DEA Schedule Change Inhibits Practice and Patient Care

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Note from NP Editor-in-Chief Marie-Eileen Onieal, PhD, CPNP, FAANP: Recently, the authors of this column and I started discussing the decision by the Drug Enforcement Administration (DEA) to reschedule hydrocodone and the resulting barriers to care. By the end of the conversation, it was evident that my colleagues needed to "get the word out" to our readers—so I afforded them this opportunity do so.

On October 6, 2014, hydrocodone combination products were reclassified from Schedule III to Schedule II of the Controlled Substances Act, per a final ruling issued by the DEA's Office of Diversion Control. The DEA's ruling was the result of an evaluation of scientific and medical evidence supplied by multiple agencies, as well as considerations related to the FDA Safety and Innovation Act of 2012.[1] The rationale for rescheduling hydrocodone preparations was based on evidence of high potential for abuse, high rates of dependency, and epidemic levels of drug diversion related to these products.

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Our purpose in this editorial is not to debate the DEA's decision to reschedule hydrocodone preparations but rather to demonstrate that all policy changes have consequences. In this case, these include substantial limitations on the ability of NPs in several states to adequately manage acute and chronic pain for their patients. As a result, NPs may be prevented from delivering comprehensive care to patients with certain conditions. (We are aware that our PA colleagues may be similarly affected by this ruling but will restrict our commentary to NPs, as we are most familiar with our profession's circumstances.)

Each state grants specific prescriptive privileges to advanced practice registered nurses (APRNs), resulting in wide variation across the country. Therefore, the effect of this ruling on patients' access to care and providers' ability to treat certain conditions differs by state. The states in which APRNs have prescriptive privileges for Schedule III but not Schedule II medications—those most impacted by this rule change—include Arkansas, Georgia, Missouri, Nebraska, Oklahoma, South Carolina, Texas, and West Virginia.[2] Prior to the effective date of this ruling, NPs in these states had hydrocodone and codeine preparations, as well

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as the nonnarcotic tramadol, in their armamentaria to treat pain.

The DEA ruling—coupled with restrictive state regulations—reduces the options for pain management in these states. The only other Schedule III narcotic treatment options are codeine preparations; for patients with codeine sensitivities or allergies, NPs are now unable to adequately manage acute or chronic pain. Besides inconvenience, this change results in additional costs, since patients will also need to be assessed by a provider with Schedule II prescriptive privileges if they hope to achieve adequate pain management. This is particularly burdensome in underserved or rural populations, which many of the affected states have.

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In response to this (presumably) unintended consequence, legislatures need to consider the impact this ruling will have on patient care and move to modernize prescriptive authority for APRNs, especially in the most affected states. The *Future of Nursing* report[3] from the Institute of Medicine (IOM) recommends that APRNs' scope of practice be reformed to conform with the model rules and regulations established by the National Council of State Boards of Nursing (NCSBN). The NCSBN's consensus model report supports full scope of practice for all APRNs, as well as collaboration among all health care disciplines as a professional norm, instead of the current restrictive practices.[4]

Historically, APRNs have struggled to gain total support from state legislators in the quest for full practice authority, including prescriptive privileges. Our professional organizations, with support from the IOM, the National Governors Association, and the Federal Trade Commission, must be ready to provide accurate data on safety and outcomes to state and federal legislators. This evidence would support efforts to modernize NP scope of practice acts, including prescribing regulations, that are currently outdated and prevent APRNs from providing optimal care.[5]

This year (2015) marks the 50th anniversary of the NP role. Thus, it is the proper time for state legislatures to recognize and support the role of the NP in the delivery of comprehensive, cost-effective health care in the United States. With millions of previously uninsured Americans seeking primary care and the increasing shortage of primary care physicians, NPs are part of the answer to the problem of access to acute and chronic care in both urban and rural communities. With NPs available to close this gap, it is imperative that both state and federal legislatures support initiatives that will eliminate barriers to care and promote legislation that offers full scope of practice to NPs.

We welcome your feedback on this topic. Please send your comments to NPEditor@frontlinemedcom.com. **CR**

REFERENCES

1. Drug Enforcement Administration. Schedules of controlled substances: rescheduling of hydrocodone combination products from schedule III to schedule II (document no: 2014-19922). *Federal Register*. https://federalregister.gov/a/2014-19922. Accessed February 13, 2015.
2. Drug Enforcement Administration Office of Diversion. Mid-level practitioners authorization by state. www.deadiversion.usdoj.gov/drugreg/practioners. Accessed February 13, 2015.
3. Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press; 2011.
4. National Council of State Boards of Nursing. *The Consensus Model for APRN Regulation, Licensure, Accreditation, Certification and Education* (2008). www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf. Accessed February 13, 2015.
5. National Council of State Boards of Nursing. Changes In Healthcare Professions' Scope of Practice: Legislative Considerations (2009). www.ncsbn.org/ScopeofPractice_09.pdf. Accessed February 13, 2015.