ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*
PENNSYLVANIA CHAPTER

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December 5, 2008

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

Dear Ms. Steffanic:

On behalf of the 6,700 members of the Pennsylvania Chapter of the American College of Physicians, I am writing to ask that you modify the proposed changes in the regulations for CRNPs working in Pennsylvania. Our organization represents both internists and internal medicine subspecialists. Many of our members have collaborative relationships with CRNPs and value their professionalism and effective, patient centered approach to patient care. Just as you do, we want these regulations to enhance that working relationship and to ensure the continued safe and effective care that is delivered to patients.

We have studied the proposed changes and offer some recommendations that would address our concerns for the safety of patients and the maintenance of the collaborative relationships we enjoy with our colleagues.

#1- Lack of definition of Collaboration in the definition section (21.251).

Please add the definition of collaboration which is found in the authorizing statutes.

We suggest: "Collaboration – A process in which a CRNP works with one or more physicians to deliver health care services within the scope of the certified registered nurse practitioner's expertise. The process includes all of the following:

(i) Immediate availability of a licensed physician to the CRNP through direct communications or by radio, telephone or telecommunications.
(ii) A predetermined plan for emergency services.
(iii) A physician available to the CRNP on a regularly scheduled basis for referrals, review of the standards of medical practice incorporating consultation and chart review, drug and other medical protocols within the practice setting, periodic updating in medical diagnosis and therapeutics and cosigning records when necessary to document accountability by both parties.

#2 - Section 21.282a provides an overly broad definition of "scope of practice" based on Act 48.

The act clearly states [sectiion1}: **A certified registered nurse practitioner may perform acts of medical diagnosis in collaboration with a physician.** It does not provide for the CRNP of perform these functions independent of this relationship. We recommend the deletion of the broad authority listed in 21.282a (d) "...to develop and implement treatment plans...," and to add language providing that CRNPs may perform the listed functions when acting within the scope of the CRNP's written collaborative agreement with a physician. The nature and extent of the collaboration needs to defined and specified in advance. Oral agreements are prone to misinterpretation and confusion in the face of a disagreement.

 # 3 – In section 21.287 you propose to remove the collaborating physician – prescribing CRNP ratio limitation.

We would retain the ratio, so as not to exceed 4 prescribing CRNPs collaborating with one physician and retain ability to apply for waiver when appropriate. This is a safety issue, for meaningful collaboration implies ongoing two way communication. We also suggest that you add a requirement that the collaborating physician has the expertise to collaborate in the CRNP's area of practice.

#4 - Qualifications for obtaining prescriptive authority.

We recommend in 21.283(b) (1) (iii) that course work in advanced pharmacology be completed within two years (rather than five years) of application for approval to prescribe drugs. Too many new drugs enter the market annually for a five-year window to be safe.

#5 – Attestation requirement that physicians have knowledge and experience with the drugs that the CRNP proposes to prescribe.

In section 21.285(b 4) you propose to delete the attestation requirement that physicians have knowledge and experience with the drugs that the CRNP proposes to prescribe. For the safety of all patients, we request that such an attestation statement confirming that the collaborating physician has knowledge and experience with the category of drugs that the CRNP proposes to prescribe, be included in the written collaborative agreement.

#6 - Lack of appropriate identification requirement.

You propose to modify the identification requirements in 21.286. We feel you should reverse the proposed modification but allow the term "Nurse Practitioner" under the name of the individual. We think there is great potential for confusion by patients when CRNPs are introduced as Doctors of Nursing Practice (DNP) and that the language in 21.286c, "A CRNP who holds a doctorate should take appropriate steps to inform patients that the CRNP is not a physician," should be retained.

#7 – Provide for a CME requirement.

In section 21.331(c) (2) the draft regulations provide for a CME requirement of 30 hours over two years with 16 hours of the 30 being required in pharmacology for those CRNPs desiring renewal of prescriptive authority. We feel this is inadequate to assure safe practice. We recommend a minimum of 60 hours be required over 2 years with a minimum of 20 hours being required in pharmacology for those desiring to renew or maintain their prescriptive authority.

In summary, we want to assure you that our members value the professionalism of our CRNP colleagues and value the effective and patient-centered care that they provide. We feel changes listed above will enhance the collaborative relationship between physicians and CRNPs and further assure the delivery of safe and effective care to patients in the Commonwealth.

Sincerely,

Charles Cutler MD

Charles Cutler, MD, FACP
President
Pennsylvania Chapter, American College of Physicians

cc: Arthur Coccodrilli, Independent Regulatory Review Commission
Honorable Robert M. Tomlinson, Senate Consumer Protection and Professional Licensure Committee
Honorable P. Michael Sturla, House Professional Licensure Committee