ADVANCED PRACTICE REGISTERED NURSES

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Advanced Practice Registered Nurses in Texas

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What is an APRN?

- RN with advanced education, national certification, and Texas APRN licensure that permits them to provide health care beyond the scope of an RN
- Regulated by the Board of Nursing
- Education includes medical diagnosis & prescribing
- Consults with and refers to physicians

APRN Education

- Bachelor of Nursing Science
- APRN program is master or doctoral level
  - 2 – 3 years
  - 48 – 94 credit hours
  - 500 to 1700 clinical hours

4 Types of APRNs

- Nurse Anesthetists
- Nurse-Midwives
- Nurse Practitioners
- Clinical Nurse Specialists

Certified Nurse-Midwife (CNM)

- 2006 - CNMs attend 2.8% of births in Texas
- 96% of CNM-attended births occur in hospitals
- Outcomes include *significantly lower*:
  - C-Section rate
  - Low and very low birth weight babies
  - Prematurity
  - Admissions to Neonatal Intensive Care Units
- Midwives are only practitioner educated to attend births in low resource situations, e.g. during disasters

Growing Gaps between U.S. and Texas in CNM & NP Ratios

- Research demonstrates more APRNs practice in states with good practice environments
  - Texas gets a D
  - Restrictive Prescriptive Authority Laws most affect CNMs and NPs
  - Texas educates APRNs & move out of state

Current APRN Regulation in Texas

APRN Practice: What is Autonomous?

- Assessments
  - Histories & physical exams
  - Ordering diagnostic exams
  - Interpreting diagnostic tests
- Recommending OTC Drugs
- Establishing treatment plans that do not require prescription drugs or devices
- Referrals, Consultation, Coordination of Care
- Patient Education and Counseling

APRN Practice: What Must Be Physician Delegated?

Authority to:

- **Establish a Medical Diagnosis**
- **Prescribe or Order Drugs & Medical Devices**

APRN Prescriptive (Rx) Authority in Texas

- Board of Nursing Regulates APRN's Rx Authority
  - Determines if applicant meets requirements
  - Issues a Prescriptive Authority Number
    §301.152, Occ. Code & 22 TAC, Chapter 222
  - APRN may not prescribe until practicing in a qualifying site and delegating physician signs protocol
- Texas Medical Board Regulates Physicians who Delegate Prescriptive Authority
  §§157.051 – 157.060, Occ. Code & 22 TAC §193.6

Limitations on APRN Rx Authority in Texas

- Delegated by a physician
- Physician can only delegate in certain sites

Physicians may delegate:

- Dangerous Drugs -Drugs that can only be dispensed with a prescription *excluding controlled substances*

- Controlled Substances

  limited to

  - Schedules III – V
  - 90-day Rx (or refills equal 90-day supply)
  - Prior authorization required
    - Refills beyond 90-days
    - Any Controlled Substance for Children Under 2 yrs.

Prescriptive Authority in Texas

- Each type of site is defined & some have multiple types of site locations
- Physician supervisory requirements based on the type of site

Prescriptive Authority

Types of Sites

- Medically Underserved
- Physician's Primary Practice
- Alternate Practice Site
- Facility-based

For specific information, see Appendix, slides 40 - 47

TMB Waiver of Site or Supervisory Requirements

- Texas Medical Board (TMB) may waive most site or physician supervision requirements except all onsite visits.
- TMB grants waivers infrequently.

Scope of Practice Limitation

Even with independent prescriptive authority, scope of practice is limited to the population the APRN is educated to serve.

Boards of Nursing Rigorously Enforce

The Problem

Health Care Crisis
Cost, Quality, & Access

➢ GOAL: Access to affordable health care for more Texans.

- APRNs are already educated and can meet 80 to 90% of primary care needs
- Three-quarters of 961 APRNs working in Texas indicated they would be extremely (28%), very (22%), or somewhat (25%) willing to work in a rural or underserved location if no longer needed physician delegation to diagnose and prescribe.

➢ GOAL: Access to affordable health care for more Texans.

- Current law
  - Based on negotiation between competing organizations rather than cooperation among physicians and APRNs to achieve better health care delivery
  - Keeps APRNs geographically tied to physicians
  - Makes no allowance for health information technology except alternate sites

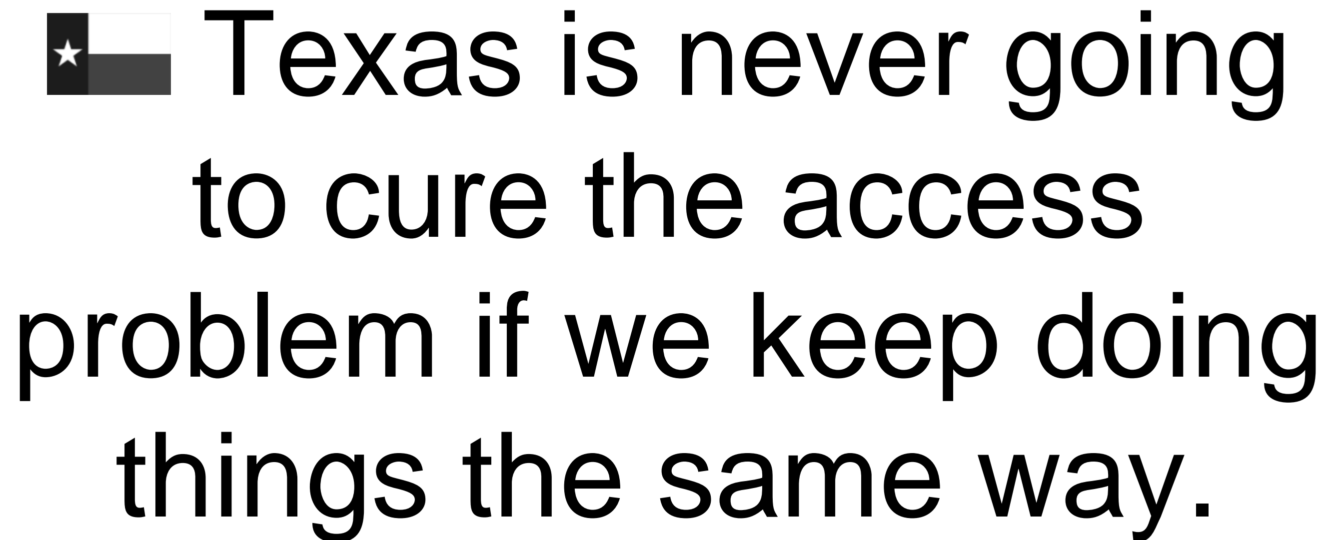
➢APRNs Practice Safely *Without* Supervision in Most States

- Prescriptive authority is currently the only aspect of practice in Texas that has specific supervision requirements.
- APRNs in 35 other states and D.C. do not have supervision and outcomes of care appear equivalent.
- *APRNs are professionals educated to recognize when consultation or referral is needed.*

APRN Prescriptive Authority in U.S.

- Relationship with physician
  - 15 + Washington D.C. – none required
  - 20 – collaborative agreement
  - 15 – delegated

    2 (Texas & Alabama) – site-based
- Controlled Substances
  - 40 – Schedules II – V
  - 8 (including Texas) – Schedules III – V
  - 2 (Florida & Alabama) - None


Texas is never going
to cure the access
problem if we keep doing
things the same way.

➢ Recommendations

1. Make laws governing APRNs in Texas consistent with recommendations by the National Council of State Boards of Nursing.

- Allow the Board of Nursing full authority to grant APRNs prescriptive privileges.
- Avoid requirements for physician delegation & written collaborative agreements. (Increase costs & reduce APRN's ability to practice in counties with no physicians)
- Include Schedule II drugs.

➢ Recommendations

2. Remove restrictions on ability of APRNs to prescribe controlled substances.
   - Prescribing Schedule II drugs is an essential part of certain practices, such as hospice.
   - 40 states allow APRNs to prescribe Schedule II drugs.
   - To allow this option at no cost to the state, remove the $25 limit on controlled substance permit fees.

➢ Recommendations

3. Encourage Nurse-Midwifery education programs in areas where none exist.
   - Medicaid pays for over 50% of births in Texas.
   - Remove barriers to lower cost, high-quality options for women.

➢ Recommendations

4. Create the right mix of healthcare providers.

   Base decisions on:

   - ✓ Current professional education and training;
   - ✓ Using everyone's education and training to maximum advantage; and
   - ✓ Health care needs of the population.

More Information

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Appendix

	Licensed	Working in Texas
➢Nurse Practitioners	7,900	5,745
➢Clinical Nurse Specialists	1,451	1,409
➢Nurse Anesthetists	3,100	2,183
➢Nurse-Midwives	351	276

➢ Nurse Practitioners (NPs)

- NPs treat specific populations such as children or adults.
- Within that population:
  - Most provide preventive health care and treat common illnesses; and
  - Some manage care for acutely or critically ill.
- Most work in clinics and private practices, but hospitals employ a growing number.

Types of Nurse Practitioners

- Family
- Gerontological
- Pediatric
- Women's Health
- Psychiatric/Mental Health
- Acute Care Adult
- Acute Care Pediatric
- Neonatal

Nurse Practitioners (NPs)

100,000 Population, U.S. and Texas, 1990-2009

➢ Clinical Nurse Specialists (CNSs)

- Improve nursing care and health for individuals or groups within a specialty
- Experts in improving care within systems through research, education and practice
- Majority work in specialty clinics, hospitals or nursing education
- Gerontological & Psychiatric-Mental Health CNSs and NPs perform identical services

Types of Clinical Nurse Specialists

- Community Health
- Gerontological
- Psychiatric/Mental Health
- Adult Health
- Pediatric
- Critical Care

Clinical Nurse Specialists (CNSs)

per 100,000 Population,
Texas, 1990-2009

Clinical Nurse Specialists per 100,000 Population

6
5
4
3
2
1
0

U.S. CNS
Texas CNS

1990 1992 1994 1996 1998 2000 2002 2004 2006 2008

➢Certified Registered Nurse Anesthetists (CRNAs)

- Population – Anesthesia care for all ages
  - Surgical
  - Obstetric
  - Anesthesia related services
    - Trauma stabilization
    - Pain management
  - General, Deep & Moderate Sedation, Regional, Local
- Determine type of anesthesia, select drugs and administer

Certified Registered Nurse Anesthetist (CRNA)

Certified Nurse-Midwife (CNM)

- Prenatal Care
- Delivery
- Postpartum Care
- Normal neonatal care
- Women's Health through the lifespan

Certified Nurse-Midwife (CNM)

per 100,000 Females Ages 15-44,
U.S. and Texas, 1990-2009

CNMs per 100,000 Females, 15-44 yrs

0
1
2
3
4
5
6
7
8
9
10

1990 1992 1994 1996 1998 2000 2002 2004 2006 2008

Texas CNM
U.S. CNM

Texas Prescriptive Authority Site-Based Specifics

Medically Underserved

§157.052, Occ. Code & 22 TAC §193.6(b)

- Medically Underserved Area (MUA & HPSA)
  - Federally or state designated
  - Rural & Urban
- Medically Underserved Population (MUP)
  - Designated by DSHS (Health Professions Resource Center)

  www.dshs.state.tx.uschs/hprc/default.shtm

  - Titles V, X, XVIII, XIX, XXI Funding, ERS or TRS

Medically Underserved

- No ratio on physician to APRN/PA
- Limited to 3 clinic sites
- Physician on site once every 10 days
- Log of physician activities
- 10% chart review

Physician's Primary Practice

- Physician spends majority of time; or
- Hospital;
- Long-term care facility;
- Adult daycare facility;
- Patient's home;
- School-based clinic; or
- If physician spends 50% of time or more with the APRN, may also delegate with no additional supervision at:
  - Another site seeing established patients; or
  - Charity care or disaster relief sites.

Physician's Primary Practice Supervisory Requirements

- 1 Physician to 4 APRN/PA ratio
- Consistent with what a reasonable, prudent physician would find consistent with sound medical judgment
- Continuous but constant physical presence *not* required
- If not on site the majority of time, must keep a log of physician quality assurance activities

Alternate Practice Site

- Site & Supervision Requirements
  - Limited to one alternate site within 75 miles of physician's practice or residence
  - Must offer similar services to primary site
  - Physician on site 10% of hours with each APRN or PA monthly
  - 10% chart review (may be performed offsite via Electronic Medical Records)
  - 1 to 4 ratio, including primary site

Facility Based

- **Licensed Hospital**
  - no delegation ratio
  - Limited to one hospital
- **Long-term Care Facility**
  - Only delegated by medical director
  - Limited to 2 facilities
  - 1 physician to 4 APRN/PA ratio

Physician Supervision same as Primary Practice Site

Site-Based Prescriptive Authority

- Illogical since all APRNs meet education, national certification & licensure standards
- Increasing complexity confuses providers
- Unnecessary complexity for regulators
- APRNs in very underserved areas cannot get prescriptive authority because no physician will come on site or is willing to delegate.

Recommendations for APRN Regulation in U.S.

NCSBN Focuses on Public Safety

- 1998 - Pew Health Professions Commission recommends "States *should enact and implement scopes of practice that are nationally uniform for each profession and based on the standards and models developed by the national policy advisory body.*
- 2008 - The National Council of State Boards of Nursing (NCSBN) developed model APRN legislation.
    - ➢ *Recommends no physician delegation or supervision*

Are Prescriptive Authority Limitations in any State Based on Evidence?

NO

Based on reports to
national practitioner data banks,
disciplinary actions by nursing boards,
and law suits,
laws requiring physician supervision
have no effect on patient outcomes.

Why Eliminate Physician Supervision? Answers from Economists & Statisticians

- W. Edwards Deming (Statistician and father of Japanese quality production methods now applied to healthcare systems)

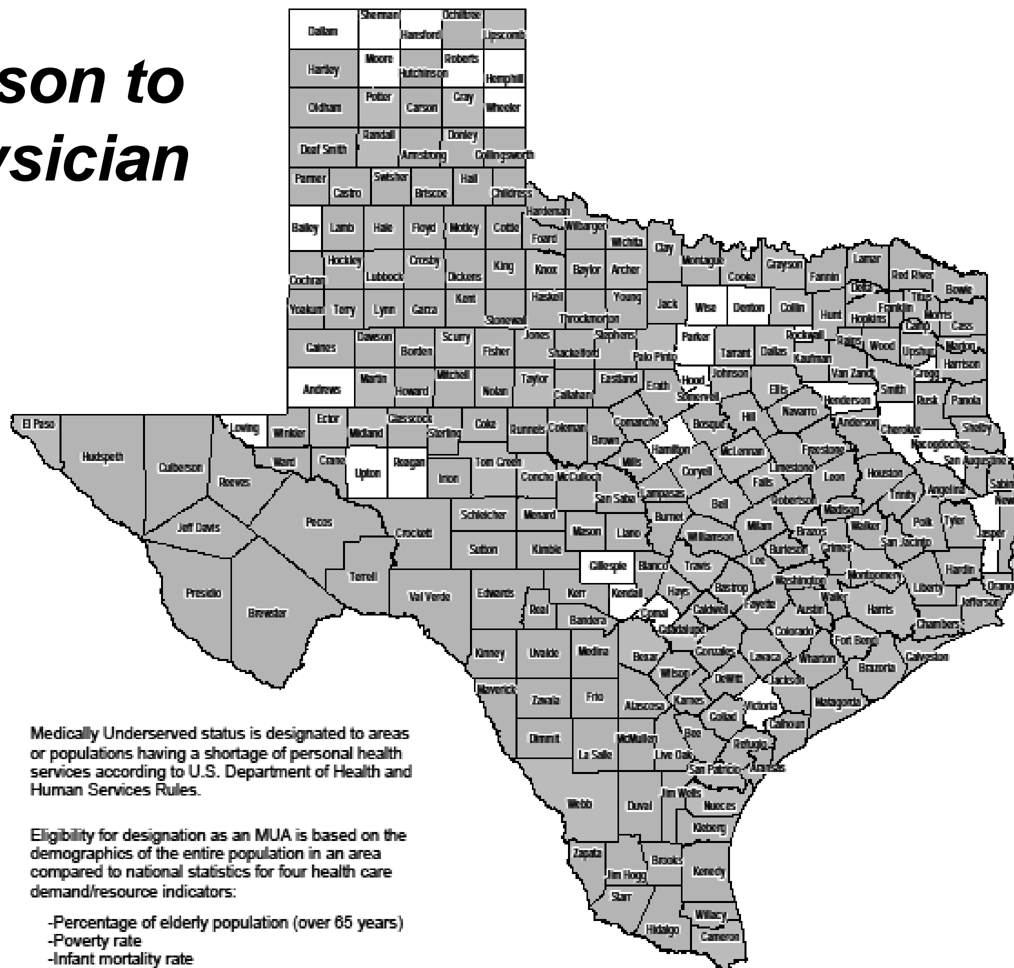
"Cease dependence on inspection to achieve quality."

- Jeff Bauer (Economist Specializing in Healthcare)

"What is the value of a physician supervising an APN's prescribing if the supervising physician is, likely as not, making mistakes in his or her own medication orders?"

MEDICALLY UNDERSERVED AREAS

The Best Reason to Eliminate Physician Supervision



Medically Underserved status is designated to areas or populations having a shortage of personal health services according to U.S. Department of Health and Human Services Rules.

Eligibility for designation as an MUA is based on the demographics of the entire population in an area compared to national statistics for four health care demand/resource indicators:

-Percentage of elderly population (over 65 years)
-Poverty rate
-Infant mortality rate
-Ratio of primary care physicians per 1,000 population

Medically Underserved Areas

- Whole County MUAs
- Partial County MUAs
- Undesignated Areas

Map Prepared By:
OFFICE OF RURAL COMMUNITY AFFAIRS
Texas State Office of Rural Health
February, 2007.

Data Source:
Texas Department of State Health Services
February, 2007.

Who would risk the money it takes to start a practice when it is based on a physician willing to accept responsibility?

22 TAC 193.6(a)

- What if the physician does not meet supervisory requirements?
- What if the physician dies or becomes incapacitated?
- What if the physician is not following current treatment guidelines?

The Solution

Balanced, 21st Century Approach to laws governing APRNs based on logic & evidence

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