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11/17/2008

To: Ann Steffanic
Board Administrator
Pennsylvania State Board of Nursing
From: Cindy Schmeltz DNP, FNP-C, CRNP
Re: 16A-5124 CRNP General Regulations

Ms Steffanic,

I am responding to public comment of the recently proposed CRNP Rules and Regulations published in the Pennsylvania Bulletin. I am a family nurse practitioner who has and am working in a variety of practice settings. My primary role is in family practice but I also worked in a specialty practice, rural practice and emergency care settings. There are many times where patient care has been discontinuous due to circumstance not within my control. I would like to provide the following patient care scenarios of patients that I have personally cared for and the barriers the current restrictions placed on my ability to perform to my full scope of practice.

While working in an emergency room setting on a busy memorial holiday weekend, I had the opportunity to care for an individual in the Fast Track section of the ER who was visiting his nephew from out of town 30 miles away. He attempted to skateboard with his nephew and had fallen and broken his right leg. He was seen in the emergency room and given the appropriate care. Due to restrictions and limitations of practice, I was only able to write for 72 hours worth of controlled II narcotics. I received a call from the wife of the patient requesting additional pain medication as he had used the small amount of medication that was prescribed throughout the weekend. The wife stated that she had attempted to call their family doctor, but the office was closed due to the holiday. They had gotten the on call person who would not prescribe additional medications as they did not know the individual involved. They suggested she call the emergency room to see if we would refill the medication. At this point, I needed to pull the patient's chart which had already been returned to medical records and pull the patient's x-rays which had already been returned to the x-ray file room. I then proceeded to the main section of the emergency room to present the case to the emergency room doctor that was working that day. This doctor had not seen the patient and I needed to ask him to write for a prescription for continued pain medications on a patient he has neither seen nor examined. Luckily, the doctor agreed to do this. As this was a controlled substance the prescription and could not be phoned in. I needed to call the wife back and she needed to drive 35 miles to the hospital to pick up the script.

Another emergency room case involved an elderly woman who had fallen and broken her arm while visiting her granddaughter. The patient resided in a senior citizen housing development. She was given appropriate emergency room care and was given a prescription for pain medication. The grand daughter was advised that the patient would need to be seen by an orthopedic doctor and they were to call for an appointment on Monday. Unfortunately, the patient had medical assistance which limited her choice of orthopedic care providers and she needed to go to see a specialist in Philadelphia (1 ½ hours away) and was given an appointment for 2 weeks later. The grand daughter was upset and stated that her grandmother needed additional pain medication. I was able to contact her primary care provider on the patient's behalf and they were able to assist in getting the needed medication and to expedite her orthopedic referral.

While working at my primary care office, I had an additional problem with pain medication. My collaborating physician was on vacation in Florida with his family and I was working in the office all week as sole provider. We have a terminal cancer patient who needed refills on their Duragesic pain patch for pain management. This particular medication is a pain patch which is applied topically to the skin and is reapplied/ changes every 72 hours. I wrote a prescription for one patch which is all the law allows me to do. I then needed to explain to the daughter that I was only able to write for 72 hours worth of medication which was one patch. The daughter was very upset. She needed to drive into the office and pick up the script and had to pay the co-pay at the pharmacy for 1 patch. Three days later, they needed an additional patch. I needed to call the doctor on vacation. I explained the problem and he stated for me to refill the prescription and do what I needed to do to assist the patient and family. Each patch was an additional co-pay. The family was quite upset about the driving back and forth and the financial issue of co-pays for 1 patch at a time.

A patient with chronic pain, fibromyalgia and rheumatoid arthritis called the primary care office requesting a refill on her pain medications. It was a controlled III substance for which current regulation states that I can only write for 30 days. She was quite upset about my inability to write for a 90 day script for her to send in to her pharmaceutical mail order prescription plan. This is a senior citizen on a fixed and limited income. She could get 1 month of pain medication at the local pharmacy for $30.00 which was what was being offered, or mail the script in and get a 90 day supply for $30.00. As she is on additional chronic medications for blood pressure and diabetes, this additional cost became a financial issue for her.

Inappropriate restrictions on the ability of advanced practice nurses to prescribe the full range of controlled substances needed to control pain and other symptoms has a negative affect on quality of care and quality of life, especially in persons at the end of life. Pain causes significant physical and psychosocial burdens. NP should be able to practice in an environment that provides ethical and effective pain management as an integral part of care. With the proposed rules and regulation changes these kinds of things would not be an issue.

Advanced practice nurses play a critical role in expanding access to services and improving quality of care for patients with advanced chronic illness and advanced disease stages. By facilitating coordination and maximizing continuity of care, their roles are enhanced when they can prescribe controlled substances, especially opioid analgesics essential for the management of moderate to severe pain. The Oncology Nursing Society issued a position statement on cancer pain management in 2006, focusing on the cancer patient's right to optimal pain relief; the need for education of patients, families, and the public about therapies available to treat cancer pain; the need to eliminate regulatory, legislative, economic, and other barriers to effective cancer pain management; and the ethical responsibility of all healthcare providers to use evidence-based pain management guidelines.

I am writing on behalf of the profession as well as the patients and families that I see on a daily basis. I would like to say the cases above are the exception, unfortunately, in 11 years of CRNP practice, I can not. I am in support of the changes listed in the proposed rules and regulations. The recommended changes would obviously remove barriers for patients as well as providers and would improve access to care. Thank you for your consideration.

Sincerely,

Cindy Schmetz DNP, CRNP