



NATIONAL ORGANIZATION OF NURSE PRACTITIONER FACULTIES
STATEMENT ON
ACUTE CARE AND PRIMARY CARE NURSE PRACTITIONER PRACTICE

September 2011

Introduction

In the *Consensus Model for APRN Regulation*¹, patient safety is a key unifying link among the components of advanced practice registered nursing (APRN) regulation – licensure, accreditation, certification, and education (LACE). Nurse practitioners (NPs), as the largest group of APRNs, have a prominent role in addressing patient health care needs in the current and evolving US health system. The alignment of the LACE components defines the NP scope of practice with a goal of public protection.² As described by the Pew Health Professions Commission, scope of practice is the “definition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice.”³ As part of an ongoing commitment to advance patient safety and clarify scope of practice, this paper elaborates on a significant issue for NP practice: The distinctions and overlap in practice by acute and primary care NPs.

Application of the Consensus Model

The drafting of the Consensus Model included various iterations and substantial discussion of acute care and primary care practice. In 2008, a work group of NP educators and representatives of NP certification organizations studied the overlap of the acute care and primary care competencies.⁴ The work group identified some unique competencies, but many competencies were similar and could only be distinguished by wording that referred to the populations served by each area. Based on this review and subsequent discussions, the work group recommended that the Consensus Model should retain only one role for the NP and that the distinction between primary and acute care should be made at the level of the population served by the NP. Of the broad populations (adult-gerontological, family/lifespan, pediatric, neonatal, psychiatric-mental health, and women’s health/gender), the acute and primary care distinctions are currently within the adult-gerontological and pediatric foci.⁵ The Joint Dialogue Group integrated these recommendations into the final version of the Consensus Model.

A fundamental premise of the Consensus Model is that NP competencies are not setting-specific. Historically, the acute care NP (ACNP) practiced predominantly in the hospital and the primary care NP (PCNP) practiced within a community setting. These setting boundaries often overlap, however. It is inappropriate and restrictive to regulate acute and primary care scope and practice based on settings but instead regulation should be based on educational preparation and scope of practice. Formal NP educational programs prepare adult-gerontological and pediatric NPs to provide either primary care or acute care services. This

educational preparation is not setting-specific, and graduates from acute care and primary care programs should be able to apply their respective scope of practice competencies across multiple settings. For example, an ACNP may practice in both hospital and home settings (e.g., inotrope therapy). The PCNP who practices predominantly in a community-based setting might also work within a hospital setting, e.g. in a diabetes clinic within the hospital. As telehealth and other technological innovations continue to expand, the settings for both acute care and primary care services will diversify further. The key issue is that scope of practice should be linked to educational preparation and corresponding NP certification; scope of practice should not be linked to setting.

Educational Preparation & Certification

Formal educational preparation, and its link to eligibility for certification, should be the key determinant of NP scope of practice. Educational programs do not prepare NPs to provide the full range of primary and acute care services. Instead, programs are limited to either primary or acute care and certification eligibility is based on the area of preparation. Although many NPs obtain informal, post-graduate education for specialization, scope of practice is determined by formal educational preparation and certification in primary or acute care practice. Pre-NP specialization at the RN level does not expand scope of practice at the APRN level. For example, a registered nurse who practiced in critical care and then completes a primary care NP formal educational program is not prepared to practice as an acute care NP. The individual would also need the ACNP preparation in the same area to be ready to provide APRN level care to the patient.

Eligibility for certification is linked to educational preparation. Graduation from a formal, NP educational program allows a NP graduate to seek certification in the **same** population focus area. Additional specialty certification, such as oncology, may be available as well to graduates who specialize in an area; however, the NP certification must be in the **same** population focus as the educational program of completion (adult-gerontological acute care, adult-gerontological primary care, family/lifespan, neonatal, pediatric acute care, pediatric primary care, psychiatric-mental health, and women's health/gender). It is the responsibility of the educational program, the graduate, and certifying bodies to ensure that an individual sits only for certification in the NP population focus area in which s/he has been prepared.

Scope of Practice

A challenge to the clarity of scope of practice for the ACNP and PCNP is the willingness of some employers to credential NPs to practice beyond their educational preparation and certification. For example, since family NPs are prepared to deliver primary care across the lifespan, some hospitals seek them out to work in emergency departments (EDs). Given their primary care-focused NP educational preparation, FNPs could see patients in ED fast track areas who present with problems that are commonly seen in primary care settings (e.g., otitis media, minor injuries, sprains). However, if FNPs are expected to provide acute care services that are not consistent with their educational preparation, then they are practicing outside their scope of practice. Regardless of how an employer may wish to utilize a NP, the NP has the onus of adhering to his/her own scope of practice. NPs practicing beyond their scope of practice (e.g. PCNPs in acute care) present legal, ethical and safety issues of which the NP – and generally not the employer - is responsible. The NP may seek post-graduate NP education if s/he wishes to expand beyond his/her primary care or acute care NP preparation to another population focus (in primary care or acute care).

The PCNP and ACNP are prepared to deliver different types of care. The main emphasis of PCNP educational preparation is on comprehensive, chronic, continuous care characterized by a long term relationship between the patient and PCNP. The PCNP provides care for most health needs and coordinates additional health care services that would be beyond the PCNP's area of expertise. In contrast, the ACNP educational preparation focuses on restorative care that is characterized by rapidly changing clinical conditions. The ACNP provides care for unstable chronic conditions, complex acute illnesses, and critical illnesses. Both the ACNP and PCNP might treat patients with similar conditions, such as patients with diabetes and asthma; however, the severity and instability of presenting symptoms might help to define the needed provider at any given time. Given that the acuity of patients continues to evolve in the health system, the line of demarcation between the acuity of the patient seen by the ACNP or PCNP will similarly evolve.

Both the PCNP and the ACNP can serve as the point of entry to health care and they also collaborate with each other when managing patients. For example, if a patient presents to the ED with an acute asthma exacerbation requiring hospitalization, the ACNP would, in addition to stabilizing and managing the patient's asthma symptoms, assess the patient's ongoing primary care needs and then refer to the PCNP for long-term management. Then, the PCNP serves as the first contact to coordinate the ongoing primary care needs of the patient. Similarly that same patient could present to a primary care setting and the PCNP would provide immediate stabilization and transfer to the hospital where the ACNP would manage the patient.

During the preparation of the Consensus Model, questions emerged about the nature of acute care and primary care practice. For acute care, the questions centered on whether or not acute care practice is merely a critical care specialization. As supported by the 2008 work group and the current review of competencies, acute care is not a specialization. Instead, ACNPs are expected to meet competencies that span the continuum of acute and severely acute, chronic, and critical illness. For primary care, both the work group and current task force reinforced that primary care is not limited to preventive and maintenance care of the well person but includes continuous care for patients with acute and/or chronic conditions. It is difficult to elucidate these nuances through a review limited to competencies alone as competencies are broad statements that do not necessarily define the level of specificity of care. A review of practice standards and curriculum content can further clarify the distinctions and intersections of primary care and acute care NP practice.

Key Messages

- The focus of care based on patient care needs – not the setting – defines ACNP and PCNP scope of practice. ACNPs focus on restorative care characterized by rapidly changing clinical conditions. The ACNP provides care for unstable chronic conditions, complex acute illnesses, and critical illnesses. PCNPs focus on comprehensive, continuous care characterized by a long term relationship between the patient and PCNP. The PCNP provides care for most health needs and coordinates additional health care services beyond the PCNP's area of expertise. NPs should be regulated according to the services they perform and population served and not **where** they provide services.
- Scope of practice must be tied to formal APRN education and not pre-APRN education or on-the-job training.

- An NP educational program is either primary care or acute care focused – it is not the full range. Certification as both an ACNP and PCNP requires completion of both formal educational programs or a dual-track adult-gerontology or pediatric program that meet all of the corresponding ACNP and PCNP competencies. (This would be adult-gerontology or pediatric ACNP competencies, and adult-gerontology, family/lifespan, pediatric, or women’s health/gender PCNP competencies.)
- Certification must match educational preparation. Certification eligibility should be linked to the educational preparation, and similarly a NP graduate should sit only for certification that corresponds with the population focus of his/her educational preparation.
- Both the PCNP and the ACNP can serve as the point of entry to health care and they also collaborate with each other when managing patients.
- Both the PCNP and ACNP may engage in specialty practice, but this specialization occurs as supplemental to the formal NP education and national certification.
- Both the PCNP and ACNP might evaluate an acutely ill patient, but the severity of the symptoms would determine which provider is most appropriate and best matched to the patient’s acuity level. The PCNP does not have the educational preparation to care for the complex acute or critical patient but does have preparation to manage the simple acute patient. Likewise, the ACNP does not have the educational preparation to provide comprehensive, continuous care but does have the preparation to provide preventive services within the context of restorative care.
- Patient safety is jeopardized when clinicians practice outside their scope of practice. Regardless of the willingness of some employers to credential the NP to practice beyond his/her educational preparation and certification, the NP is obligated to adhere to his/her scope of practice, as determined by the state in which they practice.

Conclusion

The ideal way to differentiate acute care from primary care practice is through exemplars that illustrate practice distinctions and intersections as well as collaboration between the ACNP and the PCNP. Taken in context with the key messages about ACNP and PCNP practice, these exemplars will guide the LACE components, NP clinicians, and the public to clarify how the ACNP and PCNP practice independently and collaboratively to achieve optimal patient outcomes. The following six cases illustrate the different and overlapping services of the ACNP and PCNP and the sample curriculum content that corresponds with their educational preparation.

EXEMPLARS OF PRIMARY CARE & ACUTE CARE PRACTICE

Point of care initial visit and presenting condition	Main Focus of Primary Care Nurse Practitioner (PCNP)	Main Focus of Acute Care Nurse Practitioner (ACNP)	Possible Overlap of Both Roles	Curriculum/Content
General	<ul style="list-style-type: none"> • Continuous care characterized by a long term relationship between patient and PCNP • PCNP provides care for most health needs and coordinates additional health care services beyond the PCNP's area of expertise 	<ul style="list-style-type: none"> • Restorative care characterized by rapidly changing clinical conditions • ACNP provides care for unstable chronic conditions, complex acute illnesses, and critical illnesses 	<ul style="list-style-type: none"> • Management of stable chronic conditions • Follow-up care after stabilization of complex acute and critical illnesses 	
<p>Exemplar 1 J. B. is a 61 year-old male limo driver who visits his PCNP for management of his chronic medical problems. He states that his COPD is "out of control." His COPD medications and rescue nebulizer treatments have been minimally effective, and he is requesting antibiotics. His pulse oximetry is 89% on room air. He is short of breath with pursed lip breathing. He has expiratory wheezing and bilateral rales.</p> <p>Admission note: Admit to internal medicine, Obtain admission labs, EKG and chest x-ray in ER.</p>	<p>The PCNP admits J.B. to the medical unit of the hospital.</p> <p>Admissions can be one of two kinds: 1) via the Emergency Department (ED) of the hospital where the patient is being admitted, or 2) a "direct admit", when the patient by-passes the ED and is directly admitted to the medical/surgical unit of the hospital.</p> <p>Whether the PCP is an NP or MD, writing admission orders will depend upon their</p>	<p>After J.B. is admitted to the medical unit of the hospital, the ACNP begins management to stabilize him.</p>	<p>Post-hospitalization follow-up visit could occur with either PCNP or ACNP</p>	<p>ACNP: acute exacerbation of COPD, airway assessment, intubation techniques, airway and ventilator management. Advanced diagnostics such as PFT interpretation</p> <p>PCNP: chronic management of COPD, use of hand held inhalers, nebulizer therapy for acute management, referral for more specialized care</p>

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	<p>medical privileges and credentialing at the specific hospital and the provider's scope of practice.</p> <p>Often the patient is sent to the ED from the primary care office, and admitted to a medical/surgical unit via the ED. To assist in facilitating the patient's admission and the ED staff, the PCP may order "admission" labs, EKG and chest x-ray. Acute care treatments/orders (e.g. IVs-unless started in the PC office) are generally ordered by the ACNP and ED staff.</p> <p>When the patient is a "direct admit", the orders will often be written by the PCP, then acute care orders are written by whomever will manage the patient in the hospital.</p>			
<p>Exemplar 2 T.O. is an 82 year-old male who presents for a routine primary care visit for management of chronic hypertension,</p>	<p>The PCNP admits T.O. to interventional cardiology.</p>	<p>The ACNP manages T.O. in the interventional cardiology unit.</p>	<p>Post-hospitalization, T.O. is followed up by the ACNP for pacemaker management and the PCNP for hypertension</p>	<p>ACNP: 12 lead ECG interpretation, life-threatening dysrhythmias management,</p>

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<p>osteoarthritis, and sinus bradycardia. On his previous EKGs, there was no evidence of heart block or ischemia. T.O. is taking daily hydrochlorothiazide for his hypertension. He feels well and has no symptoms. His blood pressure is 108/70 and his pulse is 42. His EKG shows sinus bradycardia with second degree heart block.</p>			<p>and arthritis.</p>	<p>including pharmacological and interventional management of hypertensive crisis, pacemaker indications and placement.</p> <p>PCNP: chronic hypertension management, osteoarthritis management</p>
<p>Exemplar 3 R.M. is a 73 year-old male with a history of chronic obstructive pulmonary disease (COPD), asthma, atrial fibrillation, Class III heart failure, and alcohol abuse who presents to primary care for routine management of chronic medical problems. R. M. has no pulmonary symptoms, but he is worried about a "sore and swelling" on his right lower leg. The history elicited indicated that R.M.had several episodes of near syncope, without loss of consciousness. He responded to a question about syncope, stating that he "almost passed out a few times."</p>	<p>The PCNP consults with the ACNP who admits R.M. to the telemetry unit for syncope and cellulitis of his right leg.</p>	<p>Within 3 hours of admission to the telemetry unit, R.M. had a burst of ventricular tachycardia that spontaneously reverted to normal sinus rhythm and the ACNP is called to consult. The ACNP orders an echocardiogram, a transesophageal echocardiogram, and an electrophysiology consult for work up for a possible pacemaker. On echocardiogram, R.M.s ejection fraction was only 25%. Since he has a history of alcohol abuse, an Automatic Internal Cardiac Defibrillator (AICD) was inserted in the hospital. The ACNP managed his diagnostic</p>	<p>After discharge, J.M is followed by the ACNP for pacemaker and cardiology management.</p> <p>The PCNP continue to manage J.M.s asthma and COPD and monitors the resolution of his cellulitis.</p>	<p>ACNP: lifethreatening dysrhythmia management, echocardiogram interpretation, indications for AICD placement, intravenous antibiotics for acute infections, syncope management</p> <p>PCNP: management of COPD, asthma, heart failure, cellulitis; follow up post hospitalization Importance of eliciting a history and listening to the patient's response(s).</p>

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		workup and post AICD insertion care.		
<p>Exemplar 4 E.H. is a 59 year-old male with a history of hypertension and substance abuse, who presents today for routine primary care follow-up. After requesting to use the bathroom twice during history taking as well as drinking bottled water, a glucose finger stick was performed. The non-fasting glucose level was 500. In addition to symptoms of polyuria and polydipsia, a change in mentation and tortuous fundi in both eyes were noted on PE. His serum glucose result is 853.</p>	The PCNP had E.H. transported to the Emergency Department for initial treatment of his serum glucose and admission to the hospital.	In the Emergency Department, the ACNP stabilized E.H. with fluids and IV insulin and admitted him to the ICU for continuous IV insulin infusion.	After discharge, E.H. could see either the ACNP or the PCNP for a follow-up visit and referral to diabetes education classes. The PCNP would be responsible for ongoing management of his diabetes.	<p>ACNP: management of diabetic ketoacidosis and hyperglycemic hyperosmolar syndrome, fluid resuscitation, intravenous insulin infusion</p> <p>PCNP: management of diabetes mellitus, obesity, hypertension, substance abuse</p>
<p>Exemplar 5 B.A., a 70 year-old female, has been a long-term resident of a subacute care facility. Her history includes hypertension Type 2 DM and COPD. Three years ago, she had surgery for an abdominal aortic aneurysm. Since her surgery, she has been unable to wean from the ventilator. She has also recently developed rapid atrial fibrillation requiring chronic anticoagulation therapy</p>	The PCNP manages her diabetes and hypertension, nutritional needs and activity.	The ACNP stabilizes dysrhythmias and monitors reaction to medications. Adjusts treatment options as necessary including interventions if needed to control rate and rhythm. First option is for rate. Also will monitor ventilator status while watching for chronic long-term effects of ventilator management while monitoring for barotraumas and infection.		ACNP: hyperalimentation and enteral nutrition management, long-term ventilator management, life-threatening dysrhythmia management, echocardiogram interpretation, and long-term anticoagulation management

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				PCNP: hypertension, diabetes mellitus and COPD management.
<p>Exemplar 6 J. T. is a 2-year old female who presents to the emergency department accompanied by her 17-year-old mother with a 2-day history of upper respiratory infection. J. T. and her mother recently moved and she does not have a primary care provider. J.T. has a history of asthma that is not well controlled, and her mother states that she ran out of medication about a month ago. J. T. has mild intercostal retractions, no flaring, no grunting, apical pulse 120. Her chest is tight with diffuse expiratory wheezes bilaterally. Her oxygen saturation by pulse oximetry is 93% on room air.</p>	<p>The PCNP follows J.T. post-hospitalization for asthma management and well child care.</p>	<p>The ACNP stabilizes J.T. with an albuteral treatment and admits her to the hospital for observation. J. T. is discharged the following day and a referral is made to the PCNP practice.</p>	<p>After discharge, J.T. could see either the ACNP or the PCNP for a followup visit. The PCNP would be responsible for ongoing management of her asthma and prevention of future exacerbations.</p>	<p>ACNP: acute exacerbation of asthma, airway assessment and management, intubation techniques, nebulizer therapy</p> <p>PCNP: chronic asthma management, use of inhaled steroids and bronchodilators,</p>
<p>Exemplar #7 A.D. is a 20 year-old house painter who fell off a ladder two hours ago and presents to the PCNP complaining of pain in his right wrist.</p> <p>PE: Marked swelling and tenderness of distal radius. Xray: Two parallel longitudinal</p>	<p>The PCNP assesses vital signs, assesses the injury (xray wrist), and stabilizes the injured extremity.</p>	<p>The ACNP manages A.D.'s hyperthermic reaction to anesthesia.</p> <p>A.D. makes a full recovery, and the fractured radius is managed conservatively with cast immobilization. He is recommended to follow up with his PCNP within one week of</p>	<p>A.D.'s initial presentation could have either been to the PCNP office or to the emergency department. Both can diagnose and refer for an injury such as this.</p> <p>The patient can follow up with PCNP after discharge from the acute care facility.</p>	<p>ACNP: severe injury assessment and management/referral, malignant hyperthermia management, ICU management</p> <p>PCNP: Musculoskeletal injury</p>

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<p>fractures measuring 3 and 4 cm. No evidence of displacement of radius and ulna. The wrist was immobilized and A.D. was referred to a local orthopedist for further care.</p> <p>24 hours later: A.D. is prepped for same day surgery with an open reduction and internal fixation of the right distal radius. Intra-operative temperature increases to 106 degrees F and Pulse = 125 within 5 minutes of initiating anesthesia. Then A.D. is hydrated, placed on a bed of ice and transported to the SICU. The ACNP receives A.D. in the SICU and assumes care of A.D.</p>		<p>discharge</p> <p>The ACNP stabilizes the patient postoperatively, monitors fluid and electrolyte status while monitoring for all postoperative complications such as compartment syndrome, and postoperative infections especially since an increase in temp was noted intra-operatively, cultures would be sent for evaluation as to possible pathogens.</p> <p>.</p>		<p>assessment and management/referral</p>

References

1. APRN Consensus Group Work Group & NCSBN APRN Advisory Committee. (2008). *Consensus model for APRN regulation: Licensure, accreditation, certification, and education*. Can be accessed at:
<http://www.nonpf.org/associations/10789/files/APRNConsensusModelFinal09.pdf>
2. *Changes in healthcare professions' scope of practice: Legislative considerations*. (Not dated) A collaborative project developed by representatives of the regulatory boards of medicine, nursing, occupational therapy, pharmacy, physical therapy, and social work.
3. Report of the PEW Health Professions Commission's Task Force on Healthcare Workforce Regulation. (December 1995). *Reforming healthcare workforce regulation: Policy considerations for the 21st Century*, Page ix.
4. Overlap between acute care and primary care competencies. (July 2008). Preliminary report of a working group to the Joint Dialogue Group.
5. APRN Regulatory Model: Nurse Practitioner Focus. (2010, Unpublished). Supplemental diagram to *Consensus model for APRN regulation* developed by C. Hartigan, American Association of Critical Care Nurses.

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