

EXPANSION OF PRESCRIPTIVE AUTHORITY

Expansion of Prescriptive Authority for Missouri Advanced Practice Registered Nurses:

Would the Benefits Outweigh the Costs?

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Problem

Advanced practice registered nurses (APRNs) in Missouri achieved prescriptive authority through collaborative practice agreements in 1993, but this was possible only with the exclusion of controlled substances. A controlled substance is a drug which has significant potential for abuse due to its ability to produce physiological or psychological dependence. Controlled substances are classified into Schedules I through V according to their dependence and abuse potential; Schedule I has the highest risk and Schedule V the lowest. Schedule I is the only group that has no current medically accepted use (U. S. Food and Drug Administration, n.d.).

Since 2004 Missouri APRNs have been pursuing controlled substance prescriptive authority, but as yet, it has been without success. Legislative arguments have been made based on the qualifications of nurse practitioners and the importance of expanded prescriptive privileges to the delivery of appropriate, high quality health care to Missouri citizens. When questions of cost-benefit have come to the forefront, Missouri APRNs have been cautious and uncertain about the best way to address this issue. The purpose of this paper is to explore the cost-benefit of controlled substances prescriptive privileges for Missouri APRNs. Would the potential benefits of expansion of prescriptive authority outweigh the potential costs?

Background

The total net social benefit of a healthcare service, such as prescription of needed medications, is derived by subtracting the total social costs of the service from the total social benefits (Santerre & Neun, 2007, p. 51). Social cost-benefit is the most extensive approach to apply, because it takes into account costs and benefits to all of those affected including individual healthcare providers, health care organizations, patients and families, and society as a whole (Vincent, 2002).

Missouri is one of only three states which do not allow APRNs to prescribe any controlled substance. Thirty-nine states permit APRNs to prescribe medications from Schedules II through V (Pearson, 2007). Because many Missouri APRNs work in rural and urban underserved areas, they perceive such expansion of prescriptive authority as both improving patient access to care and providing health care in the most cost-effective manner to these underserved populations. Missouri APRNs also believe such expansion will provide benefits to their individual practice sites by making the most productive use of both APRN and physician time.

Over the past 4 years APRNs in Missouri have pursued expansion of their prescriptive authority to include controlled substances for these reasons. Up to the present time, such efforts have been stopped in the legislature by the organized medical community who argue potential costs to patient safety and quality of care. There are also the perceived costs to physicians of loss of control in the healthcare market and of increased competition from APRNs. These costs underlie the concern of the medical community, but are not openly discussed in legislative efforts.

What Currently Exists in Missouri

An APRN in Missouri may currently prescribe medications under a collaborative practice arrangement with one or more Missouri physicians. A collaborative practice arrangement may be a broadly written agreement allowing the APRN to prescribe any medication, except controlled substances, that is within both the APRN's and physician's scopes of practice. An APRN may administer or dispense a controlled substance under the "direction and supervision" of a collaborating physician who prescribes the drug for a specific patient, but may not "under any circumstances" prescribe a controlled substance (20 CSR 2200-4.200).

APRNs and their collaborating physicians currently must employ alternative methods for providing necessary controlled substance prescriptions to patients. When the APRN and collaborating physician practice at the same site, the APRN must locate the physician, request the prescription, and wait for the physician to write the prescription. This involves, at a minimum, additional time added to the patient visit and interruption of both providers' clinic flow. At times, it may also involve the physician stopping to evaluate the patient if that patient is unknown to the physician. In situations where the physician and APRN are not at the same site, the APRN must phone or fax the physician a request for the medication; the physician must then phone the prescription to the pharmacy, if that is allowed. For schedules that require written prescriptions, the prescription must either be delivered to the APRN's site, or the patient must go to the physician's site to pick it up. If the physician wishes to evaluate the patient, a new appointment must be made with the physician, and the prescription is further delayed.

Proposed Change in Policy/Law

The proposed policy would change the current law to allow APRNs in Missouri to prescribe controlled substances within a collaborative practice arrangement. The proposed law would not change the current requirement for a collaborative practice arrangement nor would it require APRNs or physicians to enter into collaborative arrangements that allow prescription of controlled substances. Those APRNs and physicians comfortable with the current arrangements could maintain the status quo. Where the collaborating partners believe that the current system is an impediment to patient care, the collaborative practice arrangements could be changed to permit expansion of APRN prescriptive privileges.

Pro and Con Arguments of the Proposed Change on Cost and Benefits

Costs: Arguments for and against the proposed change

The direct and indirect health care costs of maintaining the current system are considered high. Direct health care costs to health care providers include decreased clinic efficiency and decreased productivity of both APRNs and physician collaborators. Direct non-health care costs to the patient may include cost of visits to two providers instead of one, increased travel costs if the patient needs to travel to a second clinic site, and increased cost of medical care due to complications that may be caused by delayed treatment, under-treatment, or lack of treatment. Indirect costs to patients and families of the current system may include cost of lost time in lengthy patient visits and potential loss of work days or disability due to delay of treatment, under-treatment or lack of treatment (Missouri Nurses Association, 2007).

Arguments against the proposed change focus primarily on indirect costs to patients and their families from alleged decreased quality of care and a potential decline in patient safety leading to potential increases in poor health, injury, disability, or even loss of life. Direct medical costs may include loss of physician income and increased health care costs from increased competition with APRNs (Grumbach & Coffman, 1998), increased liability costs to physicians and APRNs, and increased potential for diversion of controlled medications (Gwin, 2007). In addition, increasing the total number of providers of controlled substance prescriptions may actually increase medical costs by increasing total services provided. Indirect medical costs may include decreased job satisfaction for physicians who feel forced to collaborate with APRNs on controlled substances.

Benefits: Arguments for and against the proposed change

While no cost-benefit studies on expansion of prescriptive privileges were found in the literature, labor cost savings have been found with increased use of nurse practitioners in both in hospital and primary care settings (Cowan, et al., 2006; Roblin, Howard, Becker, Adams, &

Roberts, 2004). It would be logical to assume that similar labor cost savings could occur with the improved clinic efficiency and provider productivity from this policy change. Direct and indirect benefits to patients and their families from more timely treatment of conditions requiring controlled substances should also occur with decreased clinic time, decreased visits and travel, improved health status, and decreased loss of work productivity.

Numerous studies have confirmed that APRNs provide high quality health care (Hooker & McCaig, 2001; Horrocks, Anderson, & Salisbury, 2002; Kinnersley et al., 2000; Lenz, Mundinger, Kane, Hopkins, & Lin, 2004; Mundinger et al., 2000; OTA, 1986); quality of care concerns should not truly be an issue. Concerns about increased drug diversion and costs of disciplinary investigations are not well founded either. A recent study of disciplinary action indicates that APRNs have a low incidence of disciplinary actions including problems with drug diversion or chemical impairment (Hudspeth, R., 2007).

Arguments against the proposed change primarily focus on the avoidance of the increased costs previously discussed. Benefits would include maintaining the current levels of patient safety and quality of care provided in current law, no increased physician liability, and no loss of physician income or control of the current healthcare market. Also there would be no increased government regulatory costs from having another provider group to monitor regarding controlled substances.

Recommendations

After analysis of the costs and benefits, it is recommended that the Missouri legislature should change the current law to allow expansion of APRN prescriptive authority in Missouri to include controlled substances. The evidence in the literature argues in favor of reduced costs and increased benefits to patients and the health care system from this change. Very little evidence is

found to support the arguments against this change. As previously cited, the vast majority of other states allow controlled substances prescriptive privileges for APRNs. It is reasonable to assume that if this policy in other states had caused the problems listed by those in opposition, there would be more evidence for their arguments found in the current literature. In fact, the current literature on APRN quality of care and safety refutes several of the opposition's arguments.

References

- Collaborative Practice Rule, 20 CSR 2200-4.200. Retrieved September 22, 2007 from <http://www.sos.mo.gov/adrules/csr/current/20csr/20c2200-4.pdf>
- Cowan, M. J., Shapiro, M., Hays, R. D., Afifi, A., Vazirani, S., Rodgers, C. R., et al. (2006). The effect of a multidisciplinary hospitalist/physician and advanced practice nurse collaboration on hospital costs. *The Journal of Nursing Administration*, 36 (2), 79 – 85.
- Grumbach, K., & Coffman, J. (1998). Physicians and nonphysician clinicians: complements or competitors? *Journal of the American Medical Association*, 280, 825 – 826.
- Gwin, J. (2007). Controlled substances prescriptive privileges for advanced practice registered nurses. Retrieved September 23, 2007 from http://www.missourinurses.org/programs/gov_affairs.html
- Hooker, R. S., & McCaig, L. F. (2001). Use of physician assistants and nurse practitioners in primary care, 1995-1999. *Health Affairs*, 20(4), 231 – 238.
- Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal*, 324, 819 – 823.
- Hudspeth, R. (2007). Survey of advanced practice registered nurses disciplinary action. *The Online Journal of Issues in Nursing*, 12 (2), Retrieved September 16, 2007 from <http://www.nursingworld.org/ojin>
- Kinnersley, P., Anderson, E., Parry, K., Clement, J., Archard, L., Turton, P. et al. (2000). Randomized controlled trial of nurse practitioner versus general practitioner care for patients requesting “same day” consultations in primary care. *British Medical Journal*, 320, 1043 – 1048.

- Lenz, E. R., Mundinger, M. O., Kane, R. L., Hopkins, S. C., & Lin, S. X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. *Medical Care Research and Review*, *61*, 332 – 351.
- Mundinger, M. O., Kane, R. L., Lenz, E. R., Totten, A. M., Tsai, W., Cleary, P. D, et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association*, *283*, 59 – 88. Retrieved March 4, 2006, from <http://proxy.mul.missouri.edu:2063/gwl/ovidweb.cgi>
- Missouri Nurses Association. (2007). Talking points: Current status for prescribing controlled substances. Retrieved September 23, 2007 from http://www.missourinurses.org/programs/gov_affairs.html
- Office of Technology Assessment. (1986). Chapter 2: Quality of care. *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis*. Retrieved May 9, 2006, from <http://www.wws.princeton.edu/ota/disk2/1986/8615/861504.PDF>
- Pearson, L. J. (2007). The Pearson report. *The American Journal for Nurse Practitioners*, *11*(2), 10 – 101.
- Roblin, D. W., Howard, D. H., Becker, E. R., Adams, E. K., & Roberts, M. H. (2004). Use of midlevel practitioners to achieve labor cost savings in the primary care practice of an MCO. *Health Services Research*, *39*, 607 – 625.
- Santerre, R. E., & Neun, S. P. (2007). *Health economics: Theories, insights, and industry studies* (4th ed.). Mason, OH: Thompson South-Western.
- U. S. Food and Drug Administration. (n.d.) *Controlled substances act: Part B – authority to control; standards and schedules*. Retrieved November 17, 2007, from <http://www.fda.gov/opacom/laws/cntrlsub/ctlsbtoc.htm>

Vincent, D. (2002). Using cost-analysis techniques to measure the value of nurse practitioner care. *International Nursing Review*, 49, 243 – 249.