TEXAS ACADEMY OF FAMILY PHYSICIANS

April 14, 2025

The Honorable Gary VanDeaver
Public Health Committee, Chair
Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768

On behalf of the Texas Academy of Family Physicians, thank you for the opportunity to provide written testimony against HB 3794 by Representative Darby.

We know Texas' primary care system — like its mental health system — has been unable to keep pace with the needs of our growing 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 and 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.

Despite the evidence to the contrary, we understand why some well-meaning lawmakers may feel compelled to relax regulatory and licensing requirements of non-physicians and allow those practitioners to "practice at the top of their licenses and training" to address our primary care shortage.

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, in which each health care professional's unique patient management skills, insight, and expertise come together to strengthen patient safety and outcomes.

Our concerns with HB 3794 include:

A Lack of Standardized APRN Education and Training

There is very limited published, peer-reviewed data on the impact of autonomous APRN practice on patient health and safety. But 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 such training 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 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 Veterans Administration, has recommended expanding use of diagnostic competency testing, noting that nurses — independent or not — play a key role in increasing diagnostic accuracy.

Expanding APRN Scope of Practice Does Not Improve Access to Care

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 Does Not Lower Costs or Improve Outcomes

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."

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

We understand the current collaborative practice model may impose burdens on both physicians and APRNs. We support improving the model to reduce redundant or outdated regulatory requirements, without completely abandoning it.

Today, however, we don't know how many APRNs are utilizing a prescriptive authority agreement, how they are employed or if they are charged a fee for the prescriptive authority agreement and how much.

Physicians are already required to report to the Texas Medical Board if they have entered into a delegated prescriptive authority agreement and with whom. That information is available on the TMB website. We recommend that those physicians also be required to disclose whether the APRNs they have such agreements with are employed by the physicians or physician groups, or whether the APRNs own their own practices. These physicians should also be required to disclose whether they charge a fee for the delegation agreement and how much they charge for that agreement.

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. 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.

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.

Sincerely,

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TAFP President