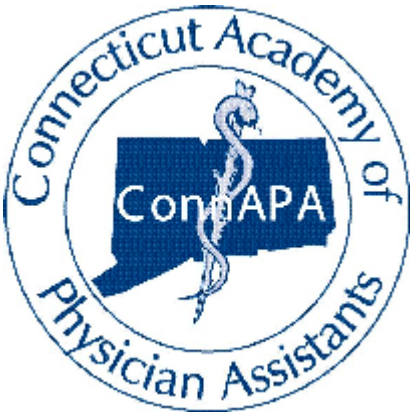

Testimony Presented by

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To

Margaret Flinter and Tom Swan, HealthFirst CT Authority Co-Chairs,
and Members of the HealthFirst Connecticut Authority

HealthFirst Connecticut Authority Public Hearing
Hartford, CT
Thursday, October 2, 2008

Good evening Ms. Flinter, Mr. Swan, and members of the HealthFirst Connecticut Authority.

My name is Tricia Marriott. I am the president of the Connecticut Academy of Physician Assistants (ConnAPA), a Distinguished Fellow of the American Academy of Physician Assistants (AAPA), and a clinically practicing physician assistant (PA) licensed in our great state. The Connecticut Academy of Physician Assistants is part of a national network of constituent chapters devoted to the PA profession. ConnAPA appreciates the opportunity to provide input and recommendations for consideration by the HealthFirst Connecticut Authority.

One of the prevailing issues within the medical community, and in many states, is whether the prospective size of the physician workforce will be sufficient to meet the medical care service needs of the public. Both the American Medical Association (AMA)[1] and the Association of American Medical Colleges (AAMC)[2] have taken the position that the previously envisioned physician surpluses are doubtful, and the Council on Graduate Medical Education (COGME) has changed its policy completely, proclaiming that shortages are an issue.[3]

Anticipated workforce shortages, coupled with a growing aging population and increasing numbers of uninsured and underinsured signify the increasing need for skilled health care professionals. In Connecticut, a report recently issued by the state medical society reveals a deteriorating health care system which is forcing patients to wait for extended periods of time for appointments, search for specialists and to rely on emergency rooms more frequently to meet their medical needs.[4] Among other things, the report found:

- Nearly 20% of the physicians surveyed indicated they are contemplating a career change because of the state's practice environment.[5]

- More than 90% of respondents in Litchfield, New London and Windham counties reported recruiting physicians was very or somewhat difficult.[6]

- 47% of the surveyed physicians increased their work hours seeing patients over the course of the last three years. Physicians in urology, neurosurgery and oncology responded that they increased their work hours substantially above the norm.[7]

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[1] American Medical Association. "AMA Revises Policy to Address Continued Demand for Physicians." December 9, 2004, quoted by Richard Cooper in "Weighing the Evidence for Expanding Physician Supply." *Annals of Internal Medicine* Vol. 141, 2004, 705-714.
[2] Association of American Medical Colleges. The Physician Workforce: Position Statement—June 2002. Washington, DC: Association of American Medical Colleges; 2002.
[3] Council on Graduate Medical Education. Reassessing Physician Workforce Policy Guidelines for the U.S. 2000-2020. Washington, DC: U.S. Department of Health and Human Services, 2003.
[4] Connecticut State Medical Society. Connecticut Physician Workforce Survey 2008: Final Report on Physician Perceptions and Potential Impact on Access to Medical Care., September 24, 2008.
[5] *Id.*
[6] *Id.*
[7] *Id.*

- The longest mean average wait time for new-patient office visits was 24 days, reported in Windham County, which also reported the biggest reduction in provision of high-risk services, the second-largest reduction in care of high-risk patients and the highest percentage of physicians contemplating a career change.[8]

The Physician Assistant Profession

It is in this context that I would like you to consider the physician assistant profession. Physician assistants are health professionals licensed to practice medicine with physician supervision. They are not independent providers. Rather, they are committed to an interdependent relationship with physicians. The scope of their responsibilities corresponds to the supervising physician's practice, and varies according to the PA's training, experience, state law and facility policy. In their work with physicians, PAs may routinely perform a comprehensive range of medical duties, from basic primary care to high-technology specialty procedures. PAs often act as first or second assistants in major surgery and provide pre-and postoperative care.

In some rural and inner-city areas where physicians are in short supply, PAs serve as the primary providers of health care, conferring with their supervising physicians and other medical professionals as needed and as required by law. PAs can be found in virtually every medical and surgical specialty.

A Brief Historical Overview of the Profession

The physician assistant (PA) profession was created by physicians in the mid-1960s in response to a shortage and uneven distribution of primary care doctors with the intention of increasing the public's access to quality health care. Similar to the workforce issues currently plaguing many states, the profession was born out of the need to allow doctors to extend their ability to care for patients by working with professionals trained in the medical model who would practice with physician delegation and supervision. Over the forty year history of the profession, this basic principle has held true. PAs embrace and seek practice with physician supervision. Physician assistants readily recognize physicians as the most comprehensively educated members of the health care team, and believe that the PA's ability to provide patient care is enhanced by this sustained relationship with supervising physicians. The physician assistant profession is enduringly committed to the tenet that PAs practice with physician supervision. To quote from the policy of the American Academy of Physician Assistants, the national professional society for PAs:

The AAPA believes that the physician-PA team relationship is fundamental to the PA profession and enhances the delivery of high quality health care. As the structure of the health care system changes, it is critical that this essential relationship be preserved and strengthened.[9]

Physician Assistant Education

Prior to their PA training, applicants to physician assistant programs must complete a minimum of two years of college courses in basic science and behavioral science. This is analogous to pre-med studies required of medical students.

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[8] *Id.*

[9] American Academy of Physician Assistants. 2007-2008 Policy Manual. Alexandria, VA.

The mean duration of PA education programs is 26.8 months. Educators of PAs include physicians, PAs and basic scientists. Physician assistant education is characterized by an intense yet practical curriculum, with both didactic and clinical modules.

The first year of PA education provides a broad foundation in medical principles with a concentration on their clinical applicability. This didactic curriculum consists of coursework in the basic sciences, including anatomy, physiology, microbiology, clinical laboratory sciences, behavioral sciences and medical ethics. In the second year, students receive hands-on clinical training through a series of rotations and clerkships in a variety of inpatient and outpatient settings. Rotations include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry. On average, students complete more than 2,000 hours of supervised clinical practice prior to graduation.

All physician assistant educational programs have pharmacology courses. In addition to these classes of instruction, PA students learn pharmacology in their clinical medicine units in the classroom and through clinical clerkships and rotations. An average of 78 hours of formal classroom instruction in pharmacology is required by PA programs.[10] The total instruction in clinical medicine averages 308.6 hours. The average length of clinical clerkships is 51.5 weeks.

Like many other professions that offer competency based degrees, i.e., M.D., D.O., D.D.S. and J.D., PA education is also competency based. Students must demonstrate proficiency in various areas of medical knowledge and must meet behavioral and clinical learning objectives.

Physician Assistant Programs

There are more than 140 accredited PA programs located throughout the United States.[11] They are generally affiliated with two-and four-year colleges and university schools of medicine or allied health. As of 2006 the majority of PA programs were sponsored by a university (72%) or four-year college (21%).[12] Seven programs were associated with a two-year college; two programs were sponsored by a hospital and one was sponsored by the armed services.[13] Over seventy percent of programs award a masters degree.[14] Twenty-one programs award a baccalaureate degree upon graduation (16%).[15] The remaining programs award either a certificate or an associate degree as the highest credential granted. Over the past five years, thirty baccalaureate programs converted to masters programs, three programs converted from a certificate to a masters degree and two programs converted from an associate to a masters program.[16]

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[10] Fifteenth Annual Report on Physician Assistant Educational Programs in the United States, 1998-1999. Alexandria, VA. Association of Physician Assistant Programs.

[11] As of October 1, 2008, there are 142 accredited programs. Programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA, Web site, http://www.arc-pa.org ; John McCarty, 770/476-1224)

[12] Link, M. Twenty-Third Annual Report on Physician Assistant Educational Programs in the United States, 2006-2007. Physician Assistant Education Association, January 2008.

[13] *Id* at 6.

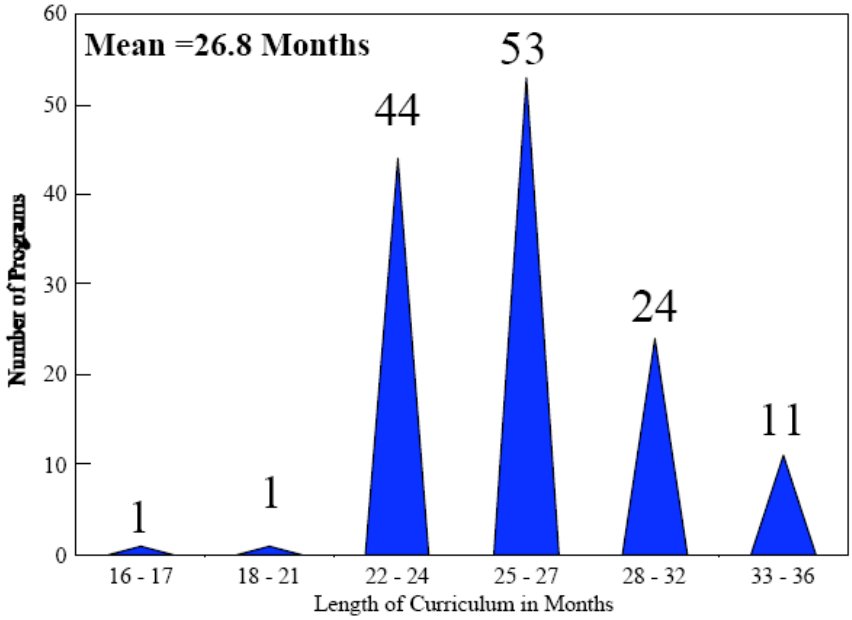
[14] *Id.*

[15] *Id.*

[16] *Id.*

Historically, the length of the professional PA curriculum has varied among programs.[17] Some institutions offer a five-year masters curriculum that admit students as freshmen.[18] The first three years of a student's matriculation entails liberal arts and preparatory science courses, followed by two years of professional PA studies.[19] Sometimes these programs admit students with advanced standing at the beginning of the professional curriculum.[20] Other graduate-level programs admit students who have completed all liberal arts and preparatory science courses and/or have earned a baccalaureate degree prior to admission.[21] In addition to the accredited professional curriculum, the graduate or master's level program generally includes additional courses and/or experiences in research related activities.

Figure 3. P.A. Programs by Length of Curriculum (N=134)



Physician Assistant Program Accreditation

Physician assistant programs must obtain accreditation from the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). All accredited programs must adhere to the rigorous national standards developed by the ARC-PA.

Accredited programs are reviewed regularly by the ARC-PA to assure their continued compliance with the standards. Programs that fail to meet the standards may be placed on probation. Programs on probation are still accredited, but must correct their deficiencies in a relatively short period of time or face loss of accreditation. Accreditation is withdrawn from any PA program that fails to demonstrate substantial compliance with the national standards.

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[17] *Id* at 7.
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*

Although all accredited PA programs must meet the same educational standards, they have the discretion and flexibility to offer a variety of academic degrees. More than three-fourths of the programs offer a master's degree. However, graduation from an accredited PA education program remains the definitive credential. Only graduates of accredited programs are eligible to sit for the Physician Assistant National Certifying Examination (PANCE) administered by the independent National Commission on Certification of Physician Assistants (NCCPA) in conjunction with the National Board of Medical Examiners. The NCCPA's PANCE exam is required for licensure as a physician assistant in all 50 states and the District of Columbia.

Physician Assistant Utilization: Role in Health Care Delivery

The clinical role of PAs includes primary and specialty care in medical and surgical practice. Historically, the profession provides such services in rural and urban areas which often lack sufficient access to healthcare. Although their training is usually focused on primary care, more than half of all PAs practice in surgical or medical subspecialty areas.[22] In addition, while the majority of PAs actively engage in clinical practice, some also incorporate their clinical knowledge into other employment settings such as clinical research, education, and administration.

- ***Primary Work Setting***

  The settings with the largest proportions of PAs include single and multi-specialty group practices, solo practice physician offices, hospital operating rooms, emergency rooms, and inpatient and outpatient units of hospitals.[23] A larger portion of PAs work in single-specialty group practices (24% vs. 22%).[24]

- ***Specialty***

  The specialty fields with the largest proportion of those in clinical practice are family/general medicine (25%), surgical subspecialties (22%), subspecialties of internal medicine (11%), emergency medicine (10%), and general internal medicine (7%).[25]

- ***Clinical Practice Status***

  As of 2007, 81 percent of PAs work full-time in clinical practice (full-time practice is defined as 32 or more hours per week), 11 percent work part-time (less than 32 hours per week), and 9 percent are not in clinical practice.[26] In 2006, eighty nine percent of PA school graduates worked full time-time in clinical practice, 4 percent worked part-time and 7 percent were not in clinical practice.[27] The data indicates that those who are trained as PAs, practice as PAs. Occupational turnover is very low compared to other occupational groups.

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[22] 2006 American Academy of Physician Assistants Census Report, *available at* www.aapa.org/research/06census-content.html (last accessed October 1, 2008).
[23] American Academy of Physician Assistants, Division of Data Services and Statistics. Trends in Physician Assistant Profession Report 1991-2007. November 2007.
[24] *Id.* These figures are based upon the results of AAPA member census respondents and are relative to all respondents.
[25] *Id.*
[26] *Id.*
[27] *Id.*

Growth of the Profession

The PA profession has grown tremendously in its short history, and the growth has been particularly pronounced in recent years. The number of people eligible to practice as PAs is expected to exceed 93,000 by the year 2010.

Total Number of PAs, New PAs, Accredited PA Programs Reporting New Graduates, and PAs in Clinical Practice at Years-End, Select Years, 1991-2007

	1991	1993	1995	1997	1999	2001	2003	2004	2005	2006	2007
People Eligible to Practice as PAs[a]	25,131	28,310	32,384	37,720	45,188	53,595	62,171	66,563	71,216	75,260	79,706
New PAs[b]	1,329	1,642	2,187	2,837	3,880	4,394	4,394	4,395	4,275	4,646	4,541
New PAs as Percentage of Total	5.29%	5.80%	6.75%	7.52%	8.59%	8.20%	7.07%	6.60%	6.00%	6.17%	5.70%
PA Programs with New Graduates[c]	53	55	62	78	100	122	128	131	131	130	138
Mean New PAs per Program	25.1	29.9	35.3	36.4	38.8	36.0	34.3	33.5	32.6	35.7	32.9
PAs in Practice at Year-End [d]	20,628	23,184	27,105	31,480	37,821	42,708	50,121	55,061	58,665	63,609	68,124
Percentage in Clinical Practice	82.1%	81.9%	83.7%	83.5%	83.7%	79.7%	80.6%	82.7%	82.4%	84.5%	85.5%

a Figures represent the count of all individuals believed to be eligible to practice as PAs in each reference year. The individuals believed to have died prior to 1996 are excluded from the figures reported in 1996 and forward since year of death is not available. The individuals believed to have died in or after 1997 are excluded from the counts for each year after the year of death. Individuals for whom no graduation date is known or available are associated with the year in which they became NCCPA-certified. Source: AAPA Masterfile 11/1/2007.

b Figures represent the numbers of PAs believed to have graduated during each reference year from accredited PA programs reporting new graduates. Individuals for whom no graduation date is known are associated with the year in which they became NCCPA-certified. Source: AAPA Masterfile 11/1/2007.

c Excludes PA programs not reporting new graduates. Source: AAPA Masterfile 11/1/2007.

d Source: Estimated from 1991-1995 AAPA Membership Census surveys; 1996 -2007 AAPA Physician Assistant Census surveys; and AAPA Masterfile 11/1/2007.

Physician Assistant Quality of Care; Time and Cost Effectiveness

The National Practitioner Data Bank (NPDB) was established through Title IV of Public Law 99-660, the Healthcare Quality Improvement Act of 1986, as amended. This registry records all medical malpractice cases that come to trial in the United States. As of 1997, the rate of settled litigation for PAs was less than one-fourth that of physicians in comparable roles.[28] This trend continues to the present. Physician assistants have been responsible for only 1,021 malpractice payments since the opening of the NPDB (0.36 percent of all payments).[29] To date, the liability of PAs in the United States is considerably less than physicians in comparable roles, as measured

[28] Cawley JF, Rohrs FC, Hooker RS. Physician assistants and malpractice risk: Findings from the National Practitioner Data Bank. *Fed Bull* 1998; 85:242-247.

[29] National Practitioner Data Bank, 2005 Annual Report. Bureau of Health Professions, Health Resources and Services Administration, US Department of Health and Human Services.

by medical insurance premiums and malpractice cases. PAs have less than one percent of all medical malpractice payment reports.[30]

Several studies have also illustrated that the quality of care provided by physician assistants is at the level of that provided by physicians in comparable situations, with high levels of patient satisfaction.[31,32,33,34] In fact, PAs are widely accepted by patients and, as members of a supervising physician's team, can perform most of the routine functions in a general medical practice.[35] In primary care practices they are able to handle common patient complaints, follow-up visits, and patient counseling. Their presence permits patients to receive prompt attention, knowing that their routine problems will be addressed effectively and that the expertise of the physician is available if needed. This also frees physicians to focus their attention on patient problems that require physician-level care.

Numerous studies have also shown that employing PAs is cost effective. A 1994 federal study of state practice environments reported: "Within their areas of competency, and within appropriate training and supervision, these practitioners may provide medical care similar in quality to that of physicians at less cost."[36] The AMA's Socioeconomic Monitoring system of approximately 4,000 practices found that 56 percent of group practice physicians and 39 percent of solo practice physicians employ nonphysician providers, including PAs. "The data show that employing nonphysician providers enhances physician productivity," according to the survey report.[37] In surgical practices, the presence of PAs enables surgeons to delegate the performance of preoperative histories and physical examination, the ordering and compiling of necessary tests and part of the postoperative care. The familiarity and experience of the physician-PA surgical team results in efficiency in the OR that can reduce operative and anesthesia times.

Physician assistants have also proven to be a viable alternative for trauma centers unable to maintain a surgical residency program.[38] Although these centers have traditionally been staffed by surgical residents who were able to provide highly skilled and cost-effective labor, recent cutbacks in residency programs of surgical specialties have required substitutions for these traditional trauma providers.[39] Based upon a study conducted at the Hurley Medical Center, the

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[30] *Id.* at 26.

[31] Hooker RS, Potts R, Ray W. Patient satisfaction: comparing physician assistants, nurse practitioners and physicians. *Permanente Journal* 1997; 1: 38-42.

[32] Counselman FL, Graffeo CA, Hill JT. Patient satisfaction with physician assistants (PAs) in an ED fast track. *Am J Emerg Med* 2000; 18: 661-665.

[33] Miller W, Riehl E, Napier M, Barber K, Dabideen H. Use of physician assistants as surgery/trauma house staff at an American College of Surgeons-verified level II trauma center. *J Trauma* 1998; 44: 372-376.

[34] Oliver DR, Conboy JE, Donahue WH, Daniels MA, McKelvey PA. Patients' satisfaction with physician assistant services. *Physician Assist* 1986; 10(7): 51-54, 57-60.

[35] Jolly DM. Patients' Acceptance of Physician's Assistants in Air Force Primary Medicine Clinics. Santa Monica. RAND Corporation. 1980.

[36] Sekscenski ES, Sanson S, Bazell C, et al. State practice environments and the supply of physician assistants, nurse practitioners and certified nurse-mid-wives. *New Eng J Med* 1994;331:1266.

[37] Gonzalez, ML, ed. Socioeconomic Characteristics of Medical practice 1995. Center for Health Policy Research, American Medical Association. Chicago, IL.

[38] Miller, William PA-C, FAAPA; Riehl, Erich PA-C, FAAPA; Napier, Melissa PA-C, FAAPA; Barber, Kimberly MA, ASCP; Dabideen, Harris MD, FACS. *Journal of Trauma-Injury Infection & Critical Care*. 44(2):372-376, February 1998.

[39] *Id*. at 372.

use of PAs in a large community hospital's Level III trauma center resulted in decreases in transfer time to the operating room (43%), transfer time to the intensive care unit (51%), the length of stay for new admissions (13%) and the length of stay for neurotrauma intensive care unit (33%) patients.

Lastly, according to the Medical Group Management Association (MGMA) care provided by PAs is very cost effective. According to 2006 data, for every dollar of charges a PA generates for a primary care practice, the employer pays on average 28 cents to employ the PA.[40] For PAs in surgical practices, the employer pays 34 cents for every dollar of charges generated.[41]

Physician Assistant Programs in the State of Connecticut
Currently, Connecticut has two physician assistant programs:

- ***Quinnipiac University Physician Assistant Program.***
  Prior to application, students must have a baccalaureate degree from a regionally accredited institution in the United States or a nationally recognized institution. In addition, they must complete prerequisite courses in mammalian or human biology, microbiology, anatomy and physiology, general, organic or biochemistry, and college algebra, statistics or other equivalent. The program is fully accredited by ARC-PA. It is a full-time, twenty-seven (27) month long curriculum, which leads to a Master of Health Science Physician Assistant degree. It includes subjects in applied medical and behavioral sciences, patient assessment, clinical medicine, and procedural skills, The first year is heavily weighted in didactic education. Courses include physical diagnosis, pharmacology, and the history, roles and responsibilities of the physician assistant. Subsequent courses provide a common clinical focus as well as epidemiological and ethical principles.

- ***Yale University School of Medicine Physician Associate Program.***
  The Yale Physician Associate Program, under the auspices of the Yale School of Medicine, offers graduate-level medical instruction with a curriculum extending over a twenty-eight (28) month period and culminating in the conferral of a Masters of Medical Science (MMSc) degree. It is designed for students who hold a baccalaureate degree prior to admission and have completed prerequisite courses in general biology or zoology, general chemistry and organic or biochemistry and upper division biology courses, one of which must be animal or human physiology . The curriculum comprises three major components: didactic, clinical, and research. The didactic phase of physician associate training begins with a twelve-month didactic phase with lectures and small-group instruction taught by the faculty of the Yale School of Medicine. Upon successful completion of the didactic phase, students move on to the sixteen-month clinical phase, consisting of both clinical clerkships and thesis work. There is no separate research phase. Instead, research is integrated into the didactic and clinical phases. During the didactic phase, research is incorporated through an "Introduction to Research" course and in journal club discussions interspersed throughout the Medicine and Surgery modules.

[40] Medical Group Management Association. Physician Compensation and Production Survey: 2007 Report Based on 2006 Data.
[41] *Id.*

During the clinical phase, students work closely with their faculty advisors in preparation for the master's thesis.

Physician Assistant Practice in the State of Connecticut

- ***Employer Type***
  Over 1500 active physician assistant licenses were in existence at the end of the 2007 calendar year.[42] According to the 2007 AAPA Physician Assistant Census for Connecticut, 26% of the state's PAs are employed by a single-specialty physician group practice while over 32% are employed by hospital other than a university hospital and 6% are employed by solo physician practices.[43]

- ***Primary Work Setting***
  The most prevalent "primary" work setting for Connecticut PAs is an inpatient unit of a hospital at just over 24% (not an intensive care unit/critical care unit).[44] Single-specialty physician group practices are the second largest primary work setting (19.6%). Other settings that serve as the primary work site for PAs include hospital emergency rooms (10.9%), intensive/critical care units of hospitals (10.7%) and solo practice physician offices (6.9%).[45]

- ***Primary Specialty Practice***
  While PAs practice in over 60 different specialty fields, the prevalent specialties in Connecticut are surgical orthopedics (11.8%), general internal medicine (10.8%), emergency medicine (10.4%) and general surgery (6.3%).[46]

- ***Functions and Responsibilities***
  PAs in Connecticut perform a variety of functions in the clinical setting. More than half (56.7%) perform minor surgical procedures or manage the care of patients in an inpatient setting (54.1%).[47] Over fifty-one percent (51.8%)of PAs precept PA students. Others (26.4%) precept students of other health professions.[48]

- ***Scope of Practice***
  Like the vast majority of states, Connecticut issues "licenses" to physician assistants. A physician assistant's scope of practice is limited to those medical functions delegated by a supervising physician when: (1) the supervising physician is satisfied as to the ability and competency of the physician assistant; (2) such delegation is consistent with the health and welfare of the patient and in keeping with sound medical practice; and (3) such functions are performed under the oversight, control and direction of the supervising

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[42] Website for the Connecticut Department of Public Health, *available at* http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389538&dphNav=| (last accessed on October 1, 2008).
[43] 2007 American Academy of Physician Assistants Census Report for Connecticut, *available at* http://www.aapa.org/research/StateReports07/CT07c.pdf (last accessed October 1, 2008).
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] *Id.*

physician. The functions that may be performed under such delegation are those that are within the scope of the supervising physician's license, within the scope of such physician's competence as evidenced by such physician's postgraduate education, training and experience and within the normal scope of such physician's actual practice.

- ***Prescriptive Authority***
  Connecticut physicians may delegate prescriptive authority to PAs. When delegated to do so by a supervising physician, PAs are authorized to prescribe and administer drugs, including controlled substances in schedule IV or V in all settings, renew prescriptions for controlled substances in schedule II, III, IV or V in all settings, prescribe and administer controlled substances in schedule II or III in all settings, and prescribe and approve the use of durable medical equipment. The physician assistant may also, as delegated by the supervising physician within the scope of such physician's license, request, sign for, receive and dispense drugs to patients, in the form of professional samples. Physician assistants who have been delegated the authority to prescribe controlled substances must register with the: (1) State of Connecticut Department of Consumer Protection and (2) the Federal Drug Enforcement Administration.

Conclusion

Many of the factors that are creating physician workforce issues can be partially offset by the use of physician assistants (PAs). Physician assistants can meet patient needs because of their medical education and training. Additional attractive features of the profession are the ability of PAs to work in diverse places of employment and a myriad of medical specialties. While practicing as part of a supervising physician's team, PAs can also extend and deliver high quality health care to patients in a variety of settings, i.e., nursing homes, medically underserved areas, inner-city clinics, and rural communities that may not otherwise have adequate access to physician services.

We would encourage the members of the HealthFirst Connecticut Authority to include physician assistant services in future legislative initiatives to provide those who live in this great state with quality, preventative and affordable, universal health care coverage. We believe doing so will assist decision-makers in all government agencies, as they examine system-wide reforms, to ensure the availability of quality, accessible medical care to all individuals.

I sincerely thank you for the opportunity to present these comments.

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