10-1-2005

Experts recommend strategies for strengthening the use of advanced practice nurses in nursing homes.

Mathy Mezey
New York University

Sarah Greene Burger
New York University

Harrison G Bloom
Mt. Sinai School of Medicine

Alice Bonner
University of Massachusett

Mary Bourbonniere
Yale University, meg.bourbonniere@jefferson.edu

See next page for additional authors

Authors
Mathy Mezey, Sarah Greene Burger, Harrison G Bloom, Alice Bonner, Mary Bourbonniere, Barbara Bowers, Jeffrey B Burl, Elizabeth Capezuti, Diane Carter, Jacob Dimant, Sarah A Jerro, Susan C Reinhard, and Marilyn Ter Maat

Experts Recommend Strategies to Strengthen Advance Practice Nurses in Nursing Homes

Mathy Mezey, EdD, RN, FAAN[*]
Sarah Burger, MPH, RN, FAAN[†]
Harrison G. Bloom, MD[‡]
Alice Bonner, APRN-BC, GNP[§]
Mary Bourbonniere, PhD, RN[‖]
Barbara Bowers, PhD, RN[¶]
Jeffrey B. Burl, MD[#]
Diane Carter, MSN, CS, RN[**]
Jacob Dimant, MD[††]
Sarah A. Jerro, MA, RN, CDONA[‡‡]
Susan C. Reinhard, PhD, RN, FAAN[§§]
Marilyn Ter Maat, MSN, RNC, CNAA, CRRN-A[‖‖]

Address Correspondence to:
Mathy Mezey, EdD, RN, FAAN
Independence Foundation Professor of Nursing Education
Director, The John A. Hartford Foundation Institute for Geriatric Nursing
New York University, Steinhardt School of Education
Division of Nursing
246 Greene Street
New York, NY 10003-6677
Tel: 212 998-5337
Email: mathy.mezey@nyu.edu

Alternate Corresponding Author:
Sarah Greene Burger, RN-C, MPH, FAAN

[*] Director, John A. Hartford Foundation Institute for Geriatric Nursing, New York University, Steinhardt School of Education, Division of Nursing
[†] xxx, John A. Hartford Foundation Institute for Geriatric Nursing, New York University, Steinhardt School of Education, Division of Nursing
[‡] Medical Director, Evercare, New York
[§] Gerontological Nurse Practitioner, Fallon Clinic,Worcester, MA; Representing the *National Conference of Gerontological Nurse Practitioners*
[‖] Assistant Professor, Yale University School of Nursing
[¶] Professor, University of Wisconsin-Madison; Representing the Expert Panel on Aging, *American Academy of Nursing*
[#] Director of Geriatrics, The Fallon Clinic, Worcester, MA
[**] President and CEO, American Association of Nurse Assessment Coordinators, Denver, CO
[††] Geriatrician, New York, NY: representing *American Medical Directors Association*
[‡‡]Director of Nursing, Eden Park Health Care Center, Poughkeepsie ,N.Y, National Board Trustee, Representing *National Association of Directors of Nursing Administration in Long Term Care*
[§§] Professor and Co-Director, Rutgers University, New Brunswick, NJ: Representing the Expert Panel on Aging, *American Academy of Nursing*
[‖‖] Department Director, Good Samaritan Society, Sioux Falls, SD; Representing *The National Gerontological Nursing Association*

ABSTRACT

In 2003, The John A. Hartford Foundation Institute for Geriatric Nursing, New York University Division of Nursing convened an Expert Panel to explore the potential for developing recommendations for the caseloads of advanced practice nurses in nursing homes and to provide substantive and detailed strategies to strengthen the use of advanced practice nurses in nursing homes. The Panel, consisting of nationally recognized experts in geriatric practice, education, research, public policy and long-term care developed six recommendations related to caseloads for advanced practice nurses in nursing homes. The recommendations address educational preparation of advanced practice nurses; average reimbursable advanced practice nurse visits per day; factors impacting advanced practice nurses caseload parameters, including provider characteristics, practice models, resident acuity and facility factors; changes in Medicare reimbursement to acknowledge non-billable time spent in resident care; and technical assistance to promote a climate conducive to advance practice nurse practice in nursing homes. Detailed research findings and clinical expertise underpins each recommendation. These recommendations provide practitioners, payers, regulators and consumers with a rationale and details of current advanced practice nursing models and caseload parameters, preferred geriatric education, reimbursement strategies, and a range of technical assistance necessary to strengthen, enhance, and increase advanced practice nurses' participation in the care of nursing home residents.

Key Words: advanced practice nursing, nursing homes, advanced practice nursing caseloads, advanced practice nursing models

12 01 04 Ethics, Public Policy, and Medical Economics

Experts Recommend Strategies to Strengthen Advance Practice Nurses in Nursing Homes

Mezey, M, Burger, S, et al[*]

ABSTRACT: appended

TEXT:

Utilization of Advance Practice Nurses (APNs: nurse practitioners and clinical nurse specialists) has been shown to improve resident outcomes in nursing homes.[1-8] It is estimated that APNs are involved in the care of residents in approximately 20% of the nations 16,000+ nursing homes (Intrator O, Zhanlain F, Mor V et al, in press).

In 2002, in order to describe the practice patterns of APNs in nursing homes, The John A. Hartford Foundation Institute for Geriatric Nursing (Hartford Institute) conducted a national survey of nursing home medical directors.[9] The survey surfaced a need for additional information on caseloads and other practice parameters for APNs in nursing homes. In 2003, the Hartford Institute convened an Expert Panel to explore the potential for developing recommendations for the caseloads of advanced practice nurses in nursing homes. The seventeen participants in the Expert Panel represented nursing and medical education, practice, research and public policy. Experts were invited to participate based on their national prominence in the field (as evidenced by publications in peer-reviewed journals and leadership of prominent associations and federal panels) and included administrators, advanced practice nurses and physicians familiar with the

role of advanced practice nurses in long-term care, and nurses and physicians who direct academic programs to prepare advanced practice geriatric nurses.

Experts met for a 2-day face-to-face meeting. A background paper distributed prior to the meeting described known models of advanced practice nurse practices in nursing homes, along with a bibliography of published studies that examined the relationship of outcomes for nursing home residents and care by advanced practice nurses. The proceedings of the Expert Panel meeting were summarized and distributed as drafts to the Expert Panel participants, with request for input and clarification.

This paper presents six of the seven recommended strategies of the Expert Panel related to caseloads for APNs in nursing homes, along with the background that underpinned the thinking of the Expert Panel in choosing each recommendation. The seventh recommendation on the need for research funding to expand the knowledge base of resident and facility outcomes for APN practice will be provided in a future article. The Panel anticipates that APNs, physicians, long-term care facilities, regulators, payers and consumers will be guided by the recommended strategies (Table 1).

Strategy 1: Increase employment/utilization of APNs in nursing homes

The Expert Panel based the recommendation of Strategy 1 on strong research literature and current practice supporting positive outcomes for nursing home residents from care by APNs. The documented need for increased APNs with gero-psychiatric expertise is also noted.

Background: Nurse practitioners (NPs): Despite the positive resident outcomes noted in the literature and in practice,[1-8] the total number of NPs in nursing homes remains small, ranging from 1,360[10] to 1,159[9]. According to one study, the number of the nation's

16,000 nursing homes with APNs doubled from 10% to 20% during the 1990's (Intrator O, Zhanlain F, Mor V et al, in press). In an unpublished 2002 survey (personal communication, L. Kennedy-Malone, PhD, APRN, BC, GNP, 11 29 03) by the American Nurses Credentialing Center (ANCC), 50% of responding certified geriatric nurse practitioners (GNPs; n=387) said that long-term care was their primary place of employment.

The Expert Panel endorsed maximizing Medicare, Medicaid and market place incentives to encourage further use of APNs and physician assistants (PAs) in nursing homes. Intrator (Intrator O, Zhanlain F, Mor V, et al, in press), for example, found that nursing homes are more likely to employ NPs/PA in states in the upper quartile of Medicaid reimbursement rates, nursing homes in more competitive markets, and homes in areas with higher managed care organization penetration.

Background: Clinical nurse specialists (CNSs): There are no national data as to the number or practice parameters of CNSs employed in nursing homes. The few studies in the literature have found CNSs to be effective practitioners in nursing homes. The Wellspring Program, for example, found that CNSs had strong teaching and management skills and were very comfortable working with staff.[11] Rantz et al[12] also report the effectiveness of CNS practice in nursing homes.

Gero-psychiatric clinical nurse specialists: There are no national data as to the employment of gero-psychiatric clinical nurse specialists in nursing homes. The American Geriatrics Society recently called for improved mental health care in nursing homes.[13] In 2003, there were 364 adult psychiatric, 426 family psychiatric, and 117 gerontological nurses accredited by the American Nurses Credentialing Center (ANCC)

as psychiatric NPs or CNSs; there are no separate credentialing examinations in gero-psychiatric nursing. One-hundred and thirteen masters programs prepared 244 nurses to practice as psychiatric/mental health adult CNSs and NPs (Table 2).[14] The Expert Panel recommended that the American Association of Colleges of Nursing (AACN) track the number of these programs that offer gero-psychiatric nursing as a major, minor, or area of concentration.

Strategy 2: Require geriatric content in all educational programs preparing advanced practice nurses (APNs)

Background: Currently, an unknown number of family and adult nurse practitioners (FNPs, ANPs), and CNSs care for residents in nursing homes and this number is expected to increase in the future. Many of these APNs have had little or no required geriatric content in their educational program. There are currently 68,000 NPs in the USA .[10] Of these NPs, only 3,700 (5%) are certified by ANCC as geriatric nurse practitioners (GNPs). The numbers of geriatric APN programs and graduates is very small compared to the number of adult APN programs and graduates (See Table 2).[14] The Expert Panel noted strategies already underway to strengthen the geriatric preparation of all APNs. In 2004, AACN developed competencies in care of older adults for masters programs preparing nurses in non-geriatric specialties.[15] With a 5 year grant funded by Atlantic Philanthropies (web site: GeroNurseOnline.org), the American Nurses Association, American Nurses Credentialing Center, and the Hartford Institute are promoting gerontological knowledge and certification for nurses who work in specialty practices such as oncology, cardiology, emergency care etc, a substantial number of whom are likely to be APNs.

Strategy 3: Reflective of current APN practice, use 14-18 reimbursable APN visits a day as the average for APNs caring for nursing home residents. This average assumes an eight-hour day and a normal range of initial, ongoing, episodic, and non-billable APN activity

Background: The Expert Panel recognition of the 14-18 range of reimbursable visits accommodates factors affecting caseload such as APN practice models and characteristics, resident acuity (acuity as used here takes into account the complexity of functional, physical, mental, and chronic conditions of the resident), and facility characteristics such as frequency of nursing home admissions and length of stay. The Panel considered the three predominant workforce models for APNs in nursing homes that emerged from the prior survey of NPs[9]: Model 1: NPs employed by or contracted with primary care physicians or physician groups (60% of NPs); Model 2: NPs employed by managed care organizations (28% of NPs); and Model 3: NPs employed directly by or contracted with the nursing home, either full time, part time or shared (19% of NPs) (Table 3). An evolving number of APNs describe a fourth model of independent practice, in which the APN has no financial relationship with either a physician or a facility and directly bills Medicare, Medicaid and other insurers for their services. In the descriptions that follow, no effort has been made to compare the efficacy and outcomes of these models because of multiple differences in practice and reimbursement associated with each model.

Model 1: APNs employed by or contracted with primary care physicians or physician groups**:** Physician practices that employ NPs report caseload averages of 150-200 residents per NP. At the Fallon Clinic, Division of Geriatrics, a mixed

model with 50% Medicare and 50% managed care, an APN carries a caseload of 120-180 in three facilities or less. The number of visits per day averages 8-10 with a goal of 12-14 visits per day (personal communication, A Bonner, MSN, GNP, 12 15 03**).** Geriatric Associates of America (GAA), P.A., a fee for service, collaborative practice model that follows nursing home residents exclusively with systems that support large numbers of NPs and Physician Assistants (PAs), averages caseloads between 180-240 residents per NP (10±% sub-acute). NPs are expected to make 8-10 routine visits per day (averaging 3-6 episodic problem oriented visits) while physicians perform 3-6 routine visits per day and 8-10 problem oriented visits. Expectations for the per/visit per day are reduced for NPs who are adjunct faculty and participate in educational and quality assurance activities in their facilities (personal communication, MP Rapp, MSN, GNP, fall, 2003).

HealthEssentials employs 400 to 450 full time equivalent (FTE) NPs and PAs in nursing facilities in 17 states, billing for Part B Medicare. NPs/PAs visit one to three facilities and average a caseload of 150 residents. An NP/PA typically bills for 15 Relative Value Units (RVUs) per day in 6.5 hours, with an additional 1.5 hours per day for paper work and other interactions with facility residents and staff (RVU calculation base: 25 minutes; code 99312= 1 RVU or 35 minutes or code 99313 = 1.6 RVU) (personal communication, D Stone, MD 11 04 03).

One for-profit, 200-bed health care facility has a full-time NP who is an employee of a physician group, Park Avenue Health Care Management. The NP

works an 8-hour day, five days per week and takes call ten days per month (5pm to 8 am), shared with two primary attending physicians for a caseload of 160 residents. The NP averages 14 to 18 billable visits per day. Similar to the findings of Kane et al[16], 50% of the NPs time is spent in non-billable activities (personal communication, S. Jerro, MA, RN, 12 10 03).

Model 2: NPs employed by managed care organizations**:** Evercare, the largest managed care organization (MCO) employing NPs, seeks to maintain an average caseload of 80-110 residents per NP. Kane et al[16] report Evercare NP caseloads of less than 100, and, in a later study,[17] caseloads averaging 84.2 residents $\pm$ 22.8 (range 47-128). The mean number of patients seen or otherwise cared for by NPs per day is 13.2. NPs report seeing an average of 8.9 $\pm$6.2 patients per day (median 8.00, range 0-39, and then working on but not seeing a mean of 4.3 additional patients ($\pm$ 3.0; median 4; range 0-14). In Kaiser Permanente, Sacramento CA, NPs maintain an average caseload of 200 residents and average 12 to 14 visits a day for residents with an undifferentiated skill mix.

Model 3: NPs employed directly by or contracted with a facility either part-time, full time or shared**:** Most of the 137 nursing homes in the U.S. Department of Veterans affairs employ NPs, with caseloads ranging between 10 and 60 (average of 40). Individual NPs average 15-20 visits per day (personal communication, K. R. Robinson, PhD, RN, FAAN, 12 18 03)**.** In the Wellspring model[11] 11 facilities joined in a collaborative alliance, and hired one geriatric clinical specialist to address best clinical practices, consult regarding individual resident care, and assist homes meet regulatory mandates, using these occasions as teaching

examples. NPs were also effective in the Wellspring Model (personal communication, S Reinhard, PhD, RN, FAAN, 01 06 04).

Model 4: Independent Provider: In several practices, the APN functions as an independent provider. Priest NP Services, which provides NPs as independent practitioners to physicians with nursing home practices, reports an average NP caseload of 200-250 residents (16-18 visits routine and episodic visits per day), based on a collaborative practice model with physicians making alternating routine visits. Visits are reduced when NPs participate in facility activities and training, which they are encouraged to do (personal communication, D Priest, MSN, FNP, 12 16 03).

In an independent provider practice of psychiatric APNs in nursing homes in NC, which evolved from direct referrals from practitioners and patient self-referrals, APNs provide an initial psychiatric diagnostic evaluation, management, family therapy, initial and follow-up consultation, and services to facility staff. In NC, CNSs bill both psychiatric and evaluation and management (E&M) codes, but lacking prescriptive privileges, work closely with MDs and NPs in medication management (personal communication, J Baradell, PhD, RN, CS, 12 18 03). The Expert Panel encouraged the further use of psych APNs in care of residents.

There is some evidence that gero-psychiatric APNs make fewer visits per day as compared with other APNs in nursing homes. Two APN gero-psychiatric nurse practices report making seven visits per day. Reasons for fewer visits stem from the characteristics of the visits. For example, AP psychiatric nurses report that an initial visit can take 2-2.5 hours. The major conditions are depression and

behavioral symptoms of dementia. The latter can take up to 1.5 hours even on a subsequent visit (See Table 3). (Personal communication, N. O'Dowd, R.N., APN,C, 10 03 03; J. Baradell, PhD, RN, CS, 12 18 03)

Strategy 4: Consider APN characteristics and practice models, resident acuity, and facility characteristics in determinations as to the impact of APN caseload on resident quality of care. Current APN practice suggests, on average, 20 or more reimbursable APN visits a day for APNs caring for nursing home residents as the level that may raise concerns about quality of care. This average assumes an eight-hour day and normal range of initial, ongoing, episodic, and non-billable APN activity.

Background: The Expert Panel considered important APN, resident and facility factors influencing APN caseloads that raise issues about quality of care. HealthEssentials reported that an average of more than 20 RVUs per day by an NP/PA warrants review. Specific cases of APNs working as "sub-specialists" in nursing homes may allow a caseload to be adjusted above the 20 visits. For example if an APN were hired by a nursing home as a wound care specialist, s/he may be able to provide safe wound assessment care, to 20 or more patients per day.

APN characteristics and practice models: In depth examination identified three aspects related to APN characteristics and practice models that impact APNs' practice in nursing homes.

Caseloads for novice APNs: The Expert Panel acknowledged the need for reduction of caseload expectations for novice APNs, those without geriatric

experience, and/or needing orientation in an unfamiliar nursing home. A "residency" program was offered as one option for novice APNs. The Panel recommended a lower caseload for the first 6 months after a novice APN enters into a new practice based on reports that the 60% of APNs who work in private physician practices have little or no orientation and/or mentoring.

APN continuing education (CE): Given the rapidly changing treatment and assessment in geriatric care, the Expert Panel strongly recommended CE for APNs caring for residents in nursing homes, irrespective of practice model. Many states mandate CE as a condition for renewal of APN licensure, and many professional nursing associations mandate CE as a condition for NP and CNS re-certification. Evercare mandates CE units for their NPs.

APN practice models: The Expert Panel agreed that APNs employed by a nursing home (Model 3 above) are more embedded in the home's structure than are APNs who make episodic visits (Model 1 above). Fee for service or part-time APNs, who only do acute/urgent visits, may be well known to all relevant parties but are often not perceived as part of the team or the culture of the facility because they have no institutional affiliation or responsibilities. Reimbursement typically restricts these APN activities to direct clinical care for which the practice is reimbursed. This compares to APNs who are involved in daily care issues and are visibly present, such as APNs employed by a nursing home and those in the Evercare and Fallon Clinic models (Model 2 above). The following factors facilitate the APNs ability to influence positive changes in resident care:

- responds to nursing staff identified resident problems as they arise

- provides informal and immediate bedside education to staff and family
- "eye-balls" residents and notes changes possibly missed by busy nursing staff
- available for lunch/coffee breaks and creates bond/trust with staff
- answers staff care questions and provides basic information about drugs, changes in condition, etc
- addresses problems seen as too insignificant to "bother"/call a doctor
- participates in institutional committees for resident care planning, evaluating Medicare SNF care, and managing risk
- evaluates outcomes of care and identifies areas for quality improvement

The Expert Panel also acknowledged that travel time between facilities impacts the productivity of APNs who care for residents in several facilities. Unless the nursing home is too small, practicing in one home is more efficient. Experts also suggested limiting the number of nursing homes one APN should visit to no more than five or six.

Resident acuity**:** The Expert Panel recommended adjusting APN caseloads downwards when caring for residents with high acuity. Resident acuity as used here takes into account the complexity of functional, physical, mental, and chronic conditions of the resident along with factors such as frequency of nursing home admissions and length of stay. If turnover of residents is high then caseloads reflect large numbers of newly admitted residents who are more likely to be unstable than residents who have been in the facility for a long time.

Research is needed on caseloads and outcomes for short stay residents and those needing hospice levels of service.

The Expert Panel also recommended lowering caseloads for APNs if residents under their care need intensive, sub-acute level of care as opposed to residents who are stable such as in ventilator and dementia units. In high acuity, post hospital type units, one full time equivalent (FTE) NP can carry a caseload of 60 patients. In the traditional Medicare SNF sub-acute unit, one FTE NP can carry a caseload of 100-120 patients (personal communication, S. Levenson, MD, CMD, 1 12 04). The Fallon Clinic, Division of Geriatrics, strives to maintain average caseloads of 25 sub-acute residents per NP, often spread over 2 or 3 facilities (personal communication, A. Bonner, MSN, NP 12 15 03).

Facility characteristics: The Expert Panel acknowledged that the potential for APNs to positively impact resident quality of care is markedly jeopardized and/or impossible in nursing homes where Registered Nurse (RN) staffing falls well below identified federal recommendations of .75 hours per resident day or a ratio of 1:32 RNs to residents and 1.3 hours per resident per day for licensed nurse (RN/LPN) 1:18 residents.[18, 19] The competency of the RNs and the RN/LPN ratio is critical. The collaborating MD and/or Medical Director are most effective, where practicable, if they are geriatricians. Other nurse staffing issues, including high RN, LPN and nursing assistant turnover and low nurse coverage at night and weekends also negatively impact on APN effectiveness.

Other facility characteristics that increase the effectiveness of APN practice include Director of Nursing support, policies that limit transfer to hospitals and/or

emergency rooms, and availability of pharmacy, laboratory, and other diagnostic services

Strategy 5: Change Medicare reimbursement to acknowledge the value of currently non-billable time APNs, physicians and PAs spend in resident care

Background: Nursing home visits are the highest category of visits billed to Medicare by all NPs (personal communication, E. Sullivan-Marx, PhD, RN, FAAN, 10 15 03). However, these billed visits do not in any way account for all APN time spent with residents. Irrespective of model of practice, and as previously noted, NPs spend approximately 50% of their time on non-reimbursable activities .[9, 17] The Expert Panel recommended changes to Medicare reimbursement to acknowledge the non-billable time APNs, CNSs, physicians and PAs spend in resident care.

As professional nurses, APNs are comfortable and expect to take a proactive role in interacting with residents, family and staff. Unfortunately, many of these activities, which enhance resident outcomes, are currently not billable. Several studies report on the billable activities of NPs in nursing homes.[2, 9, 13, 16, 17] Rosenfeld et al[9] found that NPs made sick/urgent resident visits (96%), provide preventive care to long-stay residents (88%), and perform alternating required regulatory 30/60 (88%), hospice care (80%) and wound care (78%). NPs employed by LTC facilities (Model 3 above) performed an average of 12 activities and were statistically more likely to be considered highly effective in areas that directly impact clinical care such as quality assurance, protocol development, and employee health, all non-billable activities as compared to NPs who were not facility employees. Kane et al report that family members in Evercare, which

has flexibility as to what services NPs can provide, report greater satisfaction than did controls,[20] and that patients were managed in a more cost-effective manner.[21]

Assuming that reimbursement acknowledged the value of these services, the Expert Panel proposed 2 strategies for strengthening APN involvement in non-billable activities:

- For nursing homes where APNs care for up to or more than 20% of residents, nursing home contracts with physicians, physician groups and managed care companies stipulate a mechanism for the APN to participate in the home's committee structure; care planning conferences; quality assurance activities; the survey process; etc. In rural areas, where distances are so great that the APN may not visit a particular facility very often, the Panel recommended that the APN be allowed by the reimbursement rules to serve in place of a physician on some committees.
- That Medicare reimburse APNs, physicians, and PAs for non-billable activities that directly impact clinical care. Such activities include:
- Participation in care plan meetings/care conferences with family and resident
- Family communication particularly when it becomes lengthy, e.g. > 15 minutes
- Rehabilitation meeting participation (particularly in subacute)
- Daily rounds with nursing staff
- Employee health
- Reviewing labs, x-rays, and consults
- Impromptu care plan sessions with hospice and care teams
- Nursing education

Strategy 6: Create technical assistance materials to promote a climate conducive to APN practice in nursing homes

Background: The Expert Panel recommended the creation of technical assistance materials to assist nursing homes prepare for the involvement of APNs in resident care. The purpose of these materials is to strengthen the potential of APNs to improve both resident outcomes and to model care that can improve nursing home outcomes, including staff satisfaction and retention, and reimbursement for resident care.

For the nursing home, technical assistance should promote**:**

- nursing, medical, and all other interdisciplinary team members, and administrative staff understanding of the APN credentialing, responsibilities, and role
- family and resident understanding of the APN role
- a structure/process for collaboration between the APN and facility staff (director of nursing, medical director, attending physicians, admin/owner, quality assurance, staff educator, Minimum Data Set (MDS) coordinator)
- communication patterns that address clinical responsibility for resident care among the APN, nursing staff and physicians
- a process that fosters communication between all interdisciplinary professional and paraprofessional staff
- the use of standardized protocols and guidelines to maximize efficiency

For APNs, technical assistance should promote**:**

- an appreciation of how the culture, regulations, reimbursement and politics impact the nursing home

- an appreciation of staffing issues that jeopardize resident care (staffing levels and preparation, retention, and turnover)
- clarity as to the homes' expectations of APN and MD responsibilities

In summary, the practitioners, researchers, and public policy specialists on this APN expert panel provide six substantive and detailed strategies to strengthen the use of APNs in nursing homes. For the first time, practitioners, payors, regulators and consumers are provided with detail on current APN practice models and caseload parameters, preferred geriatric education, reimbursement strategies, and a range of technical assistance necessary to strengthen, enhance, and increase APNs in the care of nursing home residents.

Table 1. Recommended Strategies to Strengthen APN[*] Practice in Nursing Homes

1.	Increase employment/utilization of APNs
2.	Require geriatric content in educational programs preparing APNs
3.	Reflective of current APN practice, use 14-18 reimbursable APN visits per day as the average for nursing home residents (assuming an eight hour day and normal range of initial, ongoing, episodic, and non-billable activity for APNs caring for nursing home residents)
4	Consider APN characteristics and practice models, resident acuity, and facility characteristics in determinations about the impact of APN caseload on resident quality of care. Current APN practice suggests, on average 20 or more reimbursable visits per day as the level that may raise concerns about quality of care (assuming an eight hour day and normal range of initial, ongoing, episodic, and non-billable activity for APNs caring for nursing home residents)
5.	Change Medicare reimbursement to acknowledge the value of currently non-billable time APNs, physicians and PAs[†] spend in resident care
6.	Create technical assistance to nursing homes to promote a climate conducive to APN practice in nursing homes.

[*] Advance Practice Nurse
[†] Physician Assistant

Table 2. Graduations of Advance Practice Nurses (APNs) 2003

	GNP*	GCNS†	FNP‡	ANP§	CNS-Adult‖	Med-Surg CNS¶	Psych/Mental Health NP-Adult#	Psych/Mental Health CNS-Adult**
Programs	62	45	262	131	52	90	41	61
Graduates	122	19	3031	955	179	180	162	93

Adapted from Berlin, Stennett, Bednash [14]
* Gerontological Nurse Practitioner
† Gerontological Clinical Nurse Specialist
‡ Family Nurse Practitioner
§ Adult Nurse Practitioner
‖ Acute and Critical Care Clinical Nurse Specialist-Adult
¶ Medical-Surgical Clinical Nurse Specialist
# Adult Psychiatric/Mental Health Nurse Practitioner
** Psychiatric/Mental Health Clinical Nurse Specialist-Adult

Table 3. Models of APN* Practice and Caseload Parameters

Model of Practice	Caseload	Visits/Day
Model 1: APNs employed by or contracted with primary care physicians or physician groups (60% of practices)		
Fallon Group: 50% Medicare & 50% MCO†	120-180 residents in ≤3 facilities	8-10 visits, with goal of 12-14
Geriatric Associates of America: Fee for Service/collaborative practice	180-240 residents	8-10 routine visits plus 3-6 episodic visits
HealthEssentials: Collaborative practice in 17 states	150 residents in 1-3 facilities	15 RVUs‡
Model 2: APNs employed by managed care organizations (MCO) (38% of practices)		
Evercare	80-110 residents (average 100)	13.2 mean visits
Kaiser Permanente	200 residents	12-14 visits
Model 3: APNs employed by a facility		

* Advance Practice Nurse
† Managed Care Organization
‡ Relative Value Unit

(19% of practices)		
Department of Veterans Affairs	10-60 residents	15-20 visits
Wellspring	APN shared by 11 facilities	
Model 4: APNs as independent providers		
(% practices unknown)		
Priest NP[§] Services: collaborative, independent NP practice	200-250 residents	16-18 visits
Geropsychiatric Practices: O'Dowd; Baradell		7 visits

[§] Nurse Practitioner

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