TEXAS NEEDS A NEW APPROACH TO APRN PRESCRIPTIVE AUTHORITY

Texas’ current site-based model for APRN prescriptive authority was first enacted in 1989 and reflects 20 years of add-on amendments. It began with sites serving medically underserved populations, then physician primary practice sites were added, hospital facility based practices, nursing home facility-based practices, and finally physician alternate practice sites. Each site has its own set of restrictions – for some sites it is the number of APRN FTEs, for others it is the geographical distance from the physician, number of hours open, number of charts that must be reviewed, where the charts must be reviewed, etc., etc. As illustrated by the diagram set out as Attachment 1, the result is a hopelessly complex model with multiple restrictions which have little to do with quality of care and actually reduce access to care, e.g., the time a physician spends traveling from site to site to provide on-site supervision is time not spent seeing patients; the APRN who wants to practice in an underserved area must find a physician in that area willing to comply with the numerous restrictions required.

Texas cannot maintain the current site-based model and expect APRNs to effectively contribute to Texas’ need for more providers – particularly primary care providers. Nursing is proposing an APRN prescriptive authority model that not only is a more rational model but more importantly one that better promotes access to safe patient care.

Nursing realizes that the issue of physician involvement in APRNs’ prescribing is a controversial one and that any proposed model that eliminates physician involvement may lack the necessary support in the Texas Legislature. Accordingly, the Texas Nurses Association, Coalition for Nurses in Advanced Practice, Texas Nurse Practitioners, Texas Association of Nurse Anesthetists, Consortium of Texas Certified Nurse Midwives and Texas Clinical Nurse Specialists have worked to develop a new, more reasonable prescriptive authority model that would retain physician involvement while permitting APRNs to practice more effectively.

The proposed model is based on a model adopted by 17 of the 32 states that require physician involvement. (18 states + D.C. do not require physician involvement.) This model is referred to as a “collaborative agreement” model. Specifically, nursing is proposing to replace the current site-based model with a model which requires for an APRN to prescribe, that the APRN:

1) must be credentialed by the Texas Board of Nursing as qualified to prescribe (the same as current law); and
2) must have a collaborative prescriptive authority agreement with a physician or physician group that provides for consultation with and referral to the physician or physician group.

A diagram of this proposed model is set out as Attachment 2. When compared with the current model (Attachment 1), it is clear the proposed model is a much simpler and unlike the current model, retains physician involvement without micromanaging how that involvement must occur. This will permit APRNs and physicians who collaborate with them to more effectively and efficiently meet the needs of many Texans for better access to care.
ATTACHMENT 2
Diagram of Proposed Collaborative Agreement Model for APRN Prescriptive Authority in Texas

STEP 1
APRN CREDENTIALED BY TEXAS BOARD OF NURSING AS QUALIFIED TO PRESCRIBE
BON Verifies Education and National Certification & Issues Rx Authority Number to Qualified APRNs
(The BON performs these functions under current law.)

STEP 2
APRN COMPLETES COLLABORATIVE AGREEMENT WITH INDIVIDUAL PHYSICIAN OR GROUP

QUALIFIED APRN MAY PRESCRIBE