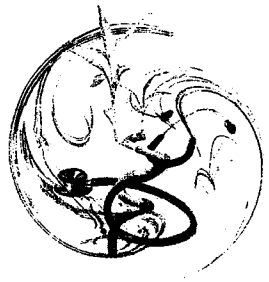

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INDEPENDENT REGULATORY
REVIEW COMMISSION

NIGHTINGALE
Health & Wellness Services

December 6, 2008

State Board of Nursing
ATTN: Ann Steffanic, Board Administrator
P.O. Box 2649
Harrisburg, PA 17105-2649
Ref. #16A-5124 CRNP General Revisions

Dear Ms. Steffanic:

I am writing in support of the proposed changes of the CRNP General Revisions recently published. As a CRNP who owns and operates three primary care and complimentary alternative medicine practices in South Central Pennsylvania, I can assure you that the proposed changes truly reflect how Primary Care Nurse Practitioners function in 2008 and should be implemented.

I maintain a collaborative agreement with a physician who I employ to collaborate with me. He does not work in my offices, and in fact he has never even set foot onto the property and he certainly does not see my patients. Although my patients know that he exists, they do not ask to meet or see him. He is Board Certified in Family Practice and credentialed as a Certified Medical Director, but he is not our practice medical director and he does not direct nor dictate my practice. He is available, as needed, which, after 15 years of practice is very rarely, and he offers collaboration not supervision. He does not routinely review my charts, and basically is available to help me prescribe the Schedule II narcotics I need for my patients who are diagnosed with ADHD or ADD. (By the way, these patients were diagnosed by a referral to a psychiatrist and through a proper evaluation by a behavioral health specialist and have both medication and behavioral modification components to the treatment plan. Unlike many patients who are diagnosed in the primary care office and placed on medications with no other evaluation, or treatment alternatives.)

This is the real world, and if you actually talk to physicians and nurse practitioners who work together in practices, this is how we function. We do not go to the physician to ask for permission to prescribe a scheduled drug, we present them with a script and they sign it without question, and sometimes with a comment about how ridiculous it is to have to do so. We do not ask them if we need to order a diagnostic test, we order it, then, we interpret it and treat the findings, because we know what the proper course of action is. We do not ask them if we should send a patient to a specialist, we refer them, because we know what is within the scope of a primary care practitioner, NP or physician, and the specialists accept our referrals because they are appropriate. They don't call our collaborators and question why the patient is there, they know that the CRNP in the PCP office has exhausted the care appropriate for that setting. When we need consultation on a problem that is unclear to us, we ask for a consult, sometimes a physician, sometimes another CRNP, sometimes a specialist in another healthcare field, whoever is the expert on that particular patient's problem.

Collaboration is not a legally required piece of paper, it is a professional relationship that is fluid and dynamic. It changes and grows as the practitioners in the relationship mature and work together. It cannot be written and inflexible. It must be able to adapt to the needs of the patients and with the professional growth of the signers. In year 1 of a collaborative relationship the contact between the providers is much different than in year 3 or 5 or 10. You cannot write down trust, or experience, you can only know by being in the relationship that one provider is competent and safe (and I am not only referring

to the CRNP.) Having a piece of paper that says an NP can perform certain tasks does not assure that he or she is able, only that s/he is allowed to do so. The relationship and knowledge of the practitioners working together and communicating is what makes healthcare safe for patients and providers. No matter how detailed a document, what facilitates communication is trust, and you don't sign for that, you build it. There is no need for extensive, complicated, and intricate written collaborative documents, only professional agreements between the parties to assure that the requirement of the law is being met. Personally, I have terminated a collaborative agreement because the physician was not practicing at the professional level I was, and I felt the physician was putting me at risk, not the other way around.

My patients neither ask to see, or speak with my collaborator. They do not want to, they trust me, and my judgment. When they have problems beyond my scope they know I will I do what any competent primary care provider, physician, NP, or PA would do, refer to a specialist. Often this means they see another Nurse Practitioner employed in a specialty practice. They are glad when this happens as they trust NP's and know they will get the time to ask questions and discuss things, unlike when they meet with most specialist physicians. To think that referral to specialist means they will see a physician, in this day and age, is false. Most of these practices have initial examinations completed by NP's. Why, because they take time and NP's do a much more thorough job of initially examining and interviewing the patient, then if the problem warrants, the physician will review the NP's findings, and discuss them with the NP to create a plan of care. Is this physician care, not really, it is collaboration in the truest sense of the word.

There are not enough physicians to see all the patients who need care, either in specialty practices or in primary care. Sometimes there are not enough practitioners in specialty care NP, PA, or physician to see patients for several months. My patients wait 6-8 weeks for neurology care, 3-4 months for dermatology care, and worst of all 5 or more months for pediatric psychiatry care due to shortages in practitioners.

Currently, I have a 9 year old boy, who's Aunt obtained custody of him after his mother was incarcerated. He was sent here from Florida with no records, no medications, and severe behavioral problems. He was not eligible for insurance coverage until he lived here for 90 days and the school would not allow him to attend "unmedicated" due to the severity of his behavioral problems. No pediatric practice would care for him because he had no insurance coverage and they could not get records, and they would not help the Aunt navigate the system to get them. The local "free behavioral health center" had a 5 month wait to see the pediatric psychiatrist (we are still waiting – February will be our appointment), and no local family physician would see him, since the Aunt only had a notarized letter from the Mother, signed in jail, to say that the Aunt had custody. He was threatening to harm himself, harm others in the house, and destroying property, but the Aunt had faith that she could make a difference if she did not institutionalize him, which is what the local Crisis Intervention center recommended. (This too was a huge undertaking since he was a minor with no insurance and "questionable" guardianship.") He needs love, not separation, he has been separated enough, and we are working with the family to keep him in the home. Through a lot of work on the part of my office staff, the Aunt, and myself we have been able to get school records, which at least listed his medications, and gave us a place to start. No physician would have undertaken this impossible task, they would have left it up to the Aunt, who was already busy trying to save this child from his past. My collaborator has chosen to write the scripts for this child's Schedule II's based solely on my evaluations and recommendations. Why? Because he trusts me and knows that I am well educated and experienced to make these decisions. When we have had to change medications it has been financially and emotionally detrimental to the family. I write a 3 day prescription to see if it makes a difference and then 3 days later they come back and 3 days later..., until we can get a written script for 30 days from the physician. This is why the changes in prescribing parameters for scheduled drugs are necessary.

There is absolutely no documentation to support the assertion from organized medicine that allowing NP's broader prescribing of scheduled drugs will increase diversion. Every state that has broadened prescribing has watched this and no increase has been noted. In fact, studies on prescribing have shown that NP's have more conservative prescribing habits for all medications including narcotics and employ more alternative methods of symptom control and pain management than physicians do. Every CRNP in Pennsylvania should be insulted and angered that the Pennsylvania Medical Society (PMS) would put in writing that allowing NP's to prescribe according to the guidelines of the Drug Enforcement Agency, 30 days scripts for Schedule II narcotics and 90 days scripts with refills for Schedule III, IV, and V would

increase the diversion of narcotics in Pennsylvania. This is obviously a control issue for the physicians and is not rooted in any truth or research. In publishing that statement PMS borders on libel of all the CRNP's in the Commonwealth, and they should be reprimanded for it.

The ratio of NP's to physicians is also an unnecessary barrier to patient care. There are not enough physicians to provide signatures for NP's who work in underserved areas or clinics for at risk populations. Planned Parenthood, migrant health clinics, and homeless shelters cannot find doctors willing to sign collaborative agreements because the services cannot pay an adequate compensation. An arbitrary number of 4:1 is just that, arbitrary. There is no research that shows that limiting NP:physician relationships improves patient care. In fact, the literature shows that NP's in these settings provide equal care and have superior patient satisfaction rates. As the number of physicians in PA continues to decline the need for more NP's in these settings and others will increase and ratios will make it impossible for vulnerable populations to access care. In Emergency Deparments (ED's) all over PA the NP's are treating the growing number of patients accessing the ED for primary care services because of financial hardship or lack of health insurance. These patients do not require the specialized care of an ED physician yet they are taking up resources in already overcrowded ED's. There are not enough physicians in some communities to collaborate with these NP's in a 4:1 ratio. When this happens these patients are deprived of the care that they need and healthcare costs increase as they get sicker and sicker and require more resources.

As for the use of the term doctor, physicians do not own that terminology. Anyone who completes academic work at that level deserves and is entitled to use the term Dr. Do I want my patients to think I am a medical or osteopathic doctor? NO, I am proud to be an NP and the provider they choose to see. I want to provide them with the highest level of healthcare provision that I am capable of attaining and I will earn the title of doctor just like the physician did, by hard work and study. Advanced Practice Nurses who are referred to as Doctor have earned that distinction. Just as difficult a course of study as an MD or a DO, a PhD or DNP, or other nursing doctorate is equally prestigious and important, just in another critical healthcare discipline. There is no best Dr. to provide care for our patients, just the right Dr. for that patient, in that situation, and to limit who can be referred to as doctor is discriminatory and paternalistic on the part of the medical profession.

Nurse Practitioners play an integral part in providing healthcare to the residents of the Commonwealth of Pennsylvania. The proposed regulatory changes put forth by the State Board of Nursing reflect how collaboration, prescription writing, and care is provided in the real world today. To think otherwise is to be in denial. We are providing care independent of physician input when the patient's needs are within our scope of practice. Our prescribing habits are safe and far more conservative in the issuance of scheduled narcotic medications, than our physician colleagues, as documented in the literature. We are earning doctorates in a specialty that is equally as rigorous and complex as medical doctorate or osteopathic doctorate degrees. We are highly trained, skilled, experienced, and competent in making healthcare diagnosis', ordering and interpreting diagnostic testing, and safe in prescribing medications when warranted. These proposed changes are not expanding our scope of practice, but changing outdated guidelines that were agreed upon, as a compromise, to get something through, when physicians were regulating nursing practice, and do not reflect the true essence of nurse practitioner care.

Sincerely,

Lorraine W. Bock, MSN, CRNP
Owner & Primary Care Practitioner – Nightingale Health & Wellness Services