



ADVANCED PRACTICE PROVIDERS (APPS): WHO ARE WE TALKING ABOUT?

BY: Dr. Terry McWilliams

HSG has adopted using Advance Practice Providers (APPs) as the naming convention for non-physician, direct care providers in the office setting. The categorization comprises Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs) – such as Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs), and Clinical Nurse Specialists (CNSs) – as these individuals have been utilized to augment physician capabilities in traditional employed network settings. These same individuals have also been characterized equally effectively as Advanced Practice Professionals (APPs), Advanced Practitioners (APs), and Non-Physician Providers (NPPs).

Since the nation does not currently embrace a common naming convention, HSG feels compelled to define who we are talking about when we mention APPs and provide sufficient background information so organizations can make informed decisions when contemplating the addition of APPs to their care delivery models.

Expansion of the traditional office-based care delivery model to integrate Behavioral Health services (psychologists and mental health counselors), add resources to more expansively address chronic conditions (dietitians and patient educators), and incorporate capabilities to address social determinants of health (social workers) may necessitate expansion of the APP concept to a potentially more inclusive designation, such as Advanced Practice Professionals.

In contrast, Medical Staffs often collectively include all non-physicians with clinical privileges – including APRNs and PAs – in a single staff category known as Allied Health Professionals (AHPs). In many Medical Staff, AHPs are not considered Medical Staff members and are, therefore, not considered as “equals.” This traditional paradigm can influence perceptions about APP utilization. In addition, most definitions of Allied Health Professionals are quite expansive and more inclusive than even the traditional Medical Staff components would signify – and much more expansive than extended scopes of office-based services. The Allied Health Professionals categorization includes upwards of 80 professions accounting for 60% of the healthcare workforce.^{1,2} For these reasons, HSG recommends against referring to APRNs and PAs as AHPs.

A driving factor for standardizing our APP naming convention is directly related to our work with health systems and employed networks in expanding proper APP adoption and utilization in care delivery model transformation. Defining our references unifies our thought leadership and moves physician leaders away

from the AHP paradigm mentioned above while mitigating potential barriers and striving toward top-of-license usage.

For our purposes, we will expound on the limited APP designation outlined above as that which most directly correlates to HSG's sphere of influence.

Advanced Practice Registered Nurses (APRNs)

An Advanced Practice Registered Nurse (APRN) is a registered nurse with additional education and training resulting in a master's degree in nursing (MSN) or practice-focused Doctor of Nursing Practice (DNP) degree in one of four specific clinical care delivery roles³ – Nurse Practitioner, Nurse Anesthetist, Nurse Midwife, and Clinical Nurse Specialist.

Upon completion of the education and training program, graduates pursue national certification through either the American Association of Nurse Practitioners (AANP) or American Nurses Credentialing Center (ANCC). The AANP exam is felt to be more clinically focused and permits adding the credential of "certified", e.g., FNP-C. The ANCC exam is felt to be more research, theory, and academically focused and permits adding the credential of "board certified", e.g., FNP-BC. Both are valid for meeting reimbursement guidelines for Medicare, Medicaid, and other health insurers and for working in a Magnet designated facility.⁴

APRNs are licensed through state boards of nursing to provide patient care within their role, patient population focus, and state regulatory parameters. As of December 2019, 28 states permit independent NP practice – 14 under all circumstances and 14 after a specified time under physician oversight.⁵ The remaining states require at least a formal collaborative relationship between an NP and a physician. As of June 2019, 17 states permit independent CRNA practice based on a CMS physician supervision waiver that has been available since 2001. Independent practice is key to patient access and care delivery in many rural settings.

Nurse Practitioners (NPs)

Nurse Practitioners are the most common type of APRN, representing well over half of the total number of advanced practice nurses in 2017 (U.S. Department of Health and Human Services).³ NPs are qualified to provide a range of both primary and acute health care services where they diagnose and treat medical conditions and perform many of the same tasks as physicians. The education and training curricula focus on six areas of "specialty" concentration – Family, Adult-Gerontology, Women's Health, Neonatal, Pediatrics, and Psychiatric/Mental Health. Studies indicate that NPs are estimated to be able to perform approximately 85% of primary care physician tasks⁶ with comparable quality⁷ and lower cost.⁶

While the "best fit" for NPs tends to be in a primary care environment targeted on providing preventive and wellness care; office-based (minor) acute care; stable chronic condition management; and patient education, scope complexity varies based on prior RN experience and subsequent NP experience.

In addition, NPs often elect to practice in other specialty areas – frequently influenced by their prior RN experiences. The base NP expertise proves invaluable in other specialties but full utilization typically requires augmentation with specialty-specific depth of knowledge through didactic and mentoring options. A specific example is acquiring or expanding surgical assistance skills through RNFA programs.

Certified Registered Nurse Anesthetists (CRNAs)

Nurse anesthetists are APRNs who are qualified to administer anesthesia to patients for surgery and other procedures and to provide immediate pre- and post-anesthesia care. CRNAs perform physical assessments of patients; manage medications used for pain management, sedation, and general anesthesia during procedures; and monitor patients emerging from anesthesia culminating in a PACU handoff. CRNAs have been utilized in almost all healthcare settings as part of the anesthesia care team (ACT) to extend the reach of anesthesiologists – particularly given the chronic national shortage.

Becoming a nurse anesthetist requires completing a graduate degree program that qualifies for certification through the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) prior to applying for APRN state-licensure. The required graduate degree is changing from Master of Science in Nurse Anesthesia (MSNA) to a DNP by 2025.⁸ The change reportedly requires “as few as 32 credit hours of online coursework”⁸ for current master’s level CRNAs.

Certified Nurse Midwives (CNMs)

CNMs provide primary health care services for women starting in adolescence and continuing throughout their lifetimes. Contrary to public impression limited to home birthing experiences, nurse-midwives provide gynecological and family planning services; prenatal, perinatal, labor and delivery, and postpartum care; and treatment of male partners for sexually transmitted infections.

Integrating midwifery in an obstetrical service line can not only extend existing obstetrical services but can also measurably expand an organization’s market share by offering an appealing patient experience for a specific client sector that cannot be captured by a physician-only paradigm. The addition of well trained and supported midwives can be a differentiating feature in a market.

Becoming a nurse-midwife requires completing a graduate degree program that prepares individuals to take the Certified Nurse-Midwife examination offered by the American Midwifery Certification Board (AMCB) prior to applying for state-licensure.

Clinical Nurse Specialists (CNSs)

Less well known than NPs, CNSs usually work in a specialized area of nursing practice and often do not deliver direct patient care – as opposed to the typical NP who tends to deliver direct patient care, most commonly in a primary care environment. A CNS’s role can be defined by parameters such as medical specialty (e.g., oncology, mental health), chronic condition (e.g., diabetes, pain management, eating disorders), population (e.g., children, seniors, women), or care setting (e.g., critical care, emergency room, rehabilitation).³

Clinical nurse specialists often take on advisory or management roles in their selected field, advancing the practice of nursing through education, consultation, project management, clinical expertise, and research. Typical roles include serving as educators or outcome managers, supervising other staff or overseeing cases to ensure the best possible treatment outcomes, guiding and educating patients and their families through the complexities of modern specialty treatment, and supporting shared decision-making processes with facts and perspective.³

The education path involves attaining a master's degree or higher from a clinical nurse specialist program (Clinical Nurse Specialist Master of Science in Nursing (MSN)) followed by national specialty certification through either the American Association of Critical-Care Nurses (AACN) or the American Nurses Credentialing Center (ANCC) leading to state licensure. Of note, several states do not currently recognize CNSs in their APRN licensing process, including Alabama, Michigan, Mississippi, and New York.

Physician Assistants (PAs)

Miriam Webster defines a physician assistant as a person certified to provide basic medical services usually under the supervision of a licensed physician⁹ while the American Academy of Physician Assistants (AAPA) indicates that PAs are medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as a patient's principal healthcare provider.¹⁰

PAs are educated in the medical model (i.e., similar to the medical school approach) with close physician involvement in curriculum development and execution. The AAPA site indicates that during "... the didactic phase, students take courses in basic medical sciences, behavioral sciences, and behavioral ethics. In the clinical phase, students complete more than 2,000 hours of clinical rotations in medical and surgical disciplines, including family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry."¹⁰

Entrance requirements mirror those required for medical school – a bachelor's degree and completion of prerequisite courses in basic and behavioral sciences. Interestingly, incoming PA students bring with them an average of more than 3,000 hours of direct patient contact experience, having worked as paramedics, athletic trainers, medical assistants and other clinical areas.¹⁰ This statistic is impressive as most assume that PAs do not have a prior clinical background and most assume that APRNs do – even though many are now entering post-graduate programs immediately after completing their undergraduate program (the exception being CRNAs, who are required to have at least one year of clinical experience prior to post-graduate program acceptance).

At the conclusion of the program's three academic years, PAs are conferred a master's degree and are eligible for national certification through the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants (NCCPA). Successfully completing the certification exam adds the credential of PA-C.

State licensure requirements vary but all states require PAs to practice under a collaboration or supervision agreement with a physician, though most states do not require the physician to be physically present when care is rendered nor require that the physician countersign each medical record entry.

PAs are quite adept at providing primary care services without further training. Studies indicate that PAs are estimated to be able to perform approximately 80% of primary care physician tasks⁶ with comparable quality⁷ and lower cost.⁶

Since PAs are exposed to a broader spectrum of specialties during their educational and training process, they are often preferentially sought in specialties other than primary care – particularly surgical specialties.

Full competency in some specialties require augmentation of basic skills through close on-the-job mentoring.

Anesthesiologist Assistants (AAs)

Anesthesiologist Assistants are being included in this review since they are essentially the PA equivalent to CRNAs. AA programs first appeared in 1969 and currently provided through 11 accredited programs⁸ associated with medical school departments of anesthesiology. Program completion results in either a Master of Science in Anesthesia or a Master of Medical Science degree. Graduates must then pass a certifying examination administered by the National Commission of Anesthesiologist Assistants (NCCAA) in collaboration with the National Board of Medical Examiners (NBME).

The educational curriculum, matriculation prerequisites, and most other program elements mirror those for physician assistant programs. Similarly, AAs work with and under the supervision of an anesthesiologist on the anesthesia care team (ACT). Skill sets and outcomes tend to be identical and interchangeable with CRNAs (short of any permitted independent practice).⁸

We hope this overview helps organizations make informed APP integration decisions and better understand HSG thought leadership. Please let us know if we can be of any assistance with developing and implementing APP strategies by contacting [Dr. Terry McWilliams](#) directly.

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