The Advanced Practice Registered Nurse as a Prescriber
What Do APRN Prescribers Need to Understand?

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Today’s health care transformations herald unprecedented opportunities for advanced practice registered nurses (APRNs) to provide and model patient-centered, evidence-based health care. As APRNs across the country secure fully autonomous practice, they must also seize the opportunity to become pacesetters for ethical and responsible prescribing. The vast majority of APRNs (nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists) work with prescription medications on a daily basis. Many are unable to imagine a practice that does not, in some way, include the ability to prescribe, provide, and/or manage medications for at least some of their patients. A goal of most APRNs, however, is utilization of a wide range of healing therapies in the process of patient-centered care. This may include, but is not focused solely on medications. Health promotion and disease prevention continue to be a hallmark of APRN practice.

At the same time, as the demand for prescriptive medications increases, prescriptive authority becomes an even more vital component of APRN practice. The number of prescriptions increased 39% between 1999 and 2009 from 2.8 billion to 3.9 billion. During this same time period, the U.S. population grew only 9% (Kaiser Family Foundation, 2010). In order to meet the prescribing needs of patients, APRNs must have unencumbered and fully autonomous prescriptive authority and practice.

Practice in today’s complex, fast-paced healthcare delivery system in which there is a constant barrage of information can be
overwhelming. Selection and monitoring of medication appropriate for patients is only one aspect of the complex process of prescribing. This book serves as an easily accessible reference to guide practicing APRNs through these challenges and supplement pharmacotherapeutic knowledge about specific medications. APRN students can also benefit from the content of this book. Standards for APRN programs specify a pharmacotherapeutic course as well as analysis of the APRN role (National Organization of Nurse Practitioner Faculties [NONPF], 2010). Educators barely have time to teach the essential knowledge about pharmacokinetics, pharmacodynamics, and evidence-based drug treatment recommendations. There is little time available in most pharmacology courses for in-depth discussion of the APRN’s role as a prescriber. The information included in this book has been compiled by experts in their areas. Each author has used her particular wisdom and creativity to synthesize and organize key ideas on a wide variety of subjects. These include:

- What it means to be a prescriber
- The many facets of the prescriber role
- The legal, regulatory, and ethical responsibilities of APRNs who prescribe medications
- Patient–APRN collaboration to reach patient-centered medication decisions
- Dealing with difficult clinical situations
- Pharmaceutical industry influences on prescriber decisions
- Cultural competencies to promote patient-centered prescribing.

THE JOURNEY OF APRN PRESCRIPTIVE AUTHORITY
For decades, APRNs have invested innumerable hours in lobbying and regulatory work to advance APRN practice. They have solidified the APRN role, strengthened the foundation for APRN education, and expanded the knowledge base for expert practice. APRNs in Idaho were the first to be authorized to prescribe medication in 1971, though it took 6 years for rules to be written and prescriptive authority to be implemented. Most APRNs have now been granted prescriptive authority in all states. APRNs have repeatedly demonstrated that they provide effective, high-quality care, including prescribing medications (Ingersoll, 2009; Newhouse et al., 2011).
Nonetheless, APRNs in nearly three-quarters of the states confront prescribing barriers on a daily basis. These barriers include requirements for supervision or collaboration, restrictions on prescribing controlled substances, and limitations on the type and quantity of medications that can be prescribed.

As a consequence of prescribing barriers, many APRNs are unable to practice to the full extent of their educational preparation, knowledge, and abilities. This negatively affects patient care and the healthcare system overall. Practice constraints handicap the APRN who is unable to fulfill roles in outpatient and inpatient settings. These restrictions continue despite an increased demand for primary, specialty and acute care providers, and the expansion of “patient-centered healthcare homes.” APRNs are in more demand as work hours for medical residents have been limited and shortages of providers to work with the underserved and those living in rural areas increase. Successful implementation of healthcare reforms in the years to come requires APRNs to be full partners with other health professionals. One of the key recommendations from the Institute of Medicine’s (2010) report, “The Future of Nursing: Leading Change, Advancing Health,” emphasizes the need to remove barriers to allow nurses to practice to the full extent of their education and expertise.

**Washington State as an exemplar**

A legislature must pass a bill to enable any changes in the scope of practice for ARPNs. The law typically cannot be implemented until the Board of Nursing adopts rules that specify the intent of the law. Scope of practice changes can take months to years to finalize. The history of APRN prescribing in Washington State begins with a 1977 law that authorized advanced practice nurses to prescribe legend drugs (medications requiring a prescription). However, dispensing medications and prescribing controlled substances were prohibited. The Board of Nursing then wrote rules that authorized APRNs to prescribe Schedule V drugs in 1982 and dispensing was added in 1983. It was not until 2000, after more than a decade of lobbying, that APRNs in Washington State obtained Schedule II–IV prescriptive authority.

This long-sought authority came with a price. For the first time since APRN practice was authorized by the legislature in 1973,
some type of physician involvement was mandated. APRNs who wanted II–IV prescriptive authority were required to obtain a Joint Practice Agreement (JPA) with a physician. Slowly over the next 4 years many APRNs began obtaining this type of prescriptive authority. However, until the JPA was removed, over one-third of APRNs did not obtain II–IV prescriptive authority. This contradicted the expectation of APRN leaders in the state that nearly all APRNs would want the legal ability to prescribe controlled substances even if it was only utilized occasionally. We conducted research in Washington State to understand this unexpected phenomenon (Kaplan & Brown, 2004, 2007, 2009; Kaplan, Brown, Andrilla, & Hart, 2006; Kaplan, Brown, & Donohue, 2010).

The findings of our research serve as a basis of understanding how APRNs may or may not transition to fully autonomous prescriptive authority and practice when provided the opportunity. It also offers lessons learned about the need to prepare APRNs for a major transition in scope of practice. Change may cause concern for some who have adapted to the status quo, even if prescribing barriers limited their ability to practice. Many of these findings are discussed in Chapter 3 on prescribing barriers. They will enhance your understanding about APRN prescribing practice, the consequences of limiting APRN practice, and the poorly understood experience of scope of practice change. It is not surprising, however, that APRNs respond to change with the natural ambivalence that accompanies most change processes.

OVERVIEW OF CHAPTERS
Chapter 2 guides the reader through an analysis of the role and responsibilities of the APRN as a prescriber. The ability to independently prescribe medications symbolizes the legitimacy of APRNs. The public often perceives the prescribing role as what defines an APRN. This chapter includes an overview of the development of the APRN role and prescriptive authority, the essential nature of autonomy, and the process of transition to the prescribing role. The chapter emphasizes the shift from prescribing medication based on professional preference and tradition to rational prescribing and evidence-based practice as strategies for achieving quality patient-centered care.

With all of the factors that influence the transition of the APRN to becoming a prescriber, there is an understandable degree of uncer-
tainty and concern about prescribing. Challenges about the transition from a role that requires administration of medications and prescribed treatments as a registered nurse to manager of care and prescriber as an APRN are delineated. Change can be a professionally invigorating challenge rather than a distressing situation. It is understandable, however, that many role transitions are characterized by uncertainty along with the excitement and promise of change.

Chapter 3 highlights the multitude of challenges and opportunities that APRNs confront when prescribing medication. Laws, regulations, policies, as well as the attitudes of other health professionals often limit prescribing. These are considered external barriers to an APRN’s adoption of the prescribing role. Internal barriers also can diminish an APRN’s interest in fully autonomous practice and can be overlooked when analyzing barriers to APRN prescribing. Internal barriers are invisible or unacknowledged factors within the individual APRN, including personal characteristics such as conflict avoidance or the “need to be liked.” Strategies to overcome internal and external prescribing barriers are offered as a way to generate enthusiasm among APRNs for facilitating change.

Chapter 4 discusses the characteristic clinical challenges inherent in prescribing controlled substances and the strategies to address them. The use of deliberate, concrete approaches to prescribing controlled substances is a key strategy to build prescribing expertise. Topics discussed range from “universal precautions” for use with the prescription of controlled substances and the assessment and management of patients with chronic noncancer pain, to clinical guidelines, consensus statements, and practice standards for the identification of a patient who is a substance abuser. The author offers online resources, examples of useful documentation, and a comprehensive reference list to further hone skill building. Accurate definitions of terms related to drug use or misuse and their application provide a rationale for creating more skillful communication with patients around complex and sensitive issues.

Chapter 5 coaches APRNs to deal with difficult and often complex clinical situations that are inherent in human relationships and professional interactions, even among experienced and dedicated APRNs. These situations often create anxiety and may even generate anger when the APRN feels ill-prepared to deal with them. The basic tenet is that these are not problem patients but
situations for which the APRN needs more knowledge, skill, and insight from self-reflection. Examples of these situations include dealing with patients who are or appear to be seeking controlled substances, are angry, request inappropriate care such as antibiotics for a viral infection, and who violate boundaries. One goal of the discussion is to enhance understanding of why these difficult situations develop and how they can impact patient-centered care. Specific strategies to identify difficult situations, respond to them appropriately, and build competence as a supportive and courageous APRN prescriber are discussed.

Chapter 6 describes pharmaceutical marketing and its influence on APRN prescribing. There are nationwide efforts to counter drug company influence on providers and healthcare organizations that in many instances have normalized this influence. Pharmaceutical drug promotion is directed at all prescribers through activities such as drug detailing, advertising in journals, and educational offerings. The United States is the only country besides New Zealand where direct-to-consumer advertising of drugs is allowed. Consumers are targeted by advertising on the Internet, television, and in print media.

Increased APRN awareness of drug company activities may assist in understanding the direct and indirect methods used to influence providers and consumers. Continued promotional activities to APRNs and lack of regulatory constraints must be balanced with heightened level of APRN awareness, vigilance, and ethical considerations among APRNs to assure cost-effective, evidence-based prescribing.

Chapter 7 details the laws, regulations, and professional issues that affect prescribing. These include state laws, board of nursing rules, and interprofessional constraints. Fully autonomous prescribing is contrasted with examples of restricted prescribing authority. Restrictions include the requirement for physician supervision, the need to use formularies, and the lack of authority to prescribe controlled substances.

The APRN Consensus Model was developed over several years of dialogue and negotiation by representatives of education, state boards of nursing, and professional practice organizations. Discussion of the consensus model highlights the need for standardized regulation that achieves fully autonomous practice with full prescriptive authority and universal adoption of the term
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APRN. This chapter can assist APRNs across the nation to visualize and positively anticipate their future practice and prescribing.

In Chapter 8 a series of case exemplars convey important legal information for APRNs. This includes prescribing authority based on state law, federal laws on prescribing controlled substances, and the standard of care for prescribing varying classes of drugs. These exemplars highlight the role of Boards of Nursing, malpractice attorneys when a lawsuit is filed, the Drug Enforcement Administration, and government auditors who monitor nursing facilities. The purpose of this chapter is to help APRNs become savvy prescribers and avoid missteps during their career.

Chapter 9 focuses on the role of cultural competence in prescribing medications. Factors such as biological variation, race, ethnicity, primary language, literacy, socioeconomics, disabilities, and religious beliefs need to be considered by the APRN. Discussion of ethnopharmacology highlights the effect of race and ethnicity on the responses to medication, drug absorption, metabolism, distribution, and excretion. Concepts about immigration, acculturation, and assimilation that influence health beliefs and behavior will enable APRNs to understand the multiple strategies necessary for prescribing in a culturally appropriate manner.

CONCLUSION
Ultimately, this book is more than a guide and reference for building and enhancing prescribing expertise. It honors the work of APRNs who use prescriptive authority to provide comprehensive quality care. The book is a tribute to the countless number of APRNs who have worked tirelessly for fully autonomous prescriptive authority. Toward that end, we hope the book is an inspiration to students. You are the next generation of APRNs on whom we depend to join in the efforts to obtain fully autonomous prescriptive authority nationwide. We look forward to the day this is achieved.

REFERENCES


