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Walden University

College of Health Sciences

This is to certify that the doctoral study by

Dorothy Were

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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2014

Abstract

Advanced Nurses' Perspectives on the Drug Addiction Treatment Act, 13 Years Later

by

Dorothy L. Were, FNP-BC

MSN, Coppin State University, 2009

BSN, Coppin State University, 2005

Project Submitted in Partial Fulfilment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2014

Abstract

The United States experiences opioid addiction at epidemic levels. In 2012, the National Institute of Drug Abuse reported that 23.1 million Americans were in need of addiction treatment services, although only 2.5 million were enrolled in treatment. Following an amendment to the Drug Addiction Treatment Act of 2000 (Public Law 106-310), advanced practice nurses were qualified as providers who could bridge the healthcare gap in treatment access. The purpose of this project was to determine the interest of advanced practice nurses in (a) prescribing buprenorphine and (b) establishing guidelines that would allow them to do so. This quantitative project used a 10-question Internet-based survey with a convenience sample of 95 nurses (recruited online) who were currently practicing in advanced nursing roles. Social media platforms, including Facebook, were used to recruit participants. The survey included questions about expanding the scope of practice in addiction treatment and establishing guidelines that would allow nursing knowledge and expertise to be used in outpatient opiate addiction treatment. Critical social theory and Kingdon's theory of policy analysis were applied to support the project. The Survey Monkey data analysis tool was used to generate descriptive statistics, which demonstrated respondents' support for an expanded scope of practice. If the recommendations of this project are adopted by national legislation, increased accessibility to addiction treatment services will save millions of dollars in justice system, healthcare system, employment, and societal costs. Nursing policy advocates nationally can apply these results to support efforts to expand scope of practice to include prescribing buprenorphine

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Dedication

This dissertation project is dedicated to the friendship and memory of my sister "Madamsi" as she was fondly known to us. She passed on at a tender age 22, leaving behind a promising future and beautiful memories. She was a second year university student at the time of her death. Your spirit lives with us. You were a loving and encouraging sister who lived life to its fullest. It was through her that I met my husband Fred and the father of my two children Fred and Evelyn. Your constant strength and faith gave me an appreciation for the meaning and importance of friendship/family. You lived your life well always reassuring our parents of a bright beautiful future. We miss you every day, may you continue to rest in glory till we meet again.

Acknowledgments

I would like to thank my family who encouraged me throughout this process, especially my children Fred and Evelyne. I also wish to thank my parents whom despite being thousands of miles away constantly kept track of my progress while encouraging me.

A special thank you to my committee chair Dr. Sue Ellen Bell who persevered with me as my advisor and guided me through the planning and writing of my dissertation. Not to forget my dissertation committee members Dr. Camilla Jaekel and Dr. Tracy Wright of Walden University. The inspiration for doing the study came from the experiences and knowledge I acquired from my preceptor Dr. Purcell G. Bailey, Jr. Thank you to all my classmates at Walden University and the DNP program for your support. A special thank you to the Advanced Practice Nurses who were kind enough to respond to my survey, many of whom just saw the post on Facebook and stood up to be counted. I thank you so much.

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Section 1: Overview of the Evidence-Based Project

Introduction

In 2014, the United States healthcare system introduced the Affordable Care Act (ACA), which mandated healthcare coverage for millions of Americans (Manchikanti & Hirsch, 2012). The introduction of ACA has seen an influx of over 4 million newly insured patients into a system that is already experiencing a shortage of primary care providers. One proposed solution to cope with the predicted shortage of primary care providers is allowing already practicing advanced practice nurses (APNs) to practice to the maximum extent of their education (Bodenheimer & Hoangmai, 2010). The Children's Health Act of 2000 allowed APNs to practice within a very limited scope, which varies from state to state. Despite their advanced education, APNs' scope of practice has been limited by many old healthcare policies that have not changed over the years to match the advancement in APN roles (Pohl et al., 2010).

The Robert Wood Johnson Foundation (RWJF; 2012) identified the fact that APNs have been confined to strict clinical barriers guarded by the American Medical Association (AMA). The AMA justifies these barriers as a patient safety measure.

Medical boards and legislators continue to enact scope of practice barriers for APNs (RWJF, 2012). Many states have instituted MD/APN collaborative agreements. These agreements ensure that every practicing APN is either directly or indirectly supervised by a licensed physician to ensure patient safety. Nursing leaders and advocates have taken the lead in challenging these clinical barriers, citing the need to utilize APNs fully (RWJF, 2012). The Institute of Medicine (IOM; 2010) also sees the need for nurses to "practice to full extent of

of their education and training" (AACN, 2006, para. 6). Policy makers and Congress have remained silent on the clinical boundary and scope of practice issues, having enacted some of the policies that are the barriers to practice. A specific policy that will be addressed in this project is the Drug Addiction Treatment Act 2000 (DATA 2000), which has barred NPs from prescribing buprenorphine, the only Federal Drug Administration (FDA) medication approved for the treatment of opioid addiction in outpatient settings House Resolution 4365(DATA 2000).

This DNP project is based on the American Association of Colleges of Nursing (AACN) Essentials of Doctoral Education for Advanced Nursing Practice, Item 5, called Health Care Policy for Advocacy in Health Care (AACN, 2006). The AACN (2006) has identified the need for nurses to engage in creating a healthcare system that meets the needs of the consumer through policy development and policy change. Nurses need to be involved actively in political lobbying and activism for policy development and change. The DNP-prepared nurse has the ability and education to evaluate, design, influence, and implement health care policies—in short, to lead the policy change process (AACN, 2006).. DNP graduates are prepared to identify healthcare needs and lobby for changing policies that perpetuate social injustice and inequality in health care (AANC, 2006). A combination of systems thinking and social justice principles enhance the need to identify NPs' perceptions about prescribing narcotic medications for all their patients—a policy that is in need of examination and possible future amendment. Critical social theory and Kingdon's theory of policy analysis supported the project and the policy analysis approach.

Statement of the Project Problem and Target Population

The problem in this project is the lack of access to care and treatment for patients with opiate abuse problems. The health promotion and disease prevention issue is opioid addiction and abuse. The purpose of objective SA-8.1 Healthy People 2020 (HP2020) is to "increase the proportion of persons who need illicit drug treatment and receive specialty treatment for abuse or dependence in the past year" (HHS, 2010, p. 12). This objective is aimed at improving access to treatment for persons with substance abuse problem. The targeted population is anyone over the age of 12 years involved in illicit opioid drug use. Data from the NIDA(2012) showed a steady increase in people who needed addiction treatment, indicating that a total of 23.1 million Americans (8.9%) need addiction treatment but only 2.5 million (1%) are currently enrolled in addiction treatment. .The number of people who enrolled in the program increased only slightly from 16% in 2008 to 18.8% in 2011(HHS, 2010). The ACA is intended to improve access to care and will likely further increase patient need for enrollment in drug abuse programs. APNs should be able to prescribe buprenorphine without limitations if the U.S. is to meet the HP2020 target (HHS, 2010).

Background

The Office of National Drug Control Policy (2011) reported that substance abuse is currently an epidemic in the United States. Irresponsible use of illicit and prescription drugs has resulted in many deaths and hospitalizations costing billions of healthcare dollars. Substance abuse impacts individual users, their families, and the community as a whole due to lost productivity of these individuals and justice system costs. The National Institute of Drug Abuse (NIDA, 2011) estimated that approximately 95% of active substance abusers are in denial or unaware of their problem. "Of those who recognize their problem, 273,000 have

made an unsuccessful effort to obtain treatment." HP2020 stressed the necessity of improving access to treatment for substance abuse and other health disorders.

In 2006, the American Academy of Nurse Practitioners (AANP) published a position paper documenting the quality of NP practice. The paper outlined the progress that APNs have made over time in training and knowledge. It encouraged APNs to maximize their education and healthcare knowledge while helping to bridge the primary care gap. AANP's efforts to advance and broaden APNs' scope of practice have sparked several professional debates between nurses and other professional colleges. Nevertheless, these efforts have set in motion a change process that will advance nursing as a profession.

Drug Addiction Treatment Act 2000

Title XXXV, Section 3502 of the Children's Health Act of 2000 (The Children's Health Act of 2000) permits only physicians who meet certain qualifications to treat opioid addiction with Schedule III, IV, and V narcotic medications. APNs are prohibited from prescribing these drugs. DATA 2000, which is at the federal level, prohibits NPs from prescribing Subutex and Suboxone (buprenorphine), which are Schedule III, IV, or V medications; while in some states with in the United States (http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment), the laws allow APNs to prescribe Schedule III, IV or V medications. Since the state law is contradictory to the federal law, state legislatures have been forced to specify that only "qualified physicians" are allowed to prescribe buprenorphine. This provides accommodation for the federal policy prohibiting APNs from prescribing Subutex and Suboxone (Cunningham et al., 2007). This has led to questions about the rationale, purpose, and validity of the federal legislation. Currently, there are over 100,000 NPs who are authorized at the state level to prescribe Schedule III drugs/ medications, such as oxycodone

and OxyContin, which may cause addiction; but they are prohibited by federal law from prescribing medication in the same class that can be used to treat opioid addiction, such as buprenorphine.

APN Scope of Practice and Prescriptive Authority

The APN scope of practice allows for patient health assessment, disease diagnosis and treatment, health education, preventive healthcare, research, prescriptive authority, and much more (Sheer & Wong, 2008). APNs have played a crucial role in meeting provider shortages in the rural and underserved areas (Agency for Healthcare Research and Quality, 2012). However, states have shown disparity in the legal autonomy of APNs to practice and to prescribe. The National Council of State Boards of Nursing introduced the consensus model aimed at helping states achieve a uniform APNs' scope of practice and independent prescribing. This model has been adopted by several states and remains in the legislative process in other states. The prescriptive authority of APNs varies greatly from state to state; partly because of the practice environment which varies from state to state (AACN, 2006).

APNs' narcotic prescriptive authority varies in each state according to the schedule of the drug, with some states allowing wider prescriptive scope than others. Florida and Alabama allow APNs to prescribe limited selection of controlled medications only, 19 other states allow APNs to prescribe Schedule II to IV drugs, while 10 additional states allow APNs prescriptive authority for Schedule III and IV controlled substances (AANP, year). This variation is questionable as the level of educational preparation for APNs is either the same or comparable across states and is regulated nationally through program accreditation. Buprenorphine, which is the only FDA approved medication for the treatment of opioid addiction, within the primary care setting.

APN Education

APNs have strived to attain the highest level of education for the sake of their career. The AACN (2012) recommended the DNP as the terminal degree for APNs, beginning in 2015. This has been an issue for a national discussion among healthcare professionals but with the increasing numbers of DNP-prepared nurses, the profession is well poised to align education and clinical practice with other doctorally-prepared colleagues in healthcare.

Political Environment

The political environment in the United States has some impact on determining the APN scope of practice through policy writing and implementation. The Agency for Healthcare Research and Quality (2012) acknowledged that, with the current primary care provider shortages, especially in light of healthcare reform coverage expansion in 2014, a review of the state laws in reference to APN scope of practice is a way to increase primary care's ability to absorb new patients as well as offer addiction treatment services. A recent National Governors Association report (2012) encouraged states to consider liberalizing the state scopes of practice. This would allow APNs more autonomy to practice and meet the current shortage of primary care services. APNs authority ability to practice more broadly will likely take considerable advocacy efforts to attain accomplish independent or wider scope of practice for APNs due to the variable scope of practice in each state (Agency for Healthcare Research and Quality, 2012). However, DATA 2000 remains a legislative act, which unless changed, will not allow APNs to be able to treat patients appropriately with opioid addiction. There is currently no documented rationale for DATA 2000 although the American Medical Association (AMA) has openly opposed the integration of APNs in opiate addiction treatment as prescribers.

Mission Statement, Goals, and Objectives

Stakeholders are individuals or organizations that have a vested interest in the project and will directly influence the project outcome. In the planning process, it is important to identify and establish stakeholders who align with the project purpose. The opposing stakeholders may likely cause unnecessary anxiety and confusion although their opinion and rationale are welcome to provide input for the project.

In expanding the role of APNs in addiction treatment, the stakeholders must be people who have a passion for addiction work and are or have been affected by addiction. Because addiction affects the whole community, there is a need to involve stakeholders such as community leaders, church leaders, law enforcement officials, local public policy makers, and patients/ families affected by addiction. Stakeholders play an important role in planning meetings, community surveys, and community assessments. They also help by sharing their opinions, acting as community liaisons, lobbying for policy change, and educating the community on the need for change. As stakeholders, community leaders, church leaders, law enforcement officials, NP organizations, legislative representatives, and patient representatives can assist in the development of this DNP project's mission, goals and objectives so that they are in line with the community need and readiness for the change.

As part of the DNP project, information was gathered that will facilitate amendment of the statute (DATA 2000), which has favored physicians over NPs in the prescription of buprenorphine. While this project will likely receive support from the community and law enforcement officials who are eager to increase addiction services and decrease addiction-related consequences, the project will likely meet resistance from physicians and their professional organizations. The end product of the project will be a set of guidelines that would allow APNs

to qualify to prescribe buprenorphine, guidelines that can be presented to the federal legislators for review and adaptation in order to amend DATA 2000. Feedback on these guidelines from practicing APNs and nursing professional organizations will be vital in this effort.

Purpose of the Project

The purpose of the project was to describe APNs' (a) perceptions of current federal legislation (DATA 2000) restricting prescriptive authority associated with buprenorphine for outpatient opioid addiction treatment, (b) opinions regarding the qualifications of APN education and expertise needed for prescribing buprenorphine, (c) feedback on author-developed guidelines that would qualify APNs to prescribe buprenorphine, and (d) personal interest in prescribing buprenorphine. The outcomes of the project, when achieved, will increase accessibility to opioid addiction treatment services through effective utilization of APNs as prescribers.

Project Goal

There is a need to expand addiction treatment services. NIDA (2012) that addiction id currently costing the United States over 484 billion dollars annually with only a fraction of substance abusers enrolled in treatment. APNs are well situated to bridge the gap. The goal of this project was to gather information that will provide evidence for, and facilitate the amendment of, DATA 2000; the ultimate goal is to advance the role of APNs by expanding their scope of practice to allow them to provide safe, timely, and cost-effective treatment of opioid addiction within the office practice setting.

Objectives

1. Gather U.S. APN participants' responses to an online survey to give their opinion on guidelines and suggested APN qualifications for prescribing buprenorphine,
2. Analyze APN participants' feedback to determine level of support on a guideline that would allow APNs to qualify to prescribe buprenorphine, and
3. Identify APN interest in prescribing buprenorphine.

Project Activities

The project was limited to an electronic survey submitted to APNs in the United States. Respondents were recruited randomly via e-mail and through posts on APN pages on Facebook. The survey results were available for review on Survey Monkey; hence, there was no need for participants to return the completed survey by mail. The survey period was limited to 3 weeks. The two project activities were as follows:

1. Develop an online survey to elicit APNs' opinion on the guidelines for qualifying APNs to prescribe buprenorphine.
2. Analyze the survey data to determine acceptability of the proposed guidelines to practicing APNs.

The AANP has a vision to expand the scope of NP practice and maximize their potential in clinical practice. The AANP believes that NPs' education and experience will translate into great benefits to patients by provision of superior healthcare and improved patient access to care. The intended result of the project was data that could be used to support political efforts to expand the scope of practice for APNs that would result in more patients enrolled in addiction treatment and additional access to appropriate medications. This project has the capacity in the future to positively impact social change resulting in improved quality of life for patients and families and

decreased criminal justice burden associated with addiction, as well as save healthcare dollars spent on addiction.

Assumptions and Limitations

The limitations identified for this project included the time limit for the study; this might have limited the possibility to gaining access to a larger group of participants or participants in certain geographic areas. The survey aimed at a randomized sample although the respondents may not be truly be a random sample as they were targeted through certain criteria, The study results were based on assumption that the responses provided were truthful and honest. The results were generalized to APNs within the U.S although some state had very low response. This is based on assumption that their opinion is representative of all practicing APNs.

Definition of Terms

The following terms are defined for the purpose of this study.

Narcotics are drugs that require a prescription from a licensed provider with a valid federal DEA number (Samsha.gov).

Advanced practice registered nurses (APRNs)/Nurse practitioners (NPs) are nurses defined by the AANC describes this as having completed master's level education in nursing and passing a national licensure examination. In this paper, they are referred to as APNs (ANA, 2006).

Buprenorphine is a narcotic analgesic that is derived from thebaine and is administered in the form of its hydrochloride, which is administered for the treatment of moderate to severe pain or to treat opioid dependence (SAMHSA.gov)

Suboxone is a FDA-approved prescription formulation of buprenorphine commonly used for the treatment of heroin addiction and opioid dependency (SAMHSA.gov).

Subutex is the same as buprenorphine defined above (SAMHSA.gov).

Prescriptive authority is "the ability of advanced practice registered nurses (APRNs) to prescribe, without limitation, legend (prescription) and controlled drugs, devices, adjunct health/medical services, durable medical goods, and other equipment and supplies" (AANP, 2007b, para. 4).

Opioid addiction is a person's inability to refrain from the use of narcotics regardless of detrimental effects and no benefits. The addiction may be to prescribed or illegal opioids (Galea, 2004).

Social factors are factors that cause disparity in healthcare services and create a barrier to patient care (Parks et al., 2008).

Political and legal factors are factors that uphold federalism and may create conflicts between federal and state regulations in reference to APN scope of practice (AANP, 2007b).

Scope of practice is "the who, what, where, when, why, and how of nursing practice, including advanced practice nursing" (AANP, 2007b, para. 2)

Summary

DNP graduates are adequately prepared to identify healthcare needs and lobby for change of policies that perpetuate social injustice and inequality in health care (AANC, 2006). A combination of systems thinking and social justice led to the development of a

project to amend a national law (DATA, 2000) that is not supported by evidence and limits the ability of APNs to practice to the full extent of their education and licensure. Section 2 is the review of literature. This section will discuss the project's framework and policy analysis.

Section 2: Review of Literature, Concepts, Models, Theories and Framework

Introduction

The purpose of the project was to describe the current trends in the continuing development of guidelines that would allow APNs to prescribe buprenorphine in treating opioid addiction on an outpatient basis. This section of the project examines previous studies theoretical framework, and APN roles. The purpose of the project was to describe the current trends in the continuing development of guidelines that would allow APNs to prescribe buprenorphine in treating opioid addiction on an outpatient basis.

Search Strategy To identify the relevant data, the following databases were used: PubMed, CINAHL, and PsycINFO. The following keywords were used: *nurse practitioner*, *scope of practice*, *addiction treatment*, *DATA 2000*, and *opioid addiction*. The literature review was limited to foundational, seminal and peer review articles published within the last 10 years.

The International Nurses Society on Addictions (IntNSA) wrote a position statement on DATA 2000 (2011) and identified DATA 2000 as a barrier to treatment and recommended its amendment. According to IntNSA, to provide accessible, safe, buprenorphine treatment for opioid addiction treatment, DATA 2000 needs to allow APNs who meet the criteria and express a desire to prescribe buprenorphine in outpatient treatment centers (OPTs) to do so. The Association of Nurses in AIDS Care (ANAC; 2011) shared this position and noted that amendment would increase access to treatment and reduce the current addiction related problems.

Due to societal problems that come with addiction, the need for access to treatment was studied by the National Center on Addiction and Substance Abuse (CASA) at Columbia University, identified a great rift that separates the people affected by substance abuse from those receiving treatment (NIDA, 2012). In its study, CASA learned that almost 1,000,000 people within the criminal justice system in the U.S. are in need of addiction services, yet less than 25% of that population actually received them. Healthy People 2020 (HP2020) estimated that the United States has lost $600 billion annually in healthcare costs and criminal justice expenses as well as lost productivity due to addiction. HP2020 agreed that expanding addiction services will have a significant positive impact on the reduction of this addiction related burden (HHS, 2010). NIDA published *Principles of Drug Addiction Treatment* (2011) that indicated a need for diversity in addiction treatment. The Institute identified that there is a promising future for addiction treatment options, which will decrease the addiction disparity as well as the financial, criminal and healthcare burden associated with it (Pearson, 2012).

NIDA (2011) in their statement agreed that substance abuse is a major burden to society and reported that the costs of drug abuse and addiction are steadily on the rise in the U.S. Hospitals are spending about one dollar of every four Medicare dollars on inpatient treatment of addiction related services. Approximately 70% of incarcerated individuals within the prison system regularly abuse illegal substances (NIDA, 2011).

NIDA (2011) reported that the cost of addiction treatment is greater than the cost of all diseases of the brain combined. Drug addiction treatment services have been shown to have a positive impact, but a lack of these services creates a continued burden for the healthcare system, the justice system, and society. Available treatments like methadone and buprenorphine are

effective in eliminating addiction and enabling a more productive community (Pearson, 2012). APNs are currently not authorized to prescribe methadone although addiction treatment with methadone is restricted to specialized clinics and cannot to provide in primary care office. Research has shown that for every dollar invested in addiction treatment there is a return of $5–10 in healthcare spending savings. The United States, through HP2020, has established an objective to decrease addiction related burden and the many effects it has on the community and the country as a whole (HHS, 2010).

Theoretical Framework

Nursing knowledge, research, and practice development are guided by theoretical frameworks. This project reflects healthcare policy analysis and advocacy as outlined by AANC (2006). The two frameworks are presented to advance and promote policy change as well as social justice advocacy.

Critical Social Theory

DATA 2000 is a public health policy that affects the abilities of patients with opioid addiction to access and effectively engage in health-enhancing healthcare/ treatment. The selected theory to address this problem is the CST. CST is a sociological theory that identified and addressed oppressive social and societal issues. Calhoun (1995) reported that CST is a theory used in societal awareness to expose inequalities within the society that have prevented people from reaching their full potential. This theory was selected because addiction is a social problem, and DATA 2000 has prevented patients from accessing much needed treatment.

In sociology, CST has been used by students to critique policies within the institutions that are viewed as oppressive. CST has also been used in nursing to support practices to address oppressive sociopolitical issues and policies influencing health and health care such as DATA

2000 (Calhoun, 1995). McEwen and Wills (2011) identified that CST has been useful to nursing when working with disadvantaged groups. They identified an example of limited access to mental health services whereby the CST was used to empower individuals to action for change. As with mental healthcare, this theory can be applied to addiction treatment to guide stakeholders to initiate action for change and enhance access to addiction treatment.

McEwen and Wills (2011) agreed that the healthcare system and organizations are not designed with proper communication channels between healthcare consumers and healthcare policy makers. This lack of communication reduces negotiation opportunities because the agencies maintain authority resulting in policies that patients may view as biased or oppressive such as access to care issues. The CST will be used in the project to identify and outline the biased and oppressive aspects of DATA 2000.

Kingdon's Theory in Policy Analysis

Kingdon's theory offered a framework for agenda setting in the policy process. Figure 1 provides an overview of the stages of Kingdon's theory in policy analysis. The initial stage of the policy agenda provides an outline of problems for the government officials and stakeholders to review. In this project, opioid addiction was identified as a problem that needs to be addressed through policy change to ensure effective solutions. This stage provides a foundation for moving the policy proposal by following a sequence of changing problems to proposals and then initiating changes through politics (Milstead, 2011). This problem advancement process is crucial in persuading policy makers and stakeholders to give the issue the attention it deserves. Guidelines were developed in this project to guide APNs interested in prescribing buprenorphine prescription. There is also a policy brief; this will be a key instrument when persuading policy makers for change. The policy brief will enable the

problem of addiction to be presented as an actual or potential crisis through available data, and previous or potential events or public concerns (Milstead, 2011).

The policy proposal is the presented agenda of the proposed problem change. The policy is outlined, reviewed, revised, debated and accepted for consideration by lawmakers. A policy brief is useful in providing an overview of the issue at hand (Milstead, 2011). The policy proposal must be seen as feasible, acceptable to policy makers, meeting public needs and cost effective goals. Using the policy brief developed through this program, the presenter of the agenda should identify policy makers whose values are in line with the proposed change to rally their support and provide the document as a guide to further educated them on the issue presented (Milstead, 2011).

Politics involves the problem advancement stage where the lawmakers and stakeholders' advocacy groups and provide the climate mood to ensure a synchronized voice for change. The agenda setting must take place when the political climate is ready for a change (O'Connor, 2010). This is probably a great time for political changes as America works to embrace the healthcare reform. The project can be replicated in the future, and the data collected presented as evidence to set the agenda stage.

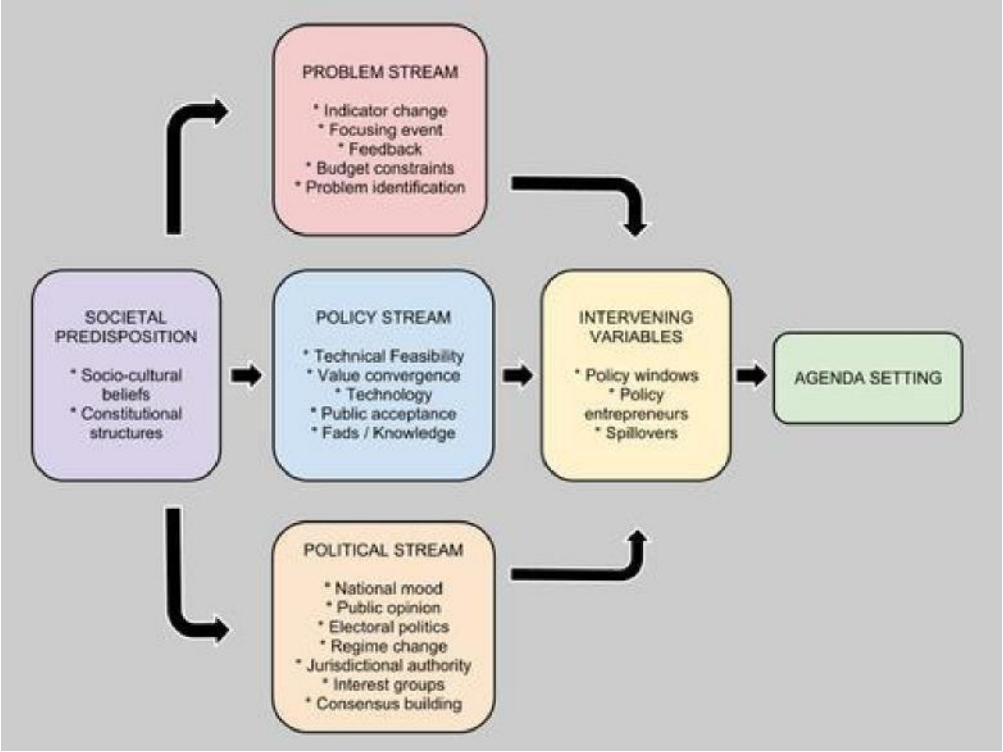


Figure 1. *An overview of the stages of Kingdon's theory in policy analysis*. (Adapted From "Beyond Simple Pessimism," by D. Keltner, P. D. Ellsworth, and K. Edwards, 1993, Journal of Personality, 64, p. 751. Copyright 1991 by the American Psychological Association. Adapted with permission of the author.)

Summary

The presentation of the problem and the burden it entails is the initial stage of problem advancement. Any policy proposal must be brief, easy to understand, organized and convincing to policy makers. The pros and cons of the legality of NP prescription of buprenorphine to improve care reduce addiction prevalence and decrease the addiction related burden to the healthcare system, the justice system, and the community must be presented objectively. The policy proposal will be crucial in rallying support from lawmakers, state boards of nursing, professional organizations, community leaders and patients and their families. Influential constituents must be involved to provide a voice for the patients. Financial responsibilities and

possibilities involved must be presented accurately to outline the costs and benefits of the policy change (Milstead, 2011).

The final stage is the politics involved. This stage will include policy makers supporting or declining to support the change (Milstead, 2011). The change provided in the proposal if presented well and reflecting accurately the societal disposition (literature review findings and APNs' beliefs from the survey) and the policy stream (public acceptance, feasibility, and value convergence) should make the politics stage easier. This final stage although important will be completed in the future. This project set the stage by collecting and analyzing data which when presented in the future will support and ensure this proposed policy change.

Section 3: Approach and Methodology

Introduction

The purpose of the project was to describe the current trends in the continuing development of guidelines or criteria that would allow APNs to prescribe buprenorphine in treating opioid addiction on an outpatient basis. The project is considered feasible because the resources, nursing and community support the initiative. Although many patients are already in treatment, many more remain unable to get treatment. Among the factors involved in the treatment disparities, access to treatment is a major concern. Many APNs have expressed a desire to prescribe buprenorphine. Patients have been receptive to care provided by APNs, and this proposed expanded scope of practice not likely be an exception. It is, however, unknown but rather hypothesized that this initiative will lead to a decrease in crime. The medical establishment has opposed this amendment in the past and will likely continue to erect a barrier to the proposed legislative change. Like with every healthcare issues, addiction is not an exception. Addiction requires collaboration of healthcare professionals to initiate positive change and decrease the related burdens.

Chronic health problems have shown to be very expensive to manage. Addiction-related issues cost America billions of dollars. This initiative is projected to possibly reduce healthcare and criminal justice system spending as well as decrease emergency room visits. APNs have an interest in treating addiction to help decrease the disparity. In some states, APNs already hold a valid DEA number so the training related costs will be minimal. As part of guideline development, I would if policy change is initiated, recommend that APNs be required take the same 8-hour course taken by physicians to qualify them to prescribe buprenorphine. With most healthcare change projects, cost is usually a factor of concern. It is crucial to make financial

sense of the project to ensure support. The amended law will increase accessibility to cost-effective treatment by expanding the number of providers who can prescribe appropriate treatment for patients with opioid addiction who sought treatment.

Implementation Plan

The implementation plan is important for ensuring that the study objectives are met. For this DNP project, the objective is to (a) invite APNs to participate in an online survey to give their opinion on developed guidelines and suggested APN qualifications for prescribing buprenorphine and (b) analyze APN participant's feedback to determine the level of support and finalize the guidelines that would allow APNs to qualify to prescribe buprenorphine. The information collected in this study will be used in the future to sought to expand the role of NPs to ensure increased accessibility to addiction treatment, decreased prevalence of opioid addiction in the U.S. The project allowed for a virtual interface without costly face-to-face meetings. Online/Internet surveys were be transmitted electronically to APN participants who responded anonymously. The responses were accessed online by this author. Data obtained were analyzed, and conclusions drawn to change the guidelines as necessary in accordance with APN input. A policy brief was developed based on the responses and the literature review.

Budget

Rabinowitz (2010) outlined the importance of a comprehensive budget that includes the program activities, manpower needs and all other expenses associated with the project. The project involves data collection through emails and social network. Expenses/ projected costs will only be estimated based on time spent on the project. There are currently no identified external sources of funding. Table 1 shows the anticipated project expenses. The actual

implementation and policy change will be done in the future and is not part of this DNP project.

Table 1

Project Budget.

	Time (hours)	Cost of time/hr.	Total cost
Project development and evaluation (Planning, literature review, proposal, and IRB approval, survey development).	50	$100	$5,000
Implementation and data analysis	40	$100	$ 4,000
Total cost	90		$9000

There was a focus on low-cost interventions to minimize the project cost. Cost of the project was calculated based on a time value so there were no actual expenditures to conduct the project. Healthy People (2020) reported that addiction currently costs the United States an estimated $600 billion annually in healthcare, lost productivity, and drug-related crime cost (USDHHS, 2010). If accessibility to treatment is not improved that cost may be higher. It is, therefore, important that the problem of addiction is addressed. Short-term implications of APN prescription of buprenorphine include a rise in costs due to increased numbers of patients being treated, whereas long-term implications may be the decreased burden of drug abuse on the community, the justice system, and the patients and their families. Preventable loss of life related to addiction is also a reason to address the problem.

To address a federal policy, the political model is most appropriate. The political model is a flexible budgetary method that allows for negotiations. In this model, stakeholders come together and agree on a compromise (Kettner, Moroney, & Martin, 2013). DATA 2000 is a policy that has seemed to favor one profession above other negotiations are, therefore, very necessary. This process calls for stakeholders to rally the community and political

leaders to seek support in the acquisition of funds and resources to support the policy change. Stakeholders have a role in resource allocation to ensure that the community needs are met (Kettner et al., 2013). Initiating change in a policy that is years old and protects the vested interests of one profession needs strong stakeholder involvement. Professional organizations, community leaders, NPs, boards of nursing, and political leaders will each have a role to play in advocating for a policy change (Kettner et al., 2013). This DNP project collected data to demonstrate to stakeholders the level of APNs' interest in treating opioid addiction.

Data Collection Methods

Data collection for this project was derived from one-survey instrument that was developed by this author. A simple online survey was developed to determine whether APNs continue to desire to prescribe buprenorphine and their reactions to the developed guideline for APN prescriptive authority for this drug. The development of the guidelines was directed by information from the state and federal drug addiction treatment guidelines that have to be met by physician providers authorized to prescribe buprenorphine.

Upon approval from the Walden University Institutional Review Board (IBR), the survey was distributed to participants. Instruments from scholarly websites and nursing practice were considered for use, but, this author developed the specific questions that were posted on social media like Facebook to reach APN participants. Social media allowed the author to reach participants from all over the U.S. The link was specifically posted to APN group pages. The link to the survey was also emailed to APNs.

The survey was made available via Survey Monkey to increase accessibility and availability as well as easy transmission of APNs' responses, comments, and observations. Demographic questions were used to classify the participants by APN specialty. It was important to this author to ensure that a good portion of respondents were APNs currently

practicing in the U.S. As part of the survey, feedback was solicited to measure the perceived value of the project and the perceived need for the project by the targeted nursing professionals. Besides completing the survey, some of the participants posted their views or questions about the project on Facebook.

Pilot Survey Tool

The survey was piloted to determine face validity of the survey, the readability of the questions, and the ability of the questions to elicit informative responses. The piloting of the survey ensured that the tool was acceptable to APNs, and understandable and easy to interpret by NPs practicing in different states. The pilot test elicited feedback from five APNs. The feedback from the pilot of the survey was used to develop the final web-based survey instrument. Through the pilot survey, it was revealed that some of the responses had to be adjusted to illicit uniform response. Free text answers were eliminated.

Test-retest reliability was conducted using five NPs to complete a Web-based survey to be sent via e-mail. The same survey was later sent to the same NPs 2–3 weeks later following IBR approval. The responses were analyzed for agreements, omissions and any additions or suggestions. The survey instrument, which is now closed, was available at https://www.surveymonkey.com/s/PY669KC. The final survey was a refined version of the pilot survey; the format included 10 questions regarding the content of the developed guidelines for prescriptive authority qualifications. The questions on the survey as well as specific responses elicited will be discussed later in this report. The data were then analyzed, and a final project report in the form of a policy brief was developed for nurse policy advocates to use in modifying state and national prescriptive authority legislation.

Sampling Methods/Participant Characteristics

A convenience sample of APNs was recruited to respond to a survey posted on Survey Monkey. No compensation was offered to participants. To be included in the project, respondents must have had a valid license, professional credentials, and a minimum of a master's degree in nursing or a DNP with course work in an advanced nursing area of practice. Anonymity of participants was be maintained. Participants were asked to respond critically and answer all questions.

Confidentiality and Human Rights Protection

Individuals meeting criteria were invited to participate. There was no formal signed consent but rather a letter of invitation to participate was sent with a returned survey response considered consent. Risks to participants were minimal and noted not to exceed those encountered in daily online interaction. There were no direct benefits to participants in this project; however, there were otherwise projected benefits to the nursing profession, the healthcare system, and society. To ensure anonymity, no identifying participant information was collected. Data obtained were secured online and password protected and will be kept online for a period of 5 years. The Walden University IBR provided an approval (# 05-27-14-0349768) for the project before data were collected.

Procedures

Social networking was used for participant recruitment. Electronic invitations were sent to a convenient sample of APNs through email and Facebook. On Facebook, the link to the survey was posted for a period of 3 weeks on closed APN-specific pages that were only accessible to APNs. One-time feedback was completed based on individual use of the Survey Monkey tool.

Final Survey

The final survey consisted of 10 questions in the following categories: respondent's demographics, education, geographic area of practice, licensure and certification, scope of practice, and regulatory issues (see Appendix A). This paper includes a report of the findings from the 10 questions on the final survey.

Data Analysis

Descriptive statistics frequency distributions and percentages were used to analyze the data. Preset guidelines to qualify APNs to prescribe buprenorphine will in future be shared with APNs for their opinion and/or approval. These guidelines will be then revised and shared with policy makers. This was not a part of this project but thought for future consideration.

The data obtained were analyzed using the Survey Monkey tool to summarize the quantitative results, while response to the draft guidelines was analyzed using content analysis to classify the open-ended results. The responses were analyzed in a common pool without consideration of practice setting or geographical location of the respondents. Results were then tabulated, and participants' characteristics discussed while maintaining anonymity.

Summary

I created an online survey which was posted on Survey Monkey to collect data from a convenience sample of NPs. The data were analyzed to determine APN support and views of the buprenorphine prescription guidelines. The projected end product of the project is guidelines for NPs qualifications to prescribe buprenorphine legally that can be presented in the future to state legislatures and Congress as a starting point for amended legislation.

Section 4 will provide a summary of project findings and will include implications of the results and discussion of the limitations of the project.

Section 4: Findings, Discussion, and Implications

Introduction

The purpose of the project was to describe the current trends in the continuing development of guidelines that would allow APNs to prescribe buprenorphine in treating opioid addiction on an outpatient basis. A 10-question survey was posted on APN specific pages on Facebook and e-mailed to 40 candidates. The link provided allowed access to the survey that was created and posted on survey monkey. The survey was responded to by 96 self-identified APNs from 32 different states within the United States. About 1% practicing APNs was invited to participate. The results were also analyzed in aggregate convenience sampling method was applied, resulting in a total of 96 respondents who self-identified as APNs.

The collected data were analyzed using Survey Monkey Tool results summary provided by survey monkey. Level of data analysis included individual responses *(n* = 96) from 32 different states. In some states, there was only one respondent or no respondents, while other states had several respondents (see Table 2). Participants were all anonymous and no identifying information was collected.

Survey Results

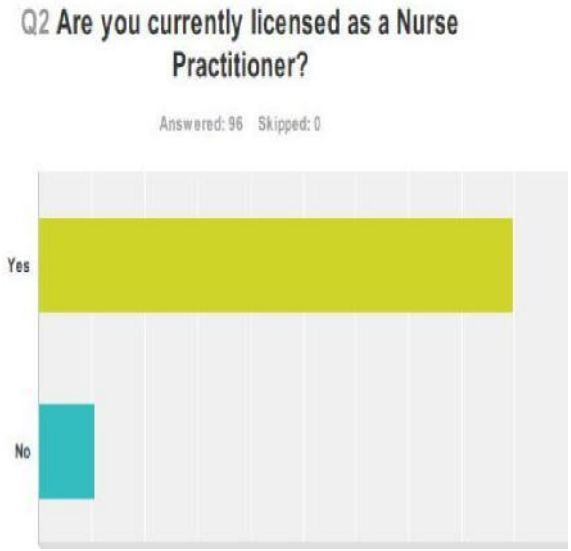
A total of 96 APNs responded to the questionnaire; 99% completed all the questions. The participants were drawn from all the 50 states of the U.S.; out of all the states. Members 32 of 50 states (64%) responded project

Answer choices	Responses
Female	91.67%
Male	8.33%

Figure 2. Classification of respondents by gender.

Participant Characteristics

Nearly all of the respondents were female (91.67%) and nearly 90% were NPs. Respondents were requested to identify their state of practice as well as their mental health practice experience. Out of the 96 respondents, 59.35% had psychiatry experience, with 20.43% reporting greater than 5 years of psychiatry experience. Over 40% (40.85%) practiced as APNs but had no psychiatry experience.



Answer Choices	Responses	
Yes	89.58%	86
No	10.42%	10
Total Respondents: 96		

Figure 3. Identifying actively licensed APN respondents

Expanding APN scope of practice in addiction treatment.

Q3 In what state or U.S. territory do you practice?

Answered: 95 Skipped: 1

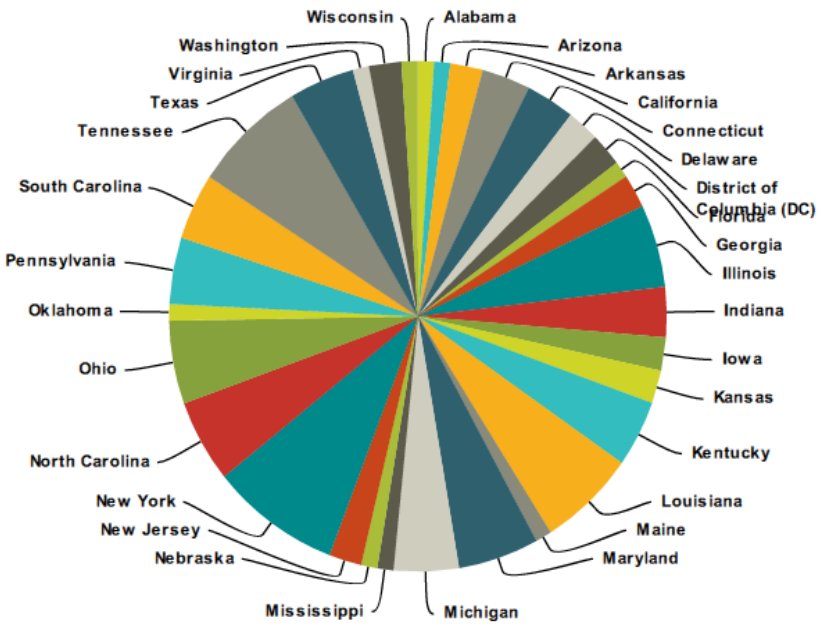


Figure 5. States represented by APNs/NPs respondents in the study.

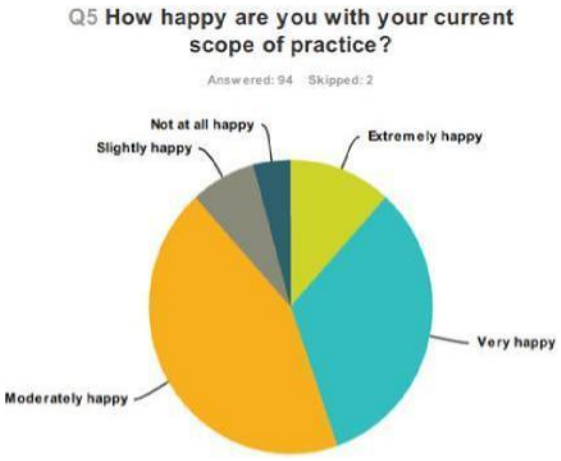
Table 2. Number of respondents by state n= 96

Alabama – 1	Wyoming - 0
Alaska - 0	Montana - 0
Arizona – 1	Nebraska - 1
Arkansas - 2	Nevada -0
California - 3	New Hampshire - 0
Colorado - 0	New Jersey - 2
Connecticut - 3	New Mexico - 0
Delaware – 2	New York - 8
District of Columbia- 2	North Carolina - 5
Florida - 1	North Dakota - 0
Georgia - 2	Ohio - 5
Hawaii - 0	Oklahoma - 1
Idaho - 0	Oregon -0
Illinois - 5	Pennsylvania - 4
Indiana - 3	Rhode Island - 0
Iowa - 2	South Carolina - 4
Kansas - 2	South Dakota - 0
Kentucky - 4	Tennessee - 7
Louisiana - 6	Texas - 4
Maine - 1	Utah - 0
Maryland - 5	Vermont - 0
Massachusetts - 0	Virginia - 1
Michigan – 4	Washington - 2
Minnesota - 0	West Virginia - 0
Mississippi - 1	Wisconsin - 1
Missouri - 0	

APN-NP Scope of Practice, Certification, and Employment

Respondents were asked to rate how happy they were with their current scope of practice. The respondents rating of their scope of practice varied based on the state where they practice. The responses indicated that most APNs would like a wider scope of practice, although most expressed satisfaction with their current practice scope as listed in Figure 5. The differences

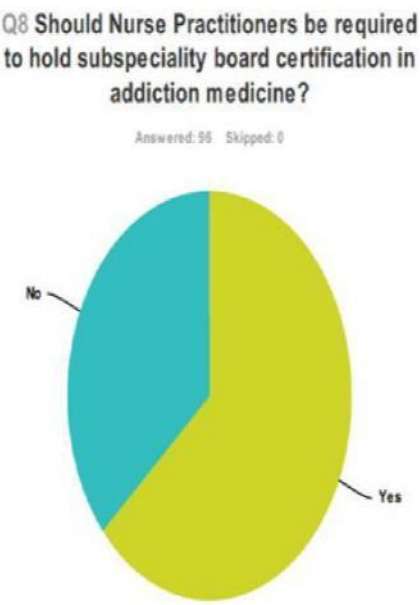
in NP-APN scope of practice exists because practice is regulated at the state level. According to the survey, 43.62% of respondents were only moderately happy with their scope of practice, 11.70% were extremely happy, 32.98% reported being very happy, and 4.26% reported not being happy at all with their current scope of practice. In all, APNs seem happy with their scope of practice but are open to expanded roles.



Answer Choices	Responses	
Extremely happy	11.70%	11
Very happy	32.98%	31
Moderately happy	43.62%	41
Slightly happy	7.45%	7
Not at all happy	4.26%	4
Total		94

Figure 5. APN attitude about their current scope of practice.

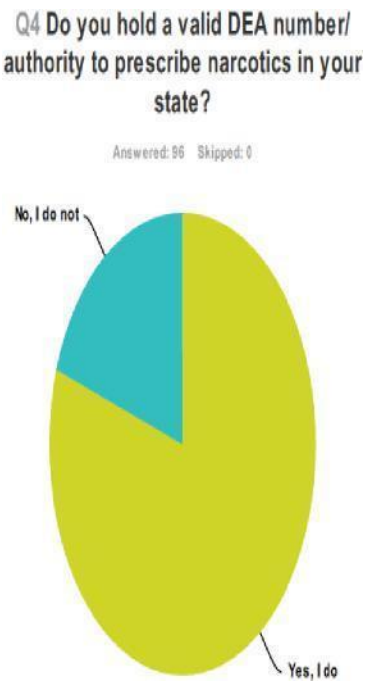
The respondents were also asked about the need for subspecialty certification in addiction medicine for APNs to prescribe buprenorphine. Well over half (63.54%) of the respondents felt that this was necessary, while the remaining 36.46% did not find this further certification necessary.



Answer Choices	Responses	
Yes	63.54%	61
No	36.46%	35
Total		96

Figure 6. Respondents view on subspeciality certification.

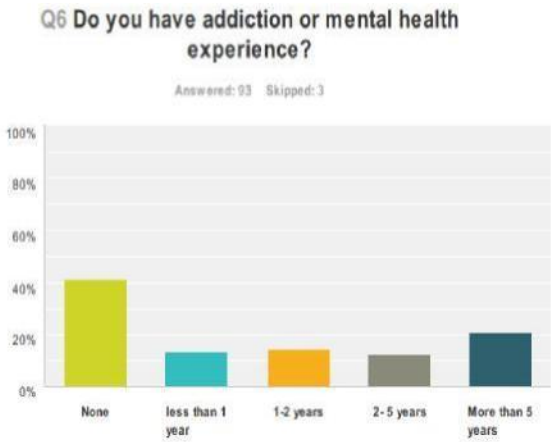
The survey revealed that 80.21% of the respondents hold a valid DEA number to prescribe narcotics in their state(s) of practice and are currently prescribing opiates (see Figure 7). APNs with a valid DEA number will only be required to meet the stipulated requirements to obtain a special DEA number to prescribe buprenorphine. The APNs in states that still do not issue DEAs numbers will have to first obtain authority to prescribe narcotics.



Answer Choices	Responses	
Yes, I do	80.21%	77
No, I do not	19.79%	19
Total		96

Figure 7. APN respondents with a valid DEA license

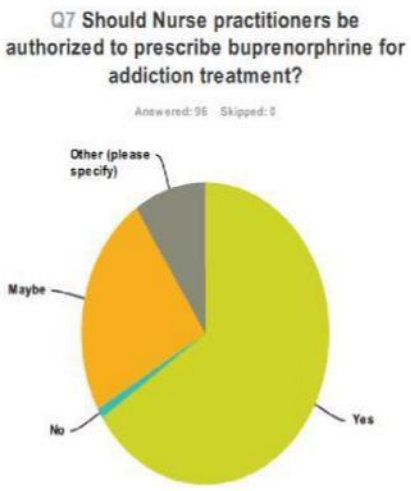
Of the 96 respondents, 59.14% reported that they had some mental health practice experience. The experience ranged from 1 to more than 5 years with a mode of more than 5 years of experience (see Figure 9). This would be beneficial in treating patients with addiction as most of the patients tend to report an underlying mental health problem.



Answer Choices	Responses	
None	40.86%	38
less than 1 year	12.90%	12
1-2 years	13.98%	13
2-5 years	11.83%	11
More than 5 years	20.43%	19
Total		93

Figure 8. Respondents' mental health experience in years.

When asked about their years of experience with mental health practice, only 20% of respondents had over 5 years of experience in mental health, while about 37% had some mental health experience. Nearly 41% (40.86%) of respondents reported no mental health practice experience.



Answer Choices	Responses	
Yes	65.63%	63
No	1.04%	1
Maybe	23.96%	23
Other (please specify)	9.38%	9
Total		96

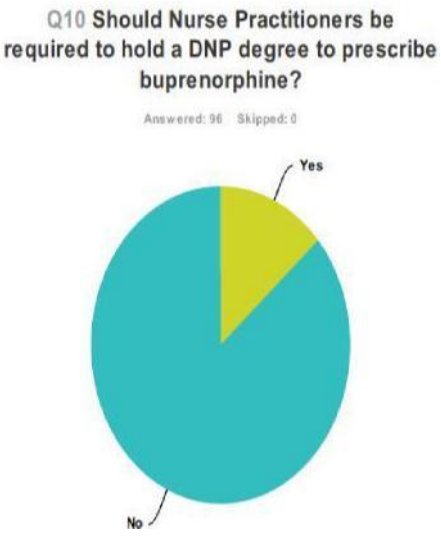
Figure 9. APNs desire to prescribe buprenorphine

Respondents were asked of their desire to prescribe buprenorphine. The majority of respondents (65.63%) expressed a desire to prescribe buprenorphine. Nearly 24% (23.96%) of respondents were unsure, and 1.04% had no desire to participate as buprenorphine providers. Interestingly, 9.33% of respondents thought otherwise about this issue without giving any specific information about their desires related to prescribing buprenorphine.

NP-APN Education

The survey included a question about the need to consider education level as a requirement in prescribing buprenorphine. The survey asked if APNs need to hold a DNP degree to prescribe buprenorphine for addiction treatment. Of the 96 respondents, only 13.54% agreed that APNs need to hold a DNP degree to prescribe buprenorphine, while 86.46% thought the degree was too new to be considered a requirement at this time. In reference to preparation for

NPs for this role, 98.96% of the respondents agreed that NPs should go through the same 8 hour training that physicians complete to prescribe buprenorphine.



Answer Choices	Responses	
Yes	13.54%	13
No	86.46%	83
Total		96

Figure 10. Do APNs need a DNP degree to prescribe buprenorphine?

Summary of Findings

Impact on practice and action

There is great variation in APN practice site, scope of practice, and prescriptive authority across the nation, while licensing requirements remain the same. It is clear that a uniform scope of practice across all states would simplify legislative changes at federal levels such as amendment of DATA 2000.

Most APNs who responded to the survey work in primary care, hold a valid DEA license to prescribe narcotics, and expressed an interest in prescribing buprenorphine for addiction treatment. This would increase accessibility to treatment for people addicted to opioids.

APNs who participated in the study showed an interest in and support for expanded scope of practice. APNs are encouraged to transform this interest into political will and actively advocate for changes that will help expand their scope of practice. This is particularly necessary due to the current shortage of primary care providers in the wake of the introduction of the ACA. It is also important for APNs to foster a productive interprofessional relationship with other providers such as physicians and pharmacists, to lobby their support.

Impact on future research.

Findings from this study can be applied to future research that seeks to expand APN scope of practice. The end product of this study can also be used as a supporting document or guide to expand addiction treatment services. The policy brief developed may be presented to enlighten the policy makers on this issue and seek support. If adopted, the results of the project will have implications for nursing policy advocates nationally.

Impact on social change.

The expansion in the role of APNs in addiction treatment is likely to increase accessibility to care. This expansion will enable patients with opioid addiction to seek treatment and decrease the social injustices caused by addiction. In the future, the findings of this project will help decrease the societal, and criminal justice system burden, as well as the healthcare burden related to addiction.

Impact on NP education and certification

One of the most difficult barriers in initiating NP/APN practice changes is the variable scope of NP-APN practice. I encourage APNs to lobby for uniform scope of practice to match the NP uniform education. A majority (63.54%) of the respondents agreed that APNs need special certification to prescribe buprenorphine while 36.46% objected to this requirement. This disagreement may lead to development of programs to provide subspecialty certification. There will be no need to develop a new 8-hour course for APNs as there is one already offered to physicians. The same course could be offered to qualified APNs seeking buprenorphine certification.

Project strengths and limitations

The project came at a time when scope of practice is generating a lot of attention from APNs, policy makers, and the healthcare community as a whole. The use of social media (Facebook) was one of the greatest strength of the study as a diverse sample of APN participants was reached with minimum effort. To ensure that participants were APNs, Facebook allowed for posting of the survey on profession specific pages where only members could access the survey and respond.

Limitations and Recommendations for remediation of limitations

Participation rates

Although 32 out of 50 states and the District of Columbia were represented, some states had a very small number of respondents and other states were not represented at all. I would have liked to have all the states represented and may open the survey at a later date to increase participation numbers overall as well as geographic distribution. As a result of the pilot study, adjustments were made to the survey item responses to increase participation and for uniform responses. Rather than allowing free text, choice options were offered. The web survey did

not allow participants to reenter and complete the survey at a later time, but it intentionally was made very brief to allow completion within a short period of time.

Analysis of Self

As scholar

This study enabled me to apply scholarship in practice through the identification of a clinical problem and work toward a solution. Through the study, many APNs were educated about the addiction field and the need for treatment accessibility. The issues addressed through the survey are significant to nursing practice and the end product of the project can be adopted or replicated to intervene in the opioid addiction epidemic in the U.S. today. Scholarship was also exhibited in this study through production of a document that can be of significance to the nursing profession. The survey elicited positive peer responses to my work, with some of the respondents calling this project very timely and necessary, while other colleagues marveled at my wealth of knowledge in the addiction field.

As a scholar, this DNP student was able to identify the gaps in addiction treatment and collect as well as analyze appropriate data to develop a practice guideline for APNs interested in addiction treatment. The data analyzed were derived from practicing APNs and showed great promise for improved access and treatment of opiate addictions if prescriptive authority were to be expanded.

As practitioner

Many medical providers encounter patients battling addiction. The study incorporated solutions that respond to the needs of the family, existing culture, and the effects that addiction has on the community. More significantly, through the eyes of APNs the study highlighted scope of practice issues while providing possible solutions.

As a practitioner, I conducted a comprehensive assessment of addiction and its effects on individuals and the society as a whole. The investigation involved looking at individual patients, families, communities, the healthcare system, and the criminal justice system to determine the burden of addiction and establish the need for expanded treatment options.

As project developer

In this project, I assumed the role of an advocate for healthcare policy change. The project looked at DATA 2000 and the need to remove the barriers to treatment associated with this policy. The policy was analyzed from the perspective of patients, nurses, other professionals, and communities to determine the need for change. The project's goal was to collect data in support of establishing guidelines that can be used to modify existing policy to remove barriers to treatment while increasing access to addiction services and reducing financial burden associated with addiction disparity. The final product will be used in the future to influence policy makers to initiate change.

What does this project mean for future professional development?

During this DNP project, data were collected in support of the expanded role of APNs in addiction treatment. The findings of this capstone project will significantly contribute to evidence-based nursing in addiction treatment and will provide a complete or partial solution to the problem of opioid addiction, which is currently an epidemic in the U. S. The guidelines that were created through this project, if adopted nationally, will significantly ease the transition of APNs into the role of buprenorphine prescribers for opiate addiction treatment.

The project revealed that APNs have an interest in the use of buprenorphine for treatment of opioid addiction as revealed by their responses to the survey. As a result of the project,

guidelines were developed that will enable APNs to prescribe buprenorphine. For APNs to qualify to prescribe buprenorphine for addiction treatment, they must

1. hold a current unrestricted state nursing license in the state where they desire to practice,
2. hold a valid Drug Enforcement Administration (DEA) and CDS Certificate,
3. have no current or previous narcotic or narcotic diversion charges against their license,
4. complete not less than 8 hours of training currently completed by qualified physicians,
5. establish a supervising physician with a completed and approved attestation to collaborate,
6. agree to stay current by completing specified Continuing Medical Education (CMEs) annually, and
7. have completed a master's degree in nursing.

Policy options/solutions

Three options for implementing changes to DATA 2000 are

partial change - expand DATA 2000 to allow only APNs who meet the speculated regulations and have a subspecialty certification to prescribe buprenorphine under the supervision of a "qualified physician,"

radical change - amend DATA 2000 to allow APNs who meet the speculated regulations and hold a subspecialty certification to independently to prescribe buprenorphine, or

maximum change - allow all APNs who have shown interest in prescribing buprenorphine, meet the set guidelines, and have completed the required training (not less than 8 hours to independently prescribe buprenorphine) to do so.

Summary

Using social networking as an avenue to reach APNs proved very interesting and effective. It provided a clear insight into the accessibility of participants through the right avenue. One post was accessed by a large number of APNs, which is more efficient than sending numerous e-mails. Through the pilot survey, I gained insight into how to simplify a survey so that it would be constructed to collect the necessary data and facilitate participation.

Several organizations outlined in this study support the need to utilize APNs to the fullest scope of their education. The nursing profession has continuously presented evidence of the high competency of APNs in practice but the profession still meets several barriers to practice. These barriers include the DATA 2000 policy. Nurses and nursing organizations are encouraged to channel energy into political advocacy to help initiate positive changes for the nursing profession. The nursing profession has over the years made advancements in education and practice, which is mirrored in the excellent service provided by APNs. APNs represent a dominant giant in healthcare, and they are key players in patient care, especially primary care. To meet the increased patient needs as a result of the ACA, APNs must cultivate effective lobbying power to initiate change.

APNs are motivated to assume roles in healthcare to help improve the quality of life for patients. Although motivated, APNs are still concerned about the effects and control other professions, especially physicians, have on their scope of practice. The project revealed that APNs are not opposed to collaboration with these professionals but they merit the autonomy to practice in a wider scope in line with their training. One APN in the study indicated that the DATA 2000 amendment is an uphill battle for APNs because buprenorphine prescription is a

significant source of income for physicians and competition is not welcomed. This position does not address the large underserved population of patients who would benefit from an expansion of APNs' scope of practice.

Based on the data collected and analyzed in this study, APNs understand that this is a good time for healthcare delivery change and that there is a great need in addiction treatment. APNs are willing to complete further training to meet the required qualifications to prescribe buprenorphine. In the U.S., amendment of DATA 2000 as a step toward increased recognition of the nursing profession as well as effective utilization of APNs. Change of the Act will also increase access to addiction treatment, improve the lives of individuals and families battling addiction, decrease disparities, and decrease the burden to the healthcare and criminal justice systems. The ultimate goal of this project is to allow APNs to provide comprehensive care to patients and families with substance abuse issues.

Section 5: Scholarly Product (Policy Brief)

Introduction

The scholarly product for this project is a policy brief. The goal of this policy brief is to present the research and data collected in this project to policy makers to initiate change and amend Drug Addiction Treatment Act of 2000 (DATA 2000). The policy brief provides recommendations that are feasible, acceptable to policy makers, cost effective, and meet the public needs. Using the policy brief developed through this project, I will seek opportunities to contact policy makers whose values are in line with the proposed change in order to rally their support and provide them with the document as a guide to the necessary policy changes (Milstead, 2011).

Drug Addiction Treatment Act (DATA 2000), 13 Years Later

The Office of National Drug Control Policy (ONDCP), (2011) agreed that substance abuse rates have hit epidemic levels in the United States. Abuse of both illicit and prescription drugs have been the cause of many deaths and hospitalizations costing Americans billions of healthcare dollars. Substance abuse directly affects the individual users, their families, and the general community and leads to a financial burden in healthcare costs, lost productivity and justice system related costs. Substance abuse contributes to social, physical, justice, psychological, and public health problems (O'Connor, 2010). The National Institute of Drug Abuse (NIDA) estimated that approximately 95% of active substance abusers are in denial or unaware of their problem. Only 273,000 (18.6%) of active substance users are actively enrolled in treatment ((NIDA, 2012). DATA 2000 has limited providers who can prescribe buprenorphine denying patients access to life-saving treatment (Lofwall & Havens, 2012).

Current politics of the issue

Buprenorphine is currently the only Federal Drug Administration (FDA) approved medication for the treatment of opioid addiction in a primary care office. Buprenorphine treatment is regulated under the federal DATA 2000, established under Public Law 106-310, Title XXXV, Sections 3501 and 3502. This legislation allows “qualified physicians” to treat opioid addiction with buprenorphine in office-based settings (Roose et al., 2008). DATA 2000 does not allow Advance Practice Nurses (APNs) to prescribe buprenorphine; thereby, excluding nurses who already hold a valid Drug Enforcement Administration (DEA) license and are authorized to prescribe Schedules III, IV, and V controlled substances (O'Connor, 2010; Roose et al., 2008).

Current policy level

In April 2012, the Secretary of Health and Human Services noted the need for more buprenorphine providers. A waiver was issued by SAMHSA to amend the DATA 2000 regulations, exempting "qualified physicians" from the rules applied to Outpatient Treatment Programs (OTPs). The waiver allowed providers to use buprenorphine for the treatment of addiction in office-based practice (Lofwall & Havens, 2012). There was no mention of inclusion of APNs to ease the shortage of providers and close the treatment gap.

The IOM *Future of Nursing Practice* (IOM; 2010) identified the need for APNs to be better utilized across healthcare settings and patient populations. APN providers have demonstrated that they are valuable across the healthcare spectrum as generalists as

well as specialists (Roose et al., 2008). The IOM also emphasized coordinated and cost-effective care, and noted that APNs have tended more than other providers to establish practices in traditionally underserved areas. The IOM agreed that there are regulatory restrictions that currently prevent APNs from being utilized to their potential. Policies like DATA 2000 have barred APNs from office-based addiction treatment using buprenorphine. The IOM found that most of these policies are "meaningless/needless and without rationale" (IOM, 2010). The authors identified the need for policy change that included outdated policies like DATA 2000.

Building Consensus

DATA 2000 is an old policy that has failed to transition with the changes in healthcare needs and provider roles. The call for change is focused on factual information and studies of APN quality of practice. The roles and education of NPs have greatly advanced over the last 13 years. Stakeholders invested in the policy change include community leaders, professional organizations, patients, practicing APNs, and Boards of Nursing.

APNs were surveyed nationally using social media to identify APNs' perceptions of DATA 2000 in the U.S. restricting prescriptive authority associated with buprenorphine for outpatient opiate addiction treatment. Opinions regarding necessary APN education, expertise, and qualifications needed to prescribe buprenorphine were elicited. The project also sought to elicit APNs' feedback on draft guidelines to qualify APNs to prescribe buprenorphine and their general personal interest in prescribing buprenorphine.

The stakeholders

In favor of amendment of DATA 2000 are stakeholders include community leaders, professional organizations, patients, practicing APNs, and Boards of Nursing. The International Nurses Society on Addictions (IntNSA), The Association of Nurses in AIDS Care (ANAC) and the IOM agree on the need to maximize the potential of APRNs. They all agree that APRNs' skills, knowledge, and education have grown tremendously within the last 10 years, yet their scope of practice remain barred by old policies like the 13-year-old DATA 2000. IntNSA (2011) identified that DATA 2000 is a barrier in the treatment and recommend for Amendment. IntNSA reported that for the provision of accessible, safe, buprenorphine treatment for opioid addiction treatment, the Drug Addiction Treatment Act of 2000 (DATA 2000) needs to be amended to allow qualified APNs who meet set criteria and express desire to prescribe buprenorphine in OPTs. ANAC (2011) supported the need to amend DATA 2000 to allow qualified APNs to prescribe buprenorphine in addiction treatment. They continue to note that this change in policy will increase access to treatment and reduce the current addiction-related burden. Many APNs already have independent prescriptive authority, a DEA license to prescribe narcotics, the state license to practice, and prescribe other opioids.

Recommendations/guidelines

Based on the literature, the APN survey responses, and stakeholder support, the following guidelines are recommended for APNs to qualify to prescribe buprenorphine for addiction treatment. APNs must

1. hold a current unrestricted state nursing license in the state where they desire to

practice,

2. hold a valid Drug Enforcement Administration (DEA) and CDS Certificate,
3. have no current or previous narcotic or narcotic diversion charges against their license,
4. complete not less than eight hours of training currently completed by qualified physicians,
5. establish a physician with a completed and approved attestation to collaborate,
6. agree to stay current by completing specified Continuing Medical Education (CMEs) annually, and
7. have completed a minimum of a master's degree in nursing.

Policy options/solutions

Three options for implementing changes to DATA 2000 are

1. partial change - expand DATA 2000 to allow only APNs who meet the speculated regulations and have a subspecialty certification to prescribe buprenorphine under the supervision of a "qualified physician,"
2. radical change - amend DATA 2000 to allow APNs who meet the speculated regulations and hold a subspecialty certification to independently to prescribe buprenorphine, and
3. maximum change - allow all APNs who have shown interest in prescribing buprenorphine, meet the set guidelines, and have completed the required training (not less than 8 hours to independently prescribe buprenorphine) to do so.

The pros and cons of DATA 2000 expansion

The proposed amendment of DATA 2000 will grant APNs ability to prescribe

buprenorphine for the treatment of opioid addiction. This change will result in increased access to buprenorphine treatment for those affected by addiction (Roose et al., 2008). Patients will be able to get treatment through their primary care provider, affording them the ability to start treatment soon as they seek help (Lofwall & Havens, 2012). The increased accessibility will result in a decline in financial and healthcare costs and justice system burden caused by opioid addiction (O'Connor, 2010). On the other hand, the more patients enrolled in treatment and who receive buprenorphine, the more likely there will be an increase in buprenorphine diversion. Providers, whether physicians or APNs, should be knowledgeable of this risk and initiate measures to decrease the possibility of diversion (Arfken et al., 2010).

Conclusion

The amendment of DATA 2000 to allow APNs to prescribe buprenorphine will relieve burdens to the healthcare and justice systems and provide affordable, quality, accessible addiction treatment. APNs are willing and motivated to prescribe buprenorphine and they are ready to meet guidelines established for safe and efficient prescribing. It is now time for lawmakers to take another look at DATA 2000 and make the long overdue amendments.

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Appendix A: Survey Tool

Expanding APN scope of practice in addiction treatment.

- 1. What is your gender?
  - ○ Female ○ Male
- 2. Are you currently licensed as a Nurse Practitioner?
  - ☐ Yes ☐ No
- 3. In what state or U.S. territory do you practice?
- 4. Do you hold a valid DEA number/ authority to prescribe narcotics in your state?
  - ○ Yes, I do ○ No, I do not
- 5. How happy are you with your current scope of practice?
  - ○ Extremely happy
  - ○ Very happy
  - ○ Moderately happy
  - ○ Slightly happy
  - ○ Not at all happy
- 6. Do you have addiction or mental health experience?
  - ○ None ○ less than 1 year
  - ○ 1-2 years
  - ○ 2- 5 years
  - ○ More than 5 years

  Other (please specify) _____
- 7. Should Nurse practitioners be authorized to prescribe buprenorphine for addiction treatment?
  - ○ Yes ○ No ○ Maybe
  - ○ Other (please specify) _____
- 8. Should Nurse Practitioners be required to hold subspecialty board certification in addiction medicine?
  - ○ Yes ○ No
- 9. Should Nurse practitioners complete the same 8 hours training required for physicians to prescribe buprenorphine?
  - ○ Yes ○ No
- 10. Should Nurse Practitioners be required to hold a DNP degree to prescribe buprenorphine?
  - ○ Yes ○ No

Curriculum Vitae

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Objective: Seeking a challenging position in a company where my extensive medical, professional, practical experience, and dedication will be fully utilized while providing age specific care to patients and their families.

Profile:

1. Provide care as sole primary care provider in the practice, returning patient phone calls, responding to incoming faxes for DME, medical supplies and equipment and completing FMLA paperwork, MVA disability forms, and death certificates.
2. Knowledge of ICD9/ ICD 10 coding.
3. Familiar with management of both acute and chronic diseases.
4. Understanding of health insurance: local providers, general plan types, and terminology.
5. Deep knowledge of the federal, state and local laws regarding patient and treatments as well as advance directives.
6. Excellent assessment, communication and clinical skills.
7. Collaborate with other providers to maximize patient care.
8. Experience with EHR documentation.

Education.

DNP - Walden University 2011 to date

MSN - Coppin State University (2009)

BSN - Coppin State University (2004)

Professional Experience.

2013 to date: Five Star Physicians

On call provider for nursing home and inpatient services.

3/2012 to date: Chesapeake Home Physicians (Primary care provider)

- Provide acute and chronic care to home bound patients in the comfort of their homes and assisted living facilities. Order diagnostic services, review results.

- Oversee care of hospice patients within their primary settings.

2010 – 2012: Turning Point Clinic (Associate Medical Director)

- Provided medical services including taking a history and physical examination for both the primary care program and the narcotic replacement therapy program.

2009 – 2012: Westside Medical Group - Family practice (Associate Medical Director)

-Performed comprehensive physical assessment of patients and immunizations.

-Established medical diagnosis and managed acute and chronic health conditions.

-Ordered, performed, and interpreted diagnostic testing including laboratory tests, EKGs, and radiographic studies.

-Completed sports physicals, school physicals, and DOT certifications.

2008 – 2009: Student Nurse Practitioner – Windsor Medical Center.

2009 – 2011: Mt. Washington Pediatrics NICU RN

2008 - 2013: Access Nursing Services

-Completed several per diem assignments and contracts at different facilities including:

-Johns Hopkins Medical (Adolescence Medicine contract) - 1/2011 to 8/2011 -

University of Maryland Medical center (Pediatrics contract) - 11/2009 to 04/2010 -

Union memorial hospital (Adult Med Surgical Nursing contract) - 3/2009 to 12/2009

-Franklin Square hospital (Pediatrics contract) - 01/ 2008 to 03/2009

-Kennedy Krieger Children's Institute, Baltimore, MD, RN II - 2005 to 2008

Credentials	**Certifications**
CRNP, FNP-BC	BLS/ PALS
Registered Nurse MD	CDS/DEA

Awards: Excellence in clinical Practice Coppin State class of 2009.

Volunteer experience:

Founder and CEO IPLEA international. Organized and led a team of healthcare professionals on 3 medical missions to Kenya 2011, 2012, and 2014 as the only prescriber and head medical provider of the team.

Professional Organizations:

Maryland Nurses Association

Nurse Practitioners Association of Maryland

References available upon request.