have now. In fact, when I called, the woman who answered the phone had NO idea what I was talking about, eventually gave me 3 referrals in which only one phone number was correct and the person seemed annoyed and frustrated that they were getting cold called for a collaborative agreement! It was not a fruitful or pleasant experience. More importantly, I get at least 3 phone calls a week from both adults and parents of children who are looking for mental health treatment. Over and over again, I hear stories about how hard it has been for them to find services or that I am the only who who actually called them back! There is a shortage of providers in the psychiatric field and removing a barrier to access to healthcare services is important for the people of this state. I do believe in the importance of good supervision and personally attend multiple supervision groups as well as individual meetings with my collaborating psychiatrist. The truth of the matter is that APRN's are very good at seeking out support and continuing education when our patients health status does not improve and we will continue to do so without this collaborative agreement. If this is truly a PUBLIC HEALTH committee then I would really urge the state to provide an alternative setting for ongoing collaboration for established treatment providers in the community. For example, an interdisciplinary monthly meeting where community providers could come for guidance around complex cases. I think this would also help increase community ties between all disciplines which may further help the populations we serve. These could even be done via message boards or online support systems. I'm just throwing the idea out there again because the idea of ongoing collaboration with a diverse group of professionals and experts is exciting!

Thank you for your time and consideration, Julie Gombieski APRN, MSN Family Psychiatric Nurse Practitioner Child & Adolescent Psychiatric-Mental Health Clinical Nurse Specialist

Susan Richman

I am writing to express my concern for the proposed legislation that would allow APRN's to practice and prescribe independently of a physician. I feel I am well positioned to weigh in on the subject, as I have been involved in the education of medical students, PA's and APRN's throughout my 30 year affiliation with Yale. I also acted in a supervisory capacity to mid level providers as an attending in the YNH Women's Center Ambulatory Care Clinic. The training, both didactic and clinical, of mid-level providers does not remotely approach the depth, breadth, and complexity of physicians. Courses in anatomy, physiology, pharmacology, and the various clinical rotations are very abbreviated, condensed, and superficial versions of the corresponding medical school curricular topics. The intent of the training is clearly to allow mid-level providers to complement and extend the practice of medicine, not to substitute for it. In post graduate practice, lacking the experience and clinical judgement of a physician, mid levels order many more consultations, imaging studies, and laboratory work than the average physician, which often delays the attainment of a correct diagnosis, and increases health care costs.

Patient satisfaction is great for time spent with mid level providers in their role as educators, supporters and promoters of preventive care. But for complex diagnosis, "they don't know what they don't know" has been the theme of my consultative professional relationships.

Dr. Susan Richman MD MPH
Director, Summit Medical
Associate, County Obgyn PC
Associate Clinical Professor Obstetrics, Gynecology and Reproductive Science
Yale Schools of Medicine and Nursing

Elizabeth Kahn

To Whom It May Concern:

I am writing in support of SB No 36. This bill removes a legal requirement that is currently a barrier to APRN practice, causing practices to close and preventing practices from opening. All ethical standards of practice relating to collaboration and consultation remain exactly as they exist today.

APRN's will continue to collaborate because collaboration is what every ethical practitioner, all doctors, therapists, nurses, engage in – it is asking a question of a colleague on a medical issue of concern for one's patient.

Unfortunately, the current situation reduces access to health care for all CT residents, but especially for vulnerable patient populations. Please give every possible consideration to the passage of this bill.

Regards,
Elizabeth Kahn, RN DNP (c)

Catherine A. Lavoie

Please HB 36: APRN independent practice.

Connecticut should join the 20 other states who have already taken this visionary step.

I have been a psychiatric nurse for over 30 years. My career has centered on caring for the most seriously mentally ill citizens of Connecticut. I have worked at the Connecticut Mental Health Center (New Haven), Fairfield Hills Hospital (Newtown), several correctional facilities, and lastly at the University of Connecticut Health Center, Out-patient Psychiatry, in Farmington.

Currently I have a private practice in Litchfield where I see people on Medicare, Medicaid, Husky, and sometimes people who have no insurance. As a member of Greenwoods Counseling Referrals, I am committed to helping people who can not afford mental health care.

Many people see a therapist such as a social worker or psychologist with excellent results. However if they also need to be on medication, they must find an APRN or psychiatrist to prescribe. As a result these patients must see two separate providers for their care. Because of my training as an APRN, I am able to provide psychotherapy as well as medications in one session. You can see that this is cost-effective but what may not be quite so obvious is how much better it is for the patient.

The reason this law HB 36, is so important is that it frees APRN's to work within our scope of practice without the legal burden of a physician collaborator. All health care providers consult with colleagues and that will not change with HB36. What will change is access to quality care with an APRN will be improved and not at risk when the physician withdraws for any reason.

Many studies have shown that APRN's provide safe, effective care with high rates of patient satisfaction. Granting us independent practice makes sense. We are here, we are ready to serve. I urge you to help clear the way. Support HB36.

Thank you very much,

Catherine A. Lavoie, APRN

Catherine A. Lavoie, MSN, APRN
15 Meadow Street - P O. Box 1164
Litchfield, CT. 06759
Phone: 860-488-1919
Fax: 877-567-6451
www.creativestressmanagement.org
Member of Greenwoods Counseling Referrals

From: Maryanne Strindberg, APRN <mcs@valleypsychiatry.com>
Sent: Monday, February 24, 2014 6:59 AM
To: PHC Testimony
Subject: Governor's Bill #36
Attachments: Barrier to practice 2.doc

Please see attached regarding Bill #36

Thank you for your attention

Maryanne Strindberg, APRN

—
Maryanne Strindberg, APRN-BC, GNP, PMHNP Valley Psychiatry
558 Hopmeadow Street
Simsbury, CT 06070

Valley Psychiatry

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(860) 408-4885 Fax
group@valleypsychiatry.com

February 24, 2014

To whom it may concern;

I am a nurse practitioner, board certified in gerontology and psychiatry and I practice in 1a private practice serving 11 nursing homes in the state of Connecticut. I service over 1000 patients. I have a physician partner and I consult a variety of attending and specialist physicians throughout my work week.

If something were to happen to my current collaborating physician, I would no longer be able to provide care for my patients due to state law requiring a written agreement between myself and a physician. It could take months before I found another physician in my specialty and my patients would be unable to receive care.

If the law is changed and the written agreement requirement went away, I would continue to consult and collaborate with my attending physicians and specialists. We do not work in a vacuum. All providers, whether physician, nurse practitioner, pharmacist or psychologist collaborates, consult and seek help and advice from others.

Please consider amending this law to discontinue this barrier to my practice for the wellbeing of my patients.

Maryanne Strindberg, MSN, GNP, PMHNP, APRN

Cynthia Heng

February 25, 2014

To the Public Health Committee,

I am writing to you today concerning the collaborative agreement upon APRNs and MDs in the state of Connecticut. As you may be aware, the Governor's Bill No. 36 proposes a modification to the current bill. I support this change and urge you to do so as well as it will present fewer barriers, allow APRNs to practice to their full potential and help ease the current shortage of primary and behavioral health care providers. This will impact not just APRNs and future APRNs but also our state as whole, patients, families and help reduce stress on other healthcare providers. As a future APRN, I believe this a turning point in future healthcare. There is a shortage in primary care providers which inhibits patient's access to healthcare. APRNs cannot continue to fill this gap if the current bill stays in term. An APRN must collaborate with a physician. As mentioned prior with physicians retiring, dying, and severing collaborative agreements, it creates a barrier for APRNs to practice and provide care for those who need it most, the underserved population.

With the modified bill, APRNs will be able to practice independently not in competition with MD's but alongside making a stronger healthcare team for the patient population. We must keep in mind that as time goes on, the elderly are getting older and the sick are getting sicker. This calls for a stronger team and action plan. Patients will have more choices in choosing a provider to their liking. Research has shown that the care of an APRN is safe, cost-effective, and of high quality. Additional data also shows that the rate of discipline related to practice errors or substance abuse of APRNs is less than 0.1%. However, there is also evidence that shows that APRNs are being restricted

from practicing in areas where they are needed most due to the fact that they cannot find a physician willing to collaborate or cannot afford the charges that the physician charges. Some of these charges can range as much 30,000 dollars a year or more if they are successful.

A change in the practice of healthcare is needed to provide quality care to make a healthier state, nonetheless a nation. The change has to start somewhere and why not here and now? Twenty other states including Rhode Island, Vermont, Maine, New Hampshire, and currently pending in Massachusetts have removed these barriers to practicing APRNs. Some may disagree and state that APRNs cannot provide optimal care, but several researches and evidence based practice have shown this to be wrong. APRNs have been proven to provide the same as or better care than our physician counterparts, higher rates of patient satisfaction, and are cost efficient. I am writing to you today to urge you to support this bill for a better healthcare future. Please support our unheard voices.

Sincerely,

Cynthia Heng BSN, RN, APRN student

Martin J. White

Dear Senator Gerratana, Representative Johnson and members of the Public Health Committee,

Thank you for the opportunity to submit written testimony to in opposition to SB 36.

I am an Orthopedic Surgeon practicing at Shoreline Orthopedics, 12 Bokum Rd., Essex Ct
06426

In my opinion, granting unsupervised privileges to APRN'S will be a huge disservice to everyone in our state seeking health care.

Who will assume the liability?

What about the increased expenses because of the many instances where they will have to refer because they do not have the training and experience to competently diagnose?

Would you send a family member or YOURSELF to an unsupervised APRN?

If you pass this bill, will you lobby to eliminate the requirement for me to update my board certification every 10 years?

Why should I be held to such a high standard if I can practice medicine with 1/6 of the training?

Thank you for your time. Please do the right thing for all of the citizens of Connecticut.

Martin J. White, M.D.

Kathleen M. Stuart

Dear Members of the Public Health Committee,

I am respectfully requesting that you support Governor Malloy's proposed Bill No. 36, "An Act Concerning The Governor's Recommendations To Improve Access To Health Care".

This proposed legislation would remove the currently mandated written collaborative agreement between an advanced practice nurse (APRN) and a physician practicing in the state of Connecticut.

In a 2/1/2014 report to the General Assembly, the CT Department of Public Health responded to a scope of practice request by the CT Advanced Practice Registered Nurse Society.

After extensive review and discussions involving 18 professional organizations, the DPH concluded that "There was...no evidence or data provided as part of the scope of practice review process

to validate that removing the mandatory collaborative agreement would alter APRN patient care or place patients at risk, or that... patients are at risk or care has deteriorated in other states

where there is no required collaborative practice agreement."

Now is the time for CT to align itself with the 20 other states who have removed barriers to full APRN practice, including Maine, New Hampshire, Vermont, and Rhode Island.

The removal of the mandated collaborative agreement would have an immediate impact on access to care for the most vulnerable of the state's citizens, easing the shortage of both primary

and behavioral health providers and enhancing the available choices in health care providers. This is especially crucial now with the increased number of individuals becoming insured

through the Access Health CT system.

The Governor's bill is a thoughtful response to findings in the very thorough DPH report.

As a recently graduated advanced practice psychiatric nurse, I can attest to the difficulties of finding a psychiatrist to collaborate with.

The benefits of removing the outdated mandatory agreement provision or substituting the request for collaboration with either an experienced Psychiatric APRN or a psychiatrist (if I can find one)

will help pave the way for me to have an available, willing, and experienced APRN guide my practice over the next three years as it is most likely that I will join an established practice with someone

who can speak to the quality of the health care that she [or he] and hundreds more

APRN's have been providing safely for over 20 years to patients throughout the state. I ask that you review the findings of the DPH report and support this effort to improve access to care for your constituents. I would be happy to discuss more details of the proposal, or of the work of APRN's who have been practicing for over 20 years with you.

Sincerely A New Psychiatric APRN Looking Forward to Providing Safe and Compassionate Care,

Kathleen M. Stuart, PMHNP-BC, MSN, APRN, HNB-BC. MA, LMT-BC
3 Strathmore Lane
Westport, CT 06880
email at home: kathleenstuart@sbcglobal.net

I would like to express my extreme objection as well as concern regarding Bill SB36. We are one of the largest pain practices in the state of Connecticut, where we have five physician pain specialist and five mid-level pain practitioners (APRN's/PA's) on staff; I can strongly state that quality of care as well as patient safety would be markedly compromised with unsupervised mid-level providers in the field of pain management. APRN and CRNA Mid-level providers lack an overall educational understanding, technical training and overall experience to adequately address and treat any moderate to more complex patients. Our mid-level providers, who have many years of experience, need to continually discuss patients with a physician in order to appropriately diagnose and treat a patient. If you were to ask the majority of all mid-level providers on their overall comfort level in diagnosing and treating any moderate or complex pain management patient, most of them, if being honest, would feel very unsettled in making any diagnostic or therapeutic plans without the ability to consult with a supervising physician. And rightfully so.

Once again, I strongly oppose Bill SB36.

I would also be happy to provide you with my additional insight to this serious issue.

Sincerely,

Jonathan Kost, MD

Medical Director

Hartford Hospital Pain Treatment Center

The Spine and Pain Center at Midstate Medical Center

Associate Clinical Professor, UCONN School of Medicine

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Hartford 
HealthCare

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S.B. No. 36

**“AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO
 IMPROVE ACCESS TO HEALTH CARE.”**

Senator Gerratana, Representative Johnson, Senator Welch, and Representative Srinivasan, thank you for considering S.B. No. 36, “*An Act Concerning the Governor's Recommendations to Improve Access to Health Care.*”

For the record, I am State Representative Roberta Willis, representing the 64th District.

I believe that a good clinician needs extensive clinical experience and a rigorous academic background. I also believe that APRNs have both. APRNs have graduate-level degrees, hundreds of clinical hours of supervised practice, and must pass national certification exams. From my personal experience, some of the best care I have ever received was from an APRN. But personal experience does not guide my decision to support this legislation. The decision on expanding APRNs' autonomy to practice must be based on improving access to care and patient health outcomes.

Groups like the Robert Wood Johnson Foundation have done extensive research on the benefits of APRN care and found that they have equal outcomes on various process and outcome quality-of-care measures when compared to their physician colleagues. While APRNs do not complete a post-graduate residency program, they are well trained to focus on chronic and preventive care management. This legislation's intent is not to turn APRNs into physicians. They are not being given autonomy to make complex diagnostic decisions. We are simply giving them greater freedom to practice in clinical areas within their existing scope of practice. I think it is very important for APRNs and physicians to have productive collaborative relationships, but not supervisory ones. The research indicates that written practice agreements often become a formality that does not foster meaningful interaction between APRNs and physicians.

Nearly 90 percent of APRNs work in primary care. With the influx of new patients into the health care system, there is a great need for expanded primary care services and APRNs play a vital and necessary role in meeting this need. Laws that restrict how and where APRNs practice or how they may be employed only restricts health care services in our state. By improving the APRNs capacity to meet CT's primary health care needs, physicians can focus on more complex health services.

Our health care landscape is changing, we must adapt and work together to meet the needs of people in our state. And I believe that APRNs can play a vital role in the new health care paradigm.

I would like to thank you for your consideration of this bill

Fitzhugh Pannill, MD
SB 36

I am a practicing internist in Southbury and am writing to urge against the passage of SB 36 that would allow Nurse Practitioners to practice independent of physicians.

I have worked with many NPs and PAs in the 35 years since I graduated from Johns Hopkins. This work has been supervising and co-joint practice in Academic Health Centers, Yale New Haven hospital and the VA and outpatient clinics and office practice and nursing homes so it includes almost every venue in existence.

These NPs are all excellent Practitioners, but none of them have the 5 plus years of inpatient training with the sickest patients that a physician does. Consequently while their training qualifies them to handle routine outpatient issues none of them are trained to recognize the unusual, the atypical or a serious perhaps life threatening complication, because they have not been trained to do so.

After 35 years of working with adults in my office, I am constantly amazed at how frequently what appears to be a "simple" sore throat will turn out to be an abscess, or a patient's cry for help for something much more serious. I saw a patient with "heartburn" who was having an acute MI just last week.

Most of the NP programs are excellent, but SB36 does not distinguish between top tier programs like Yale and other less rigorous and insufficient training venues. Once given a license, all graduates will be free to run their practice in any way they see fit, with no oversight or review. Allowing practitioners with only two years of training free reign with the public's health is a bad idea.

People who argue that NPs will fill offices in the inner city or see Title 19 patients that cannot find a physician are basically arguing that our inner city or poor citizens should be satisfied with a lower standard of care. The solution to access here is to pay physicians market rates that will allow us to see all patients and not lose money on every visit, which is the case with Title 19 reimbursement now.

Thank you

Fitzhugh Pannill MD FACP
Southbury Medical Associates
22 Old Waterbury Road
Southbury Ct 06488

**Connecticut Society of Eye Physicians
Connecticut ENT Society
Connecticut Urology Society
The Connecticut Dermatology and Dermatologic Surgery Society**

**Before the Public Health Committee
On February 28, 2014**

**Governor's Bill No 36 AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO
IMPROVE ACCESS TO HEALTH CARE**

Good Morning Senator Gerratana, Representative Johnson and distinguished members of the Public Health Committee, my name is Ken Yanagisawa, M.D. and I am a board certified otolaryngologist practicing in Hamden and New Haven, Connecticut. I am offering you testimony opposing Governor's Bill 36; An Act Concerning The Governor's Recommendations to Improve Access to Health Care on behalf of more than 1000 physicians in Ophthalmology, Ear Nose and Throat, Dermatology, and Urology.

With the coming of the ACA, medicine is facing an access challenge. This legislation, however, does nothing to help with access. APRNs that are already in the state are already seeing patients now. Allowing them independent practice will not increase their number, nor expand the number of patients they can see in a day. Even if this attracts a flood of new APRNs to the state, it will be years before any significant increase in capacity could be realized.

Further, you will lose the safety net currently provided by the collaborative agreements. I understand that the APRNs chafe at them, but as a legislator, what do you or your constituents gain by releasing this modest level of backup by practitioners with much more extensive training? Instead of a phone call or a walk down the hall, any uncertainties or questions will require a referral out to another provider to determine the correct course, or worse, a guess. This will lead to increased cost and delays in treatment. Additionally, patients requiring admission will require referral or coverage by an admitting physician, which will also create delays and safety risks. Please do not trade quality of care for perceived access.

We've heard testimony about the cost of a collaborative agreement. The costs cited have appeared exorbitant, however, the costs noted are without context. Most agreements are not expensive, and many doctors provide more than oversight and

review, adding in material, supplies, rent, education, liability coverage, and the cost of their own increased liability from taking on the collaboration.

The economics of modern, office-based medical care limit APRN expansion into more underserved areas. Overhead increases for replacing the services their collaborators provide, and for their likely increase in liability cost, and the low reimbursement provided by most underserved patients, will create enormous pressure to limit financial risk. The economic pressures that limit physician expansion into underserved areas will also limit APRNs.

For these, and many other reasons you have heard stated today, we ask that you oppose SB 36 and keep the team approach to quality medical care strong in Connecticut, thank you.

Connecticut ENT Society
Connecticut Dermatology and Dermatologic Surgery Society
Connecticut Urology Society &
Connecticut Society of Eye Physicians

Testimony Opposing
SB No 33 AAC the Governor's Recommendations to Improve Access to Healthcare

Before the Public Health Committee

On February 28, 2014

Good Afternoon, Senator Gerrantana, Representative Johnson and distinguished members of the Public Health Committee, my name is David Boisoneau, M.D. I am a board certified otolaryngologist (ENT) practicing in Waterford and Mystic, Connecticut. I was for present the Department of Public Health Program Review hearings on APRN scope expansion. As a member of the Executive Committee of the CT State ENT Society, I represent over 1000 board-certified surgeons in this state, and we collectively urge you to OPPOSE SB 36 as currently written.

I will be as brief as possible. Many of the surgeons I represent have had and will continue to have very successful collaborative agreements with APRNs. Our APRNs are essential in helping us with the management of difficult problems such as oral cavity cancer, chronic sinus disease, and postoperative care and counseling. It is a collaborative effort and an arrangement that works best for the patient and provides for the highest level of care. Allowing an APRN to be independent after three years of "collaboration", rather than practicing in a team model appears to undermine the entire system. I am not suggesting that APRNs are intending to become ENT specialists or attempting to perform specialized surgical procedures, HOWEVER there is nothing in this statute that states otherwise.

Most APRNs in this state provide primary care level medical diagnosis and treatment, and by and large they do it very well in collaboration with a trained, licensed physician. Family medicine physicians, primary care internal medicine specialists, pediatricians, psychiatrists and emergency medicine doctors all have extensive post-graduate training, accomplished during a 3+ year residency program. This rigorous and well-monitored training can include up to 12,000 clinical patient hours, as well as didactic lectures and even medical research. This is AFTER the completion of 4 years of medical school. In contrast, after obtaining an RN, only 500 clinical hours is the average training for an APRN. Thus, by allowing APRNs to independently practice after a loosely defined, much less intensive "collaboration period" seems irresponsible at best, and potentially dangerous at the worst.

The field of Ear, Nose and Throat surgery is complex and varied, and in order for us to become experts we require 4 years of medical school followed by 5-6 years of intensive post-graduate training under strict, regulated supervision

I have a close friend who has been a primary care APRN for over 20 years. She knows more about treating primary care patients than many of the providers who refer patients to me. When told of the three year period, she expressed astonishment to me that any APRN could be deemed adequately trained to be an independent provider responsible for a human life in such a short period of time. She also stated that her biggest challenge in her practice is trying to reconcile medications that are prescribed to her patients specifically by psychiatric APRNs. This alone would have motivated me to come to Hartford to oppose this bill, even if I were not the president-elect of the CT ENT Society.

In summary, APRNs are essential members of the health care team. A team in which each individual brings unique talents and education in order to deliver the best health care possible. Let us not forget that there are levels to this delivery system, and simply empowering well trained nurses to the same level as physicians who are fully trained in a

tightly regulated system has the potential to dismantle the system and do more harm than good. Remember, *primum non nocere*.

"First, Do No Harm"

Respectfully submitted

David S. Boisoneau, M.D.

President-Elect CT State ENT Society

JoAnn Eaccarino SB 36

Senator Gerratana, Rep. Johnson, Members of the Public Health Committee,

My name is JoAnn Eaccarino. I have been a board certified Family Nurse Practitioner for over 30 years and have worked in private practices, community health centers, hospital employee health departments, emergency departments, and most recently in School Based Health Centers. I am writing in strong support of the Governor's Bill #36.

The act of collaboration is an ethical responsibility of all professional persons. Nurse Practitioners will not cease to collaborate if this legal requirement is removed. In my years of experience, collaboration and referral to physicians or to other more-experienced healthcare professionals with specialty practices, has never been based on any legal requirement, but rather in the best interest of the patients for whom I have had the privilege of caring.

I am honored that this bill was proposed by our Governor and supported by so many legislators who understand that this is based on research and good for the citizens of Connecticut. Thank you for your good work.

American
Academy of
Pediatrics

HEZEKIAH BEARDSLEY
CONNECTICUT CHAPTER

HEZEKIAH BEARDSLEY CONNECTICUT CHAPTER

104 HUNGERFORD STREET • HARTFORD, CT 06106 • TEL. (860) 525-9738 • FAX (860) 727-9863

Matt Gianquinto SB 36

Testimony Opposing SB 36, An Act Concerning the Governor's Recommendations to Improve Access to Health Care

My name is Dr. Elsa Stone. I am a former president of the Connecticut Chapter of the American Academy of Pediatrics, and currently am on the Board of Governors of the New Haven County Medical Society. I have been President of the Medical Staff and served on the Board of Trustees of Yale-New Haven Hospital, and have served on the Board of the National Certification Board of Pediatric Nurse Practitioners. I have been a practicing pediatrician in North Haven for 36 years, and have worked with Advanced Practice Nurse Practitioners in my practice for almost 30 years. I speak today in opposition to this bill.

I am a strong advocate for Advanced Practice Nurse Practitioners working in collaboration with physicians. There are numerous studies that demonstrate that they can and do deliver high quality care to patients. They are much better than many physicians at educating patients about their health problems, and often spend more time with patients resulting in greater patient satisfaction. They can provide excellent preventive care services and manage many acute problems. However, they do not have the depth of education and training to enable them to replace physicians without jeopardizing patient care. This shortcoming is compensated for by their working in association with other physicians.

As APRNs are not permitted to work independently in most states, most of the studies looking at the outcomes of NP care were conducted in settings where they were working shoulder to shoulder with other medical professionals. Significant informal consultation and education occurs in those settings, and is not controlled for in the studies. This bill, if enacted, would enable and potentially encourage APRNs to practice independently outside the settings in which they could continue to learn and collaborate with other medical professionals. It would do nothing to solve the anticipated shortage of primary care providers, as there are ample collaborative settings in which they can work if the demand exists.

Even without this expansion of the scope of practice, currently abuses are occurring which undermines the quality of care patients receive in Connecticut. Retail clinics are eagerly hiring new APRN graduates to staff their clinics. The collaborating physician is available by phone somewhere in the state; the NP is not instructed to have the patient return for follow-up. As a practicing pediatrician, I appreciate that the patient is referred back to me for follow-up; I can try to make up for any mistakes that were made. But how does that NP learn anything? Is that the quality, coordinated care that we desire for our patients? An invaluable part of medical education is following the course of an illness and seeing the results of your treatments.

Lastly, this bill runs counter to the latest developments and knowledge about the delivery of high quality, patient sensitive and cost effective health care: health care teams. Physicians, APRNs, RNs, community health care workers, social workers and others, working together, capitalizing on each profession's strengths, can enhance care, reduce costs, and result in far better outcomes. This bill would move us backwards in our quest for accessible, high quality, cost effective care.

Steven Levin, M.D. SB 36

To whom it may concern:

Please accept this comment as a strong objection to SB 36 which will expand the scope of practice for APRNs and CRNAs and allow them to perform evaluative services and treatments that they have received no formal training to do. The practice of Interventional Pain Management (IPM) requires in depth evaluation of patients to determine the precise cause of pain and these evaluative services are not part of the formal training provided to CRNAs. In addition the vast majority of procedures involved in IPM are also not taught in CRNA training programs including the use of fluoroscopy which is now standard of care for IPM procedures even for epidural injections for which CRNAs do receive some limited training. In other words, even the techniques CRNAs are taught are not c/w the techniques used standardly in IPM today to ensure safety. There is no access problem in CT at this time and so no urgent need to expand the scope of practice of CRNAs.

This bill will expose CT citizens to increase risk from procedures which are being safely performed by board certified physicians. The procedures performed in IPM when not done properly can result in nerve injury, paralysis, and even death and therefore it is essential that providers be properly trained in formal training programs. CRNAs simply do not possess such training. In addition the evaluative services which are not taught in any CRNA training program are equally as important or else unnecessary procedures will be performed with risk and no benefit.

Furthermore, unsupervised prescription of opioid medication by providers untrained in this area has already proven to disrupt the appropriate balance of assuring proper access to pain management care while mitigating the potential for abuse and diversion. Such is the case with Primary Care Physicians who possess far more training than CRNA's and APRN's. In some states, the use of chronic opioid medication is already restricted to pain management specialists (physicians with residency and fellowship training in ACGME accredited program). Allowing untrained nurses to have independent practice privileges in the dynamic area of pain management would be premature and unsafe.

This will also increase the costs to the health care system with no added benefit. Thank you for allowing us the opportunity to comment on this important matter which could seriously effect CT citizens.

Steven Levin, M.D.
Advanced Diagnostic Pain Treatment Centers
Yale New Haven Medical Center at Long Wharf
One Long Wharf Drive, Suite 212
New Haven, CT 06511



Testimony of AARP Connecticut

S.B. # 36: AAC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

February 28, 2014

Public Health Committee

Good afternoon, Members of the Public Health Committee. My name is Jill Heidel; I'm a retired RN; I am also an AARP advocacy volunteer from Bethel and served as AARP's representative on the Department of Public Health's scope of practice review committee.

AARP is a membership organization of people 50 and older with 603,000 members in Connecticut and is pleased to have the opportunity to provide our comments. We are committed to championing access to affordable, high quality health care for all generations, providing the tools needed to save for retirement, and serving as a reliable information source on issues critical to Americans age 50+. Thus, we strongly encourage you to support Senate Bill 36.

We support this bill because it will increase consumer access to health care and reduce unnecessary health care costs. It would do this by removing outdated barriers that prohibit advanced practice registered nurses (APRNs) from providing care to consumers to the full extent of their education and training. These barriers often delay care to consumers, especially in rural and urban underserved areas where there is a lack of available physicians to supervise or collaborate with the APRN. And when care is delayed it not only hurts consumers, it also places added stress on family caregivers, who all too often are overwhelmed with bearing the brunt of providing and overseeing the care of a loved one. It can also add unnecessary costs by requiring payments to doctors for collaboration and take precious time away from patient care by making clinicians fill out unnecessary paperwork.

Reducing barriers to full APRN practice is supported by leaders in policy and science. A recent report from the National Governors Association, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*, documents the clear and convincing evidence that exists for nurse practitioners which shows they provide high quality care with high patient satisfaction and recommends that states consider removing barriers to practice for nurse practitioners, emphasizing their role in the growing demand for primary care. This recommendation supports the 2011 Institute of Medicine evidence-based report, *The Future of Nursing: Leading Change, Advancing Health*, which calls for changes at the state and federal levels to help increase consumer access to care by enabling APRNs to practice to the full extent of their education and training.

An APRN is a nurse:

- Who has completed an accredited graduate-level education program;
- Who has passed a national certification examination;

- Who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients;
- Whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge;
- Who is educationally prepared to assess, diagnose and manage a patient's health care, which includes the use and prescription of pharmacologic and non-pharmacologic interventions; &
- Who has clinical experience of sufficient depth and knowledge.

Health care consumers and family caregivers rely on APRNs for assessing and diagnosing conditions, prescribing medications, and referring to specialists. AARP Connecticut supports Senate Bill 36 because it will improve access to care for consumers and caregivers by reducing the wait time for such care. Accessing primary care in a timely manner increases consumers' quality of life and helps to contain their health care spending.

Decades of evidence demonstrate that APRNs provide the same high quality of health care as physicians. This high quality of care is evident whether or not APRNs are supervised by physicians.

AARP Connecticut is deeply appreciative of the primary care and chronic care management provided by all clinicians. We need to be certain, however, that our members and all health care consumers can access a primary care provider when and where they need one. This bill would help ensure such access to care.

Thank you for your time and attention.

Lucien Parrillo, MD, MPH

SB 36

My name is Dr. Lucien Parrillo and as a Pain Specialist I vehemently oppose this outrageous bill. Allowing mid-level providers to act as Pain Specialists robs patients of adequate care and will result in disastrous outcomes both medically and litigiously.

Please oppose the passing of this bill.

Thank you.

Lucien Parrillo, MD, MPH
Interventional Spine & Sports Medicine Specialist
CT Spine Institute for Minimally Invasive Surgery
505 Main Street
Portland, CT 06480

Pietro Memmo, MD

Re: Governor's Bill No 36 AN ACT CONCERNING THE GOVERNOR'S
RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

Dear Sirs,

Pain Management is a complicated specialty, requiring years of training to fully understand the interactions of various medications, and to fully understand not only the physical but also psychological aspect of pain conditions.

Allowing CRNA and APRNs to act independently will put patients at risk.

The medications that are typically prescribed are controlled substances, many of which trained primary care or even orthopedists do not want to prescribe due to their high risk of dependency. In addition, many of the procedures that are performed by trained pain physicians are high risk and if not done correctly, can result in permanent nerve damage.

Sincerely,
Pietro Memmo, MD
Orthopedic Associates of Hartford.

Igor .G Turok,MD

SB 36

I would like to oppose the proposed law to allow supporting staff (aprn/nurse anesthetists) to provide care without physician's supervision. Decision of this magnitude will lead to patient injuries & unnecessary deaths. Nurses aren't trained as physicians & have no clinical or scientific backing to perform level of care suggested by the bill without physician's supervision. This is a very dangerous bill that may provide care to many but kill many as well. Nurses do not have knowledge nor skills to provide pain care or sedation to difficult patients.
I completely oppose the bill.

Igor .G Turok,MD

Director

Comprehensive Neurology & Pain Center of CT
Diplomat of American Board of Pain Medicine
Diplomat of American Board of Neurology

Sent from my iPhone

2/27/14

Governor's SB 36

My name is Scott Credit.

I live in Killingly Connecticut and have been practicing as a Nurse Practitioner since 1999. Independent Practice by nurse practitioners is not a new concept and it is strongly supported by the literature. Please give the citizens of Connecticut your support with SB 36. Thank you for your consideration.

Sincerely,

Scott Credit DNP(C), APRN

Smc774@yahoo.com

- Nurse practitioners in 18 states and Washington DC can practice independently (Reisman, 2013)
- With an additional 32 million Americans covered through the Affordable Care Act (ACA), the primary care physician shortage could be catastrophic (Reisman, 2013)
- Nurse Practitioner-delivered care, across settings, is at least equivalent to that of physician-delivered care in regards to safety and quality (O'Grady, 2008)
- The office of technology demonstrated comparable medical care task at lower cost than physicians (NNCC, 2009)
- Fifty years of research has shown that primary care provided by nurse practitioners has been as safe and effective as care provided by Physicians (Institute of Medicine, 2011)
- APRNs are more likely than physicians to care for large numbers of minority patients (Gavel, Feinstein & Shelanski, 2013)
- Lifting the barriers on the scope of practice will help solve the health care dilemma (Institute of Medicine, 2011)

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Lynn Rapsilber SB 36

Connecticut Coalition of Advanced Practice Nurses

American College of Nurse-Midwives (ACNM), Region I, Chapter 2

Connecticut Advanced Practice Registered Nurses Society (CTAPRNS)

Connecticut Association of Nurse Anesthetists (CANA)

Connecticut Nurses' Association (CNA)

Connecticut Chapter of the American Psychiatric Nurses Association (APNA-CT)

National Association of Pediatric Nurse Practitioners (NAPNAP), Connecticut Chapter

The Northwest Nurse Practitioner Group

PUBLIC HEALTH COMMITTEE FEBRUARY 28, 2014 PUBLIC HEARING GOVERNOR'S BILL No. 36

Lynn Rapsilber, MSN ANP-BC APRN IN SUPPORT OF GOVERNOR'S BILL No. 36

AAC THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE

Senator Gerratana, Representative Johnson, and Members of the Public Health Committee

I am Lynn Rapsilber, APRN and Chair of the Connecticut Coalition of Advanced Practice Nurses. I am here to support the Governor's Bill #36.

Last year there were 78 legislators who sponsored similar language to the bill before us. The Connecticut Advanced Practice Registered Nurse Society requested a scope of practice review last August. This process brought to the table over 40 individuals and groups both in support and in opposition to discuss the merits of the request. We discussed **Quality**: over 40 years of studies demonstrating APRN outcomes are as good as or better than physicians. Many studies are cited.

We discussed **Safety**. There was no data to support any harm to the public by removing the agreement. In fact the DPH Report says no evidence was provided that indicated patients are at risk or care has deteriorated in other states where there is no required collaborative agreement practice agreement.

We discussed **Education**. Yes, we are trained differently from physicians. APRNs are population focused, competency based, with a holistic approach to education and training. APRNs are health promotion and disease prevention focused. APRNs have **national standards of certification and continuing education**. APRN SCOPE OF PRACTICE IS DEFINED BY TRAINING SPECIFIC TO A VERY DEFINED CERTIFICATION AND STUDENT'S EDUCATIONAL TIME IS 100% CONCENTRATED ON THAT CLINICAL AREA. THE BEST TEST OF PROPER EDUCATION IS THE STUDIES OF OUTCOMES AS DISCUSSED ABOVE.

We discussed **Costs**. Data show we can reduce costs in disease management and as part of a nurse led Patient Centered Medical Home. The DPH Report specifically refers to documentation of cost savings including lower drug costs, lower per-patient costs, lower visit costs, and lower costs associated with lower rates of emergency department referrals.

The last area discussed was Access. CT has provider shortage areas for primary care and behavioral health in all counties. APRNs take care of the most vulnerable populations: elderly, mentally ill, uninsured, underinsured and the homeless. APRN practices are at risk to close, unable to grow and not able to open due to this outdated mandated agreement. These issues were thoroughly discussed by the scope review group. The Department of Public Health Scope Report says that evidence demonstrates the required collaborative agreement has become a barrier to practice for many APRNs and that eliminating barriers enhances access to quality and affordable health care.

I refer to the document Changes in Health Care Professions Scope of Practice: Legislative Considerations (2012) a collaborative effort of six health care regulatory organizations including the Federation of State Medical Boards which "states that health care education and practice has evolved where most professions share skills or procedures with other professions. It is no longer reasonable to expect each profession to have completely unique scope of practice, exclusive of all others. The question that health professions must answer today is whether their profession can provide this service in a safe and effective manner. If an issue can not address this question, it has no relevance to the discussion". THAT IS THE ESSENCE OF THE SCOPE REVIEW AND THAT QUESTION HAS BEEN ANSWERED WITH AN ABUNDANCE OF DATA.

We applaud the Governor for his bill No. 36. It will put CT in line with other New England states for APRN practice. It does not grant a licensed APRN any new authority but it will remove barriers to practice and prevent practices from closing.

Association of Social Work Boards (ASWB), Federation of State Boards of Physical Therapy (FSBPT), Federation of State Medical Boards of the United States, Inc. (FSMB), National Association of Boards of Pharmacy (NABP®), National Board for Certification in Occupational Therapy, Inc. (NBCOT®), National Council of State Boards of Nursing, Inc. (NCSBN®). (January, 2012). *Changes in Health Professions' Scope of Practice: Legislative Considerations.*



*A District Branch of the
American Psychiatric Association*

Connecticut Psychiatric Society

Good afternoon. My name is Carolyn Drazinic. I am a psychiatrist and President of the Connecticut Psychiatric Society, representing almost 800 psychiatrists in Connecticut. I am here today to express our opposition to the section of Bill Number 36, AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE that will allow APRNs to work independently without collaboration with a physician.

Our opposition to this bill has nothing to do with the value of nurses at any level. Psychiatrists work with nurses in teams in many kinds of institutions and practices.

The concern is that given nurses' training models and the circumstance of clinical practice today, practicing independently in the community is not the best model for delivering care medically or economically. In fact, the model of independent practice is not working for many physicians any more either.

Over the last few years the nurses have asserted that they cannot get collaborative agreements with physicians. This causes us to ask the question: If they cannot find physicians to collaborate with them now, how is the situation going to be improved once the law is voided?

The argument that a less-trained practitioner can be available to see simple problems and relieve the load that physicians bear works well in institutions where such referrals take place down the hall, so to speak. It doesn't work that well in the community.

Allowing nurse practitioners to practice independently seems like an easy solution, but it is fraught with problems that will become more obvious to everyone should this legislation be implemented.

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Bloomfield, CT 06002

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Email: cps@ssmgt.com Website: www.ctpsych.org

Pamela Aselton, PhD, APRN SB 36

February 27, 2014

Regarding Governor's Bill #36 to remove the mandatory collaborative practice agreement for APRNs

Dear Public Health Committee Members,

I am writing in support of Governor's Bill #36 – An Act Concerning the Governor's Recommendations to Improve Access to Health Care. As a faculty member and graduate program director of the APRN programs at the University of Saint Joseph in West Hartford, I can testify to the fact that APRNs who are educated as either Family Nurse Practitioners (FNPs) or Psychiatric Mental Health Nurse Practitioners (PMHNPs) as it relates to primary care and psychiatric mental health services receive adequate education in safely prescribing pharmaceutical agents for the treatment of common conditions. The advanced pharmacology courses we teach on the subject build on their prior nursing education in their Bachelor of Science degrees where they take a yearlong course in basic pharmacology, as well as their years of experience as practicing nurses. In addition to a semester long course in Advanced Pharmacology, all of our PMHNP students take a semester long course in Neuropsychopharmacology.

The clinical courses they take after their core courses in pathophysiology, physical assessment and pharmacology also include content on pharmacology threaded throughout the curriculum in specialty courses in pediatrics, women's health, adult health as well as individual and group counseling.

APRNs must also pass rigorous national boards in order to be able to practice and in order to keep their certifications current with required continuing education in pharmacology.

I appreciate the opportunity to contribute to your discussion of this issue and recommend that the committee support the provision of independent practice status for APRNs who have been practicing in the State for many years now, and who will continue to provide quality care to its citizens, consulting when necessary with physicians and other health professionals.

Sincerely,

Pamela Aselton, PhD, APRN paselton@usj.edu

Graduate Program Director for Nursing

University of Saint Joseph

1678 Asylum Ave

West Hartford, Ct. 06117

David Kloth, MD

SB 36

Please accept this comment as a strong objection to SB 36 which will expand the scope of practice for APRNs and CRNAs and allow them to perform evaluative services and treatments that they have received no formal training to do. The practice of Interventional Pain Management (IPM) requires in depth evaluation of patients to determine the precise cause of pain and these evaluative services are not part of the formal training provided to CRNAs. In addition the vast majority of procedures involved in IPM are also not taught in CRNA training programs including the use of fluoroscopy which is now standard of care for IPM procedures even for epidural injections for which CRNAs do receive some limited training. In other words, even the techniques CRNAs are taught are not c/w the techniques used standardly in IPM today to ensure safety. There is no access problem in CT at this time and so no urgent need to expand the scope of practice of CRNAs.

This bill will expose CT citizens to increase risk from procedures which are being safely performed by board certified physicians. The procedures performed in IPM when not done properly can result in nerve injury, paralysis, and even death and therefore it is essential that providers be properly trained in formal training programs. CRNAs simply do not possess such training. In addition the evaluative services which are not taught in any CRNA training program are equally as important or else unnecessary procedures will be performed with risk and no benefit. This will also increase the costs to the health care system with no added benefit. Thank you for allowing us the opportunity to comment on this important matter which could seriously effect CT citizens.

David Kloth, MD
Executive Director, Connecticut Pain Society
100 Mill Plain Rd
Danbury, CT 06811
203-792-5118

DEBORAH SEGETTI, R.N., C.D.E
85 Fairwood Road
Naugatuck, CT

February 27, 2014

To Whom It May Concern,

I am honored to share with you my experience of having a Nurse Practitioner as my primary care provider.

In my case, Ines Zemaitis, APRN is my current health care provider. I have found her to be compassionate and knowledgeable. She listens to my health concerns, helps me make appropriate decisions regarding my healthcare, testing and treatments that may be required. She has extensive knowledge in all aspects of primary care, more so than many Physicians I have had encounters with.

I am also a Health Care Professional, Registered Nurse, currently in Cardiology and a Certified Diabetes Educator. I have referred many of my own patients to Ines and other Nurse Practitioners in our area, who specialize in Diabetes, Cardiology and other health care specialties.

With the time constraints on many Physicians, especially in many specialty areas Nurse Practitioners have become a very valuable resource in many communities, especially in Waterbury and surrounding areas.

It has been my experience that the Nurse Practitioners spend more quality time with and Listening to their patients and are equally as knowledgeable as many Physicians.

It has also been my experience that patients I have referred for care have had better health care outcomes and are more willing to partner in their own care, utilizing the services of Nurse Practitioners.

Sincerely,


Deborah Segetti, R.N., C.D.E.

Legislative Committee of the Connecticut General Assembly,

It is time to end the collaborative practice agreement requirement for nurse practitioners in the State of Connecticut. Failing to recognize nurse practitioners as independent practitioners creates a barrier to access to care for many Connecticut residents. In addition, the collaborative practice requirement limits the economic options for nurse practitioners, therefore affecting the health of the economy in this state.

The collaborative practice requirement provides a false sense of safety, insinuating that every nurse practitioner decision is overseen by a physician. In reality, this is not the case. Most nurse practitioners independently diagnose and treat their patients as well as manage their overall health. In situations where the nurse practitioner is lacking in the specialized knowledge or experience to safely diagnose and treat a particular patient, they then collaborate with a provider with that knowledge. This is not unlike a primary care physician who collaborates with a colleague in a specialty. Everyone collaborates for the best outcomes for their patients. This occurs with or without a mandated collaborative practice agreement.

Nurse practitioners often seek to care for the underserved of the population. This is not always a financially lucrative situation and therefore not particularly attractive to a collaborating physician. As a result, nurse practitioners planning on setting up an independent practice are forced to pay a collaborating physician out of money that is simply not there. Often these populations are elderly, from a low socioeconomic group, or physically or intellectually disadvantaged. These same populations would greatly benefit from the holistic model of care practiced by nurse practitioners.

Nurse practitioners are uniquely prepared to be expert primary care providers. Their background in nursing adds depth to their understanding of health and illness. Much research has shown the safety of the nurse practitioner. Other professions are similarly prepared for their niche in healthcare and are permitted to practice independently. Podiatrists and chiropractors practice independently, not in collaboration with an orthopedic physician. Optometrists practice independently, not in collaboration with an ophthalmologist. Similarly nurse practitioners should be permitted to practice independently, not in collaboration with a physician. Anything less specifically targets nurses and limits their economic options.

You will no doubt hear the copious research to demonstrate nurse practitioner safety in states with independent practice. You will also hear testimony of nurse practitioners who were limited in their economic options because of the collaborative practice requirement. You will hear the expert panels of the federal government who propose that nurses work to the full extent of their education to bridge the gap between the population's needs and provider availability. And no doubt you will hear testimony from medical organizations wishing to limit the role of the nurse practitioner in our society. It is time to consider facts when deciding to end

the collaborative practice agreement. Health care is has changed and will continue to change to meet the needs of an ever sicker, ever older population. Nurse practitioners are uniquely prepared to meet these challenges, but only independent practice can make that a reality.

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Testimony of
Elena Schjavland, Principal & Nurse Practitioner Provider
KEYS2MEMORY, LLC

Submitted to the
Public Health Committee
February 28, 2014 – Public Hearing

SUPPORT Governor's SB No. 36: An Act Concerning the Governor's
Recommendations To Improve Access To Health Care.

Thank you for the opportunity to speak in support of the bill to improve access to care, by asserting the *independent* Advanced Practice Registered Nurse (APRN) role in healthcare. As the sole provider for the house call practice called Keys2Memory, LLC, and a Connecticut licensed APRN, board certified as an Adult and Geriatric Nurse Practitioner, I am writing to express my vigorous agreement with Governor Malloy's Bill No. 36.

As you know healthcare consumers demand **safe and competent medical visits**. The opinion by Dr. Jewell Mullen, along with research studied by many multi-disciplinary and MD authorities demonstrate repeatedly that APRNs have good healthcare outcomes. APRNs are expertly educated and clinically competent; they pass certification boards, must have malpractice coverage, are periodically recertified, and require continuing education hours, including meeting changing pharmacology standards. APRNs know practice boundaries, as the same litigious culture that measures doctors, also judges NPs.

I am self-employed as a Memory Disease and Dementia Specialist, and provide care to adults and seniors in Southeast CT. I diagnose and treat cognitive impairment and the symptoms that accompany those disease; prescribe and order tests including MRIs, complicated laboratory tests, and process DNA specimens; I help the patient, family and caregiver understand a mutually agreed upon dementia management plan, both present and future. I have an individual collaborative agreement and contract with a CT physician. I have been in the field for the last 18 months dealing with the required APRN contract and its impact on my practice. I am the poster child for this legislation. In short, it has severely limited patient's access to the care I can deliver.

I am proud to render care in a professional, competent and comprehensive manner. I provide for escalation of care, collaborate and refer to physicians as needed. I also collaborate and refer patients and families to: researchers, MD specialists, social workers, geneticists, counselors and home healthcare services. It is the same logical, common sense approach among my colleagues in their first-rate NP primary care practices, niche practices and house

call services. The collaborative contract requirement is redundant; not so the physician collaboration we already integrate into our practice along with the entire health care team, patient and family. There does not need to be a signed contract.

Access and provision of healthcare is the greatest issue in 2014. The present collaborative requirement and contract causes headaches and significant time loss for me every week. It is because of: billing glitches, excessive phone calls, and turf challenges. Sometimes I refer a family to a memory center 1-1 $\frac{1}{2}$ hours away because I can't resolve the red tape. Turf challenges, legal issues and boundary questions arise from local Connecticut doctors, hospitals and care facilities. It is never my patients who erect roadblocks. Clients and families know I am a nurse practitioner; and clever as they are, they know the difference between a psychologist, a chiropractor, podiatrist, Nurse Practitioner and a medical doctor.

We need easier access to, and more appointments with APRN Primary Care Providers, Mental Health and Geriatric specialists and APRNs who provide depression behavior therapy and specialize in woman, child and adolescent care. I would be more productive, treat more patients, and have more time to improve dementia care in our community under the new legislation. There are plenty of patients for all of us, . . . especially me, considering one out of six people hearing this testimony will be diagnosed with Alzheimer's disease during their lives.

It was hard for me to get that first signed contract. Relocating my practice to Rhode Island, Vermont, New Hampshire or Maine, where there is already independent practice for NPs, is not an option as I am tied to family and my Mystic neighborhood. My practice will close if the current physician collaborator does not renew my contract, whether due to: physical inability, overwork, and geographic move, loss of CT MD license, death or retirement. I then can no longer see or support my patients and families. This uncertainty with the contract and pessimism in seeking another, is the prime reason I am reluctant to hire additional staff I desperately need. If I can't see clients and be reimbursed, I can't afford the payroll. I need more APRNs, social workers, RNs and care navigators alongside me.

APRNs are also Registered Nurses, who are the most trusted professionals in the United States; consider that impact on honesty in healthcare. Also, APRNs are specifically educated in both medical and nursing models, care and cure, and wellness and holism, and are especially nuanced to listen, a rare gift in healthcare today. Collectively, this provides the rubric for a valued service to CT healthcare consumers. I don't want the committee to pass on this unique opportunity.

Thanks

