

Removing Barriers to Advanced Practice Registered Nurse Care: Hospital Privileges

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The Institute of Medicine recommends that advanced practice registered nurses (APRNs) practice to the full extent of their education and training, which includes being able to admit their patients to the hospital and other facilities. This report discusses barriers to hospital privileges and outlines the benefits to consumers and the health care system when APRNs have hospital privileges.

Introduction

Continuity of care is improved when nurse practitioners (NPs) and other advanced practice registered nurses (APRNs) who care for patients in primary care settings can follow their patients and their families when they are admitted to the hospital. Although APRNs have made headway in practicing to the full extent of their education and training, barriers still hamper continuous, seamless patient care.

Federal and state laws and regulations, as well as individual hospital bylaws and policies, can block hospitalized patients' access to their provider of choice, if that provider is an APRN. Removing barriers to care reduces costs, increases consumer choice, and improves health care quality.¹

This report discusses barriers to hospital privileges and expands on recommendations of the Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health*² that APRNs be eligible for hospital clinical privileges, admitting

privileges, and hospital medical staff membership and also be permitted to perform hospital admission assessments—documenting medical histories and performing physical examinations.

APRNs Provide High Quality Care in Hospitals and Other Health Care Settings

The ability of a primary care provider to care for a patient who is admitted to an acute care facility is more critical than ever. As noted in a previous AARP Public Policy Institute paper, *Creating a 21st Century Nursing Workforce to Care for Older Americans: Modernizing Medicare Support for Nursing Education*, cost containment efforts have shortened the average hospital stay from 8.7 days in 1990 to 5.5 days by 2006. Hospital admissions frequently require a coordinated team to provide comprehensive and efficient care. Both the numbers and life expectancy of persons ages 65 and over are increasing. Chronic illness afflicts nearly half of Americans, and just under one quarter have five or more chronic conditions.³

Who Are Advanced Practice Registered Nurses?

Advanced practice registered nurses (APRNs):

- Are registered nurses (RNs) with master’s, post-master’s, or doctoral degrees
- Pass national certification exams
- Teach and counsel patients to understand their health problems and what they can do to get better
- Coordinate care and advocate for patients in the complex health care system
- Refer patients to physicians and other health care providers

Types of Advanced Practice Registered Nurses

Who Are They?	How Many in U.S.?	What do they do?
NPs	158,348	Take health histories and provide complete physical exams; diagnose and treat acute and chronic illnesses; prescribe and manage medications; order and interpret lab tests and X-rays; provide health teaching and supportive counseling.
CNSs	59,242	Provide advanced nursing care in hospitals and other clinical sites; provide acute and chronic care management; develop quality improvement programs; serve as mentors, educators, researchers, and consultants.
CRNAs	34,821	Administer anesthesia and related care before and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as pain management. Settings include operating rooms, outpatient surgical centers, and dental offices.
CNMs	18,492	Provide primary care to women, including gynecological exams, contraceptives, prenatal care, management of low-risk labor and delivery, and neonatal care. Practice settings include hospitals, birthing centers, and community clinics.

Sources: AARP Public Policy Institute, Center to Champion Nursing in America. Preparation and Roles of Nursing Care Providers in America. Washington, DC, 2009, http://championnursing.org/sites/default/files/u/APRN-Types_1.pdf; U.S. Department of Health and Human Services, Health Resources and Service Administration. The Registered Nurse Population: Initial Findings from the 2008 National Sample Survey of Registered Nurses. Washington, DC, 2010. (APRNs are identified by their responses to the National Sample Survey and may not reflect the true population of clinical nurse specialists.)

Patients with extremely complex conditions and with multiple disease processes are cared for in the community on a daily basis by APRNs, particularly NPs. Hospitals employ nurse practitioners in their outpatient clinics, emergency departments, and inpatient units.

Survey data from the American Academy of Nurse Practitioners demonstrate that NPs care for large numbers of older people and people with chronic, multiple disease processes. Three-quarters of all nurse practitioners have a patient population that includes people over 65,

and approximately 20 percent of these NPs see patients ages 65 and over more than half of their clinical time. For just under 11 percent of all nurse practitioners, patients ages 85 and over are more than half of their patient population.⁴ More than 88 percent of family nurse practitioners and adult nurse practitioners accept Medicare patients, and more than 80 percent of both groups accept Medicaid patients.⁵

Another category of APRNs, certified registered nurse anesthetists (CRNAs), ensure access to anesthesia and pain management services, particularly in

rural and underserved communities. A 2007 Government Accountability Office study revealed that CRNAs predominate where more Medicare patients reside.⁶ An aging population with increasing chronic conditions requires health care services that are focused on primary care, disease management, care coordination, transitional care, and prevention of disease deterioration. APRNs are educated and trained to provide high-quality health care services in hospitals and other settings.

States vary in how they license each category of APRN. Ongoing efforts by state licensure, accreditation, certification, and education organizations⁷ to standardize national credential requirements will facilitate the mobility and interstate practice of this major primary care provider group, thus decreasing one barrier to care. The IOM report *The Future of Nursing: Leading Change, Advancing Health*⁹ recognizes the positive impact APRNs can have on the health care system if barriers to care are removed.

APRNs, specifically NPs, hold prescriptive privileges in all 50 states, with the ability to prescribe controlled substances in 48 of them. Prescriptive authority is one area of state nurse practice acts that has become more uniform. A total of 96.5% of NPs prescribe medications, averaging 20 prescriptions per day,⁸ making it a part of routine care. Prescribing a medication regime or changing the existing medications of a patient who is admitted to the hospital is part of APRN education and training.

A multitude of studies show that the quality, efficiency, patient satisfaction, and cost-effectiveness of APRN care is as good as, and in some cases better than, the care provided by physicians.^{10,11,12} Care coordination and transitions of care are extremely important to positive outcomes of hospital care, not only for older patients but for any patient. Pediatric patients respond best to familiar

providers, allowing a more expedient, nonstressful admission for both patient and parent. Because of their nursing education and clinical training, APRNs know the concerns of their patients and can help make the hospital experience a more pleasant, less stressful time, thereby expediting recovery time and improving quality of life for patients.

Based on data from the most recent NP survey of the American Academy of Nurse Practitioners (AANP), only about 43 percent of the NPs in the United States have hospital privileges, and just over half of these have admitting privileges, meaning that they can admit patients from an office or outpatient setting to a hospital. This is a slight increase from the 2005 AANP survey data, when 39 percent of NPs had privileges. The reason the majority of NPs do not have admitting privileges is unclear.¹³

The three other categories of advanced practice registered nurses, certified registered nurses anesthetists (CRNAs), certified nurse-midwives (CNMs), and clinical nurse specialists (CNSs), typically practice in hospitals and other acute care settings. The American Association of Nurse Anesthetists membership data for 2010 reveal that approximately 37 percent of CRNAs are employed by hospitals and another 34 percent are employed by an anesthesia group, with the vast majority of CRNAs indicating that their primary place of employment is a hospital or affiliated clinic.¹⁴

According to the American College of Midwifery Certification Board, as of January 2011 there were nearly 12,000 certified nurse-midwives in the United States. The most recent American College of Nurse-Midwives membership survey data show that approximately 52 percent of respondents (22 percent of total) are employed by hospitals and private physicians. The majority of CNMs (69 percent) attend live births in hospitals or hospital-based birthing centers.¹⁵

Privileging CNMs as full active medical staff would promote continuity of care for their patients, and birth certificate data would more accurately reflect provider type and outcomes.¹⁶

Traditionally, clinical nurse specialists other than those who function in mental health have not sought credentialing and privileging, and then only if they have prescriptive authority—the legal right to prescribe medications. The practice of CNSs is primarily an extension and advancement of nursing practice rather than of the physician model of care that would require hospital privileges.¹⁷ This trend may change as more CNSs will have the option of prescriptive authority with the full implementation of the APRN Consensus Model. The APRN Consensus Model establishes national standards for education and training for all categories of APRNs and would extend to consumers in all states access to comprehensive care by APRNs.¹⁸

Numbers of practitioners holding hospital clinical and admitting privileges vary across the category and type of APRNs, with each group having the same hurdle of meeting the requirements of the hospital credentialing committee. In the *Nurse Practitioner's Business Practice and Legal Guide*, Buppert¹⁹ states that an NP must consider many issues when applying for hospital privileges, with or without admitting privileges. Is it necessary for the type of practice the nurse practitioner has? Does the nurse practitioner feel comfortable in the hospital care setting? The newest subspecialty of nurse practitioners, acute care NPs, receive specific education and clinical training to practice in hospital settings.

Acute care NPs are only 5.6 percent of the NP population,²⁰ but NPs are part of the rapid expansion of hospitalist services.²¹ For NPs who practice in primary care settings, hospital privileges may be necessary to be considered primary care providers (PCPs). Private insurance

Metropolitan Chicago Healthcare Council

The Metropolitan Chicago Healthcare Council (MCHC) is a membership and service organization dedicated to helping members care for their communities through access to health care and improved delivery of services. The Advanced Practitioner Regional Collaborative surveyed MCHC member organizations to determine hospital demographics, credentialing and privileging processes, scope of practice, and APRN activities. Seventeen member organizations representing almost 1,200 APRNs were surveyed. Key findings:

- APRNs by category included 60 percent NPs, 18 percent CRNAs, 16 percent CNSs, and 6 percent CNMs.
- Sixty-three percent of the APRNs were employed by the hospital; 16 percent by hospital-owned physician practices; 16 percent by independent physicians; 5 percent in other venues such as nurse-managed clinics.
- Only a few organizations bill for APRN services.
- Reasons organizations hired APRNs included the following:
 - Improve patient safety and quality
 - Increase patient throughput
 - Comply with Accreditation Council for Graduate Medical Education standard for resident work hours
 - Increase physician productivity
 - Improve continuity of care

Source: Trish Anen. "Advancing APNs: A Regional Collaborative." Metropolitan Chicago Healthcare Council, December 13, 2010.

companies typically require hospital privileges before they will allow a PCP on their provider panel and to bill for office-based services.²²

Complexities of care, coordination of care, and transitions into and out of the community during illness necessitate a transparent and seamless process that allows providers to gain access to the patients they have cared for and know best. Coordination of care and teamwork among all health care providers is not only advantageous but necessary for efficient and cost-effective care. Efforts to break down barriers between professions are showing positive results, and APRNs are leading the way. However, continuity of care is often blocked by the inability to gain privileges within the admitting hospital facility.

What Does It Mean to be Credentialed with Hospital Privileges?

Hospitals and other health care institutions grant medical professionals the privilege or authority to practice in their facility.

Credentialing and privileging were originally applicable only to physicians. Physicians were granted the privilege of admitting patients to the facility with the authority to order or perform all tests, diagnostic procedures, and treatments. When specialization of physician practice and board certification gained acceptance and hospital accreditation became the norm, the need for a more specialized privileging process also arose. Credentialing and privileging are two administrative processes that are intended to ensure that practitioners have the necessary qualifications to direct the clinical care provided to patients in hospitals. A hospital establishes required credentials for practitioners and then reviews, verifies, and evaluates an applicant's credentials—education, clinical training, certification, licensure,

and other professional qualifications. Privileging refers to authorizing the credentialed individual to perform or order specific diagnostic or therapeutic services within the hospital. Hospital privileges, which used to be a simple matter, can now include a list of hundreds of diagnostic and treatment procedures.²³ Even though a practitioner may have the credentials to perform certain diagnostic and treatment procedures, the practitioner must still be privileged, or granted permission, by the hospital or related entity to perform those procedures.

While increased numbers of APRNs work within acute care settings, not all of them are employees of the facility. Many are contractors, employees of physicians with hospital privileges, or less often, independent practitioners. There is wide variation in how hospital bylaws categorize and define health care providers such as APRNs. APRNs may be identified by category (e.g., nurse practitioner) or may simply be defined by a broad statement (e.g., health care provider, health care professional, nonphysician provider). This creates a confusing process for the credentialer.

Hospital bylaws describe the credentialing and privileging process, spell out policies and governance procedures, identify staff levels of appointment, and provide the rules and regulations for the hospital. Hospital bylaws will also designate levels of medical staff privileges, such as active, honorary, consulting, affiliate, allied, and associate. Bylaws can vary considerably from one hospital to another even in the same city or state.

Hospital bylaws typically follow the standards and guidelines of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), which accredits U.S. health facilities. Starting in January 2011, the Joint Commission requires that privileging of APRNs and physician assistants (PAs) be carried out through the

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process outlined in the Overview section of the Joint Commission’s Medical Staff standards. In other words, facilities must follow the same privileging process they use for physicians to credential APRNs and other medical staff, and not use any “equivalent” process, which was previously acceptable.²⁴ However, current Joint Commission standards permit hospitals to privilege APRNs as less than active medical staff and without medical staff membership. Only active members of the hospital’s medical staff are permitted to admit patients, and only medical staff members have voice and vote in medical staff governance. Without voice and vote, APRNs can be voted off medical staff rosters individually and categorically without recourse.

Federal and state laws and regulations are additional barriers to hospital privileges for APRNs. These barriers are outlined in the following sections.

Medicare Regulations Prevent APRNs from Conducting Patient Exams in Hospitals

Medicare regulations allow APRNs medical staff membership if permitted by state law but do not mandate APRN membership. The Medicare Hospital Conditions of Participation (CoP) contain barriers to APRNs obtaining hospital clinical privileges. Pertinent Medicare regulations include the following:

42 C.F.R. 482.22 Condition of participation: Medical staff²⁵

“The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. . . . The medical staff must be composed of doctors of medicine or osteopathy and, in accordance with State law, may also

be composed of other practitioners appointed by the governing body.”

“(c) Standard: Medical staff bylaws. The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must:

(5) Include a requirement that a physical examination and medical history be done no more than 7 days before or 48 hours after an admission for each patient by a doctor of medicine or osteopathy.”

The Medicare requirement that only a physician may conduct a history and physical is duplicative and unnecessary. APRNs are qualified to conduct medical histories and perform physical exams through their education, certification, and experience. Medicare reimburses APRNs for performing these services in outpatient settings. Although this regulation applies specifically to Medicare, it is frequently applied to patients with Medicaid and private insurance as well. This regulation is costly and burdensome to hospitals, physicians, and patients. APRNs can and should document medical histories and perform physical examinations in hospitals in addition to the other settings where they are licensed to practice.

State Laws are a Barrier for APRNs and Their Patients

The Medicare Hospital CoP specify that a hospital’s medical staff may include other practitioners such as APRNs if permitted by state law. In the 1970s, Oregon was the first state to allow CNMs, and then NPs, hospital privileges.²⁶ The law stated that NPs were subject to the credentialing institution’s bylaws and that a hospital could limit the scope of practice, require monitoring by physicians, or require that NPs co-admit with a physician. Since that time, many states have enacted similar legislation.

The Pearson Report, an annual state-by-state review of NP legislation, queries each state regarding legislative prohibitions against hospital privileges. The 2011 Pearson Report identified two states that prohibited NPs from hospital privileges. Ohio law prohibits NPs from admitting patients, and Maine law requires NPs to be supervised by a physician when providing patient care in the hospital. Even where state law does not prohibit hospital privileges, hospitals may still not grant privileges (e.g., Florida). Only a few states address inclusion of APRNs as part of medical staff, and variations of state laws may not be consistent with nursing regulations regarding scope and authority of APRNs. In Arizona, for instance, the nurse practice act includes admitting privileges to acute care facilities. The Arizona Department of Health rules, however, state that all patients admitted to a hospital must have an attending physician.²⁷

Hospital Bylaws Are a Barrier for APRNs and Their Patients

Each hospital's bylaws specify whether and how APRNs may be granted privileges. Since almost all hospitals are accredited by the Joint Commission, hospital bylaws typically follow the Joint Commission standards. In 1983, the Joint Commission opened medical staff membership to nonphysician health care professionals, including APRNs, whom the Commission referred to as "limited license practitioners."²⁸

Hospitals may decide not to credential and privilege APRNs²⁹; that is, their bylaws may not address any nonphysician providers at all. If hospital bylaws do address APRNs, the bylaws may include provisions for supervision of APRNs that are more restrictive than state laws. When physicians are required to supervise APRNs, the physician's workload and perceived liability increase. When physicians are required to cosign all

Nurse Practitioner Elected Medical Staff President

Bob Donaldson is clinical director of emergency medicine and president of the medical staff at Ellenville Regional Hospital in New York. His current projects sound much like any medical staff president's goals. What might surprise you is that Donaldson is not a physician but a nurse practitioner. He was elected to this influential position by his physician colleagues and enjoys great support from the hospital's medical staff.

As an admitting provider in the ER, the hospital's medical staff got to know Donaldson well and in 2008 he was invited to be on the team to review and revise the medical staff bylaws. "The medical staff, all physicians, voted to give equal rights to nurse practitioners on the medical staff," says Donaldson. "Which means if you have a practice here and you are involved in admissions to this hospital, that you are equal to a doctor as far as privileges at the facility and within the medical staff."

In another unusual move, Donaldson's work in the ER means he admits patients to the hospital and its various providers every day, so the hospital decided to give him attending status. Donaldson says that in 2009 the hospital needed to fill the position of medical staff president and was having difficulty attracting volunteers. So he put his name in the hat. "I look at that as like anything else nurse practitioners have done," he says. "There's a void and we step in and we do the job. So that's what I did." Clearly, this hospital has collaborative practice figured out.

Source: Excerpted from Rebecca Hendren. "Nurse Practitioner elected Medical Staff President." *HealthLeaders Media* (February 8, 2011). Accessed August 9, 2011. <http://www.aanp.org/AANPCMS2/LegislationPractice/Nurse+Practitioner+Elected+Medical+Staff+President.html>

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APRN orders, clinical care can be delayed. Inappropriate physician oversight increases costs and can diminish quality.³⁰

Several hospitals have welcomed APRNs, developing strategies to integrate and capitalize on their contributions. A few hospitals have set up special models or committees to facilitate credentialing and incorporating APRNs within the institution while recognizing their unique contributions.³¹ One hospital created a Chief of Advanced Practice position to formally recognize and manage APRNs, similar to the Chief of Medicine positions that have existed for physicians for decades.³² These efforts help to educate all hospital staff on the valuable contribution APRNs make to the health care system and pave the way for full integration.

Consumers Benefit when APRNs Have Hospital Privileges

The greatest benefit of APRN hospital privileging is continuity of care for patients. A distinguished panel of the IOM examined the record, conducted hearings, and issued a report recommending that APRNs be permitted to practice to the full extent of their education and training, and that nurses be prepared and enabled to lead change and advance health.³³ **The IOM recommended that APRNs be eligible for hospital clinical privileges, admitting privileges, and hospital medical staff membership and also be permitted to perform hospital admission assessments—documenting medical histories and performing physical examinations.**

Women benefit when they receive hospital care from CNMs. Certified nurse midwives' patients have significantly lower rates of cesarean sections, fewer episiotomies, and higher rates of breastfeeding compared to those cared for by physicians.³⁴ In a normal hospital delivery, a nurse-midwife can admit the woman to the hospital, write medical

orders, deliver the baby, and provide postpartum care independently within the scope of the CNM's education and training. When CNMs have hospital admission privileges, women planning a hospital birth or requiring hospitalization during pregnancy can remain in a midwifery practice. No obstetrical interventions should be mandated unless warranted by a woman's condition. When a pregnant woman's condition warrants referral to a physician, the established relationship between the woman and the nurse-midwife can help the woman to understand and make decisions about interventions proposed by the obstetrical specialist and allows for better continuity than if her care is assumed by a stranger.³⁵ The Medicare requirement for a physician-conducted history and physical even for a normal delivery in a hospital adds costs when the woman's insurance coverage is through an insurer that follows this Medicare precedent.

Children and their parents benefit when pediatric nurse practitioners in primary care practices have hospital privileges. Continuity of care between primary care providers and the hospital decreases the number of strangers children must deal with and improves provider-parent education and communication.³⁶

Patients with cancer and other chronic illnesses benefit when APRNs have hospital privileges. Many cancer patients have multisystem, complex, chronic illnesses that require coordination not only to follow the various disease processes, but to manage the symptoms and emphasize preventive and health promotion aspects. A recent literature review found that continuity of cancer care is significantly enhanced when primary care NPs and oncology NPs are involved in patient care across settings. NPs assume a variety of cancer-related roles, including cancer specialists, educators, researchers, and consultants, extending across settings

Benefits and Challenges

- Benefits
 - Expanding consumer choice and access to care
 - Improving continuity of care
 - Increasing cost-effectiveness (decreased rehospitalizations, decreased medication errors, fewer C-sections, decreased duplication of services, to name a few)
 - Improving interprofessional collaboration and team care
 - Improving education of other professionals regarding APRNs
 - Increasing long-term survivorship in multisystem, chronic disease, and complex cancer patients
 - Decreasing patient stressors, especially for older, obstetric, and pediatric patients
 - Providing models for hospitals to use for credentialing APRNs
 - Using available health care workforce most efficiently to coordinate and deliver care
- Challenges
 - Educating hospital boards, credentialing committees, and medical staff about the practice of APRNs to assist in updating hospital bylaws
 - Encouraging hospitals to increase the number of APRNs on hospital committees/services that can make needed changes
 - Educating consumers about their rights to continuity of care and transitional care
 - Advocating to hospitals that the primary care professionals of record be allowed access to the hospital records of their patients when the patient is admitted
 - Encouraging patients/consumers cared for by APRNs to advocate for them as competent providers to both the physicians who care for them and the hospitals to which they would be inclined to be admitted

to radiation clinics, hospitals, oncology clinics, and primary care settings.³⁷

Patients transitioning from hospitals to community care benefit when APRNs have hospital privileges and can minimize medication discrepancies between settings. Findings from patients transitioning from hospital to community indicated that medication discrepancies were astoundingly widespread, with 94 percent of the participants having at least one discrepancy. Older adults are particularly vulnerable to medication discrepancies following hospital discharge because they frequently have chronic comorbid medical conditions, functional impairments, complex

medication regimens—often with prescriptions from several providers—and extensive changes in their medications during hospitalization. Nearly 20 percent of Medicare patients are rehospitalized within 30 days of an index hospitalization.³⁸ A recent transitional care program for heart failure patients led by APRNs significantly reduced readmission rates.³⁹ These types of programs may be expanded nationally as APRNs with hospital privileges coordinate care for vulnerable populations.

Interprofessional collaboration is enhanced when APRNs have hospital privileges. Patients benefit when APRNs and physicians learn from each other, improve

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their respective practices, and gain a deeper understanding of one another's expertise and philosophy. This is the kind of practice that patients are entitled to and deserve.

Hospital administrators benefit when APRNs have hospital privileges. APRNs can be role models for nurses, medical and nursing students, residents, and attending physicians. APRNs can engage in patient rounds and informal discussions to affect patient care. Formal presentations by APRNs on patient care, research, and outcome statistics can begin to correct misconceptions held by health care providers who have no direct experience with APRNs providing independent care. Participation with voting privileges on department and hospital committees also offers the opportunity to add a different perspective to the work of these groups, and may help bring about needed change. Working in these groups also broadens the APRNs' perspectives and teaches them about complex medical care. Interprofessional care models can improve patient outcomes in large, complex institutions.

Insurance companies benefit when APRNs have hospital privileges. Hospital privileges are a requirement for becoming a preferred provider for some insurance companies, thus affecting the economics of outpatient care. For patients and consumers, receiving care from their APRN primary care provider can reduce the stress of their inpatient journey and promote a safe landing at home. Removing barriers to hospital privileges for APRNs is one way to increase access to primary care providers and improve the health care system.

Conclusion

An AARP Public Policy Institute Insight on the Issues, *Creating a 21st Century Nursing Workforce to Care for Older Americans: Modernizing Medicare Support for Nursing Education*,⁴⁰ elaborated on the need for more primary care providers in the workforce, providing research and strategies for

increasing their numbers. In addition to the shortage of primary care providers, the demand for health care services and changing population demographics all require an increased number of APRNs who are expertly prepared, are allowed to practice to the full extent of their education and training, and are readily accessible to patients in all settings.⁴¹

Increasing the number of APRNs and other primary care providers is one solution to the access to care problem, but developing the support mechanisms and processes to allow them to provide that care is also a critical factor. There is a need for these providers to be able to provide seamless, continuous care, including care from initial intake, follow-up care, health promotion and disease prevention, and care during illness, whether in or out of the acute care facility, over the life of the patient. Although strides have been made within acute care facilities to accommodate their own APRN employees, especially those who work within acute care areas, more needs to be done for nonhospital-employed APRNs.

Today's providers need to "hit the ground running" with high-level, comprehensive, optimal care. Since allowable or reimbursable admission days have drastically decreased, time is of the essence. When given hospital credentials and privileges, APRNs can improve access and care as part of the team at the point of admission; they can help to coordinate the care thanks to an in-depth background of the patient's condition and their unique responses; they can provide the transition planning and then return to caring for patients when they are discharged.

Hospital privileges for APRNs may decrease readmission rates and errors, speed recovery, and improve health for consumers. Allowing APRNs to conduct hospital admission assessments can potentially decrease costs, expedite treatment by eliminating the need for physician sign-off, and allow physicians to focus on specialized services.

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