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In regards to: No. 16A- 5124 CRNP General Revisions

Ann Steffanic
Board Administrator
Pennsylvania State Board of Nursing
PO Box 2649
Harrisburg, PA 17105-2649

Dear Ms. Steffanic:

As a pediatric nurse practitioner and a nurse educator, I appreciate the opportunity to comment on the proposed regulatory revisions for Certified Registered Nurse Practitioners in Pennsylvania. I have practiced as a CRNP for 11 years and as an advanced practice nurse for 30 years. It is imperative that the regulations be accepted as written. Given the current economic condition of our Commonwealth, the unmet primary care needs of our underinsured and uninsured citizens, and the ever decreasing numbers of primary care physicians in our state, primary care nurse practitioners are well suited to manage the majority of patients who seek primary care. These regulation changes are consistent with Act 48 authorizing the expanded scope of practice for nurse practitioners. I wish to comment on three major areas of the regulatory changes: nurse practitioner - physician ratios and collaborative agreements, lifting limits on prescribing schedule II to IV drugs, and the requirement of a collaborating physician's name to be printed on a prescription pad.

I am currently one of seven health care providers in a suburban Philadelphia pediatric practice. We have five pediatricians and two nurse practitioners who cover two offices and newborn babies in the hospital nursery. We offer early morning and evening hours on weekdays and Saturday morning sick visits to accommodate the needs of our families many of whom are full time workers with children in daycare full time. I am frequently covering one office as the sole provider with telephone access to one of my physician colleagues. We have worked together for several years and the collaboration about patient care flows throughout the provider group. It is not a one way directive from the physician to the nurse practitioner. We each have areas of expertise and we all consult one another to provide the highest quality care to our patients and their families. As primary care providers, we consult specialists if the problem is not one we can manage safely or appropriately. I have verbal collaborative agreements with many primary care providers and specialists. The requirement to have a written agreement with one collaborating physician and one backup physician who are limited to collaborating with only four nurse practitioners is not efficient, effectively insuring quality, or necessary. These restricted collaborative agreements limit choices patients and families can make in seeking out health care that is individually matched to their needs. Many nurse practitioners work with more than one collaborating physician because they have more than one job. These nurse practitioners are required to establish collaborative and prescriptive agreements with each work site. This process dramatically increases paperwork and delays the nurse practitioner's full participation as a health care provider in a new site. The delay to receive prescriptive authority is typically more than one to two months. The experienced NP's productivity is reduced by having to consult a physician to sign each prescription until the prescriptive authority is granted for the new site.

I have developed expertise in evaluating and managing attention disorders and learning disabilities through my doctoral study, continuing education, self directed study, and consultation with experts in related fields such as child development, psychology and education. My colleagues often refer these patients to me. I see a large number of patients in our practice for management of attention disorders. Local developmental pediatricians and psychiatrists who take insurance have waiting lists for appointments of four months to more than one year. Those who do not take insurance, require payment at the time of service and their fees are prohibitive for most

of our patients and their families. Families have reported the initial consultation to cost from $1500 to $2000. The pediatric literature supports primary care providers managing medications for attention deficit disorder and learning disabilities not complicated by other co-morbidities such as oppositional defiant disorder, bipolar disorder, or conduct disorder. The stimulant medications are the first line of drug therapy for attention deficit. These medications require a period of titration to achieve a safe and effective dose and they are schedule II drugs. I have a DEA number, but I am limited to writing a 72 hour prescription for my patients who require stimulant therapy. Therefore, I complete the evaluation with the family, determine the treatment plan, discuss medication administration, expected results and potential adverse effects of the medication with the family, write the prescription, and leave a progress note and the prescription to be signed by one of my physician colleagues. This requires a second visit to the office for the parent to pick up the signed prescription that will last for 30 days. If the parents choose to take the 3 day prescription, their monthly prescription co-pay only covers three days of the month and they are required to pay out of pocket for the remainder of the medication that month. The cost of this process to meet the state regulation is high for patients and their families in time, fuel, and, most importantly, delayed services for a clearly identified health care and developmental need.

The requirement that a collaborative physician's name be printed on the prescription pad is unnecessary. It is possible to access the nurse practitioner's prescriptive authority license through the State Board of Nursing website in less than two minutes ensuring pharmacists and other providers that the NP in fact does have prescriptive authority.

In summary, I urge you to pass the regulatory revisions as written by the State Board of Nursing. Collaborative agreements will continue and grow stronger with increased access to experts in all healthcare fields. Limitations of physician to nurse practitioner ratios only limit patient access to affordable, quality health care and reduce primary care access for the underserved. Prescribing schedule II medications for 30 days and schedule III and IV drugs for a total of 90 days will provide patients with the needed medication to manage emotional and behavioral disorders or control pain while saving money and time for our patients.

Again, thank you for providing this important forum.

Best regards,

Donna Faust Patterson PhD CRNP
Pediatric Nurse Practitioner

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