Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

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Abstract

Purpose:
To determine barriers impacting Florida APRNs’ decision to prescribe controlled substances post statutory change that lifted restrictions on controlled substance prescribing. Based on the results, the primary investigator developed a toolkit to decrease these barriers.

Methods:
A 39-question survey was utilized to determine what factors influence Florida APRN schedule II-IV substance prescribing behaviors. This questionnaire was delivered online and in person to active, licensed APRNs who are members of various nurse practitioner organizations in Florida.

Results:
Reasons for APRN lack of controlled substance prescribing included practice setting restrictions, physicians writing these prescriptions, and a lack of desire to prescribe these medications. Fifty-five percent of respondents who completed the 3-hour CE course on controlled substances prescribing reported that it adequately prepared them to prescribe schedule II-IV medications, compared to 77% of individuals who took the 8-hour course. Prescriber confidence was significantly associated with protocol characteristics, graduate nurse practitioner programs, colleague support, knowledge, and the extent APRNs prescribe these medications. Respondents noted benefits to prescribing controlled substances that included more efficient patient care, increased autonomy, independent patient management, increased patient access to care, and relief of required physician signatures on all schedule II-IV substances.
Discussion:

Two years post statutory change, more than 80% of Florida APRNs are DEA registered prescribers of controlled substances. A majority of APRNs feel knowledgeable and comfortable prescribing these medications. Although House Bill 423 removed a barrier to controlled substance prescribing, additional barriers remain. Providing additional skills, reducing quantity limitations for schedule II medications, and decreasing DEA cost would help to reduce these barriers.

Conclusion:

It is imperative to address the identified needs of APRNs to support them in effectively prescribing schedule II-IV substances. Full practice authority may remove unnecessary protocols and quantity limitations for certain medications, further decreasing barriers for APRNs prescribing controlled substances. This ongoing project will be expanded to determine whether these findings are consistent among all Florida APRNs.
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After more than twenty years attempting to obtain prescriptive authority, House Bill 423 (HB 423), also known as the “Barbara Lumpkin Prescribing Act,” was passed in 2016. Prior to the passage of this bill, advanced practice registered nurses (APRNs) in Florida were only able to provide controlled substances under their collaborating physician’s name. However, this required APRNs and physicians to schedule time to discuss each patient and their condition. This can be time consuming for both the APRN and physician, time which could be spent seeing additional patients (Craig-Rodriguez, Gordon, Kaplan & Grubbs, 2017; Howell & Kaplan, 2015; Kaplan & Brown, 2004; Shilling & Hodnicki, 2015; Xue, Ye, Brewer & Spetz, 2016). Furthermore, this collaboration increases wait time for patients. The new legislation now allows APRNs and physician assistants (PAs) in Florida to prescribe schedule II through IV substances under their current supervisory protocols with physicians (The Florida Senate, 2016). An additional component of this bill requires APRNs to complete three hours of continuing education every two years and register with the Drug Enforcement Administration (DEA) to prescribe these substances (The Florida Senate, 2016). Examples of schedule II drugs include hydromorphone (Dilaudid), oxycodone (Oxycontin), and amphetamine (Adderall) (Drug Enforcement Administration [DEA], n.d.). Current legislation allows those APRNs who undergo the required continuing education and DEA registration to prescribe schedule II substances for a maximum of seven days. However, only psychiatric APRNs may prescribe psychiatric medications to patients younger than eighteen years old. Therefore, many nurse practitioners may not prescribe Adderall or similar substances for pediatric patients with attention deficit hyperactivity disorder (ADHD). Additionally, APRNs may only prescribe
Adderall for a maximum of seven days for adult patients. Examples of schedule III and IV substances include testosterone, Tylenol with codeine, alprazolam (Xanax), and tramadol (Ultram) (DEA, n.d.). These drugs are commonly prescribed when taking care of patients with low testosterone hormone levels, coughs, anxiety, and pain.

With the implementation of the Affordable Care Act (ACA), the number of insured patients increased by 30 million (Shilling & Hodnicki, 2015). As a result, more patients will be accessing primary care, increasing the need for primary care providers. In many cases, nurse practitioners will be caring for these patients. Pain is the number one complaint leading patients to seek medical care, and affects more patients than diabetes, cancer, and heart disease combined (National Institutes of Health, 2013). In fact, recent statistics note that at least 50 million Americans, roughly 11% of the population suffer from chronic pain (Dowell, Haegerich & Chou, 2016). APRNs will now be able to prescribe opioids for these patients. In addition, other commonly needed medications such as testosterone, cough suppressants (Tylenol with codeine), and anxiolytic medications (Xanax) are scheduled substances (DEA, n.d.). Nurse practitioners need to have the resources to adequately care for all patients, including those who need these types of medications. When barriers are removed from nurse practitioners, such as obtaining prescriptive authority, access to quality patient care increases (Kaplan, Brown & Donahue, 2010; Timmons, 2017; Xue et al., 2016).

Prior to House Bill 423, Craig-Rodriguez et al. (2017) identified internal and external barriers that may impact a Florida nurse practitioner’s decision to prescribe Schedule II-IV medications, including knowledge deficits and the supervisory protocol requirements with physicians. These barriers are still evident. Despite the passage of House Bill 423, all APRNs have not fully transitioned to prescribing controlled substances one-year post legislative change.
A similar lag in obtaining DEA registration was observed in a five-year longitudinal study of Washington APRNs performed by Kaplan & Brown (2007). These studies underscore the importance of educating and supporting APRNs in the months and years following the statutory change (Craig-Rodriguez et al., 2017; Kaplan & Brown, 2007). Although the passage of House Bill 423 eliminated one barrier for APRNs prescribing controlled substances, additional barriers remain (Craig-Rodriguez et al., 2017).

**Clinical Question**

This project was designed to answer two questions: Among Florida APRNs, what factors have influenced their controlled substance prescribing behaviors and how has prescribing controlled substances impacted their practice?

**Purpose of the Project and Aims**

The purpose of the project was to determine barriers impacting Florida APRNs’ decision to prescribe controlled substances and with the results, develop a policy toolkit with recommendations to decrease these barriers. The final goal of this project is to remove prescribing barriers and increase the number of nurse practitioners who prescribe controlled substances to ultimately improve the quality and lower the cost of care for patients.

Aim 1: To identify the internal and external barriers that impact Florida APRN controlled substance prescribing behaviors.

Aim 2: To assess perceived knowledge after continuing education for prescribing controlled substances.

Aim 3: To assess perceived confidence for prescribing controlled substances after continuing education.

Aim 4: To analyze how controlled substance prescribing has impacted APRN practice.
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Review of Literature

Overall, there is limited research that addresses the barriers nurse practitioners face in regard to controlled substance prescribing. Research on barriers to APRN prescribing has been conducted in Washington, Georgia, and Florida in the United States. Researchers in Washington completed a five-year longitudinal study focusing on the transition of APRNs to controlled substance prescribing. The investigators reported a transition from 22% of APRNs obtaining prescriptive authority after one-year post legislation to 90% after five years (Kaplan et al., 2010). Additionally, findings in this study identified the benefits that controlled substance prescribing had on APRNs and their patients. Researchers in Georgia identified barriers to APRN practice within the state, with a focus on prescribing barriers. The investigators reported that APRNs in Georgia were able to prescribe schedule III-V controlled substances under an agreement with a physician, or phone in schedule II-V medications under the physician’s name (Shilling & Hodnicki, 2015). One study was conducted in Florida prior to APRNs being granted prescriptive authority. Findings from this project identified perceived internal and external barriers that would limit APRNs from obtaining prescriptive authority, specifically focusing on knowledge of controlled substances (Craig-Rodriguez et al., 2017).

Internal Barriers

Several studies explore barriers APRNs face with controlled substance prescribing and report similar results. Perceived lack of knowledge and lack of confidence in prescribing have been identified throughout the literature as two of the largest barriers limiting APRNs in prescribing controlled substances (Craig-Rodriguez et al., 2017; Fong, Buckley, Cashin & Pont, 2017; Howell & Kaplan, 2015; Kaplan & Brown, 2004; Kaplan & Brown, 2007; Kaplan et al., 2010; Shilling & Hodnicki, 2015). This perceived lack of knowledge can be traced back to
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graduate nurse practitioner programs. Only 50-63% of APRNs rated their education as moderate to extreme in preparing them for prescribing schedule II-IV medications (Kaplan et al., 2010; Shilling & Hodnicki, 2015). Additionally, roughly 20% of APRNs reported being poorly prepared to write prescriptions for controlled substances (Kaplan et al., 2010; Craig-Rodriguez, et al. 2017). In Florida, only 37.2-42.4% of respondents reported feeling moderately to extremely knowledgeable in at least one of the five knowledge domains highlighted in the FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics (Craig-Rodriguez et al., 2017). In order to ensure Florida APRNs are adequately knowledgeable to prescribe Schedule II-IV medications, Florida APRNs must complete a minimum of three hours of continuing education about controlled substances. The three-hour continuing education, completed once every two years, aims to enhance knowledge and increase confidence for safe and effective prescribing of controlled substances (The Florida Senate, 2016).

In addition to perceived lack of knowledge and confidence, other internal barriers to controlled substance prescribing were reported in the literature. These include: APRNs unwillingness to prescribe controlled substances, currently practicing without controlled substances, having a physician or other provider write their prescriptions, concerns about drug-seeking behaviors, and concerns about potential disciplinary action (Howell & Kaplan, 2015; Kaplan & Brown, 2004; Kaplan & Brown, 2007; Kaplan et al., 2010; Shilling & Hodnicki, 2015). APRNs currently practicing without controlled substances do not take care of patients that need these medications. Instead, another provider able to prescribe controlled substances will take care of these patients (Kaplan & Brown, 2007; Kaplan et al., 2010). Some APRNs provide controlled substances to their patients through having another provider write the prescription for their patients (Kaplan & Brown, 2007; Shilling & Hodnicki, 2015). For
example, APRNs may refer their patients to another provider, such as their primary care provider, for controlled substances. A large concern for APRNs is dealing with patients perceived to have drug-seeking behaviors (Kaplan & Brown, 2004; Kaplan & Brown, 2007; Shilling & Hodnicki, 2015). Many patients directly ask for controlled substances, which causes concern for many providers that these patients may be drug-seeking. APRNs may feel more comfortable stating that they are not legally able to prescribe these medications in order to avoid these situations (Kaplan & Brown, 2007). Additionally, APRNs are worried about their license and the potential for disciplinary action (Howell & Kaplan, 2015; Kaplan & Brown, 2004; Kaplan & Brown, 2007; Shilling & Hodnicki, 2015).

**External Barriers**

External barriers include: supervisory relationship with physicians, cost of DEA registration, and institutional barriers (Craig-Rodriguez et al., 2017; Howell & Kaplan, 2015; Kaplan & Brown, 2004; Kaplan & Brown, 2007; Kaplan et al. 2010; Shilling & Hodnicki, 2015; Xue et al., 2016). In Florida, the types of medications or names of specific medications an APRN may prescribe must be listed in the supervisory physician protocol. Consulting the physician about each needed controlled substance prescription may limit the number of patients the nurse practitioner or physician may see, and subsequently increase patient visit time. Additionally, many supervisory physicians are not located at the practice site. Therefore, collaborating with these physicians may create unnecessary delays in providing medications to patients in a timely and considerate fashion. When collaborating physicians are not present, APRNs report a greater number of barriers and an increased use of legends drugs when a controlled substance is preferred (Kaplan & Brown, 2004). Another external barrier limiting APRN prescribing controlled substances is obtaining DEA registration (Kaplan & Brown, 2004).
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APRNs report the time and effort along with the cost of registration as barriers to practice (Kaplan & Brown, 2004; Kaplan et al., 2010; Shilling & Hodnicki, 2015). The DEA registration fee is currently $731 for a three-year time period (DEA, 2012; Kaplan, 2013). Therefore, the cost and effort required may delay an APRN from obtaining prescriptive authority, especially if they have alternate options to provide their patients with these needed medications. Additionally, APRNs may face institutional barriers from their workplace. These barriers include taking and passing a pharmacology test, requesting special privileges, mandatory chart reviews, and maintenance of drug logs (Kaplan & Brown, 2007). These additional barriers are time consuming and cumbersome.

Impact of Controlled Substance Prescribing on APRN Practice

Current evidence demonstrates many advantages for patients when APRNs obtain prescriptive authority. The main benefits are improved care delivery, increased access to care, and a decrease in wait times due to APRNs not having to collaborate with others to provide a prescription to their patients (Kaplan et al., 2010; Timmons, 2017; Xue et al., 2016). Additionally, there is also a decrease or no difference in patient costs (Timmons, 2017; Xue et al., 2016). APRNs noted greater ease when treating patients with chronic pain (Howell & Kaplan, 2015; Kaplan et al, 2010; Xue et al, 2016). Although many APRNs attempt consultation with pain specialists, APRNs have waited weeks to months for this consultation (Howell & Kaplan, 2015). Therefore, being able to prescribe controlled substances has allowed these providers to adequately care for their patients while waiting for a consultation.

In addition to benefits to patients, APRNs have also reported benefits to prescribing controlled substances. APRNs noted feeling a greater sense of autonomy and that prescribing controlled substances affirms the APRN’s knowledge and skills (Kaplan & Brown, 2007; Kaplan
Barriers and Implications of Controlled Substance Prescribing for Florida APRNs et al., 2010). These providers transitioned from asking other providers for medications that were medically necessary for their patients to being the ones able to prescribe those substances.

**Theoretical Framework**

The Transition Model, created by William Bridges, focuses on individuals’ transition after a change (Bridges, 2001; Kaplan & Brown, 2007). The Transition Model was chosen to focus on Florida nurse practitioners’ response to a change in scope of practice. This model is comprised of three phases: ending, neutral zone, and new beginning (Bridges, 2001; Kaplan & Brown, 2007). The first phase, ending, focuses on a loss of old values and perspectives (Bridges, 2001; Kaplan & Brown, 2007). Individuals in this phase are often resisting change. Nurse practitioners in the ending phase will most likely not want to prescribe controlled substances or may be comfortable with their current method of providing prescriptions to patients. In stage two, the neutral zone, people are stuck between old and new ways (Bridges, 2001; Kaplan & Brown, 2007). Nurse practitioners in this stage may worry that they lack the knowledge and confidence to prescribe controlled substances. Stage three, the new beginning, focuses on an acceptance of the change (Bridges, 2001; Kaplan & Brown, 2007). A majority of nurse practitioners in this stage will be prescribing schedule II-IV substances.

**Methodology and Implementation**

This evidence-based policy project utilized a survey sent online and in person to Florida APRNs to determine what factors influence their schedule II-IV substance prescribing behaviors. Additionally, this survey determined how prescribing schedule II-IV substances has impacted their practice.
Participants

Project participants were active, licensed nurse practitioners in the state of Florida. The investigator contacted various nurse practitioner organizations in the state, such as Florida Association of Nurse Practitioners (FLANP) and Florida Nurse Practitioner Network (FNPN), to obtain access to an email list of members. These participants were contacted by the state organization via email and were asked to participate in the survey. The investigator also attended APRN meetings, such as Treasure Coast Nurse Practitioners and FLANP annual conference, to inform members in person of this project in order to recruit additional participants. Participants were anticipated to have a Masters or Doctorate degree and be predominantly female.

Setting and Resources

The project setting was the online or paper survey. The survey was sent online to active Florida APRNs through nurse practitioner organizations in addition to being disseminated to nurse practitioners during organizational meetings. Resources included a modified “Prescribing Practices” survey developed by Kaplan and Brown (2004) and knowledge of statutory requirements for Florida nurse practitioners with regard to controlled substance prescribing. Additional technology support was needed to make the survey available online through Qualtrics. Furthermore, support from Florida nurse practitioner organizations was crucial to send the survey through their email list. The investigator attended local nurse practitioner meetings to obtain additional participants. The college statistician was also consulted regarding the collection of data and analysis of the results.
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Instruments/Tools

A survey was utilized to determine whether the specific prescribing behaviors and practices of Florida APRNs have changed as a result of the recent prescribing legislation and subsequent continuing education requirements. The survey tool has been adapted from a “Prescribing Practices” survey instrument created by Kaplan and Brown (2004). The survey had been revised to include specific statutory requirements for Florida APRNs, such as the collaborating physician protocol.

Implementation Plan

During the January 2018 to May 2018 time period, the investigator received and modified the “Prescribing Practices” survey adapted from Washington State researchers Kaplan and Brown. During the summer months of May 2018 through July 2018, the investigator and major professor submitted for college Institutional Review Board (IRB) approval. Additionally, the major professor and university statistician were utilized to ensure content validity of the modified survey. After the survey had been validated, the project purpose along with the survey was sent via email through various Florida nurse practitioner organizations. Follow up emails were sent two and four weeks after the initial email to continue recruiting participants. The survey identified barriers that impact Florida APRN prescribing behaviors of schedule II-IV substances, assessed perceived knowledge and confidence for prescribing schedule II-IV substances, and analyzed how prescribing schedule II-IV substances has impacted APRN practice. The survey consisted of a total of thirty-nine questions. The first twenty questions assessed the nurse practitioner’s background demographics and current practice environment. These sections were also utilized to assess current prescribing barriers. The Prescribing Practices section was composed of nineteen questions and assessed the barriers to practice, perceived
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knowledge and confidence in prescribing schedule II-IV substances, and how prescribing schedule II-IV substances has impacted their practice (See Appendix A). Two months after the survey was launched, data was collected and the investigator and statistician analyzed the data. Findings were summarized in a poster presentation, which was then disseminated through the Florida State University (FSU) college of nursing research symposium and FNPN annual state conference. These findings were also utilized to create a policy toolkit (See Appendix B).

**Human Subject and Informed Consent**

Following IRB approval through the academic institution, an introductory email was sent to potential participants via Florida nurse practitioner organizations. This introductory email included a statement on the purpose of the research project along with a link to begin the online survey. The primary investigator attended nurse practitioner organization meetings and educated these members on the purpose of the project. Informed consent from participants was obtained through use of a statement at the beginning of the survey so participants acknowledged that completing the survey implied that they have given informed consent. An example of informed consent statement is below. “Participants will be aware that they may stop the survey at any time for any reason. Participation in the survey is completely voluntary and the return of the questionnaire will be interpreted as a consent to participate. Participants may choose not to respond to any question. Responses will be anonymous and reported only in aggregate with the responses of other APRNs.”

**Data Analysis**

The project consisted of four aims: to identify the barriers that impact Florida APRN prescribing behaviors of schedule II-IV substances, to assess perceived knowledge after completing the continuing education requirement for prescribing controlled substances, to assess
APRN perceived confidence for prescribing schedule II-IV substances, and to analyze how prescribing schedule II-IV substances has impacted APRN practice. In order to identify barriers to APRN practice in Florida, participants were able to choose as many applicable answers from a categorical list of previously identified barriers, such as lack of knowledge, lack of confidence, unwillingness to prescribe controlled substances, currently practicing without controlled substances, having a physician or other provider write their prescriptions, concerns about drug-seeking behaviors, and concerns about potential disciplinary action. Participants also had the option to free text answers if they felt there were additional barriers that were not listed. Data was analyzed using descriptive statistics along with chi-square tests comparing these barriers with perceived confidence or knowledge.

The second aim assessed self-reported knowledge for prescribing controlled substances. Participants were able to report their perceived level of knowledge using a five-point Likert scale with values similar to strongly agree, agree, neutral, disagree, and strongly disagree. A chi-square test compared perceived knowledge level to the length of the continuing education course the nurse practitioner took. The chi-square test also tested for associations between perceived education level, specialty, years as an APRN, and frequency of prescribing or providing scheduled II-IV substances, etc.

The third aim assessed self-reported confidence level for prescribing schedule II-IV substances. Participants were able to report their perceived level of confidence using a five-point Likert scale with values similar to strongly agree, agree, neutral, disagree, and strongly disagree. A chi-square test compared perceived confidence level to the length of the continuing education course taken. The chi-square test also tested for associations between perceived
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The last aim analyzed the impact of prescribing schedule II-IV substances on APRN practice. Participants were asked to free text this answer in addition to being able to choose as many applicable answers from a categorical list of previously identified responses. Descriptive statistics was utilized to categorize the free text answers along with chi-square tests. The findings of this survey will be utilized to educate APRNs on the benefits of prescribing schedule II-IV substances, thus encouraging more APRNs in Florida to be able to prescribe these medications. Additionally, the investigator related this impact to patient care.

Results

Demographics

Of the 272 respondents, over half were female (87.1%), White American (85.3%), and over age 50 (61.4%). While 11.9% practiced in communities of 25,000 or less, 71.9% (n = 194) practiced in urban cities, and 16.3% practice in both. The two most frequently reported practice settings were private office practice (48.5%) and hospital-based care (36%). Over forty-six percent of respondents had more than 10 years of advanced practice experience. However, a large percentage (31.6%) had less than five years of experience. The median length of time as an APRN was 12.6 years. In terms of education, most (70.2%) respondents were master’s educated APRNs, while another 28.3% were doctorly prepared (see Table 1).

Thirty-nine percent of nurse practitioners note that physicians are nearly always present on site (defined as 76%-100% of the time) to discuss patient problems as they arise, while 38.4% of APRNs state a physician is seldom to never present. A majority of nurse practitioners (61.5%) have a physician supervisory agreement that is a formality without any restrictions.
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While thirteen percent of APRNs had no contact with their supervising physician other than to set up the supervisory protocol, some supervisory physicians have additional requirements. These further requirements may include periodic chart reviews (25.7%), a log of all controlled substances prescribed (2.6%), or further requirements (9.1%).

Table 1
Summary of participant demographics

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<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>%</th>
<th>Highest Level of Education</th>
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<th>%</th>
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<td>6-10 years</td>
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<td>11-20 years</td>
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<td>More than 20 years</td>
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<td>Yes</td>
<td>222</td>
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<td>African American</td>
<td>21</td>
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<tr>
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<td>5.9</td>
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<td>93</td>
<td>No</td>
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Findings/Results

Ninety-two percent (n = 252) of the respondents reported having prescriptive authority. In addition, 83.5% (n = 227) of respondents reported that prescribing schedule II-V medications was currently part of their individual practice. Eighty-two percent (n = 222) of the APRNs reported having a personal Drug Enforcement Administration (DEA) number necessary to prescribe these medications.

Nurse practitioners who had a personal DEA number were more likely to feel moderately to extremely knowledgeable (87.3%, n = 164) and confident (89.6%, n = 197) compared to individuals without a personal DEA number, 65.3% (n = 32) and 72.3% (n = 34) respectively. DEA registration was significantly associated with highest educational attainment (p = .005). Every respondent (n = 3) who was baccalaureate-prepared did not have a personal DEA number. Half of respondents age twenty to thirty did not have a personal DEA number. Of the respondents who had a personal DEA number, 65.9% were over the age of 51. Having a personal DEA number was significantly associated with whether prescribing controlled substances is part of their practice (p < .001) and how important they perceived being able to prescribe these medications (p < .001). Ninety-two percent of individuals who had a personal DEA number found it moderately to extremely important to prescribe controlled substances, compared to only forty-one percent of individuals without a DEA number. There was also a significant association between DEA registration and length of CE course (p < .001), clinical practice (p = .023), future employment (p = .010), and physician relationship (p = .010). There was no association between DEA registration and years of APRN practice, whether they work in an urban or rural community, how often the physician is on site, APRN educational
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preparation, perception of disciplinary action risk, colleague support, state opioid overprescribing reputation, certification, facility, and whether the APRN was full or part-time.

Identified Barriers

The survey asked study participants: “If prescribing schedule II-IV medications is not currently part of your practice, why not?” Responders were presented with a list of 11 prescribing barriers, with directions to select all the barriers that applied. The three most frequently reported barriers were: practice setting does not allow prescribing controlled substances (41%, n = 16), physician writes prescriptions for schedule II-V drugs (33.3%, n = 13), and do not want to prescribe any controlled substances (30.8%, n = 12) (see Table 2).

Table 2

<table>
<thead>
<tr>
<th>Rank Order of Prescribing Barriers Reported by Florida APRNs</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice setting does not allow prescribing controlled substances</td>
<td>16</td>
<td>41.0%</td>
</tr>
<tr>
<td>Physician writes prescriptions for schedule II-V drugs</td>
<td>13</td>
<td>33.3%</td>
</tr>
<tr>
<td>Do not want to prescribe any controlled substances</td>
<td>12</td>
<td>30.8%</td>
</tr>
<tr>
<td>Developed a practice that does not include schedule II-IV drugs</td>
<td>8</td>
<td>20.5%</td>
</tr>
<tr>
<td>Employer created barriers</td>
<td>7</td>
<td>17.9%</td>
</tr>
<tr>
<td>Unwilling to pay for a DEA number</td>
<td>5</td>
<td>12.8%</td>
</tr>
<tr>
<td>Lack the expertise to prescribe controlled substances</td>
<td>4</td>
<td>10.3%</td>
</tr>
<tr>
<td>Concerned about my skills for dealing with drug seeking behavior</td>
<td>2</td>
<td>5.1%</td>
</tr>
<tr>
<td>Concerned about the potential for disciplinary action</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>APRN writes prescriptions for schedule II-V drugs</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Ambivalent about prescribing controlled substances</td>
<td>1</td>
<td>2.6%</td>
</tr>
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</table>
Self-Reported Knowledge after Continuing Education

Florida nurse practitioners were asked, “How prepared do you feel for the use of controlled substances in managing your patients?” Their responses were: not at all (3.3%, n = 9), a little (1.9%, n = 5), somewhat (11.1%, n = 30), moderately (18.5%, n = 50), very (43%, n = 116), and extremely (22.2%, n = 60) prepared. Additionally, when APRNs were asked if the required continuing education course prepared them to prescribe controlled substances, the answers were: not at all (4.2%, n = 11), a little (9.5%, n = 25), somewhat (19%, n = 50), moderately (31.6%, n = 83), very (28.9%, n = 76), or extremely (6.8%, n = 18). There was a significant association between the length of continuing education course and how well the APRN felt that course prepared them (p = .005), overall knowledge (p < .001), and overall confidence (p < .001) (see Table 3). Additionally, 54.5% of respondents with a personal DEA number took a continuing education course longer than three hours, compared to 40% of those without a DEA number (p < .001).

Table 3
Continuing Education Effect on Knowledge and Confidence

<table>
<thead>
<tr>
<th>Length of Continuing Education</th>
<th>Knowledge due to Continuing Education</th>
<th>Overall Knowledge</th>
<th>Overall Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>50%</td>
<td>42.9%</td>
<td>50%</td>
</tr>
<tr>
<td>3 hours</td>
<td>54.8%</td>
<td>79.9%</td>
<td>77.4%</td>
</tr>
<tr>
<td>4 - 7 hours</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>8 hours</td>
<td>76.8%</td>
<td>87.4%</td>
<td>95.7%</td>
</tr>
<tr>
<td>More than 8 hours, multiple courses</td>
<td>83.3%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

There was a significant association between self-reported knowledge and age (p = .001), years as an APRN (p = .003), and how much support they experience from practice colleagues.
Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

(p < .001). Fifty-nine percent (n = 19) of APRNs age 31-40 feel moderately to extremely prepared to use controlled substances, compared to 83.4% (n = 5) age 20-30, 84.8% (n = 50) age 41-50, and 89.2% (n = 148) of APRNs over the age of 50. Self-reported knowledge increases as the number of years as an APRN increases. Similarly, knowledge generally increased as colleague support increased, except APRNs with “some” colleague support reported the highest preparedness. APRNs report that their nurse practitioner educational program prepared them to prescribe schedule II-IV medications: poorly (18.1%, n = 49), somewhat well (19.3%, n = 52), moderately well (20%, n = 54), very well (19.3%, n = 52), extremely well (13.7%, n = 37) or too long ago to recall (9.6%, n = 26). There was a significant association between how prepared APRNs feel in prescribing controlled medications and how well the APRNs nurse practitioner education prepared them to prescribe controlled substances (p < .001). Seventy-three percent (n = 36) of APRNs who rated their APRN educational program as poorly preparing them stated they felt moderately to extremely prepared to prescribe controlled substances, compared to 94.6% of individuals who rated their APRN educational program extremely well. Furthermore, self-reported knowledge was associated with having prescriptive authority (p < .001), having a personal DEA number (p < .001), if prescribing controlled substances is currently part of their practice (p < .001), and perceived importance of prescribing schedule II-IV medications (p < .001). Individuals who perceived having schedule II-IV prescriptive authority as “not at all” important reported the lowest preparedness (47%, n = 8) compared to 96% (n = 95) among those who think it is “extremely” important. There is a significant association between self-reported knowledge and clinical practice (p < .001), and what would help them prescribe controlled substances (p < .001). Individuals who felt “not at all” prepared reported wanting additional knowledge and skills on how to deal with “drug seeking” patients. Individuals who
felt “extremely” prepared reported decreasing DEA cost and removing or reducing protocol requirements would most helpful. There is an association between knowledge and the characteristics of their supervising physician protocol \((p = .026)\). APRNs felt most prepared if they paid a physician to set up a supervising physician protocol, and least prepared if their protocol required a log of all controlled substances or additional requirements. There was not a significant association between how prepared APRNs feel in prescribing controlled medications and APRN education level, how often a physician is on site, perception of disciplinary action, certification, facility, physician relationship, extent prescribing these medications is a part of the APRNs practice, or plans for future employment.

**Self-Reported Confidence**

In order to assess confidence level, participants were asked, “Overall, how comfortable do you feel in prescribing/providing controlled substances?” The respondents’ reported comfort levels were: not at all (2.6%, \(n = 7\)), a little (3%, \(n = 8\)), somewhat (7.9%, \(n = 21\)), moderately (21.3%, \(n = 57\)), very (45.7%, \(n = 122\)), or extremely (19.5%, \(n = 52\)). There was a statistically significant association between perceived confidence level and self-reported knowledge \((p < .001)\), the length of controlled substance continuing education course \((p < .001)\), and the extent prescribing these medications is a part of the APRNs practice \((p = .024)\). Furthermore, self-reported confidence was associated with having prescriptive authority \((p = .007)\), having a personal DEA number \((p < .001)\), whether prescribing controlled substances is currently part of their practice \((p < .001)\), and perceived importance of prescribing schedule II-IV medications \((p < .001)\). Individuals who perceived having schedule II-IV prescriptive authority as “not at all” important reported the lowest confidence (48%, \(n = 8\)) compared to 99% \((n = 98)\) among those who think it is “extremely” important. There was a statistically significant association
between perceived confidence level and how much support they experience from practice colleagues (p < .001), and how well their nurse practitioner program prepared them to write controlled medications (p < .001). Additionally, there was a significance between self-reported confidence level and plans for employment (p = .018) and type of protocol (p = .011).

Confidence level was reported highest with those in the process of looking for new employment, planning to open their own practice or move to a full practice authority state. Confidence was lowest among APRNs who would like to leave their current position but are unable to do so.

With regards to confidence and the type of protocol, confidence was highest among APRNs who paid a physician to set up their collaborating protocol and those who had no contact with their physician other than to set up the supervisory protocol. Confidence was lowest if their protocol required a log of all controlled substances or additional requirements. No association was found between confidence level and age, highest degree of APRN education, years practicing as an APRN, how often a physician is on site, perceived risk for disciplinary action, certification, clinical practice, facility, or physician relationship.

Impact of Prescribing Schedule II-IV Substances on APRN Practice

To identify the impact of prescribing schedule II-IV substances, the participants were asked to choose as many applicable answers from a categorical list of previously identified responses. The five most frequently reported answers were: more efficiently meets patients’ needs (67.5%), greater sense of autonomy (62.7%), ability to independently manage patients (54.5%), relief of required physician signatures on all schedule II-IV substances (54.1%), and increased access to care for patients (53.7%) (see Table 4). Participants were able to free text additional changes to their practice. One APRN stated that hospice patients receive “greater care and symptom relief;” another respondent stated that “pharmacist scrutiny has markedly
Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

increased;” and yet another wrote that it is “more time consuming with need to access EFORCSE for every [prescription] written.” One nurse practitioner wanted people to know the breadth of medications categorized as controlled substances. They stated “not all controlled drugs are narcotics (oxy[codone], opioid, etc.). Many controlled drugs are routine meds that [thousands] of people use- hormones (testosterone), cough-syrups, anxiety meds, insomnia meds.”

Table 4
Impact of Prescribing Schedule II-IV Substances on APRN Practice

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More efficiently meets patient’s needs</td>
<td>181</td>
<td>67.5%</td>
</tr>
<tr>
<td>Greater sense of autonomy</td>
<td>168</td>
<td>62.7%</td>
</tr>
<tr>
<td>Independently manage patients</td>
<td>146</td>
<td>54.5%</td>
</tr>
<tr>
<td>Relief of required physician signatures on all schedule II-IV substances</td>
<td>145</td>
<td>54.1%</td>
</tr>
<tr>
<td>Increased access to care for patients</td>
<td>144</td>
<td>53.7%</td>
</tr>
<tr>
<td>More time effective</td>
<td>135</td>
<td>50.4%</td>
</tr>
<tr>
<td>Affirms prescriber’s knowledge and skills</td>
<td>116</td>
<td>43.3%</td>
</tr>
<tr>
<td>Increased professional liability</td>
<td>97</td>
<td>36.2%</td>
</tr>
<tr>
<td>Caring for more chronic pain patients</td>
<td>45</td>
<td>16.8%</td>
</tr>
<tr>
<td>Decreased expense for patients</td>
<td>41</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

Discussion

Although perceived lack of knowledge and perceived lack of confidence in prescribing have been identified throughout the literature as two of the largest barriers limiting APRNs in prescribing controlled substances, a majority of Florida APRNs feel moderately to extremely knowledgeable (83.7%) and confident (86.5%) prescribing schedule II-IV substances two years post statutory change. This is a significant increase compared to Florida APRNs prior to HB 423 (Craig-Rodriguez et al, 2017). Both perceived knowledge and confidence were associated with how well their nurse practitioner educational program prepared them, the length of the controlled
substance continuing education course, level of colleague support, and characteristics of their supervising physician protocol. APRNs felt most prepared if they paid a physician to set up a supervising physician protocol, and least prepared if their protocol required a log of all controlled substances or additional requirements. Although this was an unexpected finding, APRNs who pay for a supervising physician protocol may identify as having an additional resource, or they may own their own practice, resulting in the increased level of perceived knowledge and confidence. Higher levels of perceived knowledge and confidence were associated with having prescriptive authority, having a personal DEA number, whether they are currently prescribing controlled substances, and increased perceived importance of prescribing schedule II-IV medications.

Self-reported knowledge can be traced back to graduate nurse practitioner programs. Kaplan and colleagues conducted a statewide survey of 1,488 Washington State APRNs in 2001. The authors revealed that although 50-63% of APRNs in Washington rated their education as moderate to extreme in preparing them for prescribing schedule II-IV medications, 22% of study respondents reported that their nurse practitioner education “poorly prepared them to prescribe Schedule II–IV medications” (Kaplan et al., 2010). Craig-Rodriguez and colleagues (2017) and Shilling & Hodnicki (2015) also reported a lack of educational preparation in nurse practitioner programs. Similar findings were noted in this project, as 53% of APRNs rated their education as moderate to extreme in preparing them for prescribing schedule II-IV medications and 18.1% of study respondents reported that their nurse practitioner education poorly prepared them to prescribe schedule II–IV medications.

Several studies stress the importance of educating APRNs throughout the transition following the statutory change of controlled substance prescribing (Craig-Rodriguez et al, 2017;
Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

Kaplan & Brown, 2007; Kaplan et al., 2010). Currently, more than 80% of respondents report having a personal DEA number, a stark contrast to 50% of Washington State APRNs two years post statutory change (Kaplan et al., 2010). These results suggest that Florida APRNs proactively prepared themselves for prescribing controlled substances in the months leading to HB 423 taking effect. Current Florida law requires continuing education on controlled substance prescribing for each biennial APRN license renewal regardless of whether they prescribe controlled substances. The three-hour continuing education course aims to enhance knowledge and increase confidence for safe and effective prescribing of controlled substances (The Florida Senate, 2016). Regardless of which continuing education course respondents completed, over half of respondents reported the required continuing education course moderately to extremely prepared them to prescribe controlled substances. However, continuing education courses longer than 3 hours were significantly associated with a greater level of overall confidence and self-reported knowledge. Although APRNs stated more positive benefits with taking a continuing education course longer than 3 hours, APRNs should enroll in the course that best meets their individual education needs.

Additional barriers to controlled substance prescribing were similar to findings in other states, which included: APRNs unwillingness to prescribe controlled substances, currently practicing without controlled substances, having a physician or other provider write their prescriptions, concerns about drug-seeking behaviors, concerns about potential disciplinary action, supervisory relationship with physicians, cost of DEA registration, and institutional barriers (Craig-Rodriguez et al., 2017; Howell & Kaplan, 2015; Kaplan & Brown, 2004; Kaplan & Brown, 2007; Kaplan et al. 2010; Shilling & Hodnicki, 2015; Xue et al., 2016). The three most frequently reported barriers for respondents not prescribing controlled substances were: the
practice setting does not allow prescribing controlled substances, the physician writes prescriptions for schedule II-V drugs, and APRNs do not want to prescribe any controlled substances.

Identified barriers may be described through the use of Bridges’ theory of transitions. APRNs in the first stage, ending, are often resisting change (Bridges, 2001; Kaplan & Brown, 2007). Nurse practitioners in this phase may not want to prescribe controlled substances or may be comfortable with their current method of providing prescriptions to patients. In stage two, the neutral zone, people are stuck between old and new ways (Bridges, 2001; Kaplan & Brown, 2007). Nurse practitioners in this stage are supported by the safety net and may be comfortable requesting physician co-signatures on prescriptions. In stage three, beginning again, external barriers may prevent APRNs from obtaining schedule II-IV prescriptive authority (Bridges, 2001; Kaplan & Brown, 2007). Some external barriers that prevent APRNs from obtaining a personal DEA number include: institutional barriers and current state laws and the required supervisory relationship with physicians.

Impact of Controlled Substance Prescribing on APRN Practice

There are many advantages for both patients and nurse practitioners when APRNs are able to prescribe controlled substances. Although respondents noted numerous benefits to prescribing controlled substances, the most common benefits include: more efficiently meets patients’ needs, greater sense of autonomy, independently manage patients, relief of required physician signatures on all schedule II-IV substances, and increased access to care for patients. These benefits were similar to previous research (Howell & Kaplan, 2015; Kaplan & Brown, 2007; Kaplan et al., 2010; Timmons, 2017; Xue et al., 2016).
These APRNs report benefits of prescribing these medications, however, barriers still remain. Respondents were asked what would help them in prescribing or providing controlled substances. The top two responses for individuals with a DEA number were providing skills on how to deal with “drug seeking” patients and removing quantity limitations for certain medications. While Florida APRNs proactively prepared themselves on controlled substance prescribing, more education is needed to improve knowledge, skills, and confidence regarding how to handle patients with drug seeking behaviors. A substantial percentage of individuals without a DEA number would like to decrease DEA registration cost. These recommendations would decrease barriers for Florida APRNs prescribing controlled substances.

**Implications of Results**

It is imperative to address the identified needs of APRNs to support them in effectively prescribing all schedule II-IV substances. The passage of House Bill 423 increased Florida APRNs scope of practice with regards to prescriptive authority. However, both internal barriers (lack of APRN program educational preparation) and external barriers (laws restricting APRN scope of practice) must be removed to increase patients’ access to healthcare. After analyzing and evaluating the survey results, the investigator developed a policy toolkit with recommendations to reduce identified barriers for Florida’s nurse practitioners in the transition to full prescribing authority of controlled substances (See Appendix B). Furthermore, identifying how prescribing schedule II-IV substances impacted APRN practice was utilized to educate APRNs on the benefits, thus encouraging more APRNs in Florida to be able to prescribe these medications.
Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

Education

It is imperative to address the ongoing educational needs of current and future APRNs to support them in the safe and effective prescribing of all schedule II-IV substances. Evidence-based preparation for prescribing scheduled medications should be included throughout all nurse practitioner educational programs. Continuing education courses aim to enhance knowledge, skills, and attitudes for prescribing controlled substances. A majority of APRNs in Florida would like additional skills on how to deal with “drug seeking” patients. It is recommended that the development of these skills be added to current continuing education courses.

Healthcare Policy

Nurse practitioners play a crucial role in United States healthcare. More than 270,000 APRNs are licensed to work in the U.S., however, the type of practice authority differs from state to state (AANP, 2019). Florida APRNs have ‘restricted’ practice. States that restrict APRNs’ ability to practice are associated with poorer patient health outcomes. In ‘restricted’ practice states, there are larger health care disparities, greater chronic disease burden, primary care shortages, higher costs of care, and a decrease in patient health rankings (AANP, 2018).

APRNs have full practice authority in nearly half of U.S. states. Full practice authority creates greater access to care, makes care delivery more efficient, and decreases costs. Full practice authority may remove unnecessary protocols and quantity limitations for certain medications, further decreasing barriers for APRNs prescribing controlled substances.

Research

This ongoing project will be expanded to determine whether these findings are consistent among larger groups of Florida APRNs. Additionally, future studies are recommended to

Commented [AC1]: Something more substantial here.
examine the impact of this transition as it relates to the future prescribing patterns of Florida’s APRNs.

**Limitations**

The largest limitation for this project is that it utilized a survey. As noted earlier, survey responses are subject to survey fatigue and self-selection bias, which may lead to low response rates. Additionally, there is a lack of information about survey non-respondents and individuals who are not a part of nurse practitioner organizations, limiting generalizability of the findings. Furthermore, difficulties were encountered with recruitment of participants. Two Florida nurse practitioner organizations were contacted and agreed to disseminate the questionnaire via email to their members. However, numerous miscellaneous emails were sent by the organizations during the recruitment period, and survey emails may have been overlooked. Therefore, this may have resulted in a lack of participants. Additionally, respondents may have interpreted some questions differently than intended by the investigator, potentially skewing results.

**Suggestions for Future Clinical Research**

These results are an interim report of project findings. The primary investigator intends to add an additional investigator in an effort to continue this project. Continuing this clinical project will focus on addressing the limitations noted in this project. The questionnaire will be sent to active, licensed APRNs including individuals that are and are not members of nurse practitioner organizations in an effort to increase the generalizability of findings. Additionally, increasing the amount of time the survey is available and attending further nurse practitioner organizational meetings may increase recruitment of participants.

Additionally, future research will assist in determining whether identified barriers have decreased over time and whether or not more APRNs are able to prescribe schedule II-IV
medications. Future research may also focus on determining the impact APRN prescribing practices has on patient care, wait time, and overall cost. Previous research showed APRN confidence was highest when educating and monitoring client responses to medications and lowest confidence with starting a new medication or altering medications prescribed by other healthcare professionals (Fong et al., 2017). Future research could address whether this is true for APRNs in Florida and whether current continuing education courses address this.
References


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Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

https://www.deadiversion.usdoj.gov/fed_regs/rules/2012/reg_csa_fees/registration_fees_f
act_sheet.pdf


Barriers and Implications of Controlled Substance Prescribing for Florida APRNs


2019 Florida APRN Survey

Nurse Practitioners’ Experiences With Prescribing or Providing Schedule II-IV Drugs

Please complete this survey if you have NOT already done so online.

Florida State University
Dear Advanced Practice Registered Nurse:

We are conducting research on APRNs’ experiences with prescribing or providing schedule II-IV controlled substances.

This questionnaire is a follow-up to our 2014 Florida Advanced Registered Nurse Practitioner Survey. The study explores professional, legal, educational and organizational factors that influence nurse practitioners’ experiences with prescribing or providing schedule II-IV controlled substances. We are asking for your participation in the study, regardless of whether you participated in the first survey.

The data from this study will be used to provide you and other APRNs with accurate information for decision-making related to schedule II-IV controlled substances. It will also be used to change the legal and regulatory environment as well as to improve nurse practitioner education. This information will be shared with advanced practice nurses in other states who can benefit from our experience in Florida. We may use the information obtained in this study in the future for two purposes: to compare Florida nurse practitioners with nurse practitioners in other states and to survey Florida APRNs to see if their experiences change over time.

Participation in the survey is completely voluntary and your return of the questionnaire will be interpreted as your consent to participate. You may choose to not respond to any question. Identifying information will not be collected to ensure confidentiality and anonymity. The data collected in this study will be kept confidential to the extent permitted by law. Collected data will be coded and de-identified through FSU’s Qualtrics survey software. Email and IP addresses will not be linked to survey responses. Only members of the research team will have access to data. The data you provide will only be used for the specific research purposes of this study. Responses will be anonymous and reported only in aggregate with the responses of other APRNs.

The questionnaire should take about 10 minutes to complete. If you have any questions or concerns, contact us by email at [lmw16b@my.fsu.edu] and [acraigrodriguez@fsu.edu] or call Lauren Weissing at 772-678-1745. You may also contact Florida State University Human Subjects office by email at [humansubjects@fsu.edu] or via phone at 850-644-7900. Please remember that we cannot guarantee the confidentiality of any information sent by e-mail.

We would be deeply grateful if you would take the time to complete our survey. Thank you for your support of advanced practice nursing!

Lauren Weissing BSN, RN
Doctorate of Nursing Practice Student
Florida State University

Alicia Craig-Rodriguez DNP, APRN
Associate Faculty, College of Nursing
Florida State University
Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

Section I — Background Information

1. What is your highest educational attainment?
   - Associate degree
   - Diploma
   - Baccalaureate – Nursing
   - Baccalaureate – Non-nursing
   - Master’s – Nursing
   - Master’s – Non-nursing
   - Doctorate – Nursing
   - Doctorate – Non-nursing

2. What type of educational program did you attend for your APRN preparation? Check all that apply.
   - Master’s
   - Post-master’s
   - Certificate
   - Physician assistant
   - On-the-job training
   - Other (please explain)

3. What year did you complete your initial APRN education?

4. What is your gender?
   - Female
   - Male

5. What is your age?

6. What is your race/ethnicity?
   - White
   - African-American
   - Asian
   - Native Alaskan/American Indian
   - Pacific Islander
   - Other

7. Are you Hispanic?
   - Yes
   - No

Section II — Current Practice

8. What are your areas of certification? Check all that apply.
   - Acute care
   - Adult
   - Family
   - Gerontology
   - Neonatal
   - Nurse anesthetist
   - Nurse midwife
   - Pediatric
   - Psych/mental health CNS
   - Psych/mental health NP
   - School/college health
   - Women’s health
   - Other (please specify)

9. How many total years have you practiced clinically as an APRN?

10. Approximately when do you plan to retire?
    - 2019
    - In 1-2 years
    - In 3-5 years
    - More than 10 years from now
    - Undecided

11. In a typical week, how many total hours do you work?
    - How many hours do you work in a position that requires you to be an APRN?
    - How many hours do you work in a position that does NOT require you to be an APRN?
12. In what type of facility do you practice? Check all that apply.

- Private office practice
- Community clinic
- Correctional facility
- Health department
- Health maintenance organization
- Home care agency
- Hospital-based inpatient unit
- Hospital-based outpatient clinic (not an ED)
- Hospital emergency department
- Hospital obstetrics
- Hospital operating room
- Hospital—other (please specify) ______________
- Long-term care facility
- Mental health center
- Military clinic/hospital
- Occupational/employee health clinic
- Planned Parenthood
- Rural health clinic
- School/college health service
- Surgery center
- Tribal health center/Indian Health Service
- Urgent care clinic
- Veterans Administration facility
- Other (please describe) ______________

13. Is the facility in which you practice rural or urban? Rural is defined as a community with less than 25,000 residents.

- Rural
- Urban
- Both

14. Check the term(s) below that best describe(s) your clinical practice. Check all that apply.

**PRIMARY CARE**
- Adult
- Family
- Geriatric
- Pediatric
- Women’s health*

**SPECIALTY CARE**
- Acute Care
- Cardiology
- Dermatology
- Emergency care
- Endocrine
- Gastroenterology
- Hospitalist
- Long-term care
- Midwifery
- Neonatal
- Neurology
- Ob-gyn/women’s health
- Oncology
- Orthopedics
- Pain management
- Psychiatry/mental health
- Rehabilitation
- Research
- Occupational health
- Urgent care
- Other (please describe) ______________

*Primary care for women

15. What percentage of your clinical practice is primary care? ______%

16. In a typical week, how many patients do you see? __________

PLEASE ANSWER THE FOLLOWING QUESTIONS BASED ON WHERE YOU PRACTICE THE MOST IF YOU HAVE MORE THAN ONE PRACTICE SITE.

17. How often is a physician present on site to discuss patient problems as they occur?

- Never (0% of the time)
- Seldom (1%-25% of the time)
- Sometimes (26%-50% of the time)
- Usually (51%-75% of the time)
- Nearly always (76%-100% of the time)

18. What type of relationship do you have with the physician(s) in your practice? Check all that apply.

- Equal colleagues/no hierarchy
- Hierarchical/supervisory in which I must accept his/her clinical decision about the patients I see
- No physician in my practice
- No physician on site
- S/he is the medical director who oversees all of our practice and I am accountable to the medical director, as are all other providers
- Other (please describe) ______________
19. Please describe the characteristics of the supervising physician protocol that you have. Check all apply.

☐ Formality only with no restrictions
☐ Had no contact with my collaborating physician other than to set up the collaborating protocol
☐ Paid a physician to set up a collaborating protocol
  Amount paid $__________
☐ Required a log of all controlled substances prescribed
  Was this enforced?  ☐ Yes  ☐ No
☐ Required periodic chart review by the collaborating physician
  Was this enforced?  ☐ Yes  ☐ No
☐ Collaborating protocol had additional requirements (please explain)

20. What are your plans for future employment? Check all that apply.

☐ Plan to remain in my current position for the foreseeable future
☐ Plan to begin looking for another position within the next year
☐ In the process of looking for new employment
☐ Would like to leave my current position but am unable to do so
☐ Plan to retire in the next year
☐ Other Please explain

Section III — Prescribing Practices

21. Do you have prescriptive authority?

☐ Yes  ☐ No  ➔ Why not?  ☐ In process of applying
  ☐ In process of meeting requirements
  ☐ MD writes all my prescriptions
  ☐ APRN writes all my prescriptions
  ☐ No meds used in my practice, e.g., therapist/analyst
  ☐ Other (please explain) ________________________________

22. Are you aware that as of 2017 APRNs with prescriptive authority can prescribe schedule II-V medications if they have a DEA number and a collaborating agreement with a physician?

☐ Yes  ☐ No

23. Do you currently have a personal DEA number?

☐ Yes  ➔ Why not? (Check all that apply.)
  ☐ In process of applying
  ☐ Have not yet applied but plan to do so
  ☐ Do not want to write for controlled drugs
  ☐ MD writes prescriptions for controlled
  ☐ APRN writes prescriptions for controlled
  ☐ Use an institutional DEA number
  ☐ Practice without controlled substances
  ☐ Practice without meds e.g.,
  ☐ Unwilling to pay the cost
  ☐ Other (please explain) ________________________________
24. Is prescribing schedule II-V medications currently part of your practice?
   ☐ Yes ➔ To what extent?
   ☐ Very little ☐ Some ☐ Moderate amount ☐ A great deal

   ☐ No ➔ Why not? Check all that apply.
   ☐ Do not want to prescribe any controlled substances
   ☐ Lack the expertise to prescribe controlled substances
   ☐ Concerned about my skills for dealing with drug seeking behavior
   ☐ Concerned about the potential for disciplinary action by state/federal regulators
   ☐ Developed a practice that does not include schedule II-V drugs
   ☐ Unwilling to pay for a DEA number
   ☐ MD writes prescriptions for schedule II-V drugs
   ☐ APRN writes prescriptions for schedule II-V drugs
   ☐ Employer created barriers to prescribing schedule II-V drugs
   ☐ Ambivalent about prescribing controlled substances (please explain)

   ☐ Practice setting does not allow prescribing controlled substances (please describe)______

25. Since APRNs have been able to prescribe controlled substances, do your patients receive more schedule II-IV medications?
   ☐ No
   ☐ Yes ➔ To what extent?
   ☐ A little more ☐ Somewhat more ☐ Moderate amount more ☐ A great deal more

   Please describe ways in which having prescriptive authority for all legend and controlled drugs changed
your practice: _______________________________________________________
________________________________________________________________________
________________________________________________________________________

26. In a typical week, how many times do you make a prescribing decision to use a non-controlled substance
because you feel prescribing a specific schedule II-V drug is outside your area of expertise?

   ________ Times per week

27. How well did your NP education prepare you to prescribe schedule II-IV medications?
   ☐ Poorly ☐ Somewhat well ☐ Moderately well ☐ Very well ☐ Extremely well ☐ Too long ago
to recall

28. In your opinion, what is the risk for disciplinary action by state or federal regulators when prescribing
controlled substances for chronic pain?
   ☐ None ☐ Very little ☐ Some ☐ Moderate amount ☐ A great deal ☐ Don’t know

29. In your opinion, what is the risk for disciplinary action by state or federal regulators when prescribing
controlled substances for acute pain?
   ☐ None ☐ Very little ☐ Some ☐ Moderate amount ☐ A great deal ☐ Don’t know

30. How much support do you experience from your practice colleagues to prescribe or provide schedule II-IV
controlled substances to patients, such as being able to ask questions or have a prescription written for the
patient?
   ☐ None ☐ Very little ☐ Some ☐ Moderate amount ☐ A great deal ☐ N/A Solo practice

31. What is it like to work with patients whom you perceive to have “drug seeking behaviors” compared to working
with patients who ask for care you perceive to be unnecessary such as lab tests, medications or referrals. Drug
seeking behavior is:
Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

32. How important is it for you to have Schedule II-IV prescriptive authority to prescribe these medications for your patients?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Very ☐ Extremely

33. Do you feel the reputation of Florida overprescribing controlled substances impacts your decision to prescribe controlled substances?
☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Very ☐ Extremely

34. How prepared do you feel for the use of controlled substances in managing your patients?
☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Very ☐ Extremely

35. What length of prescribing schedule II-IV substance continuing education course did you take?
☐ 3 hours ☐ 8 hours ☐ Other ____________________________

36. How well do you feel the continuing education course prepared you to prescribe controlled substances?
☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Very ☐ Extremely

37. Overall, how comfortable do you feel in prescribing/providing controlled substances?
☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Very ☐ Extremely

38. What would help you in prescribing or providing controlled substances? Check all that apply.
☐ Decreasing DEA cost
☐ Additional knowledge required
☐ Remove or reduce protocol requirements
☐ Provide skills on how to deal with “drug seeking” patients
☐ Reduce quantity limitations for certain medications
☐ Other (please explain) ____________________________

39. How has prescribing schedule II-IV controlled substances impacted your practice? Check all that apply.
☐ More efficiently meets patient needs
☐ Affirms prescriber’s knowledge and skills
☐ More time effective
☐ Increased access to care for patients
☐ Decreased expense for patients
☐ Independently manage patients
☐ Greater sense of autonomy
☐ Relief of required physician signatures on all schedule II-IV substances
☐ Increased professional liability
☐ Caring for more chronic pain patients
☐ Other (please explain) ____________________________

Thank you so much for completing this questionnaire!

PLEASE return the questionnaire in the enclosed postage paid envelope or send to:

APRN Survey c/o Lauren Weissing
Florida State University
With the implementation of the Affordable Care Act (ACA), the number of insured patients increased by thirty million (Shilling & Hodnicki, 2015). As a result, more patients will be accessing primary care, increasing the need for primary care providers. In many cases, nurse practitioners will be caring for these patients. House Bill 423 (HB 423), which passed in 2016, allows Advanced Practice Registered Nurses (APRNs) and physician assistants (PAs) in Florida, who undergo the required continuing education and Drug Enforcement Administration (DEA) registration to prescribe schedule II through IV substances under their current supervisory protocols with physicians. Nurse practitioners who complete these requirements are now able to prescribe schedule II medications, such as pain medication (Oxycontin) and attention deficit hyperactivity disorder (ADHD) medication (Adderall), for a maximum of seven days. Additionally, APRNs are able to prescribe other controlled medications that people commonly use, such as testosterone, cough syrup, and anxiolytics. Nurse practitioners need to be adequately prepared to care for all patients, including those who need these medications. When barriers are removed from nurse practitioners, such as obtaining prescriptive authority, access to quality patient care increases (Kaplan, Brown & Donahue, 2010; Timmons, 2017; Xue et al., 2016). While HB 423 has removed one barrier for APRNs prescribing controlled substances, additional barriers remain.

This year, one of the most critical legislative actions impacting advanced nursing practice in Florida involves an effort to achieve full practice authority (FPA). Currently, there are two bills introduced in the 2019 Legislative session, Senate Bill 972 and House Bill 821, that would allow APRNs to provide safe, cost-effective, quality health care to patients without physician
supervision and protocols (The Florida Senate, 2019). This toolkit includes senator contact information and three sample scripts to advance the cause of allowing nurse practitioners’ full practice authority.

In Florida, APRNs cannot practice to the full extent of their education and training. They require an agreement with a ‘supervising’ physician to practice and prescribe even basic medications, let alone controlled substances. This creates difficulties for patients. Consulting with physicians may limit the number of patients the nurse practitioner or physician may see, and subsequently increase patient visit time. However, in states with full practice authority, APRNs can care for all of their patients primary care needs. According to the American Association of Nurse Practitioners (AANP), full practice authority allows APRNs to “evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing” (AANP, 2018).

Current evidence demonstrates many advantages for patients when APRNs obtain prescriptive authority. The main benefits are improved care delivery, increased access to care, and a decrease in wait times due to APRNs not having to collaborate with others to provide a prescription to their patients (Kaplan et al., 2010; Timmons, 2017; Xue et al., 2016). Additionally, there is also a decrease or no difference in patient costs (Timmons, 2017; Xue et al., 2016). Studies reveal that while many APRNs refer patients to pain specialists, patients have waited weeks to months for this consultation/appointment (Howell & Kaplan, 2015). Therefore, prescribing controlled substances has allowed APRNs to adequately care for chronic pain patients until these patients can obtain an appointment with a pain specialist.
Across the nation, the requirements for nurse practitioner education, program accreditation and board certification are consistent with national standards (AANP, 2018). To become a nurse practitioner, one must hold a minimum of a bachelor’s degree in nursing, while most APRNs have at least a master’s degree and some have a doctoral (DNP- Doctor of Nursing Practice) degree. In addition to this advanced level of education, APRNs must be licensed as a registered nurse (RN), graduate from a nationally accredited graduate APRN program, and pass a national nurse practitioner board certification exam. Despite these national standards, there is inconsistency in how state laws authorize and license APRN practice.

February through April, 2019, two hundred seventy-two nurse practitioners completed a survey assessing barriers and implications of controlled substance prescribing on Florida APRN practice. These APRNs are members of various Florida nurse practitioner organizations, such as Florida Association of Nurse Practitioners (FLANP) and Florida Nurse Practitioner Network (FNPN). Based on survey findings, respondent recommendations for decreasing barriers for prescribing or providing controlled substances include:

- Providing education and skills regarding how to deal with “drug seeking” patients (47.7%)
- Removing quantity limitations for certain medications (42.4%)
- Decreasing DEA cost (40.5%)
- Removing or reducing protocol requirements (39.4%)
- Providing ongoing training to improve current knowledge level (26.9%)

**Advocating for Full Practice Authority**

Nurse practitioners play a crucial role in United States healthcare. More than 270,000 APRNs are licensed to work in the U.S., however, the type of practice authority differs based on the state the nurse practitioner is practicing in (AANP, 2019). In Florida, their
authority is considered ‘restricted.’ The AANP describes ‘restricted’ practice as: “state practice and licensure laws restrict the ability of APRNs to engage in at least one element of APRN practice. State law requires career-long supervision, delegation or team management by another health provider in order for the [nurse practitioner] to provide patient care” (AANP, 2018).

States that restrict APRNs’ ability to practice are associated with poorer patient health outcomes. In ‘restricted’ practice states, there are larger health care disparities, greater chronic disease burden, primary care shortages, higher costs of care, and a decrease in patient health rankings (AANP, 2018).

APRNs have full practice authority in nearly half of U.S. states. Full practice authority creates greater access to care, makes care delivery more efficient, and decreases costs. With the introduction of SB 972 and HB 821, now is the time to advocate for nurse practitioners in Florida to practice to the full extent of their knowledge and training. One way to accomplish this is by having nurse practitioners, nurse practitioner students, and the general public write letters to senators and representatives asking them to support SB 972 and HB 821. A list of Florida U.S. senators and representatives is provided below with addresses, phone numbers, and further contact information. Sample letter scripts follow.

**Florida Senators**

Rick Scott - (R - FL)

716 Hart Senate Office Building Washington DC 20510
(202) 224-5274
Contact: [www.rickscott.senate.gov/contact_rick](http://www.rickscott.senate.gov/contact_rick)

Marco Rubio – (R – FL)

284 Russell Senate Office Building Washington DC 20510
(202) 224-3041
Barriers and Implications of Controlled Substance Prescribing for Florida APRNs

Contact: www.rubio.senate.gov/public/index.cfm/contact

Florida Representatives

A list of state representatives by district may be obtained from https://www.govtrack.us/congress/members/FL#representatives along with contact information.

Sample Letter Scripts for Reaching out to U.S. Senators and Representatives

Anyone can advocate for APRN full practice authority. Below are sample letters for nurse practitioners, nurse practitioner students, and the general public to use when writing to their U.S. senator or representative, adapted from the American Association of Nurse Practitioners (AANP, 2017).

Script 1 – Nurse Practitioners:

Dear [Senator/Representative’s name]:

With the implementation of the Affordable Care Act (ACA), the number of insured patients increased by 30 million. As a result, more patients are accessing primary care, increasing the need for primary care providers. There are more than 270,000 nurse practitioners who are already licensed and able to care for these patients.

In our state, nurse practitioners work under ‘restricted’ practice, meaning that they need an agreement with a collaborating physician to practice and prescribe even basic medications. This creates difficulties for patients. Even though APRNs have proven that they have the education and training to provide quality patient care while keeping costs down, they are still unable to practice utilizing their full capabilities. Currently, there are two bills, SB 972 and HB 821, that would allow APRNs to provide care to patients without physician supervision and protocols. Please support these bills and the expansion of APRN practice, under the sole authority of the Florida board of nursing.

Thank you.
Script 2 – Nurse Practitioner Students:

Dear [Senator/Representative’s name]:

As a nurse practitioner student attending [name of school, if desired], specializing in [name of field], I have a vested interest in providing optimal patient care. With the implementation of the Affordable Care Act (ACA), more patients are accessing primary care, increasing the need for primary care providers. It is evident there is a physician shortage in this country, and many people wait for weeks to see a primary care provider or specialist. For these reasons, I am a proponent of allowing APRNs in Florida full practice authority.

There are more than 270,000 licensed nurse practitioners who work in the U.S. and are able to care for these patients. However, nurse practitioners have restricted practice authority in this state. Even though nurse practitioners have proven that they have the education and training to provide quality patient care while keeping costs down, they are still unable to practice utilizing their full capabilities. As a future nurse practitioner, I ask you to support SB 972 and HB 821, and full practice authority for APRNs in Florida.

Thank you.

[Your signature]

Script 3 – General Public:

Dear [Senator/Representative’s name]:

One of the most important issues for people today is the shortage of accessible health care providers. It is evident there is a physician shortage in this country. That is why I am thankful for nurse practitioners. There are more than 270,000 nurse practitioners across the
country who provide excellent healthcare and help offset this shortage. APRNs have full practice authority in almost half of U.S. states, but not in Florida.

Many states allow nurse practitioners to fully evaluate and treat patients, by ordering and interpreting tests; and prescribing medications. This is not true in Florida, where nurse practitioners have ‘restricted’ practice. Even though APRNs have proven that they have the education and training to provide quality patient care while keeping costs down, they are still unable to practice utilizing their full capabilities. Please support change in our state and provide better access to quality healthcare for people like me.

Thank you.

[Your signature]