TEXAS ACADEMY OF FAMILY PHYSICIANS

May 1, 2025

The Honorable Bryan Hughes, Chair
Senate State Affairs Committee
Texas State Senate
P.O. Box 12068
Austin, Texas 78711

Dear Senator Hughes and State Affairs Committee Members:

On behalf of the Texas Academy of Family Physicians, thank you for the opportunity to provide written testimony against SB 3055 by Senators Middleton and Blanco.

The bill authors' sincere goal to improve access to primary care in Texas' rural and unserved communities is laudable and something family physicians strongly support. However, SB 3055 is the wrong solution and will not meaningfully improve access to care in rural Texas.

Rural areas face significant health disparities due to a combination of factors, including geographical isolation; higher poverty rates; lower educational attainment; a patient mix that is largely dependent on Medicare, Medicaid or they are uninsured; and low government pay, coupled with uncompensated care for the uninsured. All of this works together to exacerbate our rural health problems and discourage health care professionals from practicing in these areas.

Absent significant investment and delivery system reforms, Advanced Practice Registered Nurses (APRNs) will face the same, if not more significant, financial, cultural, and socioeconomic barriers that make it difficult for a comprehensively trained family physician to sustain a practice in rural Texas.

While we are opposed to the legislation, we thank Senators Middleton and Blanco for their deliberate and thoughtful efforts to try to address longstanding concerns raised by our members regarding the lack of standardized clinical training Advanced Practice Registered Nurses receive during training.

We also strongly support reforms within Subchapter D, Delegation Agreements with APRNs, which would enact sensible changes to improve accountability and transparency regarding these arrangements.

Our ongoing concerns with SB 3055 include the following.

Oversight and Standard of Care

Nurses practice in an array of ambulatory, acute and long-term care settings, where diagnostic skills are critical to improving patient safety and quality, even if the final diagnosis is determined by a physician. Texas is one of some dozen states where the Board of Nursing specifically distinguishes between "nursing diagnosis" versus a medical one. The Nursing Practice Act states that:

> "… professional nursing means the performance of an act that requires substantial specialized judgment and skill … and ***does not include acts of medical diagnosis or the prescription*** of therapeutic or corrective measures"

SB 3055 would grant APRNs the authority to make medical diagnoses and prescribe medications independently, subject to meeting specified statutory and regulatory training and licensing requirements. This will create two-tiered system for determining the standard of care for the same medical service — one for nursing and one for medicine.

Further, APRNs will be licensed and regulated by the Texas Board of Nursing, yet the members of that board are comprised of ***one*** advanced practice nurse, two registered nurses, three vocational nurses, three nurse faculty members, and four public members.

How is that regulatory body going to determine if or when the medical standard of care has been breached if all but one of those members are prohibited by law from performing those acts?

To address this, Arkansas established a joint entity governed by physicians and nurses to review applications and credentials of APRNs seeking independent practice. They also implement and oversee case and medical record reviews.

Diagnostic Training and Continuing Medical Education

Limited APRN diagnostic training also raises serious concerns because it is fundamental to any health care professional who will be independently diagnosing, treating, prescribing and managing patients, particularly patients diagnosed with complex conditions. In 2015, the National Academy of Science, Engineering, and Medicine (NASEM) named diagnostic errors "among the most common medical errors and the deadliest." It acknowledged that any health care professional can make a diagnostic error, whether because of inexperience or just being wrong.

NASEM recommended all graduate health professional training programs implement enhanced diagnostic training programs. However, it particularly emphasized the **need to improve nursing**

training, noting that nurses are inherently involved in the diagnostic process, even when it is not explicitly acknowledged.

SB 3055 should establish specific ongoing diagnostic training requirements needed to practice.

Training and Certification

SB 3055 specifies that an APRN must obtain 8,000 to 10,000 clinical training hours or have a commensurate number of years in practice. However, the bill does not define what in-person "clinical experience" means for those graduating from a Texas school of nursing. Additionally, the bill does not preclude the BON from counting hours obtained during training versus upon completion of postgraduate training and national certification.

The bill also does not require APRNs seeking independent status to obtain any of their experience in a rural setting, though they would be limited to those locations. Furthermore, it does not require that the collaborative practice setting align with where the APRN practices, meaning an APRN who predominantly gained hours working in a facility could nevertheless practice in an outpatient environment. Similarly, an APRN primarily practicing in a subspecialty collaborative practice arrangement, such as orthopedics, could potentially still practice in a rural area as a primary care clinician.

Corporate Practice of Medicine

Texas' corporate practice of medicine doctrine ensures that physicians are able to exercise professional medical judgment relating to a patient's health care needs without financial or other outside pressures. What may be in the best interests of the corporate bottom line might not align with the patient's best interests. With recent consolidation in the health care market, and growing employment of physicians by hospitals and corporate and retail interests, this foundational protection is more critical than ever.

Nurses, including APRNs, are not bound by the prohibition on the corporate practice of medicine. In other words, anyone could employ an independent APRN to access their prescription pad. Their employer, whether a retail establishment or an online "health" website, could set the APRN's compensation model on things like how many referrals they make to a certain facility or service line, how many drugs they prescribe for a certain disease state or how many durable medical equipment prescriptions they write for things like electric scooters. Without this critical protection, the opportunity for fraud is substantial.

Team-Based Care Remains the Best Model to Provide Access to High Quality Primary Care

TAFP remains ardently in favor of team-based care, where each health care professional's unique patient management skills, insight, and expertise come together to strengthen patient

safety and outcomes. APRNs bring complementary skills that promote patient health and healing through a comprehensive approach, incorporating mind, body, and soul.

While certain skill sets overlap between physicians and APRNs, they are not interchangeable. In 2022, Forbes Magazine published an excellent essay by Sachin Jain, MD, an internist and former CMS administrator, titled, "'Practicing at the Top of Your License and the 'Great' American Healthcare Labor Arbitrage,'" in which he described it thus:

> *All of this focus on labor arbitrage is built on the assumption that tasks can be easily sorted by licensure or training without sacrificing quality. This leads to an insidious equivalence being developed in which health care professionals are seen as potential substitutes for one another. Significant differences in training length and intensity are casually being washed away.*

He went on to emphasize that "independence for its own sake is not a virtue. Great patient care is the highest goal …," with team-based care being the only model that can reliably achieve it.

Put bluntly, all health care professionals have unique skills and expertise, but APRNs and other providers are not substitutes for physicians. APRNs function as force multipliers, allowing practices to expand capacity, while also strengthening services to support patient-centered, cost-effective care — primary care's hallmark.

As you well know, any legislation regarding scope of practice all too often devolves into a shouting match as each side retreats to its corner. As a result, there is a missed opportunity to discuss innovative ways in which to meaningfully address real-world barriers impacting access to care for far too many Texans

Rather than another debate regarding physician versus nurse credentials, what the Academy urges lawmakers to consider are ways to harness and strengthen the entire primary care network, including APRNs, by redoubling efforts to promote team-based care — the only model that can achieve our mutual goals to increase access, improve health outcomes, and constrain health care costs.

Respectfully,

Lindsay Botsford, MD
President

ATTACHMENT

APRN Scope of Practice Across the Country

Nationally, 27 states allow APRNs to practice with no physician supervision or collaboration. As of 2023, another dozen states, including Arkansas and Florida, have enacted "transition to practice" requirements that mandate newly graduated APRNs practice under the supervision or mentorship of an experienced clinician for a specified number of hours.

There is no agreed-upon national standard regarding the number of supplemental training hours an APRN must complete to practice autonomously. Individual state requirements vary considerably. For example, North Dakota requires APRNs to complete 1,040 hours, while Arkansas sets the bar at 6,240. Other states specify a minimum time frame, such as Maryland, which requires 18 months in collaborative practice.

For APRNs with prescriptive authority, states also set widely different requirements. Some states require supervision for this function even if an APRN can otherwise practice without it.

APRN Education and Training

In the absence of published, peer-reviewed data on the impact of autonomous APRN practice on patient health and safety, investigative reporting carries even more weight. On July 24, 2024, Bloomberg Business Week published "The Miseducation of America's Nurse Practitioners," the first article in a series, "The Nurse Will See You Now," reporting how APRN training — or lack thereof — puts patients at serious risk, even of death, while imperiling nurses legally and ethically.

Bloomberg found that Adtalem Global Education Inc., formerly DeVry University, the discredited publicly traded for-profit school runs the largest APRN training program in the country, including here in Texas. Students at Adtalam complete most of their course work virtually, gaining little real-world patient experience. The lack of experiential learning prompted several faculty and students to file reports with the school's accrediting body and national nursing associations, but to date, the complaints have not yielded results.

Limited APRN diagnostic training also raises serious concerns because it is fundamental to any health care professional who will be independently diagnosing, treating, prescribing and managing patients, particularly patients diagnosed with complex conditions.

New APRNs report that such limited training leaves them unprepared for real-world practice, particularly when caring for patients with medically complex needs. This is not meant to question their ability to exercise critical thinking. It is a reflection on their training. NASEM, along with the VA, has recommended expanding the use of diagnostic competency testing, noting that nurses — independent or not — play a key role in increasing diagnostic accuracy.

Does Expanding APRN Scope of Practice Improve Access?

Research conducted by the American Medical Association found APRNs practicing in states allowing independent practice are no more likely to practice in rural or underserved areas than are physicians, partly because they face the same financial, cultural, and socioeconomic barriers that make it difficult to sustain a practice. Some studies also show APRNs tend to see fewer patients per day, making it unclear whether granting independent practice moves the needle on primary care availability and capacity.

Additionally, despite the significant increase in practicing APRNs, the proportion choosing primary care also has shrunk, as more choose subspecialty practice. Anesthesiologists and obstetricians-gynecologists have long employed APRNs in collaborative practice models. Now, other physician subspecialists are doing so, including cardiologists, orthopedists, psychiatrists, and oncologists.

Expanding APRN Scope of Practice: What Is the Impact on Quality, Outcomes and Costs?

Despite the prevalence of independent APRN practices nationwide, data regarding whether and how autonomous practice benefits health care quality, outcomes and costs remains murky. This is in part because of the challenges differentiating between services provided by independent APRNs versus those continuing to practice in a team-based care model.

When the National Governor's Association developed policy proposals pertaining to APRN scope of practice, it found "there remain significant gaps in research relevant to state rules governing NPs' scope of practice. Although there is a growing body of evidence from health services research that suggests that NPs can deliver certain elements of primary care [emphasis added] as well as physicians, there is a dearth of rigorous research that isolates the effect of NP scope of practice rules on health care quality, cost, and access at the state level."

Oft cited in favor of expanding APRN scope of practice is a 2014 Veterans Administration (VA) study that evaluated published, peer-reviewed data comparing health outcomes of patients treated by primary care physicians versus APRNs. In particular, the VA assessed outcomes on four measures: health status, quality of life, mortality, and hospitalizations. Researchers noted that many studies

Outcome (Setting)	Results	Strength of evidence
Health status (primary care)	No difference	Insufficient (1 study)
Health status (urgent care)	No difference	Low
Quality of life (primary care)	No difference	Insufficient (1 study)
Mortality (primary care)	No difference	Low to Medium
Mortality (CRNA)	No difference	Insufficient (high risk of bias)
Hospitalization (primary care)	No difference	Low
Hospitalization (urgent care)	No difference	Insufficient (1 study)

purport to show APRNs provide the same quality of care as physicians, but also that many studies had insufficient evidence to justify scope of practice changes.

Instead, the study authors concluded the VA should assess its own internal data pertaining to APRN utilization, costs, and performance to gain greater insight.

To that end, after reviewing its data, in 2017, the VA authorized its facilities to grant autonomous practice to qualified nurses, even in states with scope restrictions, except that APRNs must abide by any state restrictions pertaining to prescriptive authority. It must be noted, though, that the VA directive leaves the decision to each VA facility, based upon an assessment of their APRN's training and competency, and that all APRNs delivering primary care do so as part of a team, known as Patient Aligned Care Teams (PACT), which are designed to promote and facilitate coordinated care.

Outside the VA, a 2018 Cochrane analysis found "for some ongoing and urgent physical complaints and for chronic conditions, ...nurse practitioners, practice nurses, and registered nurses, probably provide equal or possibly even better quality of care compared to primary care doctors, and probably achieve equal or better health outcomes for patients ... but the effects of nurse-led care on process of care and the costs of care are uncertain, and we also cannot ascertain what level of nursing education leads to the best outcomes when nurses are substituted for doctors."

In 2021, the Hattiesburg Clinic, a Mississippi-based multispecialty entity and a Medicare Accountable Care Organization, published a report analyzing its own longitudinal data, finding that patients managed by APRNs were more likely to unnecessarily use emergency departments, specialists, and laboratory tests.

For 15 years preceding its study, the clinic allowed supervised APRNs to independently manage patient panels. The clinic's chief medical officer expressed surprise at the findings, which the clinic did not determine until it examined ways to reduce the costs associated with its ACO. As a result of the study, the clinic reorganized its primary care services to ensure all patients established a relationship with a primary care physician, who then supervised and comanaged care with an APRN.