Get to Know Your APRN:
The Four Roles of Advanced Practice Nursing

Nurse Practitioner

15,482

NPs are licensed to practice in Texas.

NP

Diagnose illness, treat illness, prescribe meds, order and interpret tests.

Bring a **comprehensive approach** to health care, can be found in many medical settings.

80%

80% were prepared in primary care, while only 14.6% of physicians entered primary care residency in 2012.

Clinical Nurse Specialist

Improve quality, safety, and cost outcomes for patient populations; diagnose and treat illness, promote health, and some prescribe medications.

CNS

1,348

CNSs are licensed to practice in Texas.

Provide specialized nursing clinical expertise to patients, nurses, and organizations.

Certified Registered Nurse Anesthetist

Most cost-effective anesthesia providers with an exceptional safety record.

4,000+

More than 4,000 CRNAs practice in Texas.

CRNA

Trained to deliver anesthesia care, regardless of whether an anesthesiologist is involved. Practice in every setting where anesthesia is provided.

Certified Nurse Midwife

12,000 BIRTHS

CNMs **attended over 12,000 births** in Texas in 2013, 96% of which were in hospitals.

CNM

Provide primary care to women, including health promotion, gynecologic and family planning services, care during pregnancy, childbirth, postpartum period, and newborn care.

Advanced Practice Registered Nurses (APRNs)

Advanced Practice Registered Nurses (APRNs)

APRNs are registered nurses who have at a minimum completed graduate coursework (masters degree), 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 Anesthetists (CRNAs)

Despite decades of experience and a near impeccable track record related to patient outcomes, APRNs do not have full practice authority in Texas. That is, 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, but it is not "supervision" in the normal sense of the word. When "supervising" an APRN practice, physicians never actually see the patients, but rather merely review charts periodically and sign a form allowing the APRN to practice. In some cases, these contracts can cost close to $60,000 a year for the APRN. Effectively, many APRNs are already practicing to their fullest extent but are paying a physician at least a mortgage payment each month to be able to do so.

Twenty percent of Texans lack access to a primary care provider, and Texas was recently listed as 51st in the nation on access to and affordability of health care by the Commonwealth Fund. The Legislature has the ability to change this statistic by allowing APRNs to practice to the full extent of their education and training without useless physician supervision.

Lower Costs

APRNs are prepared more quickly and less costly than physicians. Texas taxpayers spend on average $160,000 to educate a single medical student, and in 2014, the state spent an additional $32.8 million to finance 6,500 post-graduate residency positions. In contrast, three to twelve nurse practitioners can be educated for the price of one physician and 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[1] while primary care physicians earned an average of $162,500.[2] Since then, physician wages have risen faster in full-practice states than in restrictive-practice states,[3] because as APRNs assume a more independent role as primary care providers, physicians are able to focus their expertise on more complex and thus more costly cases.[4]

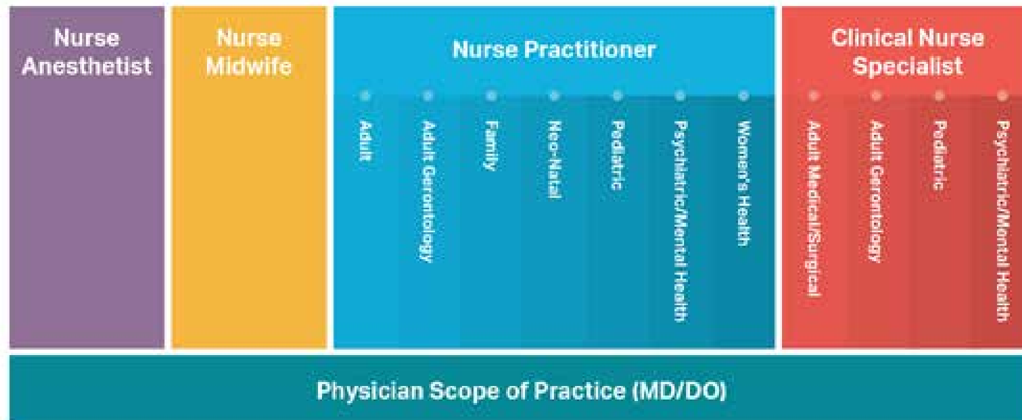
Access to Care

The Texas Medical Association estimates that Texas has approximately 43,000 physicians to care for 23 million people.[5] But by 2025, there will be a shortage of 44,000 to 46,000 primary care physicians nationwide. Texas already ranks 42nd in physicians per population and will account for nearly one-fourth of the national shortage (10,000 short of demand in Texas).[10]

Additionally, Texas has 226 regions designated as Medically Underserved Areas (MUAs). Twenty-five Texas counties have no physician, and nearly 20% of Texans, or ***4.6 million people,*** **lack access to a primary care provider.** And yet, in a survey of recent medical school graduates, only 2% chose to practice in primary care. This choice was attributed to high educational debt and relatively low salaries when compared to specialty fields.[7]

“If they want to be doctors, why don’t they go to medical school?”

APRN Scope of Practice by Licensure



APRNs don’t want to be physicians. Physicians are trained for fourteen or more years to be able to practice in all fields of medicine. APRNs have extremely narrow scopes — they specialize by becoming one of the four types of APRNs and then specialize further when they are licensed in a particular population focus area.

The lack of primary care has a significant impact on rural areas with limited access to care.[8] Patients in underserved areas needing specialty care go to a robust specialty center in an urban setting. Primary care, however, needs to be accessible within the individual’s community. Elimination of unnecessary physician supervision of APRNs would increase access to primary care in rural communities.

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.[9] The Texas Legislative Budget Board agrees that NPs and CRNAs are more likely to practice in rural locations when given more practice authority.[10]

Consumer Choice and Better Patient Outcomes

Full practice authority for APRNs has been linked to greater access[11] and fewer avoidable hospitalizations, readmissions,[12] and emergency department visits.[13] Consistently, studies demonstrate that NPs have as good or better outcomes than physicians.[14] CNSs specializing in prenatal care fare better than their physician counterparts when treating women with a high risk of a low-birth-weight baby,[15] and demonstrate shorter hospital stays and reduced costs in acute settings.[16] CNMs have lower Cesarean rates than physicians and use 12% less hospital resources than physicians.[17]

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, the utilizations of APRNs are encouraged by the American College of Obstetricians and Gynecologists, stating 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.[18]

Texas taxpayers spend on average $160,000 to educate a single medical student. Three to 12 nurse practitioners can be educated for the price of one physician and in a fraction of the time.

Texas and the Nation

Full practice authority laws are well tested. Currently 22 states grant full practice authority for APRNs and a handful more have legislation pending. Most recently, West Virginia passed a full practice authority bill in March 2016. Every state immediately bordering Texas offers greater practice authority for APRNs than Texas. In fact, the New Mexico governor recently launched an advertising campaign to recruit APRNs to New Mexico 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.

TNA Position

The Texas Nurses Association supports full practice authority for APRNs in all four roles — 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.

Legislative History

HB 1885 (2015 - Left pending in Public Health)
- 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)
- 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 that 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 the Texas Medical Board to waive the limitation on the number of APRNs that physicians may delegate to.

SB 800 (2007 - Left pending in Health and Human Services)
- 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.

Discharge Prescriptions

Issue Background

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

What It Means For Texas

State agencies are required to provide notice and hold public hearings for any rule that affects the practice of their regulated community. The FAQ circumvents the requirement to hold public hearings on rules that interpret statute and obscures the plain meaning of the statutory language. The 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

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 the prescription must be filled only in a hospital pharmacy. If the patient feels more comfortable going to their local pharmacy to fill their prescription, then 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

HB 2602 (2015 – Left pending in Calendars)

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

SB 406 (2013)

- SB 406 (2013) stated, "a physician may delegate the ordering and prescribing of CSIIs [to APRNs] ... in a hospital facility-based practice ..."

Signatures

Issue Background
Physicians have long been solely responsible for signing health care-related documents like birth and death certificates, orders for handicap placards, jury duty and 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
APRNs serve an integral role in providing primary care. Requiring a consumer to see a physician solely for an authorization 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 why an APRN should not be able to meet with patients to sign a form that is well within their scope of training. This barrier only serves to further burden patients with costly and time-intensive physician visits.

TNA Position
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
- Sections 193.005(a), (b), and (c), Health and Safety Code - Death 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
HB 1473 (2015 - Left pending in Public Health)
- Would have allowed the signing of multiple types of forms by both APRNs and PAs.

HB 1185 (2015 - Left pending in Public Health)
- Would have allowed the signing of multiple types of forms by APRNs only.

SB 466 and HB 3913 (2015 - Left pending in Judiciary Affairs)
- SB 466 and HB 3913 would have allowed APRNs to sign jury duty exemptions.

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