Pennsylvania
Psychiatric Society

The Pennsylvania
District Branch of the
American Psychiatric Association

2729

December 5, 2008

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

Re: *State Board of Nursing, Regulation 16A-5124: Certified Registered Nurse Practitioners*

Dear Ms. Steffanic:

On behalf of the Pennsylvania Psychiatric Society, an organization representing approximately 1,750+ psychiatrists practicing across the Commonwealth, we would like to offer the following comments on proposed regulations from the Board of Nursing concerning Certified Registered Nurse Practitioners ("CRNPs").

Training in Psychiatry for Physicians vs. CRNP training

Psychiatrists are, of course, physicians who specialize in the diagnosis and treatment of mental illness. Psychiatrists also take a central role in treating drug, alcohol, and other addictions. Addictions are included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which is the treatise published by the American Psychiatric Association that provides diagnostic criteria for mental disorders. Psychiatrists, after completing medical school, complete a four-year residency program solely in psychiatry. Psychiatrists who specialize, for example, in child or adolescent psychiatry, must take an additional year or two training in a fellowship position.

CRNPs involved in behavioral health care typically have one of two models of basic training. One model is CRNPs who have specialized in behavioral health care and have completed a two-year Masters degree program in behavioral health following nursing school. The other basic model is CRNPs who have completed a Masters degree program in a more general subject – such as family practice or gerontology – in which behavioral health issues were one of many components.

General Concerns and Comments

Our central concern, like that of many physicians, is that meaningful oversight requirements are necessary so that CRNPs can continue to play a productive and positive role, without causing harm to patients who suffer from mental illness and substance abuse disorders. Some feel that efforts to expand the scope of practice of health care practitioners with more limited education and training can help make more efficient use of physicians' time and training. We believe that those

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expansion efforts inevitably come at a cost, as medical decisions are made by non-physicians. It is easy to suggest that CRNPs will deal with the routine problems and physicians the non-routine, but what is and is not routine is less clear than some might think or wish. Meaningful physician oversight of CRNP practice is, in our view, essential so that the expanded scope of practice is beneficial, not harmful. We are thus quite concerned with the extent to which the proposed regulations dilute that relationship and almost seem to facilitate, if not explicitly permit, independent practice by CRNPs. There are two main bases for our concern as they relate to the practice of psychiatry.

First, diagnosing patients with a psychiatric illness or substance abuse disorder can be exceptionally hard. There are no blood tests or x-rays to guide the diagnosis. Instead, diagnosis depends on listening, interpreting, and evaluating the substance of a patient's responses and, equally, the patient's manner of speech and thought, and relating them to reported physical symptoms. Distinguishing between competing and similarly-appearing mental illnesses can also be both difficult and important to treatment. Is a patient who appears depressed actually suffering from bipolar disease rather than "unipolar" depression? The depressive states of the two diseases look quite similar, but the diseases and their treatment differ substantially. Indeed, standard treatment for unipolar depression (SSRIs, such as fluoxetine and paroxetine) can actually worsen bipolar disease. There are other similar situations in which diagnosis can be difficult and treatment varies substantially by the diagnosis. The more intensive training of physicians includes extensive development of the critical thinking skills essential to accurate diagnosis.

Because of these factors, we believe that psychiatric diagnoses must be established by psychiatrists, not CRNPs. We believe CRNPs practice best in the behavioral health field when they can assist in managing the treatment of an established diagnosis and course of treatment, rather than making the initial diagnosis and treatment decisions. We are quite concerned that CRNPs with minimal mental health training will work in primary care settings in which they will inevitably see patients presenting with psychiatric disorders and that they will have minimal physician supervision or review of treatment decisions.

Second, psychiatrists know firsthand the difficulties of treating drug addictions and the costs these addictions impose on patients. We are quite concerned that allowing less well-trained practitioners to prescribe Schedule II drugs for longer periods of time while simultaneously weakening collaboration and reporting requirements is a major step in the wrong direction. Determining to use Schedule II drugs and how to manage them are important and complicated tasks. When less well-educated and trained personnel have that authority, the likelihood of medical error increases.

Specific Concerns

- The regulations should expressly include the forms of physician supervision, under whatever name, that are mandated under the statute. The omission of these requirements is glaring and is the proposed regulations' single most important error. Proposed deleted language under the definition of "direction" in the present regulations should be restored. As CRNP's scope of practice broadens, it is more important than ever that there be meaningful physician oversight and input. The statutory definition of "collaboration" should be added to §21.251 or alternatively § 21.285, which used to address "collaborative agreements" and has now been essentially gutted, should be restored.

- The collaborative agreement should be in writing and include the ways in which the statutory oversight requirements will be met. The definition of "collaborative agreement" in §21.25 should be modified to require it to be written and signed in all cases.

- The regulations should require that a collaborating physician be actively practicing in the CRNP's specific area of practice and have experience with the medications the CRNP is authorized to prescribe. These requirements are necessary if physician oversight is to be effective. The requirement regarding prescribing is in the current regulations, at §21.285(b) (4) and its proposed deletion is a serious error. Language establishing the "knowledge and experience requirement" should be added to new §21.287(5).

- CRNPs' expanded authority to prescribe Schedule II medications should be limited to a shorter period than proposed (30 days) for a new prescription. The 30 day period is acceptable for drug maintenance. It is also important that there be physician review of at least an initial prescription for Schedule II medications. §21.284(e) (1) should be modified to allow a 7-day dosage for initial therapy and a 30-day dosage for ongoing therapy approved by collaborating physician. CRNPs should not be permitted to issue "do not fill before" prescriptions for Schedule II drugs; these essentially result in dosages beyond those limitations. A restriction to that effect should be added to §21.284(e).

- CRNPs' expanded authority to prescribe Schedule III medications (an expansion from a 30 day to a 90 day supply, plus refill authority) is acceptable only if there is adequate physician oversight. Many drugs used in psychiatric disorders, primarily the class of drugs known as benzodiazepines) are Schedule IV drugs.

- Proposed deleted language, now in §21.287, establishing the maximum number (4) of CRNPs whom a physician may supervise should be restored. Meaningful supervision requires limits. At this point, only one CRNP has asked for an exemption to the current law. For that reason alone, we feel that this deletion is unnecessary.

- Patients should know in advance if their appointment is with a CRNP. Current §21.286(a) does that. It should be retained, not deleted.

Thank you for your consideration of our concerns and comments.

Sincerely,

Mary Anne Albaugh, MD
President

Kenneth M. Certa, MD
Co-Chairman, Government Relations Committee

cc: Mr. Arthur Coccodrilli, Chairman, IRRC
The Honorable P. Michael Sturla, Chairman, House Professional Licensure Committee
The Honorable Robert M. Tomlinson, Chairman, Senate Consumer Protection and Professional Licensure Committee