SUBJECT: Physician delegation of prescriptive authority to PA or APNs

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Kolkhorst, Naishtat, J. Davis, Gonzales, Hopson, S. King, Laubenberg, Truitt, Zerwas

0 nays

2 absent — Coleman, McReynolds

SENATE VOTE: On final passage, March 26 — 31-0

WITNESSES: For — Cathy Clodfelter, CVS/Caremark/Minute Clinic; Gary Floyd, Texas Medical Association, Texas Pediatric Society, Texas Academy of Family Physicians; Melinda Moore, Texas Academy of Physician Assistants; (*Registered, but did not testify:* Kathy Barber, Texas Federation of Drug Stores; Carolyn Belk, The Methodist Hospital System; Ed Berger, Seton Family of Hospitals; Jaime Capelo, PatientsFIRST Coalition; Kellie Duhr, Wal-Mart Stores, Inc.; Michael Gutierrez; Marshall Kenderdine, Texas Academy of Family Physicians; Carrie Kroll, Texas Pediatric Society; Alyssa Parrish, RediClinic; Karen Reagan, Walgreens; Kandice Sanaie, Texas Association of Business)

Against — (*Registered, but did not testify:* Patrice Capan)

On — Jaime Garanflo, Mari Robinson, Texas Medical Board; Lynda Woolbert, Coalition for Nurses in Advanced Practice; (*Registered, but did not testify:* Jolene Zych, Texas Board of Nursing)

BACKGROUND: A physician may delegate prescriptive authority to the full-time equivalent of three physician assistants (PAs) or advanced practice nurses (APNs) practicing at the physician's primary practice site or at an alternative practice site. The PA or APN may not write a prescription that is for more than 30 days. An alternative practice site may not be more than 60 miles from the delegating physician's primary practice site. The delegating physician must be on-site and available to treat patients at least 20 percent of the time with an APN or PA who is practicing at an alternative site.

DIGEST:

CSHB 532 would revise the circumstances under which a doctor could delegate prescriptive authority to physician assistants and advanced practice nurses.

The bill would increase from 30 to 90 days the amount of time for which a prescription for certain controlled substances could be carried out or written by a person to whom this authority had been delegated by a physician. A delegating physician would register with the Texas Medical Board the name and license number of a PA or APN to whom the physician delegated prescriptive authority. The board could develop an electronic online delegation registration process.

The definition of an alternative site would be revised to include a location within 75 miles, rather than 60 miles, from the physician's primary practice site. An alternative site also could be within 75 miles of the physician's residence. The physician would provide adequate supervision to a PA or APN practicing at an alternative site if the physician was on-site with the APN or PA at least 10 percent of the hours the APN or PA worked at the site during each month, rather than 20 percent of the time. The delegating physician could meet through electronic chart review the requirement to review at least 10 percent of the medical charts for each APN or PA practicing at an alternative site.

The board could modify or waive certain limitations on physician delegation of prescriptive authority to a PA or APN to allow a physician to delegate prescriptive authority to:

- no more than the full-time equivalent of six PAs or APNs, rather than three PAs or APNs;
- a practitioner more than 75 miles from the physician's residence or primary practice site; and
- PAs or APNs for which the physician did not meet the 10 percent on-site supervision requirement, if the physician was available on-site at regular intervals.

In granting such a modification or waiver, the board could not make more restrictive the maximum number of PAs or APNs to whom the physician could delegate prescribing authority, the permissible distance of an alternative site from the practitioner's primary practice site or residence, or

the minimum amount of time a physician would be required to provide on-site supervision.

The bill also would add to the definition of a physician's primary practice site a practice location that provided care for established patients for a PA or APN who practiced on-site with the physician more than 50 percent of the time.

The bill would take effect September 1, 2009. The Texas Medical Board would have to adopt the rules to implement the revisions made by the bill by January 31, 2010.

SUPPORTERS SAY:

CSSB 532 would expand modestly the circumstances under which a physician could delegate prescriptive authority to a PA or APN, in order to balance the need for increased patient access to healthcare with the need to maintain quality of care. The bill would acknowledge the ability of PAs and APNs to work safely under limited supervision and within their scope of practice to serve more patients. Physicians could use professional judgment to determine the circumstances under which it would be appropriate to request a waiver to delegate prescriptive authority to more practitioners or to take advantage of opportunities to ease direct supervision requirements for practitioners who practice farther away and to whom they have delegated prescriptive authority. The bill would give PAs and APNs more latitude to work, while maintaining adequate oversight and ultimate medical liability with a physician who remained accountable to the Texas Medical Board.

As of March 2009, 118 counties were designated as health professional shortage areas for primary medical care by the U.S. Department of Health and Human Services. The health marketplaces in many states, including Texas, are finding ways to compensate for healthcare shortages, which are characterized by declining numbers of primary care physicians yet increasing numbers of PAs and APNs. By making these practitioners freer to work within their limited scope of practice at a doctor's satellite office or in a retail health clinic, many more patients with minor injuries or ailments could be served. Enabling PAs and APNs to address these issues frees physicians to focus on more complicated cases, for which their advanced training and education are necessary.

Retail health clinics offer to consumers benefits such as extended weekday and weekend hours, convenient locations, and low-cost care. Because

retail health clinics offer a limited set of health services for common ailments and minor injuries, they ideally would be staffed by qualified PAs and APNs who could address minor health problems without the patient needing an appointment. Because of the shortage of health care providers in Texas, the bill would make an important advance in integrating retail health clinics into the healthcare system in a way that allowed PAs and APNs to act as liaisons to patient receipt of more comprehensive care through other health care providers.

Retail health clinics do not aim to replace a patient's medical home for more serious health issues and have demonstrated the potential to expand medical homes to more patients because practitioners at retail health clinics refer patients as necessary to a primary care physician. These clinics operate at more flexible hours than doctors' offices, allowing PAs and APNs to prescribe any necessary medication if a doctor's office was not open so that a condition did not worsen. The patient could be referred to a physician for follow-up care. Retail clinics also provide a more affordable option on evenings and weekends to people with less serious conditions who otherwise would seek care in an emergency room. If the PA or APN found that a person should seek emergency care, they could direct the patient to an emergency facility, yet in most cases a costly emergency room visit could be avoided.

Retail clinics provide patients with quick solutions to common health problems and allow Texas' primary care physicians to treat more serious conditions. In underserved areas, these facilities could be a local resource that prevented patients from having to travel long distances to see a doctor or to delay seeking care when a condition could worsen. Physicians still would be required to make regular visits to any alternative practice site and to review 10 percent of a PA or APN's charts to make sure these practitioners were providing quality care. PAs and APNs also would remain subject to their own professional licensing standards.

CSSB 532 would wisely not follow the lead of a small portion of states that allow APNs to practice entirely independently of physician oversight. Physicians have advanced training and have been taught to lead a health care team, whereas APNs have been trained and educated to act as part of that team, with the physician maintaining ultimate responsibility for patient care.

OPPONENTS SAY:

This bill would reduce the amount of supervision physicians must provide for PAs and APNs working at alternative sites. People who begin to rely on the care provided by PAs and APNs in such places as retail health clinics could begin to think that these convenience clinics were an adequate substitute for developing an ongoing relationship with a primary care physician. Such clinics do not provide an adequate medical home. Allowing the doctor to be on-site less often further would diminish the opportunity that patients of retail health clinics had to see and be treated by a practitioner who could provide more comprehensive services.

PAs and APNs working at retail health clinics, which remain largely unregulated, could feel pressured to work outside their scope of practice as these clinics attempted to attract a larger share of the health marketplace by offering more comprehensive services. These clinics also could be prone to conflicts of interest since they often are located next to a pharmacy and therefore could be influenced to write more prescriptions. These reasons substantiate the ongoing need for physicians to provide at least the same amount of supervision as required under current law to maintain a check on potential PA or APN practice issues.

OTHER OPPONENTS SAY:

While CSSB 532 would make some positive changes to address healthcare access issues, the bill should go further to allow APNs to practice more independently. Texas should join 10 states and the District of Columbia in allowing APNs to practice independent of physician supervision. Short of this change to practice, the bill further should increase the number of PAs and APNs that physicians could supervise and authorize APNs to prescribe Schedule II drugs rather than the existing authority to prescribe Schedule III, IV, and V drugs.

APNs’ training and education are designed to prepare them to make diagnoses and prescribe medications in the field of medicine in which they specialize. APNs also are allowed to practice more independently in certain locations, such as public schools or nursing homes. No research shows that supervision requirements improve quality of care. Studies demonstrate that APNs are taking care of the most underserved populations, often lower-income and paying on a sliding scale. Instead of taking advantage of APNs' full potential, Texas is losing many qualified APNs who could expand healthcare to more Texans. It is a waste of money and resources to educate these necessary members of the healthcare workforce only to prompt them through burdensome regulations to practice in other states.

NOTES:

SB 532 as passed by the Senate also would have permitted physicians to delegate prescriptive authority to physician assistants or advanced practice nurses who volunteered their charity health care services at nonprofit clinics. This charity service would not have been subject to additional on-site supervision or chart review.

The fiscal note indicates the bill would not have an impact on general revenue funds during fiscal 2010-11. The Texas Medical Board indicated there would be a one-time cost of $80,000 in fiscal 2010 to establish the capability to register the physician assistants and advanced practice nurses to whom prescriptive authority had been delegated. This cost would be addressed through an increase in licensing fees.