Texans for Healthcare Access

Working to help all Texans access quality healthcare

Myth vs. Fact: SB 1859/HB 3794, SB 9-1-1

MYTH: APRN care is not safe.

FACT:

Texas Advanced Practice Registered Nurses (APRNs) provide safe, high-quality care, and have been providing care without on-site physician supervision requirements for more than a decade.

In over 40 years of peer-reviewed studies on the topic, including a report from the National Academy of Medicine[1], research has shown that APRNs improve access to care and have similar or better patient outcomes when compared to physicians. And in the National Provider Databank, the most comprehensive source for malpractice reports dating back to the 1990s, APRNs represent just 2% of all medical malpractice claims, both in Texas and nationally. This includes states that have removed physician delegation requirements.[2]

Over half the states, the District of Columbia, the Veterans Administration, and all branches of the military have full practice authority for APRNs. **No state has ever repealed legislation ending these requirements.**[3]

A peer-reviewed study published in 2024 showed **that full practice laws had zero impact on patient safety as proxied by malpractice payouts and adverse action reports against APRNs.**[4]

MYTH: APRNs don't have enough training and education.

FACT:

APRNs provide only the scope of services for which they are educated, licensed, and certified. APRNs do not perform surgery, perform complex procedures, or treat high-risk patients. Like other health professionals, APRNs make referrals to their physician colleagues and other clinicians when their patients' needs fall outside their scope or competence. Like all other healthcare providers, they must do so—or risk losing their license.

APRNs are trained to provide care in a narrow specialty such as primary care, women's health, or mental health. Every physician is trained in ALL medical specialties and surgery. Because of this, an APRN does not have the same education and training model as a physician. But every APRN is state licensed, nationally certified, and graduate or doctorally prepared to do the job they do, and they build on the strong foundation of a nursing degree and thousands of hours of clinical experience at the bedside.

MYTH: Texas law currently requires real-time supervision of APRNs.

FACT:

Texas ended the requirement that a physician be located on-site with the APRN they delegate to in 2013—12 years ago.[5] Now the only requirement left in law are the delegation contracts, which require one monthly phone call and any number of retrospective patient chart review.

MYTH: Getting rid of delegation would expand APRN scope of practice, add to scope creep

FACT:

Removing delegation does NOT change an APRN's scope of practice. If we passed SB 9-1-1, APRNs would be doing the same thing tomorrow that they're currently doing in their roles today. It would simply allow APRNs to practice under their current Texas license and national board certifications, like APRNs do in most every other state, without having to ask (and sometimes pay) a physician to sign a piece of paper to let them practice.

MYTH: Texans should only see physicians for healthcare needs.

FACT:

Texans overwhelmingly want a choice in how, when, and from whom they get their care. **90% of Texans believe Texas should make it easier to get care from APRNs**, and **81% support removing the career-long requirement that APRNs contract with physicians.**[6] Full practice authority for APRNs was also adopted onto the Texas Republican and Democratic Party Platforms in 2024.[7]

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MYTH: APRNs don't go to rural and underserved areas.

FACT:

Nurse practitioners increased by 43% in rural areas and are now 1 in 4 rural healthcare providers[8], whereas physicians in rural areas have steadily declined since 2010.[9] Studies show that APRNs go to rural areas even without incentive programs, but when restrictions are removed, they are more likely to provide care in rural areas. For example, after Arizona passed legislation to remove delegation requirements, rural nurse practitioners increased by more than 70%.[10]

MYTH: APRN are not responsible for their own patient care.

FACT:

APRNs are solely responsible for their own actions under the standard of care required by the Nursing Practice Act and are regulated and disciplined by the Texas Board of Nursing accordingly. Because APRNs hold their own license, they are responsible for the care they provide and carry their own malpractice insurance. If something happens to their patients, they can be reported to the Board of Nursing and risk losing their license. Their delegating or contracting physician is not responsible for the care they provide, and will not be held liable for that care, unless he/she was directly involved in the patient care, did not comply with Texas laws, or was otherwise negligent. Texas law states:

> *Sec. 157.060. PHYSICIAN LIABILITY FOR DELEGATED ACT. Unless the physician has reason to believe the physician assistant or advanced practice registered nurse lacked the competency to perform the act, a physician* ***is not liable for an act of a physician assistant or advanced practice registered nurse*** *solely because the physician signed a standing medical order, a standing delegation order, or another order or protocol, or entered into a prescriptive authority agreement, authorizing the physician assistant or advanced practice registered nurse to administer, provide, prescribe, or order a drug or device.*

MYTH: Giving APRNs full practice would create two standards of care for nursing and medicine.

FACT:

The standard of care does not change with the passage of SB 9-1-1. APRNs are educated and certified to provide a range of services, regardless of whether they are required to be in a contract with a physician. APRNs care for patients using the general standard of care that applies to all healthcare professions. For example, if treating a diabetic patient, there is no difference in the standard of care for an APRN or a physician. The national standards, protocols, and recommended treatments and medications would apply across professions.

MYTH: The Texas Medical board should regulate APRNs.

FACT:

Dual regulation is duplicative, costly, and raises concerns for anticompetition. Boards of Nursing (BONs) are expert nursing regulators. Regulation of APRNs should be done by individuals most familiar with the education, certification, scope, and standards of practice of that profession. The Texas BON already regulates APRNs and has been regulating them since 1980. And BONs are the primary regulator of APRN licenses in all 50 states. This also aligns with national standards, including the 2008 Consensus Model, and proposed guidance dating back to the early 1990s.

In response to legislation that would have created joint BON and medical board regulatory oversight, the Federal Trade Commission said the following:

> *"We urge you to consider whether to allow independent regulatory boards dominated by medical doctors and doctors of osteopathy to regulate APRN prescribing, given the risk of bias due to professional and financial self-interest." (Federal Trade Commission Comment Letter to West Virginia, 2016)*

> *"Such an amendment would raise concerns about potential biases and conflicts of interest. The Institute of Medicine has argued that common restrictions on independent APRN practice and prescribing are not evidence-based, and that historically entrenched forms of training and care delivery, dated or erroneous beliefs about the training or performance of APRNs, and professional bias are factors in physician opposition to regulatory reform." (Federal Trade Commission Letter to Kansas, 2020)*

References

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