Pennsylvania Podiatric Medical Association

November 1, 1999

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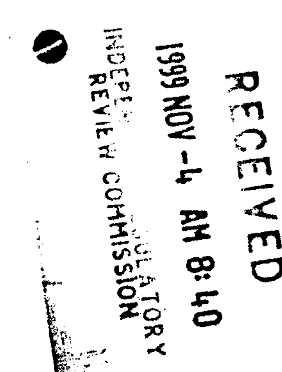

Ms. Cindy Warner
Health Licensing Division
Bureau of Professional and Occupational Affairs
P.O. Box 2649
Harrisburg, PA 17105-2649

IN RE: CRNP Prescriptive Authority

Dear Ms. Warner,

I am writing this letter in order to comment on the proposed regulations that would affect the ability of Certified Registered Nurse Practitioners to extend the prescriptive and dispensing rights under the Laws and Regulations of the Commonwealth. I reference the publication at Pennsylvania Bulletin Volume 29, Number 40, Page101, et seq. These proposals affect Chapter 18, and Chapter 21 of the Pennsylvania Code, governing the State Board of Medicine, and the State Board of Nursing respectively.

The Pennsylvania Podiatric Medical Association represents over eighty percent of the Doctors of Podiatric Medicine who are licensed to practice within the Commonwealth. The scope of practice that a Doctor of Podiatric Medicine operates within will, by definition, prevent any great intersection of interest between the CRNP and the DPM as it relates to patient care; however, I wish to point out a number of issues that cause concern in the proposal:

1. The role of the treating physician and the CRNP is "presumed" in the proposed regulation, and not explicitly required under the proposed regulation. The proposal should require a collaborating agreement with a physician or podiatrist.
2. The proposal presumes that the CRNP is in the midst of a relationship with the patient. There is no issue relating to the History and Physical of the patient, which should be mandated to be taken or reviewed prior to any prescription being issued. Pharmacology courses alone do not invest the CRNP with the depth of knowledge necessary to medically treat a patient in the manner in which that term is used in the licensing acts.
3. The structure of the proposed regulations are "parallel" in nature with one set affecting the terms of Chapter 18, under the Board of Medicine, and one affecting the

757 Poplar Church Road • Camp Hill Pennsylvania • 17011
Phone 717-763-7665 • Fax 717-761-4091

terms of Chapter 21 under the Board of Nursing. It is unclear, given that power within the Board of Nursing, as to whether that Board alone could amend the future regulations, or whether any future regulations must continue to be made in parallel with the two boards.

4. The structure of the proposed regulation indicates a type of regulatorily approved game of "Go Fish" when it proposes that a physician that learns that a CPNR is "prescribing or dispensing a drug inappropriately."... may take action. This indicates that the Commonwealth is authorizing a system through which it is assumed that some inappropriate activity is going to take place, and then it is placing the physician in the position of being the party whose responsibility it is to remedy the situation. It is respectfully submitted that this situation only arises because the CPNR is allowed to practice independently. This should be avoided.
5. To the extent that these regulations allow the CRNP a license to prescribe and dispense "without limitation" (regulatory wording), the CRNP is then in a position of independently practicing medicine. This is not a result that is contemplated by any statute that relates to the medical, podiatric or nursing profession.
6. The proposed regulations now make the CRNP the "captain of the ship" for at least a portion of the time within which the patient is in the care of the treating physician or podiatrist. For that time, and for those events, the treating physician or podiatrist remains professionally liable to the patient. It is respectfully submitted that the proposed regulations now place the CRNP squarely within that group of persons that should participate in the Medical Catastrophe Fund. The "risk" of the fund, which our members jointly and severally underwrite with every licensed physician in the Commonwealth, will be increased through the direct actions of the CRNP, and it is only fair that any licensee who increases the risk be required to participate in the joint liability. This is a legislative matter that should be addressed BEFORE the regulations granting the ability to practice medicine independently are passed.

It is our request that the proposal be withdrawn until these important regulatory and statutory issues are addressed.

Very truly yours,

Michael Q. Davis
Executive Director

Cc: State Board of Nursing
Independent Regulatory Review Commission
Chair, Professional Licensure Committee, PA House of Representatives
Chair, Consumer Protection & Professional Licensure Committee, PA Senate

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Brian J. Tiboni
Lobbying Consultants

Carl Gainor, Esquire
Legal Counsel

Carmen A. DiCello, R.Ph.
Executive Director and Director of Education

PENNSYLVANIA PHARMACISTS ASSOCIATION

508 NORTH THIRD STREET / HARRISBURG, PENNSYLVANIA 17101-1199
TELEPHONE: 717-234-6151 FAX: 717-236-1618
E-Mail Address: ppa@papharmacists.com WebsiteAddress: www.papharmacists.com

November 4, 1999

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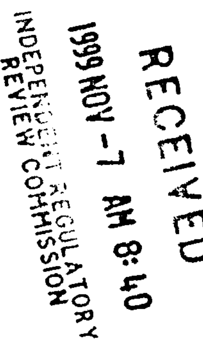

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Commission
Harristown II
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce:

The Pennsylvania Pharmacists Association which represents over 3000 pharmacists in Pennsylvania consisting of the Academy of Chain Pharmacists, Academy of Community Pharmacists, Academy of Health System Pharmacists, Academy of Long Term Care and Consultant Pharmacists, Academy of Pharmacy Industry Associates, Academy of Students of Pharmacy and Academy of Certified Pharmacy Technicians oppose the proposed rulemaking by the State Boards of Medicine and Nursing which would authorize certified registered nurse practitioners (CRNPs) to prescribe and dispense legend prescription drugs as such rulemaking was published in the October 2, 1999 issue of the *Pennsylvania Bulletin.*

Our opposition is based on the following considerations:

1) The provisions of the Medical Practice Act and Professional Nursing Law authorizing the proposed regulations are limited to "acts of diagnosis and prescription of medical, therapeutic or corrective measurers." The provisions do not extend to the dispensing of prescriptions which has heretofore been an act limited to licensed prescribers (with limitations) and to pharmacists. The proposed regulations authorize CRNPs to prescribe and dispense drugs without limitation.

2) The education requirements for CRNPs to prescribe and dispense legend prescription drugs are to include "a core course in advanced pharmacology." How is this limited training or study capable of preparing a CRNP to perform functions which a licensed pharmacist must spend five or six years of education and training in order to become similarly qualified?

3) As stated in the introductory comments to the proposed regulations, among the states authorizing prescriptive authority to CRNPs, 32 require prescriptive activities under a collaborative practice arrangement with a physician, 13 permit prescriptive authority for non-controlled substances and 27 allow for prescription of controlled substances with "varying degrees of regulation or limitation." Although the statement itself is confusing and might lead one to assume that there are 72 state jurisdictions where CRNPs are authorized to prescribe, the compelling conclusion is that the

4) Pennsylvania regulations which propose prescription and dispensing by CRNPs without limitation (other than the expansive list of categories of drugs which may be prescribed or dispensed), would give Pennsylvania the dubious distinction of allowing its CRNPs prescriptive and dispensing privileges the scope of which would be the most expansive in any of the states now authorizing such activities.

In today's rapidly changing health care delivery environment, PACDS and other organizations of health care providers recognize the need for qualified practitioners to assume expanded responsibilities in patient care. We believe that pharmacists, for example, are capable of limited prescriptive activities but only if they have received special training and work in direct collaboration with a licensed physician.

These proposed regulations for prescriptive and dispensing activities by CRNPs fail to provide adequate parameters in both necessary training and in supervision or collaboration to ensure a level of quality care to which patients are entitled.

Sincerely,

Carmen A. DiCello, R. Ph.
Executive Director

CAD/TKL

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1999 NOV -1 AM 10:04
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Ralph E. Progar
Vice President of Pharmacy Relations

November 1, 1999

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Mr. Robert Nyce
Executive Director
Independent Regulatory Review Commission
Harristown 2
333 Market Street, 14th Floor
Harrisburg, Pennsylvania 17101

RE: Certified Registered Nurse Practitioners: Prescriptive Authority
***Pennsylvania Bulletin*, October 2, 1999**

Dear Mr. Nyce:

As the Vice President of Pharmacy Relations for Eckerd Corporation (355 pharmacies and over 6,500 associates serving the pharmacy needs of the citizens of this Commonwealth), and a former member of the Board of Pharmacy, I must respectfully oppose the intention of the State Boards of Medicine and Nursing to jointly promulgate regulations permitting Certified Registered Nurse Practitioners (CRNP's) to dispense prescription medications.

It is my strong opinion that the "dispensing" provision noted in *Pennsylvania Bulletin* Vol. 29, No. 40, Pages 5101-5104 should be deleted. I offer the following:

1. *Medical Practice Act* - 422.15 (b) Even in the broadest interpretation, this statutory language does not authorize the dispensing of prescription medications by a CRNP.

2. Reference Section 8 (2) Unlawful Acts of the Pharmacy Practice Act, which prohibits "any person not duly licensed as a pharmacist to engage in the practice of pharmacy including the ... dispensing ... to any person any drug ...", but it permits "a duly licensed medical practitioner to dispense ... any drug to his own patients ... if such dispensing is done by said licensee himself". This provision does not allow for delegation of dispensing to medical staff or in the case of the *Register Notice*, to a CRNP.

3. If a CRNP is permitted to "prescribe and dispense" drugs, there will be no checks and balances to prevent errors and drug interactions. Drug Utilization Review and Patient Counseling will also be negatively effected.

Address: 615 Alpha Drive, Pittsburgh, PA 15238
Phone: 412.967.8735 Fax: 412.967.8609

4. How will the CRNP dispense drugs? Will they stock their car or their office with a complete mix of prescription drugs, vials, labels, etc.? How will these be ordered, maintained and stored? Will they have a license to order controlled drugs? Will this become an opportunity for diversion? Who will inspect their pharmaceutical stock to insure quality? What will be stocked? Will the patient get what is stocked or what is needed?

5. The Medical Society was opposed to Collaborative Agreements for pharmacists (five - six years of education) to manage drug therapy, but the Board of Medicine intends to give the same responsibility to a professional who "has completed a course of study of at least one academic year ...". Consistency should be a strong consideration here. If CRNP's can dispense, then pharmacists should be allowed to manage drug therapy regimens through the same Collaborative Care Agreements.

Call me at ◆ 412/967-8735 if more information or comment is needed.

Sincerely,

Ralph E. Progar, R.Ph.
Vice President of Pharmacy Relations

REP/dm

CC: PA Board of Pharmacy
PACDS
PPA

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

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October 29, 1999

Ms. Cindy Warner
Health Licensing Division
Bureau of Professional and Occupational Affairs
P.O. Box 2649
Harrisburg, PA 17105-2649

RE: CRNP Prescriptive Authority

Dear Ms. Warner:

The Hospital & Healthsystem Association of Pennsylvania (HAP), on behalf of its members (more than 225 acute and specialty hospitals and health systems in the commonwealth), appreciates the opportunity to comment on the State Board of Medicine's and State Board of Nursing's jointly developed and proposed regulations dealing with Certified Registered Nurse Practitioner (CRNP) prescriptive authority. HAP commends both Boards' efforts and commitment to develop regulations addressing CRNP prescriptive authority as enabled in the Medical and Nursing Practice Acts since 1974. HAP offers the following comments as a means of ensuring regulatory clarity in guaranteeing that these regulations provide sufficient public accountability for quality health care.

<u>Elimination of Unnecessary Provisions from Stakeholder Draft Regulations</u>

HAP applauds the Board of Nursing and Board of Medicine for streamlining the proposed regulations by eliminating a number of provisions that were originally included in the set of draft regulations released for stakeholder comment by both boards in the summer of 1998. Specifically, the sections that were dropped from the draft circulated for stakeholder comment are: §18.53 (§21.283). Role of the CRNP; §18.54 (§21.284). Relaying medical regimens; §18.55 (§21.285) CRNP identification; §18.56 (§21.286). Responsibilities of the collaborating physician; §18.57 (§21.287) Registration as collaborating physician regarding prescriptive authority; §18.58 (§21.288) Collaborative agreements regarding prescriptive authority; and §18.59 (§21.289) Biennial renewal of CRNP prescriptive and dispensing authority. We believe that these changes improve the regulations.

4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax

HAP believes that the relationship between a CRNP and a physician licensed to practice medicine in Pennsylvania is already addressed in §18.21. definitions, in the definition of a CRNP and in the definition of direction. The CRNP definition clearly states that, "A CRNP is a registered nurse who while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures ***in collaboration with and under the direction*** of a physician licensed to practice medicine in this Commonwealth." Within this same section is a definition of direction that requires the "incorporation of physician supervision to the certified registered nurse practitioner's performance of medical acts," which includes such things as ensuring that a physician is available to the CRNP for consultation/referral, establishing and updating standing orders and drug and other medical protocols within the practice setting, periodic updating in medical diagnosis and therapeutics and the cosigning of records when necessary to document the accountability by both the physician and the CRNP.

Therefore, HAP believes that many of the requirements that were included in the draft (see sections named above) released for stakeholder comment were unnecessary given the definitions that already exist in the Board of Nursing and Board of Medicine regulations.

In addition, HAP also would argue that both Boards already have the authority to review a collaborative agreement whenever they believe that the practice of a CRNP endangers the safety or welfare of a Pennsylvania citizen.

Collaborative Agreement

However, to assure public accountability, HAP would recommend that collaborative agreement be defined in §18.21 (§21.251), particularly since the regulations reference a collaborative agreement in the proposed regulation in §18.54 (§21.284) (c). We also believe that this will strengthen the understanding and appreciation of these regulations. HAP would suggest the following change in §18.21 (§21.251).

Collaborative Agreement - A signed written agreement between a CRNP and a collaborating physician(s) in which they agree to the details of the collaborative relationship. Elements identified under the definition of Collaboration and Direction should be addressed in the collaborative agreement.

CRNP Prescription of Medications without Limitation

HAP agrees with the drugs that are listed in this subsection, §18.54 (§21.284) (b), that defines those drug categories that CRNPs may prescribe and dispense without limitation, unless the drug is specifically limited or excluded under other subsections in the regulations. This list mirrors the list of drugs that physician assistants may prescribe or dispense without limitation with the exception of endocrine replacement agents and hypoglycemic agents. HAP believes that given the additional education and preparation of CRNPs, it is entirely appropriate to include these two additional classifications of drugs in this subsection. HAP also would recommend adding hyperglycemic agents (insulin, glucophage, rezulin, etc.) to this list since primary care of elderly patients with diabetes is a common group of patients that are seen and treated by CRNPs.

CRNP Prescription of Medications within the Context of a Collaborative Agreement

Again, HAP has no disagreement with the drugs listed in this subsection, §18.54 (§21.284) (c), if such authorization were identified in the collaborative agreement with the collaborating physician. To assure clarity, HAP would suggest that 18.54 (c) be changed to read as follows:

A CRNP may prescribe and dispense a drug from the following categories if [that authorization is documented in the collaborative agreement] the collaborating agreement specifically includes those categories of drugs.

Prescription of Medications Reserved Exclusively for Physicians

In comparing subsection § 18.54 (§21.284)(d) with the existing physician assistant regulations, there are a number of drug categories that have not been included in any of the previous subsections of the CRNP proposed regulations or in this subsection. HAP offers the following comments for consideration by both Boards:

- **Dental agents** - HAP believes that CRNPs, particularly those in pediatric practice, should have the authority to prescribe and/or dispense fluoride treatments/supplements for children. HAP recommends that this be addressed in the regulations.

- **Oxytocics** - The prescription of oxytocics is not addressed in the CRNP regulations, but should probably be listed in §18.54 (§21.284) (d). It is highly unlikely that a CRNP would prescribe or dispense this drug given the type of patient eligible for the receipt of this classification drug and the fact that this medication is most likely administered in hospitals. We believe, however, it should be clear that this drug can only be prescribed by a physician.

- **Pharmaceutical Aids and Medical Devices** - HAP questions whether prescription of pharmaceutical aids and medical devices needs to be explicitly stated in the regulations. It is unclear whether these classifications only apply to those medications that are listed in the American Hospital Formulary Service Pharmacologic-Therapeutic Classification under pharmaceutical aids and medical devices or to those items that are traditionally thought of as medical devices and pharmaceutical aids. HAP requests that the Boards clarify why these formulary drug categories were specifically omitted from the CRNP regulations. Finally, HAP requests that the Boards clarify whether it would be appropriate for CRNPs to prescribe and/or dispense devices that promote mobility such as canes, walkers or crutches; devices that immobilize body parts such as splints or slings; or aids that are necessary to administer or enhance the delivery of medication such as pumps, syringes and metered dose inhalers.

HAP also would suggest that §18.54 (§21.284) (d) be amended to include total parenteral nutrition, lipids and agents used as part of experimental treatment. Prescribing or dispensing of these agents should be reserved for physicians.

<u>Omission of Medications and/or Drug Categories</u>

The Boards did not address the prescription of blood products, blood derivatives or intravenous solutions listed in the proposed CRNP regulations. HAP is unclear as to how this should be interpreted by physicians and CRNPs when a specific item is not addressed in the regulations. HAP requests that the Boards clarify what it means to the practice of CRNPs and physicians when a certain drug or classification of drugs is not specifically addressed in the regulations.

<u>General Restrictions on Prescription of Medications by a CRNP</u>

Again in comparing this subsection, §18.54 (§21.284) (g), with a similar subsection in physician assistant regulations, it appears that certain generic restrictions around the prescribing and dispensing of medications were omitted in the CRNP proposed regulations. There are certain provisions in the physician assistant regulations that would also seem appropriate to include in the CRNP regulations for purposes of regulatory clarity. These include the following:

The practitioner may not: (1) prescribe or dispense a pure form or combination of drugs listed unless the drug or class of drug is listed as permissible for prescription or dispension; (2) prescribe or dispense a generic or branded preparation of a drug that has not been approved by the Food and Drug Administration; (3) compound ingredients when dispensing a drug, except for adding water; and (4) issue a prescription for more than a 30-day supply, except in cases of chronic illness where a 90-day supply may be prescribed.

HAP recommends that the Boards add further clarity to §18.54 (§21.284) (g) (3) to indicate that the a CRNP <u>shall not</u> delegate prescriptive authority to another CRNP not covered under the collaborative agreement or to any other health care provider.

In summary, HAP remains confident that both Boards can reach agreement on the CRNP prescriptive authority regulations to bring resolution to this issue. It is evident that the prescription of medications can be done safely and effectively by CRNPs, as demonstrated in 42 other states across the country. CRNPs should be able to fully utilize their skills, consistent with their practice act and these regulations, to serve and treat the citizens in the Commonwealth. HAP urges the Boards to consider our comments as they move forward in firmly establishing prescriptive authority regulations for CRNPs.

Again, thank you for the opportunity to comment on these regulations. If you should have any questions, please feel free to contact Lynn Gurski-Leighton, Director, Clinical Services, HAP at 717-561-5308 or by email at lgleighton@hap2000.org.

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President
Policy and Regulatory Services

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA
4750 Lindle Road
PO Box 8600
Harrisburg, PA 17105-8600
(717) 561-5326 Phone
(717) 561-5334 Fax
btaylor@hap2000.org

FAX TRANSMISSION

6 *page(s), including cover sheet*

TO: Jim Smith, IRRC

FAX: 783-2664

FROM: Betsy H. Taylor

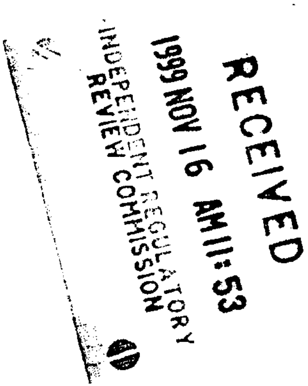
DATE: November 16, 1999

SUBJECT: HAP's Comments on the CRNP Regulations

MESSAGE: Jim: Attached are HAP's comments on the CRNP regulations which we submitted to Cindy Warner. Sorry I didn't get a copy to you directly.

If you have any questions, let me know!

Betsy



PACDS
PENNSYLVANIA ASSOCIATION OF CHAIN DRUG STORES, INC.
SUITE 300
717 NORTH SECOND STREET
HARRISBURG, PA 17102
PHONE: (717) 238-1222
FAX: (717) 238-9512

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November 1, 1999

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

Dear Mr. Nyce:

On behalf of the Pennsylvania Association of Chain Drug Stores (PACDS) whose member firms operate more than 1,500 community retail pharmacies in Pennsylvania, we herein express our ***strong opposition*** to proposed rulemaking by the State Boards of Medicine and Nursing which would authorize certified registered nurse practitioners (CRNPs) to ***prescribe*** and ***dispense*** legend prescription drugs as such rulemaking was published in October 2, 1999 issue of the ***Pennsylvania Bulletin***.

Our opposition is based on the following considerations:

1) The provisions of the Medical Practice Act and Professional Nursing Law authorizing the proposed regulations are limited to "acts of diagnosis and prescription of medical, therapeutic or corrective measures." The provisions do not extend to the dispensing of prescriptions which has heretofore been an act limited to licensed prescribers (with limitations) and to pharmacists. The proposed regulations authorize CRNPs to prescribe ***and*** dispense drugs ***without limitation***.

2) The education requirements for CRNPs to prescribe and dispense legend prescription drugs are to include "a core course in advanced pharmacology." How is this limited training or study capable of preparing a CRNP to perform functions which a licensed pharmacist must spend five or six years of education and training in order to become similarly qualified?

3) As stated in the introductory comments to the proposed regulations, among the states authorizing prescriptive authority to CRNPs, 32 require prescriptive activities under a collaborative practice arrangement with a physician, 13 permit prescriptive

authority for non-controlled substances and 27 allow for prescription of controlled substances with "varying degrees of regulation or limitation." Although the statement itself is confusing and might lead one to assume that there are 72 state jurisdictions where CRNPs are authorized to prescribe, the compelling conclusion is that the Pennsylvania regulations which propose prescription and dispensing by CRNPs ***without limitation*** (other than the expansive list of categories of drugs which may be prescribed or dispensed), would give Pennsylvania the dubious distinction of allowing its CRNPs prescriptive and dispensing privileges the scope of which would be **the most expansive** in any of the states now authorizing such activities.

In today's rapidly changing health care delivery environment, PACDS and other organizations of health care providers recognize the need for qualified practitioners to assume expanded responsibilities in patient care. We believe that pharmacists, for example, are capable of limited prescriptive activities but only if they have received special training and work in direct collaboration with a licensed physician.

These proposed regulations for prescriptive and dispensing activities by CRNPs fail to provide adequate parameters in both necessary training and in supervision or collaboration to ensure a level of quality care to which patients are entitled.

Sincerely,

Bruce E. Johnson
Executive Director

pc: PACDS Board of Directors

Pennsylvania Psychiatric Society

The Pennsylvania District Branch of the American Psychiatric Association

Oct. 29, 1999

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Cindy Warner
Health Licensing Division
Bureau of Professional and Occupational Affairs
P. O. Box 2649
Harrisburg, PA 17105-2649

Dear Ms. Warner:

I am writing as President of the Pennsylvania Psychiatric Society to comment on the regulations proposed by the State Board of Medicine and the State Board of Nursing, as published in the October 2, 1999 (Vol. 28, No. 40) issue of *Pennsylvania Bulletin*.

We believe that the proposed regulations adequately address some of the issues which concern our members, who are psychiatric physicians. In other areas, we believe that further detail is essential to clarify the prescribing CRNP's and the physician's roles, responsibilities, and limitations.

I. First, we believe it is imperative to clarify in the regulations that the prescribing of drugs which are listed in § 18.54 (b) is subject to the terms of § 18.21 and additional, related terms which we suggest as subsection (4) under § 18.53. The proposed regulation states that CRNPs may prescribe and dispense a long list of drugs "without limitation." Does this refer to the duration of time limits and refills? Does it mean that these drugs are prescribed outside the collaborative agreement, and are essentially exempt from the collaboration requirement? Does this mean that the nurse can prescribe any drug within the listed categories, giving the collaborating physician no voice in determining which particular drugs can be prescribed, or under what conditions?

We request that the term "without limitation" be deleted, and that the proposed regulations clarify that all drugs must be dispensed in the context of the collaborative agreement. To accomplish this, we suggest that the text of subsection (b) of § 18.54 be deleted, and that the list of drug categories contained in subsection (b) be included in what is now subsection (c). Such a change, of course, would require re-lettering of all the subsections in 18.54, as well as the re-numbering of the combined lists of drug types from (b) - 17 types - and (c) - 3 types.

§18.54 Prescribing and dispensing parameters

* * * *

(b) ~~A CRNP may prescribe and dispense a drug from the following categories without limitation (unless the drug is limited or excluded under other subsections). (c)~~ **A CRNP may prescribe and dispense a drug from the following categories if that authorization is documented in the collaborative agreement:**

(1) Antihistamines

(2) Anti-infective agents

* * * * * * * * * * * * * * * *

(17) Endocrine replacement agents.

~~(1)~~ **(18) Autonomic drugs.**

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Past President
Sheila Judge, MD

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Executive Director
Gwen Yackee Lehman
777 East Park Drive
P.O. Box 8820
Harrisburg, PA
17105-8820

(800) 422-2900
(717) 558-7750
FAX (717) 558-7845
E-mail glehman@pamedsoc.org
www.papsych.org

~~(2)~~ (19) Blood formation, coagulation and anticoagulation drugs, and thrombolytic and antithrombolytic agents.
~~(3)~~ (20) Central nervous system agents, except that the following drugs are excluded from this category:
(i) General anesthetics.
(ii) Monoamine oxidase inhibitors.
~~(4)~~ (21) Myotics and mydriatics.
~~(5)~~ (22) Antineoplastic agents originally prescribed by the collaborating physician and approved for ongoing therapy.
~~(d)~~ (c) A CRNP may not prescribe. . ..

The remaining lettered subsections would then have to be renumbered appropriately.

II. We also believe that the proposed regulations should be amended to provide much more detail about the nature of the collaboration between the prescribing CRNP and the physician. The existing regulations, at 49 § 18.21, contain a definition of "Certified Registered Nurse Practitioner" and "Direction" which, taken together, provide a good framework for the collaboration between a CRNP providing medical services and the collaborating physician. This section contains inadequate detail, however, for the regulation of prescription-related activities of the CRNP.

The regulations need to be amended, in § 18.53 (Prescribing and Dispensing Drugs) to specify that the collaborative agreement be in writing, so that both parties understand the responsibilities and protocols to which they have each agreed. A written agreement also allows a mechanism for ensuring that the agreement conforms to state law and regulation, including the regulations currently under consideration. In addition, § 18.53 needs to more specifically define the conditions which must be met in any collaborative agreement which includes the writing of prescriptions. We suggest the following amendments:

18.53 (4) The collaborative agreement between a CRNP and a physician authorizing the CRNP to prescribe and dispense drugs:
(i) shall be in writing
(ii) shall be available at the practice site and provided upon request to others, including, but not limited to, patients, other health care practitioners, professional licensing board investigators, and other regulatory and review agencies.
(iii) identifies, by name, the physician who serves as the collaborating physician. Physicians shall be limited to serving as the collaborative physician for no more than four CRNPs who prescribe.
(iv) provides the name of a substitute collaborating physician, who may serve in the collaborating physician's role for up to thirty days when the collaborating physician is not available.
(v) contains a list of the classes of medication from 18.54 that the collaborating physician authorizes for dispensing and prescribing by the CRNP. No collaborating physician may authorize a CRNP to dispense or prescribe any category of medication unless that collaborating physician has the expertise to prescribe that medication.
(vi) describes the circumstances under which the physician must see the patient.
(vii) establishes protocols for records review by the collaborating physician.

III. Third, although we recognize that the proposed regulations limit a CRNP's authority to prescribe a Schedule II drug, we believe a safer practice would be to restrict all Schedule II prescribing to physicians. These drugs are frequently abused, are frequently diverted for other purposes, have a high

street value, and are often dangerous in themselves. As psychiatrists, we are particularly concerned about the danger when the drugs are prescribed for a depressed or suicidal patient. We therefore suggest the elimination of current subsection (f) (1) of § 18.54, and adding a prohibition against prescribing Schedule II drugs in current subsection (g):

§ 18.54 (f) Restrictions on CRNP prescribing and dispensing practices are as follows:

~~(1) A CRNP may write for a Schedule II controlled substance for up to a 72-hour dose. The CRNP shall notify the collaborating physician immediately (within 24 hours).~~
~~(2)~~ (1) A CRNP may prescribe a Schedule III or IV. . .

* * * * * * * * * * * * * * * * * *

(g) A CRNP may not:

* * * * * * * * * * * * * * **

<u>(4) Prescribe or dispense a Schedule II drug.</u>

IV. In addition, we generally support the suggestions of the Pennsylvania Medical Society in its October 18 letter to the Bureau, and some of the amendments we suggest above adopt their language. We would specifically note our support for the following:

- We share the Medical Society's view that the regulations should contain a continuing education requirement specific to advanced pharmacology. Rapid changes in the number and types of pharmaceutical agents available, and the evolution of our understanding of various disease processes and their relation to those agents, make this an important requirement.

- We share the Medical Society's view that any CRNP who exercises prescriptive authority must include a core course in <u>advanced</u> pharmacology.

- We believe that CRNPs who prescribe should be required to carry malpractice insurance commensurate with their expanded scope of practice, conferred by the state, into areas of greater risk.

- We share the Medical Society's recommendations requiring CRNPs to notify the Board of Nursing regarding specific information within their collaborative agreements.

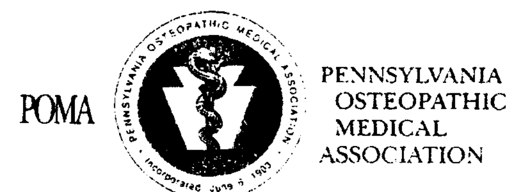
We appreciate the opportunity to comment on these regulations, and hope that both the Board of Nursing and the Board of Medicine will be responsive to our concerns. We believe that the existing and proposed regulations, with the important modifications we have suggested, will provide a workable standard for both physicians and CRNPs.

Sincerely yours,

Lee C. Miller, MD
President

cc: State Board of Nursing
Independent Regulatory Review Committee
Chair, Professional Licensure Committee, PA House of Representatives
Chair, Consumer Protection & Professional Licensure, PA Senate

gvt/CRNP Regs



PENNSYLVANIA
OSTEOPATHIC
MEDICAL
ASSOCIATION

717-939-9318
In Pa. 1-800-544-POMA
Fax 717-939-7255
e-mail poma@poma.org

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October 29, 1999

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REGULATORY REVIEW COMMISSION

Ms. Cindy Warner
Health Licensing Division
Bureau of Professional and Occupational Affairs
P.O. Box 2649
Harrisburg, PA 17105-2649

Dear Ms. Warner:

The Pennsylvania Osteopathic Medical Association (POMA) has reviewed the proposed regulations regarding Certified Registered Nurse Practitioner's (CRNP's) prescriptive authority and still strongly believe that CRNP's are to be under the jurisdiction of a physician.

Our concern is that the CRNP's are not adequately trained to practice independently with prescriptive authority. They are an invaluable asset to the overall medical care by their collaborative work under the jurisdiction of the physician.

In order not to be repetitious and for your perusal, we are attaching our testimony given on HB 50 which includes CRNP request for prescriptive authority.

If you have any questions or require additional information, please contact us.

Sincerely,

Leonard V. Limongelli, D.O.
Leonard V. Limongelli, D.O.
President

LVL/MEJL/dll

Enclosure

c: State Board of Nursing
Independent Regulatory Review Commission
Chair, Professional Licensure Committee, PA House of Representatives
Chair, Consumer Protection & Professional Licensure Committee, PA Senate

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TESTIMONY
FOR THE
HOUSE PROFESSIONAL LICENSURE COMMITTEE
ON
HOUSE BILL 50
PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION

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1999 NOV -1 AM 11:03
REVIEW COMMISSION REGULATORY

OCTOBER 27, 1999

Chairman Representative Civera, members of the Professional Licensure Committee.

My name is Dr. Ulana Klufas-Ryall, a board certified family physician practicing at the Industrial Resource Center in York, Pennsylvania.

With me is Dr. Ernest Gelb, a certified family physician practicing in West Pittston.

I received a BS degree in nursing from the State University of New York as well as a Masters in Nursing from Syracuse University and a Doctor of Osteopathic Medicine from the University of Osteopathic Medicine and Surgery, Des Moines, Iowa. I practiced as a Registered Nurse for 7 years prior to entering osteopathic medical school. I completed a 1 year rotating internship, a 1 year residency in emergency medicine and 2 years residency in family practice at Memorial Hospital in York. Upon completion of my family practice residency, I worked at Med York and thereafter joined the Industrial Resource Center. I also am a Family Practice Clinic faculty member teaching students, interns and family practice residents.

I arrived at the decision to enroll in a medical school after working as a clinical nurse specialist, functioning as a nurse practitioner (NP), at the time. I worked in New York state, where NP's do have prescription writing privileges, and a great deal of autonomy was allowed (to practice as an NP). What prompted my decision to pursue medicine was that I felt ill prepared to function as an independent practitioner, based on my nursing education.

To reiterate, my nursing background included 4 years of undergrad as well as 2 years of graduate education.

I am here today, representing the POMA and the osteopathic physicians in Pennsylvania. Thank you for giving me the opportunity to present and express our concerns regarding House Bill 50. This bill would give nurses independent practice rights without supervision of a physician.

As proposed, this legislation would indeed create a new category of nurses called "Advanced Practice Registered Nurses". This bill would have the Advanced Practice Registered Nurses (APRN) practice medicine without a license. They would have unsupervised authority to prescribe narcotics and other controlled substances, as well as the legal ability to diagnose, treat, and perform invasive procedures on people in the Commonwealth.

My extensive experience as a nurse cannot compare with the education received in medical school. Intensive studies and extensive clinical experience, in addition to my post graduate residency programs, have proven to me that if you want practice rights and want to practice medicine, one must attend and complete medical school and a residency program.

In lieu of extending my testimony, previous testimonies have demonstrated that a physician, prior to beginning practice independently, currently requires 3 to 7 years of residency following their completion of medical school.

It is not that we question the capability and dedication of nurses as Advanced Practice Registered Nurses (APRN's). They are valuable, essential links in the health care continuum. Because of their lack of training the APRN's qualifications and competency to pursue independent practices is what is brought into question.

In previous testimonies you have been presented with requirements to be met in order to become an APRN, which includes the Nurse Practitioner, Certified Nurse Midwife, Certified Nurse Anesthetist, and Clinical Nurse Specialist. These requirements are achieved after "basic nurse education" (two, three or four year programs) and involve nine months to 2 years of additional education.

A physician, for example, must complete 4 years of basic sciences (undergraduate) as well as 4 years of medical education, before even starting a residency program. In other words, APRN's complete at most 6 years, whereas physicians complete a minimum of 11 years.

How then, can APRN's understand and fully take advantage of a new radiograph imaging technique with no background in the physics of energy transmission? How can one understand and explain to the patient a new chemical therapy for cancer with no solid basic knowledge of cell biology and organic chemistry?

In the vast majority of states where APRN's have prescriptive rights and practice rights, they also have required physician supervision and limited formularies. This fact has not generally been expressed to the public here in Pennsylvania in the latest round of debates. The aforementioned studies, as well as others from the Public Health Service, National Health Service Corporation, and the Military Corp demonstrate that the most effective modules of practice involve physicians and nurses working together to improve quality care and outcome. There are no verifiable quality studies available to substantiate the opinion expressed that nurses give better quality, and more personal care than that of a physician, nor are there any studies quotable that this care is less expensive or more appropriate. There are no direct studies to verify the claim that APRN's can independently provide 60 to 80 percent of primary care in replacement of a physician, and, in fact, studies reflect utilization of a collaborative and supervisory role of physicians working in conjunction with APRN's in structured situations. The claims that APRN's will be willing to work in underserved rural or inner city areas cannot be substantiated by experience or statistical evidence.

I would also argue that the primary care providers located in the most rural or underserved areas should be our most highly trained professionals. This is because the citizens using these providers have less health care choices, and these professionals must be able to do much more because of the lack of a local diagnostic and specialist referral system. It makes little sense to put our least trained into areas that need our best trained.

One cannot appreciate how much is lacking in nursing curricula until one attends medical school and subsequently a medical residency program.

I did not realize how much vital knowledge was lacking in my nursing education until the start of my medical residency. In other words, an excellent nursing educational background did not prepare me to function as an independent practitioner. What I can say to my nursing colleagues is "you do not know this unless you've been there. I have been in your shoes, you haven't been in mine."

The driving force for my medical education was the desire to deliver the best quality health care and do no harm.

It certainly was not a financial force that prompted me. Not only did I not receive a salary for 4 years while in medical school, but I incurred a $75,000 student loan debt as well.

In conclusion, the quality and economic issues surrounding medical care delivered by physicians, as compared to non-physicians, can be best explained by the wide disparity in the education of these professionals. Physician care is based on cognitive and technical skills, shaped by a minimum eleven years of education and experience. This forms a strong foundation of clinical knowledge and skills that cannot be replaced by lesser degrees of training. To imply that a less trained and less experienced individual can deliver the same quality of care, or can provide more economic care, is illogical and cannot be substantiated. The current models demonstrate that collaborative situations, where nurses in Advance Practice are under the medical supervision of physicians, are the strongest models for quality health care and efficient health care delivery.

Again, thank you for this opportunity to express our concerns and we will be glad to answer any questions you may have.

PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS

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Ms. Cindy Warner
Health Licensing Division
Bureau of Professional & Occupational Affairs
P.O. Box 2649
Harrisburg, PA 17105-2649

Re: CRNP Prescriptive Authority;
Jointly Proposed Regulations of the State Board
of Medicine and State Board of Nursing
No. 16A-499

Dear Ms. Warner:

The Pennsylvania Academy of Family Physicians has reviewed the jointly proposed regulations of the State Board of Medicine and State Board of Nursing related to CRNP prescriptive authority and appreciates the opportunity to offer the following comments.

The Academy wholly supports the extension of prescriptive authority to CRNPs within the context of a collaborative arrangement with a licensed physician or physicians. CRNPs have been and will continue to be valuable participants in the delivery of medical care in Pennsylvania. With respect to the proposed regulations, however, we do have several concerns and suggested revisions which we trust will strengthen and clarify the scope of CRNP prescriptive authority as well as protect the patients we all serve.

I. SECTIONS 18.53 and 21.283 (PRESCRIBING AND DISPENSING DRUGS)

A. Concerns with Proposed Language

5201 Jonestown Road • Suite 200 • P.O. Box 6685 • Harrisburg, PA 17112 • Phone: (717) 564-5365 • 1-800-648-5623 • Fax: (717) 564-4235

1. CRNP Education /Continuing Education

These sections permit a CRNP to prescribe and dispense drugs if the CRNP has (1) completed a CRNP program approved by the Boards or an equivalent program in another state, and (2) the program includes a "core course in advanced pharmacology." The parameters of such a pharmacology course are not defined.

Inasmuch as CRNPs would be permitted to prescribe a virtually unlimited range of drugs that, if improperly prescribed, can have devastating effects, including antineoplastic agents (cancer drugs), coagulation and anticoagulation drugs (clotting agents and blood thinners), and the full range of scheduled controlled substances with highly addictive properties, an appropriate quantum of training needs to be defined. Similarly, because drug choices and treatments change considerably from day to day, the Academy believes it essential that CRNPs be required to remain up to date on advances in the prescribing and administration of drugs for diagnostic and therapeutic purposes.

2. CRNP Examination

There is no requirement under the proposed sections or under current regulations governing CRNP practice that a CRNP pass a standard examination for certification, much less to prescribe a wide range of drugs. The Academy notes that all other professional licensees in the Commonwealth who engage in aspects of medical practice are required to take and pass an examination qualifying them to hold the level of license under which they will be practicing in an expanded fashion. Physicians pass an extensive examination prerequisite to licensure testing medical diagnostic, pharmacological and treatment knowledge and clinical skills; optometrists pass a separate examination to be certified to prescribe therapeutic drugs; nurses pass a separate examination to practice midwifery; and physician assistants pass an examination to prescribe drugs and perform other medical activities. CRNPs should not be exempted from examination requirements to which other similarly situated practitioners are held.

3. Medical Records Documentation

Under the proposed sections, CRNPs would be required to comply with §§ 16.92-16.94 of the State Board of Medicine's regulations related to prescribing, administering and dispensing controlled substances; packaging; and labeling of dispensed drugs. Nowhere, however, would a CRNP be required to comply with § 16.95 (related to medical records) of the Medical Board's regulations which specifies the information that must be contained in a patient's medical record, including diagnoses, medical treatment plans and therapeutic procedures. The Academy suggests

that CRNPs should also be required to comply with medical records requirements, particularly with respect to the charting of prescriptions issued by the CRNP.

4. Collaborative Agreements

Although reference is made to a "collaborative agreement" throughout current and proposed regulatory provisions, nowhere is such an agreement defined. The expansion of CRNP practice to include wide-ranging prescriptive authority requires that the parameters of collaborative practice be memorialized in writing and signed by all parties involved so that all are clear on their respective responsibilities to their patients. Appropriate direction as defined in §§ 18.21 and 21.251 of the Medical Board and Nursing Board, respectively (relating to definitions) must be set out in the agreement. Parties who need to know the scope of the collaboration, particularly the scope of prescriptive authority of the CRNP (such as pharmacists and regulatory authorities) must have access to the agreement.

B. Suggested Revisions

In light of the foregoing concerns, the Academy suggests that the language of §§ 18.53 and 21.283 be amended to read:

> A CRNP may prescribe and dispense drugs if:
>
> (1) The CRNP has completed a CRNP program which is approved by the Boards or, if completed in another state, is equivalent to programs approved by the Boards.
>
> (2) The CRNP program includes a core course in advanced pharmacology including the appropriate prescription and administration of pharmaceutical agents for diagnostic and therapeutic purposes consisting of a minimum of fifty (50) hours.
>
> (3) The CRNP has obtained a passing score on a CRNP certifying examination approved by the Boards.
>
> (4) The CRNP shall, as a condition for renewal of certification, provide evidence of having completed eight (8) hours of formal education in pharmacology and clinical management of drug therapy within the two-year period immediately prior to the date of renewal.
>
> (5) In prescribing and dispensing drugs, a CRNP shall comply with standards of the State Board of Medicine in §§ 16.92-16.95 (relating to

prescribing, administering and dispensing controlled substances; packaging; labeling of dispensed drugs; and medical records) and the Department of Health in 28 Pa. Code § 25.51-25.58, 25.61-25.81 and 25.91-25.95 (relating to prescriptions and labeling of drugs, devices and cosmetics and controlled substances).

(6) The collaborative agreement between the CRNP and collaborating physician(s) shall satisfy the following requirements:

(A) The agreement shall be in writing and shall identify and be signed by the CRNP and each collaborating physician, at least one of whom shall be a medical doctor.

(B) The agreement shall describe the time, place and manner of direction each named physician will provide the CRNP, including the frequency of contact with patients.

(C) The agreement shall describe the frequency with which the collaborating physician will provide medical chart review and consultation, which shall occur at least every thirty (30) days.

(D) The agreement shall list the drugs which the CRNP may prescribe, based on the categories listed in § 18.54 [§ 21.284].

(E) The agreement shall be immediately available to anyone seeking to confirm the scope of the CRNP's prescriptive authority.

(F) The agreement shall be filed with the Boards.

II. SECTIONS 18.54 and 21.84 (PRESCRIBING AND DISPENSING PARAMETERS)

A. Concerns with Proposed Language

1. Unrestricted CRNP Prescribing

Subsection (b) of these provisions permits CRNPs to prescribe seventeen categories of drugs without any apparent restriction, including the requirement that the drugs be identified in a written collaborative agreement with a physician.

All drugs are dangerous, and if improperly prescribed, may have disastrous consequences for patients. For example, antihistamines include many drugs that are available over the counter such as cough syrups and the well-known Benadryl. However, Periactin, a drug under this category, is both an antihistamine and an antiserotonergic agent. The contraindications include newborn or premature infants and nursing mothers. Also contraindicated are patients with hypersensitivity to cyproheptadine and other drugs of similar chemical structure, MAO inhibitors, angle-closure glaucoma, stenosing peptic ulcer, symptomatic prostatic hypertrophy, bladder neck obstruction, pyloroduodenal obstruction, elderly and debilitated patients. Warnings on the use of this drug are extensive and the precautions exceed a full column in the Physician's Desk Reference. Central nervous system adverse reactions include sedation and sleepiness, dizziness, disturbed coordination, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, pares thesis, neuritis, convulsions, euphoria, hallucinations, hysteria and fainting. In order to understand adverse reactions, the prescriber needs to understand the normal process, the abnormal process, and the numerous permutations that can occur. Only then can one understand the adverse reactions.

Likewise, an advanced course in pharmacology is not designed to teach the complex medical diagnostic decision-making necessary to choosing the appropriate drug for a particular patient's condition. By way of example, Urispas (flavoxate HCL) is a smooth muscle relaxant (which CRNPs would be permitted to prescribe without limitation and outside the parameters of a collaborative agreement with a physician), indicated for symptomatic relief of dysuria, nocturia, urgency, suprapubic pain, frequency and incontinence as may occur in cystitis, prostatitis, urethritis and urethrocystitis/urethrotrigonitis. Urispas is not indicated for definitive treatment, but is compatible with drugs used for the treatment of urinary tract infections. This indication is tied to another indication for the use of antibiotics.

Initially, the correct diagnosis of the patient's condition must be made. The diagnosis includes the determination of the probable microbe responsible: gram positive-aerobe, gram positive-anaerobe, gram negative-aerobe, gram negative-anaerobe, protozoal parasite, mycelial flora or tuberculous flora. Once determined, an anti-infective is chosen based upon the patient's individual allergies and sensitivities, ability to swallow capsule or liquid, drug interactions with other medications prescribed or over-the-counter, recent use of alcohol, and so forth. Having determined the appropriate anti-infective, the physician may choose to use Urispas in conjunction with all of the above. Urispas simply treats the symptoms and not the disease. Indeed, the prescribing of drugs is not properly left to a CRNP who has no medical school training, clinical

medical residency or an appropriate examination to test medical diagnostic, treatment and drug prescription knowledge.[1]

2. Prohibitions on Prescribing Certain Types of Drugs

Subsection (c) of these provisions authorizes CRNPs to prescribe and dispense such drugs as coagulants and anticoagulants (clotting agents and blood thinners, respectively), myotics and mydriatics (capable of blinding patients if not prescribed appropriately) and antineoplastic agents (oncologic or cancer drugs) provided authorization is documented in "the collaborative agreement." Again, the Academy notes that neither current regulations governing the practice of CRNPs nor the proposed language anywhere requires a collaborative agreement to be memorialized in writing or otherwise establish the parameters of the collaboration. CRNPs should certainly not be permitted to prescribe such dangerous drugs, which may, if misprescribed, cause a patient to bleed to death, develop fatal blood clots, become blind or worse, without limitation and without the collaborative oversight of a physician. Even physicians who do not specialize in oncology refrain from prescribing antineoplastic agents. CRNPs should likewise be prohibited from prescribing the foregoing drugs, whether under collaborative agreement or otherwise.

3. Scope of Physician Collaboration

Subsection (e) of the provisions provides:

> If a collaborating physician learns that the CRNP is prescribing or dispensing a drug inappropriately, the collaborating physician shall immediately advise the CRNP and the CRNP shall stop prescribing or dispensing the drug and shall advise the pharmacy to stop dispensing the drug. The CRNP shall immediately advise the patient to stop taking the drug. This action shall be noted by the CRNP in the patient's medical record.

This provision is not only overly simplistic, but falls far short of protecting the patients of both physicians and CRNPs. As noted previously, the prescription of drugs, scheduled or otherwise, involves a complex set of decision-making, beginning with the medical diagnosis of a disease or ailment, which may require testing beyond the scope of merely viewing a patient's symptoms; a knowledge of the patient's history, habits, allergies, lifestyle, and other contraindicators; a treatment plan which may or may not

[1] Indeed, a registered nurse may be certified as a CRNP with as little as two years of nursing training (associate degree or diploma program) and one year of training in advanced practice nursing. Section 5 of the Professional Nursing Law, 63 P.S. § 215; 49 Pa. Code §§ 18.41 and 21.271.

require the prescription of a drug; if a drug is indicated, the appropriate drug among thousands available, for the particular patient, the particular disease or condition.

Such decision-making requires intensive academic and clinical training and examination beyond that required to be certified as a CRNP. Accordingly, it is imperative that a collaborating physician be timely advised of the dispensing of a particular drug and that the physician perform a record review (in accordance with the time frame suggested by the Academy as an additional subsection in §§ 18.53 and 21.283 above). Likewise, the Academy believes that when the physician learns of the misprescription of a drug, the physician be required to resume direct care of the patient and make the appropriate notifications to the patient, pharmacy, and medical records. The current provisions do not provide protection for a patient where a CRNP has improperly diagnosed a condition or prescribed a drug in the first instance.

4. Schedule II Controlled Substances

Paragraph 1 of subsection (f) permits CRNPs to prescribe schedule II controlled substances to include a dose of up to 72 hours, with notification to the collaborating physician within 24 hours of issuing the prescription. The Academy believes that, because schedule II controlled substances are the most highly addictive, CRNPs should not be permitted to prescribe them. The safety of a patient requiring such a drug requires that the patient be evaluated by a physician.

Alternatively, if the Board ultimately decides to allow CRNPs to prescribe schedule II controlled substances, such a prescription should be limited to a very short duration (no longer than 72 hours), and the types of drugs expected to be prescribed should be detailed in the collaborative agreement between the physician and CRNP.

5. Other Prescription Drugs

Paragraph 2 of subsection (f) permits a CRNP to prescribe a schedule III or IV controlled substance for up to a 30-day supply. No limitations, however, are placed on a CRNP's prescription of schedule V controlled substances nor on any other drug, despite the potential for obvious dangerous consequences that may be visited upon a patient as a result of an inappropriate prescription. The Academy therefore suggests that language be included in the regulation establishing definitive parameters for the outside limits of a CRNP's prescriptive authority, that both the collaborating physician and the CRNP understand the parameters and memorialize those parameters in a written collaborative agreement, and that the collaborating physician be timely advised of the prescription of any drug by a CRNP.

6. Parameters for CRNP Prescribing

The prescription of drugs is a serious matter. Determining whether a drug is necessary and, if so, which drug, in what dose, for what period of time, with what instructions for use involves a complex decision-making process. An improperly prescribed drug can effect a fatal response. Even physicians, with extensive academic and clinical training and examination, make mistakes.[2] Practitioners who may be certified as CRNPs with as little as three years of combined training and no examination in medical diagnosis, pharmacology, or appropriate prescribing practices, cannot be expected to recognize medical problems not otherwise apparent, or to even suspect a serious problem not manifest to a less-trained diagnostician, or, more important, the implications of the prescription of a particular drug for that condition.

B. Suggested Revisions

In light of the foregoing, the Academy suggests that the following subsections of §§ 18.54 and 21.284 be amended to read as follows:

* * *

(b) A CRNP may prescribe and dispense a drug from the following categories without limitation if that authorization is documented in the collaborative agreement (unless the drug is limited or excluded under other subsections):

(1) Antihistamines.
(2) Anti-infective agents.
(3) Cardiovascular drugs.
(4) Contraceptives including foams and devices.
(5) Diagnostic agents.
(6) Disinfectants for agents used on objects other than skin.
(7) Electrolytic, caloric and water balance.
(8) Enzymes.
(9) Antitussives, expectorants and mucolytic agents.
(10) Gastrointestinal drugs.
(11) Local anesthetics.
(12) Serums, toxoids and vaccines.

---

[2] To meet minimum requirements for medical licensure in Pennsylvania, a physician will have completed four years of college, four years of medical school (including clinical rotations) and two years of a graduate clinical residency (three years in the case of a foreign medical school graduate), as well as having passed the USMLE testing both academic knowledge and clinical medical skills.

(13) Skin and mucous membrane agents.
(14) Smooth muscle relaxants.
(15) Vitamins.

(c) A CRNP may prescribe and dispense a drug from the following categories if that authorization is documented in the collaborative agreement:

(1) Autonomic drugs, excluding sympathomimetic (adrenergic) agents.
(2) Blood formation and coagulation drugs with the exception of anti-coagulants and coagulants and thrombolytic agents.
(3) Central nervous system agents with the exception of general anesthetics and monoamine oxidase inhibitors.
(4) Eye, ear, nose and throat preparations with the exception that myotics and mydriatics used as eye preparations require specific approval from the collaborating physician for a named patient.
(5) Hormones and synthetic substitutes with the exception of pituitary hormones and synthetics and parathyroid hormones and synthetics.

(d) A CRNP may not prescribe or dispense a drug from the following categories:

(1) Gold compounds.
(2) Heavy metal antagonists.
(3) Radioactive agents.
(4) Antineoplastic agents.
(5) Oxytocics.

(e) If, upon consultation with the CRNP or in the course of a record review as required by § 18.53(6)(C) {or §21.283 (6)(C) where appropriate}, the collaborating physician learns that the CRNP is prescribing or dispensing a drug inappropriately, the collaborating physician shall immediately advise the patient, notify the CRNP and, in the case of a written prescription, advise

the pharmacy of the inappropriate prescription. The physician shall advise the patient and notify the CRNP to discontinue using the drug, and in the case of a written prescription, shall notify the pharmacy to discontinue the prescription. The order to discontinue use of the drug or prescription shall be noted in the patient's medical record by the physician.

(f) Restrictions on CRNP prescribing and dispensing practices are as follows:

(1) A CRNP may not prescribe or dispense schedule I or II controlled substances as defined in § 4 of the Controlled Substance, Drug, Device and Cosmetic Act (35 P.S. § 780-104).

(2) A CRNP may not issue a prescription for more than a 30-day supply of any drug, except in cases of chronic illnesses where a 90-day supply may be prescribed. The CRNP may authorize refills up to six months from the date of the original prescription if not otherwise precluded by law.

(3) A CRNP shall notify the collaborating physician within 12 hours, either orally or in writing, of the prescription or dispensing of any drug and the basis for the decision to prescribe or dispense.

(4) A CRNP may not prescribe or dispense parenteral preparations other than insulin, emergency allergy kits and other approved drugs listed in subsection (b).

(5) A CRNP may not prescribe or dispense a drug for a use not permitted by the U.S. Food and Drug Administration nor may he or she prescribe or dispense a generic or branded preparation of a drug that has not been approved by the U.S. Food and Drug Administration.

(6) A CRNP may not prescribe or dispense a pure form or a combination of drugs listed

in subsections (b) and (c) unless the drug or class of drug is listed as permissible for a prescription or dispensing.

(7) A CRNP may not dispense a drug unless it is packaged in accordance with applicable federal and state law pertaining to packaging by physicians.

(8) A CRNP may not compound ingredients when dispensing a drug, except for adding water.

(9) A CRNP may not delegate prescriptive authority specifically assigned to the CRNP by the collaborating physician to another health care provider.

(g) {The language of proposed subsection (g) should be deleted and subsections (h) and (i) appropriately renumbered as subsections (g) and (h).}

****

Thank you for the opportunity to provide the foregoing comments. We trust that these suggestions will provide a constructive framework for authorizing CRNPs to prescribe drugs and devices consistent with the health and safety of Pennsylvania health care consumers. We look forward to providing the Boards with any assistance they may require in formulating final form regulations.

Sincerely,

Christine M. Stabler, M.D.
President

cc: Hon. John R. McGinley, Jr., Chairman
Independent Regulatory Review Commission
Hon. Mario J. Civera, Jr., Chairman
House Professional Licensure Committee
Hon. Clarence D. Bell, Chairman
Senate Consumer Protection and Professional Licensure Committee
PAFP Board of Directors
PAFP Public Policy Commission
John Jordan, PAFP Executive Vice President
Charles I. Artz, Esq., PAFP General Counsel
John Nikoloff, PAFP Lobbyist

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820
Tel: 717-558-7750
Fax: 717-558-7840
E-Mail: STAT@PAMEDSOC.ORG

Pennsylvania
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Vice President

JAMES R. REGAN, MD
Chair

JITENDRA M. DESAI, MD
Secretary

ROGER F. MECUM
Executive Vice President

October 18, 1999

Cindy Warner
Health Licensing Division
Bureau of Professional and Occupational Affairs
P.O. Box 2649
Harrisburg, PA 17105-2649

Dear Ms. Warner:

I am writing as President of the Pennsylvania Medical Society to comment on the proposed regulations, providing for prescriptive authority for certified registered nurse practitioners (CRNPs), which have been jointly promulgated by the State Board of Medicine and the State Board of Nursing. Those regulations were published for public comment in the October 2, 1999 (Vol. 28, No. 40) issue of *Pennsylvania Bulletin.*

The Pennsylvania Medical Society does not object to allowing nurse practitioners to prescribe medication in accordance with the Medical Practice Act of 1985. We do think that portions of the proposed regulations are acceptable as published. However, adjustments need to be made to the regulations in order to make the regulations more clear as to the responsibilities and accountabilities of both the nurse practitioner and the collaborating physician, as well as to provide added patient safeguards and an oversight responsibility for both Boards. The Medical Society has therefore commented on the areas needing clarification and has suggested language to address our concerns. In the Society's recommended language changes, brackets around language indicate deletions while underlined language indicates additions. Section numbers correspond to those in the State Board of Medicine's version of the regulations.

<u>18.53 Prescribing and Dispensing Drugs</u>

At 18.53 (2) lists a requirement for a CRNP who prescribes to have completed a CRNP program that includes a core course in advanced pharmacology. However, this provision does not specify a number of hours for such a course. The Medical Society believes that such a course must, at a minimum, include 30 hours of training.

In addition, pharmacology changes so rapidly that continuing education is a necessity for the CRNP who prescribes. While a general continuing education requirement appears in 18.41 (c) of the existing regulations, it is not specific and does not focus solely on pharmacology. Therefore, the Medical Society recommends the following modifications:

> 18.53 (2)- The CRNP program includes a core course<u>, of at least 30 hours in length,</u> in advanced pharmacology. <u>The CRNP who prescribes medicine shall, at the time of each certification renewal, demonstrate continuing education in advanced pharmacology.</u>

The Medical Society also believes that the CRNP who prescribes medication should identify himself or herself clearly to the public. We believe this is very important given the many types of health care practitioners a patient may encounter and those that might be prescribing

for the patient. Without identification, most patients would not be able to readily recognize whether the prescriber is a physician, physician assistant, or nurse practitioner. The Medical Society believes that the following new section should be added to 18.53 in the proposed regulations.

18.53 (4)- The CRNP who prescribes medication must provide a clear and conspicuous notice to patients that he or she is a CRNP. This notice must contain the practitioner's name and the title "Certified Registered Nurse Practitioner" or the abbreviation "CRNP." The notice may take one of many forms such as a notice placed on a wall or door of a practice site, a nametag, or embroidered on a lab coat or jacket as long as it is visible to patients being treated. The identification may also include any academic credentials or specialties as long as the CRNP does not use abbreviations that are not recognizable to the public. However, a doctorate level nurse practitioner is prohibited from using only the title "Doctor" or its abbreviation followed by the name.

Collaborative Agreements

The Medical Society believes that the regulations should include a section that addresses the collaborative agreements between the nurse practitioners and their collaborating physicians. While we understand that these regulations do not change the existing requirement to have a collaborative agreement, when a CRNP begins writing prescriptions, much more detail is required. First, the agreement should be in writing so there are no doubts or ambiguities concerning its content, and it must be available at the practice site for appropriate persons to review. It must also specify the collaborating physician and any substitute collaborating physician by name so that the lines of responsibility are clearly defined for everyone. In addition, the regulations should limit each collaborating physician to responsibility for no more than four CRNPs who prescribe since it would be very difficult for any physician to carefully monitor more than that number.

The agreement should contain the entire list of drugs for which the CRNP can prescribe so that pharmacists or others can easily confirm the CRNP's ability to prescribe any given drug. Physicians should, however, not be permitted to authorize any drug by including it in the collaborative agreement unless he or she has the expertise required to prescribe that medication so that the physician can easily recognize any inappropriate prescribing or adverse reaction.

The agreement must outline when the collaborating physician must see the patient so that it is clear what occurrences in the course of drug therapy necessitate the physician's intervention. The agreement must also specify the frequency of record review by the physician but it must be at least once every sixty days so that this will allow for review of all Schedule III and IV prescriptions after the initial thirty-day prescription and one authorized refill.

Finally, the Medical Society believes that if the collaborative agreement includes Schedule II controlled substances, it should be filed with the State Board of Medicine so that the Board can identify who is authorized to prescribe these potentially addictive drugs.

The Medical Society believes that in order to upgrade the collaborative agreement requirements when a CRNP prescribes, it will be necessary to add another new section to 18.53 that reads as follows:

18.53 (5)- The collaborative agreement between a CRNP and collaborating physician authorizing the CRNP to prescribe and dispense drugs:

(i) Shall be in writing.
(ii) Shall be available at the practice site and provided to any person requesting to see the agreement such as, but not limited to, patients, other health care practitioners, and professional licensing board investigators.
(iii) Identifies, by name, the physician who serves as the collaborating physician.
    (a) Each collaborating physician shall be limited to serving as the collaborative physician for no more than four CRNPs who prescribe.
(iv) Provides for a named substitute collaborating physician for up to thirty days when the collaborating physician is not available.
(v) Contains a list of the classes of medication from 18.54 that the collaborating physician authorizes for dispensing and prescribing by the CRNP.
    (a) No collaborating physician may authorize a CRNP to dispense or prescribe any category of medication unless that collaborating physician has the expertise to prescribe that medication.
(vi) Describes the circumstances under which the physician must see the patient.
(vii) Establishes the frequency of record review at a minimum of once every 60 days.
(viii) Shall be filed with the State Board of Medicine if it contains the authorization for the CRNP to write for Schedule "II" controlled substances.

18.54 Prescribing and Dispensing Parameters

The Medical Society believes that in order to write for Schedule II controlled substances, the CRNP should be required to obtain authorization from the collaborating physician prior to issuing the prescription. Schedule II drugs are highly addictive and should only be used under limited circumstances. While the CRNP may have the expertise to write independently for many medications, the nature of Schedule II drugs necessitates an extra safeguard for the public that brings the physician's expertise into the prescribing decision. To accomplish this, we suggest that 18.54 (f-1) be revised as follows:

> 18.54 (f-1) CRNP may write for a Schedule II controlled substance for up to a 72-hour dose. The CRNP shall [notify the collaborating physician immediately (within 24 hours)] contact the collaborating physician and obtain approval prior to dispensing or prescribing these medications.

Professional Liability Insurance Coverage

Another section should be added to 18.53 that mandates a minimum professional liability coverage requirement of $400,000, the current level of mandatory basic liability coverage under the Health Care Services Malpractice Act. The reason that the Medical Society seeks this provision is that with an increased scope of practice, a CRNP will also have increased liability exposure. We fear that without at least some minimum level of coverage, the collaborating physician will become the only "deep pocket" in a malpractice suit. We suggest adding another section to 18.53 that reads:

> 18.53 (6)- The CRNP carries a malpractice insurance policy that provides at least a total of $400,000 in liability coverage.

Notice of Collaborative Agreement

After reviewing these regulations, the Medical Society has become aware that at present, neither the Medical Board nor the State Board of Nursing have any way of knowing what collaborative agreements between physicians and nurse practitioners exist, or any knowledge

of who is party to those agreements. If a patient complains, for example, about a nurse practitioner who is not practicing properly, neither board could tell who is the collaborating physician who is perhaps not fulfilling his or her obligations or whether the nurse practitioner is practicing within his or her scope of practice or performing a medical function appropriately obligated to him or her by the collaborating physician. The Medical Society believes, therefore, that the two boards should create a mechanism to require at least notification when any collaborative agreement exists and who is involved in that agreement.

The Medical Society recommends the addition of amendments after our proposed Section 18.53 (5) to read as follows:

(6) The nurse practitioners who enter into such a collaborative agreement shall notify the State Board of Nursing of

(a) The existence and location of the agreement;
(b) The name(s) of the collaborating physician(s);
(c) The effective date and duration of the agreement, not to exceed two years.

(7) The Board of Nursing shall maintain a listing of all current collaborative agreements, identifying all parties to the agreement, and the effective date and duration of the agreement. The State Board of Nursing shall make this listing available to the State Board of Medicine and to the public upon request. In those instances where the collaborative agreement authorizes the nurse practitioner to write for Schedule "II" controlled substances, a copy of such agreement shall be filed with the State Board of Medicine.

The Pennsylvania Medical Society appreciates this opportunity to comment on the proposed nurse practitioners prescribing regulations. The Society believes that the regulations, together with the modifications suggested by the Society, will provide a workable standard for expansion of the scope of practice of advanced practice nurses, specifically for certified registered nurse practitioners.

Sincerely,

John W. Lawrence, MD
President

Cc: State Board of Nursing
Independent Regulatory Review Commission
Chair, Professional Licensure Committee, PA House of Representatives
Chair, Consumer Protection & Professional Licensure Committee, PA Senate

P/Ed and Sci/Final Comments on CRNP Prescribing

PSNA
PENNSYLVANIA STATE NURSES ASSOCIATION
PO Box 68525
Harrisburg, PA 17106-8525
717-657-1222 ■ 1-888-707-7762
Fax: 717-657-3796
E-mail: psna@psna.org
www.psna.org

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REVIEW COMMISSION

October 26, 1999

Cindy Warner
Health Licensing Division
Bureau of Professional and Occupational Affairs
PO Box 2649
Harrisburg, PA 17105-2639

Dear Ms. Warner:

This correspondence will provide the Pennsylvania State Nurses Association's position on the proposed rulemaking for Certified Registered Nurse Practitioners Prescriptive Authority, published in the Pennsylvania Bulletin, Volume 29 Doc. No. 99-1668.

The PSNA has reviewed these regulations and believe they would improve accessibility and availability to quality health care for all residents of the Commonwealth. We recommend approval of the regulations.

PSNA supports CRNPs having prescriptive authority. A majority of other states and the Federal government have regulated prescriptive authority to Nurse Practitioners.

In regards to Section 18.53(2), PSNA recognizes that earlier CRNP curriculums may have integrated advanced pharmacology content into clinical courses rather than requiring a designated course. We would recommend for these individuals that alternative criteria be used to meet this standard. These include but would not be limited to: grandfathering, continued education course in advanced pharmacology or requiring the CRNP to provide documentation of cumulative advanced pharmacology content.

PSNA would request that a negative formulary be used rather than a listing of acceptable categories as in the proposed amendments. We believe this would simplify the future and prevent the exclusion of certain classes of drugs that would be appropriate for the CRNP to prescribe.

PSNA appreciates the opportunity to review the proposed amendments. We fully support the amendments and commend both the Pennsylvania State Board of Nursing and the Pennsylvania State Board of Medicine for their efforts to provide quality health care to Pennsylvanians.

Respectfully,

Jessie F. Rohner, DrPH, RN
Executive Administrator

Original: 2064

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REVIEW COMMISSION

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

Dear Mr. Nyce:

This letter is in reference to regulations approved by the Board of Medicine and the Board of Nursing concerning prescriptive privileges for Certified Registered Nurse Practitioners. While I applaud the efforts of both Boards to address this issue, as a Nurse Practitioner (NP) I have several serious concerns with the regulations as written.

The most serious flaw in the regulations is the 2:1 ratio of NP's to physician collaborator. While there appears to be no public health or safety reason for establishing a ratio, if one is insisted upon a more reasonable ration would be 6:1 of **full time equivalent** NP's to one physician. Currently I work in a hospital outpatient clinic with three other NP's and in the past I have worked at a Planned Parenthood where one Medical Director oversees fifteen or more NP's, many of whom are part time. Such clinics around the state would not be able to function with the 2:1 ratio in the proposed regulation. How would this be helping provide quality access to care for the citizens of Pennsylvania?

The second most serious concern is that certain categories are not included in the list of medications that may be prescribed by NP's. I would recommend that the Boards follow the language of the American Hospital Formulary to list each and every drug category in the book. The missing categories are "eye, ear, nose, and throat preparations; hormones and synthetic substitutes; oxytocics; unclassified therapeutic agents; medical devices; pharmaceutical aids."

My third concern is the requirement of a specific course in advanced pharmacology of not less than 45 hours. While current NP students may obtain this in their NP course work, NP's such as me who completed training may years ago would be hard put both financially and by time constraints to satisfy this requirement. I would suggest that the regulations be revised to allow a summation of 45 hours of advanced pharmacology and that the requirement the course be specifically advanced pharmacology be omitted.

Lastly, I am distressed that the regulations as written would shift the authority for NP acts of medical prescription to the collaborating physician and expands the categories of medications which must be specifically listed in the collaborative agreement from 5 to 21. These changes will result in a serious and costly liability issue for a collaborating physician. I urge you to return the regulatory authority to the Boards.

Nurse Practitioners in Pennsylvania have been seeking prescriptive regulations for over twenty years, for the sole purpose of being able to provide more comprehensive,

high quality, and accessible health care to its citizens. I fear that these regulations as written may actually be a step back and will impair rather than improve access to health care in Pennsylvania. Please consider these issues carefully when reviewing the regulations.

Sincerely,

Carol Huennekens

Carol Huennekens, CRNP

Carol Huennekens
628 Blair Rd
Bethlehem, PA 18017

May 30, 2000

CC:

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

Representative Mario Civera, Chair
Professional Licensure Committee
House of Represenatives
PO Box 202020
Harrisburg, PA 17120-2020

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

Senator Charles Dent
801 Hamilton Mall
Allentown, PA 18101

Representative Steve Samuelson
60 W. Broad Street, Suite 105
Bethlehem, PA 18018

Original: 2064

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May 30, 2000

Mr. Robert Nyce
Executive Director
IRRC
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce:

The Regional Nursing Centers Consortium, an association of 26 community-based nurse-run health centers, has reviewed the amendment to the Certified Registered Nurse Practitioner (CRNP) regulations that the Board of Nursing and Board of Medicine recently approved. We have several concerns about the effects that these regulations may have on access to essential quality health care for citizens of the Commonwealth. We strongly urge the Independent Regulatory Review Commission (IRRC) to revise the regulations in the following four ways:

I. 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. *While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP--physician collaboration in general.* 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.** Our member nurse-run health centers and other CRNP practices across the state provide essential quality health care services 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 (up to 60% on any given day).

3721 Midvale Avenue • Philadelphia, PA 19129 • Tel: (215) 951-0330 exts. 140, 141 & 147 • Fax: (215) 951-0342
E-mail: rncc@rncc.org • www.rncc.org

Most of these centers are staffed with multiple part-time CRNPs, are affiliated with university-based 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. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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.

II. ALLOW SUMMATION OF ADVANCED PHARMACOLOGY HOURS.

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 comments of your Commission, nor in the 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.

III. FOLLOW THE LANGUAGE OF THE AMERICAN HOSPITAL FORMULARY.

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".

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 substantive change.

Thank you for your attention to these concerns before the regulations are approved. Thank you for your attention to these critical matters and please call me at (215) 951-0330 ext. 147 if you have any questions.

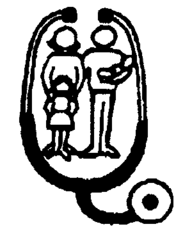
Sincerely,

Tine Hansen-Turton
Executive Director

Cc: Regional Nursing Centers Consortium Governing Council

Representative Mario Civera, Chair
Professional Licensure Committee
House of Representative PO Box 202020
Harrisburg, PA 17120-2020

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



SUSQUEHANNA FAMILY HEALTH CENTER

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Nelson H. Lehman, M.D.
Robert H. Brower, M.D.
James D. Herr, M.D.
Donald E. Playfoot, M.D.
Gerald E. Miller, M.D.
Creston M. Tate, D.O.
Donita M. Sturgis, C.R.N.P.

Original: 2064

May 19, 2000

Independent Regulatory Review Commission
333 Market St., 14th Floor
Harrisburg PA 17101

To Whom It May Concern,

I wanted to write in regards to the recent passage of CRNP prescriptive regulations. These regulations were passed April 25 and April 27 by the Boards of Nursing and Medicine. I have 2 areas of great concern. #1 Language in section 21.287 that states a physician may serve as a collaborating physician to no more than 2 Nurse Practitioners. This language was not in the regulation draft that was presented for public comment. I feel this is a substantial change to what was released for public comment and therefore should be omitted. This will have great impact on any nurse managed clinics and many educational facilities. No other state has a nurse practitioner to practitioner ratio.

The second area of concern that I have is in section 21.283. The language for advance pharmacology states a 45 hour course is required. Language stating or its equivalent, should be added so programs where pharmacology was integrated throughout the program and approved by the board of nursing, would not fail to then meet this requirement. This would prevent a major financial impact for the Nurse Practitioner community for members who graduated from those board approved programs with integrated pharmacology. They would then have to take an additional course for material that was already covered and deemed appropriate by the boards. Simple way to remedy this issue would be to add or its equivalent.

Thank you very much for taking the time to review my comments.

Sincerely yours,

Donita M. Sturgis, CRNP

DMS/slp

1159 River Road • Marietta, PA 17547 • (717) 426-1131

SUSQUEHANNA FAMILY HEALTH CENTER

Nelson R. Lehman, M.D.
Robert H. Brewer, M.D.
James D. Herr, M.D.
Donald E. Playfoot, M.D.
Gerald E. Miller, M.D.
Creston M. Tate, D.O.
Donita M. Sturgis, C.R.N.P.

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TO: IRRC

ATTN:

RE: CRNP Regulations

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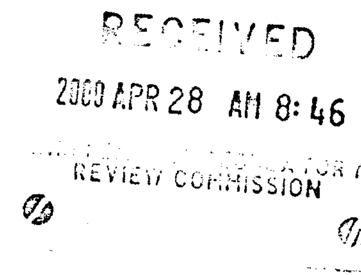


611 Electric Ave.
Lewistown, PA 17044

April 24, 2000

Mr. Steven Anderson, Chair
PA Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

I am a Nephrologist working in collaborative practice with a Family Practice CRNP in Lewistown, Pennsylvania. After reviewing the recent agreement between the Board of Medicine (BOM) and the Board of Nursing (BON) on Advanced Practice Nursing, I am compelled to voice my concerns. My initial reaction was that the agreement is purely obstructionist in nature, designed to create hurdles for Advanced Practice Nurses and their collaborating physicians. It will discourage physicians from forming practice arrangements that benefit all. It gives the appearance of protecting the public at large, but since the provisions are not outcome tested, at best they are arbitrary.

The nature of collaboration is the combination of strengths of independent individuals working together toward a common goal. In our case, the goal is provision of medical care for our patients. Ignoring the comprehensive qualifications of part of the team, hampering their function and assigning responsibility and liability to another, is not collaborative. It defeats the intent and spirit of the arrangement, and restricts the benefit to the patients. The agreement is out of date with current medical practices across the country, and hampers progressive health care in Pennsylvania.

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
717-242-2714

cc: Governor Tom Ridge
Main Capitol Building, Room 225
Harrisburg, PA 17120

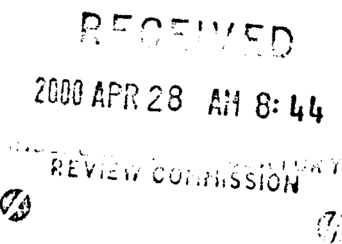
Mr. Robert Nyce, Executive Director
Independent Regulatory Review Commission
333 Market St., 14th Floor
Harrisburg, PA 17101

Hummer, Jr., M.D., Charles D., Chairman
PA State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Senator Jake Corman
Senate Box 203034
Harrisburg, PA 17120-3034

Rep. Kerry Benninghoff
East Wing
Room 164B
Harrisburg, PA 17120-2020

Mr. Steve Anderson
Chair, Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, Pa 17105-2649



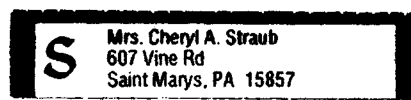
Dear Mr. Anderson,

I am a Nurse Practitoner with 3 ½ years experience from St. Marys, Pennsylvania and I am writing to urge you to implement the following recommendations in regard to the recent CRNP regulation amendments.

1. **Section 21.283 Requirement of a specific 45 hour course in advanced pharmacology.** Until recently, most programs did not have a specific 45 hour course in pharmacology. Often separate courses ranged from 24 to 35 hours depending on the length of a university's semester. In addition pharmacology was integrated into all of the clinical courses taken by the nurse practitioner student. Many programs integrated the pharmacology throughout the program instead of offering a single pharmacology course . This rule, as written, rule places the most experienced practicing nurse practitioners at a disadvantage when attempting to obtain prescriptive authority in the state, while allowing new inexperienced graduates to have full prescriptive authority right out of school, if they have a separate 45 hour course . Requiring experienced practicing nurse practitioners to take a 45 hour course in addition to the advanced pharmacology already taken, but not separated in this way and with this number of hours is obstructive and spurious. **Recommended adjustment: require a 45 hour course or its equivalent.**

2. **Section 21.287 Physician supervision: No physician may serve as a collaborating physician to more than two nurse practitioners. Only a physician may apply for a waiver.** This provision disadvantages nurse managed centers, clinics serving vulnerable populations such as migrant clinics and federally qualified health centers and practices, agencies and institutions that utilize multiple nurse practitioners in a specific setting to provide quality care. No other state has such a limited requirement. This provision is obstructive and establishes significant barriers to access for patients seeking care in any of these environments. **Recommended adjustment: Remove requirement. If this is not possible, increase the number of NP s per physician to 6-10. Allow nurse practitioners, clinics, agencies and institutions to request waivers as well as a physician.**

3. **Section 21.283 Requires 16 hours of pharmacology continuing education every two years.** This requirements limits the ability of nurse practitioners to obtain quality clinical continuing education by requiring 16 hours of pharmacology, which may have to be obtained to the exclusion of more comprehensive clinical continuing education. While pharmacologic information is important, it is equally important that clinical continuing education include diagnosing and managing conditions more comprehensively than would be included in continuing education that is strictly pharmacology. **Recommended adjustment: Reduce continuing education hours that are strictly pharmacology to 6, and require the remainder to be clinical continuing education hours.**



4. **Section 21.284 Prescribing and Dispensing Parameters.** While the majority of missing drug groups have been reinstated, some drug groups continue to be missing. Missing categories include Oxytoxics, Unclassified Therapeutic Agents, Medical Devices and Pharmaceutical Aids. Since the American Hospital Formulary Service Pharmacologic-Therapeutic Classification Framework is to be used, all categories should be addressed in the regulations. **Recommended adjustment: Formulary should address all drug categories listed in the American Hospital Formulary Service Pharmacologic-Therapeutic Classification**

5. **Section 21.284 Prescribing and Dispensing Parameters.** Limits refills of Schedule III-V drugs until there is physician authorization. This regulation can be dangerous for the patient who may miss critical doses of medication while awaiting authorization and cause undo pain and discomfort in the case of certain analgesics falling into this category. **Recommended adjustment: remove requirement for physician authorization; if necessary change to physician notification.**

6. **Section 21.284 Prescribing and Dispensing Parameters.** Limits prescriptions of Schedule II drugs to 72 hours. This regulation can be dangerous for the patient who may miss critical doses of medication. **Recommended adjustment: remove 72 hour limitation, or extend to 5 or 7 days, if a limitation is felt to be necessary.**

7. **Section 21.284 Prescribing and Dispensing Parameters.** Requires physician to take corrective action for inappropriate prescribing or dispensing by the nurse practitioner. This regulation, as stated, puts the physician in an unnecessary position of liability. While both nurse practitioners and physicians should always notify each other and take corrective action when an inappropriate prescribing or dispensing action has taken place, the responsibility for the prescription lies with the provider who prescribed or dispensed the drug. There are already medico-legal parameters established for correcting and reporting prescribing and dispensing errors, making the inclusion of this regulation unnecessary and inappropriate. **Recommended adjustment: Remove this section (d)**

8. **Section 21.285 Collaborative agreement.** Limits collaborative agreement to an agreement between a nurse practitioner, a physician and a substitute physician. This is obstructive and can be problematic when a nurse practitioner is working in a clinic, agency, hospital or nurse managed center where collaborative agreements are established among nurse practitioners and physicians affiliated with those entities. **Recommended adjustment: Broaden the participant capability of the collaborative agreement to include the practice parameters of these entities.**

9. **Section 21.385 Collaborative agreement. Section 4.** Requires physician attestation that he or she has knowledge and experience with drugs prescribed by the NP. This is a redundant requirement and suggests that physicians are not familiar with medications indicated for patients for whom the physician is consulting. It places the physician in a tenuous and

unnecessary liability situation since it is unclear how much knowledge or experience is acceptable. **Recommended adjustment: Remove this section**

10. **Section 21.385 Collaborative agreement Section 5.** Requires agreement to specify circumstances and how often collaborating physicians will see patients, based on type of practice site, condition of the patient, treatment is for an ongoing or new condition and whether the patient is new or continuing. Interaction between patients and collaborating physician are based on the specific needs and condition/s of each patient. Collaborative arrangements should be made with enough flexibility that patients needs can be met and safe care can be delivered by the nurse practitioner in collaboration with the health care team without obstruction. This requirement as written is obstructive regulation that will most likely discourage physicians to enter into collaborative arrangements with nurse practitioners. **Recommended adjustment: Remove this section or end after the words personally see the patient.**

Thank you for your immediate attention to these concerns before the regulations appear in final publication. I believe it is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens.

Sincerely,

Cheryl Straub CRNP, CS

Cheryl Straub, CRNP, CS
607 Vine Rd.
St. Marys, PA 15857
814-834-7431

CC:

Governor Tom Ridge

225 Main Capitol

Harrisburg, PA 17120

Robert Nyce, Executive Director

Independent Regulatory Review Commission

333 Market St., 14th Floor

Harrisburg, PA 17101

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

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

IRRC # 2064 Title Certified Registered Nurse Practitioner's Regulation

(Form B - CRNPConcerns)		
NAME	ADDRESS	DATE of CORRESPONDENCE
Cheryl A. Straub	607 Vine Road Saint Marys, PA 15857	April 26, 2000
Sharon P. Spear	5039 Swamp Road Ste 402 P.O. Box 417 Fountainviille, PA 18923-0417	April 26, 2000
Barbara H. Cole	P.O. Box 377 Centre Hall, PA 16828	April 20, 2000

Original: 2064

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

RECEIVED
2000 MAY 19 AM 8:56
REVIEW COMMISSION

Dear Sir;

I am a nurse practitioner working for a college health service at Slippery Rock University, one of the State System of Higher Education Universities. We have 3 full time nurse practitioners (CRNPs) with 3 part time. We have one physician who is our medical director, approves protocols and acts as our collaborating physician. The new CRNP Regs allow for only 2 CRNPs to be "supervised" by one MD, in order to prescribe medical therapeutics. Each of our nurse practitioners needs to be able to prescribe for their own clients. Some of us have been prescribing under the physician's name for nearly 15 years, now we can not?

Our facility has been accredited by the Accreditation Association for Ambulatory Health Care. We care for college students with mostly minor illnesses, injuries, and contraceptive needs. We rely on nurse practitioners (CRNP) to provide cost-effective care for 90% of our students who do not require the services of a MD. If our prescribing ability is curtailed it will severely impact our ability to provide services to the students of Slippery Rock University. Financial constraints are a constant problem and we certainly can not afford to hire additional physicians to replace nurse practitioners.

The waiver system to allow more than 2 CRNPs per physician needs to be fair and easily managed. This process can severely impede the hiring of a consultive physician. As we contract for physician services, the uncertainty of these Regs makes it very difficult to plan for future staffing.

I have other concerns about the new Regs, such as the 16 hours of pharmacology credits every 2 years. This will limit my choices of continuing education. But I realize we will have to work around it. My greatest concern is that only some of us will be able to be prescribing CRNPs. Or we may come up with a rotating schedule so that all will prescribe, but only one at a time.

Our facility should be the one to apply for the waiver, not a physician we must hire in. How do we inform a contracted employee that they must apply to the Boards for a waiver so that the University employees can do their work. Please consider nurse managed clinics when finalizing this waiver process.

Respectfully:

Laura Bateman, RN., MSN., FNP., CRNP
Student Health Center
Slippery Rock University
Slippery Rock, PA. 16057-1326
laura.bateman@sru.edu

cc; Rep. Mario Civera
Sen. Clarence Bell
PA State Board of Nursing
Rep Jeffrey Coy

LAURA BATEMAN
137 SANKEY LANE
SLIPPERY ROCK, PA 16057-

Original: 2064

May 11, 2000

RECEIVED
2000 MAY 15 AM 9:09
INDEPENDENT REGULATORY
REVIEW COMMISSION

Kathryn A. O'Donald
1421 Grant Avenue
Altoona, PA 16602

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

Dear Mr. Nyce,

Members of the Alliance of Advanced Practice Nurses have discussed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have grave concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. We strongly urge the Board to revise the regulations in the following ways.

1. Ensure access to care by eliminating the 2 CRNP : 1 physician ratio. Stakeholders and the public have had no opportunity to comment on this most limiting and arbitrary aspect of the regulations. CRNP practices and nurse-run centers across the state provide essential health care for underserved rural and urban populations. 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. While we acknowledge the importance of advanced pharmacology education for CRNPs, we believe that requiring "a specific course... of not less that 45 hours" is quite arbitrary. 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.
3. 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 affected regulated community and the public have not had the opportunity to comment on the substantive change. The revised regulations pin the responsibility upon the collaborating physician.

Please consider the above in a timely manner as we serving the communities await your decisions. There has been a great amount of attention brought to this subject to various administrations and it affects our practice and reputation. We have served the profession with the utmost concern and quality care for many years. Delaying HB50 further only serves to fail the patient care that we provide. Thank you for your attention.

Sincerely,

K O'Donald, CRNP

Original: 2064

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

Treatment Research Center

RECEIVED
2000 MAY 15 AM 9: 10
INDEPENDENT REGULATORY REVIEW COMMISSION

May 9, 2000

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

RE: Issues on CRNP regulations from Pa. SBON and SBOM

Dear Mr. Nyce:

I am writing as a nurse practitioner seeing patients in Pennsylvania to register my concerns over the joint regulations recently promulgated by the state Boards of Medicine and Nursing. I know that the next step in the regulatory process is for IRCC to review these along with the House and Senate professional licensure committees.

I have two major practical concerns with the joint regulations:

1) In section 21.287, **No physician may serve as colloborating physician for more than 2 nurse practitioners and only a physician may apply for a waiver.** This is obstructive for nurse practitioners and their collaborating physicians. At the treatment center where I work, there are 5 nurse practitioners and we have 1 medical director. There are other physicians who practice in the department, but the way this regulation is written, there would need to be multiple collaborative agreements submittedby us, and an arbitrary assignment of MD to CRNP to try to fit into an artificial ratio. What we do at the Treatment Research Center when caring for addicted patients is meet as a multidisciplinary team daily and weekly to review patients' initial assessments and follow-up to agree jointly on a plan of care. We do assign a different physician daily to be available "on call" for staff in the event that patients present medically or psychiatrically unstable at any time in their treatment so that prompt consultation is available. I see the ratio in the joint regulations as unnecessary, and the paperwork too burdensome. **I recommend a more generous ratio, as in other states, like 1 MD to 5 or 6 CRNP's. I also recommend that clinics, agencies, nurse practitioners and institutions be able to file for a needed waiver to allow for continuity of patient care in existing clinics.**

3900 Chestnut Street • Philadelphia, PA 19104-6178 • 215-222-3200 • FAX: 215-386-6770

2) Section 21.283 **mandates a specific 45 hour pharmacology course to apply for prescriptive authority in this state**. At the time I attended my graduate level nurse practitioner program at the University of Pennsylvania 1988 thru 1991, the semesters were 12 weeks in length. My pharmacology course of 3 credits, as nationally approved, was therefore 36 hours in length. I have been continuously licensed as a CRNP for 9 years, have a total of 30 years of clinical nursing experience and have a master's degree in nursing science. Yet the regulations as promulgated, ignore all this, and would mandate that I take yet another pharmacology course to meet the 45 hours. I estimate that this would cost me several thousand dollars to comply with! I have had hundreds of hours of documented integrated pharacology content with clinical courses in my formal master's program and in the years since graduation when I have been continually certified by the American Nurses' Association as a nurse practitioner in adult health care with a minimum of 75 contact hours every 5 years. My last credentialling at Penn included documention over 2 full pages of contact hours to maintain my clinical priveleges at the hospital. **Recommend: adjust the requirement to read a 45 hour pharmacology course or its equivalent.**

I am conscious of my responsibility when prescribing as a nurse practitioner to remain current with pharmacology. I have consistently exceeded recommendations for contact hours that my employer, state nursing organizations and/ or national nursing standards suggest. Most other states whose CRNP regulations identify hours of pharmacology to be taken baseline, use 30-36 hours, as in New Jersey's regulations. Why would we make this so expensive for Pennsylvania after 25 years of disagreement, when there are so many constituents now who have very little access to primary care? These barriers would create new obstacles for CRNP's to face who are trying to meet existing patient needs.

Yours truly,
Louise Epperson

Louise Epperson, MSN, CRNP
663 Jamestown St. Phila., Pa. 19128

cc: State Senator Clarence Bell
Chair Consumer Protection and Professional Licensure Committee
State Rep. Mario Civera, Chair House Professional Licensure Committee

Original: 2064

May 12, 2000

RECEIVED
2000 MAY 18 PM 1:16
REGULATORY
REVIEW COMMISSION

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

Dear Mr. Nyce,

This letter is in regards to regulations approved by the Boards of Medicine and Nursing concerning prescriptive privileges for Certified Registered Nurse Practitioners (CRNPs). As a CRNP, working with a medically under served population (prisoners), I am very concerned that the regulations will impede my ability to provide adequate, cost effective health care for several reasons.

First, several categories of medications are missing from these regulations. These include 'eye, ear, nose, and throat preparations, hormones and synthetic substitutes, oxytocics, unclassified therapeutic agents, medical devices and pharmaceutical aids'. To be frank, this language is so vague that it could prevent treatment common illnesses such as otitis externa or bacterial conjunctivitis. Furthermore, it will impede women's health care by restricting the prescription of thyroid and estrogen replacement hormone therapy, which as we all know, are used to treat illnesses common to many women. Due to the cited problems, I recommend that the Boards follow the language of the American Hospital Formulary and list each and every drug category in the book.

Secondly, the regulations limit one collaborating physician to working with only 2 CRNPs. In most states there are no limits and in the two states the ratios are 1:5. I am very concerned this would have a negative impact for many medically under served patients in clinics, drug rehabilations programs and prisons.

In addition, the proposed regulations shift the authority for CRNP acts of medical prescription to the collaborating physician. This change will result in costly liability issues for collaborating physicians, resulting in increased cost to patients, as well as, reluctance with physicians to enter in collaborating agreements with CRNPs. The bottom line is that CRNPs should be accountable for their own professional conduct.

In closing, these regulations will limit access to health care by unnecessarily restricting the CRNP. Consequently, I urge to reject these regulations and return them to the Boards for further review and for public comment.

Sincerely,
Louise Dillensnyder MSN, CRNP

Louise Dillensnyder, MSN, CRNP
1923 SW 31st Street
Allentown, PA 18103

CC: Governor Ridge
Senator Clarence Bell
Representative Mario Civera

Original: 2064

RECEIVED
2000 APR 25 AM 8:40
REVIEW COMMISSION

2077 Aster Road
Macungie, Pennsylvania
April 22, 2000

Independent Regulatory Review Commission
333 Market Street 14th Floor
Harrisburg, Pennsylvania

Dear Executive Director Mr. Nyce:

As a family nurse practitioner in the Commonwealth of Pennsylvania, I am writing to express concerns about some of the restrictions in the proposed prescriptive privileges for Certified Registered Nurse Practitioners. While I commend the process to aid in the CRNP scope of practice, I am specifically opposed to the limitation of the prescriptive authority. As a nurse practitioner in a family practice setting, I manage a large variety of different health care problems. The needs of one patient are very different from those of the next; therefore the variety of therapeutic and pharmacologic treatments are also very diverse. To limit the medications that I may use will significantly affect the care that I can provide for my patients. I suspect that this becomes even more of an issue for CRNPs who function in specialty practices because they utilize complex medication regimens within their practices. Please reconsider these limitations and follow the language of the American Hospital Formulary to list every drug category in the prescriptive privileges and specifically to include "ear, nose and throat preparations, hormones and synthetic substitutes, oxytocics, unclassified therapeutic agents, medical devices and pharmaceutical aids". Due to the variety of clinical settings of practice and the frequency of position changes, it is important to keep the prescriptive privilege at the state level rather than at the collaborating physician level. Continuity and quality assurance can be maintained more easily through this process.

Although I completed a program with a defined pharmacology course, please consider grandfathering all of those NPs who did not do so. Current nurse practitioner curricula will be adjusted to meet this requirement rapidly. I do think that the 16 hour refresher course prior to recertification is an excellent idea. It places the responsibility upon me as the practitioner to remain current in practice standards.

My last area of concern is the restriction of two nurse practitioners to one collaborative physician. Once again, I am fortunate to easily meet that requirement, but there are many NPs' who work much more independently. The NP / physician ratio should be expanded to meet the practical needs of both the nurses and the doctors. If the practitioners (both physicians and nurses) are comfortable with larger collaboration bases, why should the Boards feel that such a system is not workable?

Sincerely yours,

Karen Landis RN, MS, CRNP

Karen Landis, RN, MS, CRNP
Family Nurse Practitioner (License TP-004197-B)

cc: Governor Tom Ridge;
Representative Mario Civera;
Senator Clarence Bell

Original: 2064

HEMATOLOGY-ONCOLOGY ASSOCIATES, INC.
Suite 201
400 North 17th Street
Allentown, Pennsylvania 18104-5000
(610) 433-6691
FAX (610) 776-0533

Diplomates, American Boards of Internal Medicine, Hematology, and Medical Oncology

Lloyd E. Barron, II, M.D.
Robert M. Post, M.D.
David Prager, M.D., F.A.C.P.

Oncology Nurses

Linda Barron, R.N., B.S.N., C.G.C.
Sue Grier, R.N., M.S.N., A.O.C.N.
Karin Newell, R.N., B.S.N.
Susan Stine, R.N., O.C.N.

April 28, 2000

RECEIVED
2000 MAY -8 AM 8:51
REVIEW COMMISSION

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

Dear Mr. Nyce:

I am writing regarding regulations proposed by the Board of Medicine and the Board of Nursing concerning prescriptive privileges for certified registered nurse practitioners.

I applaud the efforts of the Boards to address this issue, but I have some concerns about the proposed regulations.

As a graduating nurse practitioner in August, 2000, from Allentown College, I will be working with Hematology Oncology Associates in Allentown, Pennsylvania. I have been employed by Hematology Oncology Associates as a clinical nurse specialist for twelve years. I have preparation prior to my nurse practitioner certificate including a master's in nursing, advanced certification in oncology nursing and I.V. certification. I will be working in the specialty of oncology and I am concerned because of some of the restrictions that have been placed in the current language of House Bill #50. I would recommend that the Board follow the language of the American Hospital formulary to list each and every drug category in the book. Missing categories that nurse practitioners prescribe on a regular basis include eye, ear, nose and throat preparations, hormones and synthetic substitutes, unclassified therapeutic agents, medical devices and pharmaceutical aids. Working in oncology, I will also need the ability to review and sign chemotherapy orders. These would not be the original orders but would be for repeat doses of chemotherapy. It is also necessary for an advanced practice nurse working in oncology to be able to write more than a three day supply of Schedule II analgesics since pain management will be a big part of my job.

The March 30 version of the proposed regulations approved by both Boards shifts the authority for CRNP acts of medical prescription to the collaborating physician and expands the categories of medication which must be specifically listed in the collaborative agreement. These changes will result in serious and costly liability issues for collaborating physicians. I urge you to review this section closely and return the regulatory authority to the Boards.

Overall, I am pleased to see the progress made on these regulations. We know that nurse practitioners provide important access to care in the state of Pennsylvania. Please make sure that the regulations adopted are thoughtful, comprehensive and assure ongoing quality access for patients and include the ability of specially prepared nurses to be able to function within their specialty.

Sincerely yours,

Sue Grier RN, MSN, AOCN

Sue Grier, RN, MSN, AOCN

SG:jhn
CC: Governor Thomas Ridge
Senator Clarence Bell
Representative Mario Savero
ONS government relations committee

Original: 2064

Lynn E. Michels, CRNP
PinnacleHealth Systems
2645 N. 3rd St., Suite 240
Harrisburg, PA 17110

RECEIVED
2000 APR 27 AM 8:29
REVIEW COMMISSION

April 24, 2000

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

Dear Mr. Nyce,

I am writing to add my comments to those you have already received regarding the amended CRNP regulations. While I am grateful to the Board of Nursing for their efforts to negotiate with the Board of Medicine on our behalf, I too have grave concerns about the effect that these regulations will have on access to quality health care for Pennsylvania's citizens, especially poor or underserved populations such as the one I serve in the Women's Outpatient Health Center at PinnacleHealth. My suggestions for revision of the proposed regulations include:

Please consider eliminating the 2 CRNP: 1 physician ratio. If a ratio must be specified, please increase it to at least 5 CRNPs to 1 physician, which is the ratio in the only other states which have a ratio, New York and Colorado. Also, please allow nurse practitioners to request ratio waivers as well as physicians.

Please consider eliminating the 45-hour separate pharmacology course requirement. In my master's degree program at the University of Maryland, pharmacology content was integrated into all of my nurse practitioner course and clinical work. I have been practicing as a nurse practitioner for five years, yet this regulation would require me to incur the considerable expense and inconvenience of taking a separate course, while allowing inexperienced NPs to obtain prescriptive authority immediately if their program happened to include a separate course. Instead, allow the equivalent of 45 hours of pharmacology course work to meet the requirement, no matter how it was structured in the educational program.

Please follow the language of the American Hospital Formulary to list every category, including eye, ear, nose and throat preparations; hormones and synthetic substitutes (especially crucial to me in OB/GYN practice); oxytocics; unclassified therapeutic agents; medical devices, and pharmaceutical aids.

Please remove responsibility and liability for CRNP-written prescriptions from the collaborating physician and place it where it belongs, with the CRNP writing the prescription. No physician should be asked to take responsibility for my clinical decisions. As a nurse with 21 years of experience caring for women in Pennsylvania, I have always been, and will continue to be, responsible for my own actions. In many instances, I have more experience than the physicians who would be required to take unnecessary responsibility for my practice.

Thank you for your consideration of these concerns, which are shared by most of Pennsylvania's approximately 2,500 CRNPs whose practice will be impacted by the new regulations.

Sincerely,

L. Michels CRNP

Lynn E. Michels, CRNP

Original: 2064

Gelnett, Wanda B.

From: MaryLee DeFrain [nur_mld@elkregional.org]

Sent: Sunday, April 23, 2000 2:36 PM

To: IRRC@irrc.state.pa.us

Subject: CRNP

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

Dear Mr. Nyce,

I am currently a Nurse Practitioner student at Penn State University and am writing to you in regard to the CRNP regulations recently approved by the Board of Nursing and Board of Medicine. I am afraid these new regulations will restrict health care access to citizens of the Commonwealth. My specific concerns are as follows:

1. The 2 CRNP: 1 physician ratio
   This provision disadvantages nurse managed centers and clinics, especially those serving underserved rural and urban populations or institutions that utilize multiple nurse practitioners in a specific setting to provide quality care. Also, the physician must apply for the waiver to this ruling, not the CRNP.No other state has such a restrictive requirement. What is the rationale for such restrictions to CRNP practice? Research published in both medical and nursing journals has shown CRNP's care and patient outcomes to be equal to or better than those of physicians. This provision limits CRNPs and puts them at the mercy of physician-initiated waivers that are determined by Boards with a history of over 20 years of stalemate regarding CRNP practice. I would like to request consideration of elimination of this provision or revision, that increases the number of NPs per physician and allows the NP to request waivers as well as a physician.
2. Prescriptive authority
   The new regulations propose a shift of authority from the Board of Nursing to the individual collaborating physician in regard to medical prescription. The proposed regulations require the collaborating physician to attest that he or she has knowledge and experience with any drug that the CRNP will prescribe. This puts the responsibility and liability for every prescription upon the collaborating physician. Wasn't this a medical argument against House Bill 50? Also, the physician is required to take corrective action for inappropriate prescribing or dispensing by the NP. The responsibility for the prescription lies with the provider who prescribed or dispensed the drug. There are already medico-legal parameters established for correcting and reporting prescribing and dispensing errors, making inclusion of this regulation unnecessary and inappropriate. I would request consideration for the language concerning both of the above mentioned situations be removed from the new regulations. Lastly, prescribing and dispensing parameters in the new regulations require physician authorization on certain drugs (Schedule III-V) and limits prescriptions of others to 72 hours (Schedule II). I would request reconsideration of these restrictions as these may be dangerous for the patient who may miss critical doses of medication while awaiting authorization or may cause undo pain and discomfort in the case of certain analgesics which fall into these categories.

Thank you for your attention to my concerns before these new regulations appear in final publication.

Sincerely,
MaryLee DeFrain, R.N., CRNP student

4/24/00

Unit Manager ICU, PACU, SPU, Cardiac Rehabilitation at Elk Regional Health Center

Original: 2064

UNIVERSITY OF PENNSYLVANIA MEDICAL CENTER

Treatment Research Center

University of Pennsylvania School of Medicine
Hospital of the University of Pennsylvania

April 21, 2000

RECEIVED
2000 APR 25 AM 8:41
REVIEW COMMISSION

Mr. Steven Anderson

Chair, Pa. State Board of Nursing

P.O. Box 2649

Harrisburg, Pa. 17105-2649

RE: Issues on CRNP regulations to be voted on by Pa. SBON and SBOM

Dear Mr. Anderson:

I am writing as a nurse practitioner seeing patients in Pennsylvania to register my concerns over the joint regulations that are due to be re-voted on next week in final form. I appreciate the hard work of the Board of Nursing to try to negotiate this issue. **It is critical that the following areas be re-addressed since a re-vote is available:**

As a graduate of the University of Pa. School of Nursing with a master of science in nursing completed in 1991, with continuous CRNP priveleges since then, I am astonished that I cannot even apply for prescriptive authority in Pa. as the document reads now. It is mandated for eligibility in Section 21.283 that a stand-alone pharmacology course of 45 hours to apply for prescriptive authority. My pharmacology course at Penn seems to have been 36 hours . **I have been a professional nurse for 30 years and I am proud of my clinical nursing experience.** Help me understand why, if I attended a program repeatedly assessed as among the **best** in the **nation** for NP's to be educated, I cannot even **apply** for prescrioptive authority in Pa.,where my graduate nursing program continues to operate. I am appalled at the unfairness of this! **No other state has this requirement!** Why did my state board of nursing vote not to recognize the curricula of state and nationally-approved nursing schools? **Surely on re-vote this can be solved by adjusting the language to require a graduate level pharmacology course or its equivalent so that the most experienced nurses are not unfairly penalized.**

Section 21.283 requires 16 hours of pharmacology continuing education every 2 years. I recently submitted **2 full-sized pages of documentation of continuing education that I attended over the last 2 years when reapplying for clinical priveleges at Penn.** However, many seminars that I took from CME, ANA and AANP, integrated the pharmacological information with patient assessment and management in diverse primary care and addictions topics. As currently written in the joint regulations this section may **exclude quality nursing and medical programs** that integrate the care of the patient with many modalities, only one of which is medication therapy. Please consider

adustment that if **solo pharmacology hours be mandated, limit this to 6 every 2 years** not to exclude more comprehensive seminars CRNP's want to attend.

I also wish to comment on the insulting language in the regulations that implies that I would ever misrepresent myself as anything other than a CRNP. I am a professional person; it is deeply inappropriate that only I wear a name-tag if physicians need not do so, as if I would misrepresent myself as a physician if not 'tagged". If I wanted to be a physician, I would indeed have gone thru that training. I have **chosen to be an advanced practice nurse.** Patients have immediately recognized the difference in my philosophy of care. I always introduce myself with my full name and say very clearly and distinctly to patients "I am a nurse practitioner". My business cards reflect this, as does our center literature. There is a sign on my office door with my CRNP status. I consider this section unnecessary and profesionally insulting.

I recommend that you remove section 21.385, # 4 in which a physician is required to have experience with drugs prescribed by the CRNP. This suggest that physicians are unfamiliar with common medications, creating an unnecessary area of liability in collaborative practice. Please remove this section.

I also take issue with section 21.285 that limits a collaborative agreement to exist between a CRNP, a physican and a substitute physician. I practice in a clinic setting with a team of physicians and other CRNP's. **Recommend: broaden participant capability of the collaborative agreement to include practice parameters of clinics, agencies, hospitals and nurse managed centers currently operating in this state.**

My final recommendation has to do with section 21.385, #5 which requires the collaborating physician to specify circumstances when he will see patients, also seen by CRNP's,. Interaction between patients, the CRNP, and the collaborating physician should be based on the patient's specific condition. Flexibility in collaborative agreements allows patient needs to be met on an individual basis. As written, this discourages a physician from collaborating with a CRNP. **Recommend: either remove this section or end it after the words "personally see the patient".**

Yours truly,

Louise Epperson

Louise Epperson, MSN, CRNP
663 Jamestown St. Phila., Pa. 19128

cc: Governor Tom Ridge
State Rep. Mario Civera, chair Professional Licensure Committee
State Representative Rosita Youngblood
State Senator Vincent Hughes
Robert Nyce, Exec. Director, Independent Regulatory Review commission

Original: 2064

2440 Chatham Ct.
State College, PA 16802

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2000 APR 24 AM 8:05
REVIEW COMMISSION

April 21, 2000

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

Dear Mr. Anderson,

I am a Family Nurse Practitioner working at Penn State University in State College, PA. I wish to share with you my opinion regarding the recent agreement with the Board of Medicine.

While I am aware that a tremendous amount of work went into negotiating the recent agreement with the Board of Medicine, I feel that the Board of Nursing members should be apprised of the ramifications of that step in it's present form. After 25 years of obstructing prescriptive authority, I can only view the BOM's recent change of heart as the ultimate obstruction to HB-50 and advanced nursing practice in Pennsylvania.

My concerns are as follows:

1. **Section 21.287** *The addition of the 2 CRNP: 1 physician ratio.* The ratio limitation is an significant change that was added after the close of the October 1999 public comment period on the proposed regulations. It will restrict provision of care in underserved rural and urban populations whose practices can be recognized by their Medicaid, Title X, and CHIP reimbursement as well as by their large volume of uncompensated care. In general, these centers are staffed with multiple part-time CRNPs, and 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. It will also affect larger practices that employ numbers of CRNPs and physicians. The reasoning behind the move is based on restriction of practice, not quality of care. Recommended adjustment: drop or make a reasonable number such as 10.

2. **Section 21.283** *Requirement of a specific 45 hours course in advanced pharmacology.* Until recently, most programs did not have a specific 45 hours course in pharmacology. Often separate courses ranged from 24 to 35 hours depending on the length of a university's semester. Many established programs integrated pharmacology throughout the program instead of offering a single pharmacology course. This rule, as written, places the most experienced practicing nurse practitioners at a disadvantage when attempting to obtain prescriptive authority. Requiring experienced practicing nurse practitioners to take a 45 hours course in addition to the advanced pharmacology already taken in their programs is obstructive. Allowing the BOM to "approve" the course is spurious after their 25 years track record of obstructionism. Recommended adjustment: require a 45 hours course or its equivalent.

3. **Section 21.283** *Requires 16 hours of pharmacology continuing education every two years.* This requirement makes it more difficult to obtain comprehensive clinical continuing education by requiring 16 hours strictly in pharmacology. It is my understanding that this rule is in excess of physician requirements! While pharmacological information is important, it is equally important that clinical continuing education include diagnosing and managing conditions. Recommended adjustment: Reduce continuing education hours that are strictly pharmacology to 6, and require the remainder to be clinical continuing education hours.

4. **Section 21.284** *Prescribing and Dispensing Parameters.* While the majority of missing drug groups were reinstated, some drug groups continue to be missing. Missing categories include

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Oxytoxics, Unclassified Therapeutic Agents, Medical Devices and Pharmaceutical Aids. The American Hospital Formulary Service Pharmacologic-Therapeutic Classification Framework was used, and all categories should be addressed in the regulations. Recommended adjustment: The best method is use of a negative formulary. If this is not possible, the Formulary should address all drug categories listed in the American Hospital Formulary Service Pharmacologic-Therapeutic Classification.

5. **Section 21.284** *Prescribing and Dispensing Parameters: Limits refills of Schedule III-V drugs until there is physician authorization.* This regulation can be both dangerous and traumatic for the patient who misses critical doses of medication while awaiting authorization. The cause of pain and discomfort in withholding medication in the case of certain analgesics is inexcusable. Is the reasoning here that NPs are not intelligent enough or that we are not morally able to handle this responsibility? Recommended adjustment: remove requirement for physician authorization; if necessary change to physician notification.

6. **Section 21.284** *Prescribing and Dispensing Parameters.* This limits prescriptions of Schedule II drugs to 72 hours. Refer to my comment on intelligence & moral fiber. Again, this regulation can be dangerous for the patient who may miss critical doses of medication. Recommended adjustment: remove 72 hours limitation, or extend to 5 or 7 days, if a limitation is unavoidable.

7. **Section 21.284** *Prescribing and Dispensing Parameters.* ***Requires physician to take corrective action for inappropriate prescribing or dispensing by the nurse practitioner.*** The regulation, as stated, puts the physician in an unnecessary position of liability. While both nurse practitioners and physicians should always notify each other and take corrective action when an inappropriate prescribing or dispensing action has taken place, *the responsibility for the prescription lies with the provider who prescribed or dispensed the drug.* There are already medico-legal parameters established for correcting and reporting prescribing and dispensing errors, making the inclusion of this regulation unnecessary and inappropriate. Recommended adjustment: Remove this section (d)

8. **Section 21.285** *Collaborative agreement.* Once again, this is not a pharmacology issue as stated here. It limits collaborative agreement to an agreement between a nurse practitioner, a physician and a substitute physician. This is obstructive and problematic when a nurse practitioner is working in a clinic, agency, hospital or nurse managed center where collaborative agreements are established among nurse practitioners and physicians affiliated with those entities. Recommended adjustment: Broaden the participant capability of the collaborative agreement to include the practice parameters of these entities.

9. **Section 21.385** *Collaborative agreement Section 4. Requires physician attestation that he or she has knowledge and experience with drugs prescribed by the NP.* This is again insulting, this time for the physicians, and suggests that physicians are not familiar with medications indicated on patients they are consulted on. It places the physician in a tenuous and totally unnecessary liability situation since it is unclear how much "knowledge or experience" is acceptable. Recommended adjustment: Remove this section.

10. **Section 21.385** *Collaborative agreements Section 5. Requires agreement to specify circumstances and how often collaborating physicians will see patients.* There is no clarification based on type of practice site, condition of the patient, treatment, etc. Interaction between patients and collaborating physician are based on the specific needs and conditions of each patient. Collaborative arrangements should be made with enough flexibility that patients' needs are met and safe care can be delivered by the nurse practitioner in collaboration with the health care team without obstruction. That is the definition and intent of collaborative practice. This requirement as written is an obstructive regulation that will most likely discourage physicians from entering into collaborative arrangements with nurse practitioners. Recommended adjustment: Remove this section or end after the words "personally see the patient."

Thank you very much for your diligent efforts on the behalf of Advanced Practice. I am grateful for those efforts, but also deeply concerned that good intentions have lead to a situation far worse than what we face at the moment. I would rather take my chances with HB 50 than be placed in an even more hostile and restrictive practice environment.

Sincerely,

GBudd

Geraldine M. Budd MS, CRNP
Gmb8@psu.edu
home: 814-861-8830
work: 814-863-2230

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2000 APR 24 AM 8:05
REVIEW COMMISSION

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Fax

To: R. Nye

Of: IRRC

Fax: 717-783-5417

Phone:

Pages: 4, including this cover sheet.

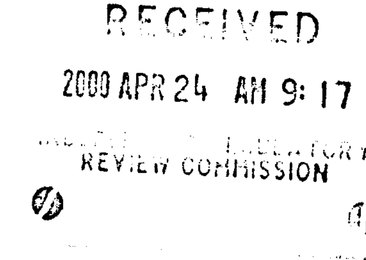
Date: 4/21/00

Message:

From the desk of...

Rebecca Beatty, MS, RN
Coordinator, Continuing and Distance Education in
Penn State University
307 Health and Human Development Building East
The Pennsylvania State University
University Park, PA 16802-6508
(814) 863-2202
Fax: (814) 863-8188

Original: 2064



April 21, 2000

Denise J. Hough, MSN, CRNP
261 Walnut Street
Carlisle, PA 17013
(717) 243-7222 dajcrnp@epix.net

Stephen K. Anderson
Chair, State Board of Nursing
P.O. Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

I am a Family Nurse Practitioner working in the Commonwealth and I have several concerns regarding the recent prescriptive authority regulations passed by the Board of Nursing on March 30, 2000. Several key areas construct serious barriers to practice for advanced practice nurses as the regulations now dictate. Please consider changes to the following sections:

1. Section 21. 283 Requirement of a specific 45 hour course in advanced pharmacology. Until recently, any programs did not have a specific 45 hour course in pharmacology. Often, separate courses ranged from 24 to 35 hours depending on the length of a university's semester. In addition, pharmacology was integrated into all of the clinical courses taken by the nurse practitioner student. Many programs integrated the pharmacology throughout the program instead of offering a single pharmacology course. This rule as written, places the most experienced practicing nurse practitioners at a disadvantage when attempting to obtain prescriptive authority in the state while allowing new inexperienced graduates to have full prescriptive authority right out of school. Requiring experienced practising nurse practitioners to take a 45 hour course in addition to the advanced pharmacology already taken is obstructive and spurious. Adjust the requirement to," 45 hours or it's equivalent"

2. Section 21. 287 Physician supervision: No physician may serve as a collaborating physician to more than two nurse practitioners. Only a physician may apply for a waiver. This provision disadvantages nurse managed centers, clinics serving vulnerable populations such as migrant clinics and federally qualified health centers and practices, agencies and institutions that utilize multiple nurse practitioners in a specific setting to provide quality care. No other state has such a limited requirement, This provision is obstructive and establishes significant barriers to access for patients seeking care in any of these environments. Remove the requirement. If this is not possible, increase the number of NP's per physician to 6-10. Allow nurse practitioners, clinics, agencies and institutions to request waivers as well as physicians.

3. Section 21. 284 Prescribing and Dispensing Parameters. While the majority of missing drug groups have been reinstated, some drug groups continue to be missing. Missing categories include Oxytoxics, Unclassified Therapeutic Agents, Medical Devices and Pharmaceutical Aids. Since the American Hospital Formulary Framework is to be used, all categories should be addressed in the regulations. Adjust the section to address all drug categories listed in the American Hospital Formulary Service Pharmacologic-Therapeutic Classification.

4. Section 21.284 Prescribing and Dispensing Parameters. This limits refills of Schedule III-V drugs until there is a physician authorization. This regulation can be dangerous for the patient who may miss critical doses of medication while waiting authorization and cause undo pain and suffering in the case of certain analgesics falling into this category. Adjust the section and remove the requirement for physician authorization, if necessary change to physician notification.

5. Section 21. 284 Prescribing and Dispensing Parameters. Limits prescriptions of Schedule II drugs to 72 hours. This regulation can be dangerous for the patient who may miss critical doses of medication. Remove the 72 hour limitation or extend to 5 or 7 days.

6. Section 21. 284 Prescribing and Dispensing Parameters. Requires physician to take corrective action for inappropriate prescribing or dispensing by the nurse practitioner. This regulation puts the physician in an unnecessary position of liability. While both nurse practitioners and physicians should always notify each other and take corrective action when an inappropriate prescribing or dispensing action has taken place, the responsibility for the prescription lies with the provider who prescribed or dispensed the drug. There are already medico-legal parameters established for correcting and reporting prescribing and dispensing errors, making the inclusion of this regulation unnecessary and inappropriate. Remove this section.

7. Section 21. 285 Collaborative Agreement. Limits the collaborative agreement to an agreement between a nurse practitioner, a physician and a substitute physician. This is obstructive and can be problematic when a nurse practitioner is working in a clinic, agency, hospital or nurse managed center where collaborative agreements are established among nurse practitioners and physicians affiliated with these entities. Broaden the participant capability of the collaborative agreement to include the practice parameters of these entities.

8. Section 21. 385 Collaborative Agreement. Section 4 requires physician attestation that he or she has knowledge and experience with drugs prescribed by the NP. This is a redundant requirement and suggests that physicians are not familiar with medications indicated for patients for whom the physician is consulting. It places the physician in a tenuous and unnecessary liability situation since it is unclear how much knowledge or experience is acceptable. Remove this section.

9. Section 21. 385 Collaborative Agreement. Section 5 requires agreement to specify circumstances and how often collaborating physicians will see patients, based on type of practice site, condition of the patient, treatment is for an ongoing or new condition and whether the patient is new or continuing. Interaction between patients and collaborating physician are based on the specific needs and conditions of each patient. Collaborative arrangements should be made with enough flexibility that patient needs can be met and safe care can be delivered by the nurse practitioner in collaboration with the health care team without obstruction. This requirement as written is an obstructive regulation that will most likely discourage physicians to enter into collaborative arrangements with nurse practitioners. Remove this section or end after the words, "personally see the patient".

In closing, thank you for all of the time and effort the Board of Nursing has dedicated to the prescriptive authority regulations. With the additional changes suggested in this letter, the Commonwealth will be in a position to offer progressive and affordable health care to it's citizens.

Yours truly,

Denise J. Hough, MSN, CRNP

Denise J. Hough, MSN, CRNP

CC:

Governor Tom Ridge
Room 225
Main Capitol Building
Harrisburg, PA 17120

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

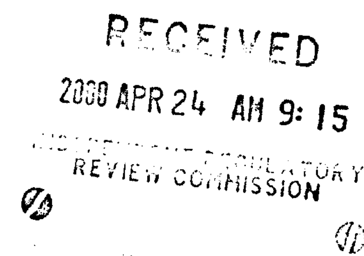
Representative Mario Civera, Chair
Professional Licensure Committee
House of Representatives
P. O. Box 202020
Harrisburg, PA 17120-2020

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

Representative Al Masland
District 199
Room 51A East Wing
Main Capital Building
Harrisburg, PA 17120

Original: 2064

April 20, 2000



Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
P.O. Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

Members of the Alliance of Advanced Practice Nurses have discussed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have grave concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. We strongly urge the Board to revise the regulations in the following four ways:

1. Ensure access to care by eliminating the 2 CRNP: 1 physician ratio. The ration limitation is a substantive change that was added after the close of the October 1999 public comment period on the proposed regulations. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ration pertains to prescriptive authority only or to CRNP—physician collaboration in general. 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 the 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. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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, or in the comments of the Independent Regulatory Review Commission not in the 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 experience 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, 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: "cyc.

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 collaboration 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 tat a CRNP might prescribe with the 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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens.

Sincerely,

Laura E. Kelly

Laura E. Kelly, MS, CRNP
133 Bayberry Lane
Cranberry twp. Pa.
16066

Cc:

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

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

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

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

Original: 2064

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2000 APR 24 AM 9: 19
REGULATORY REVIEW COMMISSION

1132 Linn Dr.
Carlisle, PA 17013

April 19, 2000

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

Dear Mr. Nyce:

I have sent a letter of concern about the proposed prescriptive privilege regulations to Mr. Anderson , Chair of the State Board of Nursing. I also felt you should be advised with the same information. I have read a copy of the proposed regulations and feel there are some problem areas that need to be addressed.

Section 21.283 (2) requires 45 hours of a specific course in advanced pharmacology. I feel this would be less discriminatory if "or its equivalent" were added. The current language ignores the pharmacotherapeutics included in integrated courses and unfairly penalizes many of the most experienced CRNPs in the State. In (3), the 16 hours of pharmacology seems too restrictive and could more appropriately be 16 hours of clinically relevant CEUs to include at least 6 hours of pharmacology.

In Section 21.284, 92.00, unclassified drugs and 94.00, medical devices were omitted and need to be there. To improve this whole section, why not just end it after dispense in (a) and eliminate the phrase subject to the parameters identified in this section. There will always be something left out! In (d), it would be more appropriate for the CRNP, not the physician, to take the corrective action.

In Section 21.285, there are no guidelines for evaluation of the collaborative agreement if practices are challenged. In (4), it is a problem for a physician to be clairvoyant and know he will have knowledge of all the drugs the CRNP will prescribe when treating patients. If this were followed the way it is written, the CRNP would have to check with the physician each time she wrote for a drug the physician hadn't specifically approved, not just what's on the list. In (5), we are moving backwards because this is currently not required and sounds like the physicians are trying to incorporate PA regulations into the CRNP regulations!

A very troublesome concern is Section 21.287, allowing a physician to supervise no more than two CRNPs. It is restraining and designed to limit what is currently being done in such places as migrant clinics and some medical center and underserved clinics that rely on CRNPs for staffing since there is a paucity of applying physicians.

Finally, although these regulations are for prescriptive authority, it is not spelled out that CRNPs can continue to practice as they have been if they choose not to apply for prescriptive privileges when the regulations go into effect. If the pharmacology hours stay as written, this could be the case for those CRNPs who need to meet this requirement with a formal course. I thank you for your consideration of the concerns I share with many other nurse practitioners. I look forward to a resolution to our practice constraints in Pennsylvania and optimistic it will be resolved.

Sincerely,

Geraldine L. Earwood

Geraldine L. Earwood, MSN, RN, CS, CRNP

Original: 2064

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2000 APR 24 AM 9: 19
REVIEW COMMISSION

April 19, 2000
1270 Toann Road
York, PA 17403

Mr. Steve Anderson
Chair Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

Members of the Alliance of Advanced Practice Nurses and Nurse Practitioners of Central Pennsylvania have discussed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have grave concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. We strongly urge the Board to revise the regulations in the following four ways:

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. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP--physician collaboration in general. 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 1/15/00 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 then those of physician practices. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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 comments of the Independent Regulatory Review Commission, nor in the 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. The requirement of 16 hours of continuing education in pharmacology is also arbitrary. This does not reflect the needs of all health care providers to be well rounded in their approach to patient care. While pharmacology is certainly an important component, it should not prevail above other aspects of continuing education. A minimum requirement of 6 hours of continuing education in pharmacology would ensure ongoing education on medical therapeutics and allow precious resources to be used to further update NP's in other areas.

4. 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".

5. 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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens. Please contact me if you would like further information.

Sincerely,
Christine Gold, MSN, CRNP
Christine Gold MSN. CRNP

CC:

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

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

Representative Mario Civera, Chair

Professional Licensure Committee
House of Representatives
PO Box 202020
Harrisburg, PA 17120-2020

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

Melinda Jenkins, PhD, RN,CS
Assistant Professor of Primary Care
Director, Family Nurse Practitioner Program
Univ. of Pennsylvania School of Nursing
420 Guardian Drive
Philadelphia, PA 19104-6096
215-898-2280, fax 215-573-7381

Original: 2064

South Philadelphia Pediatrics, P.C.

☐ 1400 South 5th Street
Philadelphia, PA 19147
Tel. (215) 467·3515
Fax (215) 467·0338

☐ 701 South 2nd Street
Philadelphia, PA 19147
Tel. (215) 592·0715

☐ 2240 South 3rd Street
Philadelphia, PA 19148
Tel. (215) 755·2652

April 19, 2000

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2000 MAY -4 AM 8:46
REVIEW COMMISSION

Charles D. Hummer, Jr., M.D., Chair
Pennsylvania Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Dear Dr. Hummer:

I recently learned about the amendment to the CRNP regulations that the Board of Medicine approved. I understand that great effort has gone into the negotiations of this amendment. However, I have serious concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. I strongly urge the Board to revise the regulations in the following four ways:

1. Mandate updated clinical education of providers by requiring clinically relevant Continuing Education Units of <u>any type</u> rather than purely Pharmacology CEU's. The overwhelming majority of excellent CEU programs offered by CEU providers in Pennsylvania have <u>some</u> pharmacology content in the context of clinical presentations. For example, a program on asthma might include current diagnostic testing and assessment of asthma classifications, environmental controls, methods to evaluate and enhance patient and family compliance, and medication use. Under these regulations, such a program would not be acceptable for Continuing Education. To restrict acceptable CEU's to Pharmacology only would put undue scheduling and accessibility burdens on my staff. The new regulations suggest that only Pharmacology content is relevant. I believe that these regulations will encourage nurse practitioners and their employers to seek and pay for CEU's that are narrowly defined primarily by their pharmacology content, thereby eliminating the rest of the clinical education sorely needed to keep pace with changes in the health care arena. This restriction was added after the October 1999 public comment period, and I believe that it will unduly narrow CEU's sought by CRNP's in Pennsylvania.

2. Ensure access to care by eliminating the 2 CRNP:1 physician ratio. I currently employ three part-time nurse practitioners, and have been safely doing so for many years. Again, the ratio limitation is a substantive change that was added after the close of the October 1999 public comment period on the proposed regulations. While the amendment ostensibly was written to clarify the CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP-physician collaboration in general. Stakeholders and the public have had no opportunity to comment on this most limiting and arbitrary aspect of the regulations.

South Philadelphia Pediatrics, P.C.

☐ 1400 South 5th Street
Philadelphia, PA 19147
Tel. (215) 467·3515
Fax (215) 467·0338

☐ 701 South 2nd Street
Philadelphia, PA 19147
Tel. (215) 592·0715

☐ 2240 South 3rd Street
Philadelphia, PA 19148
Tel. (215) 755·2652

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. 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 substantive change.

Thank you very much for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Medicine to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens. Please contact me if you would like further clarification of my concerns.

Sincerely,

Theodore S. Tapper

Theodore S. Tapper, M.D.
South Philadelphia Pediatrics

cc: Governor Tom Ridge
✓Robert Nyce, Executive Director
Independent Regulatory Review Commission
Representative Mario Civera, Chair
Professional Licensure Committee
House of Representatives
Senator Clarence Bell, Chair
Consumer Protection & Professional Licensure Committee

Original: 2064

Rosemary K. Danchick, MSN CRNP

106 North Lewisberry Road, Dillsburg, Pa. 17019
717-766-324 (cell # 717-571-9077)
email: rsmry1rn@ptd.net

RECEIVED
2000 APR 24 AM 9: 19
INDEPENDENT REGULATORY REVIEW COMMISSION

April 19, 2000

Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, Pa 17105-2649

Dear Mr. Anderson:

I am writing to thank you and the entire board for working so hard on producing prescribing regulations for Nurse Practitioners (NPs). I understand that there was great pressure to accept the regulations as revised by the medical board.

However, I do have three specific concerns regarding the proposed regulations. First, please consider holding fast on a ratio of no less than 1:5, MD: NP. A ratio of 1:2 would close many functional programs, serving needy populations, and unnecessarily hinder the scope of practice of NPs.

Secondly, while you finalize your collaboration with the Board of Medicine, please specify the basic NP educational preparation requirement to 45 hours **or the equivalent in experiential background**. Most nurse practitioner preparation programs, as late as 5 years ago, did not have specifically titled pharmacology courses. The study of pharmacology was, instead, a component of every course taken. All practicing NPs have been working and developing expertise, with current pharmaceuticals, as an integral part of their day to day professional careers.

Thirdly, I am concerned that the 16 hours of pharmacology study required for renewal of the state NP license will be, at best, difficult to determine as stated above. The best continuing educational programs are holistic approaches, to various specific health problems, with an integral component being the study of the best pharmacological interventions. Given this situation, calculating hours of "pharmacology" does not seem possible or productive. An overall professional development requirement for renewal of the NP license may be necessary with some designated pharmacological study delineated within the total number of hours.

Thank you for your consideration of these issues.

Sincerely,

Rosemary K Danchick

Rosemary K. Danchick MSN CRNP

C: Robert Nyce, Executive Director
Independent Regulatory Review Commission.

Original:2064

RECEIVED
2000 APR 26 AM 8:24
REVIEW COMMISSION

April 19, 2000

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

Dear Mr. Nyce:

As an Executive Director of Family Health Services of South Central Pennsylvania, I am writing to share my concern for the latest directives that have come to my attention regarding prescriptive authority for Certified Registered Nurse Practitioners. I understand that regulations are being put into final form and will soon be reviewed by the Governor, The IRRC (Independent Regulatory Review Commission), and House and Senate Professional Licensure Committees.

A recent note from Melinda Jenkins, CRNP addressed the vast amount of attention and effort on the Board's part that went into negotiations of the amendment to the CRNP regulations. However, several concerns were expressed in this same letter about the access to essential health care for citizens of the Commonwealth.

A major concern for our agency, located in rural south central PA, is the regulation related to collaborative agreement/physician supervision. The rural nature of our geographic location limits the number of physicians who would be available to serve as collaborating physicians. The ratio of two CRNPs to one physician, as I understand it, is a substantiative change in the regulations and has direct impact in our area. We are very fortunate to have a physician at one of our locations who volunteers his time to provide supervision of our CRNPs

.

At another site, we have to pay an hourly fee for any client seen by our physician (I am being asked to increase that allocation this summer). In that particular community, I am limited to this one physician who can serve as our Consulting Physician. As we continue to expand our services, we would find it difficult to continue to serve the poverty level and low income clients if we an incurred additional cost for medical supervision.

Additionally, our agency provides services to clients who fall predominantly in the 100% poverty income level. These clients present common diagnostic and treatment needs for family planning that can be managed with protocols and oversight by our Medical Director.

240 N. 7TH ST. • CHAMBERSBURG 17201 • 264-2957
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P.O. BOX 943 • WAYNESBORO • 17268

In response to the second major concern for CRNP's, the advanced pharmacology course, perhaps the committee could investigate the directed study format offered at Graceland College in Independence, MO. It might be helpful to have information from that institution regarding their approach to the requirements of the National Organization of Nurse Practitioners and the State Boards of Kansas and Missouri for advanced pharmacology for advanced practice. This is an expensive course; however, does not require time away from work. There would most likely be academic programs in Pennsylvania offering master's education that could develop something similar.

In my experience teaching in an accredited master's program for family nurse practitioners, I have found the research literature to demonstrate that advanced practice nurses provide outcomes equal to or better than those of physicians. Advanced practice nurses are educated to provide advanced practice nursing care. Collaboration with a physician is an essential element of their practice; however, with clear directives and protocols that establish the standard of practice at our site, we have managed very well with our current ratio of one medical director providing oversight for our advanced practice nurse clinicians.

It is my hope that the collective wisdom of those working to implement regulations, that provide services to all our citizens, will prevail.

Sincerely,

Susan Hildebrand, EdD, RN
Executive Director

Original: 2064

April 18, 2000

RECEIVED
2000 APR 24 AM 9:16
REGULATORY REVIEW COMMISSION

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

Dear Mr. Nyce;

I am writing to you in regards to regulations proposed by the Board of Medicine and the Board of Nursing concerning prescriptive privileges for Certified Registered Nurse Practitioners. While I applaud the efforts of both Boards to address this issue I have several concerns about the proposed regulations.

I am concerned that the section which requires "a specific course...of not less than 45 hours" in Advanced Pharmacology" is unnecessarily restrictive. I would request that the regulations be revised to allow a summation of 45 hours of Advanced Pharmacology and that the requirement that the course be specifically Advanced Pharmacology be omitted.

I would recommend that the Boards follow the language of the American Hospital Formulary to list each and every drug category in the book. The missing categories must be inserted as drugs we 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 which limits a collaborating physician to working with only 2 NPs is a concern for providers in a variety of settings. This is likely to have a negative impact on access to care. In other states such limitations are not common and in the two states which do set such ratios the ratios are 1:5.

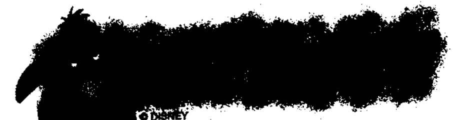
The March 30 version of the proposed regulations, approved by both Boards, shifts the authority for CRNP acts of medical prescription to the collaborating physician and expands the categories of medications which must be specifically listed in the collaborative agreement from 5 to 21. These changes will result in a serious and costly liability issue for a collaborating physician. I urge you to review this section closely and return the regulatory authority to the Boards.

Overall we are pleased with the progress made on these regulations. We know that Nurse Practitioners provide important access to care in our state. Please make sure that the regulations adopted are thoughtful, comprehensive and assure on-going quality access for our patients.

Sincerely,

Mary Kay Wegman RN, MSN, CRNP, FNP-C

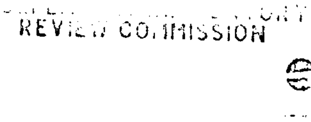
CC: Governor Ridge
Senator Clarence Bell
Representative Mario Civera



Original: 2064

RECEIVED

2000 MAY 26 AM 8:52



1132 Linn Dr.
Carlisle, PA 17013

April 19, 2000

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

Dear Mr. Nyce:

First, I want to thank the Board of Nursing for all the work done to develop joint regulations. I realize there was a lot of pressure put on members recently that resulted in the surprising approval of the CRNP Prescriptive Authority, NO.16A-499. I have read a copy of the proposed regulations and feel there are some problem areas that I will address.

Section 21.283 (2) requires 45 hours of a specific course in advanced pharmacology. I feel this would be less discriminatory if "or its equivalent" were added. The current language ignores the pharmacotherapeutics included in integrated courses and unfairly penalizes many of the most experienced CRNPs in the State. In (3), the 16 hours of pharmacology seems too restrictive and could more appropriately be 16 hours of clinically relevant CEUs to include at least 6 hours of pharmacology.

In Section 21.284, 92.00, unclassified drugs and 94.00, medical devices were omitted and need to be there. To improve this whole section, why not just end it after dispense in (a) and eliminate the phrase subject to the parameters identified in this section. There will always be something left out! In (d), it would be more appropriate for the CRNP, not the physician, to take the corrective action.

In Section 21.285, there are no guidelines for evaluation of the collaborative agreement if practices are challenged. In (4), it is a problem for a physician to be clairvoyant and know he will have knowledge of all the drugs the CRNP will prescribe when treating patients. If this were followed the way it is written, the CRNP would have to check with the physician each time she wrote for a drug the physician hadn't specifically approved, not just what's on the list. In (5), we are moving backwards because this is currently not required and sounds like the physicians are trying to incorporate PA regulations into the CRNP regulations!

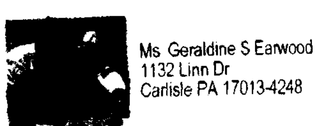
A very troublesome concern is Section 21.287, allowing a physician to supervise no more than two CRNPs. It is restraining and designed to limit what is currently being done in such places as migrant clinics and some medical center and underserved clinics that rely on CRNPs for staffing since there is a paucity of applying physicians.

Finally, although these regulations are for prescriptive authority, it is not spelled out that CRNPs can continue to practice as they have been if they choose not to apply for prescriptive privileges when the regulations go into effect. If the pharmacology hours stay as written, this could be the case for those CRNPs who need to meet this requirement with a formal course. I thank you for your consideration of the concerns I share with many other nurse practitioners. I look forward to a resolution to our practice constraints in Pennsylvania and optimistic it will be resolved.

Sincerely,

Geraldine L. Earwood

Geraldine L. Earwood, MSN, RN, CS, CRNP



Original: 2064

April 19, 2000

RECEIVED
2000 APR 24 AM 9:17
REVIEW COMMISSION

Robert Nyce, Executive Director
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17120

Dear Robert Nyce:

As a fellow Pennsylvanian, I would like to share some concerns I have over the wording of the recently approved amendment to the Certified Registered Nurse Practitioner (CRNP) regulations by the State Board of Nursing. I appreciate the amount of work that the Board has done thus far but along with other Advanced Practice Nurses, have strong concerns about changes in wording that will affect healthcare for all Pennsylvanians. I recommend the Board revise the amendment in the following four areas to assure access, and they are:

1. Eliminate the (2 CRNP: 1 physician) ratio. Eliminating the ratio requirement would:
   - ensure better access of quality healthcare for all Pennsylvanians by not requiring this tiny ratio.
   - clarify the amendment language which is confusing as to whether the ratio applies to the prescriptive authority only or to CRNP-Physician collaboration in general.
   - have Pennsylvania join most other states in not having a ratio. If a ratio is used, then at least, use the ratio used by the two states that have ratios, New York and Colorado, of 5:1.
   - avoid a regulation amendment ratio that would place NPs at the mercy of physician-initiated waivers determined by Boards. These Boards have a twenty-year history of stalemates.
2. Change the wording of the pharmacology requirement to read "a summation" of 45 hours rather than a 45 hour course. A 45 hour course requirement would add undue cost and time to meet. Advanced Practice Nurses support this important concept and a summation would allow NPs to meet this in a variety of professional ways without undue cost or time.
3. Use the language of the American Hospital Formulary by citing each and every category in the book, and insert the terms: eye ear, nose and throat preparations; hormones and synthetic substances; oxytocics; unclassified therapeutic agents; medical devices; and pharmaceutical aids, as was discussed at the March 30th Boards' approval.
4. Revise the regulation by Maintaining Statutory Board Authority over CRNP acts of medical prescription and not shifting it to a collaborating physician. The State Board of Nursing should have and maintain the authority over Advanced Practice Nurses which should include prescriptive authority.

I thank you for your time and hope that you encourage the Board to change the wording of the amendment so that we can all help Pennsylvanians receive high-quality, safe health care. As an Advanced Practice Nurse who has lived in Erie for 50 years, I know that the decisions made in Harrisburg can affect all of us and I look to your help on this important issue. Pennsylvania needs to make these changes and join the vast majority of other states and improve healthcare for the new century. For further questions please call me at 814-864-1298 or e-mail me at bcarrier@peoplepc.com.

Thank You,

Brenda J Carrier

Brenda J. Carrier MSN, CRNP

Brenda Carrier
7254 Tampa Blvd.
Erie, PA 16509-4566

Original: 2064

RECEIVED
2000 APR 25 AM 8:41
REVIEW COMMISSION

April, 18, 2000

Mr. Steven Anderson, Chair
PA Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Re: CRNP regulations

Dear Mr. Anderson,

I have been a nurse practitioner for the past 20 years and am dedicated to quality care for each patient that I serve. In providing care I use an evidenced based, algorithmic approach to diagnosis and treatment.

My original nurse practitioner education included pharmacotherapeutics integrated into the curriculum and not as a separate course. Through my years of experience I have endeavored to keep up-to-date in all areas of care including pharmacotherapeutics through continuing education opportunities and personal study.

Many nurse practitioners in Pennsylvania, experienced professionals with significant expertise, have not had a separate 45 hour course in pharmacotherapeutics. To require this of these professionals, at this point in their careers, does not seem appropriate.

It is hoped that the Board of Nursing will revisit this requirement. New York state regulations allow for nurse practitioners who did not have a separate pharmacology course "by accepting alternative criteria which would be equivalent in content and scope to a pharmacotherapeutics course". The Pennsylvania boards could amend the regulations to include equivalent education. Please consider this adjustment to the regulations.

I appreciate the enormous amount of attention and effort by the Board in the negotiation of the amendment.

Thank you for your attention.

Sincerely,

Ann Lee, CRNP
33 Abbott Road
Bradford, PA 16701

cc: Governor Tom Ridge
Mr. Robert Nyce
Representative Mario Civera
Senator Clarence Bell

Original: 2064

April 18, 2000

RECEIVED
2000 APR 24 AM 8:36
REGULATORY REVIEW COMMISSION

Mr. Steve Anderson
Chair Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,
Members of the Alliance of Advanced Practice Nurses and The Nurse Practitioners of Central Pennsylvania have discussed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have grave concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. We strongly urge the Board to revise the regulations in the following four ways:

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. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP--physician collaboration in general. 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. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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 comments of the Independent Regulatory Review Commission, nor in the 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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens.

Sincerely,

Jean Rudisill

Jean Rudisill, MS, CRNP

Vice-President of Nurse Practitioners of Central Pennsylvania

CC:

Governor Tom Ridge

225 Main Capitol

Harrisburg, PA 17120

3661 Coventry Ct.
York Pa.
17402

Original: 2064

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1900 W. Olney Avenue
Philadelphia, PA 19141-1199 • (215) 951-1565 • FAX (215) 951-1566

RECEIVED
2000 APR 24 AM 9:20
REVIEW COMMISSION

April 18, 2000

Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

Members of the Alliance of Advanced Practice Nurses have discussed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have grave concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. We strongly urge the Board to revise the regulations in the following four ways:

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collaborative relationships. Unbiased research has shown their patient outcomes to be equal to or better than those of physician practices. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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.

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Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens.

Sincerely,

Andrea Z. Okagawa, MPH, CRNP
LaSAlle University
Student Health Service

CC:

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

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

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

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

Melinda Jenkins, PhD, RN,CS
Assistant Professor of Primary Care
Director, Family Nurse Practitioner Program
Univ. of Pennsylvania School of Nursing
420 Guardian Drive
Philadelphia, PA 19104-6096
215-898-2280, fax 215-573-7381

Original: 2064

RECEIVED
2000 MAY 31 AM 9:11
REVIEW COMMISSION

April 18, 2000

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

Dear Mr. Nyce;

I am writing to you in regards to regulations proposed by the Board of Medicine and the Board of Nursing concerning prescriptive privileges for Certified Registered Nurse Practitioners. While I applaud the efforts of both Boards to address this issue I have several concerns about the proposed regulations.

I am concerned that the section which requires "a specific course...of not less than 45 hours" in Advanced Pharmacology" is unnecessarily restrictive. I would request that the regulations be revised to allow a summation of 45 hours of Advanced Pharmacology and that the requirement that the course be specifically Advanced Pharmacology be omitted.

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Overall we are pleased with the progress made on these regulations. We know that Nurse Practitioners provide important access to care in our state. Please make sure that the regulations adopted are thoughtful, comprehensive and assure on-going quality access for our patients.

Sincerely,

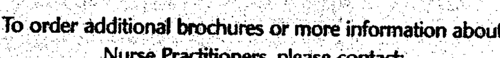
Lucinda Cebular CRNP

Dear Mr Nyce,
Please assist us in obtaining less restrictive privileges which will allow for more comprehensive care.
Thank you

CC: Governor Ridge
Senator Clarence Bell
Representative Mario Civera

Cherish each precious day

FRANK AND LUCINDA CEBULAR
2318 Bradley Way, Pottstown, PA 19464



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Fx: (512) 442-6469
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Web Site: http://www.aanp.org

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Issued 1988, Revised 1997

The Nurse Practitioner

A Primary Health Care Professional

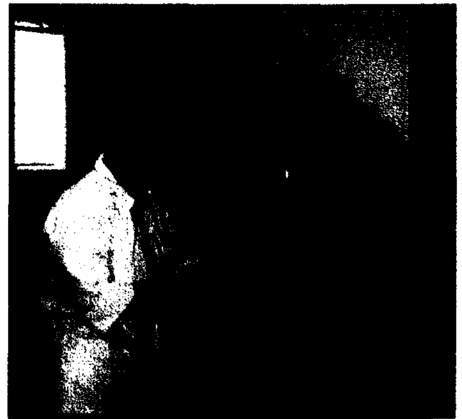
WHAT IS A NURSE PRACTITIONER?

A Nurse Practitioner is a registered nurse (RN) who has advanced education and clinical training in a health care specialty area. Nurse Practitioners work with people of all ages and their families, providing information people need to make informed decisions about their health care and lifestyle choices.

Nurse Practitioners practice under the rules and regulations of the Nurse Practice Act of the state in which they work. Most nurse practitioners are also nationally certified in their specialty area. They are recognized as expert health care providers.

urse Practitioners may be found in all 50 states. Research studies since 1965 have documented that Nurse Practitioners provide:

- ➤ High quality care
- ➤ Cost-effective care
- ➤ A unique approach to health care
- ➤ Care that results in a high level of patient satisfaction



... SERVICES DO NURSE ...ONERS PROVIDE?

Nurse Practitioners serve as the regular health care provic for children and adults during health and illness. In order provide complete health care, Nurse Practitioners:

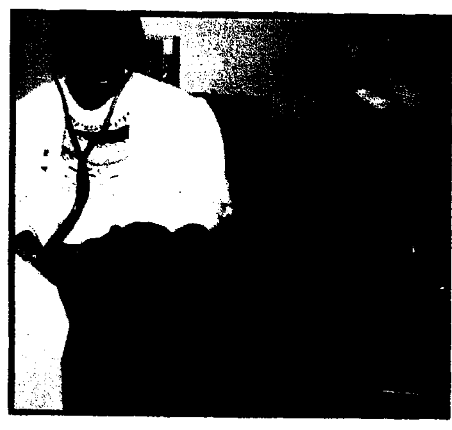
- ➤ Obtain medical histories and perform physical examinat
- ➤ Diagnose and treat acute health problems such as infec
- ➤ Diagnose, treat, and monitor chronic diseases such as d
- ➤ Order, perform, and interpret diagnostic studies such as
- ➤ Prescribe medications and other treatments
- ➤ Provide prenatal care and family planning services
- ➤ Provide well-child care, including screening and immuni
- ➤ Provide health maintenance care for adults, including ar
- ➤ Promote positive health behaviors and self-care skills th
- ➤ Collaborate with physicians and other health profession

Nurse Practitioners do more than direct patient care. Ma nurse practitioners are also actively involved in educatic research, and legislative activities to promote quality health ca for all people in the United States.

WHAT ARE THE SPECIALTY AREAS OF NURSE I

Nurse Practitioners provide primary health care in a number

- ➤ Acute Care
- ➤ Adult
- ➤ Emergency
- ➤ Family
- ➤ Gerontologic/Elder Health
- ➤ Neonatal/Perinatal
- ➤ Occupational H
- ➤ Pediatric/Child I
- ➤ Psychiatric/men
- ➤ School/College
- ➤ Women's Healtl



ns
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 as needed

ACTITIONERS?

 specialty areas, such as:

lth
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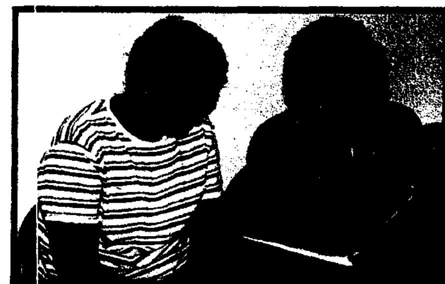
 Health
alth

WHERE DO NURSE PRACTITIONERS WORK?

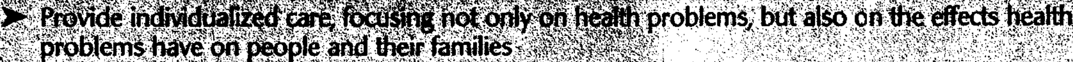
In an effort to make health care available to as many people as possible, Nurse Practitioners work in both rural and urban settings, such as:

- Community Health Centers
- Public Health Departments
- Hospitals and Hospital Clinics
- School and College Student Health Clinics
- Business and Industry Employee Health Settings
- Physician Offices
- Nurse Practitioner Offices
- Health Maintenance Organizations
- Nursing Homes and Hospices
- Home Health Care Agencies
- The Armed Forces and Veterans' Administration Facilities
- Schools of Nursing



WHY CHOOSE A NURSE PRACTITIONER?

More and more people are choosing Nurse Practitioners for their regular health care provider because Nurse Practitioners are health professionals who:



- ➤ Provide individualized care, focusing not only on health problems, but also on the effects health problems have on people and their families
- ➤ Explain the details of health problems, medications, and other topics to help people fully understand how to take care of themselves
- ➤ Ask about people's worries and concerns about their health and their health care
- ➤ Emphasize wellness and self-care by giving people the information they need to make healthy lifestyle choices and health care decisions
- ➤ Charge competitive fees which are covered by health insurance programs

☆☆ A Publication of ☆☆

American Academy of Nurse Practitioners

April 18, 2000

RECEIVED

2000 MAY 18 PM 1:15

INDEPENDENT REGULATORY
REVIEW COMMISSION

Original: 2064

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

Dear Mr. Nyce;

I am writing to you in regards to regulations proposed by the Board of Medicine and the Board of Nursing concerning prescriptive privileges for Certified Registered Nurse Practitioners. While I applaud the efforts of both Boards to address this issue I have several concerns about the proposed regulations.

I am concerned that the section which requires "a specific course...of not less than 45 hours" in Advanced Pharmacology" is unnecessarily restrictive. I would request that the regulations be revised to allow a summation of 45 hours of Advanced Pharmacology and that the requirement that the course be specifically Advanced Pharmacology be omitted.

I would recommend that the Boards follow the language of the American Hospital Formulary to list each and every drug category in the book. The missing categories must be inserted as drugs we 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 which limits a collaborating physician to working with only 2 NPs is a concern for providers in a variety of settings. This is likely to have a negative impact on access to care. In other states such limitations are not common and in the two states which do set such ratios the ratios are 1:5.

The March 30 version of the proposed regulations, approved by both Boards, shifts the authority for CRNP acts of medical prescription to the collaborating physician and expands the categories of medications which must be specifically listed in the collaborative agreement from 5 to 21. These changes will result in a serious and costly liability issue for a collaborating physician. I urge you to review this section closely and return the regulatory authority to the Boards.

Overall we are pleased with the progress made on these regulations. We know that Nurse Practitioners provide important access to care in our state. Please make sure that the regulations adopted are thoughtful, comprehensive and assure on-going quality access for our patients.

Sincerely, Eileen P. Connors, CRNP

CC: Governor Ridge
Senator Clarence Bell
Representative Mario Civera

E. Connors
2134 B State St
Allentown, PA 18011

IRRC # 2064 Title Certified Registered Nurse Practitioner's Regulation

(Form A - CRNPConcerns)		
NAME	ADDRESS	DATE of CORRESPONDENCE
Maria J. Sie	1591 Cherry Lane Macungie, PA 18062	April 25, 2000
Gail Barry	1914 Alborta Drive Whitehead PA 18052	April 25, 2000
Kimberly A Buteberg	1236 Anna Marie St Easton, PA 18018	April 25, 2000
Sandy Torres	734 Hawthorne Rd Beth, PA 18018	April 25, 2000
Barbara L Kuhn	1718 Dill Street Allentown, PA 18109	April 25, 2000
Jean Perry	4311 Ravenwood Rd, Altown, PA 18103	April 25, 2000
Dylan Falco	961 W. Emaus Ave A-Town, PA 18103	April 25, 2000
Illegible Signature	435 W. Galant Street Allentown, PA 18102	April 25, 2000
Kathleen Fritch	454 Gronge Rd. Allentown, PA 18106	April 25, 2000
Melissa M. Labar	118 W. Brookdale Street Allentwn, PA 18103	April 25, 2000
Amy L. Radcliffe	835 S. Jefferson Street Allentown, PA 18103	April 25, 2000
Ronald G. Haworth	429 Warren Street Phillipsburg, NJ 08865	April 25, 2000
Illegible Signature	4079 Waterford Drive Center Valley, PA 18034	April 25, 2000
Jennifer Nyce	839 Radclyffe Street Bethlehem, PA 18017	April 25, 2000
Tara Heckman	4131 South 5th Street Emmaus, PA 18049	April 25, 2000
Gary Bishop	176 Forsythia Lane Alentown, PA 18104	April 25, 2000
Earlene Miller	95 E. Broad Street Bethlehem, PA 18018-5915	April 26, 2000
Kely Hauley ms-npc	3316 Sherwood Road Easton, PA 18045	April 18, 2000
Susan Bryant, MSN, CRNP	1517 Pond Road Allentown, PA 18104	April 18, 2000
Elizabeth Parr	2871 Golf Circle	April 18, 2000

	Emmaus, PA 18049	
Mary Bealer, CRNP	224 Stephen Street Emmaus, PA 18049	April 18, 2000
Jacqueline Crocetti, CRNP	3835 Green Pond Road Bethlehem, PA 1020-7599	April 24, 2000
Joyce A. Brill,	1217 Lorain Avenue Bethlehem, PA 18018	April 26, 2000
Brenda L. Hay	4335 Adams Street Whitehall, PA 18052	April 18, 2000
Ann Lushis	5116 Melrose Avenue Bethlehem, PA 18017-5112	April 18, 2000
Joan A. Dunbobbin, CRNP	4520 Parkview Drive Schnecksville, PA 18078	April 18, 2000
Joyce A. Dobish	971 Bridge Court Catasaugus, PA 18032	April 25, 2000
Marion Repko	1715 Pinewind Drie Alburtis, PA 18011	April 18, 2000
Michael Gyorek	One Maryland Circle, T-18 Whitehall, PA 18052	April 24, 2000
Heidi Dauter	329 California Road Quakertown, PA 18951	April 18, 2000
Valeri Schissler	1623 Riegel Street Hellertown, PA 18055	April 18, 2000
Alice Holland,	97 Alpine Drive Jim Thorpe, PA 18229	April 18, 2000
Paula A. Riola	3343 Congress Street Allentown, PA 18104	April 18, 2000
Barbara E. Smith	141 Green Hill Road Barto, PA 19504-9319	April 18, 2000
Richard P. Solga	182 Tilghman Street Allentown, PA 18102	April 18, 2000
Joanne E. Ryan	182 Tilghman Strete Allentown, Pa 18102	April 24, 2000
Randy Trilli	1943 South Hall Street Allentown, PA 18103	April 24, 2000
Tammy L. Dymech	421 Chew Street Allentown, PA 18102-3490	April 18, 2000
Sharon G. Smith	2281 Meadow Lane Emmaus, PA 18049	April 18, 2000
Elizabeth Hyde	1010 N. 13th Street Allentown, PA 18102-1127	April 18, 2000
Constance Molehony	1064 American Street N. Catasaugua, pA 18032	April 27, 2000
Kim Zsitek	4339 Dumpling Drive Orefield, PA 18069	April 27, 2000
Cathy Bailey	293 E. 11th Street	April 18, 2000

	Northampton, PA 18067	
Mary L. Williams	2551 Columbus Drive Emmaus, PA 18049-4547	April 18, 2000
M. Todisco	6480 Fawn Lane Center Valley, PA 18034	April 18, 2000
Antoinette Santee	480 Schoeneck Avenue Nazareth, PA 18064	April 21, 2000
Maxine T. Klein	1436 Hampton Road Allentown, PA 18104	April 18, 2000
Wendy Grulse	6900 Hamilton Boulevard P.O. Box 60 Trexlertown, PA 18087-0060	April 18, 2000
Kathleen D. Post	1240 South Cedar Crest Boulevard, Ste 310 Allentown, PA 18103	April 18, 2000
Debra a. Bishwaly	1240 South Cedar Crest Blvd Ste 310 Allentown, PA 18103	April 18, 2000
Debbie J. Kumar	4936 Mar Street Coopersburg, PA 18036	April 18, 2000
Marsha K. Evans	923 Eagle Drive Emmaus, PA 18049	April 18, 2000
The Vose Family	733 North 12th Street Allentown, PA 18102	April 18, 2000
Faye A. Ellis	8215 Pheasant Run Fogelsville, PA 18051-1523	April 18, 2000
Cindy Himpler	2000 Clarenden Drive Easton, PA 18040	April 18, 2000
Richard & Maureen O'Connell	2217 Linden street Bethlehem, PA 18017-4855	May 3, 2000
Daniele Shollenberger	No return address given	April 18, 2000
Joyce V. Newman	211 Callery Drive Blandon, PA 19510	April 26, 2000
Jill E. Sabol	163 Lindfield Circle Macungie, PA 18062	April 26, 2000
D. Falco	1101 W. maus Ave Allentown, PA 18103	April 26, 2000
Norbert E. Szymaushi	416 Yorkshire Drive Bethlehem, PA 18017	April 26, 2000
Frank Gaus	78 PK Blvd Allentown, PA 18104	April 26, 2000
Mary P. Fabiammo	1101 Emaus Ave Allentown, PA 18104	April 26, 2000
Gary (illegible)	391 Bucton Road E. Windsor, NJ 08820	April 26, 2000
Matthew S. DeFazo	524 S. 25th Street	April 26, 2000

	Allentown, PA 18104	
Marguerite Schoffer	3121 Alton Ave Allentown, PA 18103	April 26, 2000
Ruth E. (illegible)	1101 W. Emaus Ave Allentown, PA 18105	April 26, 2000
Sarah Kotch	2744 Crest Ave S. Allentown, PA 18104	April 26, 2000
Amy D. Scott	1725 Brandywine Road Allentown, PA 18104	April 18, 2000
Doris & Albert Trilli	205 South 9th Street Bangor, PA 18013	May 1, 2000
Peggy Berringer	5206 8th Ave Temple, PA 19560	May 1, 2000
Jaime. Rodgers	6400 Glen Road Coopersburg, PA 18036	May 1, 2000
Karen Moskowitz	6075 Chestnut Hill Road Coopersburg, PA 18036	April 26, 2000
V. Mark Dennis	526 Furnace Street Emmaus, PA 18049	April 30, 2000
Debbie Klotz	1939 South Hall Street Allentown, PA 18103	April 30, 2000
Robin B. Kirley (Not a clear signature)	3544 Valley View Road Bethlehem, PA 18020	April 18, 2000
Antonctta Prclovsky	801 Ostrum Street Bethlehem, PA 18015	May 3, 2000
Sr. Adella Lukai	920 North Trout Street Allentown, PA 18102	May 1, 2000
Phil Troxell	445 North 5th Street Allentown, PA 18102	May 1, 2000
Sr. Agnes Simmons	920 North Front Street Allentown, PA 18102	May 1, 2000
Adriana M. Halaby	117 South 4th Street Apt 306 Allentown, PA 18102	May 1, 2000
Sister Clarice	714 Layler Bethlehem, PA 18015	May 1, 2000
Sister M. Francine	920 North Front Street Allentown, PA 18102	May 1, 2000
Sr. Rose Lechner	920 North Front Street Allentown, PA 18102	May 1, 2000
Patricia Kelley	1530 North 19th Street Allentown, PA 18102	May 1, 2000
Sister Clare	714 Laufer Street Bethlehem, PA 18015	May 1, 2000
Bonnie Heydt	920 North Front Street Allentown, PA 18102	May 1, 2000

Kristin Flora	4461 Flora Drive Emmaus, PA 18049-5332	April 18, 2000
Susan Holecz	4188 Eisenhower Drive Bethlehem, PA 18020-8946	April 18, 2000
Michelle Kratzer	842 S. 12th Street Allentown, Pa 18103	April 27, 2000
Illegible signature	525 Green Court Bethlehem, PA 18015	April 27, 2000
Maryanne (unclear)	4122 Park Avenue Slatington, PA 18080	April 27, 2000
Carrol Sorrentino	1114 Jemen Avenue Allentown, PA 18104	April 27, 2000
Karen A. Piluson	18 North Hunselberger Lane Soudection, PA 18964	April 27, 2000
Thomas J. Pallodin	18A Fairview Ave Perkasie, PA 18944	April 27, 2000
Michele Heinze	3138 Alton Ave Allentown, PA 18103	April 27, 2000
Maria Jones	1936 Tilghman Street Fogelsville, PA 18051	April 27, 2000
Thomas K. Jalinson	4229 Valley Drive Allentown, PA	April 27, 2000
E.W. (unclear)	805 Renres way Easton, PA 18040	April 27, 2000
Sargeant Giordaus	244 Wedgewood Road Beth, PA 18017	April 27, 2000
Lisa Deramo	233 D S. Penn Street Allentown, PA 18102	April 27, 2000
Robert Wegener	26 Brookfield Drive Fleetwood, PA 19522	April 27, 2000
Lynn A. Schollins	133 Deerfield Road Broomall, PA 19008	April 27, 2000
Scott Hallett	810 Gilbers hill road Lehighton, PA 18231	April 27, 2000
Cathy DePaulo, CRNP	South Mountain Family Practice Center 1545 Broadway Bethlehem, PA 18015	April 18, 2000
Jane Lessel	6358 Sewterne Drive Mocunjie, PA 18062	May 15, 2000
Mary Anne Johnson	4229 Valley Drive Allentown, PA 18104	May 15, 2000
Steven C. Shuck	1241 Broad Street #8 Whitehall, PA 18052	May 15, 2000
Jessica Kratz	1604 Kramer Road Kutztown, PA 19530	May 15, 2000
Scott Schultz	2775 Red Oak Circle	May 15, 2000

	Bethlehem, PA 18017	
Lori Bello	966 Barnside Road Allentown, PA 18103	May 15, 2000
Heather Greenspan	6155 Whitetail Drive Coopersburg, PA 18036	May 15, 2000
Todd General	3 Martland Circle Whitehall, PA 18052	May 15, 2000
Melissa Kuhns	400 Beury's Road Ashland, PA 17921	May 15, 2000
Joseph Transue	2497 Swanwood Bath, PA 18014	May 15, 2000
Tish Langan	1125 Fisk Street Scranton, PA 18509	May 15, 2000
Usula Burek	2508 Serenity Street Schwenksville, PA 19473	May 15, 2000
Eileen P. Connors, CRNP	2134B State Street Alburtis, PA 18014	April 18, 2000
Susan Wilcox	4115 Tamarack Tr Bethlehem, PA 18020	May 14, 2000
Albert Dambroslir	1600 Lehigh Parkway East Apt 4R Allentown, PA 18103	May 14, 2000
Tara Brown	491 South 10th St Apt D202 Quakertown, Pa 18951	May 14, 2000
Paul Bose	3324 Careon Street Whitehall, PA 18052	May 14, 2000
James D. (illegible)	8 Brandywine Drive Milltolley, NJ 08060	May 14, 2000
Thomas Yen	4937 Marawatha Way Meadville, PA 18106	May 14, 2000
Daniele Shollenberger	2902 Willow Lane Emmaus, PA 18062	May 14, 2000
Don Beigle	11 S. Vassar Drive Quakertown, PA 18951	May 14, 2000
Paul (illegible)	444 W. 3rd Street Bethlehem PA 18015	May 14, 2000
Kathy Frank	1510 7th Street Bethlehem, PA 18020	May 14, 2000
Dan Fabian	565 Centennial Road Albortis, PA 18011	May 14, 2000
Mary A. Verderame, RN	310 Pace Street West Chester, PA 19382	May 17, 2000
Thomas Williams	1541 Highpoint Road Coopersburg, PA 18036	May 20, 2000
Karen Williams	1541 Highpoint Road	May 20, 2000

	Coopersburg, PA 18036	
Jeanette Gruber	No address on envelope	May 20, 2000
Melissa Taylor	2411 Wnding Road Hatboro, PA 19040	April 18, 2000
Fay L. McMannus	Springton Lake Middle School 1900 N Providence Road Media, PA 19063	April 18, 2000
Helen B. Kain	Bryn Mawr Rehab 414 Paoli Pike Malvern, PA 19355	May 20, 2000
Wendy S. Markus	Bryn Mawr Rehab 414 Paoli Pike Malvern, PA 19355	May 20, 2000
Melissa Gale	Bryn Mawr Rehab 414 Paoli Pike Malvern, PA 19355	May 20, 2000
Gail Goetz	Bryn Mawr Rehab 414 Paoli Pike Malvern, PA 19355	May 20, 2000
Allison G. Steele	Bryn Mawr Rehab 414 Paoli Pike Malvern, PA 19355	May 20, 2000
Susan L. Bott	Bryn Mawr Rehab 414 Paoli Pike Malvern, PA 19355	May 20, 2000
Nancy Crane-Roberts	2443 Wassergass Road Hellertown, PA 18055	April 18, 2000
Jamie Garcia	6467 Hunter's Hill Rd. Germansville, PA 18053	May 26, 2000
Brent Juoluth	81 Water Crest Dr. Doylestown, PA 18901	May 26, 2000
Mary Archer	35 Jarth Dr. Blandon, PA 19510	May 26, 2000
Cathy Kissinger	2421 Filbert Ave. Mt. Penn PA 1960	May 26, 2000
Jim Hartey	621 Charles Dr. Gilbertsville, PA 19525	May 26, 2000
Leonard Gentlent	1236 Anne Marie St. Easton, PA 18045	May 26, 2000
Andrew D. Madevic	1154 E.Cedar St. Allentown, PA 18103	May 26, 2000
Michael R. Solge	398 Adams Lane Bath PA 18014	May 26, 2000
Alexander & Helen Solga	182 Tilghman St. Allentown, PA 18102	May 26, 2000

Theresa Anderson	1519 Walnut St. Apt 814 Allentown, PA 18102	May 26, 2000
Christopher Vedros	1320 Walnut Lane Macunge, PA 18062	May 26, 2000
Brian DeLawter	1582 Pinewind Dr. Alburhs, PA 18011	May 26, 2000
Dave Moore	234-D Levan Street Allentown, PA 18102	May 26, 2000
Patricia & William Drost	320 Sumner Ave. Whitehall, PA 18052	May 26, 2000
SM Moclevic R.N. B.S. M.S.	738 4th St. CHTA 18032	May 26, 2000
Suzanne Lagler	104 5th St. Whitehall, PA 18052	May 26, 2000
Barry Lagh	104 5th St. Whitehall, PA 18052	May 26, 2000
Jeannine L. Charest	8571 Ridge Drive Maceengie, PA 18062	May 26, 2000

Original: 2064

9211 Palmer Rd.
North East, PA 16428
April 17, 2000

RECEIVED
2000 APR 24 AM 8:35
REGULATORY REVIEW COMMISSION

Dear Mr. Nyce,

I am writing to express my deep concern over a few provisions in Certified Registered Nurse Practitioner regulations newly approved by the State Boards of Medicine and Nursing; specifically, the 45 hour pharmacology course requirement and the 2:1 NP/physician ratio. I'm sure you'll receive many letters from other NPs about these two provisions. We feel that we did not have a meaningful opportunity to give our input into these proposed regulations. The 45 hour course and the 2:1 ratio were substantial additions which went beyond the scope of the originally proposed regulations.

We NPs are worried that the 45 hour requirement will penalize those NPs who have been practicing the longest. They were educated at a time when pharmacology was integrated into their courses, and was not offered separately. It's not fair to penalize them by requiring them to spend a lot of money and time to take a course in pharmacology which they don't need. The wording should be changed to state "...completed a specific course in advanced pharmacology of not less than 45 hours, OR ITS EQUIVALENT, in accordance...". I work in New York state. That's how their regulation is worded.

We're also asking you to change the 2:1 ratio to something more workable, such as a 6:1 ratio of full-time NPs. Access to care would then be ensured for those Pennsylvanians who receive their health care in nurse-managed clinics, university clinics, or women's health clinics. These are generally the poorest patients and they need to have a guarantee that their health care centers will not be closed down due to lack of collaborating physicians. I know there's a process for a waiver but personally don't feel that the waiver will be easy to obtain, based on the Board of Medicine's behavior over the last 25 years in regards to NPs.

IRRC's regulations allow a temporary postponement of the votes on a final form regulation. I urge you to initiate such a postponement, or a "tolling", in order to more deeply examine the consequences of the final form regulations before they are adopted.

Sincerely,

S Murawski

Sue Murawski, CRNP

cc: Governor Ridge
Representative Mario Civera
Senator Clarence Bell

Original: 2064

April 17, 2000

RECEIVED

2000 APR 19 AM 8:28

REVIEW COMMISSION

Dear Sir:

As a certified registered nurse practitioner, I am writing this letter to comment on Title 49, the professional and vocational standards pertaining to CRNP practice. There are several troublesome areas in 21.283.

one of the troublesome issues is #2 with the requirement for a separate advanced pharmacology course of at least 45 hours. It is advantageous to require such a course, but it should not specify a certain number of hours as there are a variety of formats for CRNP preparation.

Another area of controversy os #3 of 21.283. is the requirement for 16 hours of continuing education in pharmacology on a biennial basis. This number of hours seems to be arbitrary, and would require tuition and lost work time.

Finally, the section 21.287. on physician collaboration is overly restrictive. There are nurse managed centers, rural medical clinics, and inner city clinics where the staffing is primarily NP, and there are more than 2 NPs to collaborating physicians.

Thank you for consideration of my comments.

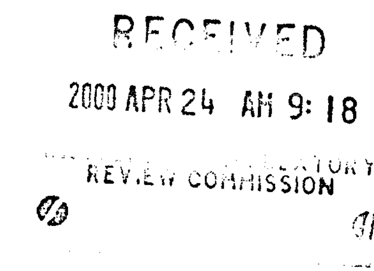
Sincerely,

Priscilla G Hooper

Priscilla G Hooper, MSN, CRNP
741 Collins Drive
Lewisberry, Pa 17339

Original: 2064

337 Dickinson Avenue
Swarthmore PA 19081
(610) 544-8890



April 17, 2000

Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

I have recently learned about the amendment to the CRNP regulations that the Board of Nursing recently approved. I understand that great effort has gone into the negotiation of this amendment. However, I have serious concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. I strongly urge the Board to revise the regulations in the following five ways:

1. Require updated clinical education of providers by requiring clinically relevant Continuing Education Units of any type rather than purely Pharmacology CEU's. The overwhelming majority of excellent CEU programs offered by CEU providers in Pennsylvania have some pharmacology content in the context of clinical presentations. For example, a program on Asthma might include current diagnostic testing, assessment of asthma classifications, environmental controls, methods to evaluate and enhance patient and family compliance, etc. Under these regulations, such a program would not be acceptable for Continuing Education. I, my employer and my professional association values all of this content in the context of complete care for the patient.
New regulations suggest that only Pharmacology content is relevant. I believe that these Regulations will encourage Nurse Practitioners and their employers to seek and pay for CEU's that are narrowly defined primarily by their Pharmacology content, thereby eliminating the rest of the clinical education sorely needed to keep pace with changes in the Health Care arena. This restriction was added after October 1999 public comment period, and I believe that it will unduly narrow CEU's sought by CRNP's in Pennsylvania.

2. 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. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP--physician collaboration in general. Stakeholders and the public have had no opportunity to comment on this most limiting and arbitrary aspect of the regulations. I believe that the ratio is indefensible and should be totally eliminated..

3. Allow summation of advanced pharmacology hours to credit a total of 45 hours. I believe you have received letters explaining this rationale, so I will not repeat this language.

4. 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".

5. 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 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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens. Please contact me if you would like further information.

Sincerely,

Colleen Guiney MSN CRNP

Colleen Guiney, MSN, CRNP
Pediatric Nurse Practitioner
South Philadelphia Pediatrics

CC:

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

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

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

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

Original: 2064

RECEIVED
2000 APR 24 AM 9:20
REVIEW COMMISSION

April 17, 2000
Robert Nyce, Executive Director
Independent Regulatory Review Commission
333 Market Street., 14th Floor
Harrisburg, PA 17101

Dear Mr. Nyce,

Members of the Alliance of Advanced Practice Nurses have discussed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have grave concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. We strongly urge the Board to revise the regulations in the following four ways:

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. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP-physician collaboration in general. 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 under served 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. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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 comments of the Independent Regulatory Review Commission, nor in the 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 course work 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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens. Please contact me if you would like further information. I am currently involved in a MSN/NP program, specializing in Psychiatry. These regulations are very important to me as they are to many Advanced Practiced Nurses in this state. Thank you for your time and attention.

Sincerely,

George C. Ehrhorn III, RN,C
355 Sunnyside Ave
Harleysville, PA 19438

CC:
Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

Mr. Steve Anderson
Chair Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

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

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

Original: 2064

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2000 APR 24 AM 9:18

REVIEW COMMISSION

April 16, 2000

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

Dear Mr. Nyce,

It is my understanding that the State Boards of Nursing and Medicine have approved final form regulations for Certified Registered Nurse Practitioner (CRNP) Prescribing Authority. It is also my understanding that several passages of those regulations differ substantially from the version opened for public comment in October 1999. We hope to address these issues with the IRRC and the Boards. This copy is for your review.

Sincerely,

R. Eric Doerfler, NP
President

1430 Bridge Street
New Cumberland, Pennsylvania 17070
Phone: 717.712.0993 Fax: 712.0994

Nightingale Health Center

April 11, 2000

Mr. Steve Anderson
Chair Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

My comments will echo those you may have now received on the CRNP Prescribing Regulations recently approved by the Board. We applaud the Board for working with this difficult issue. We do have concerns about some specific points that arose after the opportunity for public comment (items that differ widely from the version published in draft in *Pennsylvania Bulletin*). We urge the Board to revise the regulations in the following four ways:

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. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP--physician collaboration in general. 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.

We believe that the ratio 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. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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 comments of the Independent Regulatory Review Commission, nor in the 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

1430 Bridge Street
New Cumberland, Pennsylvania 17070
Phone: 717.712.0993 Fax: 712.0994

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, for an estimated total of $12.5 million! The original version presented for public comment noted: "Fiscal Note: 16A-499. No fiscal impact; (8) recommends adoption." We believe the intent of the requirement is appropriate; it's form is unsound, unfair, and unnecessarily expensive (if not for the Commonwealth, at least for its citizens). 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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens. Please contact me if you would like further information.

Sincerely,

R. Eric Doerfler, NP
President
Nightingale Health Centers Inc.

Gelnett, Wanda B.

From: Laura Bateman [laura.bateman@sru.edu]
Sent: Friday, April 14, 2000 1:16 PM
To: IRRC@irrc.state.pa.us
Subject: CRNP Regs. Prescribing and Dispensing drugs

Original: 2064

Is this legal. To make last minute additions and changes to the Regs,
approve and send them on to you with no opportunity for public comment
or
discussion!

Original: 2064

RECEIVED
2000 APR 24 AM 8:40
REVIEW COMMISSION

April 14, 2000

Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

The Regional Nursing Centers Consortium, an association of 24 community-based nurse-run health centers, and the Alliance of Advanced Practice Nurses have reviewed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have several concerns about the effects that these regulations may have on access to essential quality health care for citizens of the Commonwealth. We strongly urge the Board to revise the regulations in the following four ways:

I. 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. *While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP--physician collaboration in general.* 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.** Our member nurse-run health centers and other CRNP practices across the state provide essential quality health care services 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 (up to 60% on any given day).

3721 Midvale Avenue • Philadelphia, PA 19129 • Tel: (215) 951-0330 exts. 140, 141 & 147 • Fax: (215) 951-0342
E-mail: rncc@rncc.org • www.rncc.org

Most of these centers are staffed with multiple part-time CRNPs, are affiliated with university-based 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. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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.

II. ALLOW SUMMATION OF ADVANCED PHARMACOLOGY HOURS.

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 comments of the Independent Regulatory Review Commission, nor in the 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.

III. FOLLOW THE LANGUAGE OF THE AMERICAN HOSPITAL FORMULARY.

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".

IV. MAINTAIN THE STATUTORY BOARD AUTHORITY OVER CRNP ACTS OF MEDICAL PRESCRIPTION.

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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of the nursing profession as they protect the health, safety, and welfare of Pennsylvania citizens. Thank you for your attention to these critical matters and please call me at (215) 951-0330 ext. 147 if you have any questions.

Very truly yours,

Tine Hansen-Turton
Executive Director

Cc: Regional Nursing Centers Consortium Governing Council

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

Michael Weaver
225 Main Capitol
Harrisburg, PA 17120

Fritz Bittenbender
225 Main Capitol
Harrisburg, PA 17120

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

Representative Mario Civera, Chair
Professional Licensure Committee
House of Representative PO Box 202020
Harrisburg, PA 17120-2020

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

Original: 2064

RECEIVED
2000 APR 17 AM 9:28
REVIEW COMMISSION

April 12, 2000

Deb Papp
1211 Poplar Street
Kulpmont, Pa 17834

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

Dear Mr Nyce,

Members of the Alliance of Advanced Practice Nurses have discussed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have grave concerns about the effects that these regulations may have on access to essential health care for citizens of the commonwealth. We strongly urge the Board to revise the regulations in the following four ways:

1. Ensure access to care by eliminating the 2 CRNP: 1 physician ration. The ratio limitation is a substantive change that we added after the close of the October 1999 public comment period on the proposed regulations. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP—physician collaboration in general. 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 where 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 CRNP's by physicians. There are only tow 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 outcomes to be equal to or better than those of physician practices. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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 comments of the Independent Regulatory Review Commission, nor in the 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. Fro 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 that 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.

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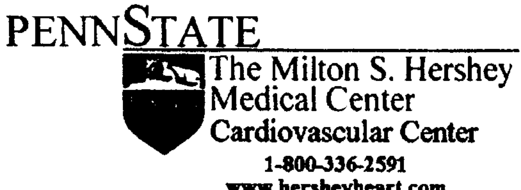
Thank you for your attention to these concerns before the regulations appears in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens. Please contact me if you would like further information.

Sincerely,

Debra Papp, MSN, CRNP, NP-C

Original: 2064


PENNSTATE
The Milton S. Hershey Medical Center
Cardiovascular Center
1-800-336-2591
www.hersheyheart.com

RECEIVED
2000 APR 17 AM 9:26
INDEPENDENT REGULATORY REVIEW COMMISSION

Michelle J. Nickolaus, CRNP
The Milton S. Hershey Medical Center
Cardiovascular Center
P.O. Box 850 MC H139
Hershey, PA 17033
Phone: (717) 531-5411 or 531-6419

April 13, 2000

Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

Recently you received a letter from the Alliance of Advanced Practice Nurses in reference to amendments made to the recently approved CRNP regulations.

I would also like to point out some grave concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. I strongly urge the Board to revise the regulations in the following four ways:

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. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP--physician collaboration in general. 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.

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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 comments of the Independent Regulatory Review Commission, or in the comments of the Pennsylvania Medical Society. While I acknowledge the importance of advanced pharmacology education for CRNPs, I 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.

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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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens. Please contact me if you would like further information.

Sincerely,

Michelle J. Nickolaus, MSN, CRNP

Michelle J. Nickolaus, MSN, CRNP
ACNP-CS, Board Certified Acute Care Nurse Practitioner
Interventional Cardiology

CC:

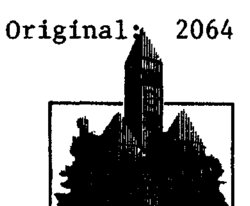
Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

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

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

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

Original: 2064



RECEIVED
2000 APR 18 AM 8:55
INDEPENDENT REGULATORY REVIEW COMMISSION

Division of Student Affairs

SLIPPERY ROCK UNIVERSITY

MEMO

TO: **Steve Anderson, Chair**
Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

FROM: ______________________
Claire R. Schmieler, Asst. Vice President for Student Affairs

SUBJECT: **CRNP Regulations**

DATE: **April 13, 2000**

I am responding to the CRNP regulations recently approved. As the director of a Nursing Model University Student Health Center, I must inform you that we will no longer have the ability to provide cost-effective service to our consumers.

McLachlan Student Health Center was accredited by the Accreditation Association for Ambulatory Health Care, Inc. in 1997. The center provides more than 20,000 client contacts each year utilizing three full-time and three part-time nurse practitioners, as well as a team of registered nurses, many ANA Certified in College Health. This accredited facility utilizes a physician two and one half hours/day with telephone support 24hours/day, seven days/week.

The health center serves as a model example of utilizing mid-level providers to provide quality health care. The new CRNP regulations will prevent the functioning of our staff by requiring a very limited CRNP/physician ratio. The available budget will not support increasing the physician complement at our center.

I am very distressed about the loss of service our students will experience due to these new regulations and I am open to your suggestions to prevent loss of this very effective program serving the students at Slippery Rock University.

C: Governor Tom Ridge
Robert Nyce, Executive Director, Independent Regulatory Review Commission ✓

McLachlan Student Health Center Slippery Rock, PA 16057-1326 (724) 738-2669 Fax (724) 738-2078
e-mail: claire.schmieler@sru.edu

Original: 2064

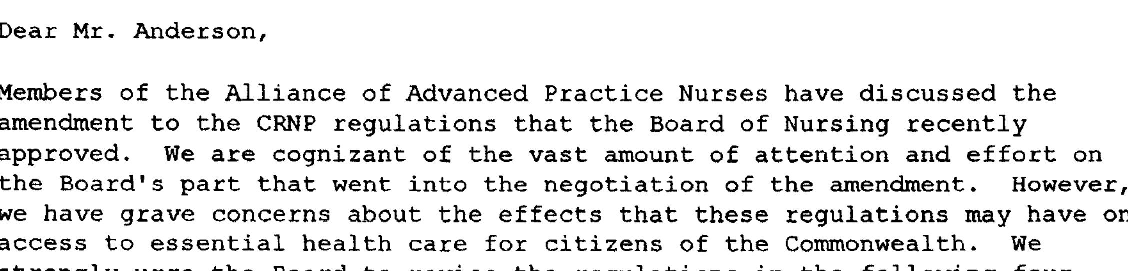
****

RECEIVED
2000 APR 17 AM 9:27
REVIEW COMMISSION

555 Abington Ave.
Glenside, PA 19038
April 12, 2000

Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,



Members of the Alliance of Advanced Practice Nurses have discussed the amendment to the CRNP regulations that the Board of Nursing recently approved. We are cognizant of the vast amount of attention and effort on the Board's part that went into the negotiation of the amendment. However, we have grave concerns about the effects that these regulations may have on access to essential health care for citizens of the Commonwealth. We strongly urge the Board to revise the regulations in the following four ways:

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. While the amendment ostensibly was written to clarify CRNP prescriptive authority, it is unclear whether the ratio pertains to prescriptive authority only or to CRNP--physician collaboration in general. 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. CRNPs should not be forced to pay the expense of a totally arbitrary number of physician collaborators. 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 comments of the Independent Regulatory Review Commission, nor in the 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 substantive change.

Thank you for your attention to these concerns before the regulations appear in final publication. It is essential for the Board of Nursing to represent the interests of our profession as they protect the health, safety, and welfare of Pennsylvania citizens.

Sincerely,

Dina M. Oleksiak

Dina Oleksiak, MSN, CRNP
Director Student Health Services LaSalle University
CC:

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

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

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

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

Gelnett, Wanda B.

From: Laura Bateman [laura.bateman@sru.edu]
Sent: Tuesday, April 11, 2000 3:32 PM
To: IRRC@irrc.state.pa.us
Subject: CRNP Practice, 21.287 Physician supervision

Re: Title 49, Part 1, Subpart A., Chapter 21. State Board of Nursing, Subchapter C. Certified Registered Nurse Practitioners. 21.283. Prescribing
and dispensing drugs. 21.287 Physician supervision.

I am a Certified Registered Nurse Practitioner (CRNP) working at a University health center within the State System of Higher Education. We
have 3 fulltime CRNPs and 1 part time. In addition we have 2 faculty CRNPs
who use our site for clinical practice. We have one physician medical director on site 2 hours a day. He also has a CRNP in his private practice.
If he is to remain our collaborating physician then only one CRNP would be
permitted to prescribe drugs. So the clients of the other 5 CRNPs would have to make a second trip to our clinic to pick up a physician written script. This really hinders quality, personalized care. We expect the process of obtaining a waiver for this requirement to be a fair and reasonable one.

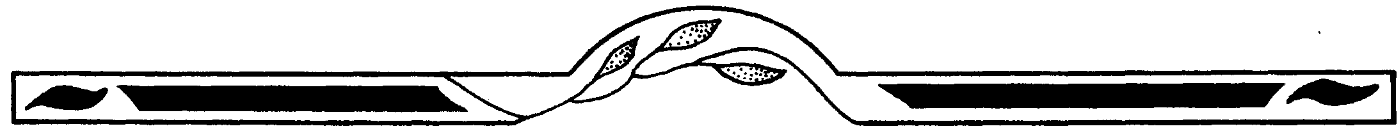
Laura Bateman, Slippery Rock University.

Gelnett, Wanda B.

From: Laura Bateman [laura.bateman@sru.edu]
Sent: Tuesday, April 11, 2000 3:51 PM
To: IRRC@irrc.state.pa.us
Subject: CRNP Regs.

Re: 21.283. Prescribing and dispensing drugs.
3. 16 hours of Continuing Education.

I am certified by ANA as a Family Nurse Practitioner and currently obtain 125 hours to renew this certification every 5 years. With these new
requirements I will need to spend a full 1/3 of my time in pharmacology courses. This leaves me 85 hours over a 5 year span to get in enough clinical classes to remain current in the ever expanding medical field of
knowledge. I do not spend a third of my time writing prescriptions. It is
much less than that. But now we will all be consumed by the need to pursue
pharmacology courses to the detriment of our current pursuit of either specialized or general course work depending on our educational needs.



Original: 2064

Loyalsock Family Practice
901 Westminster Drive • Williamsport, PA 17701 • (570) 322-3141

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

"personalized family healthcare"

Rana A. Colaianni, CRNP
Angela N. Haas, M.D.

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2000 APR 17 AM 9:24
REVIEW COMMISSION

April 11, 2000

Mr. Steve Anderson, Chair
Pennsylvania Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Mr. Anderson,

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Sincerely,

Rana A. Colaianni, CRNP, CS
Family Nurse Practitioner
Loyalsock Family Practice
Williamsport, PA 17701

CC:

Governor Tom Ridge
225 Main Capitol
Harrisburg, PA 17120

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

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

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

1200 Old York Road, Abington, PA 19001-3788

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Wilmarth
Sandusky, Wyatte

November 16, 1999

Robert J. Harbison III
2185 Paper Mill Road
Huntingdon Valley, PA 19006

Dear Bob:

I have reviewed the comments from the Independent Regulatory Review Commission (IRRC) on Insurance Department Regulation #11-195, Quality Health Care Accountability and Protection (Act 68), and provide the following input on behalf of Abington Memorial Hospital. The comments are fairly provider friendly, but this is primarily because, due to heavy insurance industry lobbying, many key terms and provisions continue to be alarmingly vague after multiple drafts.

In Section 154.1(c), IRRC requests definition of the term "entity", i.e., applicability of the Act to various payers. Unfortunately, we have already lost the battle to include all preferred provider organizations (PPOs), due to last-minute lobbying by IBC and Highmark (Western Blue Cross). However, a potential "fallback" position could be to distinguish between single-payer and multiple-payer PPOs; i.e. multiple-payer PPOs would satisfy the definition of "entity" and suggest inclusion, while single-entity PPOs could still be excluded (satisfying IBC and Highmark). IRRC also asks for clarification of the gatekeeper concept in subsection (d), but this concept is what allowed exclusion of PPOs in the first place, so we don't see any relief in pursuing this.

In Section 154.14(b), Emergency Services, IRRC asks for clarification on what constitutes an emergency. We agree with the suggestion, "all services provided during the period of the emergency": it is virtually impossible for emergency room personnel to draw a clear line and switch gears from the moment emergency assessment ends and treatment begins, and few if any hospital billing systems can administer this. Also, in subsection (d), there is lengthy discussion of provider notification to payers: over a year ago, one of the largest HMOs in this market voluntarily determined that a timely claim was sufficient notification, which could and should be the standard.

In Section 154.17, IRRC raises issues regarding member/provider complaint/grievance. It was always the intent of the Act that providers had the **OPTION** to file grievances for patients and, unless the terms are clarified by the Department of Health, we have not decided whether we will provide this service. This is also an appropriate place to raise a major issue again: no member grievance process should replace historic provider grievance processes with HMOs. One major HMO has unfortunately taken this position, and more may follow suit without clarification.

We are obviously pleased with the entire section regarding clarification of prompt provider claim payment requirements. Specifically, a clear definition of a clean claim must be developed, and complete UB92/HCFA 1500 billing forms would be simple for all parties to administer. It is also absolutely essential that providers be notified if a claim is pended for additional information, otherwise, we will continue to suffer from significant payment delays, and have no ability to track late payment and assess the penalties we're entitled to.

I appreciate the opportunity to provide you with our input, and look forward to hearing of discussions regarding these issues at your meeting on Thursday.

Sincerely,

Tom

Thomas E. Mallon
Vice President of Finance/CFO

cc: Richard L. Jones, Jr., President & CEO
Karen Green, Director of Managed Care Services