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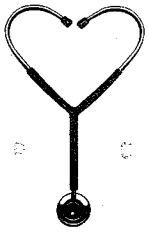
INDEPENDENT REGULATORY REVIEW COMMISSION



THE FAMILY PRACTICE & COUNSELING NETWORK

November 17, 2008

Ann Steffanic
Board Administrator
State Board of Nursing
P.O. Box 2649
Harrisburg, Pa 17105-2649

Letter Regarding 16A-5124: CRNP General Revisions

Dear Ms. Steffanic:

I write to you on behalf of The Family Practice & Counseling Network to express our support for the proposed regulatory revisions to amend Pennsylvania Code Chapter 21, Subchapter C (16A-5124: CRNP General Revisions).

We are an independent nurse-managed health center in Philadelphia with three sites located in severely underserved and low income communities. We currently have more than 11,000 active patients and some of our services include primary care from cradle to grave, family planning, prenatal, behavioral health, oral health, physical therapy, podiatry, diabetes education, nutrition, smoking cessation and exercise. Our first center opened in July 1992 and we have grown steadily since that time. Nurse-managed health centers like ours are a crucial part of the Commonwealth's health care safety net, and we provide care to many patients who have difficulty accessing primary care physicians.

The proposed revisions to Pennsylvania's CRNP regulations will help our center provide high-quality primary care to low-income and underserved people in a more efficient way. By removing the 4:1 maximum CRNP-to-physician ratio that currently exists in the regulations, we will have less difficulty finding enough physicians who are willing to enter into collaborative agreements with the CRNPs in our health centers. We will also potentially save money, as we generally pay each collaborating physician a fee in exchange for his or her services. We currently pay more than $38,000 a year to collaborating physicians. If we could cut this cost in half, we could add

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another lay outreach worker to help educate our patients about the importance of mammograms and pap smears.

Regarding collaborative agreements with physicians, currently the State Board of Nursing requires a prescription agreement with a physician in order for the CRNP to prescribe. The Managed Care Organizations (MCOs) require a separate agreement that defines the collaborative relationship. I recommend that the State Board of Nursing collaborate with the MCOs to create one agreement that is acceptable to both.

In addition, the proposed regulations will help us provide better, more cost-effective care to low-income patients who need Schedule II, III, and IV drugs. Current regulations that restrict CRNPs' ability to prescribe Schedule II, III, and IV drugs create a special financial burden for our low-income patients, who must refill their prescriptions (and pay the associated co-pays) more often than patients of physician-run safety net clinics. Revising regulations regarding CRNP prescriptive authority with regard to Schedule II, III, and IV drugs will help relieve an unnecessary financial burden on low-income and Medical Assistance-eligible patients who use nurse-managed health centers as their source of primary care. I particularly commend you on these proposed changes:

The Board proposes to delete subsection (d), which regulates the collaborating physician and allows the State Board of Medicine to regulate physicians. The Board proposes to amend subsection (e)(1) and (2) to conform to acceptable practice standards and to delete subsection (f)(2) to conform to common usage of certain prescription medications. The proposed rulemaking would authorize a CRNP to write a prescription for a Schedule II controlled substance for up to a 30-day dose, instead of a 72-hour dose. The proposed rulemaking would authorize a CRNP to write a prescription for a Schedule III or IV controlled substance for up to a 90-day dose, instead of a 30-day dose. These amendments will allow consumers to utilize common 30-day and 90-day insurance discounts for these categories of drugs. The current provision in subsection (e)(1) requiring notification of the collaborating physician within 24 hours is deleted as an unnecessary paperwork requirement that does not positively influence patient care. The current provision in subsection (e)(2), providing that only a physician may refill a prescription for controlled substances, is deleted as an unnecessary duplication of health care efforts.

Justification for above proposed change: As nurse practitioners, we have been very responsive to our patients caring for all their needs including the management of chronic pain sometimes in the last months of their lives as they struggle with cancer or other debilitating

diseases. We do not tell patients in need of chronic pain medication including opiates that we are unable to provide this level of care though the current regulations create an undue burden on us as well as our collaborating physician. The current regulations that require us to re-notify the collaborating physician every thirty days we renew a controlled substance are unwieldy, time consuming and impractical and may understandably lead NPs to shirk the responsibility of managing chronic pain when opiates are a necessary mode of treatment and refer the patient elsewhere. This can be disruptive to their care. There is a significant body of evidence suggesting that both acute and chronic pain continue to be undertreated. The under-treatment of pain is recognized as a serious public health problem that results in a decrease in patients' functional status and quality of life and may be attributed to a myriad of social, economic, political, legal and educational factors, including inconsistencies and restrictions in state pain policies.

The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain and nurse practitioners are in a position to competently manage chronic pain.

The diagnosis and treatment of pain is integral to the practice of medicine and nurse practitioners as recognized primary care providers in the state of Pennsylvania must be able to embrace this responsibility without undue obstacles. The Family Practice and Counseling Network encourages Nurse Practitioners to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness.

In addition to these specific comments, we would also like to note that we support these proposed changes in their entirety. If adopted, these changes will help nurse-managed health centers like our provide care to Pennsylvania's low-income and vulnerable populations more efficiently and effectively.

Thank you for the opportunity to submit these comments to you. If you have any questions, please feel free to contact me at 267.597.3601.

Sincerely,

Donna L. Torrisi, MSN
Network Executive Director