APRN Autonomy and Full Prescriptive Authority:

Washington State—A Case Study

By

Jeri Donahue

A manuscript submitted in partial fulfillment of the requirements for the degree of

Master of Nursing

December 2009

WASHINGTON STATE UNIVERSITY
College of Nursing
Acknowledgments

I would like to thank my committee chair, Louise Kaplan, for her resolute support and guidance, and her research partner, Marie-Annette Brown, for allowing me to use their data for this project. Also, thank you to Lorrie Dawson and Melody Rasmor for serving on my committee. I would also like to thank Holly Andrilla for her assistance and for tutoring me in statistics. Lastly, thanks to my husband, Dan, and daughter, Mari, for their patience and support. It was truly a joint endeavor!
To the Faculty of Washington State University:

The members of the Committee appointed to examine the non-thesis of JERI DONAHUE find it satisfactory and recommend that it be accepted.

Chair: Louise Kaplan, PhD, ARNP

Lorrie Dawson, PhD, ARNP

Melody Rasmor, MS, ARNP
APRN Autonomy and Full Prescriptive Authority:

Washington State—A Case Study

By Jeri Donahue, RN, BSN
Washington State University
December 2009

Chair: Louise Kaplan

Abstract

Prescriptive authority is an essential component of fully autonomous practice for advanced practice registered nurses (APRNs). In 2005 Washington State APRNs obtained complete prescriptive authority and became fully autonomous. This paper describes a survey that examined the prescribing patterns of Washington APRNs one year after the law passed. Results of the study revealed the extent to which responders were prescribing scheduled drugs before and after elimination of a Joint Practice Agreement (JPA), perceptions and circumstances contributing to varying levels of adoption of the new scope of practice, and sense of educational preparedness for full prescriptive authority. Also, themes emerged identifying factors that enhance or moderate autonomy for APRNs. Findings conclude that education and preparation for changes in scope of practice must be assured in order to achieve optimal levels of adoption. Washington State serves as a model for advancement of scope of practice among APRNs across the nation.
TABLE OF CONTENTS

LIST OF TABLES ............................................................................................................ iv

INTRODUCTION ............................................................................................................. 1

BACKGROUND OF STUDY ............................................................................................ 2

METHODS .................................................................................................................... 4

RESULTS ...................................................................................................................... 5
  Profile of Respondents ............................................................................................ 5
  Prescribing Practices ............................................................................................... 5
  Autonomy ................................................................................................................ 8

DISCUSSION ................................................................................................................ 9

CONCLUSION .............................................................................................................. 12

REFERENCES ............................................................................................................. 13

TABLES ....................................................................................................................... 15
LIST OF TABLES

Table 1—Education Level.................................................................16

Table 2—Prescribing of Schedule II-IV Drugs in Practice.............................17

Table 3—Patients Receiving More Schedule II-IV Drugs Post JPA Elimination.........18

Table 4—APRN Education Preparedness for Prescribing Schedule II-IV Drugs........19
Introduction

Attaining autonomy for advanced practice registered nurses (APRNs) has required unwavering diligence of nurse leaders and activists. Inherent in this endeavor, a conundrum exists which encumbers the process. Competence must be displayed to persuade regulators to broaden and strengthen scope of practice (SoP), but this would exceed existing legal limits (Safriet, 2002). Practitioner SoP is regulated state by state, which has resulted in considerable variation among the states nationwide (Pearson, 2009). Change in SoP is often slow and incremental and results from the efforts of APRNs who facilitate enactment of new laws (Phillips, 2009). Prescriptive authority is a fundamental element of professional autonomy and an essential component of providing comprehensive quality patient care (Kaplan & Brown, 2008). In 13 states and the District of Columbia, APRNs have full autonomous prescriptive authority (Phillips, 2009; Pearson, 2009).

Washington State APRNs have fully autonomous prescribing since a 2005 law removed the requirement for a joint practice agreement with a physician to prescribe schedule II-IV drugs (CS). Prior to the implementation of this law, only 60% of Washington APRNs had obtained prescriptive authority for CS (personal communication, V. Zandell, July 2005). This article describes how APRN prescribing practices changed after implementation of this law. It will also discuss the relationship of complete prescriptive authority with APRNs' overall sense of autonomy. This case study of Washington State APRNs serves as an exemplar for practitioners in other states who anticipate or have recently experienced a change in SoP.
Background of the Study

APRNs in Washington State were legally recognized in 1973 and obtained prescriptive authority for legend and schedule V substances in 1979. The lack of schedule II-IV prescriptive authority affected the ability of APRNs to provide comprehensive care to patients who often had to see a second provider, increasing the cost of care and the amount of time spent seeking care. APRNs sometimes resorted to quasi-legal methods of providing controlled substances to patients (Kaplan & Brown, 2004). For more than a decade, nurse leaders in Washington State lobbied for schedule II-IV substance prescriptive authority. Compromise legislation passed in 2000 granting schedule II-IV prescriptive authority with the requirement for a Joint Practice Agreement (JPA) with a physician. In 2005, the JPA was eliminated (RCW. 2005).

Kaplan and Brown and colleagues (2004, 2006) have conducted a longitudinal study of Washington State APRNs’ prescribing patterns prior to and after implementation of the laws granting schedule II-IV authority. Phase I of the study, conducted prior to enactment of II-IV prescriptive authority with the JPA, identified external and internal barriers to providing controlled substances. An example of an external barrier was the time and effort involved in obtaining a prescription for a controlled drug for a patient from a physician. An internal barrier was aversion to working with patients perceived to be “drug-seeking”.

In 2003, two years after implementation of II-IV prescriptive authority with a JPA another statewide survey was conducted. The main purposes of Phase 2 of the study were to determine whether prescribing with indirect physician involvement eliminated barriers to practice and whether the law itself created barriers to prescribing. Study results revealed that for many APRNs the law eliminated barriers to prescribing controlled substances.
although for some new barriers occurred. For example, not all APRNs were able to obtain a JPA and others had institutional requirements beyond the scope of the law such as passing a test before a physician was allowed to enter into a JPA. Many APRNs, both with and without II-IV prescriptive authority, reported not wanting to work with patients perceived to have drug-seeking behavior, an internal barrier also identified in Phase I (Kaplan, Brown, Andrilla, & Hart, 2006).

Phase III of the study was conducted utilizing focus group interviews and a survey of participants at continuing education conferences. The findings elucidated “the invisible nature of the transition process triggered by efforts to adopt new scope of practice laws... [and] the importance of understanding the effect of legislative change at the individual level (Kaplan & Brown, 2007, p.185)”. The implications identified were: “(a) [APRN]s need preparation for a new scope of practice long before legislation actually passes; (b) Policy makers need to recognize that patients benefit when [APRN]s are legally authorized to utilize their expertise; and (c) [APRN] faculty should socialize students to value full autonomy (Kaplan & Brown, 2007, p.185)”.

This article discusses Phase IV of the study, a statewide survey of Washington Advanced Practice Registered Nurses (excluding CRNAs), following the 2005 elimination of a requirement for the JPA with a physician and its subsequent impact on prescriptive practice. It describes the prescriptive authority status of respondents before and after elimination of the JPA, and analyzes reasons for the extent to which prescribing controlled substances was part of the APRN practice. Also, it describes the extent to which Washington APRNs feel fully autonomous and explores contributing factors.
Methods

This exploratory descriptive study used survey methodology. The study instrument, the Washington State 2006 ARNP Survey, was developed based on a review of the literature and results of two prior statewide surveys (Kaplan & Brown, 2004) (Kaplan, Brown, Andrilla, Hart. 2006). The 50 item instrument included 9 questions related to prescribing practices and two about autonomy. Other items not included in this analysis collected demographic information, educational background, income, clinical practice characteristics job satisfaction, and perspectives on the DNP.

A list of all APRNs licensed in Washington State was obtained from the Department of Health. After obtaining institutional review board approval, questionnaires were mailed to 2864 licensed NPs with addresses in the states of Washington, Oregon and Idaho to assure NPs who worked in Washington but lived in a neighboring state were included. Each NP received up to two mailings in an effort to obtain a high response rate. Questionnaires that were returned because of incorrect addresses were re-sent when address corrections were available. One hundred seventeen questionnaires were disqualified and 1803 returned for an adjusted response rate of 65%. Respondents were included in the study if they were practicing in Washington, yielding a sample 1488 APRNs. Percentages reported in the results section are based on the number of people who responded to that specific question. Certified registered nurse anesthetists (CRNAs) were surveyed separately and the data presented here does not include CRNAs.

Analysis of frequencies was conducted using SPSS. Statistical significance was explored utilizing t-tests and Chi-squares. Responses to the questions addressing sense of autonomy were analyzed to determine if the variables gender, setting, practice specialty,
provider age, and years in advanced practice nursing correlated with feeling autonomous. Content analysis was conducted for the open-ended questions soliciting ways in which practice has changed since elimination of the JPA.

Results

I. Profile of Respondents

The study respondents were 91% female with an average age of 49.4 years. The age range was from 24 years to 72 years with half over age 50. Ninety-three percent of the respondents were Caucasian and the highest educational attainment was primarily a master's degree (Table 1). The top four areas of employment were private office practice (43%), hospital outpatient unit (15%), community clinic (12%), and hospital inpatient unit (9%). The main areas of practice were adult health (35%), family practice (29%), OB-Gyn (21%), psych/mental health (16%), and pediatrics (13%). Responders could check all areas that applied.

II. Prescribing Practices

Respondents were asked a series of questions about prescriptive authority and their prescribing practices (Table 2). Ninety-nine percent of the respondents had prescriptive authority. Nearly all respondents (98%) were aware that as of July 2005 ARNPs with prescriptive authority could independently prescribe schedule II-IV medications. Drug Enforcement Administration registration is necessary to prescribe controlled substances, and 93% had individual or institutional registration. Respondents who did not have DEA registration (10%) were asked why and given the option to check all choices that applied. The four most frequently reported reasons were: Unwilling to pay cost; Do not want to write
for controlled drugs; Currently practice without controlled substances; and Current use of an institutional DEA number.

Nearly three quarters (72%) of study participants who had a JPA prior to its elimination in 2005 and were asked to describe the nature of the agreement. The majority (81%) were described as a ‘formality only’ with no restrictions. Another 16% reported that they did not have contact with the physician other than to set up the JPA. The two most frequently reported reason for not obtaining a JPA were that having it was not a high enough priorit, and preferring not to prescribe controlled substances (CS). Of note, 3% (n=46) were unwilling to prescribe under a joint practice agreement.

There were 212 participants who responded to an open ended question about whether they had a different perspective about not having obtained II-IV prescriptive authority prior to the elimination of the requirement for a JPA. Over three-quarters considered it had been the right decision at the time. Only 10 responded “I wish I had done it sooner” and 22 APRNs reported barriers that were beyond their control.

Prescribing CS was part of the clinical practice of 90% of the APRNs. Over half (57%) answered it was from a moderate to a great extent. Respondents who did not prescribe CS were asked to select from a list of reasons and choose all that applied. Just over one-third (38%) reported not wanting to prescribe controlled substances and a similar percentage reported having developed a practice that did not include schedule II-IV drugs (Table 2). Since the elimination of the JPA, the patients of 12% of respondents receive more schedule II-IV medications with about half (49%) noting the extent as a little more; 26% as somewhat more; and 25% as a moderate to great deal more (Table 3).
An open ended question asked to describe ways in which having independent prescriptive authority for all legend and controlled drugs changed practice. There were 195 (17%) respondents of which 21% reported there had been no change in their practice. Content analysis of the responses that reported change revealed two overall categorizes with two-thirds about change related to the patient's experience and the other one-third related to the practitioner's experience.

All comments about the patient experience identified that their practice changed positively with enhanced patient care including improved access to care, decreased redundancy and expense. Almost one-third (30%) of the patient experience comments, highlighted efficiency as a quality indicator. Nearly one-quarter (22%) specifically mentioned more available treatment for chronic pain patients and 15% referred to incorporating medical regimens for treatment of the ADHD patient population.

More than half (57%) of respondents whose comments reflected on the practitioner experience about change in practice since elimination of the JPA reported a greater sense of autonomy and that the law had aligned with NP capability. Eighteen referred to relief from direct day-to-day physician involvement that had required signatures for all schedule II-IV medications prescribed. Eight stated that the only change was elimination of the formality of the JPA. Five noted dissatisfaction with the dynamics of caring for more chronic pain patients.

In a typical week, ninety percent of the study participants do not make a prescribing decision to use a non-controlled substance because prescribing a specific schedule II-IV drug is outside their area of expertise. Of the 10% who had opted to use a non-controlled substance in lieu of a controlled one, this most often occurred one-time-per-week. Study
participants were asked how well their NP education prepared them for prescribing schedule II-IV medications. Almost one-quarter (22%) responded they were poorly prepared while in contrast one-quarter felt their NP education prepared them very or extremely well (Table 4). Analysis was conducted to determine if educational preparation correlated with the extent to which CS prescribing occurred. Twenty-nine percent of NPs who perceived they were poorly prepared by their NP education reported that patients received more schedule II-IV controlled substances (CS) since elimination of the JPA. Twenty percent of respondents who were somewhat well prepared indicated that patients received more CS. There was no overall increase in CS prescribing among those who were *moderately, very, and extremely well prepared*. In the group that stated *it was too long ago to recall* to what extent their ARNP education prepared them for prescribing CS, 20% are now prescribing more controlled substances.

**Autonomy**

The survey asked about the extent one’s sense of autonomy changed since ARNPs obtained fully autonomous prescriptive authority in 2005. One third (34%) reported it had not changed at all while one-quarter (23%) indicated a moderate to great deal of change. Respondents were asked, “Do you feel fully autonomous as an ARNP?” The vast majority (83%) did feel fully autonomous. There was no correlation between feeling fully autonomous and gender, age, years of experience, or years since completing ARNP education. Respondents who did not feel fully autonomous were asked to provide a text comment to explain why. Content analysis of the 239 responses revealed both external and internal barriers to full autonomy. External barriers included the imposition of institutional/organizational restrictions such as facility practice bylaws, policies, privilege
limitations, and "paternalistic determinations" by insurers. The dynamics of specialty practice was also a factor. For example, APRNs in emergency departments reported that documentation was reviewed and co-signed by physicians, and cardiac specialty practitioners stated their patient interactions were directed by cardiologists. Legal and regulatory constraints included NP inability to admit Medicare patients to home health, OB practitioners required to have an OB/GYN physician consultation agreement in place, and other restrictions imposed by the Department of Labor and Industries and Medicare. Hierarchical influences affected autonomy with the physician-as-employer relationship as a limiting force. This health care social structure also manifested as an internal barrier with 10% (n=24) of this group of respondents self-identifying as enjoying a "collaborative and team-player" approach to practice with some adding that no health professional was ever fully autonomous. Another small group (n=22) identified a lack of experience or confidence as the reason they were not fully autonomous. Sixteen respondents identified cultural mores and perceptions of consumers, other health-care-providers, and laypersons, as factors that affected their sense of autonomy.

Limitations

The lack of data about non-responders prevents identification of specific response biases. For example, nearly all respondents (98%) knew about the elimination of the JPA. This high level of awareness may reflect that respondents were more likely to be more professionally engaged than non-responders. The relatively high response rate bolsters confidence in the findings but caution is still warranted because non-respondents could
systematically differ in their attitudes and behavior from respondents regarding prescriptive authority.

Discussion

Results of this study reveal that prescribing controlled substances was a part of the clinical practice of the overwhelming majority (90%) of these Washington State APRNs. It is important to note that nearly all of the study APRNs eligible to prescribe CS in fact, do. In addition, the elimination of the joint practice agreement significantly increased the percentage of APRN’s prescribing CS. Prior to elimination of the JPA, state data indicated only 60% of eligible Washington APRNs had obtained prescriptive authority for CS. Among this survey’s respondents, 92% were able to prescribe II-IV CS. The JPA may have inhibited some APRNs from obtaining CS prescriptive authority.

This study also revealed that APRNs do not automatically adopt or change prescribing of controlled substances when a SoP change occurs. Nearly all respondents (98%) knew about the elimination of the JPA, demonstrating effective communication of the change. This high level of awareness may also reflect that respondents were more likely to be more professionally engaged than non-responders. Despite elimination of the requirement for a JPA, 8% percent of the study respondents did not have individual or institutional DEA registration required to prescribe scheduled drugs. This is consistent with a prior study of Washington ARNPs who did not prescribe controlled substances when the JPA was required (Kaplan & Brown. 2008).

For the majority of respondents, the JPA was either a formality or an arrangement with no subsequent contact with the physician. This indicates that most APRNs did not need
physician oversight or direct involvement in their practice. It suggests a high level of collegial practice among APRNs and physicians and raises the question as to why the state medical associations lobbied long and hard against fully autonomous practice when most physicians did not require prescribing restrictions in the JPA. This also provides evidence against the need for a JPA in other states when APRNs seek improvement in prescriptive authority.

Some respondents who had chosen not to obtain CS authority when a JPA was required indicated it was not a high enough priority. The respondents for whom not prescribing CS was the right decision at the time represent a group not engaged in change which occurs when transition to a new SoP change takes place (Kaplan & Brown. 2007). This study revealed that despite having a SoP that includes full prescriptive authority, only 90% of respondents prescribe CS. This is an important finding as it highlights the fact that changing the law to allow fully autonomous prescribing eliminates an external barrier but does not necessarily change APRN prescribing behavior. Many who reported not having a DEA number after elimination of the JPA did not want to pay the cost, did not want to write for controlled drugs, and had developed a practice without CS. These reasons represent internal factors that create barriers to fully autonomous practice. These internal barriers require different strategies to overcome than when working to eliminate external barriers such as restrictive laws (Kaplan & Brown. 2007).

Nearly all respondents who do prescribe CS felt confident in prescribing them and did not substitute use of a non-controlled drug. Nearly all respondents reported their patients had not received more CS since elimination of the JPA. This suggests that the JPA did not constrain APRN prescribing of CS.
Another noteworthy finding is that 22% reported their NP education poorly prepared them to prescribe schedule II-IV medications. This has important implications for educators who may want to review pharmacology course content to assure that there is both adequate and appropriate information about prescribing CS. APRNs who perceived they were poorly prepared by their NP education more often reported that patients received more CS since elimination of the JPA. This may reflect that as the practitioners prescribed more CS their level of self-confidence in doing so increased.

The elimination of the JPA did not have much of an impact on the sense of autonomy felt by nearly two-thirds of the study participants who indicated their sense of autonomy had not changed at all or very little. This seems to be consistent with 97% reporting that the JPA was a formality only or that there was no contact with the physician once the JPA was signed.

Only 83% of the study's participants felt fully autonomous. Despite the best practice laws in the country, 17% did not feel fully autonomous which raises the question as to what people regard as autonomy. It is also important that gender, age, years of experience, and years since APRN education were not factors that affected one's sense of autonomy. Open ended comments suggest that external and internal barriers can diminish the sense of autonomy experienced by APRNs despite state law that provides for fully autonomous practice.

Conclusion
Access to care has become increasingly challenging for the vast majority of the population. Health care reform that provides better access to more people will bring with it the need for more health care professionals who can provide primary and specialty care.
APRNs across the nation are poised to assume a greater role to fulfill this vital need. APRNs, as "autonomous professionals [who are well prepared with understanding of legal and political issues], will be more likely to impact and shape future healthcare policy [and provision] (Bahadori & Fitzpatrick. 2009. p. 518)".

Washington State serves as a model for other states by providing examples and methods for attaining the legal and regulatory foundations necessary to advance nurse practitioner SoP. Educators must assure that pharmacology courses appropriately prepare students for prescribing controlled substances as well as socialize APRN students to adopt prescribing controlled substances as part of their practice. In states where APRNs are not authorized to prescribe CS or where there is not autonomous CS prescribing, preparation in advance of laws changing will facilitate APRNs embracing and implementing changes in SoP (Kaplan & Brown, 2007). "It is not just in action but in thought that we create autonomy for ourselves" (Kaplan & Brown, 2006).
References


<table>
<thead>
<tr>
<th>Education Level</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Degree</td>
<td>2%</td>
</tr>
<tr>
<td>Diploma</td>
<td>2%</td>
</tr>
<tr>
<td>Baccalaureate-Nursing</td>
<td>5%</td>
</tr>
<tr>
<td>Masters-Nursing/non-Nursing</td>
<td>86%</td>
</tr>
<tr>
<td>Doctorate-Nursing</td>
<td>5%</td>
</tr>
</tbody>
</table>
### Table 2

Currently Prescribing Schedule II-V Drugs in Practice

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>N*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>89.5</td>
<td>1537</td>
</tr>
<tr>
<td><strong>To what extent?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Little</td>
<td>16.6</td>
<td>223</td>
</tr>
<tr>
<td>Some</td>
<td>26.4</td>
<td>355</td>
</tr>
<tr>
<td>Moderate Amount</td>
<td>31.3</td>
<td>422</td>
</tr>
<tr>
<td>Great Deal</td>
<td>25.8</td>
<td>347</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>10.5</td>
<td>156</td>
</tr>
<tr>
<td>Do not want to prescribe CS</td>
<td>37.8</td>
<td>59</td>
</tr>
<tr>
<td>Developed practice not including II-V</td>
<td>37.2</td>
<td>58</td>
</tr>
<tr>
<td>MD Writes</td>
<td>18.6</td>
<td>29</td>
</tr>
<tr>
<td>Unwilling to pay for DEA number</td>
<td>14.2</td>
<td>22</td>
</tr>
<tr>
<td>Practice setting does not allow</td>
<td>14.1</td>
<td>22</td>
</tr>
<tr>
<td>Lack expertise</td>
<td>10.9</td>
<td>17</td>
</tr>
<tr>
<td>Concern regarding skills</td>
<td>5.1</td>
<td>8</td>
</tr>
<tr>
<td>Employer created barriers</td>
<td>3.8</td>
<td>6</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>3.8</td>
<td>6</td>
</tr>
<tr>
<td>Another ARNP writes</td>
<td>2.6</td>
<td>4</td>
</tr>
<tr>
<td>Concern regarding discipline</td>
<td>1.3</td>
<td>2</td>
</tr>
</tbody>
</table>

*Total = 1647 responded to question

Note: Respondents could select multiple reasons
Table 3

<table>
<thead>
<tr>
<th>To what extent?</th>
<th>Percent</th>
<th>Number*</th>
</tr>
</thead>
<tbody>
<tr>
<td>A little more</td>
<td>48.7%</td>
<td>77</td>
</tr>
<tr>
<td>Somewhat more</td>
<td>25.9%</td>
<td>41</td>
</tr>
<tr>
<td>Moderate amount more</td>
<td>15.2%</td>
<td>24</td>
</tr>
<tr>
<td>A great deal more</td>
<td>10.1%</td>
<td>16</td>
</tr>
</tbody>
</table>

*Total N = 158
<table>
<thead>
<tr>
<th>Extent</th>
<th>Percent</th>
<th>Number*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorly</td>
<td>22.2%</td>
<td>313</td>
</tr>
<tr>
<td>Somewhat well</td>
<td>19.5%</td>
<td>275</td>
</tr>
<tr>
<td>Moderately well</td>
<td>24.5%</td>
<td>345</td>
</tr>
<tr>
<td>Very well</td>
<td>15.9%</td>
<td>224</td>
</tr>
<tr>
<td>Extremely well</td>
<td>9.1%</td>
<td>129</td>
</tr>
<tr>
<td>Too long ago to recall</td>
<td>8.8%</td>
<td>124</td>
</tr>
</tbody>
</table>

*Total N = 1410