



American Academy of Nursing on Policy

American Academy of Nursing: Improving health and health care systems with advanced practice registered nurse practice in acute and critical care settings

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Introduction and Background

Patients in acute care hospitals receive more than 18 million days of intensive care unit care annually at an estimated cost of nearly 1% of the gross domestic product (Health Research Services Administration [HRSA], 2006). A significant need for acute/critical care services remains, especially in the context of an aging American population. Advanced practice registered nurses (APRNs) working in acute care settings are well positioned and well prepared to reduce health care costs while improving access, addressing health systems issues, and providing high-quality care.

Purpose

The purpose of this policy brief is two-fold: (a) to highlight the central role of APRNs in leading changes to create innovative health care system solutions for acute and critically ill hospitalized patients and (b) to shape federal, state, and local policy and legislation to remove barriers to APRNs' full scope of practice in acute and critical care settings, so that APRNs can optimally contribute to the provision of health care and health care reform.

The Role of APRNs in Acute and Critical Care

APRNs have an essential role in ensuring that hospitalized patients receive evidence-based care and timely interventions to optimize care. APRNs manage the care of acutely and critically ill patients, prevent patient deterioration, provide continuity of care, and enhance the movement of patients throughout the health care system.

Insurers and the public continue to be interested in the quality of care delivered in the hospital setting. In keeping with this emphasis on quality, the Centers for

Medicare and Medicaid Services have implemented "value-based purchasing" (or "pay for performance"). Value-based purchasing will reimburse hospitals' base diagnostic-related group payments on the basis of a mix of three factors in fiscal year 2014 including the clinical process of care (core measures), quality indicators, and patient satisfaction (Centers for Medicare & Medicaid Services, 2013). Incentive payments will be determined based on how well hospitals perform on each domain measure and improvement beyond the baseline period (Centers for Medicare & Medicaid Services, 2013). APRNs are effective in maximizing reimbursement that is based on the quality of patient outcomes, and teams that include acute and critical care APRNs are more likely to adhere to clinical practice guidelines that improve patient outcomes than teams without APRNs (Gracias et al., 2008). There also is strong evidence of the positive impact of APRNs as leaders in improving patient, nurse, and system outcomes (Newhouse et al., 2011). APRNs develop and promote adherence to best-practice guidelines; they improve patient satisfaction, prevent injury and harm, and decrease the length of patient hospitalization.

State of the Science Regarding Quality of Care by APRNs

APRNs Provide High-quality, Cost-effective, Safe Patient Care

The landmark Newhouse et al. (2011) research report clearly documents the positive hospitalization-related outcomes achieved by nurse practitioners, clinical nurse specialists, and nurse midwives, supporting the fact that APRNs provide high-quality, safe care. Improved outcomes achieved include the following: (a)

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fewer ventilator days and improved patient satisfaction scores; (b) reduced hospital-acquired infections (e.g., blood stream infections, urinary tract infections, and infections caused by multiple drug-resistant organisms); (c) reductions in patient falls, restraint use, incidence of pressure ulcers, and improved nurse retention; (d) improved patient functioning, decreased length of hospital stay, and decreased readmission rates; (e) decreased incidence of in-hospital preventable deaths with APRN-led rapid response teams; and (f) decreased episiotomy rates.

A significant body of research shows that direct care provided by APRNs is equivalent to care provided by physicians in similar populations (Cragin & Kennedy, 2006; Dulisse & Cromwell, 2010; Gracias et al., 2008; Hoffman, Tasota, Zullo, Scharfenberg, & Donahoe, 2005; Hogan, Seifert, Moore, & Simonson, 2010; Jackson et al., 2003; Karlowicz & McMurray, 2000; McMullen, Alexander, Bourgeois, & Goodman, 2001).

APRNs Reduce Costs and Save Lives

APRNs have designed models for improving care transitions between acute care and long-term care settings and home, including palliative care and care of pediatric and adult patients with a high risk or chronic diseases (Brooten, Youngblut, Deatrick, Naylor, & York, 2003; Coleman, Parry, Chalmers, & Min, 2006; Friedrichsdorf, Remke, Symalla, Gibbon, & Chrastek, 2007; Naylor et al., 2004). APRNs practicing with these models have reduced costs and saved lives because poor transitions often lead to rehospitalization and increased morbidity and mortality.

Greater use of APRNs is a proven strategy to improve patient care while lowering costs (Perryman Group, 2012). The Perryman Report concluded that “empirical evidence highlights that APRNs can be more fully utilized without compromising patient outcomes” (Perryman Group, 2012). The efficient use of APRNs in acute and critical care results in economic benefits as well as a more effective health care system. To optimize these APRN contributions, it is essential that barriers to the full scope of APRN practice in acute and critical care be removed, allowing APRNs to fully use their education and training. These barriers include state legislation restricting scope of practice and requiring collaborative agreements and federal guidelines restricting APRN reimbursement.

Barriers to Full-scope APRN Practice

Scope of Practice Barriers

Scope of practice is a set of rules, regulations, and boundaries within which a fully qualified APRN may practice (Federation of State Medical Boards, 2005; National Council of State Boards of Nursing [NCSBN],

2009). Our current “patchwork quilt” approach in legislation across states delineating APRN scope of practice is a barrier to improving health care for citizens. State regulations for APRNs range from entirely unrestricted full practice and prescriptive authority to states without recognition of APRN roles (NCSBN, 2012). APRN scope of practice in acute and critical care settings should not be based on a state location but rather by a health care system designed to address its citizens’ health care needs.

In states that require physician supervision to practice, APRN scope of practice may be restricted by the requirement of collaborative practice agreements between an APRN and a physician and adds unnecessary administrative costs to health systems. The Federal Trade Commission has stated that unnecessary restrictions of APRN scope of practice, such as unfounded mandatory physician supervision requirements, can likely lead to restrained competition resulting in increases in health care costs, reduced quality of care, and decreased access to health care as well as innovation in care delivery models (Federal Trade Commission, 2014). The U.S. Military addresses APRN scope of practice barriers through recognition by the U.S. Air Force and Navy of the value of having nurse anesthetists with unencumbered practice to ensure full access of military personnel and their families to safe, high-quality care (American Association of Nurse Anesthetists, 2012).

Provider Shortage

Demand for critical care is projected to rise because of increases in patient acuity and the elderly population (HRSA, 2006). In 2003, Congress directed the HRSA to analyze the adequacy of the critical care workforce for the future care of an aging population. The HRSA found a substantial and growing physician intensivist shortage and forecasted a severely inadequate supply of physician intensivists (HRSA, 2006). By 2020, just over 2000 MD intensivists are expected to be available to practice in the United States; yet, over 4,300 will be needed by conservative estimates (Krell, 2008). This gap could be reduced through the full use of APRNs specifically trained in this specialty. Educational programs already prepare nurse practitioners and clinical nurse specialists for acute and critical care for adults and children. The role of APRNs as nurse intensivists is emerging, and educational programs to prepare for this role have been developed (Squiers, King, Wagner, Ashby, & Parmley, 2013).

Barriers to Reimbursement

In some states, APRNs cannot be reimbursed other than through a collaborative physician agreement. APRN care impact can be “hidden” because of financials/current reimbursement structures not listing the APRN as the billing provider. In states where APRNs do not have unrestricted practice, this results in undercoding or not coding at all under Medicare or

Medicaid for some services provided ([Michigan Department of Community Health Task Force on Nursing Practice, 2012](#)). APRNs should be directly reimbursed for services they provide in acute and critical care settings.

Recommendations and Solutions

The primary recommendation across federal, state, and local levels is to adopt the NCSBN APRN Consensus Model for Regulatory Language ([NCSBN, 2008](#)). The consensus model was developed by key stakeholders and has been vetted by legal and regulatory experts. It addresses licensure, accreditation, education, and scope of practice for APRNs, providing uniformity across State Boards of Nursing in the United States to reduce state-by-state variation in licensure, regulation, education, and practice of APRNs.

Additional recommendations are proposed to increase the effective use of APRNs in acute and critical care settings. Recommendations at the national/federal level are as follows:

1. Improve Centers for Medicare and Medicaid Services guidelines and directives relevant to APRNs.
 - a. Remove the requirement for physician attestation for medical needs for durable medical equipment in addition to APRN face-to-face documentation in CFR §410.38(g)(3).
 - b. Directly reimburse APRN services in the Medicare program that are within the scope of practice under applicable state law. Reimbursement at the national/federal level should match APRN scope of practice.
 - c. Authorize APRNs to perform hospital admission assessments as well as certification of patients for home health care services and for admission to hospice and skilled nursing facilities for Medicare reimbursement.
 - d. Modify regulatory language issues that specify only “physician” as provider. Use more neutral language in regulation, such as “physicians and other licensed healthcare practitioners within the scope of practice as defined by federal/state law of that profession” or simply “provider.”
 - e. Allow and reimburse APRNs to provide consultation to other allied health professionals (e.g., physical, occupational, and speech therapists) and prescribe according to patients’ needs (durable medical equipment, etc.).
2. The U.S. military branches and the Veterans Administration should allow APRNs to practice to the full extent of their education and training.
 - a. Recognize APRNs and create job descriptions and scopes of practice that allow full practice authority including, but not limited to,

performing acts of advanced assessment, diagnosing, performing advanced skills, prescribing, and ordering.

- b. Modify regulatory language issues that specify only “physician” as provider.

Recommendations at the state level are as follows:

1. State nurses associations, specialty organizations, and state boards of nursing should do the following:
 - a. Develop an action plan to change statutes, codes, laws, and regulations that restrict, restrain, or prohibit APRN practice.
 - b. Target and work to change statutes, codes, or regulations that prohibit APRNs from being full voting members of hospital medical staffs, recognition as licensed unrestricted providers, or have admitting privileges.
2. Executive and legislative branches of state governments should remove the scope of practice barriers.
 - a. Ensure APRNs have legal authority to obtain informed consent for procedures and surgeries when working in interdisciplinary teams.
 - b. Identify and modernize statutes, codes, or regulations that prohibit APRNs from full practice authority and removal of costly supervision requirements through legislative and regulatory mechanisms.
 - c. Remove barriers from State Healthcare Exchanges to recognize APRNs as providers for reimbursement.
 - d. Opt-out of the Centers for Medicare and Medicaid Services requirement that a supervising physician must be an anesthesiologist (see November 13, 2001, Federal Register 66 FR 56762).
 - e. Modify regulatory language issues that specify only “physician” as provider.
3. In-state insurance companies: initiate dialogue about direct reimbursement for APRN practice in acute and critical care settings.
 - a. Directly reimburse APRNs by third-party payers who participate in “fee for service.”
 - b. Include APRNs in empanelment arrangements for planned care for a group of patients.
4. In-state professional and consumer organizations: identify and collaborate with professional and consumer organizations to advance APRN utilization and recognition of their value.
 - a. Jointly work with organizations to move change forward. Examples of potential collaborations include American Association of Retired Persons, Blue Cross Blue Shield, APRN Coalitions, and Gray Panthers.
 - b. Actively support legislation that removes barriers in insurance companies’ recognition of APRN legislation.
 - c. Educate physicians and other health care providers about the successful patient outcomes of APRN practice in acute and critical settings.

- d. Promote APRN value and outcomes in media opportunities.
5. Health care systems: credential, provide appropriate privileges, and use APRNs in acute and critical care practice settings to the fullest extent of their education and training consistent with state regulations.
 - a. Provide models of care for hospitals in appropriate credentialing of APRNs.
 - b. Educate hospital boards, credentialing committees, and medical staff about APRN practice to facilitate updating hospital bylaws (*American Association of Retired Persons, 2011*).
 - c. Develop or implement evidence-based care models that measure patient and process outcomes and address issues related to quality of care and efficient movement of patients through their hospital stay.
 - d. Seat APRNs on hospital boards of directors to provide governance in interdisciplinary models of care.

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