Addressing the Texas Health Care Crisis: Effective Use of Advanced Practice Registered Nurses

Jessica L. Peck, DNP, RN

ABSTRACT
Texas is experiencing an unprecedented health care crisis, including a shortage of primary care providers. The current site-based delegation practice model for advanced practice registered nurses (APRNs) restricts public access to qualified providers. APRNs are equipped to immediately address the crisis in Texas by providing accessible, affordable, high-quality care if they are permitted to practice to the full extent of their education and training. Texas APRN organizations are working with stakeholders to propose a new collaborative practice model during the 2013 legislative session. Using APRNs is projected to increase economic output to $26 billion and create 177,200 jobs by 2040.

Keywords: access to care, advanced practice registered nurse, APRN, independent prescriptive authority, primary care, scope of practice
© 2013 Elsevier, Inc. All rights reserved.

The state of Texas is facing an unprecedented health care crisis. In 2008, more than 5.8 million Texans (nearly 25%) lacked health insurance, twice the national average. Indeed, Texas was the most uninsured state in the nation, ranking last for access to health care, 47th in the active primary care physician supply ratio, and 46th in overall health care. Texas has 214.2 physicians per capita, 41st in the nation. Of 254 total Texas counties, 28 do not have a single practicing physician, and 18 have only 1 physician.

Current practice restrictions on advanced practice registered nurses (APRNs) limit their potential to play a critical role in addressing the primary care shortage. If permitted to practice within the full scope of their education and training, APRNs can address the health care provider crisis in Texas by providing accessible, affordable, high-quality care.

PROBLEM IDENTIFICATION
A national shortage of primary care providers (PCPs) began in 1994 when a surplus of 165,000 physicians was predicted. Between 1980 and 2005, medical school enrollment remained the same, despite a population increase of nearly 100 million. Medical colleges are now charged to increase enrollment by 30%, but the average time to train a physician is 10 years, and there is no immediate relief in sight. In addition, the majority of medical students entering practice opt to pursue a specialty practice over primary care.

Medical schools are not keeping pace to produce enough PCPs to meet national demand. Only 48% of available family medicine slots in 2010 were filled, as opposed to more than 90% of specialty slots, such as orthopedic, plastic, and vascular surgery. In 2009, only 9% of medical school graduates chose to pursue primary care. With 50 million uninsured Americans (including 6 million Texans) set to receive health insurance in 2014 as a result of the Affordable Care Act, the nation’s supply of primary care physicians will be quickly overwhelmed.

Current predictions show the United States will need up to 200,000 additional physicians by 2020. Rural and underserved areas will suffer most. Studies have shown that APRNs are more likely than physicians to show interest in serving these rural communities and are also more likely to provide after-hours care. Further, the numbers of persons over 65 years old are estimated to reach 72.1 million by 2030, equating to 1 in every 5 Americans. With an aging population comes increased incidence of chronic disease and disability.
APRNs are well situated to respond to these issues and integrate them into the delivery of primary care.\textsuperscript{12} The public awareness of the APRN role in the provider shortage has increased as press coverage has touted APRNs as accessible, affordable, and focused on patient-centered care and prevention.\textsuperscript{13} Physicians in Texas have voiced concerns about APRNs in practice and purport that diagnosing and prescribing are rights to be granted solely to physicians.\textsuperscript{14} Studies, however, have shown that patients have equal or better satisfaction scores with care from APRNs,\textsuperscript{15,16} and APRNs with independent practice are sued two-thirds less often than those with delegated authority. APRNs provide quality care with no significant difference in patient outcomes,\textsuperscript{17} number of prescriptions written, number of return visits, or referrals to other providers.\textsuperscript{18} Approximately 15,000 APRNs in Texas are qualified to provide care and help alleviate the health care provider shortage, yet they are unable to practice to the full extent of their education and training because regulation surrounding APRN practice in Texas is so restrictive.\textsuperscript{19} As a result, the public is denied access to the care of qualified health providers.

**BACKGROUND ON APRN PRACTICE IN TEXAS**

The Texas Board of Nursing (BON) first began to regulate the education, eligibility, and practice requirements of APRNs in 1978. State laws were enacted in 1989 to increase access to care in rural clinics, and thus the need arose for independent prescriptive authority for APRNs. Stakeholders were able to negotiate delegated prescriptive authority to APRNs in medically underserved areas. The legislative trail that started then resulted in 1 of the most complex and confusing laws on prescriptive authority in the US.\textsuperscript{20} As a result, APRNs have some autonomous elements of practice, such as diagnosing, which is delegated but carries no actual practice restrictions.

However, prescriptive authority is very complicated, with many variables and scenario-based rules that govern the ability to prescribe. Not only does Texas require each APRN to secure a collaborating agreement with a physician, but there are also many other limitations, which vary from practice to practice (Figure 1).

Simply lifting these complex restrictions would greatly increase Texans’ access to care at no additional expense to the state.\textsuperscript{21} The Texas Legislative Budget Board’s January 2011 report to the 82nd Texas Legislature said that the state’s “site-based, delegated model of prescriptive authority limits patient access to affordable, quality health care providers, particularly in rural and health professional shortage areas.”\textsuperscript{22}

In 35 states, diagnostic and prescriptive authority is granted by the BON. Sixteen of these states do not require a statutory relationship with a collaborating or delegating physician. Texas is 1 of only 4 states with site-based restrictions on prescriptive authority.\textsuperscript{23} In 2003, the Texas Medical Association (TMA) offered a legislative compromise, granting APRNs the right to prescribe some (but not all) controlled substances. The prescriptions were still to be written under existing physician-delegated protocols. The price for this was agreement to a moratorium on all APRN initiatives related to autonomy expansion until 2009. APRNs agreed, viewing this as an opportunity to strategize and raise the necessary capital to plan a vigorous effort for independent prescriptive authority when the moratorium expired.\textsuperscript{20} In 2009, 2 bills that would have increased the scope of independent practice for Texas APRNs were introduced to the 82nd Texas Legislature. SB 1260 would have amended the Medical Practice Act to eliminate delegated prescriptive authority. SB 1339 would have allowed the BON to grant full diagnostic and prescriptive authority to qualified APRNs who completed a set number of hours of supervised practice.\textsuperscript{24} The Federal Trade Commission (FTC) advised the 82nd Texas State Legislature that the passage of SB 1260 and SB 1339 would benefit Texas health care consumers by offering competition for quality, affordable health care.\textsuperscript{16} The bills would give consumers more variety in the range of choices, as well as spark innovation in service delivery.

However, the political opposition to both bills was massive. TMA, which consists of nearly 50,000 licensed Texas physicians and medical students, expressed opposition to the expansion of APRN practice, and their opposition creates hesitancy for any politician tempted to step into the APRN camp. The TMA Political Action Committee (TEX-PAC) has an annual fund of over $1.5 million for lobbying efforts, 5 times more than the entire operating budget of the Coalition for Nurses in Advanced Practice.
(CNAP), a coalition of all statewide APRN organizations. TMA had dedicated lobbyists who designated defeating any legislation related to APRN scope of practice as their top priority, with the second item on their agenda being defeat of any legislation backed by APRNs. These factors contributed to the defeat of the bills that would have increased the independence of APRN practice and prescriptive authority in Texas during the 82nd Legislature.

**ECONOMIC AND ETHICAL FACTORS**

One factor that restricts APRNs from providing primary care in Texas, and other states with delegated or collaborative practice models, is the cost associated with recruiting and retaining a collaborating physician. The fees that APRNs must pay to hire a collaborating physician are not regulated, so they can run up to $8,000 per month. The fees are not governed by the BON, and the arrangement is strictly a business deal between the physician and the APRN, which frequently necessitates additional legal fees required to create formal agreements. Ultimately, this means access to care may be limited because APRN practice depends on finding and funding a collaborating physician who is willing to provide complicated oversight. A conservative fee of $2,000 per month can translate into nearly $100,000 per year for a physician, given that each physician is permitted to collaborate with up to 4 APRNs. There are clear ethical considerations in imposing practice restrictions when such significant financial interests are involved. Ethical issues also emerge around billing practices when APRNs deliver care and in turn, carriers reimburse physicians for that care.

Restraint of trade accusations are beginning to emerge as APRNs seek to fully utilize or expand scope of practice. The FTC has entreated several states to repudiate scope-of-practice restrictions that stifle competition among providers because such restrictions hinder access to health care providers and services. This
hindrance contributes to burgeoning costs and further diminishes accessibility. In addition, the FTC found that some APRN practice restrictions appear to have surpassed what is necessary to provide consumer protection. However, innovative care delivery models that effectively use nurses, including APRNs, have been lauded as a fiscally savvy way to improve patient care outcomes while using available resources.

In May 2012, the Texas Team Advancing Health through Nursing, a statewide coalition of Texas stakeholders that includes businesses, hospitals, and higher education institutions, released a groundbreaking report authored by noted economist Dr. Ray Perryman. The report, “The Economic Benefits of More Fully Utilizing Advance Practice Registered Nurses in the Provision of Health Care in Texas: An Analysis of Local and Statewide Effects on Business Activity,” asserts that Texas can increase economic output by $8 billion annually and create 97,205 permanent jobs simply by more fully using APRNs in practice, with growth trends predicted to reach $26 billion and 177,200 jobs by 2040. The report urges lawmakers in the 2013 legislature to remove unnecessary practice restrictions on APRNs.

Florida recently released similar findings, projecting an annual savings of $339 million in the state health care system related to the full use of APRNs in practice.

THE FUTURE OF APRN PRACTICE IN TEXAS
Texas APRNs realize that seeking a scope of practice independent of physician delegation or collaboration is controversial and not likely to be a politically viable solution with the current legislature. Consequently, CNAP, Texas Nurses Association, Texas Practitioners, Texas Association of Nurse Anesthetists, Consortium of Texas Certified Nurse Midwives, and Texas Clinical Nurse Specialists have jointly developed a collaborative APRN practice model (Figure 2) that will be proposed in the 83rd Texas legislative session this spring. This model is used by 17 other states that require physician involvement in APRN practice. The outcome of this proposal is history in the making.

The American Association of Colleges of Nursing reported that the total population of APRNs in 2008 was at least 270,000. APRNs encompass 4 defined roles (Table 1). The nurse practitioner (NP) population is projected to double by 2025, resulting in an increase from 128,000 in 2008 to 244,000 in 2025, with an estimated 198,000 of those NPs providing direct patient care. Approximately 80% of NPs work in primary care. Physicians are increasingly collaborating with APRNs, with 49% of office-based physicians working with NPs. Studies suggest that health care delivery systems can be optimized with

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Registered Nurse Anesthetist (CRNA)</td>
<td>40,000</td>
</tr>
<tr>
<td>Certified Nurse Midwife (CNM)</td>
<td>6,300</td>
</tr>
<tr>
<td>Clinical Nurse Specialist (CNS)</td>
<td>2,500</td>
</tr>
<tr>
<td>Certified Nurse Practitioner (CNP)</td>
<td>180,230</td>
</tr>
</tbody>
</table>
professional collaboration between multiple providers to administer coordinated care.

In 2010, the Institute of Medicine released the groundbreaking report “The Future of Nursing: Leading Change, Advancing Health.” The report serves as a framework catalyst for nurse-led solutions in the national effort to transform the health care system. The first of 4 major issues addressed in the report is the call for nurses to practice to the full extent of their education and training.34 The contributions of Barbara Safriet, JD, LLM, to this report have been compelling in their persuasion to maximize the value of APRNs to provide well-coordinated, quality, cost-effective health care. The barriers to this care are regulatory in nature and deprive the nation of the option for access. Releasing APRNs from these constraints will enable Americans to more easily access services they need at a price they can afford.34

CONCLUSION
APRNs provide accessible, affordable, high-quality care to varied populations in diverse settings. APRNs have a significant collaborative role in providing health services and optimizing health promotion. Removing restrictions on APRN scope of practice and reimbursement guidelines would permit new interdisciplinary models of care to be developed and tested.35 APRNs need to support efforts at state and national levels to free APRNs from complicated and unnecessary oversight.

Health care reform efforts should embrace the use of APRNs who practice to the full extent of their education and training. Pay-for-performance initiatives should consider integrating APRNs into outcome indicators that influence direct and equitable reimbursement. Texans have a vested interest in this issue. Restrictions on APRN scope of practice endanger consumer access to high quality, affordable, and affordable health care.5,35 Permitting APRNs to practice to the full scope of their education and training will increase access to health care, decrease costs, and generate revenue. Will APRN practice be bigger and better in Texas someday? Only time will tell.3

References
Jessica L. Peck, DNP, RN, MSN, CPNP-PC, CNE, CNL, is an assistant professor of nursing at the University of Texas Medical Branch in Galveston and a certified nurse educator. She is also a member of the Government Action Committee for Texas Nurse Practitioners and president of the Houston Area Chapter of the National Association for Pediatric Nurse Practitioners. She can be reached at jlpeck@utmb.edu. In compliance with national ethical guidelines, the author reports no relationships with business or industry that would pose a conflict of interest.