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PENNSYLVANIA HOUSE OF REPRESENTATIVES PROFESSIONAL LICENSURE COMMITTEE

HOUSE BILL 50 HEARING

HARRISBURG, PENNSYLVANIA OCTOBER 28, 1999

TINE HANSEN-TURTON, EXECUTIVE DIRECTOR
REGIONAL NURSING CENTERS CONSORTIUM

DONNA TORRISI, DIRECTOR
SCOTT BRECHER, CONSUMER
ABBOTTSFORD AND SCHUYLKILL FALLS
FAMILY PRACTICE AND COUNSELING

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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

PENNSYLVANIA HOUSE OF REPRESENTATIVES
PROFESSIONAL LICENSURE COMMITTEE

HOUSE BILL 50 HEARING

STATEMENT OF TINE HANSEN-TURTON, EXECUTIVE DIRECTOR
REGIONAL NURSING CENTERS CONSORTIUM

HARRISBURG, PENNSYLVANIA
OCTOBER 28, 1999

Chairman Civera and other members of the House of Representatives Professional Licensure Committee, my name is Tine Hansen-Turton, and I am here on behalf of the Regional Nursing Centers Consortium (RNCC/Consortium). The Consortium represents 24 nurse managed health centers in the Commonwealth that provide quality health care services to well over 25,000 people and encounter more than 250,000 people annually, of whom half are children and youth. I want to thank you, Mr. Chairman, for the opportunity you have provided for me and other members of the Regional Nursing Centers Consortium to provide testimony today on House Bill 50. I also want to thank Representative Pat Vance, Representative Kathy Manderino and other members of the committee who have co-sponsored this bill.

Joining me today are Donna Torrisi, Director of the Abbottsford and Schuylkill Falls Family Practice and Counseling and Past Chair of the RNCC, and Scott Brecher, a health care consumer.

WHAT IS A NURSING CENTER?

So what is a nursing center? Nursing centers are community-based health care centers managed by nurses in partnership with the communities they serve. They provide a combination of high quality comprehensive primary health care, health promotion, disease prevention and health education services. The thrust of our care is health promotion, disease prevention and health education programs. Our centers provide programs in the areas of tobacco cessation, lead poisoning prevention, health screenings, family planning, diabetes, asthma and abstinence education, violence prevention, well child care and covering kids through Medical Assistance and CHIP. This is just a sampling of the many programs that are offered to children, youth, families and elderly in our nursing centers.

Nursing centers are usually located in or near health profession shortage areas and medically under-served areas in both rural and urban communities in Pennsylvania. The targets of service for the nursing centers have traditionally been those who are under-served and least likely to be engaged in ongoing health care services for themselves and their family members. Since the late 1970s, in conjunction with the development of educational programs for public health nurses and nurse practitioners, faculties in schools of nursing have established nursing centers to provide necessary services to the community.

RNCC NURSING CENTERS:

Nursing centers have increasingly been the foundation for building and maintaining healthy neighborhoods in both rural and urban areas of Pennsylvania. Many of them have been recognized locally, statewide and nationally as safety-net models of health care that work. All nursing centers exist at the invitation of the community and have established community boards. Our nursing centers are located in public and Section 8 housing developments, schools, churches, community and recreation centers, as well as homeless and domestic violence shelters.

NURSING CENTER REIMBURSEMENT:

In Pennsylvania, nurse practitioners are eligible to receive reimbursement for the services they provide. In the Commonwealth, nurse practitioners are included in the regulatory definition of primary care providers. Guidelines have been developed by nursing centers, the PA Department of Health, and the Health Care Financing Administration for Health Maintenance Organizations (HMOs) that want to contract with nurse-managed practices.

ISSUE OF THE UNINSURED/OUTCOMES:

The RNCC is especially concerned about the number of uninsured children, youth and adults in Pennsylvania. At any given day our nursing centers provide quality health care to 20%-63% uninsured children, youth and adults.

To date managed care data has shown us that our member centers have demonstrated outcomes that when compared to conventional primary health care, indicate that our

comprehensive models of care result in significantly fewer emergency room visits, fewer hospital in-patient days, and less use of specialists. Nursing centers see their members an average of 1.8 times more than other providers. Their patients are hospitalized 30% less and use the emergency rooms 15% less than other health care providers. Children in our care are immunized on time and receive the proper care needed to ensure they grow up to be healthy individuals. Nursing centers have aggressive tracking and outreach programs that are especially vital to well child-care. Centers have also demonstrated remarkable success in prevention of low birth-weight babies. Following comprehensive prenatal care, several primary care nurse-managed health centers have experienced 100% of women giving birth to normal birth-weight infants. You will hear more of these outcomes in Donna Torrisi's testimony.

In conclusion, the RNCC asks that you take House Bill 50 into consideration because by allowing Advanced Practice Nurses to prescribe, they can continue to provide quality health care to vulnerable families in Pennsylvania. Nursing centers have proven to be a viable safety-net health care model in both rural and urban communities where families seek quality health care services from caring people.

Finally, we would like to extend an invitation to you to come and visit one of our neighborhood nursing centers. Thank you for allowing the Regional Nursing Centers Consortium to provide testimony on behalf of our member nursing centers.

Respectfully submitted on behalf of the Regional Nursing Centers Consortium.

Tine Hansen-Turton, Executive Director

PENNSYLVANIA HOUSE OF REPRESENTATIVES
PROFESSIONAL LICENSURE COMMITTEE

HOUSE BILL 50 HEARING

STATEMENT OF DONNA L. TORRISI, MSN, CRNP, DIRECTOR
ABBOTTSFORD AND SCHUYLKILL FALLS
FAMILY PRACTICE AND COUNSELING
REGIONAL NURSING CENTERS CONSORTIUM, IMMEDIATE PAST CHAIRPERSON

HARRISBURG, PENNSYLVANIA
OCTOBER 28, 1999

Good morning Mr. Chairperson and members of the committee and thank-you for allowing me to testify on House Bill 50. I am the director of two nurse managed primary health care centers in Philadelphia public housing communities which I started in 1992 and I have been a practicing nurse practitioner for over 23 years. Both of our health centers are located in public housing communities in Philadelphia, they are funded by the US Public Health Service and they serve the several thousand residents of the community in which they are located. The US Public Health Service funded the centers in 1991 as their first nurse managed primary care center....they did so because they were interested in testing this model.

In 1996 the centers won a National Models that Work Award from the US Dept. Of Health Resources & Service Administration. In 1996, the centers won the Smith Kline Beecham Community Impact Award, they have also received honorable mention by the Pew Foundation and many other notorieties. They won the awards for one very important reason....their incredible

outcomes. When compared to the aggregate of similar populations of people, the patients who receive their care at these nursing centers stay healthier. These reports come from the HMOs that contract with the nursing centers...the reports repeatedly point out that the patients are hospitalized 25-30% fewer days, use the emergency room 15% less often, use specialists 40% less and use substantially less costly prescription medications. Each patient is seen for a longer visit than the average doctor appointment and for about twice as many visits per year compared to the average for a doctor. The centers currently have contracts with 3 Medicaid HMOs and one commercial HMO. They are in process of being credentialed by two other commercial HMOs. The HMOs want us because we keep their patients healthy....we save health care dollars.

Today I am accompanied by three of my patients. I could have brought three hundred but I did not think you had room for all of them; I know that they are all here in spirit. The consumers with me are Scott Brecher who will be testifying, Pat Sample, and Wilhelmina Green all of who will be happy to answer any questions you have. They have all been our patients for over 7 years. They are here today because they believe that the nurse managed health model has brought quality health care to their community. I am here today because I care deeply about each of them and because I care deeply about access to health care, especially for our nations most vulnerable people. Most of the nursing centers like ours are located in medically under served areas serving our cities' and our rural areas' most vulnerable people. Since our centers opened over 7 years ago in the Abbottsford public housing community, not one physician has ever challenged our presence or our capability to serve our patients competently and safely. I mention this point because I have repeatedly heard house bill 50 attacked on the basis that the independent practice of nurse practitioners will endanger patients.

This simply is not true. Our patients who have multiple complex medical and psychosocial problems stay healthier than similar patients cared for by physician practices. The literature is replete with studies and studies of studies that show that nurse practitioners can independently provide the same or better care to patients than physicians. We have been studied now for over thirty years. We may be the most studied health profession. The facts are clear and unarguable. I think we can put to rest the issue of patient safety. House Bill 50 supports the practice of nurse practitioners, many of whom serve the under served. House Bill 50 is about increasing access to care for Pennsylvanians.

House Bill 50 puts the practice of nursing under the jurisdiction of the Board of Nursing. The Pennsylvania State Board of Nursing has been governing the practice of nursing since at least the turn of the century. The State Board of Nursing is charged with protecting the public. I think they do this well, and I think they can continue to do that if House Bill 50 passes. Presently dual boards govern Nurse Practitioners only in PA, Mississippi, South Dakota and Virginia. Can the other 44 states be wrong? Twenty five years ago when primary care practice by nurse practitioners was new, joint regulation may have made sense. But, times have changed and the practice of primary care does not need to be solely the practice of medicine. There was a time that a nurse was not permitted under her scope of practice to measure a blood pressure or to administer an intravenous medication. House Bill 50 challenges us to change with changing times.

House Bill 50 identifies the functions of Nurse Practitioners including prescriptive authority. Do Nurse Practitioners have this authority now? Lets look at what happens typically in a practice in

Pennsylvania including my practice at Abbottsford. The Nurse Practitioner sees the patient, takes a medical history, examines the patient, makes an assessment and establishes a plan of care. The Nurse Practitioner uses clinical practice guidelines that are continuously updated to guide decision making. If that plan includes a prescription medication, she or he may call that medication into a pharmacy under the name of their collaborating physician. The physician has not had any contact with the patient and yet his/her name is on the medication bottle. This has been going on in Pennsylvania for thirty years and it simply does not make any sense. Only in Pennsylvania and Ohio does it happen like this. Could the other 48 states all be wrong?

Perhaps you are wondering what the role of a physician is in independent practices such as ours. Though I have used the term independent nursing practice, our practice depends on our collaborative relationship with a physician who is available by telecommunication and who visits the centers about once every six weeks. The nurses are dependent upon the expertise of a physician when needed and the nurse knows when the need exists. I don't believe any one discipline can do everything... we are dependent upon physicians, specialists, physical therapists, and mental health professionals to meet the needs of our patients. I often think how much healthier a physician's patients would be if he had a collaborative agreement with a nurse to help care for his patients. Perhaps the physician would improve his hospital rates as we have if all patients had access to a nurse to take extra time with them, teach them about their medications, their illness, and provide preventive health education. With or without House Bill 50, I will continue to have a collaborating agreement with a physician because collaboration is the healthiest way to take care of patients.

I do not believe that arguments against House Bill 50 are about safety for patients. I believe the arguments are about power and control. This saddens me deeply. Nurses and physicians have worked together for the same purpose for several hundred years. They have worked together in the best interest of their patients to prevent suffering and to help them heal. Physicians have relied enormously on nurses in the hospital and in the community to provide good nursing care to their patients. This was collaborative practice though physicians believed that the nurse was doing nothing but following his órder. I believe that the two professions are both committed to caring for patients. Both have the primary purpose to relieve suffering, to prevent and treat illness and to promote health. House Bill 50 is diverting us from the work we must be doing. **House Bill 50 is not giving us new freedoms**, it is supporting what we already do and it removes control and accountability from the physician and puts it where it belongs, with the Board of Nursing and the practitioner who has cared for the patient. If I did not have to take time to prepare this testimony and if I was not here today, I would be providing much needed health care in our communities.

I have spent countless hours on House Bill 50 and on other issues that impose barriers to my practice. If we could tally all the hours that nurses and physicians have spent on defending our positions and channel it into caring for others, I am certain we could provide health care for the whole state. As I have reflected on this conflict between physicians and nurses, I wonder why we are not marching in the same direction. House Bill 50 is not complex. House Bill 50 is simple and

it makes sense. It must be passed so that Nurse Practitioners are freed to provide health care to Pennsylvanians who need it; it must be passed so that physicians do not assume misplaced accountability, and it must be passed so that Pennsylvanians especially the most vulnerable people may receive accessible health care.

Respectfully submitted by Donna L. Torrisi, Director of the Abbottsford and Schuylkill Falls Family Practice and Counseling.

PENNSYLVANIA HOUSE OF REPRESENTATIVES
PROFESSIONAL LICENSURE COMMITTEE

HOUSE BILL 50 HEARING

STATEMENT OF SCOTT BRECHER, CONSUMER
ABBOTTSFORD AND SCHUYLKILL FALLS
FAMILY PRACTICE AND COUNSELING

HARRISBURG, PENNSYLVANIA
OCTOBER 28, 1999

Good morning ladies and gentlemen. My name is Scott Brecher, and I am here in support of House Bill 50. You should know first that I have not seen a doctor in nearly eight years. That is not to say that I have not received excellent health care in all that time. Donna Torrisi, a Certified Registered Nurse Practitioner, and her staff of nurse practitioners at the Abbottsford/Schuylkill Falls Family Practice and Counseling in Philadelphia have looked after all of my health care needs since 1992.

I came to the Health Centers in 1992 at the beginning of my recovery from 25 years of addiction to drugs and alcohol. Not only did I receive regular physical examinations, necessary tests and vaccinations, I also received individual and group counseling to assist me in an ongoing recovery process that continues to this day. As part of the support I received from a staff composed entirely of nurse practitioners, I was encouraged to return to school and pursue a university degree. In 1998, I graduated Magna Cum Laude from Temple University with a degree in Social Work. This past May, I graduated again, this time with my Masters in Social Work Administration and Planning, also from Temple University. Last month, on September 16, 1999, I celebrated seven years of complete

abstinence from drugs and alcohol. I credit the professional care and human concern of the staff of the Abbottsford and Schuylkill Falls Health Centers for providing me with the foundation to have accomplished all that I have, and for allowing me to become a productive member of society. Did I mention that the Health Centers are staffed by Certified Registered Nurse Practitioners?

The bottle that I am holding in my hand contains a prescription for extra-strength Ibuprofen, commonly known as Motrin. I take this medication for occasional headaches and muscle aches from running. The name of the prescribing doctor on this bottle is that of a Dr. Scott McNeal, MD. Although I am reasonably certain that Dr. McNeal is a good doctor, he and I have never met. He has never examined me, knows nothing of my medical history, yet his name is on this bottle. The professional who takes care of me, the woman who does know my history, and who has my best interest at heart is sitting right here. I submit to you that it should be her name and no other, on any prescription she decides I should have.

Along the same lines of reasoning, Certified Registered Nurse Practitioners should be governed by only <u>one</u> Board: the State Board of Nursing. Doctors are overseen by their peers, the State Board of Medicine, and that is considered sufficient oversight of them. The Board of Nursing should be considered sufficient oversight for this uniquely skilled group of health professionals, a Board composed of <u>their</u> peers.

I urge you to pass this Bill, allowing single oversight for nurse practitioners, and permitting them to not only prescribe for their patients, but to put their names on those prescriptions, not the name of some faceless, uninvolved doctor who knows nothing of the patient he or she is allegedly prescribing for.

Ladies and gentlemen, I do not believe that in this day and age of managed care, that a doctor would have had the time or the inclination to provide me with the extra help I needed, the support and the encouragement that I received, which has enabled me to completely transform my life. Nurse practitioners are making a difference in similar lives across this state. I certainly believe in their abilities and professionalism. I invite you to do the same. Thank you for your time and attention.

Respectfully submitted by Scott Brecher, Consumer.

STATEMENT OF EARL GREENWALD, MD BEFORE THE HOUSE PROFESSIONAL LICENSURE COMMITTEE ON HOUSE BILL 50, OCTOBER 28, 1999

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Extending Prescriptive Privileges to Nurse Practitioners

As Director of Education for the Department of Obstetrics and Gynecology, then Vice Chair, then Chair of Departments of Obstetrics and Gynecology from 1975 until 1991, I had numerous opportunities to interact with nurse practitioners. My first professional interaction with nurse practitioners occurred around 1982 when I was assigned the responsibility to structure the clinical experience for nurse practitioners in gynecology. At that time, I was Chair of the Department of Obstetrics and Gynecology at Staten Island University Hospital in Staten Island, New York. The nurse practitioners entering clinical education in my department had completed their nursing education, were licensed registered nurses and were in intensified, advanced education to provide gynecologic care as Advance Practice Nurses (nurse practitioners). Not only did I structure their educational experience to be sure that it fulfilled the educational requirements for these professionals, I then hired the first several nurse practitioners completing their clinical education in my department to become part of the clinical care delivery system for patients seeking gynecologic care at Staten Island University Hospital. Then and now, whether nurse practitioners fall within the medical or nursing board, nurse practitioners have and will continue to function in a defined, professional relationship with a physician and with that physician's covering physicians when the primary physician is away or ill. In addition, nurse practitioners have and will practice within a scope defined by protocols, promulgated by the nurse practitioner and the related physicians. These protocols define the types of care nurse practitioners can give in cooperation with their collaborating physicians, how the nurse practitioner can provide care, what medications the nurse practitioner can offer the patient, and the indications and doses which the nurse practitioner may use.

Nurse practitioners are essential to modern health care delivery. Without nurse practitioners, it would be literally impossible to provide quality, immediately available care for patients. Quite simply, the need for care by the American patient population far exceeds available physician time to accommodate the need for health care. It has become universal practice in the United States to incorporate in clinical practice nurse practitioners who have specialized and undergone intensive education in the specific area for which patients seek care in the particular clinic or office in which the nurse practitioner practices. In this manner, physicians are able to direct their attention to highly complex medical issues and to be available, either on site or by telephone, to consult with the nurse practitioners when unanticipated problems or medical complexity arises.

As part of what they do, nurse practitioners are well educated to diagnose and treat patients for conditions defined by their protocols. Treatment includes obtaining a relevant medical history, performing appropriate patient examinations and selecting the best medicine to use for treatment of a patient's particular needs. As part of nurse practitioners' basic education as registered nurses, prior

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to specialized education as advance practice nurses, they receive at least one semester of intensive education about medicines, the indications and contraindications for their use, the side effects and complications of their use and proper doses. After completing pharmacology education, as these professionals complete their education as registered nurses, their clinical experience includes intensive education about drug therapy, and nursing students are constantly evaluated about medicines and their proper use. This education in proper drug use is intensified and fine-tuned to a specific medical area as the registered nurse undergoes advanced education to become a nurse practitioner.

Registered nurses and nurse practitioners are an essential line of defense in preventing errors in drug therapy. This is true because they are so intensively educated, and because they are given the responsibility to discuss perceived errors in selection or dosing of drugs with the ordering physician and/or pharmacy. In my capacities as Education Director, Vice Chair and Chair of departments, I have been aware of many physician errors in drug administration averted by astute, well-educated registered nurses and nurse practitioners.

At present, physicians are required to sign nurse practitioners' prescriptions. There is simply no clinical need for a physician to read and sign each prescription written by nurse practitioners within the scope of their practice as defined by their protocols. The mandate for physicians to sign nurse practitioners' prescriptions is an unreasonable intrusion into physicians' time, which is better devoted to providing direct, complex patient care. This mandate for physicians to sign nurse practitioners' prescriptions written within the scope of their practice also creates a situation which requires a physicians' on-site presence while nurse practitioners provide care. This is unnecessary and this requirement to salary physicians to be present merely to sign prescriptions is another inappropriate financial burden to the health care system and to the patient whom we serve.

In my nearly 35 years of medical practice, I have observed and learned that registered nurses and nurse practitioners are well educated, professionally responsible health care providers. They have demonstrated the capacity to understand the limits of their expertise, to seek consultation and assistance from physicians when needed, to monitor the quality of their care, and to take effective corrective action when problems or errors occur.

Prescriptive privileges are well within the expertise of nurse practitioners and should be legislatively permitted within the existing structure of nurse practice. This includes nurse practitioners' practicing in a professional relationship with physicians and within a scope of practice defined by written protocols.

I encourage you to act favorably with respect to extending nurse practitioners' prescriptive privileges. This will only enhance the quality and availability of care to the patients we serve.

Earl F. Greenwald, M.D.

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PENNSYLVANIA MEDICAL SOCIETY

PRESENTATION

HOUSE PROFESSIONAL LICENSURE COMMITTEE

HARRISBURG, PENNSYLVANIA

HOUSE BILL 50

REGULATING THE PRACTICE OF PROFESSIONAL NURSING

BY

DONALD H. SMITH, MD
PRESIDENT
OCTOBER 28, 1999

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Good morning, Chairman Civera and members of the House Professional Licensure Committee.

I am Dr. Donald H. Smith. I appear before you today as a concerned physician and as the newly installed President of the Pennsylvania Medical Society. The Pennsylvania Medical Society is the largest organization representing physicians in the Commonwealth. With me is Mr. Don McCoy, the Medical Society's Director of Policy and Regulatory Affairs. Following my presentation, Mr. McCoy and I will be available to respond to questions from the Committee.

I want to speak to you about House Bill 50, a bill that permits the increase of the current scope of the practice of nursing and allows the Board of Nursing to have regulatory authority over the practice of medicine.

Today, I will discuss making some modifications to the currently proposed Nurse Practitioner Prescribing Regulations, including addressing the prescriptive authority of certified registered nurse practitioners (CRNPs).

Recognizing that the Medical and Nursing Boards have published proposed Nurse Practitioner Prescribing Regulations, the Pennsylvania Medical Society stands ready to support these regulations, if certain modifications are made to protect patient interests.

As background, the Medical Practice Act of 1985 authorized the Medical Board and the Board of Nursing to jointly promulgate regulations authorizing CRNPs to perform acts of medical diagnosis and prescription of medical, therapeutic, diagnostic, or corrective measures. These provisions were originally enacted in the practice acts of 1974. Under the 1974 laws, regulations were jointly promulgated by the two boards that provide for the certification of nurse practitioners.

The stumbling block has been and remains the addition of prescriptive authority to the authorized treatment measures.

In the interim, the Boards failed to reach an agreement on regulations that would establish parameters for how CRNPs are to prescribe. One attempt at joint promulgation in 1994 produced draft regulations that were approved by both boards. The Board of Nursing later rescinded its approval for reasons unknown. A second draft was circulated in 1998 to stakeholders for comment. Based on significant concerns from both physicians and nurses, that draft was abandoned.

This year, a new draft was considered and published by both boards. It establishes a drug formulary for use by CRNPs and retains the joint promulgation authority of both boards. The public comment period is scheduled to end on November 1, 1999.

Attached to my testimony are:

- A copy of the proposed regulations and
- Comments on the proposed regulations submitted on behalf of the Medical Society.

You will note that the Medical Society does not object to nurse practitioners practicing in accordance with current law. In a survey recently conducted by the Medical Society with nearly 1,000 Pennsylvania physicians responding, three out of four physicians thought advanced practice nurses should be able to prescribe. 97 percent believed advanced practice nurses should practice in collaboration with and under the direction of a physician. Let me discuss some of our proposed changes.

The first recommendation deals with training in pharmacology. There needs to be a defined requirement that CRNPs complete a *minimum* of 30 hours of course work in pharmacology as part of their core training program. To stay current with the rapid advances in pharmacology, we recommend CRNPs who prescribe medication also be required to take continuing education courses in advanced pharmacology. In the majority of states where CRNPs have prescriptive rights, they also have required physician supervision and limited formularies. Remember that CRNPs have been trained and educated to work as part of a treatment team. In fact, they do not have the educational or clinical background to practice completely independently.

Because a collaborative relationship between CRNPs and physicians helps ensure quality patient care, the Medical Society is also recommending that there be a defined, written collaborative agreement between a CRNP and collaborating physician authorizing the CRNP to prescribe and dispense agreed-upon drugs. The scope of this proposed agreement is outlined in the attached comments.

Having defined protocols in place is good medicine for the patient, nurse, and physician. A formal collaborative agreement supports the strong partnership between physicians and nurses that makes our healthcare system work. It also identifies and defines the parties to the agreement and their individual and collective responsibilities. The Medical Society also recommends that the Board of Nursing and, in certain circumstances, the Board of Medicine, be made aware of the professionals in such arrangements.

The Medical Society strongly recommends that the issue of liability be addressed and has so commented. Especially in situations where the collaborating physician is not physically available, the nurse practitioner would be assuming increased liability.

My purpose for discussing the proposed regulations and our comments is to demonstrate a willingness to address the legitimate concerns of the nurse practitioner through the existing regulatory process. If you read the regulations, together with our comments, I believe you will see that what we have proposed

establishes a workable framework for the creation of a collaborative working arrangement between nurse practitioners and their collaborating physicians. It also provides for adequate safeguards for good patient care and safety.

Supporters of House Bill 50 have said that we can rely on the Nursing Board to act responsibility with regard to the potential for an expanded scope of practice. I understand that just last week your committee held wide-ranging discussions concerning the recurring incidence of boards that stray from your legislative intent.

During that discussion of the regulatory process, supporters of House Bill 50 claimed the legislation is needed because of the failure of that process. We disagree with that claim. The Medical and Nursing Acts clearly set forth the legislative intent that the Boards <u>jointly</u> address the role of Certified Registered Nurse Practitioners. The failure of both Boards to do so until recently indicates their previous inability to reach consensus. House Bill 50, by eliminating the involvement of the Medical Board, also removes the interests and the participation of one of the two parties to any collaborative agreement resulting between nurse practitioners and physicians. It also relegates the Medical Board to just another commentator whose comments and concerns may be ignored or at least discounted in the final regulation.

House Bill 50 includes provisions that clearly cross over into areas where nurses could independently practice medicine. By making the Nursing Board the <u>sole</u> authority over those areas, physicians and the Medical Board would have no opportunity to provide valuable and necessary medical guidance and input.

On a final note, you have heard from supporters of House Bill 50 that this proposed legislation would improve access to care in rural areas. However, there is no independent proof that this will happen. The studies they cite are flawed in that they have been conducted in mostly urban rather than rural areas. To suggest that nurses, any more than doctors, will automatically migrate to underserved, rural areas is unrealistic.

Nurse practitioners require the same degree of medical back up and support services as physicians. They will be attracted to the same enticements related to family, activities, and lifestyles in a community as physicians. And when medical providers are motivated to serve in medically underserved areas, it becomes important that these professionals be able to provide more advanced medical care, not less.

In conclusion, the Pennsylvania Medical Society supports the provisions of the existing Medical and Nursing Practice Acts with respect to the scope of practice of certified registered nurse practitioners. We believe that the proposed regulations, with the modifications suggested in our comments to the Bureau of Professional and Occupational Affairs, can accurately implement these acts as they were intended by the General Assembly.

House Bill 50, on the other hand, moves nursing in a broad sense - not <u>just</u> advanced practice nursing - far closer to independent practice. It eliminates the collaborative agreement. It also removes the promulgation of the Medical Board. HB 50 does nothing to require or define "collaboration," which we believe is critical to the relationship between the advanced practice nurse and the physician. Use of terms like "invasive procedures" without definition clearly opens future expansion into the practice of medicine without oversight by the Board of Medicine.

The Medical Society asks that you not consider HB 50. It isn't needed, it's legislation that requires major revision, and it's sure to have detrimental effects on the relationship between nurse practitioners and physicians.

under at 1 Pa. Code §§ 7.1—7.4, we propose to amend our regulations by adding § 53.69, as noted above and as set forth in Annex A; Therefore,

It Is Ordered that:

1. The Secretary shall submit this order and Annex A to the Office of the Attorney General for preliminary review as to form and legality.

2. The Secretary shall submit a copy of this order, together with Annex A, to Governor's Budget Office for review of fiscal impact.

3. The Secretary shall submit this order and Annex A for review and comments by the designated standing committees of the General Assembly, and for review and comments by the Independent Regulatory Review Commission.

4. The Secretary shall certify this order and Annex A and deposit them with the Legislative Reference Bureau for publication in the *Pennsylvania Bulletin*.

5. Within 30 days of the date of publication of this order in the *Pennsylvania Bulletin*, an original and 15 copies of any comments concerning this order shall be submitted to the Office of the Secretary, Pennsylvania Public Utility Commission, P. O. Box 3265, Harrisburg, PA 17105-3265. One copy of a diskette containing comments in electronic format should also be submitted. One copy of each comment should also be submitted to the contact persons below.

6. The contact persons for this matter are Thomas P. Maher, Fixed Utility Services, (717) 787-5704, maher@puc.state.pa.us, and Lawrence F. Barth, Assistant Counsel, Law Bureau, (717) 772-8579, barth@puc.state.pa.us. Alternate formats of this document are available to persons with disabilities and may be obtained by contacting Sherri DelBiondo, Regulatory Coordinator, Law Bureau (717) 772-4579.

7. A copy of this order and Annex A be sent to each natural gas distribution company subject to the Commission's jurisdiction, each natural gas supplier licensed to conduct business within this Commonwealth, the Office of Consumer Advocate, the Office of Small Business Advocate and the Commission's Office of Trial Staff.

By the Commission

JAMES J. MCNULTY,
Secretary

Fiscal Note: 57-207. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 52. PUBLIC UTILITIES

PART I. PUBLIC UTILITY COMMISSION

Subpart C. FIXED SERVICE UTILITIES

CHAPTER 53. TARIFFS FOR NONCOMMON CARRIERS

RECOVERY OF FUEL COSTS BY GAS UTILITIES

§ 53.69. Fixed rate option.

(a) Components of the fixed rate option shall include all gas costs as defined in section 1307(g) of the act (relating to sliding to scale of rates; adjustments). The natural gas distribution company may offer a fixed rate option to collect these costs for either the heating season or for another time period which exceeds the heating season in duration, but in no event exceeds 12 months.

(b) Natural gas distribution companies adjusting rates for natural gas sales on a regular, less than quarterly but no more frequent than monthly, basis shall submit a separate reconciliation calculation of the fixed rate option service, consistent with the company's response to § 53.64(i) (relating to filing requirements for natural gas distributors with gross intrastate annual operating revenues in excess of $40 million). This reconciliation shall present the fixed rate option sales, revenues and costs, separated from the reconciliation of other retail sales. The reconciliation period of fixed rate option sales shall be the same period used to reconcile the company's other retail sales as presented in compliance with section 1307(f)(3) of the act.

(c) Eligible customers may sign up for the fixed rate option during the 3-month period which ends on the 1st day of the 12-month fixed rate option contract period.

(d) Chapter 56 (relating to standards and billing practices for residential utility service) is applicable to all fixed rate option sales to residential customers.

[Pa.B. Doc. No. 99-1667. Filed for public inspection October 1, 1999, 9:00 a.m.]

STATE BOARD OF MEDICINE STATE BOARD OF NURSING

[49 PA. CODE CHS. 18 AND 21]

Certified Registered Nurse Practitioners Prescriptive Authority

The State Boards of Medicine and Nursing (Boards) propose to amend their regulations governing certified registered nurse practitioners (CRNPs) Chapters 18 and 21 (relating to State Board of Medicine; and State Board of Nursing), to read as set forth in Annex A, relating to CRNP prescriptive authority.

A. Effective Date

The proposed regulations will be effective upon publication of final-form regulations in the *Pennsylvania Bulletin*.

B. Statutory Authority

Section 15(b) of the Medical Practice Act of 1985 (63 P. S. § 422.15(b)) authorizes the Boards to jointly promulgate regulations authorizing CRNPs to perform acts of medical diagnoses and prescription of medical, therapeutic, diagnostic or corrective measures. Section 2(1) of the Professional Nursing Law (63 P. S. § 212(1)) similarly indicates that a professional nurse may perform acts of medical diagnosis or prescription of medical therapeutic or corrective measures only if the Boards promulgate regulations authorizing these acts. These provisions were originally enacted in the practice acts of 1974. Under the 1974 laws, the Boards jointly promulgated the current regulations which provide for certification of nurse practitioners.

C. Background and Purpose

In accordance with their statutory authority the Boards have negotiated rulemaking which would authorize

CRNPs to prescribe and dispense drugs. CRNPs are advanced practice nurses who are certified by the Boards in a particular clinical specialty area. See §§ 18.21 et seq. and 21.251 et seq. An applicant for certification as a CRNP shall be a currently licensed professional or registered nurse who has successfully completed a course of study of at least 1 academic year in a program approved by the Boards. See §§ 18.41 and 21.271. Almost all nurse practitioner programs grant a master's degree and include a course in advanced pharmacology. The proposed regulations will enable Pennsylvania CRNPs to make full use of their advanced education and skills.

At the present time CRNPs in most states have varying degrees of prescriptive and dispensing authority. Only about eight states do not permit CRNPs to prescribe or dispense drugs.[1] The remaining states authorize CRNPs to prescribe or dispense, or both, with varying degrees of regulation or limitation. Of the states permitting CRNPs to prescribe drugs, 32 states require the authority to be identified in the collaborative agreement, 13 states limit prescribing authority to substances which are not controlled, and 27 allow prescription of controlled substances, but with varying degrees of regulation or limitation.[2]

D. Description of Proposed Regulations

The proposal would add two new sections to the existing regulations regarding CRNPs. The first section, §§ 18.53 and 21.283, of the State Board of Medicine and the State Board of Nursing, would establish the requirements a CRNP shall meet to prescribe and dispense drugs: completion of a CRNP program approved by the Boards, which includes a course in advanced pharmacology, and adherence to standards for prescribing already established by the State Board of Medicine and the Department of Health.

The second sections, §§ 18.54 and 21.284, specify categories of drugs which a CRNP may prescribe and dispense without restriction, those which the CRNP may prescribe and dispense with limitations, and those which the CRNP may not prescribe or dispense. The first category contains those drugs a CRNP will be able to prescribe and dispense without specific limits (§§ 18.54(b) and 21.284(b)). The second category contains those drugs a CRNP will be able to prescribe and dispense only if the collaborative agreement between the physician and CRNP authorizes prescribing and dispensing those drugs (§§ 18.54(c) and 21.284(c)). The third category contains those drugs which a CRNP may not prescribe or dispense (§§ 18.54(d) and 21.284(d)). This section also establishes the parameters for prescribing and dispensing controlled substances (§§ 18.54(f) and (g) and 21.284(f) and (g)). Further provisions would establish procedures to deal with an inappropriately prescribed or dispensed drug (§§ 18.54(e) and 21.284(f)), requirements pertaining to prescription blanks (§§ 18.54(h) and 21.284(h)) and documentation of the prescription in a patient's medical record (§§ 18.54(i) and 21.284(i)).

E. Compliance with Executive Order 1996-1

In accordance with the requirements of Executive Order 1996-1 (February 6, 1996), in drafting and promulgating the proposed regulations the Boards solicited input and suggestions from the regulated community. The Boards mailed a draft on June 26, 1998, to 54 organizations, entities and individuals who had an interest in CRNP prescribing. The Boards received 373 responses to the solicitation. The Boards revised the draft as a result of the responses.

F. Fiscal Impact and Paperwork Requirements

There will not be an adverse fiscal impact or additional paperwork imposed on the Commonwealth, political subdivisions or the private sector. Citizens of this Commonwealth will benefit from having more ready access to cost-effective, quality health care.

There will be a very slight increase in paperwork to the regulated community in regard to certain categories of drugs because a CRNP would be authorized to prescribe or dispense from these categories only if the authorization is documented in the collaborative agreement.

G. Sunset Date

The Boards continuously monitor their regulations. Therefore, no sunset date has been assigned.

H. Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on September 17, 1999, the Boards submitted a copy of these proposed regulations to the Independent Regulatory Review Commission (IRRC) and the Chairpersons of the House Professional Licensure Committee and the Senate Consumer Protection and Professional Licensure Committee. In addition to submitting the proposal, the Boards have provided IRRC and the Committees with a copy of a detailed regulatory analysis form prepared by the Boards in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

If IRRC has objections to any portion of the proposed regulations, it will notify the Boards within 10 days after the expiration of the Committees' review period. The notification shall specify the regulatory review criteria which have not been met by that portion. The Regulatory Review Act specifies detailed procedures for review of objections prior to final publication of the proposed regulations by the Boards, the General Assembly and the Governor of objections raised.

I. Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed regulations to Cindy Warner, Health Licensing Division, Bureau of Professional and Occupational Affairs, P. O. Box 2649, Harrisburg, PA 17105-2649 within 30 days following publication of the proposed regulations in the *Pennsylvania Bulletin*. Please cite to *CRNP Prescriptive Authority* when submitting comments. Please do not send copies of the same comment to both Boards.

DANIEL B. KIMBALL, Jr., M.D.,
Chairperson
State Board of Medicine
and

CHRISTINE ALICHNIE, Ph.D., R.N.,
Chairperson
State Board of Nursing

Fiscal Note: 16A-499. No fiscal impact; (8) recommends adoption.

[1] U.S. Department of Health and Human Services, Health Resources & Services Administration, "Curriculum Guidelines & Regulatory Criteria for Family Nurse Practitioners Seeking Prescriptive Authority to Manage Pharmacotherapeutics in Primary Care, Summary Report. 1998 (Curriculum Guidelines)," (Prepared by National Council of State Boards of Nursing and National Organization of Nurse Practitioner Faculties) page 14, Table 1.

[2] Curriculum Guidelines, pages 17-18, Tables 3-4.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 18. STATE BOARD OF MEDICINE—PRACTITIONERS OTHER THAN MEDICAL DOCTORS

Subchapter C. CERTIFIED REGISTERED NURSE PRACTITIONERS

CRNP PRACTICE

§ 18.53. Prescribing and dispensing drugs.

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.

(3) In prescribing and dispensing drugs a CRNP shall comply with standards of the State Board of Medicine in §§ 16.92—16.94 (relating to prescribing, administering and dispensing controlled substances; packaging; and labeling of dispensed drugs) 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).

§ 18.54. Prescribing and dispensing parameters.

(a) The Board adopts the *American Hospital Formulary Service Pharmacologic-Therapeutic Classification* to identify drugs which the CRNP may prescribe and dispense subject to the parameters identified in this section.

(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):

(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) Antitussive, expectorants and mucolytic agents.

(10) Gastrointestinal drugs.

(11) Local anesthetics.

(12) Serums, toxoid and vaccines.

(13) Skin and mucous membrane agents.

(14) Smooth muscle relaxants.

(15) Vitamins.

(16) Hypoglycemic agents.

(17) Endrocrine replacement agents.

(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.

(2) Blood formation, coagulation and anticoagulation drugs, and thrombolytic and antithrombolytic agents.

(3) Central nervous system agents, except that the following drugs are excluded from this category:

(i) General anesthetics.

(ii) Monoamine oxidase inhibitors.

(4) Myotics and mydriatics.

(5) Antineoplastic agents originally prescribed by the collaborating physician and approved for ongoing therapy.

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

(1) Gold compounds.

(2) Heavy metal antagonists.

(3) Radioactive agents.

(e) 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.

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

(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).

(2) A CRNP may prescribe a Schedule III or IV controlled substance for up to 30 days. The prescription may not be refilled unless the collaborating physician authorizes refills.

(g) A CRNP may not:

(1) Prescribe or dispense a Schedule I controlled substance as defined in section 4 of the Controlled Substance, Drug, Device and Cosmetic Act (35 P. S. § 780-14).

(2) Prescribe or dispense a drug for a use not permitted by the United States Food and Drug Administration.

(3) Delegate prescriptive authority specifically assigned to the CRNP by the collaborating physician to another health care provider.

(h) A prescription blank shall bear the certification number of the CRNP, the name of the CRNP in printed format at the top of the blank and a space for the entry of the DEA registration number, if appropriate. The collaborating physician shall also be identified as required in § 16.91 (relating to identifying information on prescriptions and orders for equipment and service).

(i) The CRNP shall document in the patient's medical record the name, amount and dose of the drug prescribed, the number of refills, the date of the prescription and the CRNP's name.

CHAPTER 21. STATE BOARD OF NURSING

Subchapter C. CERTIFIED REGISTERED NURSE PRACTITIONERS

CRNP PRACTICE

§ 21.283. Prescribing and dispensing drugs.

A CRNP may prescribe and dispense drugs if:

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
MEDICAL SOCIETY®

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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

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PROFESSIONAL LICENSURE COMMITTEE
House Bill 50

Thursday, October 28, 1999
9:30 a.m.
Room 140, Main Capitol Building, Harrisburg, PA

Opening Remarks
The Honorable Mario J. Civera, Jr.

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9:30 a.m. **Donald H. Smith, MD, President**
Pennsylvania Medical Society

9:55 a.m. **Michael A. Donio, Director of Projects**
Peoples' Medical Society

10:20 a.m. **Tine Hansen-Turton, Executive Director**
Regional Nursing Centers Consortium

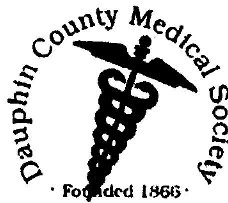
Donna Torrisi, Director
Scott Brecher, Consumer
Abbottsford and Schuylkill Falls Family Practice and Counseling

10:45 a.m. **Earl Greenwald, MD**
Doreen Saltiel, MD
Panel of Physicians in Support of House Bill 50

11:10 a.m. **Paula A. Bussard, Senior VP Policy and Regulatory Services**
Hospital and Health Systems Association of Pennsylvania (HAP)

11:35 a.m. **Christine Stabler, MD, President**
Pennsylvania Academy of Family Physicians

12:00 p.m. **Domingo T. Alvear, MD, President**
Dauphin County Medical Society



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Dauphin County Medical Society

Presentation before the

House Professional Licensure Committee

Harrisburg, Pennsylvania

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House Bill 50

by

Domingo T. Alvear, MD
President

October 28, 1999

Good morning, Mr. Chairman, and members of the House Professional Licensure Committee. My name is Doctor Domingo T. Alvear, and I appear before you today as the President of the Dauphin County Medical Society, representing nearly 700 physicians in Dauphin and Cumberland Counties. I am a practicing pediatric surgeon in the Harrisburg area. I am also the Chairman of the International Medical Graduate Section of the Pennsylvania Medical Society, representing nearly 8,000 physicians statewide.

The Dauphin County Medical Society is very concerned with several aspects of House Bill 50 and how it will have a negative impact on the quality of patient care if enacted in its present form. Today, my testimony will focus primarily on the educational and training aspects of the bill.

I'd like to take just a few moments to give you some background on my education and training as a physician. I received my medical training from the University of Santo Tomas, College of Medicine, in the Philippines. In 1964, I began my rotating internship at the U.S. Air Force Hospital at Clark Air Force Base in the Philippines, and also completed one year of general surgery residency there. I came to the United States in 1966 and was required to repeat a domestic rotating surgical internship at the Presbyterian University of Pennsylvania Medical Center in Philadelphia, and

completed general surgery residency in 1971. In 1973, I completed a fellowship in pediatric surgery at St. Christopher's Hospital for Children before starting independent practice in July 1973 in Harrisburg, Pennsylvania. All in all, I completed 13 years of post-graduate medical training before practicing independently.

On May 12, 1982 I became a United States citizen.

Currently, I am an attending pediatric surgeon for Pinnacle Health Systems in Harrisburg, and at York Hospital in York. I also serve as a consulting pediatric surgeon for Holy Spirit Hospital in Camp Hill and Memorial Hospital in York.

The dedicated physicians of the Dauphin County Medical Society have serious questions about the prudence of House Bill 50. We're gravely concerned about the impact it would have on the quality of patient care if passed. This bill would give advance practice nurses—or APNs—the ability to care for patients independently...to render diagnosis and treatment, perform invasive procedures, and prescribe virtually all drugs. All without the support or collaboration of physicians. House Bill 50 would allow APNs to practice medicine with the same treatment authority as physicians but with only half the training. Giving APNs the authority to perform invasive procedures and prescribe and administer medications—including highly

addictive Schedule II controlled substances—without physician oversight is throwing patient safety to the wind. APNs simply do not have the education or training to practice without a structured, collaborative relationship with a physician.

To illustrate, let's compare the training and education a physician must complete, before he or she can practice independently, to the education and training that an APN has. To become a physician, a student must earn a degree from a four-year college or university in pre-medical education. Next, he or she must complete four years of medical school. Following medical school, the physician enters a three- to five-year residency or specialty training program, plus subspecialty training for an additional two to three years depending on the selected subspecialty, where actual patient care is administered under the ***supervision*** of a physician. Following completion of the internship or specialty training, the physician is often required to obtain board certification to practice within that specialty. But, the education and training doesn't stop there. Physicians are required to earn continuing medical education credits each and every year of their entire medical career. They also must be recertified every five to ten years. Just last week, I completed the arduous task of recertifying via my board exams This was the ***third*** time I've completed recertification.

To put this in perspective, consider that physicians spend, after high school, from 11 to 16 years in education and training. This means that **before a physician is considered capable of being in independent practice**; he or she must acquire **as much as *16,000 hours*** of formal education, clinical experience, and training. **APNs are required to train for only a fraction of those hours.** Master's level programs that lead to APN credentials can amount to ***less than 1,000 hours.***

What House Bill 50 will do is grant APNs who have two years of graduate education the same authority and independence as physicians who complete one of the most rigorous and comprehensive educational and training processes of any profession in the country. This is not good medicine for anyone.

We are not disputing the value or competency of APNs to do what they have been trained to do. They are a vital part of the medical team. The key word here is "team." APNs have been trained to serve with physician guidance, supervision, and oversight. I have worked with many APNs throughout my career as a surgeon and will continue to do so. As with any team, each member possesses his or her own unique role and ability level.

We ask each of you to please give careful consideration to our concerns about House Bill 50. Patient safety and welfare are the real issues here. House Bill 50, as it is written, ignores these critical issues.

Thank you for your time and attention. I will be happy to respond to any questions from members of the committee.

Comments on HB 50
Doreen Saltiel, MD, FACC
Sayre, PA

I am here today to address issues related to HB 50 from my perspective. I am an Invasive/Interventional Cardiologist currently practicing in Pennsylvania. Until 4 months ago, I was in private practice in a small group in the state of Washington. In that practice, I employed a Nurse Practitioner. In my current position, I also work with several Nurse Practitioners.

As you may know, Washington allows certified NP's to work independently, including prescribing medications. However, the vast majority of NP's I have worked with were employed by, and worked relatively closely with, physicians in a variety of settings.

I entered private practice knowing that I would hire one or more NP's because I had substantial experience with, and respect for, the skills of advanced practice nurses during my years in the military. As a subspecialist, I believe there are a variety of areas in which Nurse Practitioners are able to complement my skills. In my 16 years in medicine, I have never encountered a situation where a NP and I disagreed about what those areas are. I have no fear that NP's will attempt (or wish) to exceed their scope of practice as defined by law and various nursing boards.

In fact, I cannot deliver the best care to patients without the assistance of Nurse Practitioners, and their ability to provide care and write prescriptions independently only enhances the care of patients. In Washington, my NP had a number of responsibilities, including clinical research. However, her largest role was in the management of on-going care for patients. The best example of her contributions was in the ever-growing group of patients with heart failure. Following my initial evaluation and diagnostic testing, she initiated a multidisciplinary plan which included on-going assessment to detect problems in early stages, flexible diuresis, titration of drugs to achieve the best possible end points, and referrals as indicated. No other Cardiologists were able to achieve our level of improved quality of life for patients, decreased hospital admission and patient satisfaction. We could not have achieved this without the NP's ability to assess, adjust or initiate medications and write prescriptions independent of whether I was in the office or at the hospital.

Nurse Practitioners have substantial training, and usually substantial clinical experience before their advanced training, that directly benefit patients in a variety of settings. Their potential for contribution to patient care is enormous and will only be hampered by not allowing them to practice their profession to the full extent that they are able.

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TESTIMONY TO THE PENNSYLVANIA STATE HOUSE OF REPRESENTATIVES'

COMMITTEE ON PROFESSIONAL LICENSURE

Honorable Mario J. Civera, Jr., Chair

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Public Hearings on HB 50

October 28, 1999

by Christine M. Stabler, MD
President, PA Academy of Family Physicians

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Chairman Civera, members of the Committee:

Thank you for the opportunity to speak to you today regarding House Bill 50. My name is Dr. Christine Stabler. I am the President of the Pennsylvania Academy of Family Physicians and represent more than 4,500 Family Physicians in our Commonwealth. My principal occupation is as a deputy director of a Family Practice Residency and as a coordinator of Medical Student rotations. I am here to voice our members' opposition to House Bill 50.

I will preface my remarks by saying that I am appreciative of the role Advanced Practice Nurses (APN's) play in healthcare. Under existing collaborative agreements they augment the care provided to and are effective educators of patients. There is a body of research that documents that Nurse Practitioners provide complementary healthcare within the framework of a collaborative agreement with physicians.

But HB 50 would amend the Professional Nursing Law and the Medical Practice Act of 1985 in significant ways that would jeopardize the quality of healthcare to Pennsylvanians by dissolving the requirement for collaboration between physicians and APN's and establishing an independent practice of medicine for these practitioners.

Proponents of this bill claim it seeks only to give APN's the tools to do what they have already been granted in law. I would respectfully suggest that, with the exception of prescriptive authority in a collaborative agreement, APN's today are fully utilizing their authority and providing valuable services. Authority to prescribe certain therapeutic drugs has been granted by both the Board of Medicine and the Board of Nursing, with proposed regulations pending at this time. If this were the real goal of the APN's, we would not be spending our time and yours debating expansion of scope of practice, but simply commenting on the proposed regulations. PAFP will continue to be a part of that process.

As for HB 50 itself, the Academy has serious concerns relating to both scope of practice issues and Constitutionality. I will address a few of these issues today, and have attached copies of memoranda of law from our general counsel for your review and consideration. We strongly urge you to review these memoranda and will be happy to respond today or later to any questions you may have.

Section 1 of HB 50 relegates the definition of the scope of practice and standards of care for an APN to those defined by the national organizations of each specialty. This is an outright and unconstitutional delegation to organizations that have no accountability to the Pennsylvania General Assembly, the body ultimately responsible for these determinations.

Section 2 of HB 50 adds a new section to the Professional Nursing Law that provides that an APN " is authorized to diagnose and treat illnesses, perform therapeutic and invasive procedures, prescribe dispense and administer drugs and devises and order and administer anesthetics..."

This definition is the functional equivalent of the unlicensed practice of medicine. One may challenge that APN's in essence already provide these services, but under current regulations they practice only within the guidelines of a collaborative arrangement with a licensed physician.

Section 3 deletes the statement "confers no authority to practice dentistry, podiatry, optometry, chiropractic, medicine or surgery" and replaces it with "does not limit the right of an individual to practice a health occupation that he or she is otherwise authorized to practice under this act." HB 50 further redefines the practice of professional nursing to "include but not be limited to the initiation and maintenance of therapeutic health care regimens." Under these provisions, limitations on the scope of APN's practice under current law would be removed, and replaced with subtle, yet real catalysts for expansion.

Section 4 of HB 50 expressly states that Section 15 of the Medical Practice Act is repealed. Section 15 of that Act establishes the parameters for the practice and regulation of certified registered nurse practitioners including the collaboration with physicians. Under this provision the State Board of Medicine would have no regulatory or supervisory authority over the practice of medicine by APN's and would remove any requirement for a collaborative agreement between APN's and physicians.

Section 5 of the Nursing Law requires that an APN be a currently licensed registered nurse (who may have as little as a two-year associate degree in nursing) who has passed the professional nursing examination prepared and administered by the National Council of State Boards of Nursing. The APN must have one additional academic year of training in a "program administered by nursing in an institution of higher education." There are no requirements for certification or recertification examination imposed by the Nursing Law.

Proponents of HB 50 cite improved ACCESS to health care through the bill. But, if as the proponents contend, no changes are made in the scope of practice, one must ask how this access will be improved. It is unreasonable to expect Advanced Practice Nurses to provide care in underserved areas to any greater extent than physicians are. Current studies show that only seven percent of master's degree nurse practitioners are likely to practice in rural areas – 19 percent of certificate trained nurse practitioners. This is not surprising, as nurses and physicians cite the same reasons for their reluctance to live permanently in these underserved areas. They don't have sufficient free time, satisfactory quality of life or professional collegiality.

Proponents of HB 50 also assert that passage of the bill will increase access to QUALITY health care for PA Consumers. PAFP believes that non-physician providers should undergo credentialing consistent with the services they provide. We have heard often of the equivalency of these primary care practitioners, but that equivalency has simply not been demonstrated.

Physicians have developed a degree of medical sophistication that even draws distinctions between practicing physicians and residents, let alone medical school graduates or others with Masters Degrees.

When physicians and nurse practitioners work as a team, the NPs can effectively care for patients who require health maintenance or health education or who have minor illnesses and the physician is free to see the more seriously ill or medically complicated patient. Nurse Practitioners generally are effective providers of health maintenance and acute care to patients with common minor illnesses and to those with certain chronic illnesses. NO published studies show Nurse Practitioners in independent practice providing better quality or more cost-effective care for patients than physicians.

The Academy has surveyed the curricula of 18 nurse practitioner schools in Pennsylvania. Most require a bachelors level degree and between 16 and 24 months of additional training. Completion of this training confers a master's degree in nursing. There is an alternate pathway whereby a nurse can receive a nursing certificate in lieu of a master's level degree. The certificate requires less intensive training in 27 to 34 credit hours of training. There is no formal internship, residency or additional clinical training or experience required. APN's are not trained in the pathophysiology (the "why") of disease. They are not trained in the detailed reasoning necessary to manage undifferentiated symptoms for patients with complex problems.

On the other hand, to practice medicine and prescribe medications and devices in Pennsylvania, a physician must complete an undergraduate course of study, graduate from an accredited 4-year medical school. In addition, the physician must successfully pass the 3 step United States Medical Licensing Examination and complete a minimum of 2 years of post-graduate residency training in clinical medicine or one year for graduates of Osteopathic training programs.

Graduates of foreign medical schools must meet additional requirements. These requirements were established in response to the Flexner Report of 1910. Abraham Flexner was charged with an analysis of medical education in the United States.

By the turn of the last century, America was experiencing a shortage of physicians. In response, more than a hundred medical schools with less formal training had opened. Americans were being treated by practitioners with substandard training and their health care was inadequate. Supply was met, but quality suffered. Mr. Flexner recommended that physicians receive standardized education and training to guarantee equal quality to anyone seeking medical care. It seems ironic that the solution to the problem of access to medical care as we approach the next century would be similar.

The net effect of HB 50 would be to permit individuals with significantly less education and training to practice medicine without restriction in Pennsylvania. With no disrespect to Advanced Practice Nurses, the Pennsylvania Academy of Family Physicians cannot support this.

To suggest, as organized nursing groups have, that HB 50 would not expand the scope of an APN's practice to include the independent practice of medicine and surgery where the bill provides no limitations on practice, and indeed repeals safeguards which are currently in place, is disingenuous at best.

The Commonwealth Court's words in a case brought by the Pennsylvania Coalition of Nurse Practitioners against the State Boards of Pharmacy, Medicine and Nursing are instructive here. In that case, the APN coalition asked the Court to order that APN's may execute prescriptions without the signature of a physician as evidence that the APN prescribed "in collaboration with and under the direction of a physician," as required under current law. The Court said:

> The old saying is "the devil is in the details." We do not ascribe any improper motive to the Petitioners and Nursing/Respondent, but it would be improvident to ignore the fact that any APN disposed to ignore the limitation imposed by the regulation would have a *carte blanche* to do so with virtual impunity.

Towers, et al. v. State Board of Pharmacy, et al., No. 234 M.D. 1994 (Pa. Cmwlth. 1995).

Likewise, HB 50 would not provide the limitations that the organized nursing entities insist are there. Indeed, with the repeal of joint regulatory authority between the State Boards of Medicine and Nursing, and the expanded definition of an APN, coupled with the delegation of authority to set parameters for advanced practice nursing to nursing organizations, without requiring any physician collaboration, supervision or review, provides a virtual *carte blanche* to APN's to engage in the independent practice of medicine.

We fully recognize the issue of access to healthcare for all Pennsylvanians and are willing to be an active participant to finding solutions to this problem. We strongly believe that all Pennsylvanians deserve the highest quality healthcare by the most qualified individuals and that right should not be waived by virtue of where they reside.

There is substantial research to prove that the healthcare team of physicians, physicians' assistants and APN's can and do work together effectively to deliver high quality healthcare within established formats and guidelines. There is no evidence to suggest that dividing this team will help expand either access or quality.

With the development of advanced technology, this team will be able to deliver that quality health care to all Pennsylvanians. PAFP and its member physicians are dedicated to delivering that quality, and will work with APN's to do so. But we cannot support legislation that would fundamentally affect the delivery of health care without sufficient justification, and thus, we must oppose HB 50.

Thank you all for your time and consideration.

CHARLES I. ARTZ & ASSOCIATES
ATTORNEYS AT LAW
207 STATE STREET
HARRISBURG, PA 17101

(717) 238-9905
FAX (717) 238-2443

MEMORANDUM OF LAW

TO: Pennsylvania Academy of Family Physicians

FROM: Charles I. Artz, Esq.
April L. McClaine, Esq.

DATE: October 14, 1999

RE: Expansion of Advanced Practice Nursing Scope of Practice

The Pennsylvania Academy of Family Physicians ("PAFP") has taken the position, on advice of counsel, that HB 50, P.N. 1199 expands the scope of advanced practice nursing in Pennsylvania to the functional equivalent of the unrestricted practice of medicine. Nursing trade organizations have criticized this position as not being grounded in HB 50. The criticisms are disingenuous as demonstrated by the following legal analysis.

CURRENT LAW

1. The Medical Practice Act

"Medicine and surgery" is defined in § 2 of the Medical Practice Act of 1985 ("MPA"), Act of December 20, 1985, P.L. 457, as amended, as:

> The art and science of which the objectives are the cure of diseases and the preservation of the health of man, including the practice of the healing art with or without drugs, except healing by spiritual means or prayer.

63 P.S. § 422.2. Section 2 of the MPA further defines "healing arts" as "the science and skill of diagnosis and treatment in any manner whatsoever of disease or any ailment of the human body." 63 P.S. § 422.2. Medical practice is therefore unrestricted in Pennsylvania.

Section 28 of the MPA provides:

> An individual is not qualified for a license to practice medicine and surgery unless the individual has received an academic degree in medicine and surgery from a medical college and the individual satisfies the other qualifications for the license contained in or authorized by this act.

63 P.S. § 422.28. Medical practice is unique in its breadth under Pennsylvania law.

2. The Professional Nursing Law

Section 2 of the Professional Nursing Law ("PNL"), Act of May 22, 1951, P.L. 317, as amended, defines the practice of professional nursing as:

> ...diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The foregoing shall not be deemed to include acts of medical diagnosis or prescription of medical therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the [Nurse] Board, which rules and regulations shall be implemented by the [Nurse] Board.
>
> "Diagnosing" means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen.

63 P.S. § 212 (emphasis added).

Under current law, it is absolutely clear that nurses, including advanced practice registered nurses ("APRNs") may not practice medicine except to the extent authorized under the regulatory authority of both the State Board of Nursing and the State Board of Medicine. No reasonable interpretation of existing law could constitute this language as permitting APRNs to practice medicine independent of physician regulation, and the courts of Pennsylvania agree.

3. Supreme Court Authority

The Supreme Court of Pennsylvania has acknowledged the difference between medical diagnosis and treatment on one hand, and nursing diagnosis and treatment on the other, as follows:

> ...A nursing diagnosis identifies signs and symptoms to the extent necessary to carry out the nursing regimen. It does not, however, make final conclusions about the identity and cause of the underlying disease. ...A medical diagnosis is commonly understood to be an identification of a disease based on its signs and symptoms.

Flanagan v. Labe, 547 Pa. 254, 258-59, 690 A.2d 183, 186 (1997). In that case, the Supreme Court held a doctoral degreed nurse was incompetent to testify as an expert witness in a medical malpractice case because the nursing scope of practice did not include medical diagnosis.

Indeed, § 4 of the PNL, specifically provides: "This Act confers no authority to practice dentistry, podiatry, optometry, chiropractic, medicine or surgery..." 63 P.S. § 214.

4. MPA/PNL CRNP Overlap

Section 15 of the MPA provides in pertinent part:

> A certified registered nurse practitioner shall act in accordance with regulations authorized by this section. ...The board and the State Board of Nurse Examiners shall jointly promulgate regulations authorizing a certified registered nurse practitioner to perform acts of medical diagnoses and prescription of medical, therapeutic, diagnostic or corrective measures....

63 P.S. § 422.15. Thus, physician regulation of CRNP practice through the Medical Board is required under current law.

Regulations currently promulgated by the Medical and Nursing Boards define a certified registered nurse practitioner ("CRNP") as:

> A registered nurse licensed in this Commonwealth who is certified by the Boards in a particular clinical specialty area and 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. ...

49 Pa. Code §§ 18.21 and 21.251 (emphasis added). Thus, CRNPs cannot currently practice any aspect of medicine independently. Instead, CRNP practice occurs within the context of physician supervision, collaborative agreement with a physician, and physician direction.

"Direction" under the regulations is defined as:

> The incorporation of physician supervision to the certified registered nurse practitioner's performance of medical acts in the following ways:
>
> (i) immediate availability of a licensed physician through direct communications or by radio, telephone or telecommunications;
> (ii) a pre-determined plan for emergency services which has been jointly developed by the supervising physician and the certified registered nurse practitioner;
> (iii) a physician available on a regularly scheduled basis for:
> (A) referrals;
> (B) review of the standards of medical practice incorporating consultation and chart review;
> (C) establishing and updating standing orders and drug and other medical protocols within the practice setting;
> (D) periodic up-dating in medical diagnosis and therapeutics;
> (E) co-signing records when necessary to document accountability by both parties.

49 Pa. Code §§ 18.21 and 21.251. Current law could not be clearer that CRNPs may not practice medicine independent of physicians. Indeed, approval granted to a registered nurse for certification as a CRNP may be terminated when the State Board of Nursing finds, *inter alia*, "that the registrant has engaged in the performance of medical functions and tasks other than at the direction of a physician licensed by the [Medical] Board..." 49 Pa. Code §§ 18.81 and 21.321.

HOUSE BILL 50 PROPOSAL

1. HB 50 Definitions

HB 50 would amend the Professional Nursing Law and the Medical Practice Act of 1985 in significant ways.

Section 1 of HB 50 would amend § 2 of the PNL to define an APRN as:

> ...An individual who has met the requirements to practice as an advanced practice registered nurse as set forth in regulations promulgated by the Board of Nursing and practices in one or more of the categories of certified registered nurse practitioner (CRNP), certified registered nurse anesthetist (CRNA) or certified clinical nurse specialist (CCNS) in accordance with the scope of practice and standards of care that are defined by national organizations of each specialty area of practice.
> (emphasis added)

Determining the scope of practice of APRNs would be delegated outright to national organizations, none of which are accountable to or guided by the Pennsylvania General Assembly. This provision violates Article II, Section 1 of the Pennsylvania Constitution. *See* legal memorandum appended.

Likewise, the practice of professional nursing would be re-defined as:

> ...diagnosing and treating human responses to actual or potential health problems across the life span. This practice involves the performance of acts requiring substantial knowledge, judgment and skill based upon the principles of the biological, physical, behavioral and social sciences. The professional nurse develops and initiates a plan of care to accomplish defined goals and evaluates responses to care and treatment. The practice of professional nursing includes, but is not limited to, initiation and maintenance of therapeutic health care regimens and comfort measures, promoting and supporting human functions and responses, establishing and managing an environment conducive to well-being, providing health counseling and teaching, case finding and case management and executing therapeutic patient care orders of a licensed professional health care provider, including, but not limited to, advanced practice registered

nurses, certified nurse midwives, physicians and dentists. (emphasis added)

Conspicuous by its absence from this new definition is the prohibition against nurses practicing medicine independent of the regulatory authority of both the Medical Board and the Nursing Board. In fact, nurses would be specifically permitted to **initiate** and maintain **therapeutic** health care regimens. This is the practice of medicine. *See* Feingold v. State Board of Chiropractic, 568 A.2d 1365 (Pa. Cmwlth. 1990), where the Court held that a naturopath may use different words to describe his practice, but nonetheless engages in activities which constitute the practice of chiropractic and therefore must hold a chiropractic license to practice in Pennsylvania. In Feingold, the Court said: "Chiropractic by any other name is still chiropractic." *Id.* at 1367. Similarly, with respect to HB 50, medicine by any other name is still medicine.

Section 2 of HB 50 would add a new § 3.1 to the PNL to provide that an APRN:

> ...is authorized to **diagnose and treat illnesses, perform therapeutic and invasive procedures, prescribe, dispense and administer drugs and devices** and **order and administer anesthetics**, pursuant to the rules and regulations established by the [Nursing] Board consistent with the advanced practice registered nurse scope of practice. APRNs may **prescribe and administer controlled substances in categories II through V** pursuant to Federal Drug Enforcement Agency's (DEA) rules and regulations in a manner consistent with their scope of practice (emphasis added).[1]

The emphasized text would have two clear effects: (1) to place the APRN scope of practice on par with the unrestricted practice of medicine and (2) to provide APRNs with extensive prescriptive authority.

Section 1 of HB 50 would likewise add a new subsection (a.1) to § 2.1 of the PNL to permit an advisory council composed of seven APRNs and two consumers to serve as "expert consultants" in APRN education, scope of practice, quality of service and grievances to the State Board of Nursing which, also by composition, excludes physician participation.

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[1] It is important to note that DEA defers all scope of practice decisions to state licensing authorities. Moreover, controlled substances are scheduled and regulated not only at the federal level, but by state authorities as well. The Department of Health and the State Board of Pharmacy regulate in this area and the Pennsylvania Controlled Substance, Drug, Device and Cosmetic Act, Act of April 14, 1972, P.L. 233, as amended, is also controlling.

Section 3 of HB 50 also deletes the restriction under the current § 4 of the PNL prohibiting nurses from practicing "dentistry, podiatry, optometry, chiropractic, medicine or surgery." It replaces the prohibition with an actual expansion in authorized practice using the following words: "This act does **not limit** the right of an individual to practice a health occupation that he or she is otherwise authorized to practice under this act..." (emphasis added).

Finally, section 4 of HB 50 expressly states as follows:

> Section 15 of the Medical Practice Act is repealed.

Section 15 of the MPA established the parameters for the practice and regulation of certified registered nurse practitioners in their practice of certain aspects of medicine. Its repeal under HB 50 eviscerates Medical Board supervision and oversight over APRNs, as well as required physician collaboration in an APRN practice.

2. HB 50 Would Effectively Repeal Current Controls

It is abundantly clear from the foregoing that, under current law, certified registered nurse practitioners may not independently practice medicine. This is logical and in keeping with the relative education, training and examination requisite to the independent practice of medicine not only in Pennsylvania, but throughout the United States.

Indeed, in order to practice medicine, an applicant for a medical license must graduate from a recognized medical school, successfully pass the three-step United States Medical Licensing Examination and complete a minimum of two years of graduate medical training properly accredited. Additional requirements must be met by graduates of foreign medical schools. Section 29 of the Medical Act, 63 P.S. § 422.29, 49 Pa. Code § 17.1. To meet minimum requirements, an applicant for medical licensure in Pennsylvania will have completed, at a minimum, twelve total years of elementary/secondary education; four years of college or university training; a minimum of four years of medical school training (for example, graduates of foreign medical schools must complete a total of 32 months and 4,000 hours of academic instruction in medical curriculum as well as 72 weeks of approved clinical rotations before graduating from medical school, 49 Pa. Code § 17.1(b)), and a minimum of two years of graduate medical training in an accredited hospital (three years for foreign medical school graduates), and most graduate medical training (residency programs) are at least three years in duration.

CRNPs, on the other hand, must be currently licensed registered nurses who may have as little as a ***two-year associate degree in nursing or two-year diploma nursing***

program education[2] and have passed the professional nursing examination prepared and administered by the National Council of State Boards of Nursing, plus one additional academic year of training in a "program administered by nursing in an institution of higher education" (emphasis added). Section 5 of the Nursing Law, 63 P.S. § 215, 49 Pa. Code §§ 18.41 and 21.271. No additional examination requirement is imposed upon registered nurses in order to qualify for certification as a CRNP to perform certain acts of medical diagnosis and treatment.[3] Accordingly, the logical result under current law is that CRNPs are not permitted to practice medicine independent of the ongoing collaboration or supervision of a licensed physician.

This logical legislative policy is also evident in current law related to all other health care practitioners who do not hold unrestricted licenses to practice medicine, but who are permitted to engage in acts of medical diagnosis and treatment. Those practitioners who perform certain therapeutic and invasive procedures and who prescribe and dispense drugs, are required, at a minimum, to obtain a modicum of medical training and pass an additional examination certifying them to expand their practices. Moreover, such other practitioners are also subject to ongoing supervision by licensed physicians. See §§ 2, 4.1 and 5 of the Optometric Practice and Licensure Act, Act of June 6, 1990, P.L. 197, as amended, 63 P.S. §§ 244.2 and 244.4(a); 49 Pa. Code §§ 23.82, 23.201-23.202 (**optometrists** required to complete a minimum of 100 hours in the prescription and administration of pharmaceutical agents for therapeutic purposes and to pass a national examination to certify them to prescribe and administer a narrow list of drugs approved by the Secretary of Health, despite already holding a license to practice optometry); §§ 12 and 35 of the MPA, 63 P.S. §§ 422.12 and 422.35; 49 Pa. Code §§ 18.1-18.7 (**registered nurse midwives** required to take certifying examination as well as an accredited program in midwifery and to operate within collaborative arrangements with physicians memorialized in writing); §§ 13 and 36 of the MPA, 63 P.S. §§ 422.13 and 422.36; 49 Pa. Code §§ 18.121-18.181 (**physician assistants** required to complete accredited physician assistant program and successfully pass the national physician assistant examination to operate under the direct supervision of a physician within the strict confines of a written agreement approved by the Medical Board limiting the parameters of medical acts and prescriptive authority they may exercise).

HB 50, if enacted in its current form, would permit registered nurses (with a minimum of two years of nurse's training) who have completed a one-year program in advanced practice nursing, and who have passed no additional examination, to practice medicine independent of the regulatory or practical collaborative authority of a physician trained, examined and licensed to practice medicine and surgery in Pennsylvania. An APRN under the circumstances noted would be authorized under HB 50 to "diagnose and treat illnesses, perform

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[2] Nursing Board records will confirm that a substantial percentage of currently certified CRNPs in fact only have a two-year associate degree or a two-year nursing school diploma.

[3] HB 50 does not change or increase any educational or training requirement to achieve APRN status.

therapeutic and invasive procedures, prescribe, dispense and administer drugs [including] controlled substances in categories II through V."

HB 50 could not more clearly or dramatically expand the scope of practice of an APRN to the functional equivalent of the unrestricted, independent practice of medicine and surgery. This it would do without incorporating the extensive academic and clinical education and training requirements and examinations requisite to a license to practice medicine and surgery in Pennsylvania.

3. <u>HB 50 Would Repeal the Limitation on CRNPs' Rights to Practice Medicine</u>

HB 50's repeal of the limitation in the PNL prohibiting APRNs from independently practicing medicine or surgery and its repeal of the provisions of § 15 of the MPA, (providing for medical oversight of CRNP practice), completely obliterates any practical or legal supervision over the unfettered practice of medicine and surgery by APRNs. It is axiomatic that where legislative and regulatory language authorizes, but does not circumscribe, a particular practice, the practice is not limited. Likewise, **where the language in a statute that authorizes agency regulations has been repealed, the regulations are effectively repealed.** <u>Pennsylvania Human Relations Commission v. Uniontown Area School District</u>, 455 Pa. 52, 313 A.2d 156 (1973).

Accordingly, current regulations of both the Nursing Board and the Medical Board setting parameters for CRNP collaborative practice would no longer be enforceable, providing APRNs with unfettered <u>medical</u> discretion subject only to the regulatory authority of an agency composed, not of persons trained and licensed to practice medicine, but of persons trained and licensed to practice <u>nursing</u>.

DELEGATION OF APRN SCOPE OF PRACTICE TO NATIONAL ORGANIZATIONS REPRESENTING AN UNCONSTITUTIONAL DELEGATION OF LEGISLATIVE AUTHORITY

We have written a separate memorandum of law discussing the constitutional infirmity of HB 50's delegation to national organizations of each specialty area of advanced practice nursing the authority to determine the scope of practice and standards of care for Pennsylvania advanced practice nurses. A copy of our opinion on this issue is attached.

CONCLUSIONS

To suggest, as organized nursing groups have, that HB 50 would not expand the scope of an APRN's practice to include the independent practice of medicine and surgery where the bill provides no limitations on practice, and indeed repeals safeguards which are currently in place, is disingenuous at best.

The Commonwealth Court's words in a case brought by the Pennsylvania Coalition of Nurse Practitioners against the State Boards of Pharmacy, Medicine and Nursing are instructive here. In that case, the CRNP coalition asked the Court to order that CRNPs may execute prescriptions without the signature of a physician as evidence that the CRNP prescribed "in collaboration with and under the direction of a physician," as required under current law. The Court said:

> The old saying is "the devil is in the details." We do not ascribe any improper motive to the Petitioners and Nursing/Respondent, but it would be improvident to ignore the fact that any CRNP disposed to ignore the limitation imposed by the regulation would have a *carte blanche* to do so with virtual impunity.

Towers, et al. v. State Board of Pharmacy, et al., No. 234 M.D. 1994 (Pa. Cmwlth. 1995).

Likewise, HB 50 would not provide the limitations which the organized nursing entities insist are there. Indeed, with the repeal of joint regulatory authority between the State Boards of Medicine and Nursing, and the expanded definition of an APRN, coupled with the delegation of authority to set parameters for advanced practice nursing to nursing organizations, without requiring any physician collaboration, supervision or review, provides a virtual *carte blanche* to APRNs to engage in the independent practice of medicine.

CIA/ALM/kr

CHARLES I. ARTZ & ASSOCIATES
ATTORNEYS AT LAW
207 STATE STREET
HARRISBURG, PA 17101

(717) 238-9905
FAX (717) 238-2443

MEMORANDUM OF LAW

TO: Pennsylvania Academy of Family Physicians

FROM: Charles I. Artz, Esq.

DATE: October 14, 1999

RE: Constitutional Infirmity of HB 50

The question presented is whether Section 2 of HB 50, P.N. 1199, which delegates the scope of practice and standards of care of advanced practice nursing to national organizations violates Article II, Section 1 of the Pennsylvania Constitution. The following legal and constitutional analysis compels an affirmative answer.

1. HB 50's Delegation Provision

HB 50 defines "Advanced Practice Registered Nurse" (APRN) as follows:

> "Advanced practice registered nurse" means an individual who has met the requirements to practice as an advanced practice registered nurse as set forth in regulations promulgated by the Board of Nursing and practices in one or more of the categories of certified registered nurse practitioner (CRNP), certified registered nurse anesthetist (CRNA) or certified clinical nurse specialist (CCNS) in accordance with the scope of practice and standards of care that are ***defined by national organizations of each specialty area of practice.***"

HB 50, Section 2 (emphasis added).

2. **The Power Conferred Upon The Pennsylvania Legislature To Make Laws Cannot Be Delegated.**

"A fundamental precept of the democratic form of government imbedded in our Constitution is that the people are to be governed only by their elected representatives." Hetherington v. McHale, 458 Pa. 479, 484, 329 A.2d 250, 253 (1974). This precept is clearly set forth in Article II, Section 1 of the Pennsylvania Constitution, which reads as follows:

> The legislative power of this Commonwealth shall be vested in a General Assembly which shall consist of a Senate and a House of Representatives.

P.S. Const. Art. II, Sec. 1.

It is axiomatic that legislative power is the power to make, alter and repeal laws, Blackwell v. Commonwealth, State Ethics Commission, 523 Pa. 347, 567 A.2d 630 (1989), and although not specifically set forth in the Pennsylvania Constitution, there is a well recognized rule against non-delegation of legislative power, which is premised on Article II, Section 1. See Locke's Appeal, 72 Pa. 491 (1872). In other words, *the power conferred upon the legislature to make laws cannot be delegated to any other body or authority*. In re O'Hara's Appeal, 389 Pa. 35, 47, 131 A.2d 587, 593 (1957) (emphasis added); Gilligan v. Pennsylvania Horse Racing Commission, 492 Pa. 92, 95, 422 A.2d 487, 489 (1980); Common Cause/Pennsylvania v. Commonwealth, 710 A.2d 108 (Pa. Cmwlth. 1998); Sullivan v. Commonwealth, Department of Transportation, 550 Pa. 639, 708 A.2d 481 (1998). Instead, basic policy choices are to be made by the General Assembly. Pennsylvania Chiropractic Federation v. Foster, 583 A.2d 844, 849 (Pa. Cmwlth. 1990); Blackwell v. Commonwealth, State Ethics Commission, 523 Pa. 347, 360, 567 A.2d 630, 637 (1989); Charters Valley Joint Schools v. County Board of School Directors of Allegheny County, 418 Pa. 520, 529, 211 A.2d 487, 492 (1965).

The prohibition against the delegation of legislative power is a necessary outgrowth of the fundamental theory of the separation of governmental functions, which permeates the State and Federal Constitutions. Holgate Bros. Co. v. Bashore, 331 Pa. 255, 259, 200 A. 672, 674 (1938). Governmental powers cannot be delegated to private individuals or organizations, Hetherington v. McHale, 458 Pa. 479, 484, 329 A.2d 250, 253 (1974), and regardless of exigencies, the legislature cannot abdicate, transfer or delegate its authority or duty. Holgate, 331 Pa. at 260, 200 A. at 675. Additionally, expertise of a particular body is not justification to alter the fundamental principle that we are to be governed by our elected representatives in accordance with the Constitution. Hetherington, 458 Pa. at 484, 329 A.2d at 253 (1974).

The non-delegation doctrine serves two interrelated purposes. "First, it seeks to insure that basic policy choices be made by duly authorized and politically responsible

officials. Second, it seeks to protect against the arbitrary exercise of unnecessary and uncontrolled discretionary power." Parker v. Dept. of Labor & Industry, 540 A.2d 313, 331 (Pa. Cmwlth. 1988); citing William Penn Parking Garage, Inc. v. City of Pittsburgh, 464 Pa. 168, 212, 346 A.2d 269, 291 (1975).

The Legislature, however, may confer upon administrative officers, boards and commissions, authority and discretion in connection with the execution of a law, **but basic policy choices must be made by the legislature**, and if there is such a grant of authority, the legislation must contain adequate standards, which will guide and restrain the exercise of the delegated administrative functions. Whitlatch v. Commonwealth, Department of Transportation, 552 Pa. 298, 302, 715 A.2d 387, 389 (1998) (emphasis added); Gilligan, *supra*; Holgate, 331 Pa. at 260, 200 A. at 675. Stated another way, authority may be granted to a government official or administrative agency to make rules and regulations to cover merely matters of detail for purposes of statute implementation, but where the statute itself lacks essential substantive provisions, the power to supply them cannot be delegated. Sullivan v. Commonwealth, Department of Transportation, 550 Pa. 639, 647, 708 A.2d 481, 485 (1998). For the reasons stated below, that is exactly what will occur if the current version of HB 50 is enacted into law.

3. HB 50 Contains An Unconstitutional Delegation Of Legislative Authority By Granting Non-Governmental Bodies The Power To Define Scope Of Practice And Standards Of Care For Three Categories Of Nursing.

Although the requirements to practice as an APRN are to be determined by the State Board of Nursing, the scope of practice and standards of care will be determined by national organizations based upon how those organizations, now and in the future, define scope of practice and standards of care. This clearly violates the constitutional mandate that we are to be governed by our elected officials, not un-elected groups of nurses.

HB 50, in the initial portion of section 3.1(a)[1] attempts to generally identify an APRN's scope of practice; however, it then expands the scope of practice by requiring that the rules and regulations determined by the State Board of Nursing be consistent with the APRN scope of practice, which according to Section 2 of HB 50, are defined by national organizations. A basic tenet of statutory construction requires courts to

[1] "An APRN is authorized to diagnose and treat illnesses, perform therapeutic and invasive procedures, prescribe, dispense and administer drugs and devices and order and administer anesthetics, pursuant to the rules and regulations established by the Board consistent with advanced practice registered nurse scope of practice. APRNs may prescribe and administer controlled substances in categories II through V pursuant to Federal Drug Enforcement Agency's (DEA) rules and regulations in a manner consistent with their scope of practice." HB 50, Section 3.1(a).

construe words of a statute according to their plain meaning. Grom v. Burgoon, 672 A.2d 823 (Pa. Super. 1996); 1 Pa. C.S. § 1903. Additionally, to ascertain legislative intent, a court must begin with the presumption that the legislature did not intend any statutory language to exist as mere surplusage. Bamber v. Lumbermens Mutual Casualty Company, 680 A.2d 901 (Pa. Super. 1996). Thus, the definition section, which incorporates how national organizations define scope of practice and standards of care, cannot be ignored or minimized.

Section 2 is the cornerstone of HB 50, and therefore, the meaning of its terms must be given corresponding weight. Section 2 cannot be severed from HB 50, in order to withstand constitutional scrutiny, because it is so inextricably intertwined with the remainder of the proposed statue.[2] Thus, because the Legislature's specific intent is to grant authority to national organizations, the inescapable result is that if the current draft of HB 50 were to become law, certain national nursing organizations, whether they know it or not, will be empowered with legislative authority. The final result would be that the State Board of Nursing would have to follow the mandate of national organizations as opposed to following the mandate of the Pennsylvania Legislature. Such an outcome would certainly be an unconstitutional delegation of legislative authority.

If the Legislature makes the basic policy choices, it can confer authority to a governmental agency if adequate standards and restraints are also imposed. In other words, while the Legislature cannot delegate the power to make a law, it can confer authority to an administrative tribunal in connection with the execution of the law. Belovsky v. Redevelopment Authority, _____ Pa. _____, 54 A.2d 277 (1947). This, however, has not occurred and cannot occur for several reasons.

First, defining scope of practice and standards of care of an APRN are not mere matters of detail, but basic policy choices. Standards of care and scope of practice are essential substantive provisions, and it is the Legislature which must make the basic policy choices. Sullivan, 550 Pa. at 646, 708 A.2d at 484. For example, it is the Legislature that defines scope of practice in the Dental Law, 63 P.S. § 121, not the American Dental Association. Scope of practice and standards of care are fundamental policy decisions that cannot be delegated.

Second, even if defining scope of practice and standards of care were not fundamental policy decisions but were mere matters of detail subject to delegation, national organizations of nursing are certainly not administrative agencies of the Commonwealth of Pennsylvania. They were not created by the Pennsylvania Legislature. They are not representative bodies elected by the citizens of Pennsylvania. They owe no allegiance to Pennsylvania. Furthermore, the Pennsylvania Legislature cannot, now or in the

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[2] The severability principle allows the portion of the non-offending statute to survive unless it is inseparably connected and dependent upon the offending portion. Commonwealth v. Liquor, 407 A.2d 83 (Pa. Cmwlth. 1979).

future, control how those organizations define scope of practice and standards of care. Quite simply, national nursing organizations are not constrained by Pennsylvania statutes, Pennsylvania regulations, or Pennsylvania case law nor can safeguards be drafted into a bill by which national organizations must abide.

The current version of HB 50 requires the State Board of Nursing to utilize definitions of scope of practice and standards of care from national organizations over which neither it nor the Pennsylvania Legislature have any control. Those national organizations, with respect to HB 50, have unbridled discretion and can at any time they desire alter how they determine scope of practice and standards of care, which will have the resultant effect of amending Pennsylvania law. The power to amend a statute is as much a legislative function as the power to enact a statute. Holgate, 331 Pa. at 264, 200 A. at 676.

Any attempt to defend the current version of HB 50 by contending that national organizations are not being empowered with legislative authority but that their definitions of scope of practice and standards of care are merely being adopted would be meritless. Although there are cases where standards not created by the Pennsylvania Legislature or a Pennsylvania administrative agency were incorporated into Pennsylvania law were deemed not to be unconstitutional delegations of authority, those exceptions are very limited and are not applicable in this instance.

For example, in East Suburban Press v. Township of Penn Hills, 397 A.2d 1263 (Pa. Cmwlth. 1979), the Pennsylvania Legislature incorporated a federal postal regulation in the Pennsylvania Newspaper Advertising Act, 45 Pa. C.S. § 101 *et seq.* The issue concerned whether the newspaper publisher was a "qualified publication," which it had to be in order to bid on the township's legal advertising. To qualify as a "qualified publication" one of the requirements was that the publication be entered or be entitled to be entered under the postal rules and regulations as a second class matter in the United States mails. East Suburban Press contended that such incorporation of a federal regulation into a state statute was an unconstitutional delegation of legislative power.

In reviewing the statute, the Court held that since it appeared that the second class mail qualification would be whatever the United States Postal Service might determine from time to time for it to be, that it appeared to be a rule making statute without the Commonwealth's ability to control the rule-making. But then the Court focused on the fact that the Pennsylvania Statute concerned legal advertising, and since it did not delegate rules on the subject of legal advertising to any external agency and given the fact that the federal regulation concerned an entirely different matter, i.e., postal operations, over which it had exclusive control, there was no delegation of legislative authority.

By contrast, in HB 50, it is clear that the proposed statute deals with APRNs and it utilizes the definitions of national organizations on that very topic.

Another example is Commonwealth v. Warner Bros. Theatres, 345 Pa. 270, 27 A.2d 62 (1942), where for purposes of Pennsylvania excise tax, the Pennsylvania statute referred to the federal definition of net income. The Court held that there was no delegation of authority because the Pennsylvania statute addressed excise tax not income tax, the federal definition of net income was used as a guide to determine something completely different, and the definition of net income was within the exclusive province of the federal government. But the important point in Warner Bros. Theatres is that the Court stated that if the Pennsylvania Legislature had the right to levy a graduated income tax and that it would be determined by the federal government, then there would be an unconstitutional delegation. With the exception of substituting national organizations in place of the federal government, this is essentially what is being proposed in HB 50.

Finally, in Pennsylvania Medical Society v. Foster, 585 A.2d 595 (Pa. Cmwlth. 1991), the Court had to address whether the incorporation of a federal Medicare reimbursement principle into § 1797 of the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S. § 1701 *et seq.*, to determine a medical provider's fees was an unlawful delegation of legislative authority. The Court held that it was not, because using Medicare (which deals with federal entitlement to benefits) as merely a financial guidepost to determine costs that can be charged for services was not a rule making delegation. In contrast, HB 50 is not using national organizations as guideposts but as quasi-legislative bodies.

Unlike the above examples, there is no reference in HB 50 to a federal statute or regulation. Instead, reference is made to non-governmental organizations. Second, even if reference was made to a federal statute or regulation, the matters of scope of practice and standards of care are not exclusive to the federal government or national organizations. Third, scope of practice and standards of care, which are fundamental policy making decisions, are being inescapably linked to how national organizations define them.

4. Conclusion

Scope of practice and standards of care are fundamental policy decisions that must be made by the Pennsylvania Legislature. National organizations, regardless of their expertise, cannot stand in the shoes and fulfill the obligations of the Pennsylvania Legislature. Inextricably intertwining national nursing organizations' definitions of scope of practice and standards of care into a Pennsylvania statue is an unconstitutional delegation of legislative authority, which violates Article II, Section 1 of the Pennsylvania Constitution.

CIA/kr

Testimony of

THE PENNSYLVANIA SOCIETY OF PHYSICIAN ASSISTANTS

Before

THE HOUSE COMMITTEE ON PROFESSIONAL LICENSURE

Concerning

ORIGINAL: 2064
HARBISON
COPIES: Sandusky
Jewett
Smith
Wyatte

HOUSE BILL 50

Presented by
Stephen D. Wilson, PA-C

October 27, 1999
Harrisburg, Pennsylvania

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INDEPENDENT REGULATORY REVIEW COMMISSION

INTRODUCTION

I wish to thank the Committee for this opportunity to testify on behalf of the Pennsylvania Society of Physician Assistants. My name is Steve Wilson. I graduated from the Alderson-Broaddus College Physician Assistant Program in West Virginia in 1974. Alderson-Broaddus is the second oldest Physician Assistants program in the country and the first to offer a Bachelor of Science Degree with completion of the program. I have previously worked at the Maryland Institute of Emergency Medicine at Maryland University Hospital in Baltimore, taught at a PA program in Maryland and worked in general and trauma surgery in Greensburg, Pennsylvania. For the last fourteen years I have worked in cardiovascular surgery in Harrisburg. I have served as Director at Large, Secretary of the House of Delegates and on various committees for the American Academy of Physician Assistants. I am a Past President of the Pennsylvania Society of Physician Assistants and I am the immediate-past Chair of the Governmental Affairs Committee. I have served in various capacities since joining the Society in 1978.

Scope of practice issues for any health-related profession is always met with a great deal of debate. This is understandable, as the health care needs of the people of this Commonwealth should not be taken lightly. In the debate concerning House Bill 50, which deals with the practice of nursing, there has been a great deal of interest in the scope of practice provided for nurse practitioners and other nursing specialists. During the last public hearing on these issues, held in Pittsburgh, comparisons were made between nurse practitioners and physician assistants. Some of the information cast the PA profession in less than favorable light and its accuracy was restricted by the lack of detail. The Society was quite surprised to find ourselves brought into this debate. It has been our experience when dealing with our own scope of practice issues, that it is up to the profession to justify the need for change based upon the needs of the patients and the qualifications of the

professional. However, since the Committee has been asked to consider the scope of practice of nurse practitioners based upon the capabilities of physician assistants, we believe the committee should be provided accurate and confirmable information regarding the history of the profession, the education and certification of the professionals, and the current contributions to the health care needs of this State.

HISTORY OF PROFESSION

During the 60's the vision was to develop "The Great Society". One of the goals for this vision was to improve access to medical care, particularly in rural, underserved areas. It was in 1961 that Dr. Henry Hudson, of the Cleveland Clinic, first wrote in the "Journal of the American Medical Association" of the possibilities of expanding medical professional service with nonphysician personnel. This idea took root in 1966 when Duke University, under the guidance of Dr. Eugene Stead, Jr., developed the first physician assistant (PA) program. Though Dr. Stead's work with advanced educational experiences for nurses in the late 50s and 60s proved to him that non-physician provided health care could be achieved, the nursing profession was somewhat reluctant to embrace the new idea due to existing shortages of nurses to provide traditional nursing care. Experienced corpsman returning from Viet Nam service provided the type of capable applicant to make the idea a reality. The programs were designed to give these new professionals a broad basic background in medicine and good practical medical education to enhance their previous experience. The educational programs used to fast-track physicians during World War II were the model for the PAs educational experience. As part of the federal government funding requirements the programs were designed to enable PAs to assist the primary care physician, particularly in rural areas. The early success in accomplishing this goal was recognized by the government with inclusion of PA services under Medicare Part B payment to rural health clinics. The capabilities of PAs were recognized by the medical

community to the point that PAs were accepted in every medical specialty and every medical setting across the country. From the beginning PA programs have continued to provide a professional who would augment the ability of the physician to provide care, serve in areas of medical need, and supply cost effective health care.

For Pennsylvania, the history of the profession began in 1972 with the first graduating class of Physician Assistants from the Penn State Hershey Physician Assistant Program followed by the first graduating class from Hahnemann Medical College in 1973. In 1976 the Pennsylvania Society of Physician Assistants was organized. In 1979, Governor Milton Shapp signed Senate Bill 586, which amended the Medical Practice Act to provide for the ability of Physician Assistants to practice in Pennsylvania. Though not the first state law providing for PA practice, it was the first to provide for PAs to be delegated prescriptive privileges. However, a joint promulgation clause requiring the State Board of Medicine and the State Board of Pharmacy to agree on a prescriptive formulary delayed inaction of this part of the Act. In 1981, the State Board of Medicine proposed new regulations which would have enhanced PA utilization, but these regulations underwent public hearings and were assigned to the Governors Task Force on Regulatory Review without being adopted. In 1985, the Medical Practice Act underwent Sunset Review. As a result, the current PA practice statutes were adopted. The regulations for this new statute, including prescriptive privileges, were adopted in 1993.

CURRENT PRACTICE STANDARDS

Today, Physician Assistants are health professionals educated to practice medicine with the supervision of a physician. That supervision does not require on site supervision, but does establish an interdependent relationship with the physician depending on the PA to treat the patient in the same manner as when the physician is providing the care. A physician

assistant provides health care services that were traditionally performed only by a physician. Duties include, but are not limited to, performing history and physical examinations, diagnosing and treating illnesses, ordering and interpreting laboratory tests, performing bedside surgical procedures, assisting in surgery, providing patient education and counseling, and making rounds in hospitals and nursing homes. Forty-six states now have laws that allow supervising physicians to delegate prescriptive authority to PAs. The scope of the PAs practice corresponds to the supervising physicians' practice and is regulated by State statute, local privileges, and physician oversight.

Currently, of the 30,000 Physician Assistants, over 53% provide these services in a primary care setting with another 20% working in surgery and surgical subspecialties and the rest in emergency medicine, occupational medicine, and other specialties and subspecialties. The largest employers are group practices and hospitals with the remainder employed by solo physicians, ambulatory clinics, HMOs, and other settings. The continued commitment to serving areas of need is noted with 22% practicing in communities of less than 10,000 people. Over 25 % work in areas designated as being rural and over 12% are considered to work in the inner city. This evidence of broad base acceptance, reliability and accountability is a testament to the foresight of Dr. Stead, the individuals who qualify to become PAs, and an educational and credentialing system so strong that 42 states have changed their regulatory status for PAs from certification to licensure.

I want to thank the Committee for the opportunity to provide this testimony. I will be happy to answer any questions the committee may have, but would request that they be held until further testimony by the Society concerning the PAs education and credentialing process is completed.

Testimony of

THE PENNSYLVANIA SOCIETY OF PHYSICIAN ASSISTANTS

Before

THE HOUSE COMMITTEE ON PROFESSIONAL LICENSURE

Concerning

ORIGINAL: 2064
HARBISON
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Jewett
Smith
Wyatte

HOUSE BILL 50

Presented by
Sherry Stolberg, PA-C

October 27th, 1999
Harrisburg, Pennsylvania

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Thank you for the opportunity to speak with you about the physician assistant profession, and specifically about PA education. I am Sherry Stolberg, the Program Director of the Physician Assistant Program at MCP Hahnemann University in Philadelphia, where I am an Associate Professor. I have been a certified physician assistant and involved in PA education for 22 years and a program director for 14 years. I was a member of the Accreditation Review Committee for Physician Assistant Education for six years, Vice-Chair for two years, and continue to make several accreditation visits yearly. I have served as an elected member of the Boards of the Association of Physician Assistant Programs and the Pennsylvania Society of Physician Assistants. I was appointed to a two-year term as a member of the Education Council of the American Academy of Physician Assistants. I am the co-editor of the first comprehensive text book on PA education and practice, which is currently in its second edition.

Today I plan to discuss the demographics of students entering PA programs, and describe PA education and accreditation.

In the 33 years since the first PA program, the profession has grown in many ways. The profile of students entering PA programs has changed dramatically. The average PA student enters a program at about 28 - 29 years old, has had 3-4 years of prior college education and almost 4 years of prior health care experience. About 60% of entering students are women, and about 22% of the PA student population nationwide is from underrepresented minority groups. About 60% of students entering PA programs already have bachelors degrees, 7 % have a graduate degree, and 14% have associates degrees.

This average student, however, represents a wide range in the demographics. Some younger students enter PA programs in their early 20s, since the physician assistant profession is their first career. Other students enter in their 30s, 40s or 50s, choosing to

become PAs after one or more other careers. The most common prior health care experience of PA students involves pre-hospital care, such as EMTs or paramedics. Other students come from backgrounds in nursing, allied health technologies, mental health fields and social work, as well as a variety of volunteer activities.

Physician assistant education has grown and changed over the last three decades. Currently 116 accredited programs provide PA education in the United States. Pennsylvania has 14 programs. As the scope of PA practice has expanded, the length and depth of PA education has increased.

The typical PA program now consists of 111 weeks (over two full years), about two thirds of the typical medical school time (155 weeks). The typical curriculum is composed of about one year of didactic or classroom work including*:

Coursework in the basic sciences such as anatomy, biochemistry, physiology, pathophysiology, pharmacology, microbiology, nutrition and clinical laboratory sciences. On average, PA programs include about 420 hours of instruction in the basic sciences, including an average of 75 hours of pharmacology. To put it another way, this translates into 28 semester credits total of basic sciences and 5 credits of pharmacology

Coursework in the clinical sciences and clinical skills, including didactic clinical medicine, patient assessment (history/interviewing and physical assessment) and clinical skills such as EKG, suturing, casting, CPR, etc. Typical clinical medicine courses include units on a range of medical and surgical topics, such as cardiology, radiology, obstetrics & gynecology, pediatrics, emergency medicine and surgery. On average, PA programs include about 580 hours in this area or about 39 credits.

Coursework in the behavioral sciences, such as psychosocial/dynamics, health promotion/disease prevention, biomedical ethics, PA professional issues, health care organization, human sexuality, cross-cultural issues, medical literature review, research methods and statistics. On average, PA programs include about 160 hours or 11 credits in these behavioral science areas.

The second year of PA programs consists of clinical rotations. On average, students have 50 - 55 weeks (a very full year) of clinical education, divided between primary care medicine and various specialties. The average time for each area follows:

Primary Care		
Family Medicine	9 weeks	
Internal Medicine	6 weeks	
Pediatrics	5 weeks	
Obstetrics & Gynecology	5 weeks	
Primary Care Preceptorships	10 weeks	for a total of 35 weeks
Specialty Areas		
Surgery & Surgical Subspecialties	10 weeks	
Internal Medicine Subspecialties	4 weeks	
Emergency Medicine	6 weeks	
Psychiatry	4 weeks	for a total of 24 weeks

During clinical rotations, PA students work directly under the supervision of physician preceptors, frequently with the input of graduate PA preceptors and other health care professionals. Students participate in the full range of patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education and

counseling. An average week during the clinical rotation phase involves 40 - 50 hours/week in the clinical setting, plus required reading and studying. Settings used for clinical rotations include clinics, physician offices, hospitals, emergency departments, and nursing homes. Many clinical sites are located in urban and rural underserved communities, since one of the predictors of graduate employment is the location of training sites.

Upon graduation, the physician assistant must take the national certification exam issued by the National Commission on the Certification of Physician Assistants. Successful completion of the exam is required to obtain licensure or certification in all states. To maintain national certification, this examination must be successfully completed every 6 years. This examination is primary care focused. Between testing cycles, the physician assistant is required to log one hundred hours of continuing medical education credits every two years.

In PA programs, we focus on the core knowledge and skills that PAs need for clinical practice, with a particular emphasis on clinical problem solving, communication skills, working in multidisciplinary teams and practice in underserved communities. Since working with physician supervision is fundamental to PA practice, we teach students to function within the limits of their knowledge and skills. Research studies indicate that PAs can perform about 80% of physician tasks in a primary care setting, so PA programs prepare graduates to take on a high level of responsibility but always to ask for consultation when needed from their supervisors.

Physician assistant programs are accredited by an independent accrediting body, the Accreditation Review Committee for PA Education, which functions under the umbrella organization of the Commission on Accreditation of Allied Health Education Programs.

Other organizations including the American Academy of Family Physicians, the American College of Physicians, the American College of Surgeons, the American Medical Association, the American Academy of Physician Assistants and the Association of Physician Assistant Programs cooperate to establish, maintain and promote appropriate standards of quality for entry level education of physician assistants and to provide recognition for educational programs that meet or exceed the minimum expectations.

In Pennsylvania about half of the PA programs graduate students with Master's degrees, the rest of the programs offer bachelor's degrees. PA education is competency based, rather than degree based. This approach to accreditation has encouraged diversity in the PA profession. Students from disadvantaged backgrounds are able to become PAs and return to their communities to provide health care in areas of need.

In order to be accredited, each program must comply with Standards for Education, which specify a range of knowledge and skills. Accreditation is a continual process, in which programs conduct ongoing self-evaluation, as well as periodic external evaluation of the Accreditation Review Committee. The accreditation Standards and process are rigorous and ensure quality education for PAs and quality health care services for the public.

PA programs have worked very hard to improve health care in the United States, particularly in underserved communities. PA programs in Pennsylvania are distributed around the state, some in urban areas, some in rural areas, educating PAs to improve the health status of citizens of the Commonwealth. We are proud of our graduates and their contributions to their patients, their patients' families and their communities.

I wish to thank the Committee for the opportunity to provide testimony. We will be happy to answer any questions the Committee may have at this time.

*Source of information about curriculum and students:

Fifteenth Annual Report on Physician Assistant Education Program in the United States, 1998-1999. Simon A et al. published by the Association of Physician Assistant Program. May, 1999.

PHYSICIAN ASSISTANT PROGRAMS IN PENNSYLVANIA

Program	Location	First Class Began	Current Class Size
Allentown College of St. Francis De Sales	Allentown	1997	40
Beaver College	Glenside	1996	36
Chatham College	Pittsburgh	1995	36
Duquesne University	Pittsburgh	1992	30
Gannon University	Erie	1974	35
King's College	Wilkes-Barre	1975	45
Lock Haven University	Lock Haven	1996	24
Marywood University	Scranton	1998	24
MCP Hahnemann University	Philadelphia	1971	80
Pennsylvania College of Technology	Williamsport	1996	25
Philadelphia College of Textiles And Sciences (Philadelphia University)	Philadelphia	1995	45
Saint Francis College	Loretto	1977	55
Seton Hill College	Greensburg	1998	26
University of the Sciences in Philadelphia And Philadelphia College of Osteopathic Medicine	Philadelphia	1998	49

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Sandra Bernstein, MSN, RN, CS
593 Bethlehem Pike, #4B
Montgomeryville, PA 18936
215-822-2224

Testimony for the House of Representatives Professional Licensure Committee
House Bill 50
October 27, 1999

I want to thank Chairman Civera and the members of the committee for this opportunity to provide testimony in support of House Bill 50.

I am a psychiatric advanced practice nurse, certified as a Clinical Nurse Specialist in Adult Psychiatric-Mental Health Nursing by the American Nurses Credentialing Center (ANCC). I am also a Clinical Member and Approved Supervisor for the American Association for Marriage and Family Therapy. I have had a private psychotherapy practice since 1975, and have been practicing in Montgomery County since 1980. I have also worked as a psychiatric advanced practice nurse in a variety of in- and outpatient and educational settings.

Clinical nurse specialists are registered nurses with advanced nursing degrees- masters and doctorates- who are expert clinicians in a specialized area of practice such as mental health, gerontology, cancer or cardiac care, and community or neonatal health. Clinical specialists work in hospitals, outpatient clinics, nursing homes, private practices, and other community based settings such as industry, home care, and HMOs. They manifest a high level of expertise in the assessment, diagnosis, and treatment of the complex responses of individuals, families, or communities to health problems. They are concerned with the prevention of illness and injury, and the maintenance of wellness and optimal levels of functioning. They provide direct patient care, which in many states includes the ability to prescribe both pharmacological and non-pharmacological treatment, and have roles in education, research, and consultation.

I am one of 568 ANCC certified clinical nurse specialists in PA, of whom 428 are specialists in psychiatric/mental health nursing. Additional clinical specialists, in fields such as oncology and neonatology, are certified by other professional credentialing groups. Certification as a clinical specialist requires graduation from an accredited or approved graduate school program that provides course work and supervised clinical experiences and a certification examination. Education for certification as a psychiatric nurse specialist requires a minimum of 18 graduate or post-graduate academic credits in psychiatric theory and supervised clinical training in at least two psychotherapeutic modalities (e.g.: cognitive therapy, family systems therapy). Also required are at least 800 hours of direct patient contact in advanced practice roles (400 of which must be earned following completion of educational preparation), and 100 documented hours of clinical supervision (at least 50% of which must be earned post-education). Candidates are examined in areas including models of practice, mental health disorders, treatment modalities (psychotherapeutic and pharmacologic), professional roles and issues, education, and consultation and research. Recertification is required at 5 year intervals: psychiatric advanced practice nurses must document a minimum of 1000 hours of direct psychiatric practice and evidence of continuing

education (CE): in 1998, the requirement was 75 hours of CE. The continuing education requirement may also be met through academic course work, or other selected professional activities. Recertification may also be obtained through re-examination. Appendix I contains ANCC specialty certification and recertification requirements.

In Pennsylvania, clinical nurse specialists practice under the sole regulation of the state Board of Nursing. This regulation of practice has been successful and can serve as a model for regulation of all advanced practice nurses by nursing. Recognition of this autonomous functioning was acknowledged by the state legislature in 1986, when clinical specialists were included in third party reimbursement for those services that were covered when performed by other providers (and by the Federal government in 1998 when CNS services were covered by Medicare). This legislation essentially accepted national standards for advanced practice as the basis for reimbursable services and practice. However, the lack of formal recognition of advanced practice in state statute leaves clinical specialists in a something of a state of limbo- we may be legally reimbursed as appropriate providers for care at levels not clearly defined by our practice act.

National standards of practice for advanced psychiatric/mental health nurses and other clinical nurse specialists are well defined by the American Nurses' Association publications *A Statement on Psychiatric/Mental Health Nursing Practice and Standards of Psychiatric/Mental Health Clinical Nursing Practice* (1994) and *The Scope and Standards of Advanced Practice Registered Nurses*, but this is not a substitute for identification and recognition of advanced practice roles within the state statute.

Psychiatric advanced practice nurses in Pennsylvania work as psychotherapists in a variety of patient care settings. They provide individual, group, and family therapy to diverse populations, including the chronically mentally ill. They work in consultation/liaison services in hospitals and clinics to address the mental health needs of physically ill patients. They teach in schools of nursing and other mental health programs (e.g.: family therapy, cognitive therapy). As nurses, they practice with a concern for and understanding of the general health issues as well as the mental health needs of their clients, making them making them unique among non-physician providers. Like all other mental health professionals, psychiatric advanced practice nurses use the *Diagnostic and Statistical Manual IV* (American Psychiatric Association Press, 1997) to diagnosis mental disorders. (The *DSM IV* is recognized as the standard diagnostic classification in mental health.). They assume full responsibility and accountability for the patient care decisions they make. Psychiatric advanced practice nurses in private practice (and many in employment situations) carry their own liability insurance- I am insured at the $1million/3 million dollar level.

Psychiatric advanced practice nurses work collaboratively with many other health care providers. These may include psychiatrists, medical specialists and primary care providers, and other members of the heath care team, such as social workers and other nurses at both generalist and advanced practice levels. In recent weeks within my own practice I have collaborated with family physicians in the treatment of patients with anxiety disorder, with a urologist to identify an

appropriate plan of care for a patient with sexual dysfunction, and with psychiatrists regarding medication. I am also working with a neuropsychologist in a case involving cognitive deficits in a patient following a respiratory arrest and coma. I collaborate with case managers and work closely with family members.

Without the ability to prescribe, however, I am not able to practice to the full extent of my knowledge and education. At times, my patients face delays in instituting pharmacologic treatment, or a lag period in addressing needed changes in medication. It can take several weeks to get an appointment with a psychiatrist for a medication evaluation, or for re-evaluation when there are side effects or the prescribed medication is not effective. There are increased costs in having to see two providers and patients report they find that the psychiatric evaluation is a duplication of the process they had with me. When care is rationed, as is typical with many managed mental health care plans where patients can be limited to a total of 20 mental health visits per year, having to see two providers reduces the number of sessions available to the patient for psychotherapy treatment. Prescriptive authority would lessen duplication of services, thereby reducing costs, and free up valuable specialist time to treat the more complex problems requiring physician intervention. Patients with complex, difficult to treat disorders, medical conditions complicating treatment, or who fail to respond could then be seen by the most appropriate provider, or team of providers.

A different dilemma is posed in cases where physicians prescribe based on my recommendation and evaluations. They must assume the accountability and liability for my clinical decision making, not I. Additionally, non- psychiatric practitioners are not always as familiar with psychiatric medications and diagnoses as I am, and often under treat, if not mistreat, psychiatric disorders. For instance, I have seen many cases where patients with panic disorders have been treated on a long term basis with anti-anxiety drugs, which can be addictive, rather than with another category of medication recognized as the most effective for this disorder and not addictive.

Prescriptive authority is in many ways a natural extension of the collaborative process already in place in mental health practice. Nurses have long had responsibilities for decisions about medications. For instance, in inpatient facilities it is not uncommon for doctors to leave orders for patients to receive medications on a "PRN" (as needed) basis. It is the nurse's responsibility to determine when to give the medication, and where more than one medication can be given as a PRN, which drug should be used. Nurses also routinely assess patient response to medications, identify and treat side effects, and evaluate therapeutic response. Psychiatric advanced practice nurses regularly monitor the ongoing response of their patients to psychotrophic drugs, referring back to the prescribing physician on an as needed basis. Prescriptive authority for advanced practice nurses builds on what nursing has always done, and it is a step we are well educated to take. There are several states in which psychiatric clinical nurse specialists are the only category of CNS granted prescriptive authority.

Education for prescriptive authority in psychiatric advanced practice nursing includes content on patient assessment, pharmacological principles, neurobiology, physiology, drug interactions, and treating patients across the life span. A syllabus from the University of Pennsylvania School of Nursing's Psychopharmacology Course is included in Appendix 2. Continuing education in pharmacology is well supported to keep knowledge current. Advanced practice nurses are well prepared to meet the demands of prescribing, and cognizant of patient well being and safety issues.

The state legislature has voiced concerns about the "brain drain" in Pennsylvania- the number of people educated in this state who leave to work elsewhere. This is certainly true for psychiatric advanced practice nurses, who seek employment and practice opportunities in nearby states, such as New Jersey and Delaware, where state regulations allow them to practice to the full extent of their training. Our graduate school programs are educating psychiatric clinical nurse specialists who leave Pennsylvania because they find better opportunities elsewhere, in the states that recognize advanced practice and grant clinical nurse specialists prescriptive authority. Additionally, psychiatric advanced practice nurses in Pennsylvania are finding employment opportunities limited, and salaries cut, because they can not practice to the full extent of their preparation. For instance, a colleague and I were laid off from outpatient positions in favor of "cheaper" providers, because, I believe, without prescriptive authority we were unable to practice in a manner which differentiated us from other masters prepared mental health professionals. In a time of ever tightening cost controls, employers are not willing to pay for providers with skills that can not be utilized in this state. I might note here that in states where psychiatric nurses have prescriptive authority they are well accepted on managed care panels, something which remains problematic for my colleagues in Pennsylvania at times. The job listings for psychiatric clinical nurse specialist positions in PA have been quite limited lately- most of the positions I see are in other states. The lack of recognition of advanced practice is a concern to AP nurses who move into the state, and hinders the ability of Pennsylvania nurses who wish to practice elsewhere- reciprocity becomes a problem. Pennsylvania appears to be unique in the country in it's lack of recognition of specialty and advanced practice nursing in statute according to a recent publication of the American Nurses Association.

I believe HB 50's recognition of advanced practice nursing and confirmation of prescriptive authority could have important implications for mental health care in Pennsylvania. Psychiatric disorders, including substance abuse, constitute a very large illness burden in the state.. It is estimated that 10-20% of the population experience diagnosable psychiatric illness in a given year. Most mental health disorders are untreated, or under treated, and most of those who receive treatment are not treated by specialists in the field. Many physical disorders are complicated by mental health problems, and it is estimated that up to 50 or 60% of visits to primary care are driven by psychosocial, or non disease, factors. The cost to businesses in terms of decreased efficiency, absenteeism, and accidents is enormous. Many current unmet needs could be addressed effectively and efficiently if advanced practice psychiatric nursing is facilitated. Studies demonstrate that clinical specialists contribute to decreased costs and effective outcomes.

Passage of House Bill 50 will allow Pennsylvanians to more fully benefit from the skills of advanced practice nurses, and will create employment opportunities to keep and attract these skilled professionals. I urge your support of this legislation.

Thank you for your consideration.

Bernstein
10/27/99

APPENDIX I

American Nurses Credentialing Center

Certification and Recertification Requirements for Clinical Nurse Specialists

(selected)

Clinical Specialist in Child and Adolescent Psychiatric & Mental Health Nursing (02)

Description of Practice

Clinical specialists in psychiatric and mental health nursing must possess a high degree of proficiency in therapeutic and interpersonal skills. These specialists not only influence and modify attitudes and behaviors of the patient, but also assume responsibility for the advancement of nursing theory and therapy. In addition to therapy, their roles include teaching, research, consultation, supervision, case management, and administration.

Eligibility Requirements

By the time of application, you must:

1. currently hold an active RN license in the United States or its territories;

   AND

2. Be currently involved in direct patient contact in psychiatric and mental health nursing an average of four hours per week. Administrators, educators, researchers and consultants can meet this requirement if they are involved in direct patient contact;

   AND

3. be currently involved in clinical consultation or clinical supervision;

   AND

4. have experience in at least two different treatment modalities after completion of the education requirement in options 5a or 5b below.

   AND

5. Have met the following requirements:

   a. hold a master's degree or higher in nursing with a university identified major in psychiatric and mental nursing. A university identified major is one that is listed in the university course catalog and contains specific psychiatric and mental health nursing didactic and psychiatric and mental health nursing clinical experiences.

   -OR-

   b. hold a master's or higher degree in nursing;

   AND

   have a minimum of 18 graduate or post-graduate level academic credits in psychiatric and mental health theory. A minimum of nine of these 18 graduate or post-graduate credits must contain didactic and clinical experience specific to psychiatric and mental health nursing theory. (Core course in nursing theory, nursing research, and thesis hours will not be accepted as part of this nine-credit requirement.) A maximum of nine of the 18 graduate or post-graduate level credits may be in courses containing didactic and clinical experiences specific to psychiatric and mental health theory. (Examples are courses in counseling and psychology.)

   AND

   have supervised clinical training at the graduate or post-graduate level in two psychotherapeutic treatment modalities.

have at least 800 hours of direct patient/client contact in advanced clinical practice of psychiatric and mental health nursing; up to 400 of these hours may be earned through the clinical practicum in a masters program of study; at least 400 of these hours must be earned following completion of the educational preparation listed in option 5 above;

AND

document 100 hours of individual or group clinical consultation/ supervision and submit endorsement(s) from the consultant/supervisor(s). Form A must be submitted for all supervision, including practicum supervision and post-education supervision;

AND

a. at least 50% of these hours must be earned following completion of the educational preparation listed in options 5 or 5a above;

   AND

b. up to 50 of the 100 hours may be earned within the master's degree program;

   AND

c. a minimum of 65 of the consultation/supervision hours must be provided by a nurse who is ANCC certified or eligible for ANCC certification as a clinical specialist in psychiatric and mental health nursing;

d. no more than 35 of the consultation/supervision hours may be provided by a non-nurse who meets one of the criteria listed below. (For those nurses who expect to hold prescriptive privileges, these hours might be applied toward supervision of the prescription of medications.) The non-nurse(s) may be:
   - a master's prepared licensed/certified mental health social worker;
   - a psychiatrist;
   - a psychologist prepared at the doctoral level and listed in the National Register of Health Service Providers in Psychology; or
   - a psychologist prepared at the doctoral level in an APA-accredited program in one of the following clinical areas: clinical psychology, counseling psychology, or school psychology.

NOTE: In order to obtain this consultation/supervision from nurse colleagues, creative alternatives are encouraged. A suggested model for such consultation/supervision may be found in Appendix A.

Examination Topics

Clinical Specialist in Adult Psychiatric and Mental Health Nursing

- Conceptual models of practice
- Mental health disorders
- Nursing intervention strategies/approaches
- Professional roles
- Professional issues

Clinical Specialist in Child and Adolescent Psychiatric and Mental Health Nursing

- Practice theories
- Psychopathology
- Treatment modalities

for both exams.

- Lifestyle and environment
- Trends and issues
- Education
- consultation + research

Description of Practice

Graduate-prepared clinical specialists in medical-surgical nursing provide care for individuals who have a known or predicted physiological alteration. Specialists demonstrate an in-depth understanding of complex medical-surgical problems, as well as interventions to manage and improve patient care. Guided by theory and research, their practice considers all influences on health status and the related social and behavioral problems arising because of the patient's physiological condition. Specialists are engaged in education, case management, expert clinical practice, consultation, research, and administration. Clinical specialists practice in settings where primary, acute, or long-term nursing care is delivered

Eligibility Requirements

By the time of application, you must:

1. currently hold an active RN license in the United States or its territories;

   AND

2. hold a master's degree in nursing, with evidence of Medical-Surgical CNS concentration;

   AND

3. currently provide direct patient care in medical-surgical nursing an average of four hours or more weekly;

   AND

4. have practiced (with an active U.S. license), a minimum of 12 months following completion of the master's degree;

   AND

5. have met the following in your current practice:

   a. have provided a minimum of 800 hours of direct patient care within the past 24 months.

   -OR-

   b. if you have been employed full-time (post-master's) as a consultant, researcher, administrator, or educator for two of the past three years, you must have provided direct patient care in medical-surgical nursing a minimum of 400 hours during this same time period.

NOTE: Supervision of students' patient care fulfills the requirement for direct patient care or clinical management only when the supervisor interacts with the patient/client and is personally responsible and accountable for the outcome of that interaction.

Examination Topics

- Clinical practice
- Consultation
- Management
- Education
- Research
- Issues and trends

Description of Practice

The graduate-prepared community health nurse specialist can perform all functions of the community health nurse generalist. The specialist possesses substantial clinical experience in the assessment of the health of a community and proficiency in planning, implementation, and evaluation of population-focused programs. The skills of this specialist are based on knowledge of epidemiology, demographics, biometrics, environmental health, community structure and organization, community development, management, program evaluation, policy development, and case management. In addition, this specialist engages in research and theory application relevant to community practice and health policy development. While there are graduate-prepared nurses whose area of expertise is the care of a particular segment of the community, the practice of the community health nurse specialist emphasizes the use of skills to promote the health of an entire community.

Eligibility Requirements

By the time of application, you must:

1. currently hold an active RN license in the United States or its territories;

   AND

   a. hold a master's or higher degree in nursing with a specialization in community/public health nursing practice;

   -OR-

   b. Hold a baccalaureate degree in nursing and a master's or higher degree in public health with a specialization in community/public health nursing;

   AND

2. meet the following practice requirements:

   a. currently practice an **average** of 12 hours weekly in community/public health nursing;

   -OR-

   b. have practiced, post-master's, a **minimum** of 800 hours in community/public health nursing within the past 24 months.

   NOTE: Supervision of students, others, practice in community/public health nursing can be used to meet this practice requirement. In addition, practice in community/public health nursing as a consultant, educator, researcher, or administrator can be used to meet this requirement. The specialization in community/public health nursing must be verified by a letter from the institution where the degree was obtained or by a statement on the official transcript.

Examination Topics

- Public health sciences
- Community assessment process
- Program administration
- Trends and issues
- Theory
- Research
- Health care delivery system

This certification examination is offered in collaboration with the American Public Health Association, Public Health Nursing Section.

ANCC RECERTIFICATION REQUIREMENTS:
Clinical Nurse Specialists
(Selected

(01) Psychiatric and Mental Health Clinical Specialist — Adult
(02) Psychiatric and Mental Health Clinical Specialist — Child & Adolescent

Practice Requirements

- 1,000 hours of direct psychiatric mental health nursing practice. An ongoing consultation/clinical supervision relationship is also expected. You do not need to document this consultation/supervision in any way.

  Effective January 1, 2001, practice hours will increase to a minimum of 1,500 hours.

Select Recertification Option:

- **OPTION 1 -- Examination**
  Sit for and successfully pass the written certification examination.

  -OR-

- **OPTION 2 -- Continuing Education Requirements**
  A minimum of 2 of the following 4 categories or double any 1 single category:

  Category 1: 37.5* contact hours of continuing education.

  Category 2: 2.5* academic semester hours credit (or 3 quarter hours).

  Category 3: Participation as a presenter/lecturer in 5 different continuing education or professional (academic) education offerings.

  Category 4: Evidence of publication of one article in a refereed journal, book chapter or completed research project in the area of psychiatric mental health nursing. Completion of a doctoral dissertation or master's thesis within the specialty area may be used, but candidate may not use any academic credit earned from these activities.

  *These two categories will double Jan. 1, 2001.

(05) Medical Surgical Clinical Specialist

Practice Requirements

- 1,500 hours of medical-surgical nursing practice or direct onsite clinical supervision. An average of 4 hours per week for consultants, researchers, educators and administrators.

  Practice may include the management, supervision, education, or direction of other persons to help achieve patient/client goals.

  Nursing faculty may use up to 500 hours of didactic lecture in a nursing program toward this practice requirement.

continued...

- **OPTION 1 -- Examination**
  Sit for and successfully pass the written certification examination.

  -OR-

- **OPTION 2 -- Continuing Education Requirements**
  A minimum of 2 of the following 5 categories or double any 1 single category except category 3:

  Category 1: 75 contact hours of continuing education.

  Category 2: 5 academic semester hour credits (or 6 quarter hour credits).

  Category 3: Participation as a presenter/lecturer in 5 different continuing education offerings/presentations.

  Category 4: Evidence of publication of one article in a refereed journal, book chapter or published research paper in an appropriate area of nursing. Completion of a doctoral dissertation or master's thesis within the specialty area may be used, but candidate may not use any academic credit earned from these activities.

  Category 5: 120 hours of onsite clinical preceptorship supervision of graduate-level advanced practice nursing student.

(18) Gerontological Clinical Specialist

Practice Requirements

- 1,500 hours of gerontological nursing.

Select Recertification Option:

- **OPTION 1 -- Examination**
  Sit for and successfully pass the written certification examination.

  -OR-

- **OPTION 2 -- Continuing Education Requirements**
  A minimum of 2 of the following 5 categories or double any 1 single category:

  Category 1: 75 contact hours of continuing education.

  Category 2: 5 academic semester hour credits or 6 quarter hour credits.

  Category 3A: Participation as a presenter/lecturer in 5 academic semester courses (or 6 academic quarter courses).

  Category 3b: Participation as a presenter/lecturer in 5 different continuing education or professional (academic) education offerings.

  Category 4: Evidence of completion and dissemination of a research project, publication of one article in a refereed journal or publication of a book or chapter. Completion of a doctoral dissertation or master's thesis within the specialty are may be used. Academic hours awarded for dissertation or thesis may not be used for Category 2.

  Category 5: 120 hours of on-site clinical preceptorship/supervision of graduate level nursing students, either clinical specialists or nurse practitioners.

Bernstein
10/27/99

APPENDIX II

Graduate Level Education in Psychopharmacology: Course Descriptions and Course Outlines (University of Pennsylvania School of Nursing)

Bernstein
10/27/99

NURS 622. Biological and Behavior Correlates in Mental Health and Illness.
Fall. 1 c. u.
PREREQUISITE: None.
The course focuses on biological and behavioral correlates of mental health and illness. The student will be helped to develop a broader systems perspective for psychiatric-mental health practice by building upon basic bio-psycho-social aspects of mental health and illness. The course will link two content domains: 1) basic biomedical science (genetics, biochemistry, neurophysiology, and pharmacology) including the most up to date clinical and research data on brain structure and function as it relates to client behaviors; and 2) psychological, socio-cultural relational processes influencing the behavior of individuals, families, and social networks, including theories of etiology, diagnostic classifications and clinical management in acute and chronic mental illness. The emphasis of the course will be on theory and research related to assessment, diagnosis, clinical management and prevention.

NURS 645. Psychopharmacology.
Spring. 1 c. u. Staff.
PREREQUISITE: N622.
This course focuses on the development of assessment, diagnostic and problem solving skills, in particular psychopharmacologic treatment skills, necessary for the advanced practice of psychiatric-mental health nursing with culturally diverse client populations, across the life span, who present with a range of symptom manifestations, at all levels of severity. The emphasis is on research based clinical decision making and psychopharmacologic intervention

UNIVERSITY OF PENNSYLVANIA
SCHOOL OF NURSING

N645 PSYCHOPHARMACOLOGY
COURSE OUTLINE
Spring 1999

Title: Nursing 645 Psychopharmacology

Credit: 1 c.u.; 3 hours per week

Catalog Description:

This course focuses on the development of assessment, diagnostic and problem solving skills, in particular psychopharmacologic treatment skills, necessary for the advanced practice of psychiatric-mental health nursing with culturally diverse client populations, across the life span, who present with a range of symptom manifestations, at all levels of severity. The emphasis is on research based clinical decision making and psychopharmacological intervention.

Faculty: , DNSc, RN, CS

, MSN, RN, CS

Guest Lecturers

Teaching Assistant: , MSN, RN, CS

Prerequisites: N622 or permission of the instructor

Course Overview:

The course is designed to prepare advanced practice nurse specialists to apply psychopharmacotherapy as a treatment modality, including the exercise of prescriptive authority where legally permitted, within the context of advanced psychiatric-mental health nursing assessment and diagnosis. Content includes commonly used psychiatric-mental health assessment and diagnostic instruments and measures, general principles of psychopharmacologic treatment, major drug groups and the uses and effects of psychotropics in clinical management.

General Objectives:

Assist the student to develop the knowledge in psychopharmacology required to apply pharmacotherapy as a treatment modality, including the exercise of prescriptive authority where legally permitted.

Specific Objectives:

Upon completion of the course, the student is expected to:

1. Describe the uses and applications of pharmacologic treatment for clients with a wide range of symptom presentations, at all levels of severity, across the life span.

2. Describe the risks and benefits of using psychotropic medications to treat psychiatric disorders.

3. Analyze and apply research findings in psychopharmacology.

4. Integrate general principles of psychopharmacologic treatment including knowledge of major drug groups, their uses, effects and adverse reactions into the clinical management of psychiatric-mental health disorders and disabilities and physical disorders and disabilities.

5. Identify the physical assessment components, including laboratory and diagnostic tests, basic to the evaluation of clients for pharmacotherapy.

6. Develop the knowledge and skills to teach clients and families about the uses and effects of psychotropics.

7. Develop the knowledge and skills to monitor short and long term effects of psychotropics on clients with a range of symptom presentations, across the life span, in diverse settings.

8. Describe the effects of cultural diversity, family history, age and gender on the choice of psychotropics.

9. Describe the ethical and legal issues related to the clinical management of psychotropics.

10. Appropriately document the effects and side effects of psychotropics.

11. Identify continuing education options for maintaining state of the art knowledge in psychopharmacology.

12. Develop collaborative relationships with physicians and others who have assessment and treatment responsibility for clients and families in order to provide comprehensive and continuous care in varied health care settings.

Required Text:

Janiack, P. et al. (1997), Principals and Practice of Psychopharmacotherapy, Williams & Wilkins.

Recommended Texts:

Kaplan, H. & Sadock, B. (1996), Pocket Handbook of Psychiatric Drug Treatment, Williams & Wilkins.

Rosse, R. et al. (1989), Laboratory Diagnostic Testing in Psychiatry, American Psychiatric Press.

Stahl, S. (1996). Essential Psychopharmacology, Cambridge University Press.

Recommended References: (On reserve in Biomedical Library)

Schatzberg, A. & Nemeroff, C. (1995). The American Psychiatric Press Textbook of Psychopharmacology. Washington: American Psychiatric Press.

Selected Articles (available at reference desk)

Bernstein
10/27/99

N645
General Topic Outline

I. **General Pharmacological Principles**

A. Pharmacokinetics

1. Absorption

2. Distribution

3. Metabolism

4. Excretion

B. Other Considerations

1. Half life

2. Steady-state levels

3. Cumulation

4. Combined effects of drugs

5. Factors modifying drug effects

II. **Receptor Concept**

A. Definition

B. Characteristics of drug-receptor interaction

C. Potency vs. Efficacy

D. Drug-receptor transmembrane signaling mechanisms

E. G-proteins

F. Second messengers

III. **Principles of Neuronal Function**

A. Classification of neurons

B. Physiology of nervous tissue

1. Membrane potentials

2. Conduction

3. Synaptic transmission

4. Neurotransmitters

IV. **Central Nervous System**

A. Functional anatomy

B. Integrative systems

C. Role of neurohormones in the CNS

Testimony
Of

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REVIEW COMMISSION

John BianRosa, M.D., J.D.
President
Pennsylvania
Society of Anesthesiologists

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HARBISON
COPIES: Sandusky
Jewett
Smith
Wyatte

Before The
House of Representatives
Professional Licensure Committee

On
HB 50

October 27, 1999

Testimony
of
Dr. John BianRosa

Good morning, Mr. Chairman, and members of the House Professional Licensure Committee. My name is John BianRosa and I am the President of the Pennsylvania Society of Anesthesiologists. I am also Chairman of the Anesthesia Department and President of the Medical Staff at Graduate Hospital in Philadelphia. After medical school, I completed my anesthesiology residency at the University of Pennsylvania and obtained a law degree from Temple University.

My colleague seated next to me, Doctor Carol Rose, will also be presenting testimony. Carol is a Past President of our Society and we are all very proud of the fact that she is the Vice President of the Pennsylvania Medical Society and will be the first woman President of that organization.

The most critical factor that any legislative body should consider when discussing legislation that will effect the delivery of health care must be the quality of care that the legislation will produce and the safety that might be compromised. We will discuss this crucial factor today. It is important that the Committee members be aware that **HB 50 WOULD DEFINITELY CHANGE** the way anesthesia care is delivered in Pennsylvania. Numerous letters, brochures and flyers have been circulated to members of the Legislature, stating that HB 50 does not change a nurse anesthetist's scope of practice in any way. That is not correct.

First, on page 3, beginning on line 23, HB 50 states that "The professional nurse develops and initiates a plan of care...". That is not the way anesthesia is currently delivered in Pennsylvania. Only a physician evaluates the patient to determine what anesthetics should be used in the procedure. It is critical that the physician reviews the patient's medical record to determine if the patient has any health conditions that might interfere with the anesthetic. Only a physician has the education and training to make the right decision on which drugs should be used in this setting for this patient.

Second, on page 7, beginning on line 23, nurse anesthetists would be allowed to "...prescribe, dispense, and administer drugs and devices and order and administer anesthetics..." which includes controlled substances. Nurse anesthetists today are NOT allowed to prescribe the anesthetics to be used in a surgical procedure, and for good reason. When nurse anesthetists tell you that

HB 50 does not automatically give them this right, they are being disingenuous since we all know that the Board of Nursing would certainly grant that privilege to them if HB 50 becomes law.

Third, nurse anesthetists state that the Board of Nursing regulations already require that they may only administer anesthesia "in cooperation with a surgeon" and HB 50 does not change that. What they don't tell you is that the Department of Health's regulations, which govern all hospitals, require that anesthesia care must be provided "by a qualified physician, anesthesiologist, resident physician in training, dentist anesthesiologist, [or] qualified nurse anesthetist under the supervision of the operating physician or anesthesiologist..." Supervision is the key word for patient safety, not cooperation. If HB 50 passes the Nursing Board's regulation would take precedence and patient safety would be put in jeopardy.

A similar set of circumstances exists for ambulatory surgical facilities. The Department of Health regulations for these settings require that nonphysicians administering anesthesia must be under the overall direction of an anesthesiologist or physician who is present. Again, the key words are "overall direction" - not cooperation.

The literature promoting HB 50 consistently refers to APRNs, a term that under the legislation actually includes several nursing categories, and one of which is nurse anesthetists. When a statement is made about APRNs , - it is then inappropriately applied to all the categories. This is very misleading. Permit me to give you some examples.

"HB 50 increases access to quality health care for Pennsylvania consumers." Whether or not this statement is true for certain categories of APRNs, it is certainly not true for the category of nurse anesthetists. The Pennsylvania Department of Health's statistics for 1997, the most recent year available, show that 1,564,000 operations were performed in the Commonwealth's 200 general hospitals. Of that number, 1,543,668 - 98.7% - were performed in hospitals staffed by anesthesiologists. It is impossible for anyone to claim that this legislation increases patient access to quality anesthesia care.

"APRNs' care is highly satisfying to patients, and in many cases, patients prefer treatment by APRNs." This generalization is just not true. The Pennsylvania Society of Anesthesiologists retained one of the nation's most highly regarded research firms for decisions in politics and public affairs, The Tarrance Group of Alexandria, Virginia, to determine if Pennsylvania's citizens -

our patients and your constituents - were satisfied with the current practice of how anesthesia is administered in the Commonwealth.

A decisive majority - 79% - of the 600 adults (48% male and 52% female) who were interviewed, say they oppose a proposal being considered by the General Assembly (HB 50) that would eliminate the supervision requirement currently governing anesthesia administration. Opposition to this proposal garners over 70% among every demographic subgroup and transcends all age groups, from young adults to seniors. When individuals were asked whether they would want a medical doctor or nurse anesthetist to administer their anesthesia, Pennsylvanians select Doctors (78%) over nurses (6%) by a margin of 13 to 1.

Additionally, the survey found that 78% of Pennsylvania adults have been administered anesthesia at least once in their lifetime. Of these respondents, 81% reported that they are "extremely" or "very" satisfied with the quality of anesthesia care they received. With so much discontent among people today about the quality of the health care they receive, why would you want to change the one aspect that delivers the highest quality of care and safety, and is also overwhelmingly supported by your constituents? We ask you to delete nurse anesthetists from HB 50.

At this time, I would like to have Doctor Rose present her testimony. Thank you for the opportunity to speak to you today.

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Of

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our patients and your constituents - were satisfied with the current practice of how anesthesia is administered in the Commonwealth.

A decisive majority - 79% - of the 600 adults (48% male and 52% female) who were interviewed, say they oppose a proposal being considered by the General Assembly (HB 50) that would eliminate the supervision requirement currently governing anesthesia administration. Opposition to this proposal garners over 70% among every demographic subgroup and transcends all age groups, from young adults to seniors. When individuals were asked whether they would want a medical doctor or nurse anesthetist to administer their anesthesia, Pennsylvanians select Doctors (78%) over nurses (6%) by a margin of 13 to 1.

Additionally, the survey found that 78% of Pennsylvania adults have been administered anesthesia at least once in their lifetime. Of these respondents, 81% reported that they are "extremely" or "very" satisfied with the quality of anesthesia care they received. With so much discontent among people today about the quality of the health care they receive, why would you want to change the one aspect that delivers the highest quality of care and safety, and is also overwhelmingly supported by your constituents? We ask you to delete nurse anesthetists from HB 50.

At this time, I would like to have Doctor Rose present her testimony. Thank you for the opportunity to speak to you today.

Statement of Irene Bernstein, consumer, in support of House Bill 50 before the Profession Licensure Committee, October 28, 1999.

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Good afternoon, Mr. Chairman and Committee members,

Allow me to introduce myself and my background so you may better understand what has led me to testify today.

I was born in Baltimore, Maryland in 1913, making me a Senior Citizen with 86 years of experience to my credit. I live in the city of Harrisburg, in the district of the Honorable Mr. Ronald Buxton. Having no family responsibilities, I was able to combine travel and teaching for 25 of my years, teaching English and Social Studies in the public schools of New York, New Jersey, California and Pennsylvania.

A teaching experience in 1945 in San Francisco tutoring hospitalized bed-ridden teenagers stricken with polio made a lasting impression on me regarding the role and professionalism of nurses. During my 18 month tenure, I admired the dedication, compassion and skill of the nurses on the health care team who seemed to have no set hours but were often about, visiting the patients during a lunch break, dropping by with a comic book, puzzle, or piece of candy. The mutual respect and affection between the teenagers and the nurses was apparent and heart-warming. This experience strengthened my respect and admiration for what nurses could accomplish without possible restrictive supervision and judgment, imposed by an authority other than their own membership.

In addition, my experience with school nurses in addressing the learning and health problems of my students along with the parents has also strengthened my admiration for nurses and their professional role.

However, my testimony today focuses on my experience with my Nurse Practitioner, Ms. Linda Woodin, CRNP. In 1999, after many years of physician care, I sought out her services on the advice of a close friend. At my first appointment, I found myself talking freely about my health concerns, which, to some, may have seemed expected and mundane, given my age. Ms. Woodin listened attentively and answered my questions thoughtfully and comfortably, with no evidence of age discrimination.

Ms. Woodin began by assessing my risk for osteoporosis and falls, which could have devastating consequences in my age group. By ordering a special x-ray interpreted by physicians, she determined that I have mild to moderate osteoporosis and has started me on a well-accepted medication to retard my osteoporosis and build new bone growth. She carefully reviewed the medication regimen and side effects with me as well as my dietary habits for calcium intake.

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She also made recommendations for my home environment to decrease the risk of falling. I was surprised by this concern as two previous physicians, including a woman, had not addressed this issue of my aging process.

Next she turned her attention to an abdominal hernia I had incurred three weeks earlier. My own consultation with family members and health care acquaintances left me confused on the need for surgery at my age. Using a paper towel as a visual aide, pushing her finger up through a tear in the towel and not being able to retract her finger, Ms. Woodin clearly demonstrated the danger of possibly strangulating the intestine. However, she did not pressure me into a decision - she simply said "think about it and call me if you want to talk further". A few days of rehearsing the graphic demonstration in my mind was all it took for me to opt for a surgical consultation. Ms. Woodin referred me to a very competent surgeon, and since my recovery from the August surgery, I am now able to slowly enjoy without worry, the pleasures I have avoided...line dancing, swimming in an indoor pool and brisk walks along the Susquehanna River.

Over my years of experience in physicians' offices, I had gotten the sense that Doctors are extremely busy, sometimes too busy for the patient's good. By focusing on routine health concerns and health maintenance, Nurse Practitioners may have more time to listen, and may be more sympathetic to patient concerns, no matter how trite, expected, or unrealistic they may seem, given the patient's age.

I do not regard my relationship with my Nurse Practitioner as one of doctor/patient, but rather as one of a patient with an educated, experienced, sympathetic woman, in collaboration with doctors as needed for the health and well-being of the patient. I am impressed with Ms. Woodin's understanding of her role, and prompt referral to physician specialists when the need arose. The physicians also responded quite readily, accepting her judgment and her role as a colleague.

I feel very fortunate in being cared for by a Nurse Practitioner and I look forward to future visits and the warm, open rapport we enjoy. I trust as I continue in this journey of life, Ms. Woodin will continue to hear and address my concerns of aging, and will remind me gently if I reach a point of self-absorption or unrealistic expectations. I thank you for allowing me to share this testimony today.

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

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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.

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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.

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Testimony of
Corey Rigberg, MD, Chief of Psychiatry, PinnacleHealth Hospitals
and
Emily Pressley, RN, DO, 4th year Psychiatry Resident, Hershey Medical Center
regarding House Bill 50, PN 1199
before the House Professional Licensure Committee
Wednesday, Oct. 27, 1999

Good morning, Rep. Civera, Rep. Vance, and members of the Committee. My name is Corey Rigberg. I'm a psychiatric physician currently serving as Chief of Psychiatry for the PinnacleHealth hospitals here in the Harrisburg area. Also with me today is Emily Pressley. Dr. Pressley is both a registered nurse and a licensed physician, and she will discuss the issues from her dual perspective. Together, we will address the Pennsylvania Psychiatric Society's thoughts about both House Bill 50 and, because of their obvious relationship, the regulations recently proposed by the Boards of Nursing and Medicine.

Collaboration

We oppose House Bill 50. It allows a scope of practice for nurses, including but not limited to prescription writing authority, which is not in the best interest of patients. Although we also have a few reservations about the prescribing regulations recently proposed by the Boards of Nursing and Medicine, we think they offer a superior vehicle and a more appropriate response to the request by some nurses for greater medical authority.

The most important component of expanded prescription-writing authority for nurses is mandated and structured collaboration with a physician, including limits on the type and duration of prescriptions. These conditions will help ensure that patients can enjoy maximum access to treatment while receiving maximum protection from the dangers that attend the prescription of medication and the diagnostic and treatment process. Unfortunately, House Bill 50 fails to require either collaboration or sensible limits and conditions.

On the other hand, the proposed regulations retain the current requirements for supervision and collaboration, and they impose conditions and restrictions depending on the type of drug prescribed. We believe that they are much more in line with sound policy than the bill.

In contrast, House Bill 50 eliminates the statutory language which prohibits nurses from performing acts of medical diagnosis and the prescription of medical therapeutic measures unless they are authorized to do so by regulations jointly promulgated by the nursing and medical boards. It is precisely this language which has resulted in the current regulations requiring nurses with medical authority to work under the direction of a physician, in a collaborative relationship. Besides raising questions about the continuing validity of the current regulations, the change clearly allows their removal. It also takes the Medical Board out of the picture, allowing the Board of Nursing to unilaterally move to delete them. It is important to note that even if they are retained, without change, they only apply to CRNPs, and not to the other two classes of advanced practice nurses given prescriptive authority in House Bill 50.

In fact, there is little in House Bill 50 which seems to allow regulations limiting an advanced practice nurse's ability to prescribe medications, diagnose, or perform invasive

procedures, other than language allowing the Board to regulate according to the scope of practice of the various advanced practice nursing categories it references.

Scope of practice

That scope of practice, however, is not defined in this bill for any of the three groups. It is, instead, left to the determination of unnamed, national organizations. In other words, if House Bill 50 is enacted, the Legislature will have ceded its authority to define the scope of practice for its own licensees. Although the line between professional self-determination and legislative oversight of standards may sometimes be difficult to place, leaving the scope of practice out of a licensing law represents an abdication of power. The power to license and define the scope of practice is entrusted to the Legislature by the public. Don't give it away.

Training: how much and what kind?

Structured collaboration and limits on certain types of drugs are important because the training of advanced practice nurses is generally inadequate for the independent prescribing privileges which would be possible under House Bill 50. Nurses are trained very well to do very many things, but that training is designed for nurses working in the context of a treatment team, of which they are a critical element. Their training, even that of the Certified Registered Nurse Practitioners who have completed a two-year master's program, falls far short of the prescribing-related training which physicians receive in preparation for independent practice authority.

There are several measurements to consider. One is length of training. CRNPs generally have six years of post-high school training (although we are told that some programs can be completed in less time). Physicians, on the other hand, train for ten years after high school before they are eligible for an unrestricted license to practice medicine, and most train for twelve years before they do any significant independent prescribing. The four to six extra years of training cannot be condensed into a simple pharmacology course, which some suggest as a method for training CRNPs for independent prescriptive authority. In fact, medical students, having successfully completed four years of medical school, cannot prescribe. Yet House Bill 50 would allow nurses, whose overall training is less focused on medical diagnosis and treatment than that of medical students, to prescribe after completing a two-year program.

The second measurement of adequate training is content. Pharmacological training in medical schools and residency programs is more intense than that which occurs in nursing school, with physicians in training working under the direct supervision of experienced physicians throughout the four years of medical school and during their four years of residency training. Further, unlike master's level training programs for advanced practice nurses, all medical residency programs adhere to the same national standards of review for curriculum and training, with all psychiatric residency programs being subject to stringent review by the American Board of Psychiatry and Neurology's Residency Review Committee. Nursing programs, on the other hand, are subject to greater variation from place to place, with less standardization between them.

There is also a significant difference between the preparation of Certified Registered Nurse Practitioners and Clinical Nurse Specialists in regard to the prescribing of medications and medical regimens, a difference which the proposed regulations properly recognize by limiting those functions to CRNPs. As psychiatrists, we frequently work with psychiatric clinical nurse

specialists, a group which provides very valuable services. Even under a collaborative model, however, the clinical nurse specialist should be required to acquire the CRNP training if they are to have prescriptive authority. In our area of medicine, the title "Clinical Nurse Specialist" can be conferred by a hospital or a training program, with qualifications and duties differing from place to place. Psychiatric clinical nurse specialists lead group therapy, may provide some individual psychotherapy, supervise other nurses, develop treatment plans, and perform a great many administrative tasks. All of these are valuable services – but none of them provide supervised experience related to prescribing.

To illustrate the complexities involved, I'd like to describe what I do when I consider a patient's treatment needs. The act of prescribing is a complex process that calls upon a store of scientific training and supervised experience that is of far greater depth than is readily apparent. It requires input from a variety of biological perspectives. Medical school integrates this knowledge of body physiology, mechanisms of health and disease, drug absorption and metabolism, and numerous other factors that need to be weighed and balanced.

To properly prescribe one must consider:

- the accuracy or certainty of the diagnosis
- the range of available treatments for the disease or condition
- alternative approaches beside medication
- side effects of the available choices balanced against the likelihood of achieving the desired response in each case
- possible interactions with other medications and over-the-counter preparations which the patient may be taking
- other diseases or conditions which the person may have

As psychiatrists, we are particularly concerned that any prescribing of psychiatric drugs by advanced practice nurses be very limited, as in the proposed regulations. Our rapidly expanding knowledge of the biologic basis of mental illnesses, combined with the development of many new, powerful, and complex drugs, makes this an area where real care must be taken. Our relative lack of experience with these drugs makes it doubly important that those who are prescribing them be as highly trained as possible. Mental illnesses sometimes affect an individual's capacity for making judgments, and some people with mental illnesses especially need to rely on the state's certification that the people treating them are adequately trained.

Dr. Pressley can speak to all these issues from the vantage point of a nurse – not an advanced practice nurse, but an RN who elected to pursue a medical degree rather than certification as a nurse practitioner.

Testimony of Emily Pressley, RN, DO

Even though I am a nurse, I am opposed to House Bill 50. To understand my opposition, you might want to know a little about my background. I first attended a three-year diploma nursing school, and then attended college in order to receive my BSN (Bachelor of Science in Nursing). I practiced nursing as an RN for twenty years, five as a medical-surgical nurse and 15 years in acute psychiatry. During the last few years of my work as a psychiatric nurse, I also

attended medical school. After completing medical school, I entered a psychiatric residency program and am currently in my fourth years as a psychiatric resident at Hershey Medical Center.

I enjoyed my work very much, and I consider myself a good nurse. Eventually, however, I decided that I wanted to be able to provide more to my patients – and the way to do that was by going to Medical School and becoming a physician. Working as an RN with both physicians and advanced practice nurses, I did not have confidence that another year or two of nurse's training would be sufficient to give me the knowledge one needs to independently diagnose or prescribe – activities which I wanted to perform.

I do believe that advance practice nurses generally have skills and abilities that are extremely useful, and that I could have improved my nursing skills by becoming certified as a clinical nurse specialist or certified registered nurse practitioner. But that training would not have been sufficient, in my view, to make me feel confident about prescribing medication or operating independently, without a collaborative relationship with a supervising physician. My decision was that the only way to acquire the skills which are really necessary for competent independent practice, where patients are dependent on my judgment, was to go to medical school. My medical school and residency experiences have reinforced my feelings on this.

One other aspect of House Bill 50 which I can speak to, and one that has not received much attention, is the changes it makes to the scope of practice for all nurses, not just those it calls "advanced practice nurses." The bill eliminates the current definition of "practice of nursing," replacing it with a reordering of some of the very same phrases it has just eliminated. At first glance, this could be construed as a change without a difference. The new definition, however, contains a very significant change: it leaves out the sentence in the current definition stating that "practice of nursing" does not include "acts of medical diagnosis or prescription of medical therapeutic or corrective measures." Without this clarification, the meaning of the remaining language is open to broad interpretation. If the bill does not mean to allow RN's to perform acts of medical diagnosis or prescriptions of medical therapies, then there is no reason to eliminate the prohibition against those practices. And in my experience, as an RN, that prohibition is reasonable.

I do believe that Certified Registered Nurse Practitioners can safely prescribe some medications, under certain conditions and within certain limits, if they are working with a supervising or collaborating physician. I also think that the Board of Medicine should be involved in oversight of this process. As I have learned personally, there is a real and substantive difference between a nurse's understand of the complexities of prescribing, and that of physicians. It will be better for patients if physicians are involved in the regulatory oversight of nurse prescribing.

Although I am sympathetic to those of my nursing colleagues who support House Bill 50, and have great respect for the abilities of my fellow RNs and those with extra training, this should really be about what's best for patients. Medicine today is extremely complex, and our understanding of disease and medical conditions, as it increases, indicates the need for <u>more</u>, not less, training and preparation.

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