YOU ASK:
What are the national trends regarding the prerogatives, rights and role of advanced practice nurses? Admitting privileges? Guidelines for criterion for special procedures? Extent of independence/supervision

Hugh Responds:

Great question, and one that is increasingly being discussed in hospitals throughout the U.S. and abroad. Let’s first quickly examine the factors driving the evolution of the APN’s role in patient care.

Historically APNs were an oddity except in the surgical suite (the Certified Registered Nurse Anesthetist, CRNA, and in the delivery suite (the Certified Nurse Midwife). Even in these two areas use of the highly skilled APNs was often affected by the presence of MDs or DOs who either did not believe the APN had a role to play or were concerned about potential competition. The quality of service provided by these two types of APNs was never in doubt as many studies have shown that patient outcomes were either unaffected or slightly improved through their use.

In locations where physicians were in short supply the use and role of the APN increased, and in fact in some locations, APNs provided (and still provide) the vast majority of both anesthesia and obstetrics. (For reference please research the Frontier Nursing Service, smaller rural hospitals, or larger medical centers with multidisciplinary provider groups providing both anesthesia and obstetrical services.)

Readers recognize that laws, regulations and accreditation standards also have a profound effect upon the role of APNs both within and outside the hospital. However, even in these slow to change arenas there are many examples in which APNs are allowed a far greater patient care role than in states with more restrictive and traditional policies. Once again such regulatory changes seem to be driven by the laws of supply and demand. (If the supply or cost of physician services is below demand regulations and hospital policies tend to permit greater roles for APNs)

An apt example of this principle at work is to be found in hospital emergency departments across the nation. In many locations patients presenting with emergencies will more likely be seen by an APN or PA than by a trained emergency physician, and anesthesia is often provided by a CRNA under either real or desultory physician supervision.

Physician practices increasingly find that hiring APNs to augment their clinical practices is often easier, less costly, as productive and more patient centric than hiring or partnering with other physicians. These and other factors have led to an explosion in the number and types of APNs. There are now dozens of types of certifications available to APNs providing them with recognizable credentials in fields as common as acute care and as specific as orthopedics.

The roles and responsibilities of APNs will continue to expand as dictated by laws of supply and demand, politics, economics and diminution of the power of existing physician dominated groups to slow such evolution.

How about “admission privileges” for APNs?

Medicare defines the attending physician as follows:
“Qualifications of the ordering/admitting practitioner: the order must be furnished by a physician or other practitioner ("ordering practitioner") who is: (a) licensed by the state to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision.”

See also: https://www.the-hospitalist.org/hospitalist/article/125621/cms-allows-residents-advanced-practitioners-admit-inpatients

On February 18, 2014, Ohio Governor Kasich signed into law H.B. 139 permitting clinical nurse specialists (CNS), certified nurse-midwives (CNM), certified nurse practitioners (CNP) and physician assistants (PA) to admit patients to hospitals under certain conditions. Under current law, only a doctor, dentist, or podiatrist who is a member of a hospital’s medical staff may admit a patient to the hospital (Ohio Revised Code 3727.06). However, H.B. 139 authorizes a CNS, CNM, or CNP to admit a patient to a hospital if three conditions are met:

1. The CNS, CNM or CNP has a standard care arrangement with a collaborating doctor or podiatrist who is a member of the medical staff.
2. The patient will be under the medical supervision of the collaborating doctor or podiatrist.
3. The hospital has granted the CNS, CNM, or CNP admitting privileges and appropriate credentials.

Bearing the above in mind these are the points an MSP or VPMA should at least consider regarding “admitting privileges” for APNs.

1. Does the state allow hospitals to grant admitting privileges to APNs?
   Check your state licensing law(S) regarding this issue. (Increasingly state laws and regulations are becoming more permissive and establishing rules under which APNs may admit in collaboration with a physician.)
2. A physician will assume overall supervision of the inpatient stay.
3. The hospital, through the authorized process, has granted APNs to admit under what circumstances.

Let us now explore the granting of special procedure privileges to APNs.
This process will be identical to that used for the granting of privileges to any practitioner.

Ideally the MEC will approve the minimum amount and type of education, training and experience (either direct or indirect/related) required to apply for the privilege.
Letters or questionnaires documenting current competence in the procedure will also be required. I recommend that at least one be obtained from the collaborating physician and that this person agree to the supervision that will be required both initially and on an ongoing basis. A period of FPPE may also be defined and instituted. Such FPPE may be of any type deemed appropriate by the MEC. (Concurrent review/proctoring, retrospective review, gathering of practitioner specific data for evaluation by a designated physician leader.)
Under ideal circumstances the collaborating physician should be present for the first couple of special procedures preformed by the APN and should forward his or her review results to the designated physician leader.

The last question in this series deals with the extent of supervision or collaboration that will be expected by the MEC. As with practically all questions of this type the answer is “check your policy, if you have one follow it, if there is no policy create one.”
The “supervision” or more aptly “collaboration” between physicians and APNs will depend upon a host of factors some focusing on patient care others dependent upon the local history, tradition and power structure of the Medical Staff. Generally speaking those physicians who regularly interact with, employ, or collaborate with APNs believe that they should be free to determine how much or little observable supervision will be necessary as this will depend upon the length of time the APN has been working with them, and the type of clinical care that is involved. However there are a few absolutes that should be considered.

1. State, Federal law, and accreditation standards. Here the hospital has much discretion.
2. Medical staff culture and observed impact upon patient care safety.

In Summary:
The role of APNs has for many decades been substantial in certain clinical (and critical) patient care areas. (CRNAs and CNM.)

The extent of APN involvement in patient care continues to evolve and increase generally in line with supply, demand, regulation and medical staff leadership. Hospitals in Ohio and throughout the nation should expect and welcome additional involvement of the Advanced Practice Nurse.

MECs should begin to plan for incorporation of the APN into the organized professional or medical staff as there is very little supportable rationale for not recognizing the contribution of the APN as a member of both the patient care and leadership team.