FULL PRACTICE AUTHORITY FOR APRNS

Policy Position | 2020-2021 Policy Council

The Texas Nurses Association (TNA) supports full practice authority for all four advanced practice registered nurse (APRN) roles. APRNs are registered nurses who have completed graduate coursework, passed a national certification exam, and achieved advanced licensure in the state. APRNs include nurse practitioners clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetist. ARPNs should be able to practice to the full extent of their training and within their defined Scope of Practice without burdensome government restrictions and anti-competitive supervision by another profession. TNA urges the legislature to consolidate all regulatory authority of nurses, including APRNs, under the Board of Nursing (BON).

OVERVIEW

Despite decades of experience, and a near impeccable track record related to patient outcomes, APRNs do not have full practice authority in Texas.[1] APRNs can practice to the full extent of their education and training *only* when they contract with a physician to "supervise" their practice. Texas is one of the few states that still require such supervision, which only requires physicians to review charts periodically and sign a form allowing the APRN to prescribe. In some cases, these contracts can cost close to $60,000 a year for the APRN, and the physician may not even see the patient. Effectively, many APRNs are already practicing to their fullest extent but are paying a physician thousands each month to do so.

The value of APRNs is demonstrated by the impressive patient outcomes they achieve — patient satisfaction and patient outcomes as good or better than physicians.[2,3] APRNs are not physicians and do not practice medicine. They practice nursing and should be liberated to practice their profession without unnecessary oversight. Like all primary care providers, APRNs typically have a network of health care professionals, including physicians, to whom they refer when particular expertise is required.

Twenty percent of Texans lack access to a primary care provider, and Texas is listed as 49th in the nation on access to and affordability of health care.[4] The legislature can change this statistic by allowing APRNs to practice to the full extent of their education and training.

FULL PRACTICE AUTHORITY BENEFITS TEXANS

LOWER COSTS

APRNs can be licensed more quickly and at less cost than physicians. Rather than $160,000 in taxpayer funds to educate a single medical student, with an additional $62.2 million for post-graduate residency positions, three to 12 nurse practitioners can be educated instead.[5] Full practice for APRNs provides an economic boost across the board. In 2019, nurse practitioners earned an average of $110,000 while primary care physicians earned an average of $237,000.[6,7] Since then, physician wages have risen faster in full-practice states than in restrictive-practice states because with APRNs assuming primary care provider roles, physicians can focus their expertise on more complex, and thus more costly, cases.[8]

ACCESS TO CARE

The Journal of Medical Regulation estimates Texas has approximately 78,000 physicians for 28 million people.[9] According to the Annals of Family Medicine, by 2032, there will be a shortage of up to 55,200 primary care physicians nationwide.[10] Texas ranks 41st in physicians per population and will account for nearly one-fourth of this shortage (10,000 short of demand).[11]

Additionally, Texas has 226 regions designated as Medically Underserved Areas. Twenty-five Texas counties have no physicians. Yet, in a recent study, out of a total of 17,509 graduates from medical school, it was projected only 17% intended to practice in primary care.[12]

The lack of providers has a significant impact on rural areas with limited access to care.[13] Patients in underserved areas needing specialty care can go to a robust specialty center in an urban setting. Primary care, however, needs to be accessible within the community. Elimination of unnecessary physician supervision of APRNs would increase rural access to primary care as nurse practitioners are more likely to provide key primary care services in rural areas, in a wider range of community settings, and with more Medicaid patients. When Texas APRNs were asked whether they would be willing to work in underserved areas if they were free from physician supervision requirements, 75% said that they would be extremely (28%), very (22%), or somewhat (25%) willing to do so.[14] The Texas Legislative Budget Board agrees that NPs will better meet the needs of Texans in rural locations when given more practice authority.[15]

COVID-19 CONSIDERATIONS

TNA acknowledges in the current pandemic of COVID-19 that all health care providers are in high demand and are being called to care for primary, specialty and seriously ill patients regardless of their normal practice population and settings. We appreciate the Texas legislative waiver efforts during this unprecedented time. As the volume in Texas health care needs continue to escalate in parallel with primary, specialty, and serious and often life-limiting illness, we encourage the Texas legislature to utilize APRNs to their full extent of education, training and licensure to increase access to high quality and affordable health care. This will improve the overall

health outcome and quality of life of both consumers and clinicians while utilizing creative resource allocation and decreasing cost to Texans and the state.

A NursesEverywhere survey found that 87% of patients thought nurses were indispensable during the pandemic, and 80-90% felt nurses could increase access to care, especially among minorities and in rural areas. In addition, 79% wanted nurses to play a greater role in their health care in the future.

CONSUMER CHOICE AND BETTER PATIENT OUTCOMES

Full practice authority for APRNs has been linked to greater access,[16] and fewer avoidable hospitalizations, readmissions,[17] and emergency department visits.[18] Consistently, studies demonstrate that NPs have as good or better outcomes than physicians.[19] CNSs specializing in prenatal care fare better than their physician counterparts when treating women with a high risk of a low-birth-weight baby,[20] and demonstrate shorter hospital stays and reduced costs in acute settings.[21] CNMs have lower Cesarean rates than physicians and use 12% less hospital resources than physicians.[22]

Recent literature lauds the use of team-based, patient-focused care models in which all providers (nurses, physicians, pharmacists, physical therapists, dieticians) work as a team and exchange patient care leadership based on patient needs. Within this model, using APRNs is encouraged by the American College of Obstetricians and Gynecologists, who state that all providers should "function to the full extent of their education, certification and experience" and that collaboration in teams must be between autonomous individuals.[23]

TEXAS AND THE NATION

Full practice authority laws are well tested. Currently 23 states authorize full practice authority for APRNs and a handful more have legislation pending. Most recently, South Dakota passed a full practice authority bill in February 2017. Every state immediately bordering Texas offers greater practice authority for APRNs than Texas. This risks the flight of nurses to more favorable practice environments in other states, potentially exacerbating the nursing shortage in Texas. In fact, the New Mexico governor recently launched an advertising campaign to recruit Texas APRNs to NM where APRNs have long enjoyed full practice authority. As long as Texas restricts APRN practice, we will continue to struggle to attract and keep APRNs.

States adopting full practice authority encompass a broad range of characteristics — from those considered more conservative than Texas (e.g., Utah, Alabama, West Virginia, and Tennessee) to extremely liberal states (e.g., Delaware, Connecticut, and Oregon). Not one state that has adopted full practice authority has ever reverted to more restricted practice.

LEGISLATIVE HISTORY

HB 1415 and SB 681 (2017 — Left pending in Public Health Committee)

- Would have removed requirement of Prescriptive Authority Agreement but practice authority would have remained the same.

HB 1885 (2015 — Left pending in Public Health Committee)

- Would have granted full-practice authority to the four roles of APRNs.

SB 406 (2013)

- Created the current Prescriptive Authority Agreement system.
- Created an exception for APRNs to prescribe Schedule II substances in hospital facilities.

SB 846 (2011 — Left pending in Finance Committee)

- Would have allowed APRNs to provide limited health services independent of a physician in sites serving medically underserved populations.

SB 532 (2009 — passed by Patrick)

- Authorized a physician to delegate the carrying out or signing of certain prescription drugs.
- Increased the number of APRNs a physician may delegate to from three to four.
- Provided that physician supervision is adequate when the physician is on site at least 10% (down from 20%) of the hours of operation, the physician reviews 10% of the APRN's medical charts electronically, and the physician is available for consultation.
- Allowed Texas Medical Board to waive the limitation on the number of APRNs physicians delegate to.

SB 800 (2007 — Left pending in Health and Human Services Committee)

- Would have increased the number of APRNs that a physician may delegate to from three to six.
- Would have eliminated requirements that physicians be on site with the APRN at least 20% of the time.

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