Proposed CoP reg to expand use of nonphysicians

Medicare is proposing a major overhaul to its conditions of participation (CoP) that would give hospitals wider latitude in the use of practitioners such as advanced practice RNs (APRNs) and physician assistants (PA). The rule would also expand use of standing orders and protocols.

The intent of the revision is to remove requirements that are unnecessarily burdensome as well as to promote safety and quality, Donald Berwick, MD, administrator of the Centers for Medicare and Medicaid Services (CMS), writes in JAMA.

If finalized, the draft, published in the October 24, 2011, Federal Register, would be the first major overhaul in 25 years. Comments are due December 23, 2011.

CMS estimates streamlining the rules could save more than $900 million in the first year.

Revising medical staff rules

Among proposals is one to revise current medical staff rules to allow hospitals to grant privileges to advanced practitioners other than physicians and allow them to practice within their scope under state law, regardless of whether they are also appointed to the medical staff. The draft says “technical membership in a hospital’s medical staff would not be a prerequisite for a hospital’s governing body to grant practice privileges to practitioners.”

Nonphysician practitioners would still be subject to the same requirements as the medical staff, including the medical staff bylaws and oversight.

CMS says it believes the proposed language would give hospitals “the clarity they need to explore new and expanded approaches to care giving.”

Current conflict with state law

The agency says it is responding to stakeholders who said some current rules may conflict with state law and unnecessarily restrict the practice of advanced practitioners. That could limit access to care, delay treatment, and cause undue burdens, such as having to seek a physician to cosign orders.

With the changes, APRNs and PAs could within state law carry out activities such as patient assessments, review of test results, and documentation of orders.

APRNs include nurse practitioners, clinical nurse specialists, certified nurse-midwives, and certified registered nurse anesthetists.

CMS estimates a third of physicians’ patient time in the hospital could be covered by other practitioners at an average salary difference of $71 an hour.

Other savings could come from standardizing care based on evidence-based protocols and avoiding delays, for example, by having advanced practitioners write orders and discharge patients.

Standing orders

The proposed rule would expand hospitals’ ability to use standing orders, order sets, and protocols if certain conditions are met.

For example, advanced practitioners would be allowed to order medications if that is within their state law, scope of practice, and privileges.
**Reviewing the evidence on advanced practice RNs**

A comprehensive review in *Nursing Economics* examines 18 years of research on outcomes for care given by advanced practice RNs (APRNs) in a variety of settings.

The review is the first to include evidence on APRNs in acute care, notes a co-author, Julie Stanik-Hutt, PhD, ACNP, CCNS, FAAN, of Johns Hopkins University, Baltimore.

For surgical inpatients, there is evidence on outcomes when one type of APRN, the clinical nurse specialist (CNS), is added to inpatient units.

Among findings:
- There is a high level of evidence that lengths of stay went down for patients having open-heart surgery, total knee replacement, and major prostate surgery when a CNS was added on an inpatient unit.
- For high-risk obstetrical patients and patients after prostate surgery, adding a CNS assisted in improving care and lowering costs.
- For open-heart patients and critically ill postop patients, there is a moderate level of evidence that complications are reduced if there is a CNS to assist, supervise, and improve care.

Stanik-Hutt notes that the findings from the review are consistent with policy papers on the use of APRNs from the Future of Nursing Initiative, the AARP, the Josiah Macy Jr Foundation, and others that APRNs, PAs, and other advance practitioners need to be able to practice to the full extent of their education and training.

CMS gives an example of a 230-bed hospital in Indiana that used order sets to boost compliance with Surgical Care Improvement Project (SCIP) measures such as timely antibiotic administration (www.innovations.ahrq.gov/content.aspx?id=1750).

**Other highlights**

The proposed rule would also:
- allow hospitals in a multi-hospital system to have a single governing body
- allow hospitals using interdisciplinary care plans to include the nursing care plan in the overall plan rather than having separate care plans
- allow hospitals the flexibility to develop policies and procedures for patients and their caregivers/support persons to administer specific medications such as nitroglycerine and inhalers and selected nonprescription meds such as rewetting eye drops
- remove unnecessary duplication of certain blood-type verification requirements for transplant centers
- eliminate the requirement to authenticate verbal orders within 48 hours if there is no state law with that time frame
- make permanent a temporary provision that allows orders to be authenticated by another practitioner who is responsible for care of the patient and is authorized to write orders
- allow critical access hospitals to contract for certain services such as laboratory or radiology rather than have the services provided directly by hospital staff
- clarifies that surgery is an optional service for critical access hospitals.

**Have a question on the OR revenue cycle?**

Keith Siddel will respond to questions in the column. Send your questions to editor@ormanager.com. You can also reach Siddel at ksiddel@hrmlc.com.
Coming into the spotlight
In many hospitals, APRNs, PAs, and other advanced practitioners are already practicing to the full extent of their scope under state law.

Currently, 22 states allow APRNs to practice without physician oversight, and 12 states permit them to prescribe without restriction, according to the 2010 Future of Nursing report from the Institute of Medicine.

Use of advanced practitioners has been spreading. Among reasons: reductions in medical residents’ work hours and the expected rise in demand for services as the baby boomers age, and as newly covered patients enter the system under health care reform.

“They’re coming into the spotlight,” Julie Tsirambidis, CNP, MSN, a nurse practitioner and director of the Advanced Practice Center at Akron Children’s Hospital in Ohio told the Akron Beacon Journal. Akron Children’s employs 164 advanced practitioners and is recruiting more. Tsirambidis is a voting member of the medical staff executive committee, which traditionally included only physicians.

Julie Stanik-Hutt, PhD, ACNP, CCNS, FAAN, a faculty member at the Johns Hopkins University School of Nursing, Baltimore, and coauthor of a new review on APRN patient outcomes, is also an acute care nurse practitioner at Johns Hopkins Hospital. She says she’s long been credentialed as an associate member of the medical staff. “We’ve been doing this in Maryland for years, and I’m sure other places have as well,” she told OR Manager, adding that in some cases, NPs and PAs are billing for inpatient services.

Puzzled on a proposal
Stanik-Hutt says she is puzzled by the CMS proposal that privileges could be granted to advanced practitioners regardless of whether they are technically a member of the medical staff.

“Does this mean you would be held to the same standards [as the medical staff] but can’t even participate in its governance?” she asks. “Why not have a professional staff organization—let’s include everybody.”

David E. Young, MD, medical director of perioperative services at Advocate Lutheran General Hospital in Park Ridge, Illinois, says that though he “totally supports” expansion of the advanced practice nurse role, “I am concerned that hospital administrations that bypass the medical staff process could unknowingly jeopardize teamwork and critical communication between midlevel providers and physicians.”

Benefits of revisions
For critical access hospitals, the revised CoP could have benefits, observes Kathleen Miller, MSHA, RN, CNOR, a consultant with Catholic Health Initiatives.

For example, a PA employed by the hospital, if state law allowed, could order care without having to wait for the cosignature of a physician, who might be far away.

Acceptance of standing orders and protocols could also have positive effects, she says, such as in the development of criteria for patient testing in the preadmission area. Anesthesia departments could develop protocols for nurses to use in ordering tests based on information they gather during the history and physical. Some facilities currently use this process, but the proposed revision would give CMS’s endorsement.

Broader use of APRNs and PAs could help streamline the preoperative process and reduce cancellations, notes Christy Dempsey, MBA, RN, CNOR, senior vice
president of clinical operations, patient flow, for Press Ganey. They could have wider latitude to be able to complete histories and physicals and order tests and consults.

Dempsey thinks larger hospitals could benefit if APRNs were more widely used to coordinate care on patient units. Currently, care is often fragmented among providers, leading to longer stays and the possibility of errors from multiple handoffs.

With the need to improve quality and lower costs while covering millions more patients, hospitals are likely to feel they can use all of the qualified help they can get.

—Pat Patterson

The proposed rule is available at http://www.ofr.gov/OFRUpload/OFRData/2011-27175_PI.pdf

References
Conway P H, Berwick D M. Improving the rules for hospital participation in Medicare and Medicaid. JAMA. Published online October 18, 2011.