Senate Committee on State Affairs
Testimony by Jimmy Widmer, MD, Texas Medical Association
Against Senate Bill 3055
May 1, 2025

Good afternoon, my name is Dr. Jimmy Widmer. I practice internal medicine in Temple. On behalf of the Texas Medical Association (TMA) and its more than 59,000 members and the Texas Chapter of the American College of Physicians, we thank Chair Hughes, Vice Chair Paxton, and the members of the Senate State Affairs Committee for the opportunity to provide testimony in opposition to Senate Bill 3055.

As an internist, I practice in hospitals and outpatient settings and provide primary care for my patients. Primary care physicians are the first line of defense not just for preventative care, but also for lowering the cost of care for patients. Correct and effective treatment is critical to preventing more complex health conditions that can lead to increased specialist care, emergency department visits, prolonged hospital stays, and time away from jobs and family.

Quality of care improves with appropriate physician-led, team-based care models, which promote oversight and collaboration while keeping patient safety the priority.

Under Texas' current framework, a physician is involved before, during, and after care is provided by an advanced practice registered nurse (APRN). On the front end, a physician's written protocol sets forth the steps for an APRN to take in respect to specific conditions, diseases, or symptoms, and states the medications that may or may not be prescribed. The delegation and supervision/prescriptive authority agreement between the physician and APRN must include a plan for consultation, referral, and the process for communication and the sharing of information between the physician and the APRN.

On the back end, there are chart review and meeting requirements to discuss the patient's treatment and care, needed changes in patient care plans, issues relating to referrals, and patient care improvement. Let me be clear though, this is the minimum and for myself and many of my colleagues, daily we are in constant communication with our APRNs.

In my primary care practice, we have dedicated time set aside weekly to sit down and review previous or upcoming patient charts. Yet not a day goes by that my advanced practice provider and I do not talk about at least one patient. Recently, I saw a patient with previously uncontrolled diabetes and hypertension. We have worked very hard over the past two years to get both of these chronic conditions under better control, yet the years of poor control have resulted in the patient having decreased kidney function and diminished eyesight. At this most recent visit her

labs indicated a downturn in her kidney function from baseline and upon discussing with her during the appointment she revealed that her son who usually helps with her medications had been working nights and less available to assist with medications, so she had not been as compliant. So, we initiated a medication adjustment with a plan to have her follow-up with my advanced practice provider (APP) the following week with pre-clinical labs. I then discussed the plan of care with my APP to prepare her for that visit and what I was looking for. On the day of the follow-up appointment, I reviewed the labs, my APP and I discussed the plan of care and then she saw the patient. After the visit we talked again and tweaked her plan slightly. I will see the patient again soon for follow-up and repeat labs. This is but one example whereby the close collaboration with non-physician providers improves access to care and avoids specialist consultation or hospitalization.

Additionally, I serve as core faculty for our internal medicine residency program and in that capacity I have precepted the resident continuity clinic. The idea behind this training is that the residents increase their autonomy throughout their training but with appropriate physician supervision to ensure appropriate evidence-based practice habits are established. It is not simply the number of hours residents amass throughout their training but the supervised hours with opportunities for discussion and continued guidance to build on the four years of medical school education that serves as their foundation upon which their medical acumen is based.

Lastly, I would like to point out that physicians feel the patient access crunch on a daily basis, whether it is a patient trying to establish care with me or a patient seeking an acute care visit. We want to work with the legislature to continue to make positive strides for patients in Texas. We applaud the work of Senator Kolkhorst and her work on Senate Bill 2695 that would create a rural access medical program like JAMP and open doors for rural Texans to pursue medical school. Additionally, it would remove delegation and supervision/prescriptive authority agreement fees charged by physicians to APRNs who practice in rural areas if they enter into delegation and supervision agreements with physicians retained or contracted with the Texas Medical Board through a new program created by the bill. Importantly, this bill preserves the safety net of the physician involvement in patient care and avoids creating two standards of care in Texas.

While APRNs are a critical part of the health care team, removing physician involvement is not the answer for better patient care.

Thank you for the opportunity to testify, and I am happy to answer any questions.