TEXAS Health and Human Services | Medical and Social Services

Center for Excellence in Long Term Care

Advanced Practice Registered Nurses (APRNs) in Texas Nursing Facilities (NFs)

Background: APRNs are high quality providers who work with patients in all settings, including NFs. They are specially trained to manage the problems of chronic illness in the aging population. A report to the Secretary of the Department of Health, Education, and Welfare noted that in a nursing home setting, nurses with additional training beyond their initial licensure could assess the physical status of patients at a more sophisticated level than is now common in nursing practice in Texas. Working within the extent of their education, APRNs now provide healthcare billable through third party reimbursement.

Evidence has shown that APRNs who work in NFs have improved resident care and outcomes compared to facilities without APRNs by decreasing preventable, adverse events such as rehospitalizations, trips to the emergency room, pressure ulcers, and a deterioration in the resident's ability to perform activities of daily living (ADLs). Studies have validated that the key role of the APRN in health promotion and treatment and suggest that they take a greater initiative to assess the advance care planning preferences of residents in the NF setting, potentially reducing the initiation of costly, unwanted treatments. An APRN in an NF would also be able to take on the role of medical oversight in the Quality Assurance Performance Improvement (QAPI) meetings as well as fulfilling the tasks of Care Planning with the Interdisciplinary Team (IDT) as required in the Requirements of Participation (ROP).

Operational/Implementation Plan: In an effort to increase the outcomes of residents in an NF, bringing in APRNs to provide care in addition to the Physician is highly beneficial for the residents and the NF. The best way to go about doing this is to follow a few steps:

1. Advanced Planning: In this step, the NF would want to determine the intended practice model. This determination needs to be made through discussions with all of the key people in the NF (physicians, nurses, administrative staff (Director of Nursing and the Administrator), and any other members that may be needed such as the Corporate staff (if the NF is part of a Corporate structure)). In order to effectively implement the APRN's role in the NF, a comprehensive plan must be developed. It is important to account for the time and energy that this process will require from the clinical team to place in the timeline.

2. Role Definition: Once the practice model is determined, the APRN's role and expected contribution should be discussed and determined. When the APRN's role set is well-defined, there is consensus about how the resident management responsibilities are distributed, each team member's skills, and scope of practice, as well as differences and similarities of roles. While the actual role that the APRN will play on the care team should be discussed with the APRN during the hiring process, it is important for the team in the NF to discuss it beforehand to ensure that it is realistic. Determining the role ahead of time will also allow for the team to use it as a tool during candidate interviews.

   The role of the APRN in the NF can contain several elements. Medicare requires that the initial visit, which includes the history and physical for the purpose of certifying the necessity of skilled care, be performed by the physician. The APRN in this case however, can make a visit that is "medically necessary" without an initial physician visit. "Medically necessary" visits include those is which health-care services or supplies are needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms. An example of this would include: A 53 y/o male is admitted to the NF for skilled rehab following a hip replacement. He has been in the NF for 1 day and the admitting physician hasn't been to the NF to do the initial visit yet. The nurse providing care to him notices that the incision site was red, warm to the touch, and had discharge. She calls the APRN to let her know her findings. The APRN sees him and orders a wound culture and oral antibiotics. This treatment is documented and the admitting physician is called and informed of the treatment plan. This "visit" would be

considered "medically necessary" as he had the signs and symptoms of an infection and the treatment provided was to prevent the infection from getting worse.

3. Several Resident Care Models, No Specific Requirement: The typical practice model of an APRN is one of collaboration with their physician partner to provide for the resident's needs collectively. This can present itself in a joint model (the APRN and Physician follow the same residents at different points in their care) or a consultative model (the APRN and the Physician each follow a different panel of residents and the physician is consulted as needed. In this model, most residents are followed by the APRN and never see the physician except for the visits that are required by rule, primarily the initial visit). A NF may choose to use either one of these models dependent on the needs of their residents, the experience of the physician and the APRN and the number of physicians providing care to residents in the NF. It is best that the NF determine which model they prefer to use prior to brining the APRN on board.

4. Collaboration: In order for the NF to successfully implement the use of APRNs in the care of their residents, there must be collaboration between the care team. Good collaboration among the care providers fosters a positive work environment and helps to optimize the quality of care and resident management. Collaboration may not happen on its own, with training offered to assist the physicians and APRN(s) in effective collaboration. Data has shown that APRNs appreciate activities that involve joint training or clinical case discussions and consider them as team-building activities. Focusing discussions in trainings on quality of care and placing an emphasis on person-centered/person-directed care approaches are good ways to foster productive team discussions.

5. Support: In order to effectively integrate APRNs into the NF setting, they, as well as those in the care team will require support. Support will be necessary on different levels, including clinical, team, and systemic. Clinical support will be needed to ensure that the APRN is comfortable executing their role in the NF as defined, taking in to consideration that the role may evolve over time.

The primary care team will also require support as the APRNs role is rolled out. Evidence shows that strong leadership and consistent support to primary care teams foster the emergence of an effective resident management model. Effective communication mechanisms are a key factor in encouraging the emergence and maintenance of a shared vision of the team's objectives and values. In any change process, it is normal that tensions and differences in preferences would arise between team members. In some cases, tensions are best resolved by face-to-face discussion. Resolving disagreements directly within the team is part of the process of creating team dynamics.

Systemic support is also very important in ensuring an effective implementation of the APRN. It is not enough to simply ensure that everyone knows what will take place with implementation of an APRN into the NF. The system in the NF must also be changed to provide support to everyone involved. This is done in the way of changing policies and procedures in the NF to accommodate the APRN into practice. Changes to NF policies and procedures will be based on the defined role of the APRN, the care model being used, and collaboration between the team members.

Process for Implementation of the APRN in the NF:

1. Obtaining an NPI number: Prior to hiring an APRN in the NF and in order to ensure that billing can be completed timely once an APRN has been hired, the NF needs to obtain an NPI number. NFs who employ APRNs may obtain an NPI number to bill for the APRN's services by visiting https://nppes.cms.hhs.gove/NPPES/Welcome.do.

2. The Hiring Process: Once it has been decided that the NF wants to proceed with hiring an APRN and what the role is going to be, the NF will need to begin recruiting qualified individuals. It is important that the NF evaluates the candidates to ensure the best fit for the facility. This will include a verification of licensure to ensure that the candidates are qualified to provide care to residents in an NF. Additionally, it is important to assess the experience level of the candidates being considered. A newly graduated APRN may require

some mentoring to enhance their skills to care for the residents. The NF should assess their ability to provide this mentoring if a newly graduated APRN is hired. A specific set of interview questions should be developed for this hiring process, as this will allow you to compare the responses of all individuals that are interviewed for the position. Another recommendation would be to have key staff involved in the interview process to obtain their input on each interview. While it is important that the candidate's skills match the NF's needs, it is also important to ensure that the candidate and the NF staff will work well together. Once a candidate is chosen, the next step is to extend an offer and initiate a contract for the candidate to accept and sign. The NF will also need to ensure that there is a written agreement between the APRN and the collaborating physician for the services that the APRN will be providing. It is important to note that any services not listed in the agreement cannot be billed to the Medicare program.

3. Collaboration: The APRN in Texas is required to provide services in "collaboration with a physician". "Collaboration" means a process whereby an APRN works with a physician to deliver health care services within the scope of the APRN's professional expertise with medical direction and appropriate supervision as provided for in jointly-developed guidelines or other mechanisms defined by federal regulation and state law.

   The NF must work with the individual physicians, who are providing medical services to the residents, to coordinate their care with the APRN on staff. Policies and Procedures would need to be implemented that detail the role of the APRN to provide care and services within their scope, such as maintaining a health history, and within protocols mutually agreed on by medical and nursing staff, making adjustments in medication, initiating requests for and interpreting certain laboratory tests, and making judgements about the use of accepted pharmaceutical agents as standard treatments in diagnosed conditions, with the understanding that they are collaborating with the resident's PCP for all care. These P/Ps would need to be reviewed with all physicians who have residents in the facility and acknowledged.

The APRN is not a replacement for the resident's PCP who still has responsibilities as a part of the care team. The positive to having an APRN on staff working in collaboration with the resident's PCP is that the APRN is immediately available to provide medically necessary care to the resident as needed. Often times a resident's condition may cause concern with the NF staff so they will reach out to the physician for guidance on the care to provide. The physician is typically not available to come and assess the resident and will make decisions about the treatment plan based on information received. With the APRN available, he/she can perform an assessment at the first sign of an issue and begin treatment that may delay or prevent additional issues. After ordering treatment for the resident, the APRN would then collaborate with the PCP on the next steps in the treatment plan. This provides the PCP with an extra set of eyes that understand the nuances of caring for population of residents in the NF.

A misconception that must be discussed is that federal rule only allows for delegation between an APRN and the physician if the APRN is not employed by the NF. This requirement is found in the State Operations Manual (SOM) Appendix PP under F390. It does in fact state that the physician is only to delegate to an APRN that is not working in the NF, however, in this instance, we are not talking about delegation, we are talking about collaboration. Because an APRN is allowed to perform E/M visits for the residents, if something out of the ordinary is noted with the resident, the APRN will need to collaborate with the physician on the care that is provided, to ensure that the highest level of care is maintained for that individual.

A common misconception at this point is that the provider will lose money by having the APRN that is employed by the NF, providing care to the residents. The APRN is able to carry out E/M visits. These types of visits are those in which there has been a change with the resident and the APRN is able to assess and treat right then. In many cases, when there is a change in a resident, the physician is called, provided with symptoms, and then provides a treatment based on those symptoms. The physician doesn't bill for those phone calls and is relying on the information provided by the nursing staff to provide a treatment. In some cases, the physician may recommend that the

resident be sent to the hospital. With an APRN on staff, they are able to assess the resident right then and make the best treatment determination based on what is being seen. This can also save the NF money, as the rate of hospitalizations may go down by having a provider readily available to provide treatments for a resident. The physician should then come to the NF and perform a follow-up visit on the resident, a visit that they would already perform if the APRN wasn't on staff.

4. Oversight: It has been noted above that APRNs are required to collaborate with a physician for the care that they provide. Due to there being several physicians providing care for the resident's in the NF, the APRN would need to collaborate with all of them. In order to be effective, the NF should ensure that there is oversight of this process. The logical person to provide this oversight is the Medical Director, as he/she is already providing medical direction to the NF for all of the residents and can serve as the primary person to coordinate between the ARPN in the NF and the primary care physician (PCP).

5. Billing and Reimbursement: The NF will use the NPI number that they have obtained to bill for the qualified services that the APRN provides. An APRN who is employed by the NF will not be able to bill Medicaid directly for the services they provide if that billing would result in a duplicate payment for the same services.
   Billing for APRN services is as follows:
   - Medicare Reimbursement: Medically necessary Evaluation and Management (E/M) visits are payable under the physician fee schedule at 85% of the schedule amount. Medicare assignment must be accepted on all claims submitted by Non-Physician practitioners.
   - Medicaid Reimbursement: Per 1 TAC §355.8281, covered professional services provided by an APRN are reimbursed the lesser of the billed charges or 92% of the reimbursement for the same service paid to a physician. APRNs are reimbursed at the same level as physicians for laboratory services, x-ray services, and injections.

The APRN and Quality Measures (QMs): As noted above, having APRNs in the NF setting has been shown to increase the quality of care for the residents and decrease adverse events. It stands to reason that if APRNs are able to improve quality of care that they will also have a positive effect on the NF's QMs. In looking at the QMs, taking for example flu vaccinations, the APRN could potentially have a significant impact on the rate of flu vaccinations in a NF, increasing the percentage of residents who receive the Flu vaccine each year. When it comes time for vaccinations each year, the NF staff currently discuss the vaccine with the resident, asking them or their guardian (in the event that they can't sign for themselves) to sign the vaccination form either permitting the NF to provide the vaccine or refusing it. If the vaccine is refused, the NF staff often will document the refusal and not pursue any additional action.

Having an APRN in the NF provides the resident with a practitioner that can provide substantial education on the importance of receiving the Flu vaccine to each and every resident. In the event that residents or their guardians refuse to receive the vaccine, the APRN can provide additional education related to the individual reason for refusal. Being able to obtain consent from all residents (who are able to) in receiving the flu vaccine will significantly decrease the risk that there will be a flu outbreak that will potentially affect the other residents and the employees. Decreasing the risk of an outbreak decreases the NFs financial responsibility to treat the outbreak, thereby positively affecting the NFs cost savings. Additionally, one of the QMs that are used in the calculation of the NFs Nursing Home Compare 5-Star Rating is the percent of residents assessed and appropriately given the seasonal influenza vaccine (Long Stay). If all of the residents in the NF receive the vaccine, then the NF will have 100% of their residents vaccinated, which will be reflected in their QM data and their 5-Star Rating.

The APRNs impact on this QM reaches far past the resident who received the vaccine, having an effect on the other residents in the NF, the employees, the NFs cost savings, and the QM data that is reported to CMS and ultimately is used in the NFs 5-Star Rating.

The APRN and Evidence-Based Practice (EBP): The APRN is an instrumental part of ensuring that EBP is implemented throughout the NF. The APRN should be practicing EBP at all times when providing care for their residents, however, they can also assist the NF in adopting EBP into the

facility's policies and procedures to ensure that changes are made throughout on a systematic level and not a person-only level.

Conclusion: Integrating APRNs into the primary care team in a NF can likely be a complex and dynamic process in the beginning. Many of the elements necessary for integration can often be done simultaneously but care needs to be taken to back track, find and fix anything that didn't work well the first time to ensure effective integration. Planning is an integral part of this process and shouldn't be taken lightly. Once the planning process is complete, the steps necessary to bring an APRN on board in the NF are rather simple. Once all the steps to integration of an APRN into the NF are complete and deemed successful, the benefits to the residents and the NF are invaluable.