The Advanced Practice Registered Nurse: Credentialing, FPPE and OPPE

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APRNs and PAs

Definitions:
Advanced Practice Registered Nurse or Nurse Practitioner (NP)
Physician Assistant

NP (Historically well known to hospitals (CRNMs and CRNAs)

Approaching 280,000 nationwide and increasing rapidly.
Direct care provider, educator, consultant, researcher, in hospitals and other large integrated organizations
most often provides care in collaboration with one or more physicians
Licensed and Certified
Most definitive info on quality and use:
http://www.ahrq.gov/professionals/clinicians-providers/resources/nursing/resources/nurseshdbk/OGradyE_APRN.pdf

NPs

+ 30 specialties
Growing rapidly
Expanding scope of services
Gaining right to practice independently (20 states and growing.)
Practicing in nearly every hospital or medical center
Employed by physicians, hospitals and clinics.
All available evidence shows care quality as good or better than that of physicians and often involves use of fewer resources.
CREDENTIALING AND MEDICAL STAFF STAFF IMPLICATIONS

TO APPOINT OR NOT TO APPOINT, THAT IS THE QUESTION:
Arguments against: It’s not how we do things here, not on my watch, the staff is for physicians, next they will want to be on the MEC, they will press for expanded privileges. Who cares, appointment is no longer an important issue, patient care, influence and participation in service lines is important.
Arguments for: We are moving towards a team approach to care, why not, we are moving away from a hospital centric culture toward a broader continuum of care model.

Central questions that should be addressed by all leaders

Benefits to expanding the qualification for staff appointment to include NPs (Just like MDs, DOs, DPMs, DMD/DDS, PhDs/Psy.D)
Should we begin to move toward a PROFESSIONAL STAFF instead of Medical Staff
Downsides to exclusivity?
Clinical prerogatives/privileges
Why should NPs not be permitted to practice at the top of their certification?
Is a collaborative agreement still necessary?
(Yes, if required by state statute, in all other cases it is up to the organization.)

Central questions that should be addressed by all leaders

What will be the working requirement if collaborative practice continues to be required?
With collaborative practice what role/responsibility will the designated physician have in both F and OPPE
Physician Assistants

Over 90,000 and growing rapidly
Employed by physicians, hospitals and others
Must be licensed (Be aware of unlicensed Certified Orthopedic Physician Assistants)
May only practice under supervision of a physician, but may (unless prohibited by law) do whatever their supervising physician permits.
They often are the only care giver a patient may see in the ED.
They often are the only care giver a patient might see in a clinic or physicians office.

The practical side of NP and hospitals

Employed NPs and PAs now practice virtually independently in the ambulatory setting under the "Direction and supervision of a Medical Director". In many hospitals the primary care giver in the ED could easily be a NP or PA
Groups of physicians who employ an NP or PA want them to be able to practice at the top of their license.
There is absolutely no evidence demonstrating the NPs and PAs provide unsafe or poor care.

NPs and PAs

Credentialing is basically the same as for all others. Verify qualifications as required by law and the organization
Verify competence-References; from collaborating phys, employer, past practice associates.
Privileges:
For PAs the sky in the limit (unless prohibited by law). Since they are only allowed to do what their supervising physician allows them to do the concept of individually assigned privileges does not really apply
Privileges for PAs

But they are required:
Make them broad enough to permit supervision
physician to use a PA as he or she desires
Privileges “to assist supervising physician as directed.”
(Providing such direction does not conflict with
hospital/medical staff policy.)
Policy and supervisory agreements signed by physicians
should be the primary tools used establish practice
limits of PAs.

Privileges for NPs

Should be similar (but with limited procedures) to
those of physicians and based upon certification and
experience.
Try to avoid a requirement for “consultation in
complex cases” (as this is nearly impossible to police
on a real time basis.)
F and OPPE (for JC accredited facilities) virtually the
same as for physicians.

Bottom line

Numbers and use are growing
In the face of a protracted health care worker shortage
NPs and PAs will continue to fill important rolls and
their scope of practice will continue to expand
As medical staffs gravitate toward semi professional
leadership reduction in barriers to expanded
practice.
NPs will be accorded functional if not actual
appointment to the staff just as DPMs, DDS, DMDs
and PhDs have been. (occurring first in governmental
facilities and in Critical Access hospitals.)
Key Needs

Specialty specific sets of core privileges
In states requiring a collaborative practice model, hospitals must define “collaboration” and monitor its implementation.

More active monitoring of PAs actual practice to assure that it is within hospital policy and is being supervised actively by attending’s.
More involvement in F and OPPE by supervision docs.