2729

Hon. Barbara McIlvaine Smith
25B east Wing
PO Box 202156
Harrisburg PA 17120

Dear Ms. McIlvaine Smith;

I am writing to you for your support and approval of CRNP General Revisions 16A-5124, specifically to expand our prescriptive authority of Class II medications to include a 30-day quantity for patients.

In review of the State Medical Board site and many of the opposed letters you have received, I take great offense to many of their "unfounded" concerns as to why this should not be allowed.

I have been in Nursing for over 25 years, I have two bachelor degrees, a master's degree in nursing and a Post Masters Nurse practitioners degree in Adult/Geriatric Medicine, in all I have 12 years of higher education. For the past ten years I have had the great opportunity to be in a collaborative agreement with one of the leaders in the specialty of Pain Medicine, I have taught both Interns and residents in two major University settings related to the practice of pain medicine, the use and titration of both opioid and non-opioid management for pain, and how to "properly" write a prescription for opioid medication, all due to the fact that on average "medical students" receive 2 hours on pain management. For physicians to state that a CRNP would "not be able to distinguish between patients with legitimate pain needs for medication and those who do not" due to our lack of "expertise and experience" is both insulting and derogatory. On a daily bases I am seeing pain patients who have not been assessed properly by new physicians/residents and often have no clue as to how to begin management of a patients pain, whether an exacerbation of their chronic pain or an acute new onset of pain.

The AMA verbalizes concern that should this revision pass they are concerned of the "Lack of identification requirements so that patients can know that they are being treated by a CRNP rather than an MD". I cannot speak for all CRNP's but in all the institutions, hospitals, and outpatient clinics I have worked all employees are required to wear name tags/ID badges with our credentials clearly printed. Again I can only speak for myself but when ever I walk into a patients room, or meet a new patient in clinic, I first introduce myself and clearly state I an a Nurse Practitioner, not a Physician.

To allow CRNP's to prescribe a 30 day supply of a Class II medication, after a comprehensive assessment, history and physical, diagnosis, established plan of care, and an opioid contract agreement signed, all in collaboration with a MD, would move Pennsylvania towards the goal of improving patient access to care. Presently many of the patients we have been seeing within our pain practice have been

patients for over 10 years. They have documented intractable chronic pain conditions, or are cancer/palliative pain patients. The daily use of opioids helps them to work, raise families, and retain good quality of life.
Often when one of my collaborating MD's is on a speaking engagement, and a patient that is very familiar to myself is due for follow-up, they must receive a 3 day prescription from myself requiring a co-pay, and then again come back in three days to pay another office co-pay, t receive another prescription from the MD which requires yet another co-pay.

For the AMA to insinuate that changing this regulation and allowing for CRNP's to prescribe 30 day quantity of medication (Class II) to appropriate patients would lead to increased aberrant behavior, is unfounded and I believe a "scare" tactic. There have been no studies to date directly correlating increased "mis-use" of Class II medications specifically written by a CRNP, on the contrary there is only data suggesting improved outcomes and quality improvement with CRNP care.
In a report:
A Study of Expanding Prescriptive Authority for Controlled Substances to Advanced registered Nurse Practitioners (2004 House Bill 595) Legislative research Commission; Report No.323
It was found that "Licensure actions taken against ARNP's for controlled substances are rare". There were relatively few actions found given the roughly 170,000 practicing ARNP's (Pearson. Sixteeth. 31). For all 50 states through the six-year period, there were a total of 41 actions related to controlled substances. In addition 37 states reported no actions for all six years. (p.46)
Based on this six year study and the small number of total actions and many states with no actions at all, it was determined that there was "***No statistical analysis to uncover any effects from ARNP/CRNP prescriptive authority, and that the only other information that can be drawn from this data is that, overall, reported actions taken against ARNP's based on controlled substance or other substance abuse problems are rare". (p.46)***

This is an important time in the area of health care reform with the goal being increased access to care, and improved patient outcomes. Nurse Practitioners if given the reform can help to achieve this.

Sincerely,

Maripatricia Welz-Bosna RN,MSN,CRNP-BC
Pain Medicine and Palliative Care
Department of Medicine
Christiana Health Care System
Department of Pain Medicine
Hospital of the University of Pennsylvania
Adjunct Faculty University of Pennsylvania School of Nursing