The campaign envisions a health care system where all Americans have access to high-quality care, with nurses contributing to the full extent of their capabilities.

Since its release in October 2010, the Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*, has made a considerable impact on the way stakeholders view the nursing workforce. Supported by the Robert Wood Johnson Foundation, it remains one of the most viewed online reports in the IOM’s history.

Prompted by the landmark report, the Future of Nursing: Campaign for Action aims to transform the nursing profession to improve the quality of health care and the way it is delivered. The initiative encompasses 48 state Action Coalitions, more than 70 national organizations and a wide range of health care professionals, consumer advocates, policy-makers and business, academic and philanthropic leaders.

On the national, state and local level, the campaign is moving ahead on four key areas recommended by the *Future of Nursing: Leading Change, Advancing Health*:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and an improved information infrastructure.

The Campaign Needs Your Help

To truly improve patient-centered care, the report recommendations must be translated into action. We need active participation of local, state and national organizations and individuals from health care, business, education, government and philanthropy.

Here are some ways you can get involved:

- Visit the Campaign for Action website. (www.thefutureofnursing.org)
- Read about the research and data that support the Institute of Medicine report. (http://thefutureofnursing.org/data)
- Download and share the campaign overview. (http://thefutureofnursing.org/about)
- Download and share the report summary. (http://thefutureofnursing.org/sites/default/files/FutureofNursing2010ReportBrief.pdf)
- Watch a campaign webinar. (http://championnursing.org/webinars)
- Contact your state’s Action Coalition leaders to find out about campaign activities in your state. (http://championnursing.org/action-coalitions)
- Submit a funding proposal on the Campaign for Action Research Agenda. (http://thefutureofnursing.org/research).

The time to find common purpose is now. Get involved with the campaign, and together let’s ensure that all Americans have access to high-quality care.

More information on getting involved in the Campaign for Action is available at: http://thefutureofnursing.org/get-involved.

Follow us on twitter at www.twitter.com/futureofnursing.
Key Messages

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and an improved information infrastructure.

Recommendations

Recommendation 1: Remove scope-of-practice barriers. Advanced practice registered nurses should be able to practice to the full extent of their education and training. To achieve this goal, the committee recommends the following actions.

For the Congress:

- Expand the Medicare program to include coverage of advanced practice registered nurse services that are within the scope of practice under applicable state law, just as physician services are now covered.
- Amend the Medicare program to authorize advanced practice registered nurses to perform admission assessments, as well as certification of patients for home health care services and for admission to hospice and skilled nursing facilities.
- Extend the increase in Medicaid reimbursement rates for primary care physicians included in the ACA to advanced practice registered nurses providing similar primary care services.
- Limit federal funding for nursing education programs to only those programs in states that have adopted the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18).

For state legislatures:

- Reform scope-of-practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18).
- Require third-party payers that participate in fee-for-service payment arrangements to provide direct reimbursement to advanced practice registered nurses who are practicing within their scope of practice under state law.
For the Centers for Medicare and Medicaid Services:

- Amend or clarify the requirements for hospital participation in the Medicare program to ensure that advanced practice registered nurses are eligible for clinical privileges, admitting privileges, and membership on medical staff.

For the Office of Personnel Management:

- Require insurers participating in the Federal Employees Health Benefits Program to include coverage of those services of advanced practice registered nurses that are within their scope of practice under applicable state law.

For the Federal Trade Commission and the Antitrust Division of the Department of Justice:

- Review existing and proposed state regulations concerning advanced practice registered nurses to identify those that have anticompetitive effects without contributing to the health and safety of the public. States with unduly restrictive regulations should be urged to amend them to allow advanced practice registered nurses to provide care to patients in all circumstances in which they are qualified to do so.

Recommendation 2: Expand opportunities for nurses to lead and diffuse collaborative improvement efforts. Private and public funders, health care organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to conduct research and to redesign and improve practice environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices.

To this end:

- The Center for Medicare and Medicaid Innovation should support the development and evaluation of models of payment and care delivery that use nurses in an expanded and leadership capacity to improve health outcomes and reduce costs. Performance measures should be developed and implemented expeditiously where best practices are evident to reflect the contributions of nurses and ensure better-quality care.

- Private and public funders should collaborate, and when possible pool funds, to advance research on models of care and innovative solutions, including technology, that will enable nurses to contribute to improved health and health care.

- Health care organizations should support and help nurses in taking the lead in developing and adopting innovative, patient-centered care models.

- Health care organizations should engage nurses and other front-line staff to work with developers and manufacturers in the design, development, purchase, implementation, and evaluation of medical and health devices and health information technology products.


• Nursing education programs and nursing associations should provide entrepreneurial professional development that will enable nurses to initiate programs and businesses that will contribute to improved health and health care.

Recommendation 3: Implement nurse residency programs. State boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses’ completion of a transition-to-practice program (nurse residency) after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas.

The following actions should be taken to implement and support nurse residency programs:
• State boards of nursing, in collaboration with accrediting bodies such as the Joint Commission and the Community Health Accreditation Program, should support nurses’ completion of a residency program after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas.
• The Secretary of Health and Human Services should redirect all graduate medical education funding from diploma nursing programs to support the implementation of nurse residency programs in rural and critical access areas.
• Health care organizations, the Health Resources and Services Administration and Centers for Medicare and Medicaid Services, and philanthropic organizations should fund the development and implementation of nurse residency programs across all practice settings.
• Health care organizations that offer nurse residency programs and foundations should evaluate the effectiveness of the residency programs in improving the retention of nurses, expanding competencies, and improving patient outcomes.

Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020. Academic nurse leaders across all schools of nursing should work together to increase the proportion of nurses with a baccalaureate degree from 50 to 80 percent by 2020. These leaders should partner with education accrediting bodies, private and public funders, and employers to ensure funding, monitor progress, and increase the diversity of students to create a workforce prepared to meet the demands of diverse populations across the lifespan.

• The Commission on Collegiate Nursing Education, working in collaboration with the National League for Nursing Accrediting Commission, should require all nursing schools to offer defined academic pathways, beyond articulation agreements, that promote seamless access for nurses to higher levels of education.
• Health care organizations should encourage nurses with associate’s and diploma degrees to enter baccalaureate nursing programs within 5 years of graduation by offering tuition reimbursement, creating a culture that fosters continuing education, and providing a salary differential and promotion.
• Private and public funders should collaborate, and when possible pool funds, to expand baccalaureate programs to enroll more students by offering scholarships and loan forgiveness, hiring more faculty, expanding clinical instruction through new clinical partnerships, and using technology to augment instruction. These efforts should take into consideration strategies to increase the diversity of the nursing workforce in terms of race/ethnicity, gender, and geographic distribution.

• The U.S. Secretary of Education, other federal agencies including the Health Resources and Services Administration, and state and private funders should expand loans and grants for second-degree nursing students.

• Schools of nursing, in collaboration with other health professional schools, should design and implement early and continuous interprofessional collaboration through joint classroom and clinical training opportunities.

• Academic nurse leaders should partner with health care organizations, leaders from primary and secondary school systems, and other community organizations to recruit and advance diverse nursing students.

Recommendation 5: Double the number of nurses with a doctorate by 2020. Schools of nursing, with support from private and public funders, academic administrators and university trustees, and accrediting bodies, should double the number of nurses with a doctorate by 2020 to add to the cadre of nurse faculty and researchers, with attention to increasing diversity.

• The Commission on Collegiate Nursing Education and the National League for Nursing Accrediting Commission should monitor the progress of each accredited nursing school to ensure that at least 10 percent of all baccalaureate graduates matriculate into a master’s or doctoral program within 5 years of graduation.

• Private and public funders, including the Health Resources and Services Administration and the Department of Labor, should expand funding for programs offering accelerated graduate degrees for nurses to increase the production of master’s and doctoral nurse graduates and to increase the diversity of nurse faculty and researchers.

• Academic administrators and university trustees should create salary and benefit packages that are market competitive to recruit and retain highly qualified academic and clinical nurse faculty.
Recommendation 6: Ensure that nurses engage in lifelong learning. Accrediting bodies, schools of nursing, health care organizations, and continuing competency educators from multiple health professions should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan.

- Faculty should partner with health care organizations to develop and prioritize competencies so curricula can be updated regularly to ensure that graduates at all levels are prepared to meet the current and future health needs of the population.
- The Commission on Collegiate Nursing Education and the National League for Nursing Accrediting Commission should require that all nursing students demonstrate a comprehensive set of clinical performance competencies that encompass the knowledge and skills needed to provide care across settings and the lifespan.
- Academic administrators should require all faculty to participate in continuing professional development and to perform with cutting-edge competence in practice, teaching, and research.
- All health care organizations and schools of nursing should foster a culture of lifelong learning and provide resources for interprofessional continuing competency programs.
- Health care organizations and other organizations that offer continuing competency programs should regularly evaluate their programs for adaptability, flexibility, accessibility, and impact on clinical outcomes and update the programs accordingly.

Recommendation 7: Prepare and enable nurses to lead change to advance health. Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels, while public, private, and governmental health care decision makers should ensure that leadership positions are available to and filled by nurses.

- Nurses should take responsibility for their personal and professional growth by continuing their education and seeking opportunities to develop and exercise their leadership skills.
- Nursing associations should provide leadership development, mentoring programs, and opportunities to lead for all their members.
- Nursing education programs should integrate leadership theory and business practices across the curriculum, including clinical practice.
- Public, private, and governmental health care decision makers at every level should include representation from nursing on boards, on executive management teams, and in other key leadership positions.
Recommendation 8: Build an infrastructure for the collection and analysis of interprofessional health care workforce data. The National Health Care Workforce Commission, with oversight from the Government Accountability Office and the Health Resources and Services Administration, should lead a collaborative effort to improve research and the collection and analysis of data on health care workforce requirements. The Workforce Commission and the Health Resources and Services Administration should collaborate with state licensing boards, state nursing workforce centers, and the Department of Labor in this effort to ensure that the data are timely and publicly accessible.

- The Workforce Commission and the Health Resources and Services Administration should coordinate with state licensing boards, including those for nursing, medicine, dentistry, and pharmacy, to develop and promulgate a standardized minimum data set across states and professions that can be used to assess health care workforce needs by demographics, numbers, skill mix, and geographic distribution.

- The Workforce Commission and the Health Resources and Services Administration should set standards for the collection of the minimum data set by state licensing boards; oversee, coordinate, and house the data; and make the data publicly accessible.

- The Workforce Commission and the Health Resources and Services Administration should retain, but bolster, the Health Resources and Services Administration's registered nurse sample survey by increasing the sample size, fielding the survey every other year, expanding the data collected on advanced practice registered nurses, and releasing survey results more quickly.

- The Workforce Commission and the Health Resources and Services Administration should establish a monitoring system that uses the most current analytic approaches and data from the minimum data set to systematically measure and project nursing workforce requirements by role, skill mix, region, and demographics.

- The Workforce Commission and the Health Resources and Services Administration should coordinate workforce research efforts with the Department of Labor, state and regional educators, employers, and state nursing workforce centers to identify regional health care workforce needs, and establish regional targets and plans for appropriately increasing the supply of health professionals.

- The Government Accountability Office should ensure that the Workforce Commission membership includes adequate nursing expertise.
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The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 as the health arm of the National Academy of Sciences, the Institute of Medicine is a nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public.
Champion Nursing Coalition Members

The Champion Nursing Coalition joins together a broad spectrum of groups each with a stake in ensuring all Americans have access to a highly skilled nurse when and where they need one. This diverse national coalition represents the voices of consumers, purchasers and providers of health care, all in support of common sense, common ground solutions to build a 21st century nursing workforce. Its purpose is initially to raise awareness and ultimately to achieve permanent solutions.

- AARP
- Aetna
- AFL-CIO
- AFSCME International
- America's Health Insurance Plans
- American Association of People with Disabilities
- American Cancer Society Cancer Action Network
- American Federation of Teachers
- American Geriatrics Society
- American Health Care Association
- American Heart Association
- American Hospital Association
- American Public Health Association
- Catholic Health Association
- CIGNA
- Consumers Advancing Patient Safety
- Convenient Care Association
- Disabled American Veterans
- Easter Seals
- Families USA
- Hill-Rom
- Healthcare Information and Management Systems Society
- Johnson & Johnson
- Kaiser Permanente
- LeadingAge (formerly AAHSA)
- Leapfrog Group
- March of Dimes
- National Alliance for Caregiving
- National Association for Home Care & Hospice
- National Association of Community Health Centers
- National Association of County and City Health Officials
- National Association of Public Hospitals and Health Systems
- National Association of States United for Aging and Disabilities
- National Business Coalition on Health
- National Business Group on Health
- National Education Association
- National Family Caregivers Association
- National Hispanic Medical Association
- National Hospice and Palliative Care Organization
- National PACE Association
- National Partnership for Women and Families
- National Rural Health Association
- Paralyzed Veterans of America
- Susan G. Komen for the Cure
- Take Care Health Systems (Walgreens)
- Target
- UnitedHealth Group
- Verizon
- Visiting Nurse Associations of America
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 Health² 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
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. 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 organizations 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 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, 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. 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.

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.

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.
Removing Barriers to Advanced Practice Registered Nurse Care: Hospital Privileges

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

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**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

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

“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. 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 APRNs; 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.

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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.
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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

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. A recent transitional care program for heart failure patients led by APRNs significantly reduced readmission rates. 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
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*, 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.

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.
Endnotes


16 M. Christina Johnson, American College of Nurse-Midwives, personal communication, August 8, 2011.


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24 Karen M. Cheung, *TJC changes MS.08.01.01 and MS.08.01.03: ‘Medical’ APRN and PA to be privileged through med staff process* (Credentialing Center Resource blog) http://blogs.hcpro.com/credentialing/2011/02/tjc-changes-ms-08-01-01-and-ms-08-01-03/.


29 Carol S. Cairns, *Solving the AHP Conundrum: How to Comply with HR Standards Related to Nonprivileged Practitioners* (Danvers, MA: HC Pro, 2007).

30 American Academy of Nurse Practitioners, “AANP Comments on the IOM Report.”


33 Institute of Medicine, *The Future of Nursing: Leading Change, Advancing Health*.


40 AARP Public Policy Institute, *Creating a 21st Century Nursing Workforce to Care for Older Americans*.