

# Words Matter – Guide to Discussing APRN Practice



## *Nurses are entitled to full practice authority, consistent with education and training.*

A major obstacle to achieving effective collaboration and inter-professional understanding is that there are different interpretations of key terms. Dialogue between the professions is sometimes hampered by terms with charged meanings, such as "scope of practice," "supervision," "independent" and "lead" that "often have us talking past each other."<sup>1</sup>

However, given the widespread use of these terms in the current legal and regulatory framework, it might be helpful to have a common understanding of how those terms might be interpreted. Participants in the Macy Foundation meeting, *Who will Provide Primary Care and How Will They Be Trained?* were largely successful in achieving such understanding.<sup>2</sup>

### **Understanding "Independence"**

The term "independent" is perhaps the most prone to misinterpretation and is best avoided when possible.<sup>3</sup>

"Independent" practice refers to the ability and responsibility of a provider to utilize the knowledge, skills, judgment and authority to practice to the full extent of their education and licensure. For example, APRNs as well as other health care professionals are often defined as "licensed independent practitioners," by the Joint Commission and other leading forces of health care.

*Independent* should not be interpreted to mean "in a vacuum." All health care practitioners – physicians, nurses, physical therapists, pharmacists, etc., - must be cognizant of the limits of their scope of practice and skilled in knowing when and how to refer or collaborate to provide truly team-based patient-centered care.

In the words of the American College of Physicians (ACP)<sup>4</sup>, "Today, no one clinician should practice independently of other clinicians. Instead, the goal should be to develop collaborative and team-based models that allow every member of the team to contribute to the best possible outcomes to the full level of their training and skills while recognizing differences in their training and skills."

*Independent* practice is also not defined by the place of employment, the business model of the practice, or the method of reimbursement.

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<sup>1</sup> RWJ Foundation *Physician-Nurse Dialogue on Collaboration*

<sup>2</sup> Gillis C. On interdisciplinarity and why it matters...A lesson from primary care. *Nurs Outlook* 2010;58:119-121.

<sup>3</sup> Apold S. Best practices in interprofessional communication: The right words. *J for Nurse Practitioners*, Vol. 7, no 2, Feb 2011 p. 96-7

<sup>4</sup> American College of Physicians Response to the Institute of Medicine Report, *The Future of Nursing: Leading change, Advancing Health*. November 1, 2010

While many physician groups continue to express concern about independent practice of APRNs, the American Congress of Obstetricians and Gynecologists (ACOG) embraced the concept. In the *Joint Statement of Practice Relations between Obstetrician Gynecologists and Certified Nurse-Midwives/Certified Midwives*,<sup>5</sup> issued with the American College of Nurse-Midwives, ACOG stated:

“Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients.”

### **Collaboration**

Like physicians, APRNs collaborate and consult with many other health care providers, often on a daily basis, requesting consultations, and referring patients for specialized care. Like APRNs, physicians do so freely, without any requirement or consideration of a written collaboration agreement. Clearly, we agree that health care in all its current complexity is a team rather than a solitary activity.

Collaboration becomes a barrier to practice when laws, regulations or institutional guidelines spell out *requirements for written* collaborative agreements. Such agreements typically come about as a result of compromise in the legislative arena. They are, however, rarely rational in the day-to-day practice of APRNs and fly in the face of building interdisciplinary teams. Payment for collaborative agreements (versus payment for consultation and care to a patient who has been referred) raises ethical and legal questions.<sup>6</sup>

### **Supervision**

The notion that physicians should supervise care provided by APRNs is outdated and dangerous. It is particularly problematic when it creates an unnecessary barrier to access to care in rural and underserved areas. It is inappropriate to expect physicians, or any other provider, to accept responsibility for care they have not provided. Physicians are not responsible for supervising care delivered by registered nurses, (including APRNs), therapists, or any other licensed health care professional.

Each APRN is personally accountable for their practice, to patients, their respective licensing board, the nursing profession, and society. When a pediatric nurse practitioner is managing a well-child visit in an outpatient clinic, or a nurse-midwife is managing a labor and birth in a hospital, or a family nurse practitioner treats a respiratory infection or manages a patient’s diabetes or hypertension in his or her practice, those APRNs are legally responsible for the scope and quality of care which they provide. It is within APRNs’ professional judgment to assess and treat those patients within the bounds of their legally authorized scope of practice.

### **What’s wrong with physician supervision?**

- It is inappropriate to expect physicians, or any other provider, to accept legal responsibility for care they have not provided.
- Requirements for physician supervision create an unnecessary barrier to access to care, particularly in rural and underserved areas.

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<sup>5</sup> [www.midwife.org/siteFiles/position/Joint\\_Statement\\_05.pdf](http://www.midwife.org/siteFiles/position/Joint_Statement_05.pdf)

<sup>6</sup> Payment of Collaborating Physicians by Nurse Practitioners. The State Education Department, State Board of Nursing, New York. July 2006. [www.nysna.org/practice/scope/np\\_phys\\_pmts.htm](http://www.nysna.org/practice/scope/np_phys_pmts.htm)

- Requirements for physician supervision lead to fragmented care and duplication of services.
- Such fragmented care and duplication of services needlessly drives up healthcare costs.
- Requirements for physician supervision are at odds with our attempts to build interdisciplinary teams. “By perpetuating a ‘mine, and therefore not yours’ practice culture, current laws erect, rather than remove barriers to inter-professional collaboration, practice and respect.”<sup>7</sup>

### **Statutory Autonomy**

This term gained prominence when suggested by Marilyn Chow at IOM FON implementation meeting. Lawyers cannot provide a technical legal definition, but it serves to effectively communicate the goal of having laws and regulations mirror the scope of practice created by the educational systems, certifying bodies and professional scope and standards documents.

### **Full practice authority**

American Association of Nurse Practitioners has defined full practice authority as, “the collection of state practice and licensure laws that allows nurse practitioners to evaluate, diagnose, order and interpret diagnostic tests, initiate and manage treatments – include prescribe medications – under the licensure and authority of the state board of nursing” (“Issues At-A-Glance: Full Practice Authority,” 2014).

### **Seeking provider neutral language**

In an attempt to refer to a long list of health care professionals that are not physicians (APRNs, PAs, therapists, etc.) the use of the terms “physician extender” and “mid-level provider” have been used. These terms need to be retired.<sup>8</sup> These terms

- Underscore the outdated hierarchical model of health care
- Hinder the progress toward development of interdisciplinary teams
- Undermine consumer/patient confidence in the vast majority of the healthcare workforce (anyone not “high level”)

In 2014 the Society of Hospital Medicine announced they would phase out “inaccurate nomenclature for healthcare professionals,” and replace terms like “allied health,” and “non-physician provider” with the names for the individual groups, like “physician assistants,” “nurse practitioners,” or “pharmacists.”<sup>9</sup>

## **Key Documents and Sources**

### **Consensus Model for APRN Regulation**

Like medicine, nursing has evolved. Today, the Consensus Model for APRN Regulation,<sup>10</sup> provides for consistent national standards for licensure of APRNs to complement those for accreditation, certification and education that already exist. These standards form the legal foundation for APRN practice. However, a patchwork of state laws and regulations sometimes bar APRNs from practicing to the full

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<sup>7</sup> Safriet, B.J., (2002) Closing the gap between can and may in health-care providers’ scope of practice: A primer for policymakers. Yale Journal on Regulation, 301-333.

<sup>8</sup> APRNs within the Indian Health Service created position statements to formally recommend that these terms be retired from use. Fullerton L. Who’s Mid-Level? IHS Provider, March 2000, p. 39.

<sup>9</sup> Society of Hospital Medicine. [The Hospitalist, May 1, 2014.](#)

<sup>10</sup> APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee (2008). “Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education.”

extent of their education and qualifications, and hinder their ability to make maximal contributions to health care. The Consensus Model seeks to remedy that situation.

The Consensus Model uses the term “independent” in defining APRNs; the definition also recognizes the limits of APRN practice and the responsibility of the APRN to consult and refer as appropriate:

“Advanced practice registered nurses are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession, and the licensing board to comply with the requirements of the state nurse practice act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN’s expertise; and for consulting with or referring patients to other health care providers as appropriate.”

### **Joint Commission**

From the Comprehensive Accreditation Manual for Hospitals (CAMH) Glossary: **Licensed independent practitioner (LIP):**

Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. **When standards reference the term licensed independent practitioner, this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state's regulatory mechanism or federal guidelines and organizational policy.** [emphasis added]

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