TEXAS ACADEMY OF FAMILY PHYSICIANS

August 26, 2024

The Honorable Lois Kolkhorst
Senate Health & Human Services Committee, Chair
Texas State Senate
P.O. Box 12068
Austin, Texas 78711

On behalf of the Texas Academy of Family Physicians, thank you for the opportunity to provide written testimony on the Senate Health & Human Services Committee's interim charge to: "Evaluate current access to primary and mental health care. Examine whether regulatory and licensing flexibilities could improve access to care, particularly in medically underserved areas of Texas. Make recommendations, if any, to improve access to care while maintaining patient safety."

Primary care serves as the bedrock of Texas' health care system, providing the first point of contact for patients entering the health care delivery system. Nationally, primary care practices provide more than one in three health care visits and often serve as the only source of care for patients, including patients with chronic conditions, such as diabetes, or mental health needs. Indeed, for many rural and medically underserved communities, primary care often is the only option.

Numerous studies show that robust access to primary care benefits both individual patients and communities. Patients with a regular primary care relationship have better health outcomes, higher satisfaction, and lower overall health care costs. A 2021 National Academies of Science, Engineering, and Medicine (NASEM) report made this point abundantly clear, stating, "Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes."

Despite overwhelming evidence that primary care is a common good, we know Texas' primary care system — like its mental health system — has been unable to keep pace with the needs of our population. Over the past year, state and national headlines, such as "The Doctor Won't See You Now," have revealed how challenging it can be to obtain a primary care appointment, even if a patient already has an existing primary care physician, much less if they don't.

Myriad, cumulative, festering factors have led Texas to this situation, which has only been worsened by the lingering effects of the COVID-19 pandemic. Among the challenges: a fee-for-service payment system that undervalues comprehensive, continuous, and coordinated primary

care services; declining or flat governmental and commercial insurance payments, coupled with higher overhead costs; unrelenting and unproductive administrative hassles, which reduce time with patients; inoperable electronic health records; and shortages of every type of health care personnel, from physicians to nurses to front office staff.

To increase access to high quality, team-based primary care across the state, the Texas Academy of Family Physicians recommends the Legislature to:

- Advance Value-Based Care payment models
- Create a primary care research fund designed to improve the effectiveness and efficiency of primary care delivery and payment
- Expand loan forgiveness for those entering primary care
- Increase primary care GME funding
- Foster and pay for team-based care

We understand some lawmakers may feel compelled to find policy prescriptions to our primary care shortage by relaxing regulatory and licensing requirements of non-physicians and allowing those practitioners to "practice at the top of their licenses and training."

But the term "practicing at the top of one's license" is itself meaningless without clearly understanding the training and expertise of each health care professional. 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," where 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 onto 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. **TAFP does not support full independent APRN practice.** Rather, TAFP remains ardently in favor of team-based care, where each health care professionals' unique patient management skills, insight, and expertise come together to strengthen patient safety and outcomes.

We know the current collaborative practice model imposes burdens on both physicians and APRNs. We support redesigning the model to reduce redundant or outdated regulatory requirements, without abandoning it.

Moreover, while Texas does not explicitly acknowledge APRN's role in the medical diagnostic process, they contribute to it when they interact with patients. Enhancing APRN diagnostic skills will improve patient safety and quality — a win for everyone. TAFP supports implementation of innovative strategies to improve APRN diagnostic skills, including enhancing opportunities for experiential learning through nursing preceptorships and residencies.

While we may ultimately disagree with some policy recommendations, we are committed to providing you and the Committee a candid review of existing scope of practice research and the status of other state's scope of practice requirements.

Advanced Practice Registered Nurses (APRNs)

APRNs are registered nurses with master's and often doctorate degrees with advanced education and training beyond registered nurses. They include nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), certified nurse-midwives (CNMs), and clinical nurse specialists (CNSs).

APRNs act as force multipliers, allowing practices to expand capacity, while also strengthening services to support patient-centered, cost-effective care — primary care's hallmark. Among the benefits APRNs bring to a team-based model are:

- ensuring appropriate care coordination,
- improving patient education and compliance with care plans, and
- assessing and managing non-medical drivers of health.

Additionally, these skills are foundational to success in many value-based care initiatives.

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 also 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 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. In 2015, NASEM named diagnostic errors "among the most common medical errors and the deadliest." It acknowledged that any health care professional can make one, whether because of inexperience or just error.

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.

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 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, too, 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, which 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 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.

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)

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.

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

As health care delivery continues to evolve toward advanced payment models and value-based care, fewer and fewer physicians, APRNs, and other providers will practice independently. Instead, they will increasingly collaborate, sharing knowledge, resources, and experience across care teams.

Should the Legislature choose to revise Texas' APRN scope of practice, such action must be paired with enhanced experiential APRN learning, medical diagnostic training, and ongoing monitoring to protect patient safety.

Thank you for the opportunity to provide comments. We stand ready to work with you to address this critical issue and ensure that patients have access to high quality, physician-led, team-based primary care.