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Gerontological Advanced Practice Nurses Association

Position Statement

Eliminating Practice Barriers of the Gerontological APRN in the Long-Term Care Setting

Description:

Gerontological advanced practice registered nurses (APRNs) have practiced in long-term care (LTC) settings for nearly four decades, providing healthcare for long term residents and for short term residents receiving post-acute care. The evidence has consistently identified gerontological APRNs as critical members of the interprofessional team. The COVID-19 pandemic brought unpredictable challenges, for which APRNs provided extraordinary leadership. This position statement outlines the critical role of the gerontological APRN in long-term care, highlights barriers to APRN practice, and suggests recommendations for continued advancement of the role.

GAPNA Position:

1. Eliminate regulatory practice barriers.
    a. Gerontological APRNs have received the needed education and training to practice safely and independently. Gerontological APRNs should continue to collaborate with on-site physicians and other health care professionals when available, but direct physician oversight is not needed.
2. Promote APRN Leadership with LTC.
3. Examine traditional and emerging leadership opportunities for APRNs in LTC. Maximize APRN education and training.
    a. APRNs 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. APRNs 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). APRNs constitute 60% of all PCPs in LTC and are on site more often than their physician colleagues. APRNs have the education and training to provide this type of leadership.

   c. APRNs 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 Eliminate outdated Centers for Medicare & Medicaid Services (CMS) regulations.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 APRNs to sign admission orders, perform and bill for admission history and physical examinations.
   b. Eliminate the requirement of physicians to alternate regulatory visits with APRNs.

Background:

Growth of the APRN 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, and to prevent costly transfers to acute care settings, transitional care issues, and rehospitalizations (Kilpatrick et al., 2020). Long-term care facilities face increased expectations of treating acutely ill residents in place to avoid hospitalizations.

Gerontological APRNs have practiced in LTC settings for nearly four decades, with notable growth in the number of APRNs, who now represent 60 percent of full-time primary care providers in LTC (Goodwin et al., 2021). Approximately 12.8% percent of nurse practitioners report having practice privileges in LTC facilities (American Association of Nurse Practitioner [AANP], 2022). Gerontological APRNs are well-equipped with the advanced education and training to independently assess, diagnose, and treat older adults living in these settings. Physicians and APRNs in LTC provide complementary skills sets, but the number of LTC-based physicians has not seen the same growth as that of gerontological APRNs. The number of patients in LTC care with a physician as their primary care provider decreased from 82.9% in 2008 to 59.1% in 2018 (Goodwin et al., 2021), and physicians who practice predominantly in LTC facilities are more likely to be age 70 and older and less likely to participate in innovative care models such as Accountable Care Organizations (ACOs) (Jung et al., 2021).

Gerontological APRNs in LTC often play the lead role as primary care providers (Yang et al., 2016). Given the growth of the APRN role in LTC, it is not surprising that descriptive and observational studies have shown that APRNs in LTC provide substantially more direct patient care and care coordination activities, including resident and family communication and

education, than their physician colleagues (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, a lack of an available on-site clinician in LTC facilities may contribute to adverse outcomes (Ouslander et al., 2010); we have the responsibility to address the gap in care and potential consequences.

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). Dual eligible beneficiaries being cared for by APRNs in states with full practice authority have lower hospitalization rates and improved health outcomes (Oliver et al., 2014). 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.

Cost-effective Quality of Care

Across a variety of settings and diagnoses, evidence from the past three decades has overwhelmingly shown that APRNs achieve clinical outcomes and patient satisfaction comparable to physicians across a variety of settings and diagnoses, and they provide this care at a lower cost (Perloff et al., 2016). Systematic reviews have shown that APRNs in LTC reduce unnecessary hospitalizations and emergency room visits, improve quality of care, and improve resident and family satisfaction (Lovink et al., 2017; Milesky et al., 2020). Gerontological APRN care in LTC is also associated with decreased polypharmacy, falls, and restraint use (Kilpatrick et al., 2020).

Gerontological APRNs 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, gerontological APRNs 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).

APRN Leadership

Gerontological APRNs 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, gerontological APRNs 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. APRNs' bedside nursing backgrounds yield an understanding of nursing issues and processes that impact resident care. Gerontological APRNs are trained and highly skilled educators; APRNs 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 APRN 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.

Barriers to Care

Gerontological APRNs 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 APRNs 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 APRN may complete other medically necessary visits prior to or after a physician's initial comprehensive evaluation. APRNs who are not employed by the LTC facility may conduct the initial comprehensive visit, write admission orders and treatments, and certify/recertify admissions, but APRNS 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 APRN, as long as the physician sees the resident every other visit (USGPO, 2011).

The CFR 483.40 have not been revised since they were put into place in 1997, despite the expanding of APRN roles in LTC and the inadequate supply of physicians in LTC. These regulations, along with restrictive state practice acts and prescriptive privileges, are systematic barriers that hinder APRNs 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 APRN 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 APRN often completes a thorough visit for a resident who is newly admitted to a facility, but, because the APRN 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 APRN, 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 APRNs 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 the regulatory barriers is unlikely to dis-incentivize physician visits, but instead allow APRNs practicing in LTC facilities to accomplish care in a timely, more effective, high quality matter.

COVID-19 Pandemic

The COVID-19 pandemic has disproportionately affected LTC facilities due to resident frailty, impaired immune function, and communal living circumstances. It has disproportionately affected LTC facilities in which there are larger populations of African American and Latino residents (Abrams et al., 2020; Gebeloff et al., 2020). More than 200,000 residents and staff in nursing homes have died from COVID-19, representing approximately 25% of all COVID-19 deaths in the United States (KFF, 2022). Regardless of COVID-19 infection, increasing numbers of LTC residents have experienced poor outcomes, including depressive symptoms, weight loss, incontinence, worsening cognitive function, loneliness, and isolation (Simard et al., 2020; Pitkälä et al., 2020; Abbasi, 2020; Levere et al., 2022).

Throughout the COVID-19 pandemic, gerontological APRNs provided direct face-to-face care for residents in LTC facilities (Thomas-Gayle & Muller, 2021). At the beginning of the COVID-19 pandemic, emergency declaration blanket waivers were put into place, temporarily removing CMS-regulated APRN practice restrictions impacting resident care. Specifically, the waivers: 1) allowed physicians to delegate physician tasks in skilled nurse facilities to APRNs (42 CFR §483.30(e)(4)); 2) permitted the delegation of required physician visits to an APRN (42 CFR §483.30(c)(3)); and 3) waived the requirement for physicians, APRNs, and physician assistants (Pas) to perform in-person visits for long term care residents (42 CFR §483.30). The waivers have now expired; APRNs have returned to practices impacted by regulatory barriers. Although outcomes data during this time of emergency authorization waivers has not yet been published, there are no known reports of residents experiencing related harm or suffering. In addition to a longstanding record of providing high quality care for LTC residents, the exhibition and outcomes of APRN care during the pandemic warrants prompt removal of these practice barriers.

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Position Statement

Need For Nursing Home Reform

The Omnibus Reconciliation Act of 1987 (OBRA) made significant regulatory changes to address quality of care in LTC facilities (Kelly, 1989). Although the quality of care in LTC facilities has long been a concern, the COVID-19 pandemic exposed and magnified longstanding problems. The need for nursing home reform was endorsed by 22 nationally known gerontological nurse leaders (Kolanowski et al., 2020). The Gerontological Advanced Practice Nurses Association's (GAPNA) 2020 position statement, *Addressing Nursing Home Safety During the COVID-19 Pandemic and Beyond*, outlines key areas of needed improvement that affect the quality of care provided to older adults living in LTC facilities.

In April 2022, the National Academies of Sciences, Engineering, and Medicine (NASEM) released its *Quality of Care in Nursing Homes Report,* calling for reform with seven specific recommendations. The report identifies APRNs as an important component of improving care in LTC facilities; it calls for nursing home administrators to establish relationships with APRNs for clinical consultation, staff training and improvement of care systems. The report also recommends that CMS should create incentives for LTC facilities to hire qualified APRNs for clinical care, including the allowance of Medicare billing and reimbursement for these crucial services.

During this same timeframe, The Biden administration issued an executive order empowering the Department of Health and Human Services (HHS) and CMS to launch four initiatives to ensure high quality care for long term care residents: 1) establish a minimum nursing home staffing requirement, 2) reduce resident room crowding, 3) strengthen the skilled nursing facility (SNF) value-based purchasing (VBP) program, and 4) reinforce safeguards against unnecessary medications and treatments (HHS, 2022; White House, 2022).

At a time when government officials, organizations, and key stakeholders are focused on creating and modifying strategies to improve the safety and wellbeing of LTC residents, we propose that allowing gerontological APRNs to practice to their highest level of their education and clinical training is a key component of LTC reform.

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