2729

**Steffanic, Ann**



**From:** ST, NURSE
**Sent:** Monday, December 08, 2008 9:41 AM
**To:** Steffanic, Ann
**Subject:** FW: Regs - Reference # 16A-1524 CRNP General Revisions

-----Original Message-----
**From:** Debbie Marino [mailto:dmarinommtj@comcast.net]
**Sent:** Saturday, December 06, 2008 4:58 PM
**To:** ST, NURSE; sschalles@irrc.state.pa.us
**Cc:** 'Susan Schrand'
**Subject:** Regs - Reference # 16A-1524 CRNP General Revisions

To Whom It May Concern,

Although this email comes late in process, I felt it was necessary to give you my experiences and thoughts on the subject of NP's having greater autonomy over Schedule II prescription medications.

I was a nurse practitioner in NY several years ago where my role at the Pain Management office on Long Island was to treat my pain patients. Based on my nursing backround, I took on this task and built upon my role every day. This was to assess, plan, implement and evaluate my patient's pain. Quite often, this treatment included Schedule II meds. I worked with 5 other physicians who completely trusted my experience and judgement in prescribing such meds when necessary. I saw hundreds of patients and had complete control over my patient's prescription medications, when required. Not only did I do the prescribing, but based on my nursing backround, I formulated a careplan for every patient in which a set schedule was implemented, expectations laid out, guidelines between patients/families were discussed and outcomes were reevaluated at the next office visit, which I was responsible for scheduling. I am very proud of the autonomy that I was given in NY, as well as the respect that I absorbed every day from the five collaborating physicians. They were pleased to have me there so that they could focus on the patients who required prolotherapy, epidurals and acupuncture, while I treated the patient's who received pain meds during the timespan that they were undergoing other treatments or if they had failed any other treatments.

I moved to PA several years ago and now practice at an Assisted Living Facility in Bucks County which includes Assisted Living, Nursing Home and Hospice. My office is in a central location on campus while also being open to the community at large. I presently collaborate with 2 other physicians. One is with the Hospice Unit and the other is with the Nursing Home/Assisted Living areas. On a day to day basis, I prescribe Fentanyl, Oxycontin, Morphine etc....to my Hospice patients. My collaborating physician takes minimal part in this decision-making process, for he comes in to make rounds for 30-45 minutes once a week in the hospice unit, which is about 18 beds. Although his name is next to mine on every order, the decision is solely on me. We have several patients who receive Schedule II meds in the Nursing Home and Assisted Living. As far as the Nursing Home goes, I often prescribe morphine, when appropriate, for our comfort care residents. This decision, again, is placed on me. As for the assisted living area, I am writing a 3-day supply for current scripts due to the regulations. This is often a big barrier with the care that I can offer for many reasons.

These patients see me for their multiple diagnosis (sometimes 12-18 diagnosis) year to year on a 2-3 month basis, since it is a geriatric facility. Although I take care of their entire health, I do not have the autonomy that I had in NY regarding the treatment of their pain. Since I need to review my careplan with the physician, it often causes a gap in care. This is because he may not be at the facility that day because he is working at his other primary care office, because he is teaching at a seminar, or working as the hospitalist at the community hospital. Because their pain schedule is often "off schedule", he ends up with calls on weekends, nights and holidays. Sometimes the patient chooses to wait to meet with the physician to discuss a different dosage and this can lead to withdrawal, since the patient is now out of pills. Once the physician finally follows up with the patient, the careplan and goals are minimal, compared to my expectations, due to the physicians time constraints and other important duties. I find myself withdrawing from this portion of the care when possible because it could never meet my high expectations and standards that I expected of myself in NY.

He has verbalized quite often that he would rather I take over this entire pain role since he is too busy. Having said that, we have been so busy at work that my letter is late, and his letter may or may not come, in which he expresses similar thoughts.

This letter will go out in the mail with attached copies of 3 letters of recommendations that were given to me from the collaborating physicians in NY based on their experience working with me as a Nurse Practitioner handling their pain patients. The physician I presently work with will also be mailing out or emailing you a letter early in the week, if possible.

Please strongly consider changing the regulations in PA, as was done in NY, to allow NP's greater autonomy which will lead to a more appropriate outcome for our patients.

Thank you.

Sincerely,

Deborah A. Marino, CRNP