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Sara Wright, MSN, CRNP
173 Clover Valley Road, Kutztown, PA 19530

Ann Steffanic
Board Administrator
Pennsylvania State Board of Nursing
PO Box 2649
Harrisburg, Pa. 17105-2649
November 8, 2008

RE: 16A-5124 CRNP General Revisions

Dear Ms. Steffanic,

I have practiced as a Geriatric Nurse Practitioner for 22 years. The story I have to share is one based on those past years of personal professional experiences. It is also a story of the future- one that has been told before but unheeded by those whose wish is to arbitrate what the "acceptable" scope and practice parameters should be for other licensed professionals within Pennsylvania. Despite the lack of recognition of Geriatrics as a specialty by the professional medical associations and the providers of reimbursement e.g. CMS, the experience I have had over my years of geriatric practice has proven that it *is* a specialty. It is often the health care provider that is skilled and specialized in geriatrics- a geriatrician *or a geriatric nurse practitioner*- that actually prompts the needed collaboration and consultation for the elderly patient *not recognized by* the other specialists and generalists involved in the elder's care. Illustrative case examples:

- An elder is discharged to a nursing home or their own home following hospitalization for an acute episode of congestive heart failure. Although twice-a-day dosing of a diuretic, initiation of an ACE inhibitor or a beta blocker may have been indicated during the hospitalization, there will come the time when the doses and dosing schedule will *need to be re-evaluated based on conditions/syndromes associated with the elderly* e.g. fall risk, urinary incontinence, orthostatic/post-prandial hypotension, confusion, *in addition to* the standard treatment protocols for managing heart failure.
- An 86 year-old has a ten-year history of Parkinson's Disease, which has progressed to the point that the person is able to transfer to chair/bed, but no longer able to ambulate. He is now experiencing hallucinations and changes in behavior. A physician has suggested that an anti-psychotic be initiated for the hallucinations and behaviors. From a geriatric perspective, perhaps a decrease in the current Parkinson's medications might be indicated prior to a trial of an anti-psychotic agent with its potential attendant side effects. In geriatrics, one must weigh the burdens/risks of *all* medications and continually re-examine the goals of care and treatment that are based on realistic expectations and the risk/benefits presented in the treatment plan. In this case, the goal would be to maintain swallowing ability, maintain the stand-pivot transfer ability, monitor for emergence of tremors or increased rigidity while initiating a trial of tapering down the dose of Parkinson's medication to determine if the hallucinations and behaviors subside.

Many demonstration projects have been completed or are currently underway that support elders to remain at home rather than enter a nursing home when functional and/or cognitive declines are present. In 2007, the national patient/provider ratio was reported to be one geriatrician for every 2,456 elders. By 2030, this ratio is predicted to rise to one for every 4,254.[1] In 2004, 0.90% of Medicare reimbursement for outpatient visits was for house calls.[2] *What other health care provider will be able to deliver the specialized geriatric care needed to maintain these elders within their homes? Identify the early signs of conditions/syndromes such as delirium associated with aging? Be able to initiate the appropriate evaluation, consultation, and treatment for the underlying conditions/syndromes as it is within their scope of practice? Potentially prevent an unnecessary hospitalization that would further disrupt the elder's life and potentially result in increased functional and cognitive declines?* It will be the CRNP. It is well beyond the time to have a clear statement of the scope of practice outlined within the CRNP regulations so that they cease to continue to place the NP at risk for becoming a subordinate, dependent practitioner for aspects critical to their *advanced nursing practice. Collaborate* is defined as working together, working in partnership with others. Nurse Practitioners are *expert nurses and patient advocates, vital members of the health care team,* not physician substitutes or extenders. The proposed changes in §21.282a are essential and would enable the CRNP to better meet not only the exponentially increasing health care needs of the elderly, but all people across the lifespan in light of the renewed focus on health care at the federal level. I have no issue with maintaining a prescriptive collaborative agreement and there is no reason why the Board of Nursing is not competent to oversee such practice. Prescribing is but only a part of professional CRNP practice. However, the current limits of the prescription of Schedule II controlled substances for up to a 72 hour dose places hardships on the elderly within my practice who have chronic pain that is well managed on an analgesic regimen that include Schedule II medications. Such medications are also included in palliative and hospice care protocols.

I urge you to pass the proposed regulatory changes contained within these general CRNP revisions. They will serve to position the CRNP to assume a leading role in improving access to care across a variety of settings to provide quality health care to all citizens of the Commonwealth.

Sincerely,

Sara Wright, MSN, CRNP

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[1] Hoppel AM (2008). The elder boom: Caring for an aging America. *Clinician Reviews, 18(11);*2-4.

[2] Landers SH (2005). Trends in house calls to Medicare beneficiaries. *Journal of the American Medical Association, 249(19);* 2435-2436.