

Eliminating Practice Barriers for APNs in the Long-Term Care Setting

Description:

Advanced practice nurses (APNs), including those specializing in the care of older adults, have practiced in long-term care (LTC) settings for nearly four decades, providing health care for long-term residents and for short-term residents receiving post-acute care. Public health emergencies and escalating resident acuity have highlighted the essential role of APNs in strengthening clinical care delivery and leadership within LTC settings. Evidence consistently identifies APNs as critical members of the interprofessional team. This position statement outlines the critical role of the APN in long-term care, highlights barriers to APN practice, and suggests recommendations for continued advancement of the role.

GAPNA Position:

1. Eliminate regulatory practice barriers.
 - a. APNs have received the needed education and training to practice safely and independently. APNs should continue to collaborate with on-site physicians and other health care professionals when available, but direct physician oversight is not needed.
2. Promote APN leadership with LTC.
3. Examine traditional and emerging leadership opportunities for APNs in LTC.

Maximize APN education and training.

 - a. APNs are an integral part of the LTC team and can elevate the knowledge and skill set of nursing and other staff working in LTC facilities.
 - b. APNs should have equitable opportunities to be nursing facility directors. In 1974, Medicare began regulation that requires a physician to be a medical director for a skilled care facility (American Medical Directors Association, 2011). APNs comprise approximately 60% of full-time primary care clinicians in nursing

- homes (Goodwin et al., 2021). APNs have the education and training to provide this type of leadership.
- c. APNs need to lead LTC leadership teams and staff to continue to strengthen these systems providing care for vulnerable older adults.
4. Eliminate outdated Centers for Medicare & Medicaid Services (CMS) regulations.
- a. Allow APNs to sign admission orders, perform and bill for admission history and physical examinations.
 - b. Eliminate the requirement of physicians to alternate regulatory visits with APNs.

Background:

Growth of the APN Role

There are approximately 1.2 million Americans living in LTC facilities (Kaiser Family Foundation [KFF], 2022). These residents are frail and medically complex, 60% of whom are wheelchair dependent, have a diagnosis of dementia (50-70%), are aged 85 and older (50%) and are on psychoactive medications (64%) (Harrington et al., 2017; KFF, 2022). All LTC residents have a high risk of hospitalization and residents receiving post-acute care have a high risk of rehospitalization. The acuity of residents receiving post-acute care has dramatically increased, the clinical challenges of which necessitate the availability of on-site medical care to manage acute conditions before they progress into life-threatening situations (Kilpatrick et al., 2020). Long-term care facilities face increased expectations to treat acutely ill residents in place to avoid hospitalization and prevent costly transfers, transitional care disruptions, and rehospitalizations.

APNs have practiced in LTC settings for nearly four decades, with notable growth in the number of APNs, who now represent 60 percent of full-time primary care providers in LTC (Goodwin et al., 2021). More recent analyses indicate that nurse practitioners now account for nearly half of all nursing home visits nationally, reflecting their expanding role in meeting the complex medical needs of residents (Ryskina et al., 2024). Importantly, workforce sustainability depends not only on the number of available APNs, but on practice environments that support autonomy, interprofessional collaboration, and efficient care delivery (Posey et al., 2025). Approximately 12.8 percent of nurse practitioners report having practice privileges in LTC facilities (American Association of Nurse Practitioners [AANP], 2022). APNs are well-equipped with the advanced education and training to

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independently assess, diagnose, and treat older adults living in these settings. Physicians and APNs in LTC provide complementary skill sets, but the number of LTC-based physicians has not seen the same growth as that of APNs and the number of patients in LTC care with a physician as their PCP decreased from 82.9% in 2008 to 59.1% in 2018 (Goodwin et al., 2021).

APNs in LTC often play the lead role as primary care providers (Yang et al., 2016). Given the growth of the APN role in LTC, it is not surprising that descriptive and observational studies have shown that APNs in LTC provide substantial direct patient care and care coordination activities, including resident and family communication and education (AANP, 2019; Boninger et al., 2020; Bonnel et al., 2000; Kane et al., 2001; Kuo et al., 2013; Teno et al., 2017). Regardless of provider type, lack of an available on-site clinician in LTC facilities may contribute to adverse outcomes (Ouslander et al., 2010). Across all clinical settings, nurse practitioners are more likely to provide care for non-White, dually eligible Medicare and Medicaid beneficiaries living with multiple chronic conditions (Perloff et al., 2016). The dually eligible population accounts for a disproportionate share of health care spending due to a higher prevalence of multimorbidity, physical disabilities, and substantial care needs (Medicare Payment Advisory Commission [MedPAC] and Medicaid and CHIP Payment and Access Commission [MACPAC], 2022). Dually eligible beneficiaries being cared for by APNs in states with full practice authority have lower hospitalization rates and improved health outcomes (Johnson et al., 2025). Policy makers have long focused on the dually eligible population, supporting the development of strategies and healthcare models that improve the quality of care and reduce healthcare costs. Contemporary policy analysis demonstrates that states permitting full practice authority for APNs experience improved health outcomes and enhanced access to care for Medicare beneficiaries (Johnson et al., 2025), reinforcing the need to align federal LTC regulations with evidence-based scope of practice standards.

Cost-effective Quality of Care

Evidence from the past three decades has overwhelmingly shown that onsite APNs improve clinical outcomes and resident and family satisfaction, and that they provide care at a low cost (Mileski et al., 2020; Perloff et al., 2016). Systematic reviews have shown that APNs in LTC reduce unnecessary hospitalizations and emergency room visits, improve quality of care, and improve resident and family satisfaction (Lovink et al., 2017; Mileski et

al., 2020). APN care in LTC is also associated with decreased polypharmacy, falls, and restraint use (Kilpatrick et al., 2020).

APNs in LTC are billing medical providers who also spend a substantial amount of time, approximately 50%, providing services that enhance coordination of care, and resident/family communication and education, which may include non-billable services. Outcomes data in research studies supports the importance of these activities for improving the quality of care in LTC facilities.

Additionally, APNs increase resident and family engagement in advance care planning and ensure that the residents' goals of care are in alignment with current treatment plans (Donald et al., 2013). Findings from a national survey of nurse practitioners in U.S. nursing homes indicate that autonomy and meaningful patient care are among the strongest contributors to job satisfaction, reinforcing evidence that practice environments enabling full APN scope are essential to workforce retention and quality outcomes (Posey et al., 2025).

APN Leadership

APNs have both medical and nursing knowledge about the assessment and management of residents and of chronic and acute conditions commonly seen in LTC. Given their expertise in care of the older adult, APNs are often identified as both care providers and formal and informal leaders in their respective facilities and can be a tremendous on-site resource for LTC staff.

APNs' bedside nursing backgrounds yield an understanding of nursing issues and processes that impact resident care. APNs are trained and highly skilled educators; APNs provide teaching and coaching for LTC staff about clinical assessment, early illness identification, and management of ill residents (Boninger et al., 2020; Kane et al., 2001). An on-site APN is in a prime position to elevate nursing staff knowledge and skills to improve the management of residents with complex care needs while concurrently focusing on health promotion, disease prevention, and facility-wide issues such as infection control. Advanced certifications, such as the Gerontological Specialist–Certified (GS-C) credential, further demonstrate the depth of clinical expertise and commitment to evidence-based care among APNs caring for older adults in LTC settings.

Barriers to Care

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APNs who practice in LTC do so under different practice models. They may be employed by the facility, a physician, or a managed care organization (MCO). They also may be independent providers who practice collaboratively with physicians and other healthcare providers. Regardless of the employment arrangement, many APNs in LTC practice autonomously; yet their practice is restricted under federal regulations.

Under the Code of Federal Regulations (CFR) x483.40(c) (1), all residents must receive an initial assessment by a physician within 30 days of admission to a LTC facility. An APN may complete other medically necessary visits prior to or after a physician's initial comprehensive evaluation. APNs who are not employed by the LTC facility may conduct the initial comprehensive visit, write admission orders and treatments, and certify/recertify admissions, but APNs employed by the LTC facility are prohibited from doing so (United States Department of Health and Human Services [USDHHS], 2013; United States Government Publishing Office [USGPO], 2011). The regulations further mandate that a physician sees the resident every 30 days for the first 90 days and then at least every 60 days thereafter (CFR x483.40(c)(1); USDHHS, 2013). A physician may delegate a regulatory visit to an APN, as long as the physician sees the resident every other visit (USGPO, 2011).

The requirements under 42 CFR §483.40 have not been substantively revised since 1997, despite significant expansion of APN education, certification standards, and demonstrated clinical impact in LTC. These regulations, along with restrictive state practice acts and prescriptive privileges, are systematic barriers that hinder APNs from providing optimal care for older adult residents. Research findings support and have called for revisions to these regulations to improve the quality of and access to care for LTC residents (Rantz et al., 2017).

There are varying APN practice patterns within the LTC environment that are used to compensate for these regulatory barriers. Given the high acuity of LTC residents admitted for post-acute care, an APN often completes a thorough visit for a resident who is newly admitted to a facility, but, because the APN cannot code for or bill the visit as a history and physical examination (99304-99306), it is often coded as a highly complex visit, allowable under CFR 483.40. A physician's required history and physical examination often duplicates the assessment that was previously done by the APN, which may lead to generating unnecessary costs for CMS, aside from the misuse of time and professional expertise.

Ideally, payment models would encourage and reimburse interprofessional care. However, the current model incentivizes “alternating care,” and in the context of APNs providing a majority of resident medical care, the requirement for alternation serves as an impediment to the provision of timely, high-quality care, rather than as an incentive for interprofessional care. Removing these regulatory barriers will allow APNs to deliver timely, efficient, and high-quality care in LTC settings.

Lessons from Public Health Emergencies and Regulatory Flexibility

Public health emergencies, including the COVID-19 pandemic, exposed longstanding structural vulnerabilities in LTC facilities. Residents living in LTC settings are medically complex and functionally impaired, and congregate living environments heighten risk during infectious outbreaks. These events brought national attention to longstanding issues related to staffing, clinical oversight, health disparities, and regulatory rigidity within LTC.

During the federal public health emergency, temporary regulatory waivers permitted expanded delegation and flexibility in physician and APN visit requirements under 42 CFR §483.30 (Centers for Medicare & Medicaid Services [CMS], 2020). These waivers allowed physicians to delegate required visits to APNs and permitted greater flexibility in in-person evaluation requirements (CMS, 2020). The temporary regulatory flexibility demonstrated that APNs can safely and effectively provide comprehensive care within LTC settings without mandatory alternating physician visits. These experiences serve as policy precedent supporting permanent modernization of outdated federal regulations.

Ongoing Need For Nursing Home Reform

The Omnibus Budget Reconciliation Act of 1987 (OBRA) established foundational federal standards for nursing home quality and resident rights (Kelly, 1989). Since that time, resident acuity, care complexity, and post-acute demands have substantially increased, yet many federal regulations governing provider roles have not been meaningfully revised.

The 2022 National Academies of Sciences, Engineering, and Medicine (NASEM) report, *The National Imperative to Improve Nursing Home Quality*, called for comprehensive reform across workforce, quality oversight, financing, and accountability structures. The report identified APNs as critical contributors to improving care delivery, strengthening clinical leadership, and supporting quality improvement systems in nursing homes.

Federal agencies have continued to explore policy initiatives aimed at improving staffing, strengthening quality oversight, and enhancing value-based purchasing programs in skilled nursing facilities. However, regulatory requirements that restrict APN scope of practice remain misaligned with contemporary workforce realities and the demonstrated clinical impact of APNs.

Modernizing CMS regulations to allow APNs to practice to the full extent of their education and training is a necessary and evidence-based component of sustainable long-term care reform.

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