Pennsylvania
MEDICAL SOCIETY®

June 26, 2000

Commissioner John R. McGinley, Jr., Chair
Independent Regulatory Review Commission
14th Floor, 333 Market Street
Harrisburg, PA 17101

Original: 2064

Re: Final Rulemaking: State Board of Medicine State Board of Nursing CRNP Prescriptive Authority (16A-499)

Dear Commissioner:

I am writing as President of the Pennsylvania Medical Society to support the proposed final rulemaking of the State Boards of Medicine and Nursing related to prescriptive authority for certified registered nurse practitioners (CRNPs) currently before the Independent Regulatory Review Commission (IRRC).

The Boards are to be congratulated for their efforts which have resulted in the regulations before you for consideration. We understand that the Boards are continuing to clarify the regulations and their implementation, including the method nurse practitioners may utilize to request a waiver from the physician supervision limitation.

The regulations in their current form address the educational quality and safety concerns raised by the Medical Society during the comment process.

The Society urges the approval of these regulations by the IRRC.

Sincerely,

Donald H. Smith, MD
President

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Cc: The Honorable Clarence Bell, Chair
Senate Consumer Protection and Professional Licensure Committee
The Honorable Mario Civera, Chair
House Professional Licensure Committee
Charles D. Hummer, MD, Chair
State Board of Medicine
Robert Muscalus, DO
Physician General
K. Stephen Anderson, CRNA, Chair
State Board of Nursing

DNM/doc/cor/IRRC62000

Gelnett, Wanda B.

From: Arookee@aol.com
Sent: Friday, June 23, 2000 11:57 PM
To: irrc@irrc.state.pa.us
Subject: NP reugulations

Original: 2064

June 12, 2000
John McGinley

Dear Mr. McGinley:
I am a CRNP practicing for 14 years in a pediatric clinic for the under and uninsured patients. I work two days/week. One of the days is spent as a health consultant in a child care center. I am writing because the proposed regulation changes are unfair. They would be an exceptional burden to try to fulfill the requirements. Our clinic is funded by the United Way, the county health department, and local townships. I make a minimal salary as per deim employee with no benefits as do the other four nurse practitioners. This helps keep the cost manageable for the office. I am certified by ANCC and I am required to acquire 75 contact hours every five years. I accomplish this through conferences and professional meetings. I am a member of our pediatric nurse practitioner group. I also read various pediatric journals on a monthly basis. I feel I am very qualified in my position. I do minimal prescribing of antibiotics. I do maximum counseling about nutrition, safety, discipline, first aid.

The specific 45 hour Pharmacology course, 16 hours biennially of Pharmocology credits, the limited formulary, and the 2:1 CRNP to MD ratio would mostly likely cause me and other part-time employees to stop practicing as NPs because the cost and time expended would be prohibitive. Noone tells the MDs what their CEU credits need to be in. Addtionally, only a small number of NP are jointly promegated in other states by the BOM and the BON. NPs in all but about five states have prescriptive authortity.

Quality of care is not enhanced by overwhelming regulations. Patient care is not necessarily improved because someone has CEU credits in pharmacology.

These are the reasons I have concerns about the regulations. Please reconsider them. Thank you.

Sincerely,

Aleksandra A. McDonnell, RN, MSN, CRNP

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found)
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Auto-Submitted: auto-generated (failure)
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Gelnett, Wanda B.

From: sheela portersmith [sportersmith@hotmail.com]
Sent: Sunday, June 25, 2000 12:10 PM
To: irrc@irrc.state.pa.us
Subject: crnp regulations

Original: 2064

To Whom it May Concern:

I am a Women's Health Nurse Pratitioner residing in Northest PA. I currently provide patient care in a Family Planning Center. I urge you to disapprove the amendment to the CRNP regulations that were recently voted upon by the Board of Nursing. I am most concerned about:

1. The 2 CRNP /1 physician ratio. This not only focuses on hypothetical and undocumented abuses of CRNP's by physicians, but also is not congruent with most states which do not have ratios (the two that do have a 5NP: 1physician ratio. This would limit/curtail the functioning of many CRNP practices and nurse-run centers across the state which provide essential health care for underserved rural and urban popultions.
2. Requiring a specific 45 hour pharmacology course. Defining the advanced pharmacology hours to include 45 hours in total rather than 45 hours in one course would allow credit for previous coursework even though it may not have been all in one course.
3. The shift of authority in acts of prescription from the Statutory Board to the individual collaborating physician. This shift means the collaborating physician has the responsibility and liability for each and every prescripiton which CRNP's write.

I agree with Barbara Safreit, Associate Dean of Yale Law School:

"Once the state has legally recognized the Advance Practice Nurse as a competent provider, it is odd indeed to condition practice upon the agreement or persmission of a private individual...any state that adopts such a mechanism has in effect yielded its governmental power to one individual...the physician." (Safreit, B.J., 1996).

PLEASE DISAPPROVE THE REGULATIONS AND RETURN THEM TO THE BOARD OF NURSING.
IT IS ESSENTIAL FOR THIS BOARD TO REPRESENT THE INTERESTS OF OUR PROFESSION.

SINCERELY,

SHEELA PORTERSMITH CRNP, CNM

Elliott G. Leisawitz, M.D.
Michael Kastenbaum, M.D.

Mary J. Bonner, M.D.
Jorge J. Scheirer, M.D.

SHILLINGTON INTERNAL MEDICINE ASSOCIATES, P.C.
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Mr. Robert Nyce
Executive Director
Independent Regulatory Review Commission
333 Market Street, 13th Floor
Harrisburg, Pennsylvania 17101

June 20, 2000

Original: 2064

Dear Mr. Nyce:

I am writing regarding the new CRNP regulations that have recently passed the House Professional Licensure Committee. The new regulations contain some provisions which are deleterious to CRNP functioning.

Item 1: The Nurse Practitioner:Physician ratio of 2:1

Where did this specific ratio come from? Was any research used? There are only two states in the entire United States that have a ratio, and those are stated as 5:1. This provision makes it very difficult to provide care with supervision in practices and clinics that employ many part-time NPs. Please either remove this provision, or if you must keep the ratio, change it to 5 full-time NPs per physician.

Item 2: A 45-hour advanced pharmacology course

I agree that NPs must have a well-rounded pharmacology course. But most of the NPs who did not have such a course in their education had pharmacology incorporated into other courses. Because they have practiced longer, they also have a wealth of experience. I would like to suggest that you require a 45-hour course *or its equivalent*.

Item 3: 16 hours of pharmacology required every 2 years.

I read journals and listen to drug reps in the same way that the physicians in my office do. They are not required to complete any type of refresher pharmacology course. Either make the regulation equal, or eliminate it.

Item 4: Nurse Practitioner prescriptive mistakes

When a nurse practitioner makes a prescriptive mistake, I believe he or she needs to be responsible to take corrective action. I do believe in physician oversight of NPs, and that the physician should be informed of the error and proposed correction, but the ultimate responsibility for a prescriptive error needs to be placed on the NP.

Respectfully submitted,

Trudy A Bush, CRNP MSN

Trudy A. Bush, CRNP, MSN
Shillington Internal Medicine
101 W. Lancaster Avenue
Shillington, Pennsylvania 19607

209 South 20th Street
Harrisburg PA 17104
June 18, 2000

Robert Nyce, Executive Director
Independent Regulatory Review Commission
333 Market St., 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce,

I have been reviewing copies of the proposed final form Certified Registered Nurse Practitioner (CRNP) Prescribing Authority regulations that were—as I understand it—recently approved by the House Professional Licensure Committee and Senator Bell's Committee. I know that IRRC is now reviewing them as well before final publication. I am dismayed that the Boards have changed them so substantially without formal public scrutiny. Here are some specifics.

Page Three, Section 18.54 (3): "DEVICES AND PHARMACEUTICAL AIDS" are listed as okay for the CRNP to prescribe if "ORIGINALLY PRESCRIBED BY THE COLLABORATING PHYSICIAN". Is this to mean that if a patient with, say, *new-onset* diabetes comes into my nursing center, and we decide to start insulin therapy (requiring syringes, a "pharmaceutical aid"), that that patient needs to travel to another clinic to see a physician for the new prescription? If my clinic is in a medically underserved area (and of course, there's no emergency requiring the patient to be in an ER or in the hospital) does this mean the Boards want my patient to have to travel to an unfamiliar practice, or an ER, or to wait a few weeks for an appointment (if he can get one) in order to start therapy, which could be conveniently started that day if this provision were not to exist? Does this mean clinics in Southwestern Pennsylvania, Northern Philadelphia and the housing projects in Harrisburg will have to stop seeing diabetics?

Page Eight, Section 18.57: Regarding this very arbitrary ratio (one that exists in few states, and in those states they're apparently trying to get those sections removed), was it intended that such a ratio should put nursing centers out of business? These centers operate within the scope of nursing practice, and consultation occurs as it needs to. From all available evidence, these centers are serving their patients well. In fact, many of their patients would otherwise have little in the way of effective health care without the nursing centers, since physicians didn't seem to be serving them. These centers often contract with groups of physicians for consultation. This has worked well. The Board of Medicine's clumsy attempts to have a "named physician" licensee attached to each CRNP, is an obvious attempt to try to fit a system that is working well for Pennsylvania's underserved, into a model more of Medicine's liking. So I ask, in a center that employs, say, six CRNPs, who have a contract with a two-physician practice for consultation, is the nursing center to fire two of the CRNPs and cut its hours while it casts around for more consultation that it perhaps cannot afford?

I do hope these two examples of the Medical Lobby's attempts to constrain advanced nursing practice in Pennsylvania with these regulations, will steer IRRC from final approval. We realize that the way these regulations were modified and shoved through final board approval has been meant to reduce the pressure to move House Bill 50. Our concern is that the fallout from their political ploy will be borne by Pennsylvania's most needy citizens.

Sincerely,

R. Eric Doerfler, CRNP

Pennsylvania Psychiatric Society

The Pennsylvania District Branch of the American Psychiatric Association

Original: 2064

June 20, 2000

Robert Nyce, Executive Director
The Independent Regulatory Review Commission
14th Floor, 333 Market Street
Harrisburg, PA 17101

Dear Mr. Nyce:

I am writing on behalf of Jeremy Musher, MD, the President of the Pennsylvania Psychiatric Society, in support of the CRNP Prescriptive Authority regulations (16A-499, May 26, 2000, Annex A) recently endorsed by the Board of Medicine and the Board of Nursing.

The regulations in this final-form annex adequately address the concerns we expressed to the Boards in response to the proposed regulations published in the Oct. 2, 1999 issue of the Pennsylvania Bulletin. If approved, we believe they will provide a reasonable balance between the objectives of patient protection and access to care.

Sincerely yours,

Gwen Yackee Lehman

Gwen Yackee Lehman
Executive Director

cc: Jeremy S. Musher, MD

Executive Director
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June 16, 2000

Robert Nyce Original: 2064
Executive Director
Independent Regulatory Review Commission
333 Market Street, 14th floor
Harrisburg, PA 17101

Dear Mr. Nyce:

I am writing you as a concerned health care consumer and health care provider. My concern regards the recent House Professional Licensure Committee's approval of Certified Registered Nurse Practitioners' (CRNP) regulations that were passed by the Boards of Medicine and Nursing.

A few facts:

-nurse practitioners have served the public since 1965.

-in the Journal of the American Medical Association, March, 2000 issue, a recent study compared quality of care received by patients from physicians and nurse practitioners. Patients were as pleased with nurse practitioners as they were with physicians. There was a slightly better improvement in blood pressure readings in the group treated by nurse practitioners.

-nurse practitioners provide a vital service in the health care community; more needs to be done to facilitate their opportunity to provide health care.

Two areas of concern in the new regulations are 1) the necessity of 2CRNP: 1 physician ratio and 2) necessity of a total of 45 credit hours of advanced pharmacology. The small ratio of CRNPs to physicians is a barrier accessing care. We currently need more health care providers. What do the CRNPs do when the physician is on vacation? Currently, CRNPs have nurse-clinics that have a collaborative role with physicians. The clinics provide a much needed service to under-served populations. They have been successful without needing a 2:1 provider relationship. The new regulations would cause a halt to this vital community service. It would also cause many problems for most CRNPs and their collaborating physicians.

The health care system is already strained. We need innovative, safe methods to provide quality health care without impeding care. As for the required pharmacology course, this is not required of physicians. Why for nurses and not physicians? Nurse practitioners do have pharmacology in their curricula. Nurse practitioners preparation includes advanced level topics that are necessary in preparation for providing quality health care.

My vote, if I was part of the IRRC, would be to not accept the CRNP regulations as they currently stand. Appropriate regulations need to be substituted that would promote the vital role that nurse practitioners have and continue to contribute to quality patient care.

Sincerely,

Gail Kaempf

Gail Kaempf, MSN, CRNP

American Nurses Association©
PRESCRIPTIVE AUTHORITY
2000 Chart

State	Who May Prescribe	Drug Schedules Which May Be Prescribed	Is Physician Collaboration Required to Prescribe?	Other Requirements
ALABAMA	NP, CNM	Noncontrolled drugs only	YES	Must be in collaborative relationship, working under a protocol.
ALASKA*	NP[1], CRNA	II - V	NO	Must have an approved consultation plan.
ARIZONA*	NP	II - V[2]	NO	Have full prescribing and dispensing privileges. Must have "collaborative," i.e., consultative or referral relationship with a physician as RNP. No specific protocol required. Schedules IV-V: 34-day supply.
ARKANSAS	NP, CNS+	III - V	YES	Law allows certified CNSs and NPs to prescribe drugs when in collaborative practice agreement, to include protocols.

[1] In Alaska, NP includes, NPs and CNMs, NP=Nurse Practitioner, CNS =Clinical Nurse Specialist, CNM=Nurse Midwife, CRNA=Certified Registered Nurse Anesthetist.

Both controlled and noncontrolled drugs require a prescription. Controlled drugs are organized according to schedule (II to V), with the lowest schedule number having the highs potential for abuse. Noncontrolled drugs include: antibiotics, analgesics, and anti-inflammatory medications, among others.

[2] Previously Arizona limited schedules II-III to 48-hr supply and amended law for consistency in schedule IV-V authority. In 1998, they are considering changes to Article 5 to include: elimination of 1000-hour work requirement for prescribing and dispensing authority (R4-19-101(1)); (R4-19-507(A.2)); elimination of the submission of the name of the collaborating physician (R4-19-505(b)); (R4-19-507(A.3.h) and R4-19-507(J)); elimination of the renewal of prescribing and dispensing authority; addition of definitions of "administer", "prescribe", "dispense" and "clinical nurse specialist"; addition of title protection for clinical nurse specialists and clarification that NPs should prescribe and dispense within the scope of their practice.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Type of Practitioner	Drug Schedules Under Which Practitioner Has Authority to Prescribe	Is Practice Agreement, Collaboration, or Protocol Required to Prescribe?	Remarks
CALIFORNIA[3]	NP	Noncontrolled drugs only	YES	Protocol is required to prescribe. Effective January 1, 2000, NPs can apply for DEA numbers. Law was changed to replace the term "furnishing" with the term "ordering".
COLORADO*	NP, CNS, CNM, CRNA	II-V	NO	Prescriptive authority collaborative agreement must exist; however, law specifically states that nothing shall be construed to limit the liability of the APN to make an independent judgement, or to require supervision by a physician.
CONNECTICUT*	NP, CNM, CNS NA	II - V	YES	Limitations on scope of prescriptive authority of CRNA based upon certification. Limitations on Schedules II & III for NP and CNS.
DELAWARE*	APN, CNS, NP	All drugs including controlled II - IV	YES	Must be under collaborative arrangement and in compliance with joint practice committee rules.
DISTRICT OF COLUMBIA*	NP, CNM, CNS CRNA	II-V	NO	
FLORIDA (M)	NP CNS	Noncontrolled drugs only	YES	Under statutory-authorized protocol and practice agreement. CNS can prescribe only if licensed as ARNP.

3 Change in law reported by the California Coalition of Nurse Practitioners.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Type of Practitioner	Drugs Schedule Under Which Prescriptive Authority is Granted	Is Physician Agreement, Collaboration or Protocol Required to Exercise Authority?	Comments
GEORGIA	NP	None	YES	No independent prescriptive authority, but APN can be delegated authority to order controlled substances and dangerous drugs, medical treatments or diagnostic studies in a public health setting or in certain hospitals and patient clinic settings (ordered under nurse protocols).
HAWAII	APRN[4]	Noncontrolled drugs only	YES[5]	Exclusionary formulary, cannot order controlled substances. Legislation is pending that would allow APRNs to order controlled substances.
IDAHO	CNS, NP, CRNA, CNM	II - V within scope of practice	YES	Sole promulgation by BON, no formula, no protocol.
ILLINOIS	NP, CNS, CNM	Noncontrolled and controlled III - V	Yes	Must have collaborative agreement to be licensed as an APN. Legislation signed 8/13/98. Rules are not promulgated (expect to take 18 months).
INDIANA[6]	NP, CNS, CNM	II - V	YES	In collaboration with licensed MDs as evidenced by practice agreement or privileges.

[4] In Hawaii, APRN title includes Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs).

[5] In Hawaii, APRNs must have a collegial agreement with a physician.

[6] Burns Ind. Code Ann. §25-23-1-30 (1995) specifically states that prescriptive authority not required for administration of anesthesia.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Type of Practitioner	Drug Schedules Under Which Practitioner Has Authority to Prescribe	Is Practice Agreement, Collaborative or Protocol Required to Prescribe?	Remarks
IOWA*	NP, CRNA, CNM, CNS	II - V	NO	Physician's assistant or registered nurse may supply when pharmacist services are not reasonably available or when it is in the best interests of the patient, on the direct order of the supervising physician, a quantity of properly packaged and labeled prescription drugs, controlled substances, or contraceptive devices necessary to complete a course of therapy.
KANSAS	NP, CNM, CNS+	II-V	YES	NPs, CNMs, and CNSs may prescribe under jointly adopted protocols between the nurse and "the responsible physician," including controlled drugs. Effective April 1, 2000, must obtain DEA numbers to prescribe II-V.
KENTUCKY	NP, CNS+, CNM, RNA	Noncontrolled drugs only	YES	Enacted legislation authorizing APNs to prescribe noncontrolled prescriptive authority under a written collaborative agreement with a physician.
LOUISIANA[7]	CNM, NP, CNS	Non-controlled drugs only except as specifically authorized by the Joint Administration Committee	YES	Joint promulgation of rules by Board of Nursing and Board of Medical Examiners. BON has total enforcement authority.

[7] Bill signed by Louisiana legislature to provide limited prescriptive authority in collaborative practice, May 1995.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Which Practitioners	Drug Schedules Under Which Practitioners Have Prescriptive Authority	Is There a Requirement for Collaboration or Protocol Required for Prescription?	Remarks
MAINE*	NP, CNM	III - V	YES	New NP works with a collaborating physician for the first two years.[8]
MARYLAND*	NP[9]	II - V	YES	Written agreement between MD and NP.
MASSACHUSETTS*	NP, CNM, Psych CNS	II - VI[10]	YES	Orders to manufacturer/wholesalers limited to schedule VI only.
MICHIGAN	NP, CNM, CRNA	II - V	YES	Michigan NPs and CNMs may prescribe both controlled and non-controlled substances as a delegated act. CRNAs may prescribe non-controlled substances as a delegated act.[11]
MINNESOTA*	NP, Psych CNS	II - V	YES	NPs must have agreement with physician in order to prescribe; nurse midwives do not need to.
MISSISSIPPI(M)	NP	Noncontrolled drugs only	YES	Protocols are required in order to prescribe. They must be on file with the BON.

8 Under new law in Maine, new NP must practice under supervision before he/she is allowed to practice independently. Also, the NP retains a copy of the collaborative agreement.

9 In Maryland, prescriptive authority for NPs only, not for nurse psychotherapists.

10 In Massachusetts, all prescription medications not classified by the federal government as II-V are categorized as Schedule VI.

11 In Michigan, controlled substance rulemaking has been proposed.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Type of Practitioner	Drug Schedules Under Which Practitioner Has Authority to Prescribe	Is Practice Agreement, Collaboration, or Protocol Required to Prescribe?	Remarks
MISSOURI	APN[12], CNM, CNP, CNS, CRNA	Noncontrolled substances only	YES	Can prescribe non-controlled substances as a delegated medical act through collaborative agreement or protocols and the requirements are jointly determined by BON and BHA through rules.
MONTANA*	APRN, NP Nurse Specialist to include CNMs and some CNSs	II - V	NO	No protocol required for prescribing. Quality assurance program exists. Schedule II limited to a 72-hour supply.
NEBRASKA	ARNP, CRNA	II[13], III-V	Yes-ARNP No-CRNA	ARNPs without master's degrees and/or certain coursework must have protocols to prescribe.
NEVADA*	APN, CNS[14]	Noncontrolled substances	YES	Must also apply to Board of Pharmacy. No controlled substances drugs may be listed in protocol. APNs can only administer and dispense scheduled II-V drugs.
NEW HAMPSHIRE*	NP	II - V	NO	Prescribing only allowed from state formulary for controlled and noncontrolled substances. No protocol required for prescribing.
NEW JERSEY	NP, CNS+	Noncontrolled drugs	YES	Medication protocols are required to prescribe. No practice protocols are required.

12 Under new law in Missouri, new APNs must practice under supervision before he/she is allowed to practice independently. Also, the new APN retains a copy of the collaborative agreement.

13 In Nebraska, APNs can prescribe schedule III-V drugs without limitation. They can only prescribe schedule II drugs as listed on the state schedule for pain control.

14 If certified as advanced practice nurses in Nevada.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Nurses Granted Prescriptive Authority	Controlled Drugs Which Prescriptive Authority Is Granted	Formal Supervision or Collaboration Required	Remarks
NEW MEXICO*	NP, CNS+	II - V	NO	Formulary certified by the BON. This is an independent practice state for APNs and CNSs.
NEW YORK*	NP, CNM	II - V	YES	Collaborative relationship, with written practice agreements and protocols.
NORTH CAROLINA*	NP	II - V	YES	NPs and CNMs have authority to prescribe drugs including controlled substances according to site-specific protocols. NPs and CNMs may also be approved to compound and dispense drugs by the NCBOP.
NORTH DAKOTA*	NP, CNS+, CNM CNS, NP	II - V Noncontrolled drugs	YES YES	Scope of practice statement is required, to cover collaboration. Per formulary under supervision.
OHIO*[15]	CNM, CNS, NP	II-V[16]	YES	Per formulary under supervision in written collaborative agreement between physician and APN who is available in person, by radio, telephone, or some other form of communication. APNs are granted limited prescriptive privileges.

15 Ohio enacted legislation to give limited prescriptive authority to APNs (House Bill 241). Previously, prescribing was site-restricted.

16 In Ohio, schedule II drugs may be prescribed only if a patient has a terminal condition, the nurse's collaborating physician initially prescribed the drug, and the amount prescribed does not exceed the amount necessary for a singly 24-hour period.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Type of Practitioner	Drug Schedules Under Which Practitioner Has Authority to Prescribe	Physician Agreement, Collaboration, or Protocol Required to Prescribe?	Remarks
OKLAHOMA	CNM, CNS, NP	III - V Noncontrolled drugs	YES	Per exclusionary formulary under supervision.[17]
OREGON*	NP[18]	II - V	NO	Pursuant to formulary determined by the Board of Nursing. No protocol required for practice.
PENNSYLVANIA*	CNM, CRNA, NP	Cannot prescribe without physician's signature	YES[19]	
RHODE ISLAND*	NP, CNS+ CNM	Cannot prescribe scheduled drugs III - V	YES YES	While NPs cannot apply for their own DEA number, this may change. The DEA is reviewing SBON request. Formulary is now required; NP must be in collaboration with MD[20]. Certified nurse midwives are permitted to apply for their own DEA number.
SOUTH CAROLINA*	NP, CNS	V	YES	Listing of drugs in the MD-approved SBON-approved protocol.

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17 In Oklahoma, CRNAs have the option to apply for the authority to select obtain and administer schedule III-V and legend drugs - subject to an inclusionary formulary under supervision.

18 In Oregon as of 1999, NPs who have the need for Schedule II medications will have to apply to the DEA for this expansion of prescriptive authority.

19 Although statutory authorization exists in Pennsylvania, joint rules have not been completed by Board of Nursing and Board of Medicine.

20 Rhode Island is presently considering legislation to authorize CNS prescriptive authority.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Type of Practitioner	Drug Schedules Under Which Practitioner Has Authority to Prescribe	Is Practice Agreement, Collaboration, or Protocols Required to Prescribe?	[illegible] Remarks
SOUTH DAKOTA	NP	III - IV	YES	The SBON rules and regulations state that while the NP may apply for an independent DEA number, the NP is not permitted to use it. The NP must be authorized by the primary physician to prescribe and must use a code consisting of the supervisory physician's DEA number and the suffix of the first four numbers of the RN's license number. The order must be reviewed and countersigned by supervisory physician at least weekly and may not be refilled without consent of supervisory physician.
TENNESSEE*	NP, CNS, CNM, CRNA	II - V[21]	YES	Upon receipt of a BON Certificate of Fitness to prescribe, nurses in advanced practice may write and sign prescriptions and/or issue drugs. 1997 law dependent upon rules in process, promulgated but in Attorney General's office.
TEXAS	APNs (NPs, CNSs, CNMs, CRNAs)	Dangerous/Legend Drugs (Noncontrolled Substances)	YES	APNs (NPs, CNSs, CNMs, & CRNAs) may prescribe under physician delegation using protocols, standing orders, or other orders. Protocols need not take cookbook approach and should be defined "to promote exercise of professional judgment of APN" BON and BOM have defined broadly as "legal authorization to initiate medical aspects of patient care." Prescriptive authority is site based but most practice sites are covered.

[21] In Tennessee, controlled substances prescribing Schedules II through V subject to protocols established with a supervising physician.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Type of Practitioner	Drug Schedules Under Which Practitioner Has Authority to Prescribe	Is Formal Agreement (Collaboration or Protocol) Required to Prescribe?	Remarks
UTAH	APRN	III - V, PA	YES	Utah requires collaboration with a physician. Prescriptive practice collaboration is spelled out in a consultation referral plan, signed by the collaborating physician.
VERMONT*	NP, CNS, CNM, CRNA	II - V	YES	Must prescribe under collaborative guidelines which do not necessarily spell out formulary. The focus is on scope of practice, referral, consultation, and quality. The BON reviews the agreements.
VIRGINIA	NP[22], CNS+	VI	YES	A practice agreement is required to prescribe, Schedule VI are prescribed per formulary.
VIRGIN ISLANDS	CNS, NP	Noncontrolled drugs	YES	Independent prescriptive authority.
WASHINGTON*	NP	V	NO	
WEST VIRGINIA*(M)	NP, CNW	III - V	YES	Collaboration agreement is required to prescribe, and must include written guidelines or protocols for prescriptive authority.
WISCONSIN*(m)	NP, CNM, CRNA, CNS	II - V	NO	Independent prescriptive authority, however nurses must facilitate collaboration. Limitations on schedule II drugs nurses can prescribe.

[22] In Virginia, NPs have prescriptive authority with the exception of CRNAs.

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PRESCRIPTIVE AUTHORITY
2000 Chart

State	Type of Prescriptive Authority	Drug Schedules Under Which Practitioner Has Authority to Prescribe	Is Practice Agreement (Collaboration or Protocol) Required to Prescribe?	Remarks
WYOMING*[23]	NP, CNS	III - V and Legend Drugs	YES	The BON is seeking permission from the DEA for nurses who have prescriptive authority to apply for their own independent DEA registration number. NPs must have a plan of referral to work with a physician as needed.
GUAM	NP	None	YES	Collaboration is required.

Legend

* States where nurses can apply for their own DEA numbers.

\+ As long as CNS is licensed as an ARNP

◊ DEA numbers on hold

m = state-imposed minimum mandatory malpractice insurance coverage requirements for nurses who have prescriptive authority.

© Data compiled by Winifred Y. Carson, ANA Nurse Practice Counsel

G:\Charts\DEA.WPD
Revised 2/00

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[23] During 1997 and 1998, the Wyoming Board of Medical Examiners twice proposed rulemaking which would make the protocols more restrictive. Rules have not been promulgated in final form.

Original: 2064

PSNA
PENNSYLVANIA STATE NURSES ASSOCIATION
2578 Interstate Dr. ■ PO Box 68525
Harrisburg, PA 17106-8525
717-657-1222 ■ 888-707-7762
Fax: 717-657-3796

FAX TRANSMISSION COVER PAGE
Fax 717-657-3796

Date 6/15/00

Number of Pages (Including cover page) 12

To: John Jewett
Location:
Fax Number: 783-2664

From: Jessica Rohrer

Message: Charts on Prescriptive Privileges in other States

Please call _____ at 717-657-1222 if you have any problems receiving this fax.

PSNA
PENNSYLVANIA STATE NURSES ASSOCIATION
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FAX TRANSMISSION COVER PAGE
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Date 6/15/00

Number of Pages (Including cover page) ~~12~~ (5)

To: John Jewett
Location:
Fax Number: 783-2664

From: Jessica Rohner

Message: Charts on Prescriptive Privileges in other States

Please call _____ at 717-657-1222 if you have any problems receiving this fax.

Original: 2064

784 Cornwall Road
State College, PA 16803
June 15, 2000

Representative Lynn Herman
301 S Allen Street
State College, PA 16801

Dear Representative Herman,

I request you to contact the Independent Regulatory Review Commission to ask them to disapprove the amendment to the CRNP regulations that were voted upon by the Board of Nursing. I understand a great effort went into the negotiation of this amendment, but I have serious concerns about how the current version will limit health care access in Pennsylvania. The following topics are the reasons for my apprehension.

1. 2 CRNP: 1 physician ratio. No other state in the US has such a limiting ratio. I have worked in several situations in Pennsylvania where this ratio would constrain current practice, therefore in-turn reducing access to care for clients.
2. 45-hour pharmacology course requirement. Most CRNPs have had this course, but it was integrated in a larger course of study. Certainly pharmacology should be a requirement for all prescribing CRNPs. Allowing summation of advanced pharmacology hours to a total of 45 hours serves the same purpose.
3. Drug categories. CRNPs should be able to prescribe and dispense "eye, ear, nose, and throat preparations; hormones and synthetic substitutes; oxytocics; unclassified therapeutic agents: medical devices; pharmaceutical aids". Basic practice often dictates the use of these fundamental items.
4. Maintain Board statutory Board authority vs. the collaborating physician identifying drug categories that a CRNP may prescribe and dispense. Current regulation revisions put the responsibility on the collaborating physician for CRNP prescription writing. The affected regulated community and the public have not had an opportunity to comment on this change.

Thank you for reviewing my concerns. Please ask the IRRC to disapprove the regulations as they are now written and return them to the Boards for further negotiation and collaboration with the regulated community. It is vital the Board of Nursing represent the interests of the profession in its role to protect the health, safety and welfare of Pennsylvania citizens.

Sincerely,

Linda Shorey CRNP

Linda Shorey, CRNP

Cc:
Robert Nyce, Executive Director
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17101

Representative Mario Civera, Chair
Professional Licensure Committee
House of Representatives
P.O. Box 202020
Harrisburg, PA 17101-2020

Senator Clarance Bell, Chair
Consumer Protection & Professional Licensure Committee
Senate Box 203009
Harrisburg, PA 17101

Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
P.O. Box 2649
Harrisburg, PA 17101

Original: 2064

110 Creekside Lane
Spring Mills, PA 16875-9708
June 13, 2000

Governor Thomas Ridge
225 Main Capitol Building
Harrisburg, PA 17120

Dear Governor Ridge:

I urge you to contact the Independent Regulatory Review Commission to ask them to disapprove the amendment to the CRNP regulations that were recently voted upon by the Board of Nursing. I realize a great deal of effort went into the negotiation of the amendment, however, I have grave concerns about the effects these regulations will have on the access to health care for citizens of the Commonwealth, especially rural citizens. The following four issues are reasons why the regulations should be disapproved:

1. The 2 CRNP: 1 physician ratio. Only 2 other states have ratios–they are NY and CO. Both states have a 5 NP: 1 physician ratio. Limiting the NP: physician ratio would cause hardships for CRNP practices and nurse-run clinics across the state which provide care for under served urban and rural populations.

2. Requiring a 45- hour pharmacology course for all CRNP's. For the approximately 2500 experienced PA CRNP's, the estimated cost of a 45-hour pharmacology course, including time lost from work, would be $4000.00. This is a substantial amount of money! Allowing summation of advanced pharmacology hours to a total of 45 hours would serve the same purpose, but be easier for NP's to acquire.

3. The following categories of drugs must be inserted as drugs which CRNP's may prescribe and dispense: "eye, ear, nose, and throat preparations; hormones and synthetic substitutes; oxytocics; unclassified therapeutic agents: medical devices; pharmaceutical aids".

4. Need to maintain the statutory Board authority over CRNP acts of medical prescription instead of shifting to an individual collaborating physician the authorization to identify drug categories that a CRNP may prescribe and dispense. The revised regulations put the responsibility and potentially very costly liability, for every prescription written by the NP, upon the collaborating physician. The affected regulated community and the public have not had an opportunity to comment on this change.

Thank you for your attention to these concerns. Please ask IRRC to disapprove the regulations as they are written and return them to the Boards for further negotiation and collaboration with the regulated community. It is essential for the Board of Nursing to represent the interests of our profession in its role to protect the health, safety, and welfare of Pennsylvania citizens.

Sincerely,

Carol A. Myers, C.R.N.P.

cc Mr. Steve Anderson, Chairperson
PA Board of Nursing

Robert Nyce, Executive Director
Independent Regulatory Review Commission

Original: 2064

To IRRC
Re: CRNP Regulations

Below is a copy of a letter I sent to my Representative, Tom Scrimenti. Please review it before your next meeting. Thank you.

9211 Palmer Rd.
North East, PA 16428
June 12, 2000

Dear Representative Scrimenti,

I am writing once again to ask for your help regarding Nurse Practitioners, or NPs. As you know, HB 50 never left your committee because in March the State Boards of Medicine and Nursing came to an agreement regarding prescriptive authority for NPs and proposed new regulations. I understand that your Professional Licensure Committee is meeting tomorrow, June 13th, to vote on these regulations.

In general these regulations are fine except for two key points: they require that a physician collaborate with no more than two NPs, and that each NP who would like to prescribe must complete a separate 45 hour pharmacology course. We NPs did not have an opportunity to review and comment on either of these two sections because they were added onto the regulations AFTER the regulations were published in the PA Bulletin.

Please read the following comments about these sections, and then share them with your fellow committee members plus forward them to the Independent Regulatory Review Commission before their July 13th meeting, so they can have time to consider these comments. I have been told that the IRRC is very responsive to legislators.

Comments

(1) The 2 NP to 1 physician ratio limitation: When objections to the ratio were raised on 3/15/00 by members of the Board of Nursing and the Board of Medicine, comments by the Chair of the Board of Medicine and the Physician General that supported the ratio focused on hypothetical and undocumented abuses of NPs by physicians. There are only two other states known to have ratios-New York and Colorado. The ratio in both is 5 NPs: 1 physician. Access to care is clearly threatened by this tiny ratio, by the fact that a physician-not a NP-must apply for a waiver from this regulation, by the lack of definition of "good cause" for a waiver, and by the undefined process to obtain a waiver. NP practices and nurse-run centers across the state provide essential health care for underserved rural and urban populations. Most of these centers are staffed with multiple part-time NPs, are affiliated with schools of nursing, hospitals, and other reputable agencies, and hold numerous collaborative relationships. Unbiased research has shown their patient outcomes to be equal to or better than those of physician practices, as Rep. Mary Ann Dailey of Montgomery County can attest.

(2) Allow summation of advanced pharmacology hours to credit a total of 45 hours. While we acknowledge the importance of advanced pharmacology education for NPs, we believe that requiring "a specific course...of not less than 45 hours" is arbitrary. For the approximately 2,000 experienced Pennsylvania NPs without a documented separate 45-hour course, the estimated cost, including time lost from work, is $5,000!. Defining the advanced pharmacology hours to include 45 hours in total rather than 45 hours in one course would allow credit for previous pharmacology coursework. New York state, where I practice, allows this PLUS they permit an NP without a separate pharmacology course to take a test which, if passed, allows them to prescribe.

Thank you for your time in this matter and I hope you bring up these two issues regarding NP prescriptive authority at tomorrow's committee meeting.

Sincerely,

Sue Murawski, CRNP

Gelnett, Wanda B.

From: Arookee@aol.com
Sent: Monday, June 12, 2000 11:45 PM
To: irrc@irrc.state.pa.us
Subject: NP regs

Original: 2064

June 12, 2000

IRRC
Robert Nyce, Executive Director
John R. McGinley, Jr. Chairman
333 Market Street 14th floor
Harrisburg, PA 17101

Dear Mr. Nyce and Mr. McGinley:

I am a CRNP practicing for 14 years in a pediatric clinic for the under and uninsured patients. I work two days/week. One of the days is spent as a health consultant in a child care center. I am writing because the proposed regulation changes are unfair. They would be an exceptional burden to try to fulfill the requirements. Our clinic is funded by the United Way, the county health department, and local townships. I make a minimal salary as per deim employee with no benefits as do the other four nurse practitioners. This helps keep the cost manageable for the office. I am certified by ANCC and I am required to acquire 75 contact hours every five years. I accomplish this through conferences and professional meetings. I am a member of our pediatric nurse practitioner group. I also read various pediatric journals on a monthly basis. I feel I am very qualified in my position. I do minimal prescribing of antibiotics. I do maximum counseling about nutrition, safety, discipline, first aid.

The specific 45 hour Pharmacology course, 16 hours biennially of Pharmocology credits, the limited formulary, and the 2:1 CRNP to MD ratio would mostly likely cause me and other part-time employees to stop practicing as NPs because the cost and time expended would be prohibitive. Noone tells the MDs what their CEU credits need to be in. Addtionally, only a small number of NP are jointly promegated in other states by the BOM and the BON. NPs in all but about five states have prescriptive authortity.

Quality of care is not enhanced by overwhelming regulations. Patient care is

not necessarily improved because someone has CEU credits in pharmacology.

These are the reasons I have concerns about the regulations. Please reconsider them. Thank you.

Sincerely,

Aleksandra A. McDonnell, RN, MSN, CRNP

PENNSYLVANIA STATE NURSES ASSOCIATION
PO Box 68525
Harrisburg, PA 17106-8525
717-657-1222 ■ 888-707-7762
Fax: 717-657-3796
E-mail: psna@psna.org
www.psna.org

Original: 2064
Duplicate cc: Rep. Mario Civera

June 12, 2000

The Honorable Clarence D. Bell
20 East Wing
Senate Box 203009
Harrisburg, PA 17120-2020

Dear Senator Bell:

The Pennsylvania State Nurses Association (PSNA) is writing to express a serious concern with the proposed amendments to the CRNP regulations. Specifically the Association is strongly opposed to the ratio mandating that one (1) physician could have a collaborative relationship with only two (2) prescribing CRNPs. This ratio limitation would severely hamper the practice of the CRNP and ultimately impact on quality health care for Pennsylvania citizens by limiting access to care. Many CRNPs provide services to underserved rural and urban populations. The proposed ratio could increase the possibility of fewer health care services being provided to the poor and already underserved populations. Also, the regulations are not specific regarding whether the CRNP is working full time or part time. A strict interpretation of the regulations would mean that CRNPs who work part time would be required to meet the same ratio as those working full time.

Also of concern is the fact that this limitation was added after the close of the public comment period in October 1999. Stakeholders and the public have not had an opportunity to comment on what PSNA considers to be a substantive change. The Association believes that because the ratio would limit access to care, it should be eliminated from the proposed regulations. We urge you to disapprove this amendment.

Thank you for your consideration of PSNA's concerns.

Sincerely,

Jessie F. Rohner

Jessie F. Rohner, DrPH, RN
Executive Administrator

JFR:fm

cc: IRRC

Constituent, American Nurses Association

PENNSYLVANIA STATE NURSES ASSOCIATION
PO Box 68525
Harrisburg, PA 17106-8525
717-657-1222 ■ 888-707-7762
Fax: 717-657-3796
E-mail: psna@psna.org
www.psna.org

Original: 2064

June 12, 2000

The Honorable Mario Civera
Chair, Professional Licensure Committee
House of Representatives
P.O. Box 202020
Harrisburg, PA 17120-2020

Dear Representative Civera:

The Pennsylvania State Nurses Association (PSNA) is writing to express a serious concern with the proposed amendments to the CRNP regulations. Specifically the Association is strongly opposed to the ratio mandating that one (1) physician could have a collaborative relationship with only two (2) prescribing CRNPs. This ratio limitation would severely hamper the practice of the CRNP and ultimately impact on quality health care for Pennsylvania citizens by limiting access to care. Many CRNPs provide services to underserved rural and urban populations. The proposed ratio could increase the possibility of fewer health care services being provided to the poor and already underserved populations. Also, the regulations are not specific regarding whether the CRNP is working full time or part time. A strict interpretation of the regulations would mean that CRNPs who work part time would be required to meet the same ratio as those working full time.

Also of concern is the fact that this limitation was added after the close of the public comment period in October 1999. Stakeholders and the public have not had an opportunity to comment on what PSNA considers to be a substantive change. The Association believes that because the ratio would limit access to care, it should be eliminated from the proposed regulations. We urge you to disapprove this amendment.

Thank you for your consideration of PSNA's concerns.

Sincerely,

Jessie F. Rohner

Jessie F. Rohner, DrPH, RN
Executive Administrator

JFR:fm

cc: IRRC

Constituent, American Nurses Association

June 10, 2000

721 Meadowlark Way
North Wales, PA 19454

Rep. J Gladeck
1515 DeKalb Pk Ste 106
Blue Bell, PA 19422

Original: 2064

Dear Representative Gladeck,

I am a Pediatric Nurse Practitioner residing in your district. I teach graduate nurse practitioner students at the University of Pennsylvania's School of Nursing. In addition I provide primary care to children and their families at the Children's Hospital of Philadelphia. For my nearly 18 years as a Pediatric Nurse Practitioner I have provided care to underserved children throughout the Philadelphia region. **I urge you to contact the Independent Regulatory Review Commission to ask them to disapprove the amendment** to the CRNP regulations that were recently voted upon by the Board of Nursing.

My biggest concern relates to the newly added requirement of " a specific pharmacology course...of not less than 45 hours". We can all agree that advanced pharmacology education is important for CRNP's. A better solution would be to define the advanced pharmacology hours to include 45 hours in total rather than 45 hours in one course. This would allow credit for previous coursework.

When I graduated with my Master's nearly 18 years ago, the academic belief was that pharmacology should be incorporated directly into every course. Therefore a lecture on diseases related to the heart would discuss related heart medications, an asthma lecture would discuss treatment of asthma and so forth. It is estimated that nearly 2500 **experienced** Pennsylvania CRNP's do not have a documented 45-hour course.

This does not mean that CRNP's in Pennsylvania do not continue to be updated in pharmacology. I am the Course Director for the University of Pennsylvania's Continuing Education Pediatric Pharmacology Course. (One of the few pediatric courses in our part of the state I might add). I regularly lecture to graduate students & experienced nurse practitioners about pharmacology and it's application in primary care settings. I base my lectures on the latest research and current clinical practice. Yet I would be one of the people required to take a 45- hour course.

As a pediatric primary care provider, I would like to write prescriptions for a very limited number of medications. These include agents such as: oral antibiotics,

asthma medications, topical skin creams and over -the-counter medications that the insurance companies of my poorest patients will reimburse if written as a prescription (fever reducers for example). As a professional, I regularly chose continuing education courses that update me on these medications. Many full semester (45 hour) courses cover pharmacology that I will **never** need or use: adult drugs, in-patient medications, and chemotherapy agents. I worry that CRNP's will be forced to sit through a 45 hour course to met the requirement, yet not really increase their knowledge base. **As professionals, let use chose the pharmacology information that we need to fill our individual needs. Allow a 45-hour summation of advanced pharmacology** over a period of several years. (Or some other less arbitrary number).

Please do not hesitate to contact me if you have further questions.

Sincerely,

Victoria A. Weill RN,CS, MSN. CRNP
215 699-8157

cc:

Rep Mario Civera
Robert Nyce
Gov Tom Ridge
Sen Clarence Bell
Mr. Steve Anderson
Members of the House Professional License Committee

Gelnett, Wanda B.

From: Colleen Guiney [gerardmurray@earthlink.net]
Sent: Friday, June 09, 2000 6:55 AM
To: irrc@irrc.state.pa.us
Subject: Nursing: Final Rulemaking- to Mr. Nyce

Original: 2064
cc: Mr. McGinley (duplicate)

Dear Mr. Nyce,
I write to share with you my concerns about the Final Form Regulations which arrived from the Boards of Medicine and Nursing in my mailbox last night.

I believe that the 2:1 CRNP/MD ratio will limit access to care for many Pennsylvanians. Like many other CRNP's, I work part time in an office where three individual NP's comprise less than two full time positions. Although I have great confidence in the Nursing Board, I am concerned the Medical Board might not approve a waiver for our office, thereby potentially forcing one of us to resign.

The negative formulary also is a major concern. For example, I see that hypoglycemic agents have now been excluded. Does this mean that CRNP's may no longer care for non insulin dependent diabetics? What if new types of medications become available? Is it likely that the Medical Board would be open to permitting new medications?

Finally, the 45 hour Pharmacology course requirement means that many of the wonderful faculty who taught me at University of Pennsylvania, and other seasoned CRNP's will need to decrease other professional activities in order to retake a 45 hour course. Their Pharmacology content was integrated into disease courses rather than taught as a discrete course. This issue has been hotly debated for months, and I believe that the intransigence of the Medical Board on this problem is inexcusable.
Finally, how will we know in advance which Continuing Education programs in Pharmacology will be approved by the State Board of Nursing?

Please consider these concerns, and return these regulations to the Boards for revision.

I thank you for your time and effort.

Sincerely,
Colleen Guiney, MSN, CRNP
337 Dickinson Avenue
Swarthmore, PA 10981
cguiney@pobox.com

Original: 2064

June 8, 2000

Mr. David G. Hooper
741 Collina Dr.
Lewisberry, PA 17339-9586

Dear Mr. Nyce:

As a practicing family nurse practitioner, I am delighted that both the BON and the BOM have come to an agreement on prescriptive privileges for the nurse practitioner. However, several of the more controversial points in this regulation were never released to the membership for comment in October.

Every Nurse Practitioner Program in Pa is accredited by the Board of Nursing. The BON, in its approval process stipulates that an advanced pharmacology course be included in each program. However, there is no specific number of hours specified, and the hours of the pharmacology course depend on the length of the specific university semester. Requiring practicing nurse practitioners to take a 45 hour advanced pharmacology course would be time consuming and expensive. I would recommend a change in wording to require a 45 hour course or its equivalent.

Another section of the document requires 16 hours of pharmacology continuing education every two years. This would place a burden on the practicing nurse practitioner. While 16 hours of pharmacology continuing education are important, continuing education on diagnosing and managing medical conditions including the pharmacology is more comprehensive. I would recommend a change to 16 hours of continuing education with 6 of these hours be devoted to pharmacology.

The section on limiting refills of Schedule III-V drugs until there is physician authorization may cause pain and discomfort to the patient. A recommended adjustment would be to remove the requirement for physician authorization. I would also recommend the removal of the 72 hour limitation of the prescription of Schedule II drugs, and extend the limitation to 7 days.

Hopefully, these comments will be noted in the review of this important document.

Sincerely,

Priscilla Hooper MSN, CRNP

Priscilla Hooper, MSN, CRNP

Original: 2064

Gelnett, Wanda B.

From: Jennifer Gabany [jgabany@hotmail.com]
Sent: Thursday, June 08, 2000 6:31 AM
To: irrc@irrc.state.pa.us
Subject: CRNP regs

I am writing you to express my concerns about the new CRNP regulations and the effect they may have on access to essential health care for citizens of the Commonwealth. I strongly urge the IRRC to disapprove the regulations based on the following four issues that are critical to the health, safety, and welfare of the citizens of the Commonwealth:

1. Ensure access to care by eliminating the 2 CRNP: 1 physician ratio. The ratio limitation is a substantive change that was added after the close of the October 1999 public comment period on the proposed regulations. Stakeholders and the public have had no opportunity to comment on this most limiting and arbitrary aspect of the regulations. When objections to the ratio were raised on 3/15/00 by members of the Board of Nursing and the Board of Medicine, comments by the Chair of the Board of Medicine and the Physician General that supported the ratio focused on hypothetical and undocumented abuses of CRNPs by physicians. There are only two other states known to have ratios--New York and Colorado. The ratio in both is 5 NPs: 1 physician.

Access to care is clearly threatened by this tiny ratio, by the fact that a physician-not a CRNP-must apply for the waiver, by the lack of definition of "good cause" for a waiver, and by the undefined process to obtain a waiver from the ratio. This contradicts the Boards' claim in the Regulatory Analysis Form that "this rulemaking is expected to result in greater availability of quality, cost-effective health care services". We believe that the ratio is indefensible and should be totally eliminated. CRNP practices and nurse-run centers across the state provide essential health care for underserved rural and urban populations. Many of these practices can be recognized by their Medicaid, Title X, and CHIP reimbursement as well as by their large volume of uncompensated care. Most of these centers are staffed with multiple part-time CRNPs, are affiliated with schools of nursing, hospitals, and other reputable agencies, and hold numerous collaborative relationships. Unbiased research has shown their patient outcomes to be equal to or better than those of physician practices. Prescribing CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. Prescribing CRNPs should not be at the mercy of physician-initiated waivers to be determined by Boards with a history of over 20 years of stalemate regarding CRNP practice.

2. Allow summation of advanced pharmacology hours to credit a total of 45 hours. A 45-hour course was not specified in the proposed regulations published for public comment, nor in the written comments of the Independent Regulatory Review Commission, nor in the written comments of the Pennsylvania Medical Society. While we acknowledge the importance of advanced pharmacology education for CRNPs, we believe that requiring "a specific course... of not less than 45 hours" is quite arbitrary. For the approximately 2,500 experienced Pennsylvania CRNPs without a documented 45-hour course, the estimated cost of a 45-hour pharmacology course, including time lost from work, is $5,000.00, a substantial amount. Defining the advanced pharmacology hours to include 45 hours in total rather than 45 hours in one course would allow them credit for previous coursework even though it may not have been all in one course. This will minimize costly tuition and time lost from work for CRNPs who have been safely practicing for years.

3. Follow the language of the American Hospital Formulary cited to list each and every drug category in the book. The missing categories must be inserted as drugs a CRNP may prescribe and dispense. These categories were discussed in the March 15 joint public meeting of the Boards and their inclusion was a condition of the Board of Nursing's March 30 vote to approve the regulations. They are: "eye, ear, nose, and throat preparations; hormones and synthetic substitutes; oxytocics; unclassified therapeutic agents; medical devices; pharmaceutical aids".

4. Maintain the statutory Board authority over CRNP acts of medical prescription instead of shifting to an individual collaborating physician the authorization to identify drug categories that a CRNP may prescribe and dispense. As published in October, the regulations listed only 5 classes of drugs that a CRNP might prescribe with authorization documented in the collaborative agreement; 17 classes were allowed to be prescribed "without limitation". A substantive change was made in the March 15 document to list 21 classes of drugs that must be authorized by the collaborative agreement.

Furthermore, the revised regulations require the collaborating physician to attest "that he or she has knowledge and experience with any drug that the CRNP will prescribe." Thus, the revised regulations pin the responsibility and potentially very costly liability for each and every prescription upon the collaborating physician. Again, the affected regulated community and the public have not had the opportunity to comment on this substantivechange.

I agree with Barbara Safreit, Associate Dean of Yale Law School, who wrote, "Once the state has legally recognized the APN [Advanced Practice Nurse] as

a competent provider, it is odd indeed to condition practice upon the agreement or permission of a private individual...Any state that adopts such a mechanism has in effect yielded its governmental power to one private individual, the physician...At worst, [such schemes] constitute a wholesale privatization of a core governmental function: assessing competence for licensed practice." (p. 452) [Safreit, B.J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. Yale Journal on Regulation, 9, 417-490.]

Thank you for your attention to these concerns. Please ask IRRC to disapprove the regulations as they are written and return them to the Boards for further negotiation and collaboration with the regulated community. It is essential for the Board of Nursing to represent the interests of our profession in its role to protect the health, safety, and welfare of Pennsylvania citizens. Please contact me if you would like furtherinformation.

Sincerely,

Jennifer Gabany MSN,CRNP,CCRN

Gelnett, Wanda B.

From: eboyda@usa.net
Sent: Thursday, June 08, 2000 11:39 PM
To: irrc@irrc.state.pa.us
Subject: CRNP Regulations for Prescriptive Authority

Original: 2064

Dear Robert E. Nyce, Executive Director,

The new Regs. that have been written recently by the Board of Medicine have some serious practice issues, especially as they relate to the 2 to 1 ratio of physicians to CRNPs and the pharmacology requirement for a specific 45 hour course, which will force experienced CRNPs to go back to school - something physicians have never been required to do in PA.

In addition, we did not have an opportunity to review and comment on the regs after they were written. We urge that these regs be disapproved by the IRRC and that you ask the Board of Medicine and Nursing reexamine the issues - and allow CRNPs to have input into their own practice guidelines.

Thank you so much for your consideration of this matter.

Ellen K. Boyda, MS, CRNP
Family Nurse Practitioner

Gelnett, Wanda B.

From: Laura Bateman [laura.bateman@sru.edu]
Sent: Wednesday, June 07, 2000 10:11 AM
To: irrc@irrc.state.pa.us
Subject: CRNP Regs

Original: 2064

Please disapprove the CRNP Regs. The regs were rewritten by the State Board of Medicine after the public comment period. Substantial changes were made with no opportunity for public comment.

The 2 to 1 ratio of CRNP to MD is in essence restraint of trade. The 16 hours of continuing education in pharmacology every 2 years severely limits our educational opportunities. We will be forced to attend pharmacology programs on medications we don't even use and thereby miss educational opportunities that are pertinent to our work situation. Physicians are not required to obtain separate pharmacology credits as the information is included in pertinant lectures, which is how current CRNP programs are organized.

There must be an opportunity for public input on these new changes in order to have a workable system in place.

Please do not approve of these regs until we get another public comment period.

Laura Bateman, RN, MSN, CRNP
Slippery Rock University
Student Health Center
Slippery Rock, PA. 16057-1326

Gelnett, Wanda B.

From: Duckym@aol.com
Sent: Wednesday, June 07, 2000 5:22 PM
To: irrc@irrc.state.pa.us
Subject: House Bill 50 - CRNP regs

ATTN: Robert E. Nyce, Executive Director
John R. McGinley, Jr., Chairman

Dear Sirs:

I apologize for the informal way I am contacting you, however, I feel this is urgent. As a student nurse practitioner, I am gravely concerned about the expediency with which the CRNP regulation component of House Bill 50 is being rushed through the House Professional Licensure Committee.

The way the regulations were rewritten by the Board of Medicine relate to the 2 to 1 ratio of physicians to CRNPs and a pharmacology requirement for a specific 45-hour course, which would require many CRNPs to go back to school to meet this requirement; making it untenable for most CRNPs. There was no opportunity for review by the Board of Nursing.. My concern is the Senate Consumer Protection and Professional Licensure Committee, charied by Senator Clarence Bell (R-Del) and Democratic chair Lisa Boscola (D-Northampton), is not expected to take up the regs, but will likely deem them approved by not considering them during their 20-day comment period. The Senate is less familir with CRNP issues because HB 50 was in the House.

I am formally asking you to disapprove the regs as they stand. I appreciate your kind consideration in this matter. Please do not hesitate to contact me at any time should you require my assistance in any way.

Sincerely,

Deborah E. Warshawsky, RN, BSN
duckyrn@aol.com

Gelnett, Wanda B.

From: Geri Budd [gmb8@psu.edu]
Sent: Tuesday, June 06, 2000 2:29 PM
To: irrc@irrc.state.pa.us
Subject: CRNP regs

To Whom It May Concern:
Please do not approve the CRNP regulations that are soon to be before your agency. These regulations were voted on in a hasty and irresponsible manner by the Board of Nursing, and did not consider the effect on access to health care for underserved populations (Penn State University is one example of this). There are more than 6 CRNPs and only one or 2 physicians who are in a position to collaborate with them. The 2 to 1 ratio will affect many other populations as well: another example is the Rural Nursing Center in Mt. Union, PA and Family Health Services and Planned Parenthood.

I urge you to deny approval of these until more public comment and legislator impact.
Thank you.

Geri Budd
Instructor
Penn State University

Gelnett, Wanda B.

From: ShariYB@aol.com
Sent: Tuesday, June 06, 2000 10:37 PM
To: irrc@irrc.state.pa.us
Subject: Nurse Practitioner Regulations

To: Robert E. Nyce, Executive Director
John R. McGinley, Jr., Chairman

Please accept this email as a formal request that IRRC disapprove the Certified Registered Nurse Practitioner Regulations in their current form.

These Regs were rewritten by the Board of Medicine and the CRNPs did not have the opportunity to review and comment on them after they were rewritten.

There are several major problems with these regs as currently written - Specifically, they are MORE restrictive than current practice, limiting the ratio of physicians to CRNPs to 2 to 1. This limitation will adversely impact on the availability of quality health care to underserved communities within the Commonwealth. In addition, the requirement that CRNPs take a specific 45 hour pharmacology course will force many CRNPs who have been practicing for years to go back to school, a totally untenable situation.

I urge the members of IRRC to disapprove these regs and return them to the Boards of Nursing and Medicine for further review and revision.

Thank you for your attention to this matter.

Sincerely,
Shari Baron, MSN, RN, CS
Havertown, PA

Gelnett, Wanda B.

From: Brenda Hage MSN CRNP [bhage@epix.net]
Sent: Wednesday, June 07, 2000 5:51 AM
To: IRRC@irrc.state.pa.us
Subject: Proposed changes in prescriptive regulations for CRNP's

June 07, 2000

Members of the IRRC,

I am a nurse practitioner working in a busy physical and rehabilitation medicine practice and I appreciate the time and effort that the Boards have invested in developing new CRNP regulations. Following a review of these recently proposed CRNP prescriptive regulations of the BOM and the BON, I must share my concerns with you.

Nursing and medicine are disciplines that base their practice on science. Each day as health care providers, we make clinical decisions predicated on latest research findings and outcomes. As critical thinkers, we analyze research data to make these decisions. However, major changes in proposed CRNP regulation have been based on unfounded supposition, not fact. As professionals in science based disciplines, it is imperative that we examine the scientific evidence when considering changes in regulations that will affect the delivery of health care to Pennsylvanians.

Well-designed clinical studies support nurse practitioners as safe, high quality providers of care (Mundinger et al.,2000; Weiner, Steinwachs, Williamson, 1986; U.S. Congressional Budget Office, 1979). We have had the opportunity to observe the practice of nurse practitioners in New York and over 40 other states who have long had prescriptive privileges. Nurse practitioners continue to have good outcomes (Mundinger et al, 2000). Where is the data that supports the restrictive prescriptive regulations that the Boards voted on? We must not make decisions based on inflammatory anecdote due to turfism or ignorance. It simply isn't good science and does not serve the citizens of the Commonwealth. I must agree with M. Cem Harmanci, MD regarding the regulations and his concerns (which I share) are quoted as follows:

"A short list of my concerns with this agreement:
The completely new section, unrelated to pharmacology, that limits
collaboration ratios to 2:1. Many practices are with clinics, hospitals,

or NP run clinics such as Penn State's clinic in Huntington, PA. It is unreasonable, and designed to restrict practice, not quality of care. This should be dropped. There is no evidence to justify the fears of the

BOM. Setting a requirement for pharmacology, both a set initial 45 hours and continuing education of 16 hours is not required for physicians, and
unfairly hinders experienced CRNPs whose programs may have integrated pharmacology, or had different semester hours. Pharmacology is important, but there are many ways to achieve the same quality goal. Look at the medical schools. The approval of the BOM on the course also opens the door for further obstructionist behavior, a justified suspicion after 25 years.
The agreement to base the formulary on the American Hospital Formulary Service Pharmacologic-Therapeutic Classification was breeched. A
negative formulary is much more rationale, but if the Formulary is to be

used, then it should simply be listed as that. Period.
The limits on Schedule II-V drugs on refills, duration of use, etc.are not warranted. It is another restriction of practice that hampers
patient care and comfort. The clause requiring the physician to take action is paternalistic, and incurs liability where none should exist. The person dispensing the drug is responsible, with parameters already in place to cover this. It is insulting and unnecessary, and should be dropped. The section requesting attestation that a physician be knowledgeable about drugs ordered is ridiculous as well as insulting. It

too should be dropped.

The specification of how many times a physician sees a patient is

inappropriate with a CRNP. The collaboration is based on the individual patient, and a CRNP, in the same manner of a Family Practice physician, is able to refer as needed based on the patient's condition. It is another form of obstruction, designed to discourage physicians from collaborating with CRNPs.

Thank you for the work you have done toward Advanced Practice Nursing. I

must point out however, that this agreement is a step backward, not forward, for the collaborating team. The solution is to allow the Board of Nursing to regulate Advanced Practice Nursing independent of and without fear of interference by the Board of Medicine, and to permit Pennsylvania's CRNPs their full scope of practice. Those of us in a collaborative practice are anxious for the political nonsense to be resolved so that we may practice sound quality patient care in a rationale manner. Only then will the strengths brought from both physician and CRNP be fully realized.

Sincerely,
M. Cem Harmanci, MD".

I hope that you will reconsider the unnecessarily restrictive regulations that were proposed. With reasonable changes, the regulations could provide a framework for collaborative care that would truly serve the health care needs of Pennsylvanians.

Sincerely,

Brenda Hage, MSN, CRNP

[refer to the following web site for links to research about NP's quality of care STUDIES OF QUALITY AMONG NPS
Gold Sheet 1(10), 1999. http://nurses.medscape.com/22397.rhtml
Read it Here]

Temple University Hospital
Temple University Health System

Cancer Center

3322 N. Broad Street
Philadelphia, PA 19140-5189

Tel: (215) 707-4000

Original: 2064

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Commission
333 Market Street 14th Floor
Harrisburg, PA 17101

June 5, 2000

Dear Mr. Nyce,

I am an oncologist who works with advanced practice nurses (APNs) at Fox Chase - Temple University Cancer Center in Philadelphia, PA. I am writing regarding the recently promulgated joint regulations by the state Boards of Medicine and Nursing for Advanced Practice Nursing. I feel that the agreement will discourage physicians from forming collaborative practices with APNs. The nature of collaboration is the combination of strengths of independent individuals working together toward a common goal. Our goal is to provide good, quality care for our patients and these proposed regulations would make the collaborative nature of our goal difficult to achieve.

I have several concerns with the joint regulations:

1) Section 21.287: No physician may serve as collaborating physician for more than 2 nurse practitioners and only a physician may apply for a waiver. This is obstructive for APNs and their collaborating physicians. Access to care will be threatened by this small ratio and by the definition of "good cause" for a waiver, and by the undefined process to apply for a waiver. We recommend elimination of the ratio.
2) Section 21.283, mandates a specific 45-hour pharmacology course to apply for prescriptive authority in this state. We would recommend defining the advanced pharmacology hours to include 45 hours or its equivalent in total rather than 45 hours in one course. This will minimize lost time from work for APNs. The ability for the APNs to prescribe will greatly enhance the flow dynamic of our clinic. It would prevent delays for the patients in obtaining needed medications when I am not available.

I recommend that APNs be allowed to prescribe unclassified therapeutic agents, medical devices and pharmaceutical aids. In our practice we see many breast and colon cancer patients requiring breast prostheses, compression sleeves

for lymphedema and ostomy supplies. This would allow the APNs to better serve our patients.

The clause that the physician is to be responsible is paternalistic. The person dispensing the drug is responsible.

I know that the APNs I work with will be responsible when prescribing and remain current with pharmacology. Working in collaboration with an advanced practice nurse has been very rewarding and will continue to be so in a more efficient way with implementation of the above recommendations. Our APNs are an asset to our practice and the above recommendations will help the APNs and our practice meet the more demanding needs of patients in today's society.

Thank you for the work you have done toward Advanced Practice Nursing. I will point out that this agreement is a step backward not forward for collaborating teams unless the above recommendations are considered. The solution is to allow the Board of Nursing to regulate Advanced Practice Nursing independently of and without fear of interference by the Board of Medicine, permitting APNs their full scope of practice. We are anxious for the political matters to be resolved so that we may practice sound quality patient care in a rational manner. We will all then be able to fully realize the strengths brought from a collaborative Physician/Advanced Practice Nurse relationship. Thank you for your time.

Sincerely,

Chao Huang
Assistant Professor of Medicine
Fox Chase/Temple University Cancer Center

CC: Representative Mario Civera, Chair
Professional Licensure Committee
House of Representatives
PO Box 202020
Harrisburg, PA 17120 – 2020

717-783-2664

THE TEMPLE UNIVERSITY CANCER CENTER

FAX TRANSMITTAL

FAX # 215-707-1668

TO: Robert Nyce, Executive Director IRRC

FROM: Dr. Joseph Treat, Dr. Nevena Danjanovic, Dr. Chao Huang

DATE: 6-13-00

NUMBER OF PAGES TO FOLLOW: 6

NOTES: re: Prescriptive Rey for CRNPs

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2000 JUN 13 PM 4:16
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MILLERSVILLE
UNIVERSITY

P.O. Box 1002, Millersville PA 17551-0302

Department of Nursing
(717) 872-3410
FAX: (717) 872-3985

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Commission
333 Market St., 14th Floor
Harrisburg, PA 17101

Original: 2064

June 5, 2000

Dear Mr. Nyce,

I am writing to you with regard to regulations proposed by the Boards of Medicine and Nursing concerning prescriptive privileges for Certified Registered Nurse Practitioners (CRNP's). I am pleased the Boards have addressed the issue, but I do have concerns about the proposed regulations.

I believe the requirement of a 45- hour course in "Advanced Pharmacology" is unnecessarily restrictive. Many practicing CRNP's completed educational programs in which advanced pharmacology was integrated through their courses and not taught as a separate course. This new requirement would prohibit them from prescribing until they could complete such a course. I request that the proposed regulations be changed to allow a sum total of 45 hours of Advanced Pharmacology instead.

Additionally, I request that the Boards follow the language of the American Hospital Formulary to list each and every category in the book. The missing categories must be inserted as drugs CRNP's can prescribe. These categories are "eye, ear, nose, and throat preparations; hormones and synthetic substitutes; oxytocics; unclassified therapeutic agents; medical devices; pharmaceutical aids".

The restriction that limits a collaborating physician to working with only two CRNP's is a concern for providers in a variety of settings. This may very well have a serious negative effect on access to care. In other states such limitations are not common and of those that have a ratio the ratios are much more reasonable, e.g. 1: 5 or 6.

The March 30, 2000 version of the proposed regulations shifts the authority for CRNP acts of medical prescription to the collaborating physician and expands the categories of medications that must be specifically listed in the collaborative agreement from 5 to 21. Although CRNP's have an excellent track record in terms of error free prescription writing, these changes could result in a serious and costly liability issues for a collaborating physician. I beg you to review this section carefully and return the regulatory authority to the Boards.

Overall I am pleased with the intent of these proposed regulations. I know that CRNP's provide essential access to health care in the Commonwealth. Please be certain the regulations, when adopted in final form, assure on-going quality access for the patients whom CRNP's serve.

Sincerely,

Barbara F. Haus

Barbara F. Haus, EdD, CRNP, CS, CPNP
Associate Professor and Graduate Programs Coordinator

CC: Governor Ridge
Senator Clarence Bell
Representative Mario Civera
S. Anderson, Chairperson, SBON

Temple University Hospital
Temple University Health System
Cancer Cent
3322 N. Broad Street
Philadelphia, PA 19140-5189
Tel: (215) 707-40

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Commission
333 Market Street 14th Floor
Harrisburg, PA 17101

Original: 2064

June 5, 2000

Dear Mr. Nyce,

We are oncologists who work with advanced practice nurses (APNs) at Fox Chase - Temple University Cancer Center in Philadelphia, PA. We are writing regarding the recently promulgated joint regulations by the state Boards of Medicine and Nursing for Advanced Practice Nursing. We feel that the agreement will discourage physicians from forming collaborative practices with APNs. The nature of collaboration is the combination of strengths of independent individuals working together toward a common goal. Our goal is to provide good, quality care for our patients and these proposed regulations would make the collaborative nature of our goal difficult to achieve.

We have several concerns with the joint regulations:

1) Section 21.287: No physician may serve as collaborating physician for more than 2 nurse practitioners and only a physician may apply for a waiver. This is obstructive for APNs and their collaborating physicians. Access to care will be threatened by this small ratio and by the definition of "good cause" for a waiver, and by the undefined process to apply for a waiver. We recommend elimination of the ratio.
2) Section 21.283, mandates a specific 45-hour pharmacology course to apply for prescriptive authority in this state. We would recommend defining the advanced pharmacology hours to include 45 hours or its equivalent in total rather than 45 hours in one course. This will minimize lost time from work for APNs. The ability for the APNs to prescribe will greatly enhance the flow dynamic of our clinic. It would prevent delays for the patients in obtaining needed medications when we are not available.

We feel that setting a pharmacology requirement unfairly hinders experienced nurse practitioners. If the American Hospital Formulary Service Pharmacologic – Therapeutic Classification is to be used then it should be used without deletion or

adjustment. The limits on Schedule II – V drugs on refills and duration of use is not warranted.

We are oncologists and we constantly manage the pain of our patients. The APNs in our office oversee their management, making sure patients know what they are taking, that they are taking the right dose at the right times, and adjusting the dose and frequency as indicated. The pharmacology requirement will hamper patient care and comfort.

We also recommend that APNs be allowed to prescribe unclassified therapeutic agents, medical devices and pharmaceutical aids. In our practice we see many breast and colon cancer patients requiring breast prostheses, compression sleeves for lymphedema and ostomy supplies. This would allow the APNs to better serve our patients.

The clause that the physician is to be responsible is paternalistic. The person dispensing the drug is responsible. Also the section about the physician attesting knowledge about drugs ordered should be dropped.

We know that the APNs we work with will be responsible when prescribing and remain current with pharmacology. Working in collaboration with an advanced practice nurse has been very rewarding and will continue to be so in a more efficient way with implementation of the above recommendations. Our APNs are an asset to our practice and the above recommendations will help the APNs and our practice meet the more demanding needs of patients in today's society.

Thank you for the work you have done toward Advanced Practice Nursing. We will point out that this agreement is a step backward not forward for collaborating teams unless the above recommendations are considered. The solution is to allow the Board of Nursing to regulate Advanced Practice Nursing independently of and without fear of interference by the Board of Medicine, permitting APNs their full scope of practice. We are anxious for the political matters to be resolved so that we may practice sound quality patient care in a rational manner. We will all then be able to fully realize the strengths brought from a collaborative Physician/Advanced Practice Nurse relationship. Thank you for your time.

Sincerely,

Joseph Treat, M.D.
Vice Chairman Department of
Medical Oncology
Fox Chase/Temple University Cancer
Center
Medical Director, Temple University Cancer
Center

Nevena Damjanov, M.D.
Assistant Professor of Medicine
Fox Chase/Temple University Cancer
Center

CC: Representative Mario Civera, Chair
Professional Licensure Committee
House of Representatives
PO Box 202020
Harrisburg, PA 17120 – 2020

Senator Clarence Bell, Chair
Consumer Protection and Professional Licensure Committee
Senate Box 203009

717-783-2664

THE TEMPLE UNIVERSITY CANCER CENTER

FAX TRANSMITTAL

FAX # 215-707-1668

TO: Robert Nyce, Executive Director IRRC

FROM: Dr. Joseph Deati, Dr. Nevena Danjanovi, Dr. Chao Huang

DATE: 6-13-00

NUMBER OF PAGES TO FOLLOW: 6

NOTES: re: Prescriptive Rey for CRNPs

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June 2, 2000

Mr. Robert Nyce,Executive Director
IRCC
333 Market St., 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce:

Original: 2064

I am a Family Nurse Practitioner with over 20 years experience. I am writing to express my grave concern over the recently approved CRNP regulations as they stand. As written, these regulations will have A negative impact on access to care for Pennsylvania's citizens.While the original intent of the revised regs was to clarify prescriptive authority for Nurse Practitioners, the new regs erect new barriers to NP practice in the following ways:

1. Section 21.283 requires a specific 45 hour pharmacology course. Additionally, 16 hours are required every 2 years. Many experienced NP's such as myself graduated from programs where the pharmacology component was integrated throughout the curriculum rather than a specific 45-hour course. Additionally, many of us have earned the equivalent (or in my case exceeded-I have over 60 hours cummulative pharmacology credit in addition to my advanced curriculum) of this requirement. By allowing this specific requirement to stand as is rather than allowing a summation of credits, the most experienced NP's who have been prescribing safely for many years will be excluded from prescribing, while new grads with no experience will be permitted to prescribe. I am recommending that the language be adjusted to allow a 45 hour course or its equivalent.

2. Section 21.283 requires 16 hours of pharmacology continuing education every 2 years. While recognizing that this is important, this number of hours is excessive and will require many NP's to obtain these hours to the exclusion of more comprehensive clinical continuing education. I am recommending that the strictly pharmacology hours required be reduced to 6-8 every 2 years.

3. Section 21.287 states that a physician may not serve as supervisor to more that 2 NP's. Only a physician may apply for a waiver. This is a substantive change from the original regs published in October, and a worrisome one as there is no rationale to support it. Many NP's work in clinics or nurse managed centers serving vulnerable populations. This requirement seriously disadvantages these centers and their ability to provide much needed care. No other state has such a restrictive requirement. Additionally, I fail to see what this has to do with prescribing. The requirement should be removed.

Please do not approve these regs as they stand. Nurse practitioners have been providing safe, high quality care to our citizens for over 30 years. As written, access to care for many will be threatened. Thank you for your consideration of my concerns.

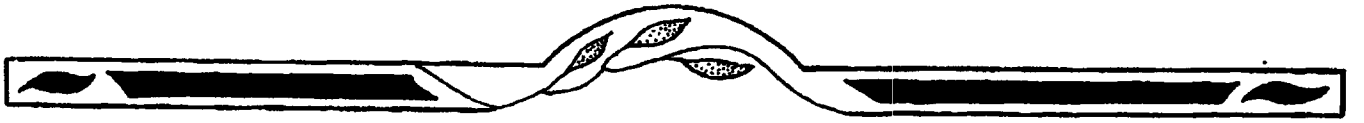
Sincerely,

Rana A. Colaianni, CRNP, CS

cc-see attatched

Representative Mario Civera, Chair
Professional Licensure Committee
House of Representatives
P.O. Box 202020
Harrisburg, PA 17120-2020

Senator Clarence Bell, Chair
Consumer Protection & Professional Licensure Committee
Senate Box 203009
Harrisburg, PA 17120



Loyalsock Family Practice

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David N. Ambrose, M.D.
Elizabeth E. Anderson, M.D.

"personalized family healthcare"

Rana A. Colaianni, CRNP
Barbara E. Hemmendinger, ACSW
Angela N. Haas, M.D.

Fax Transmittal Cover Sheet

Loyalsock Family Practice phone number- (570) 322-3141
Fax number- (570) 322-0135

Deliver Fax To: MR. NYCE, IRCC

Number of Pages: 3 (include cover sheet)

Fax From: R. A. COLAIANNI, CRNP

Message:

June 2, 2000

Mr. Robert Nyce,Executive Dirrector
IRCC
333 Market St., 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce:

Original: 2064

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2. Section 21.283 requires 16 hours of pharmacology continuing education every 2 years. While recognizing that this is important, this number of hours is excessive and will require many NP's to obtain these hours to the exclusion of more comprehensive clinical continuing education. I am recommending that the strictly pharmacology hours required be reduced to 6-8 every 2 years.

3. Section 21.287 states that a physician may not serve as supervisor to more that 2 NP's. Only a physician may apply for a waiver. This is a substantive change from the original regs published in October, and a worrisome one as there is no rationale to support it. Many NP's work in clinics or nurse managed centers serving vulnerable populations. This requirement seriously disadvantages these centers and their ability to provide much needed care. No other state has such a restrictive requirement. Additionally, I fail to see what this has to do with prescribing. The requirement should be removed.

Please do not approve these regs as they stand. Nurse practitioners have been providing safe, high quality care to our citizens for over 30 years. As written, access to care for many will be threatened. Thank you for your consideration of my concerns.

Sincerely,

Rana A. Colaianni, CRNP, CS

cc-see attatched

Representative Mario Civera, Chair
Professional Licensure Committee
House of Representatives
P.O. Box 202020
Harrisburg, PA 17120-2020

Senator Clarence Bell, Chair
Consumer Protection & Professional Licensure Committee
Senate Box 203009
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Rana A. Colaianni, CRNP, CS

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P.O. Box 202020
Harrisburg, PA 17120-2020

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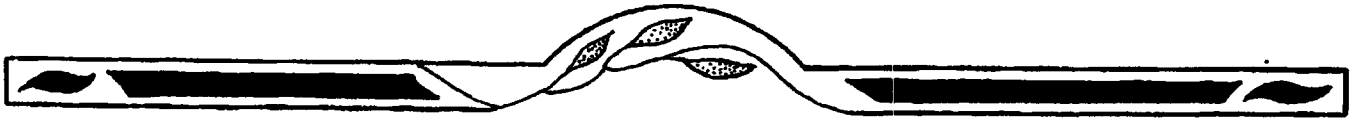

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