



# ADVANCED PRACTICE REGISTERED NURSES

## 2018-2019 Policy Positions

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 (NPs)
- Clinical Nurse Specialists (CNSs)
- Certified Nurse Midwives (CNMs)
- Certified Registered Nurse Anesthetist (CRNAs)

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**NPs** make up the majority of APRNs and are commonly thought of as primary care providers in outpatient settings. While they perform in that arena very well, they also provide services in other settings such as specialty practices and complex acute care settings.

**CNSs** provide specialized clinical expertise in direct care to individuals and additionally serve as health care educators, consultants, and researchers.

**CNMs** provide perinatal (prenatal, delivery, postpartum) services as well as providing women’s health services such as primary gynecologic and family planning care. CNM’s attend over 300,000 births per year in the U.S.<sup>1</sup>

**CRNAs** provide anesthesia services in all settings – obstetrics, surgical, trauma, etc. CRNAs may also specialize in pain management services.

## OVERVIEW

Despite decades of experience, and a near impeccable track record related to patient outcomes, APRNs do not have full practice authority in Texas.<sup>2</sup> That is, APRNs can practice to the full extent of their education and training

<sup>1</sup> Hamilton B, et al., “Births: Final Data for 2014. National Vital Statistics Reports,” National Center for Health Statistics, Vol. 64, No. 12, (2015).

<sup>2</sup> Scope of Practice Barriers for Advanced Practice Registered Nurses: A State Task Force to Minimize Barriers.

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.<sup>3,4</sup> 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.

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**While APRNs are educated differently than physicians, they are educated perfectly for the roles they assume.**

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Twenty percent of Texans lack access to a primary care provider, and Texas was recently listed as 51<sup>st</sup> in the nation on access to and affordability of health care by the Commonwealth Fund. The legislature can change this statistic by allowing APRNs to practice to the full extent of their education and training.

## LOWER COSTS

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APRNs can be licensed more quickly and at less cost than physicians. Texas taxpayers spend on average \$160,000 to educate a single medical student. In 2018-19, the state will spend an additional \$62.2 million to finance post-graduate residency positions. In contrast, three to 12 nurse practitioners can be educated for the price of one physician<sup>5</sup> in a fraction of the time.

Full practice for APRNs provides an economic boost across the board. In 2008, nurse practitioners earned an average of \$92,000<sup>6</sup> while primary care physicians earned an average of \$162,500.<sup>7</sup> 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.<sup>8</sup>

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J Nurs Adm. 2017 Sep;47(9):465-469. doi: 10.1097/NNA.0000000000000515.

<sup>3</sup> Munding MO, et al. “Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial.” JAMA (Jan 5, 2000).

<sup>4</sup> Newhouse, R., et al. “Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review”. CNE Series (2011). <https://www.nursingeconomics.net/ce/2013/article3001021.pdf>

<sup>5</sup> Patricia Starck, The Cost of Doing Business in Nursing Education, “Journal of Professional Nursing 21, no. 3 (June 2005): 183–90.

<sup>6</sup> American Academy of Nurse Practitioners, “Annual salary survey” (2008).

<sup>7</sup> G.G. Weiss, “2009 Earnings Survey: How Do You Compare?,” Medical Economics (September 18, 2009).

<sup>8</sup> Patricia Pittman and Benjamin Williams, “Physician Wages in States with Expanded APRN Scope of Practice, Physician Wages in States with Expanded APRN Scope of Practice,” Nursing Research and Practice, Nursing Research and Practice 2012 (February 7, 2012).

## ACCESS TO CARE

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The Texas Medical Association estimates Texas has approximately 43,000 physicians for 23 million people.<sup>9</sup> By 2025, there will be a shortage of 44,000 to 46,000 primary care physicians nationwide. Texas ranks 42<sup>nd</sup> in physicians per population and will account for nearly one-fourth of this shortage (10,000 short of demand).<sup>10</sup>

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**Nearly 20% of Texans — 4.6 million people — lack access to a primary care provider.<sup>12</sup>**

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Additionally, Texas has 226 regions designated as Medically Underserved Areas. Twenty-five Texas counties have no physicians. Yet, in a survey of recent medical school graduates, only 2% chose to practice in primary care, due to high educational debt and relatively low salaries when compared to specialty fields.<sup>11</sup>

The lack of providers has a significant impact on rural areas with limited access to care.<sup>12</sup> 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.<sup>13</sup> The Texas Legislative Budget Board agrees that NPs and CRNAs are more likely to practice in rural locations when given more practice authority.<sup>14</sup>

## CONSUMER CHOICE AND BETTER PATIENT OUTCOMES

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Full practice authority for APRNs has been linked to greater access,<sup>15</sup> and fewer avoidable hospitalizations, readmissions,<sup>16</sup> and emergency department visits.<sup>17</sup> Consistently, studies demonstrate that NPs have as good or better outcomes than physicians.<sup>18</sup> CNSs specializing in prenatal care fare better than their physician counterparts when treating women with a high risk of a low-birth-weight baby,<sup>19</sup> and demonstrate shorter

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<sup>9</sup> Texas Medical Association. "Why Texas Needs More Physicians." <https://www.texmed.org/template.aspx?id=5427>

<sup>10</sup> Garson, A. (2011, November) Texas will need 10,000 new physicians over the next 10 years: True or false. *Houston Chronicle*.

<sup>11</sup> Hauer, K.E. et al., "Factors Associated with Medical Students' Career Choices Regarding Internal Medicine," *JAMA* 300, no. 10 (September 10, 2008): 1154–64.

<sup>12</sup> Buerhaus et.al. "Practice characteristics of primary care nurse practitioners and physicians." *Nursing Outlook*, 2015. 63, 144-153

<sup>13</sup> Texas Nurse Practitioners. *Advanced Practice Registered Nurses: Providing Primary Health Care to Those Most in Need*. (2014).

<sup>14</sup> Texas Legislative Budget Board Staff. "Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations," 297 (Jan. 2011)

<sup>15</sup> Stange, K. How does provider supply and regulation influence health care markets? Evidence from nurse practitioners and physician assistants. *Journal of Health Economics*, 2014. 33, 1-27.

<sup>16</sup> Oliver et. al. "Impact of nurse practitioners on health outcomes of Medicare and Medicaid patients." *Nursing Outlook*, 2014. 62(6), 440-447.

<sup>17</sup> Traczynski J &Udalova V. "Nurse practitioner independence, health care utilization, and health outcomes." Paper Presented at the Fourth Annual Midwest Health Economics Conference, April 4-5, 2013, Madison, WI.

<sup>18</sup> Munding, M. O. "Advanced-Practice Nursing -- Good Medicine for Physicians?" *New England Journal of Medicine* 330, no. 3 (January 20, 1994): 211–14.

<sup>19</sup> D. Brooten et al. "A Randomized Trial of Nurse Specialist Home Care for Women with High-Risk Pregnancies: Outcomes and Costs," *The American Journal of Managed Care* 7, no. 8 (August 2001): 793–803.

hospital stays and reduced costs in acute settings.<sup>20</sup> CNMs have lower Cesarean rates than physicians and use 12% less hospital resources than physicians.<sup>21</sup>

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.<sup>22</sup>

## TEXAS AND THE NATION

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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 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.

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**Full practice authority garners support from both sides of the aisle because it is good public policy and is beneficial for consumers.**

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## TNA POSITION

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The Texas Nurses Association (TNA) supports full practice authority for all four APRN roles. Each APRN 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).

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<sup>20</sup> Newhouse et. al. “Advanced practice nurse outcomes 1990-2008: A systematic review.” *Nursing Economics*, 2011. 29(5), 1-21.

<sup>21</sup> Rosenblatt, R. A. et al. “Interspecialty Differences in the Obstetric Care of Low-Risk Women,” *American Journal of Public Health* 87, no. 3 (March 1997): 344–51.

<sup>22</sup> Collaboration in Practice: Implementing Team-Based Care. *The American College of Obstetricians and Gynecologists*, Vol. 127, No. 3, March 2016.

## LEGISLATIVE HISTORY

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### 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.

## NATURAL DISASTERS

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### ISSUE BACKGROUND

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In September 2017, the Texas coast sustained a direct hit from Hurricane Harvey, a Category 4 hurricane, resulting in catastrophic damage from high winds, rain and storm surge in the coastal and southeast areas. The storm stalled over Texas and, over four days, produced historic rain, totaling over 60 inches. In all, 68 people died, and Harvey caused around \$125 billion in property damage. In addition, Harvey spawned 57 tornadoes

in Texas and nearby states, including Louisiana, Mississippi, Alabama and as far north as Tennessee. Hurricane Harvey was declared the second most costly hurricane in the U.S., behind Hurricane Katrina in 2005.<sup>23</sup>

Disaster responses at the local, state and federal levels were swift. First responders from across Texas poured into affected regions. Given the unprecedented destruction of this storm, nurses across the country also answered the call to fill in at the bedside — covering for the nurses affected themselves. The Texas Board of Nursing granted temporary licensure to more than 600 out-of-state nurses in this time period to work in hospitals, clinics and shelters for the purpose of rendering disaster aid. In addition, APRNs were granted expedited processing of interim licensure application, with requests for prescriptive authority as a separate review.

## WHY IT MATTERS FOR TEXAS NURSES

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While these waivers helped during the disaster recovery for APRNs from outside of Texas, the nurses — many of whom came from full-practice-authority states — still had to follow Texas physician supervision requirements. In order to prescribe, the nurses needed to have a written agreement with a physician showing supervision and delegation of prescription authority. Unfortunately, this seems to have led several APRNs to leave the state without providing any care because APRNs outside of Texas don't have pre-existing relationships with Texas physicians and were unable to effectively provide care for patients.

## TNA POSITION

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Absent full practice authority for APRNs in Texas, APRNs in Texas should, at a minimum, be trained with Community Emergency Response Teams to provide cohesive disaster planning with local first responders. Within areas of governor-declared disasters in Texas, out-of-state APRNs who practice without physician supervision in their home state should be allowed to practice without supervision in providing aid to Texans.

## NON-OPIOID CSII

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### ISSUE BACKGROUND

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By law, APRNs in Texas can prescribe medications the Drug Enforcement Agency (DEA) classifies as Schedule III, IV or V. Until 2014, Schedule III included hydrocodone combinations — the most commonly prescribed opioids for pain management. However, in October 2014, the DEA reclassified these drugs as Schedule II controlled substances<sup>24</sup>, and APRNs in Texas could no longer prescribe them except in limited circumstances.

New research on sales of controlled substances on the darknet through cryptocurrency shows the reclassification limited the number of providers able to prescribe drugs, but the black market steadily increased from 2013 to

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<sup>23</sup> Blake, E.S., Zelinsky, D.A. National Hurricane Center, Hurricane Harvey (2018). [https://www.nhc.noaa.gov/data/tcr/AL092017\\_Harvey.pdf](https://www.nhc.noaa.gov/data/tcr/AL092017_Harvey.pdf)

<sup>24</sup> Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products From Schedule III to Schedule II, 21 CFR §1308 (2014). [https://www.deadiversion.usdoj.gov/fed\\_regs/rules/2014/fr0822.htm](https://www.deadiversion.usdoj.gov/fed_regs/rules/2014/fr0822.htm)

2016. In 2016, sellers of opioids on the darknet represented 13.7% of all illicit drug sales, in contrast to the expected 6.7% researchers modeled had the DEA reclassification not taken place.<sup>25</sup> The researchers concluded:

*The scheduling change in hydrocodone combination products coincided with a statistically significant, sustained increase in illicit trading of opioids through online US cryptomarkets. These changes were not observed for other drug groups or in other countries. A subsequent move was observed towards the purchase of more potent forms of prescription opioids, particularly oxycodone and fentanyl.*

The United States is undeniably experiencing an epidemic of opioid abuse and preventable deaths. In 2016 alone, over 11 million Americans misused opioids and opioid-related deaths have quadrupled since 1999.<sup>26</sup> The Centers for Disease Control and Prevention estimates that more people died last year from drug overdose than from the peak total of deaths from guns, car crashes or HIV.<sup>27</sup> The national crisis prompted President Trump to declare it a public health emergency and multiple states, including Texas, are focusing resources to stem the tide of opioid addiction and misuse.

## WHY IT MATTERS TO TEXAS NURSES

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We have a mental health provider shortage in the state, despite our best efforts to incentivize providers to go into mental health fields. Data from the 2015 American Medical Association Physician Masterfile indicates approximately 8,350 child and adolescent psychiatrists are available to serve 14.8 million children affected by mental illness in the United States.<sup>28</sup> According to Meadows Mental Health, each year over 545,000 children and adolescents in Texas experience serious mental health needs.<sup>29</sup> And according to the Substance Abuse and Mental Health Services Administration, in 2016, six out of ten adolescents who experienced a major depressive episode in the last year received no treatment.

To best serve Texans, we need to free up our providers to provide access to mental health care and reduce the probability that mental health care needs go unaddressed. Not all Schedule II controlled substances are opioids, but all stimulants used in the care of people with mental health needs are Schedule II. This limits the number of providers that are able to prescribe stimulants as part of mental health care.

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<sup>25</sup> Martin James, Cunliffe Jack, Décarry-Héту David, Aldridge Judith. Effect of restricting the legal supply of prescription opioids on buying through online illicit marketplaces: interrupted time series analysis *BMJ* 2018; 361:k2270.

<sup>26</sup> Robert J. Blendon, Sc.D., and John M. Benson, M.A., The Public and the Opioid Use Epidemic. *n engl j med* 378;5 (2018)

<sup>27</sup> Ingraham, C. (2018, August 15). Fentanyl use drove drug overdose deaths to a record high in 2017, CDC estimates. *The Washington Post*. Retrieved from <https://www.houstonchronicle.com/>

<sup>28</sup> American Academy of Child & Adolescent Psychiatry. Depression in children and teens. July 2013 [https://www.aacap.org/aacap/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/The-Depressed-Child-004.aspx](https://www.aacap.org/aacap/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Depressed-Child-004.aspx)

<sup>29</sup> The Meadows Mental Health Policy Institute. (2016). Estimates of Prevalence of Mental Health Conditions among Child and Adolescents in Texas. Retrieved from <http://www.texasstateofmind.org/wp-content/uploads/2016/01/MMHPI-ChildAdolescent-Prevalence-Summary-2016.03.24.pdf>

Nov. 9, 2017, the Texas Board of Examiners of Psychologists passed rules to allow Masters-Prepared Licensed Psychological Associates to practice independently. While this will lead to increased psychological services, the change will not address the need for providers with prescriptive authority.

As the opioid epidemic looms large over any proposal to allow additional providers to prescribe opioid medication, TNA has another idea.

## TNA POSITION

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Due to the significant shortage of mental health providers across Texas and the costly delay in care for patients as a result, TNA recommends that the legislature allow APRNs outside of hospital-facility based and hospice practices to prescribe limited non-opioid Schedule II drugs. These drugs allow providers to improve access to care for adolescent and mental health patients without significant risk of addiction, and the current prescribing prohibition placed on these non-opiate drugs only increases costs for patients and delays in necessary care.

## LEGISLATIVE HISTORY

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### HB 2548 (2017 - Reported favorably from Public Health Committee)

- Would have allowed physician assistants to prescribe Schedule II controlled substances under the supervision of a physician.

## DISCHARGE PRESCRIPTIONS

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### ISSUE BACKGROUND

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In SB 406 (2013) physicians gained the ability to delegate the ordering and prescribing of Schedule II controlled substances to APRNs in a hospital facility-based practice. Shortly after, an interpretive FAQ surfaced from state agencies overseeing implementation stating that APRNs may prescribe Schedule II medications to patients *only if the prescription is filled in the hospital's pharmacy*, effectively changing the meaning of the statute.

### WHAT IT MEANS FOR TEXAS

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State agencies are required to provide notice and hold public hearings for any rule that affects the practice of their regulated community. The FAQ circumvented the requirement to hold public hearings on rules that interpret statute and obscures the plain meaning of the statutory language. This interpretation prevents APRNs at hospitals without a pharmacy from acting within their statutory authority to issue discharge prescriptions as clearly allowed by SB 406. It causes confusion and favors some practitioners and some pharmacies over others.

## TNA POSITION

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Texas Occupations Code, Section 157.0511 (b-1) states that an APRN may prescribe Schedule IIs in a hospital. The law does not say that APRNs must fill the prescription *only in a hospital pharmacy*. If the patient feels more comfortable going to their local pharmacy, state boards should not prohibit them from doing so.

TNA recommends that the legislature clarify this statute to remove any doubt regarding the interpretation and allow all APRNs to issue discharge prescriptions for patients, regardless of the pharmacy the patient chooses.

## LEGISLATIVE HISTORY

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### HB 1846 (2017 - Reported favorably from Public Health Committee)

- Would have allowed any pharmacist to fill prescriptions for Schedule II controlled substances from APRNs in hospital facility-based practices.

### HB 2602 (2015 – filed by Coleman)

- Would have allowed community pharmacies to fill discharge prescriptions from APRNs in hospital facility-based practices.

### SB 406 (2013)

- States “a physician may delegate the ordering and prescribing of CSIIIs [to APRNs]... in a hospital facility-based practice...”

## SIGNATURES

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### ISSUE BACKGROUND

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Physicians have long been solely responsible for signing health care-related documents like birth certificates, orders for handicap placards, jury duty waivers, immunization waivers and worker’s compensation forms. But as APRNs provide increasing proportions of primary care, the requirement of physician authorization has become a barrier to practice.

### WHAT IT MEANS FOR TEXAS

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APRNs serve an integral role in providing primary care. Requiring a consumer to see a physician solely for a signature is a waste of time for both patient and physician when the physician’s time would be better spent on clinical issues. There is no reason an APRN should not be able to meet with patients to sign a form within their scope of training. This barrier only further burdens patients with costly and time-consuming physician visits.

## TNA POSITION

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TNA recommends that the legislature allow APRNs to lower costs and serve consumers by amending outdated laws that prevent APRNs from authorizing certain forms (statutory references listed below):

- Section 38.001 (c), Education Code — Immunization waivers for elementary and secondary schools
- Section 51.933(d), Education Code — Immunization waivers for institutions of higher education
- Section 51.9192(d), Education Code — Bacterial meningitis vaccination waivers
- Sections 62.109(b) and (f), Government Code — Jury duty exemptions
- Section 89.011 (a), Health and Safety Code — Certifications of completed tuberculosis screening at correctional facilities
- Sections 192.003(a) and (c), Health and Safety Code — Birth certificates
- Section 504.201 (d), Transportation Code — Statements authorizing specialty license plates
- Sections 681.003(c) and 681.004(d), Transportation Code — Disabled parking placards
- Section 408.025, Labor Code — Worker’s compensation documents

## LEGISLATIVE HISTORY

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### HB 2950 (2017)

- Allows APRNs to certify death if the patient is in hospice or palliative care.

### HB 1473 (2015 - Left pending in Public Health Committee)

- HB 1473 was an omnibus bill covering the signing of multiple types of forms by both APRNs and PAs.

### HB 1185 (2015 - Left pending in Public Health Committee)

- HB 1185 was an omnibus bill covering the signing of multiple types of forms by APRNs only.

### SB 466 and HB 3913 (2015 - Left pending in Judiciary Affairs Committee)

- SB 466 and HB 3913 would have allowed APRNs to sign jury-duty exemptions.