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The year was 1965. U.S. troops were in Vietnam. Civil rights protests were being staged in D.C. and around the country. Politics, race and gender were at the forefront of what would become historic upheavals by the end of the decade. America's social fabric was showing signs of revolutionary change. Many institutions and issues were stirred by the energy of this time, and the health care industry was no exception.

One of the major concerns of the day focused on providing health services for underserved groups. Loretta Ford, at that time a public health nurse who was on the faculty at the University of Colorado, saw a need to expand the services of public health nurses who filled many roles in rural areas of the state. Together with Dr. Henry Silver, a pediatrician at the University of Colorado Medical Center, they began developing a graduate curriculum to educate nurses, creating a model for the role of nurse practitioners. Six months after they started, they had a curriculum developed and used it as a pilot program with one student.

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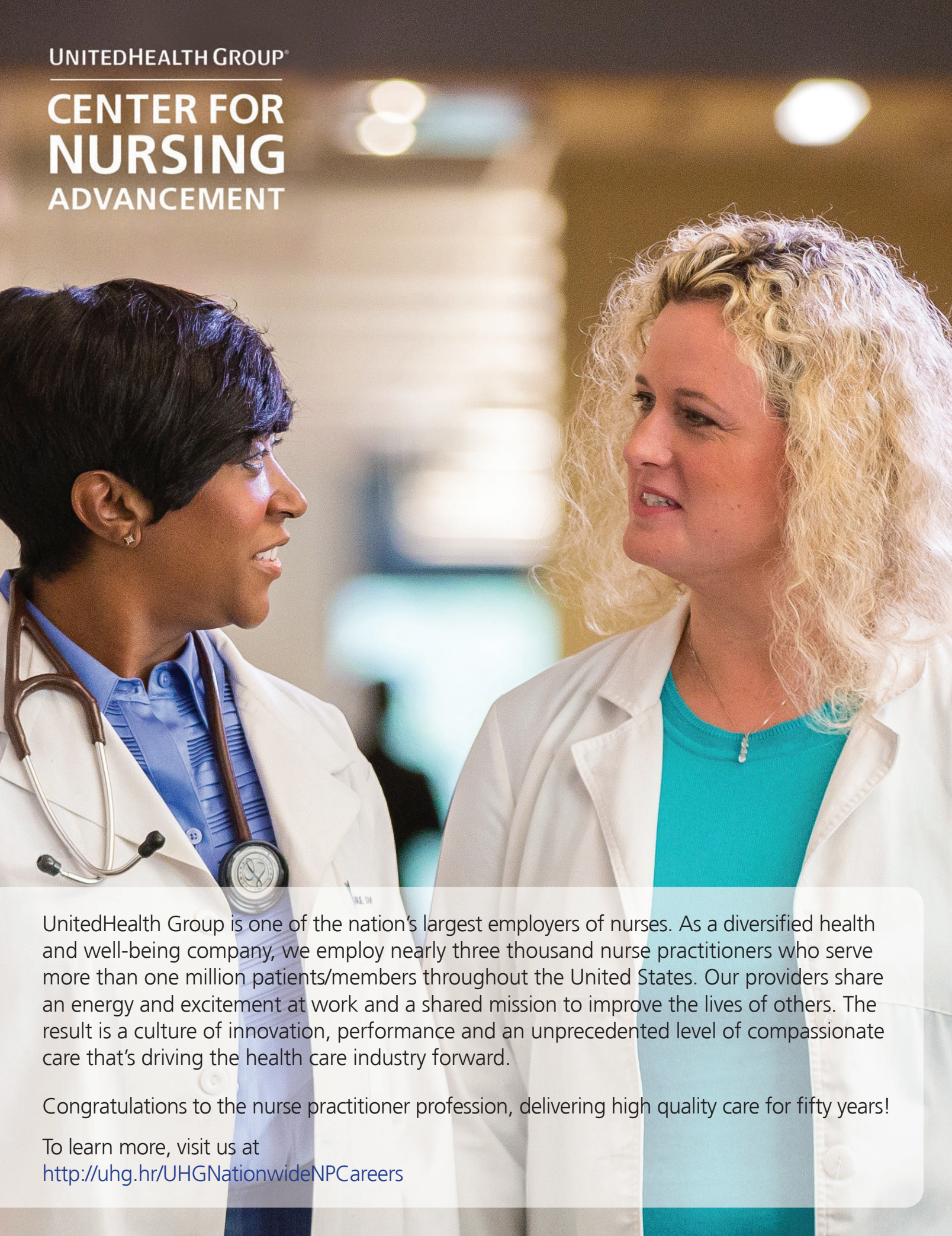
This 50th Anniversary book provides an up-close and personal look at health care and the nurse practitioner. We are grateful to everyone who contributed to the book by sharing moments of a remarkable history. As we reflect on half a century of achievement and look ahead toward a bright and rewarding future, AANP applauds NPs for consistently providing high-quality, comprehensive, personalized and patient-centered care in primary, acute and specialty health care settings - care that brings positive recognition to the NP role.

Sincerely,

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A photograph of two healthcare professionals, a Black woman on the left and a white woman on the right, both wearing white lab coats. The Black woman has a stethoscope around her neck and is looking towards the white woman. The white woman has curly blonde hair and is looking back at the Black woman. They are in a brightly lit hospital hallway with blurred lights in the background.

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Table of Contents

Welcome Letter from AANP Leadership	5
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INTERVIEWS

A Conversation with Loretta C. Ford	42
By Craig Collins	

Interview with Sarah Thompson, PhD, RN, FAAN Dean, College of Nursing, University of Colorado	67
By Gail Gourley	

Interview with Doreen C. Harper, PhD, RN, FAAN Dean and Fay B. Ireland Endowed Chair at the University of Alabama at Birmingham School of Nursing.....	89
By Gail Gourley	

Interview with Eileen Breslin, PhD, RN, FAAN Dean, School of Nursing at University of Texas Health Science Center San Antonio	107
By Gail Gourley	

Interview with Julie Marfell, DNP, APRN, FNP-BC, FAANP Dean of Nursing, Frontier Nursing University.....	158
By Gail Gourley	

FEATURES

Loretta C. Ford and Henry K. Silver	12
<i>The Founding of Nurse Practitioner Education</i> By Craig Collins	

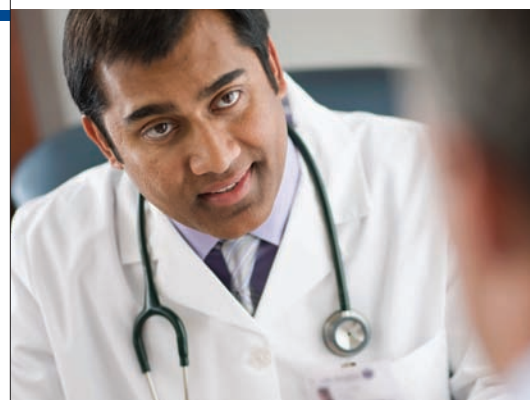
The American Association of Nurse Practitioners: Speaking with One Voice.....	20
By Craig Collins	

Past Presidents of AANP and ACNP	37
--	----

The Fellows of AANP: Leading the Way	38
By Craig Collins	

NP Education Reflects 50-Year Effort to Promote Excellence	56
By Charles Dervarics	

An Expanding Role	72
<i>Particulars of the NP Profession</i> By Eric Tegler	



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Nurse Practitioner Subspecialties	79
<i>AANP's Dr. Mary Ellen Roberts Discusses the Trend Toward Specialization</i>	
By Eric Tegler	
The Certification Landscape	82
<i>AANPCP's Dr. Diane Tyler on NP Certification in 2015</i>	
By Eric Tegler	
NP Certification Historical Timeline.....	83
By Diane Tyler, PhD, RN, NP-C, FAAN, FAANP, CAE	
AANP Enhancing Its Research Capacity	95
By Charles Dervarics	
Closing the Policy Gap.....	96
<i>AANP's Effort to Extend the Benefits of Full Practice Authority Nationally</i>	
By Jan Tegler	
Why I Chose to Be an NP	114
By Gail Gourley	
Demand for Nurse Practitioners at an All-Time High	135
By Jeff Waddill	
The Military, Veterans, and the Expanding Role and Need for Nurse Practitioners	143
By Chuck Oldham	
The Future of NP Education and Practice	146
By Charles Dervarics	
AANP Conferences	165
By Ana E. Lopez	
Nurse Practitioners Mark 50 Years with a Celebration of the Past and a Look to the Future	166
By David A. Brown	
Like, Share, and Spread the Word: AANP and Social Media.....	173
By Ana E. Lopez	

RESOURCES

Historical Timeline	175
NP Facts	177
NP Infographic	179
AANP Position Papers*	181

*AANP is reviewing and updating additional position papers,
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Loretta C. Ford and Henry K. Silver

The Founding of Nurse Practitioner Education

BY CRAIG COLLINS

It's often pointed out that the role of the nurse practitioner (NP) was born of the political and social turmoil of the 1960s, but to assume the nursing profession was riding the coattails of the civil rights movement is to form an incomplete picture. Many of the factors that led to the NP role were distinct from other crises of the era.

In the mid-20th century, Americans increasingly lacked access to health care – in part because so many doctors and nurses had volunteered or been called to serve in the Vietnam War – and there was growing concern for the underserved, particularly the nation's children. Urban populations grew beyond the capacity of health care providers, and rural populations continued to suffer from inadequate medical infrastructure. As the demand for health care continued to grow, the cost of it continued to rise. The Great Society programs of President Lyndon Johnson were, in part, aimed at improving these health care disparities through the creation of the Medicare and Medicaid programs.

Many American nurses, meanwhile, had simply chosen to become inactive rather than work within a system so rife with inequality: poor salaries, substandard working conditions, a lack of benefits, and a career that offered few options for advancement – the ladder generally led upward to administrative and academic positions, and away from patient care.

Early attempts to create advanced practice programs for nurses failed for several reasons: Initiated by physicians and social scientists, rather than nurses, they were generally hospital-based and tailored to hospitals' needs. These programs tended to culminate in a

master of science in nursing (MSN) degree in either functional areas – education, supervision, or administration – or specialty areas such as anesthesia.

An MSN program created at Duke University in 1958 was different. Established by a nurse, Thelma Ingles, and a physician, Dr. Eugene Stead, its curriculum expanded the scope of nursing practice to include skills such as taking patient histories and performing physical examinations. Ingles and Stead envisioned a future in which their graduates could work in the clinic as responsible and independent providers – that patients would be told to come in and “see the nurse,” and that the nurse would be paid a per-visit call in the same way a doctor might. They hoped to grant nurses much greater autonomy in diagnosis, treatment, and follow-up than had been the tradition.

Such a future would have been well in line with the universally accepted definition of nursing soon to be put forth by Virginia Henderson, arguably the 20th century's most famous nurse educator:

The unique function of the nurse is to assist the individual, sick or well, in performance of those activities contributing to health or its recovery (or a peaceful death) that he/she would perform unaided if he/she had the necessary

strength, will or knowledge. And to do this in such a way as to help him/her gain independence as rapidly as possible.

And yet the role envisioned by Ingles and Stead was so new and different that it failed to gain acceptance, most notably from within the nursing profession itself. The National League for Nursing (NLN), the lead organization for faculty nurses and leaders in nurse education, refused to grant accreditation to the Duke program despite three attempts, and as a result, students stopped enrolling. The program was discontinued in 1962.

Ford and Silver Join Forces

It wasn't long, however, before a new champion took up the gauntlet and revived this ambitious vision of the nursing role. Loretta “Lee” Ford had been a nurse for nearly a decade – for the Visiting Nurse Service (VNS) in her native New Jersey, and then as a first lieutenant in the Army Air Forces – by the time she earned her MSN degree from University of Colorado-Boulder (CU) in 1949. She earned a public health nurse (PHN) certificate and soon afterward became director of nursing for the Boulder City-County health department.

At the time, there were two types of well-child clinics in rural Colorado: permanent clinics attended by physicians, and temporary, intermittent nursing clinics run by public health nurses without physicians in attendance. Ford found health care – especially pediatric



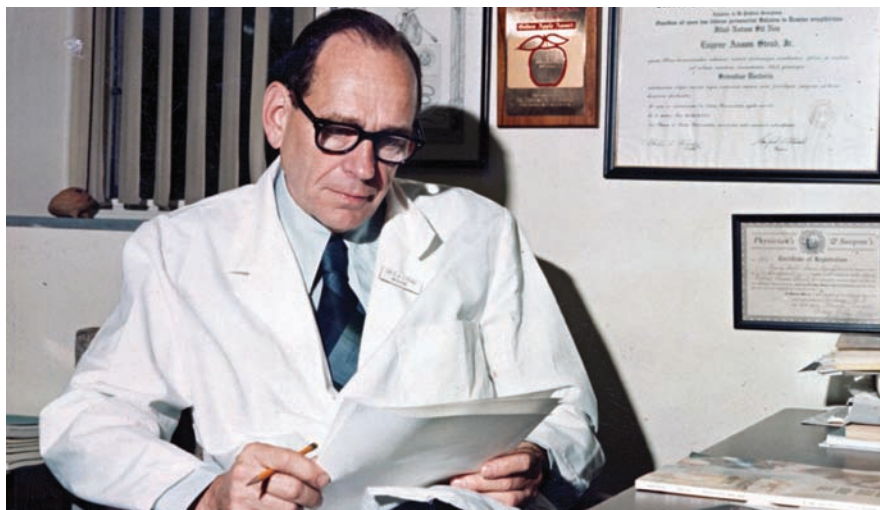
care – in the surrounding rural communities to be seriously lacking, and believed public health nurses, if they were capable of running their own clinics, could be trained to deliver basic primary care to these underserved areas.

Ford also had the vision to understand that this change would have to be effected within the context of a nursing education program. She continued her studies as she practiced, earning a PhD in nursing education

Drs. Loretta Ford and Henry Silver, co-founders at the University of Colorado of the first nurse practitioner education program, lead project rounds with students from the first four pediatric nurse practitioner cohorts in 1966. Pictured from left to right are Audrey Dahlen, Heather Walters, Maddie Nichols, Sue Stearly (the first student in Ford and Silver's NP program), Loretta Ford, Henry Silver, Mary Alexander Murphy, Jane Conwin, Rosemarie Egle, Nancy Brown, and Mary Alice Rude.

from CU in 1961. By 1965, Ford was a full professor in the CU College of Nursing, which had moved to Denver.

Smart, compassionate, driven, and disciplined, Ford had acquired a big-picture view of health while earning her degrees: "As an educator," she said, "you're always looking for ways to advance the field to be more valued, and more valuable, to the public. Nursing should focus on public need, and in that sense you need to be concerned not only with the family,



but the environment in which that family lives and works, and also with the need for a change in the culture, from a focus on sickness to a focus on wellness and health.”

It was while serving on the search committee for a new dean for the College of Nursing that Ford began discussing her ideas with Dr. Henry Kempe, the world-renowned chair of pediatrics at the CU Medical Center. Kempe agreed that advancing the practice of public health nurses, to include many of the routine clinical tasks typically performed by physicians, was the most logical solution to the lack of adequate care for rural children and families.

The catch – as Ingles and Stead had acknowledged in forming their program at Duke – was that because the role of the nurse had been restricted for so long, no nurse educator was qualified to teach nurses how to perform these tasks. Kempe recommended that Ford speak with his second-in-command, Dr. Henry Silver, a pediatrician desperate to find ways to connect underserved children with primary care services. Silver had himself just returned from a conference at which he’d received multiple complaints from public health nurses about inadequate pediatric services in rural areas. If Ford and Silver joined forces, Silver could teach the students clinical skills – how to

In the late 1950s, Dr. Eugene Stead and Thelma Ingles, a nurse, worked together at Duke University to devise an MSN curriculum that expanded the scope of nursing practice. The program failed to gain acceptance and was discontinued in 1962.

take medical histories, perform basic tests and routine examinations, and provide immunizations, among other things – and Ford could design the nursing curriculum and ensure that the program conformed with the nursing model, which focused on wellness, health promotion, and disease prevention, rather than the “sick care” model favored by the medical establishment.

Ford and Silver began to discuss and outline a curriculum for a training program that would produce nurse practitioners capable of these primary care tasks. They surveyed rural public health nurses to learn what these nurses needed to know in order to perform this advanced practice role. The role was initially named the public health nurse pediatric nurse practitioner, but was later shortened to the pediatric nurse practitioner (PNP).

The demonstration project, launched in 1965, was designed to evaluate the efficacy and viability of the PNP, after which the program could be integrated into the graduate curriculum. Taught

by physicians and nurses, the project would involve an intensive four-month academic study of theory and practice, followed by an eight-month supervised practice clinical rotation.

Dr. Ric Ricciardi, a nurse practitioner and acting director of the Division of Practice Improvement at the federal Agency for Healthcare Research and Quality, paid tribute to Silver, his longtime friend, in the September/October 2015 issue of the *Journal of Pediatric Health Care*. The two met in 1983, when Ricciardi was studying to become a pediatric NP at Fitzsimmons Army Medical Center in Aurora, Colorado. After he had known Silver a while, Ricciardi said, he asked him why he’d decided to launch the PNP training program with Ford.

“His main reason was that he wanted to improve access to care,” said Ricciardi, “and he felt the nurses were highly capable clinicians and well positioned to meet the needs of underserved populations – and that his own discipline, medicine, was not doing enough to reach out to children and families in underserved areas. And, too, he knew the skills necessary to do some of this work didn’t require physicians – as Henry would say, ‘Much of what we do as physicians can be done by nurses’ – and that nurses had a keen understanding of the most necessary concepts, particularly prevention. Prevention just wasn’t

being taught in med schools at that time. The medical school curriculum was very much disease-focused.”

A “New Breed of Nurses”

The initial demonstration project for the PNP training program, funded by a modest grant from the CU School of Medicine, began with one student, Susan Stearly, a seasoned public health nurse with a master’s degree who had just completed a two-year stint with the Peace Corps in Honduras.

From the start, the project faced stiff resistance from nursing faculty, who didn’t like the idea of “vanguard” nurses with advanced skills – they viewed it as a denigration of the nursing role, particularly because the nurses were being taught by a physician. In a commemorative reflection published in the March 2015 *Fellows of the American Association of Nurse Practitioners (FAANP) Forum*, “Reflections on Fifty Years of Change,” Ford wrote: “While we, pediatrician Henry K. Silver and I, thought we were complying with the nursing organizations’ professed goals: autonomous practice, collegueship with physicians, health and prevention of disease, partnership with patients, surprisingly our efforts to expand the public health nurse’s role in well child care were met, especially by nurse educators, with criticism, skepticism, and suspicion.”

Ford struggled to convince her colleagues that nurses, in learning to perform physical exams and use stethoscopes, weren’t abandoning the nursing perspective in favor of medicine, but faculty were slow to come around. “I think,” said Ford, “we were getting much more attention than some of my colleagues enjoyed.”

Indeed, the program received national exposure in its first year: The July 22, 1966 issue of *Time* magazine included a short feature on the program, “Nurses: Where Doctors Don’t Reach,” which profiled the new PNP program and followed its first graduate, Stearly, on her rounds in

and around the town of Trinidad in southeastern Colorado, a depressed rural area where the physicians-to-people ratio was roughly 1-to-3,000.

To read this *Time* article today is to receive an eye-opening lesson in the health care power structure of the 1960s. While praising the “new breed of nurses,” the article takes great pains to reassure readers that Stearly isn’t trying to practice medicine, and is working under the close supervision of “its founder, Pediatrics Professor Henry Silver.” Silver is interviewed extensively in the article, which refers to the program as “his program” and the graduates as “Dr. Silver’s nurse-practitioners.” Ford isn’t mentioned at all in the article.

The article also takes a skewed view of the nurse practitioner’s core purpose:

Trinidad’s new nurse was the advance guard from a University of Colorado School of Medicine program designed to lighten the work loads of practicing physicians by training nurses to perform most of the duties of a pediatrician, and to carry medical care to the children of poverty-stricken laboring families, including many Spanish-Americans, who rarely consult a doctor except in dire emergencies.

Ford has always been described as a warm, generous person, never quick to anger, but there is no surer way to irritate her than to suggest the nurse practitioner role was created to “lighten the work loads of practicing physicians.” In “Reflections on Fifty Years of Change,” she wrote: “Despite our efforts to clearly state that our goals were to meet the health needs of children in the community, still today, I read articles in journals reporting the NP was introduced to relieve the physician shortage. Can you imagine a nurse educator risking her career for medical deficits?”

Today, when asked about the *Time* article, Ford is understandably reticent. “I was happy for Sue,” she said. “I real-

ly didn’t have any other feelings about it. I realized that back then physicians had the power, and they still have a tremendous amount of power and control. It didn’t bother me, because in a way, Henry and I went in different circles. He took care of things in medicine, and of other things, like the interview with *Time*. And of course the *Time* reporter would call him, rather than me. But I had plenty of things to do.”

And there was much to be done on the heels of the demonstration project’s completion: By all accounts it had been a success, and Stearly had excelled in her role as nurse practitioner. Ford set about collecting data that would validate the PNP education and establish admission standards, academic requirements, and accreditation criteria. She traveled extensively to other nursing schools and organizations, describing the PNP role and substantiating its successes.

Because the project still confronted such widespread skepticism among the CU nursing faculty, Ford and Silver decided not to attempt to integrate their advanced practice curriculum into the nursing school. Instead they chose to extend the project by four years, in order to gather more data and establish the model’s validity on a larger scale. The initial funding for the extension came principally in the form of a \$253,998 grant from the Commonwealth Fund, with smaller amounts coming from the Robert Wood Johnson Foundation and the federal Department of Health, Education and Welfare (now Health and Human Services).

The CU Project’s Legacy

The first class of CU nurse practitioner students, a group of about a half-dozen, began their studies in the fall of 1966. Despite Stearly’s success, Ford and Silver’s new program confronted several challenges. To have the necessary rigor, Ford wanted strict eligibility requirements: It would be open only to registered nurses with a master’s degree in public health

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Dr. Loretta Ford works with a student at Strong Memorial Hospital (SMH), University of Rochester Medical Center, in 1973. Ford left the University of Colorado to become the founding dean of the University of Rochester School of Nursing in 1972.

nursing. Not all of the incoming students, however, had master's degrees, and Ford assumed that many qualified candidates had opted to attend accredited degree programs rather than enter into a program that was still considered experimental – and perhaps a little sacrilegious – by the nursing establishment.

At the same time, because the nurse practitioner role was still so poorly understood, Ford and Silver had a difficult time finding clinical sites that would agree to work with the students. Fortunately, the Denver VNS stepped in to provide NP students with opportunities to practice their new knowledge and skills.

As Ford continued to travel the country and publicize the PNP concept and findings from her program, she began to realize she may have overestimated academia's potential to help grow this new advanced practice nursing role – the Veterans Health Administration, the military branches, and physicians themselves began to train nurse practitioners, in public health and other specialty areas, out of necessity.

Perhaps understandably, university nursing faculty did not feel this necessity quite as urgently. But over time, as the effectiveness and versatility of the NP role – and its clear philosophical roots in the nursing model – became clearer, the idea began to snowball, and demand among students compelled university nursing schools to offer NP training, and ultimately advanced NP degrees. This rapid growth briefly threatened to become the NP's undoing; as new programs in different specialties sprouted up around the country, faculty struggled to standardize and define what a "nurse practitioner" was.

Interestingly enough, CU's College of Nursing wasn't among the first to offer



an NP master's degree; until the 1980s, it offered the training as a certificate program through its continuing education department.

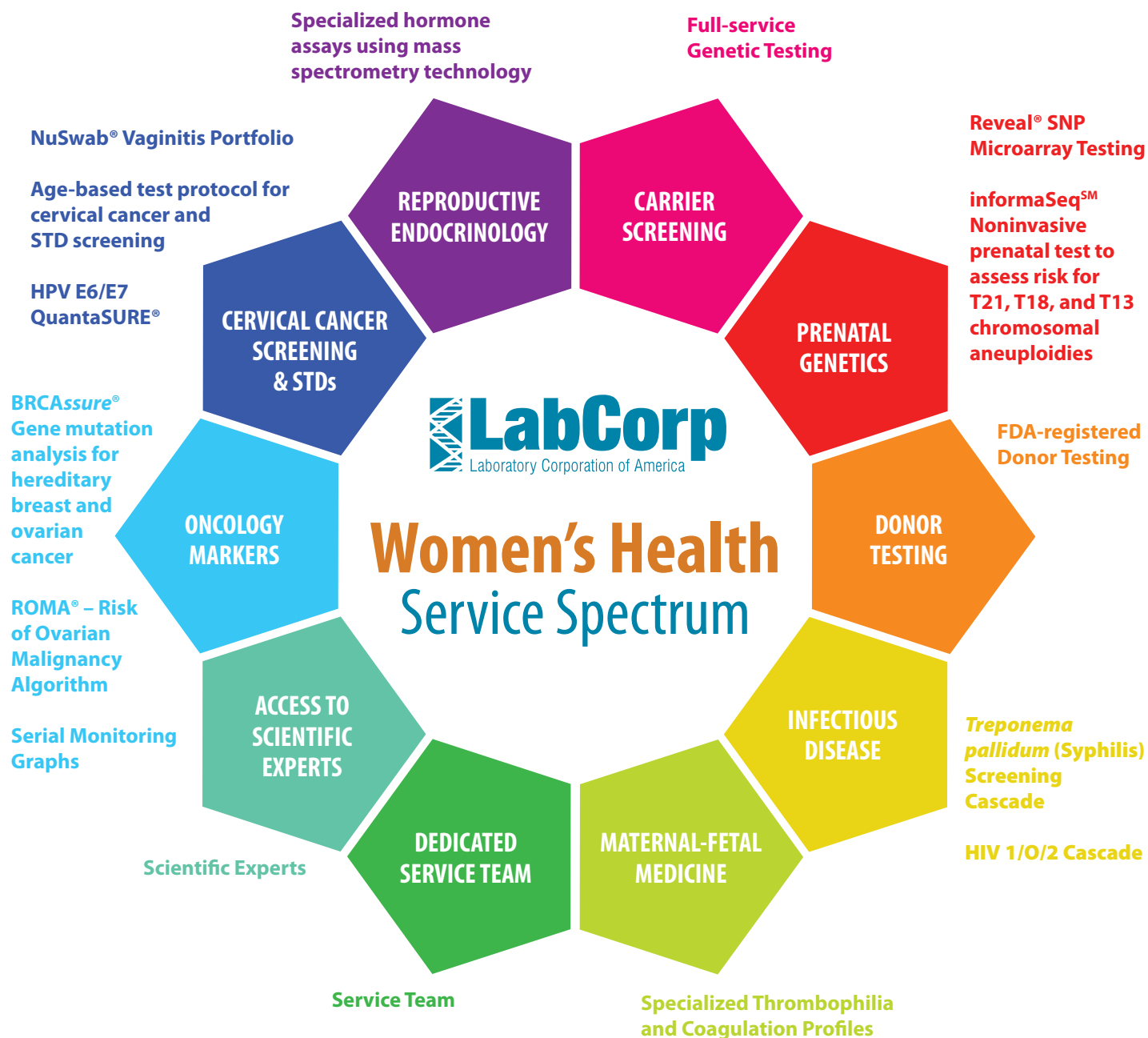
By that time, Ford had already moved on, lured away by the University of Rochester, which made her founding dean of its School of Nursing in 1972. At Rochester, Ford had the opportunity to put her big-picture vision of nursing to work, in a setting that was committed to the

preparation of nurse practitioners and nurses. The Rochester School of Nursing now has nine specialty NP programs, including a program in child psychiatry, which is helping to fill a need for mental health services in rural upstate New York.

While NP programs had begun to crop up all over the country by the mid-1980s, the turf wars were far from over within the health care establishment. Legislative battles over NPs' scope of

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practice, prescriptive authority, and provider status raged for years; today, 21 states and the District of Columbia have approved “full practice” status for NPs, allowing them to diagnose, assess, interpret tests and prescribe medications independently, and to operate their own independent practices in the same way physicians do.

The reasons behind the other 29 states’ lethargy in granting this status have much more to do with the politics of power and inertia rather than the needs of patients, but the number of NPs in American health care, and the evidence of their benefit, are becoming simply too overwhelming for this to be the case much longer. No other group of health care providers has been so carefully researched. Thousands of studies, looking at NPs from every angle – patient satisfaction, quality of care, cost-effectiveness, malpractice suit rates, and many more – have validated the model and brought NPs firmly into the mainstream of health care delivery. Today there are more than 2,000 NP education programs in 400 universities across the United States, producing approximately 17,000 NP graduates every year.

Silver, who went on to become the CU School of Medicine’s dean of admissions, died in 1991. Ricciardi says he still misses him. “Henry was ahead of his time in the way he thought nurses could be integrated in the care delivery model – and also in the way he valued nurses as members of a health care team,” he said. “Back in the sixties, nursing was undervalued by the policymakers, the health care payers, and the medical community. For a physician to elevate their status, to an extent they couldn’t do themselves, was truly remarkable.”

At the same time, said Ricciardi, it would be a mistake to remember Silver as a crusader only for the nursing profession. In his time at Colorado, he helped to create other roles – the child health associate and the pediatric physician assistant – to reach underserved children. “I would say the fundamental



bottom line for Henry,” Ricciardi said, “was that he cared about the patient above all ... Henry wasn’t saying, ‘We need to make nursing bigger and better.’ That’s not what he cared about most. He envisioned nurses as professionals and colleagues who are important contributors to improve access and quality of patient care.”

The world’s first nurse practitioner, Stearly, who married and became Susan Ripley in 1983, passed away in August 2015 at the age of 77. Her obituary, published in *The Santa Fe New Mexican*, read in part: “From the Pico Congolon Mountains of Central America to our magnificent Rockies, whether in major cities or tiny villages, Sue touched many hearts treating people of all ages.”

Ford retired from practice in 1985 and moved to Florida, but for the last 30 years, she has neither remained still nor kept quiet. Her tireless efforts to champion nurse practitioners and nurses continue, and she travels constantly to spread the message of their value and necessity. She turned 95 on Dec. 28, 2015.

After co-founding the first NP education program, Dr. Henry Silver went on to create the child health associate and pediatric physician assistant roles to improve access to care for underserved children.

Today widely regarded as one of the most influential nurses of the 20th century, Ford deflects all attempts to give her credit for the existence of more than 205,000 American nurse practitioners today. The credit belongs, she says, to those first NPs who showed the world what nurses could do: courageous pioneers and idealists, gifted and knowledgeable but often disillusioned, willing to take one last chance on the nursing profession. In combining their new clinical skills with nursing’s best principles, they revolutionized the profession and proved their relentless critics wrong.

“You know, the only way I’ve found you can deal with critics who are not going to change,” Ford said, “is to outlive them.”

The American Association of Nurse Practitioners:

Speaking with One Voice

BY CRAIG COLLINS

In 1965, at the height of the Civil Rights era, the newly created Medicare and Medicaid programs extended health coverage to the nation's underserved: low-income women, children, the elderly, and the disabled. It's tempting to view this development as a crowning achievement, but in fact, it was merely the beginning of another half-century of change, particularly in the expanding role of the nurse in delivering what's now known as "primary care."

When Dr. Loretta "Lee" Ford, a professor in the University of Colorado's (CU) College of Nursing, and her colleague, the pediatrician Henry Silver, created what is recognized today as the nation's first nurse practitioner (NP) education program, they were merely trying to solve a problem: Residents of the surrounding rural areas, many of them itinerant agricultural families, were having a difficult time connecting with providers to meet their basic health care needs. When Medicare and Medicaid suddenly provided health care coverage to many of these residents, the new programs exposed a dire shortage of qualified professionals.

Before the 1965 launch of CU's NP education program, primary care physicians, increasingly unable to meet this demand, had already begun to mentor and collaborate with nurses who had

clinical experience. This suited many nurses, who had themselves become dissatisfied with their "handmaiden" role in the provision of health care and were eager to expand their professional responsibilities. A pediatric nurse practitioner role began to develop as an outgrowth of public health nursing. Nurses filled the void by performing medical tasks – such as taking medical histories, conducting physical examinations, and measuring vital signs – that had previously been considered the exclusive domain of physicians.

While Ford and Silver led the way, their colleagues throughout the United States likewise wanted to move the nursing profession forward and expand its wellness-oriented philosophy. Additional NP education programs proliferated around the United States, with curricula that reflected this shared vision. In the early going, NP certificate programs

were typically led by nurse-physician teams in the Ford/Silver model.

The nation's first nurse practitioners were daring and ambitious professionals, with an idealistic belief that they could make a difference in the nation's health. They knew they would encounter criticism for daring to alter the traditional nursing role – and they did. One of the most significant misconceptions was that NPs were nurses who couldn't make it as physicians and decided to be "almost-doctors."

From the start, surveys and studies continually showed that patients were at least as satisfied, and often happier, with the health care they received from nurse practitioners. According to Dr. Jan Towers, an AANP founder who currently serves as the organization's senior policy advisor, there were few initial objections from physicians: "The doctors were the ones who got us started in the first place."

The NP profession continued to draw dedicated nurses who wanted to practice in a broader capacity. By 1973, there were more than 65 nurse practitioner programs nationwide, and while they were still mostly postgraduate certificate programs, some of the first master's-level programs were opening their doors. The

The nation's first nurse practitioners were daring and ambitious professionals, with an idealistic belief that they could make a difference in the nation's health.

An artist's rendering of the apple tree on Dr. Jan Towers' farm under which the bylaws of the American Academy of Nurse Practitioners were drafted by the organization's founders in 1985.



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{ Seemingly overnight, nurse practitioners had become indispensable health care providers, and the role had grown and evolved so quickly that laws and regulations couldn't keep pace – nor could those in health care leadership.

role continued to evolve into other specialty areas, including adult, geriatric, and women's health nurse practitioners. As the federal government began to offer funding to these programs, they continued to proliferate, and for the first time, students were being taught clinical skills by other nurse practitioners.

In 1977, when the Rural Health Clinic Services Act was passed to ensure health care access for poor and low-income families, it marked the first recognition of NPs as a professional group deserving reimbursement as primary care providers. From its humble beginnings, the NP role had achieved remarkable growth.

Nurse practitioners, however, had not been able to form a united front in developing and advocating for their role. This may have been an outgrowth of the controversy surrounding the NP, or because of the role's rapid growth. Whatever the reasons, at least 11 NP organizations centering on clinical specialties or practice settings were created from 1973 to 1985, most of them focused on gathering knowledge and standardizing practice.

A Champion for Nurse Practitioners

Seemingly overnight, nurse practitioners had become indispensable health care providers, and the role had grown and evolved so quickly that laws and regulations couldn't keep pace – nor could those in health care leadership. While the out-

comes and curricula of NP education programs were becoming more standardized, there was no way of substantiating whether professional practice was following suit. Many nurse practitioners, unaware of what their colleagues were doing – or even where they were – began to feel an increasing sense of isolation.

By the mid-1980s, there were about 24,000 nurse practitioners nationwide, but there was no single group that could provide them a shared forum, or represent them all on a national scale, regardless of their specialty.

In 1985, to address this problem, members of a steering committee composed of leaders from these NP organizations met at Towers' Pennsylvania farmhouse. Under an apple tree in her back yard, they drafted a set of bylaws for a national organization. The organization's name – the American Academy of Nurse Practitioners – was revealed later that year at another national meeting of nurse practitioners in Chicago.

By all accounts, the Chicago debate was energetic and animated. "There was consternation in relation to forming this new group," recalled Towers. "One of the comments that was made was: 'Let them go ahead and form their group. If it's needed, it will grow. If it's not needed, it will die.' And it grew."

First incorporated in Lowell, Massachusetts, AANP had, for some time, no physical office space; its members conducted the work of the new organization from their homes and their practice settings –

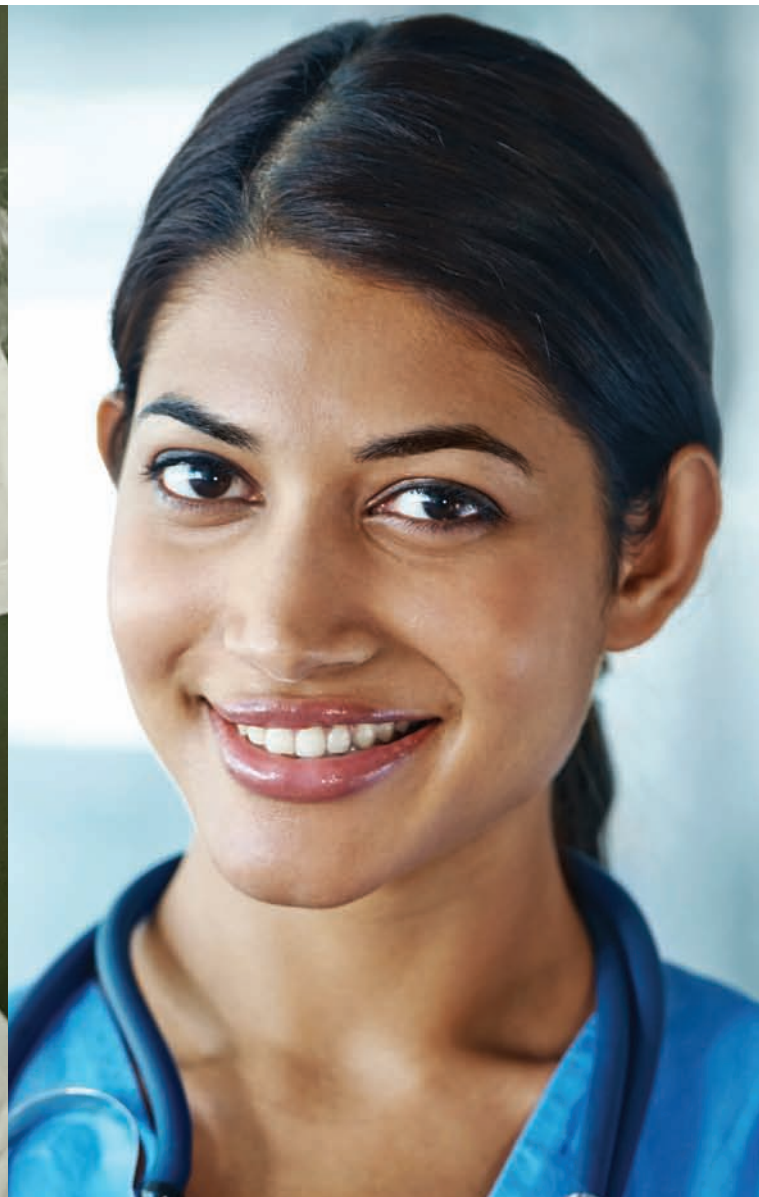
and from the outset, this work was considerable.

Founding member Zo DeMarchi, a women's health practitioner in Austin, Texas, took on the task of developing a database of information about the nation's nurse practitioners. Within the first year, she had developed a list of more than 15,000; to date, the AANP's national database, which includes information on more than 200,000 NPs, is the only database of its type in the United States.

Given the contentious debate surrounding the AANP's formation, the new organization was extremely thoughtful about how it would offer membership to these nurse practitioners. It was reluctant to impose more than the kind of loose regional structure modeled after the public health regions. Rather than form chapters, which could be inadvertently divisive, AANP created group membership, a category that allowed local, state, and national organizations to support and network with AANP, without the underlying organizational hierarchy. Today, there are more than 200 of these organization members.

While DeMarchi began assembling a national NP database, Towers began investigating ways AANP could exert some influence on national health policy. "As soon as we formed the organization," Towers said, "I started finding out about the meetings of national organizations, and I went down to Washington, D.C., to see what was going on. The nursing midwives were getting a lot done, and I asked them: 'How do we get

{ By the mid-1980s, there were about 24,000 nurse practitioners nationwide, but there was no single group that could provide them a shared forum, or represent them all on a national scale, regardless of their specialty.



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involved?’ And the answer was: ‘Send somebody to the Hill.’ So that’s what we did.” Towers made regular visits to Washington to effect health care legislation representing the concerns of the nation’s nurse practitioners, often giving testimony to Congress and the White House.

AANP’s early efforts bore fruit almost immediately. The first national survey conducted by AANP was invaluable, in 1987, in fending off a crisis in malpractice insurance coverage for nurse practitioners. Deciding that nurse practitioners were too high-risk, carriers that were providing nursing liability insurance withdrew coverage. AANP was able to challenge the carriers’ claim with its survey data, which showed NPs had a sue rate of less than 1 percent. The carriers were unable to refute the AANP’s data, and within just a few weeks of the crisis, nurse practitioners around the country, thanks to the AANP’s survey data, had their insurance re-established at a reasonable rate.

In Washington, Towers and her team of AANP lobbyists were not alone in representing the interests of nurse practitioners. From the start, she joined forces with other NP interest groups and lobbying partners to win legislative victories and expand the circumstances under which NPs would be reimbursed directly by the federal government. By 1990, AANP and its allies had secured direct or indirect Medicare reimbursement for rural area NPs, Medicaid payments to family and pediatric NPs, and long-term care Medicare reimbursement; it had also laid the groundwork for the expansion of prescriptive authority for NPs in many U.S. states. At last, a national organization had begun to defend and promote the work of nurse practitioners, regardless of their specialty or setting.

By now, AANP had grown to between 1,200 and 1,500 members, and had begun publication of the first blind peer-reviewed journal for nurse practitioners, the *Journal*



Just as AANP was emerging as a full-service organization offering continuing education, a certification program, and a large annual conference, another voice for nurse practitioners began to emerge in Washington, D.C.

of the American Academy of Nurse Practitioners (JAANP). It held its first national conference in Philadelphia in 1989 – which was also the year AANP moved its headquarters to Austin, Texas.

A United Purpose

AANP’s rapid growth necessitated moves to establish an infrastructure to support the organization. Within a few years, AANP was hiring additional support staff and was occupying its own office space in Austin.

Change came rapidly in the early 1990s as AANP grew and evolved to meet members’ needs. The number of NPs surged nationwide, and the organization worked to remain both unifying and influential as these professionals formed partnerships and further defined their standards of practice. They also continued to conduct studies of increasing scientific rigor to affirm their significance. In 1994, an article in the *New England Journal of Medicine* concluded: “When measures of diagnostic certainty, management competence, or comprehensiveness, quality, and cost are used, virtually every study indicates that the primary care provided by nurse practitioners is equivalent or superior to that provided by physicians.”

Still, nurse practitioners continued to struggle with their “in-between” status, a public identity pegged somewhere between handmaiden and physician. NPs, in fact, occupied a distinct primary care role that combined the knowledge and skills of medicine and nursing – and AANP had a profound influence on

bringing about this recognition, at least among the institutions that regulated their practice. By the dawn of the 21st century, a confusing list of titles and credentials had been largely resolved by the National Council of State Boards of Nursing, which ultimately defined advanced-practice nursing, established the master of science in nursing degree, set the minimum standard for NP certification, and recommended licensure as the preferred method for regulating the profession.

Just as AANP was emerging as a full-service organization offering continuing education, a certification program, and a large annual conference, another voice for nurse practitioners began to emerge in Washington, D.C. In the early 1990s, as the Clinton administration and Congress debated several key economic proposals – including major health care reforms – AANP, through the work of Towers, was an influential advocate for the interests of nurse practitioners and their patients. For better or worse, there were many other groups speaking on behalf of NPs, and each seemed to have a slightly different core purpose: Some focused on professional development and clinical care – on internal cohesion and standardization – while others focused on developing laws and regulations that would further legitimize the NP role in health care.

In 1992, the National Organization of Nurse Practitioner Faculties (NONPF) funded a leadership conference in Tysons Corner, Virginia, to encourage these groups to speak with one voice. Dr. Janet Selway, then-president of the Nurse

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Above: Members of the 2009 American College of Nurse Practitioners' board of directors cut the ribbon of the exhibit hall at the 2009 ACNP National Clinical Conference. By the late 2000s, ACNP had established its clinical conference as well as a health policy conference, a political action committee, and a peer-reviewed clinical journal. **Right:** ACNP members gather on the steps of the Capitol, circa 2003, with Dr. Loretta Ford (center, in long, light-colored coat) for NP Hill Day. ACNP was founded in 1993 to advocate for specific policy proposals in the interests of NPs.

Practitioner Association of Maryland, remembers driving to Tysons Corner in a blizzard to join the conference. "Part of the impetus was the Clinton administration health care reform," she said. "We still had quite a lot of restrictions in our practice, and for reimbursement as independent health care providers. And the concern was that we were not going to be heard if there wasn't a unified voice."

Over three days, these NP leaders discussed what they wanted to see from a national association focused on representing the interests of nurse practitioners in the nation's capital. A new organization, designed to allow input from a variety of sources to advocate for specific policy proposals, was formed in 1993; it was later named the American College of Nurse Practitioners, or ACNP. According to Dr. Ken Miller, who was president of ACNP when it merged with AANP in 2013, the goal of the new organization was straightforward: "They began to focus on developing



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legislation and regulations,” he said, “that would break down the barriers to NP practice.”

Like AANP, ACNP offered membership to larger group entities, to provide a larger forum for NPs to develop a policy agenda. “We had three levels of membership,” said Selway, “national affiliates, state affiliates, and individual members. What was different about ACNP was that we had board representation for these other affiliates.” Not long after its formation, the organization hosted its first annual Health Policy Conference, where issues of concern for NPs would be discussed and consensus reached for a way forward.

By the mid-1990s, one of the most significant barriers still remaining for nurse practitioners was that under most circumstances, they were not recognized as independent care providers who could be reimbursed directly under the Medicare and Medicaid programs. This issue, perhaps more than any other, became the one that galvanized NPs around the country and brought them together. From the earliest days of the NP role – during which nurse practitioners were paid primarily as employees of physicians or hospitals, often under rules that reimbursed their activities under the physician’s provider number – NPs understood that direct federal reimbursement, or provider status, was necessary for them to be recognized as independent health care providers whose services had a known value.

AANP and ACNP worked closely together on the issue – and they weren’t alone, recalls Miller. “There were probably about 10 or 20 nurse practitioner organizations and other groups that were actually working together in a much larger organization, which included some ancillary groups,” he said. “And we all started working toward the same legislative goals. That was helpful, because it pulled in the acute care people. It pulled in the geriatric people. It pulled in the psych people.

Each of those specialties had their own organizations. And there were other health care providers who joined us.”

Selway’s successor as president of the Nurse Practitioner Association of Maryland, Margaret Koehler, became a key player in the push for provider status on behalf of ACNP, launching a home-based e-mail campaign focused on the needs of underserved populations. Most weekends, Koehler would be giving presentations to NPs or students somewhere around the country, teaching them how to lobby policymakers about the merits of extending provider status to NPs. “I think what the College contributed,” said Selway, “was a really great big grassroots push, where lobbyists would contact nurse practitioners in various states and then they would take their message to the appropriate congressman to get sponsors for the legislation, which would remove some of these restrictions for reimbursement. It was all aimed at increasing patients’ access to nurse practitioner care.”

The strategy adopted by Koehler, Towers, and their many allies contained several components and had been decades in the making: helping people to recognize the potential for expanding the nursing role; documenting the value of NPs; establishing education and credentialing standards; accepting incremental gains over time; and using professional organizations, such as AANP and ACNP, to empower individual nurse practitioners. It was a winning strategy. The Balanced Budget Act of 1997 granted nurse practitioners provider status and authorized them to bill Medicare directly for services furnished in any setting.

“We were a very significant contributor to the language in that bill,” said Towers, “because we worked directly with the legislator who put it in.” Today, as the growth of managed care organizations has broadened the responsibilities

of non-physician clinicians, many private insurers have followed suit, allowing patients to choose a nurse practitioner as their primary care provider.

“That was a really huge win,” said Selway. “Everyone was happy about it.”

On the heels of this victory, both AANP and ACNP began to widen their focus, expanding outreach, advocacy, networking, and professional development opportunities for members. In October 1999, ACNP hosted its first annual clinical conference in Nashville. In 2001, the organization established its first full-time working staff in Washington, D.C., and within a year had established a political action committee, ACNP-PAC. The College’s official, peer-reviewed clinical journal, *The Journal for Nurse Practitioners*, was first published in 2005.

AANP, meanwhile, stepped up its advocacy efforts and its education, training, and certification programs. The AANP Foundation, a separately incorporated 501(c) nonprofit, was established in 1998 to benefit NPs in all specialties. The Foundation Scholarship and Grant program began to make its first awards to AANP members in the same year. In 2000, AANP initiated its Fellowship program to develop leaders in the national nurse practitioner community and encourage excellence in the profession; in the same year, AANP hosted the first international NP conference in the United States and created its own political action committee, AANP-PAC. The daily *AANP SmartBrief*, an electronic newsletter pulling together health care news highlights from multiple news sources, was first published in 2003.

2007 was also the year AANP launched its online Continuing Education Center, to allow members to access activities and earn credits. The CE Center has been greatly expanded in recent years, according to AANP’s president, Dr. Cindy Cooke. “Our CE Center is one of the reasons people

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say they belong to AANP,” she said. “We’re all required to get CE for our state licenses and to maintain our certifications. It’s much more robust than it was. We have multiple staff members on that side, and if you’re a member, a great majority of the CE is part of your membership fee. It’s a key benefit.”

As another landmark law, the Patient Protection and Affordable Care Act (PPACA) of 2010, was being debated on the Hill, it became clearer than ever that more change was needed to break down the social, cultural, and economic barriers between patients and the care provided by nurse practitioners. The PPACA provided the opportunity for NPs to become full participants in developing the health care reform provisions that would weaken or eliminate these obstacles – and in order to take advantage of that opportunity, the nation’s NPs would need to be more united than ever.

In their decades of working together to effect change, AANP and ACNP had grown more alike in their offerings to members, and they had always shared a common purpose. “What we wanted was what everyone wanted,” said Selway, “and that was

Members of the American Association of Nurse Practitioners’ board of directors pose with state representatives at the AANP 2013 National Conference, the first national conference after the American Academy of Nurse Practitioners and the American College of Nurse Practitioners merger.

to get rid of the restrictions and allow us to practice to our full capacity.”

Today’s AANP

The next step for both organizations had begun to seem inevitable, said Cooke: “In some cases it was confusing to people to have two organizations. Legislators would say: ‘Who are we supposed to go to? We have two national organizations.’ There were some things that ACNP and AANP worked together on, and we felt that we had great commonalities,” she said. “So the discussion began. I was on the AANP board at that time, and when I first was asked, ‘What do you think about merging with ACNP?’ I thought: ‘What’s taken us so long?’ It’s better to speak as one organization.”

On Jan. 1, 2013, the American Academy of Nurse Practitioners and the American College of Nurse Practitioners joined to form a single full-service organization: the American Association of Nurse Practitioners. The new AANP integrated the Academy’s and the College’s valued leaders, and that January the new board came together for a strategic planning session to set the stage for moving forward.

David Hebert, the attorney who served as ACNP’s chief executive officer before the merger, has since assumed the CEO position for the Association. Uniting NPs in one group was only the first step for the organization, he said; the new AANP has expanded its role in advocating for health policy, enhanced its education programs, and grown and diversified its conference events. “We went from one national conference,” Hebert said, “to an additional specialty conference, and then an enhanced health policy conference in Washington, D.C. What we’ve done is substantially ramp up the voice of the NP.”

Another area of increased effort has been collaboration and consultation with private players in the health care

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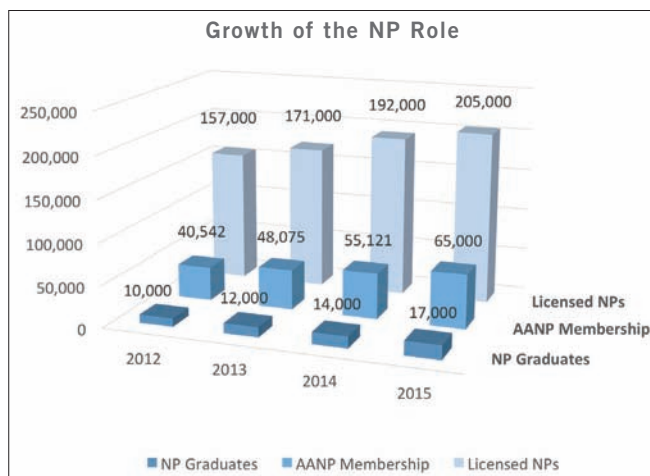
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A graph depicting the significant increase in numbers of licensed NPs, AANP members, and NP graduates since just 2012.

market – managed care organizations, hospital networks, pharmaceutical companies, and retail clinics – through AANP’s Corporate Council. “One of the things that’s increasingly important,” Hebert said, “is our liaison with companies to make sure they understand what NPs do.

As the number of NPs increases almost geometrically – an estimated 17,000 NPs complete their academic programs annually – the organization’s membership has grown to keep pace. “We were about 37,000 members at the point of the merger,” said Hebert. “Last year at our national conference we celebrated our 50,000th member, and now we’re 65,000 strong. Conversely, we have more than 205,000 NPs across the country, so there are a lot of NPs out there who aren’t members – and that’s one of the things we constantly think about and try to address.

“I’m very proud of the things we have accomplished over the past three years,” said Hebert. “In addition to incredible membership growth, we launched a national television and radio campaign, created public service advertising which has been shown at three major U.S. airports, dramatically expanded our CE programs, made substantial progress in health policy areas, grown our Political Action Committee (PAC) into one of the largest health care PACs in the country, as well as substantially enhancing our revenue base and making our Association even stronger financially than ever before,” he noted.

From June 9-14, 2015, more than 5,500 people gathered at the Ernest M. Morial Convention Center in New Orleans, Louisiana, for the AANP National Conference, the largest national conference for NPs of all specialties. Throughout the week, they networked with colleagues from the United States and overseas; attended clinical workshops, CE courses, policy discussions and seminars; and celebrated the 50th anniversary of the nurse

Corporate Council

The Corporate Council (CC) is the premier partnership opportunity for corporations and organizations striving to connect with more than 205,000 licensed nurse practitioners. In partnership with the AANP, CC membership enables organizations to join with other health care industry leaders to promote and support NP excellence for the benefit of the nation’s health. Corporate Council member benefits include direct AANP leadership and member engagement, marketing and communication opportunities, sponsorship at conferences and meetings, and research and advocacy opportunities. AANP was pleased to have the support of 31 Corporate Council members in 2015.

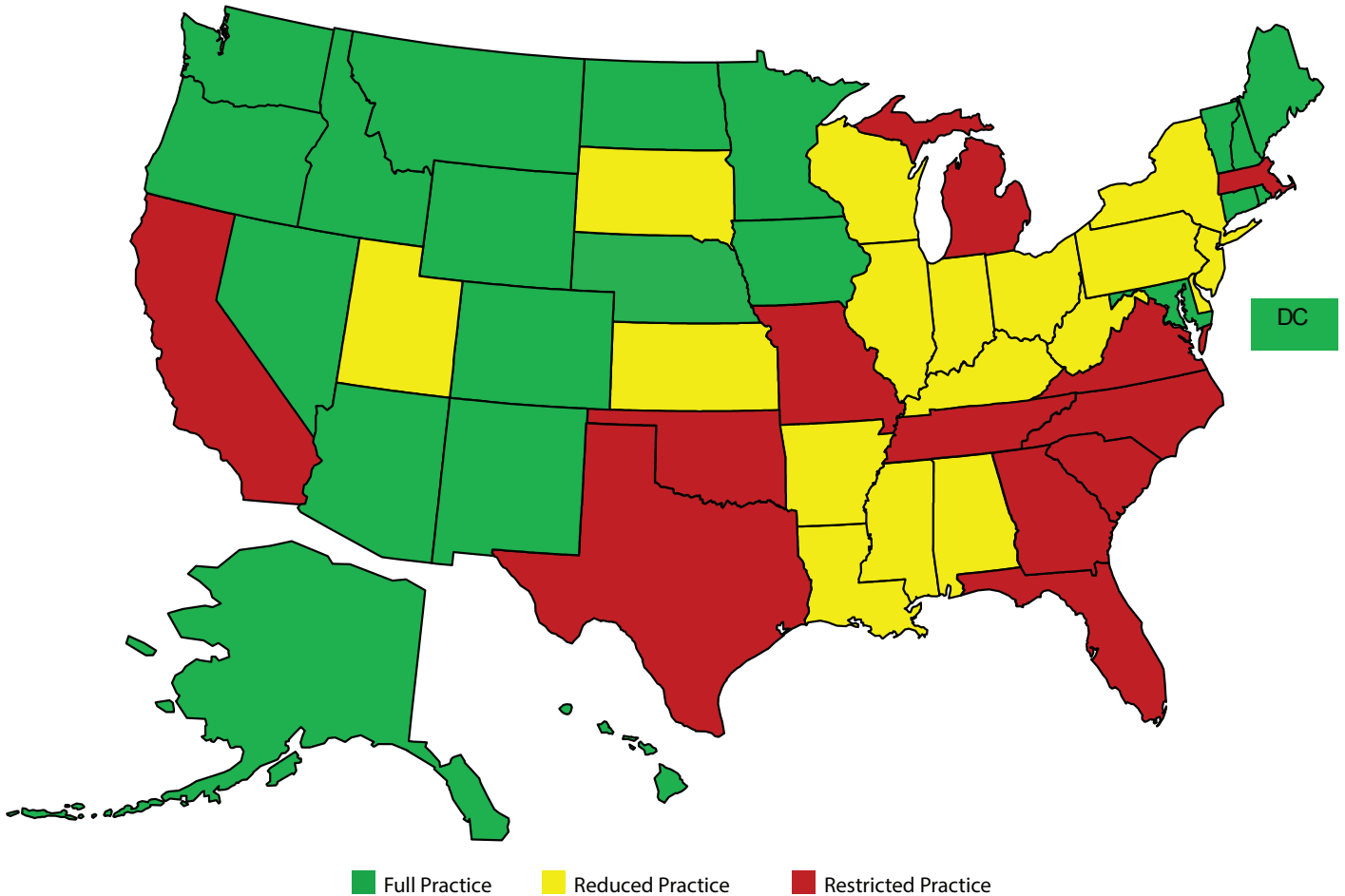
Special Practice Groups

AANP has launched Specialty Practice Groups (SPG), communities within AANP who share common goals in advancing knowledge and professional development in select areas. The initial specialty areas were acute care and dermatology, with plans to add convenient care/urgent care, orthopedics, and pain management. Each SPG has a chair and/or co-chair to facilitate discussion within its online community. There are currently 790 acute care and 203 dermatology members. AANP’s Specialty Practice Groups are designed to support discussions, document sharing, collaboration, and networking. For more information, visit www.aanp.org/membership/specialty-practice-groups.

AANP Leadership Program

The AANP board of directors recognized that it must assure the future of our organization – which is the future of our profession – by building a cadre of nurse practitioners versed in leadership competence. In 2014, AANP launched the AANP Leadership Program. This 12-month program was designed to develop the next generation of NP leaders through a variety of initiatives that will provide leadership training through engagement in Association activities. In the first year, 18 NPs were selected from approximately 70 potential candidates, and in the second year, 12 NPs were selected. The development of NP leaders has never been more important: The time has never been more opportune.

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practitioner role. During the opening session, they were greeted by none other than Dr. Loretta Ford, founder of the nation's first NP education program at the University of Colorado in 1965. "I am the ghost of our historical and hysterical past," said Ford, "and you are the future. You will be challenged to innovate, change, acquire and invent."

On Wednesday, Ford briefly took the stage to join the week's keynote speaker, Naomi Judd, the Grammy Award-winning recording artist who supported her family as a registered nurse until her singing career had taken off. Judd shared her story and praised the power of nurse

AANP's current board of directors. In the front row, left to right, are Karen Ketner, Tracy Klein, Deanna Babb, Joyce Knestrick, Ken Miller, Cindy Cooke, Cynthia Edwards-Tuttle, Deborah Varnam, and Kathleen Haycraft. In the back row, left to right, are Sophia Thomas, Donald Gardenier, Kevin Ballard, Susan Schrand, David Hebert, Jean Aertker, and Nancy O'Rourke.

practitioners. "What are we going to do about health care in America," she said to the audience, "if we don't have people like you?"

"When you see that many nurse practitioners in one place,

networking and teaching and learning together," Cooke said, "that's always exciting to me. The conference is a way to both honor our past and energize our future."

For Cooke and other AANP leaders, the focus on the future of American health care – on educating and empowering practitioners to lead it – lies at the core of the organization's mission. "I think, from our students to our seasoned practitioners, we make sure we're the voice for the nurse practitioner in every realm," said Cooke, "whether it's the health care setting, academia, health policy, legislation and regulation, or the media. I really feel the merger was the right thing, and that it happened at the right time, with the right people involved. I think we are in a very good place moving into the future to help American health care be better for our patients."

The focus on the future of American health care – on educating and empowering practitioners to lead it – lies at the core of the organization's mission.



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The Fellows of AANP: Leading the Way

By Craig Collins



Since its 1985 inception, the American Academy of Nurse Practitioners – now the American Association of Nurse Practitioners (AANP) – has been focused on advancing the nursing profession by cultivating the organization's core values: integrity, excellence, professionalism, leadership, and service. While these values are shared by all AANP members, the organization began, in 2000 – while it was still the American Academy of Nurse Practitioners – to recognize members who had made outstanding contributions in clinical practice, research, education, or policy development. The Fellows of the American Association of Nurse Practitioners (FAANP) program has become one of AANP's primary tools both for advancing the profession and asserting nurse practitioners' influence over key issues in nursing and health care policy.

Dr. Mary Ellen Roberts, current chair of the FAANP program – and a member of the second class of Fellows, selected in 2001 – explains that the Fellows “really are the thought leaders in the field. Over the years, we've inducted Fellows who have done stellar work to promote nurse practitioners and to move the profession forward.”

Every year, Fellows are selected annually and honored at the AANP National Conference in June, but according to Roberts, there is no set number of Fellows per class. “If every applicant who applies meets the bill,” said Roberts, “they'll be inducted – but that's not usually the case. There's a rigorous application process.”

Invitation to apply and selection to the program are based solely on the NP's accomplishments and contributions to advance the NP role. FAANP candidates are invited to apply by two current Fellows, and the eligibility criteria are:

- AANP membership;
- Exceptional contributions and outcomes in two of the four main focus areas: NP clinical practice, education, policy, or research;
- Significance and scope of influence in the two main focus areas; and
- Potential for contributing to the mission of AANP and to FAANP initiatives.

FAANP's Initiatives

The FAANP program's approach is two-pronged: At the individual level, it works to promote and recognize professional excellence through several initiatives. Its mentorship program, launched in 2006, connects Fellows who are leaders in their field and willing to share their expertise with motivated but less-experienced colleagues. Mentors are matched with mentees by other Fellows, and in June, at AANP's National Conference, they meet for the first time and begin their year-long collaboration, a work project undertaken by the novice under the mentor's supervision. If the mentee chooses, he or she can present project outcomes at the next National Conference. The FAANP Mentorship Program is open to all NP members.

To honor individual contributions to the NP role, the FAANP has also established two awards. The Loretta C. Ford Award for Advancement of the Nurse Practitioner Role in Health Care was established in recognition of Ford's induction into the National Women's Hall of Fame. The award recognizes the many achievements of Ford, co-founder of the NP model, and is bestowed annually to a nurse practitioner who demonstrates participation in health care policy development at an international, national, or local level; sustained and specific contribution to clarification of the role and scope of practice of nurse practitioners; and/or a creative and effective action to turn a challenge to the nurse practitioner role into an effective opportunity to advance practice and improve patient outcomes.

FAANP also recently established a new category of awardee: the Honorary Fellow. “An Honorary Fellow,” said Roberts, “is a person who can't be inducted as a Fellow because they're not a nurse practitioner – but who has really advocated for the profession.” The first Honorary Fellow, Barbara Safriet, is a lawyer who has worked tirelessly to advocate for advanced practice. Last June, FAANP recognized Patrick DeLeon, past president of the American Psychology

Association, and Dr. Henry K. Silver, who co-founded the NP model with Ford, as Honorary Fellows.

The Fellows of the AANP also work on a national scale to influence the development of the NP model and its role in the health care system. At their annual winter meeting, the Fellows convene to talk about health care policy and form workgroups to hammer out consensus on key issues. "Some of the workgroups have produced health policy modules for faculty to help teach health policy courses," said Roberts. "Some groups produce and publish white papers. Last year at the winter meeting, we updated all of the policy and practice briefs for the Association." In October 2014, a Fellows workgroup published the NP Patient Outcomes Toolkit, a

procedural document designed to help nurse practitioners evaluate the effectiveness and efficiency of NP care on patient-centered outcomes, including specific measurement strategies.

In 2002, to include other key stakeholders in the national health care policy debate, the Fellows began hosting Invitational Think Tanks. They're not hosted every year, Roberts says; they're convened when the Fellows determine there's a really pressing need for the organization to comment on an issue.

"The Invitational Think Tanks have really helped us to get the word out," said Roberts, "in terms of writing white papers, position statements, or policy briefs that are important for their time." The most recent Invitational Think Tank focused

on the content and development of accountable care organizations (ACOs) in the context of a pilot program established by the Affordable Care Act of 2010. "We're also in the process," said Roberts, "of rewriting the National Nurse Practitioner Research Agenda, to identify where we think we need to do more research in terms of our programs."

542 Fellows have been inducted into the program as of June 2015. "It's a real honor to be a part of this program," Roberts said, "and particularly an honor to be able to chair this incredible group of individuals – all of whom continue to have multiple achievements after they're inducted. I think they're not just the go-to people, the brain trust, of our organization; they're really the brain trust of the entire nurse practitioner profession."

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A Conversation with Loretta C. Ford

BY CRAIG COLLINS

Dr. Loretta C. Ford, dean and professor emerita of the University of Rochester's School of Nursing, is an internationally renowned thought leader in nursing who has devoted her career to practice, education, research, collaboration, and advocating for change in health care delivery, community health, and military nursing. She has authored more than 100 publications on the history of the nurse practitioner, the unification model, and issues in advanced nursing practice and health care policy.

Born Loretta Cecelia Pfingstel on Dec. 28, 1920, in the Bronx, New York, Ford was the fourth of seven children. At the age of 16, at the urging of a relative, she enrolled in the nursing program at Middlesex General Hospital in New Brunswick, New Jersey. It was the beginning of a long – and historic – career, one that would take her to wartime service at several military bases; to Colorado, where she worked as a public health nurse, met her husband, Bill Ford, and co-founded the world's first nurse practitioner education program with Dr. Henry K. Silver; and to the University of Rochester, where she served as founding dean of its School of Nursing and director of nursing in the university's Strong Memorial Hospital.

Ford's work at the University of Rochester was aimed at combining nursing education, practice, and research; this "unification model" of nursing education placed Rochester's School of Nursing at the forefront of academic nursing preparation, both nationally and internationally. She has served as a visiting professor at the University of Washington, St. Luke's College of Nursing in Tokyo, Japan, and the University of Florida School of Nursing, and has led several nursing education visitations from overseas visitors. After her retirement from

nursing in 1985, she served as interim dean at the University of Rochester's Graduate School of Education and Human Development.

Ford earned her bachelor of science degree (1949), master of science in nursing (MSN) degree (1951), and doctor of education (1961) from the University of Colorado (CU). In 1995, the University of Rochester dedicated an endowed chair in her name, and Ford insisted it be called the William J. Ford and Loretta C. Ford Chair. She now holds nine honorary doctorates from several prestigious universities. The awards she has earned over her lifetime of achievement, too numerous to catalogue completely, include the Gustav Lienhard Medal from the National Academy of Sciences' Institute of Medicine, the Living Legend award from the American Academy of Nursing, the American College of Nurse Practitioner's Crystal Trailblazer Award, and the Elizabeth Blackwell Award from Hobart and William Smith Colleges.

On Oct. 1, 2011, Ford was inducted into the National Women's Hall of Fame, and in recognition of this honor, the Fellows of the American Academy of Nurse Practitioners (FAANP) created The Loretta C. Ford Award for Advancement of the Nurse Practitioner Role in Health Care, bestowed annually to a nurse practitioner who

has been influential in health policy and advancing the role and scope of practice of nurse practitioners.

Now living in Florida, Ford continues to consult and lecture on the development of the nurse practitioner role and on issues related to nursing education, advanced practice, and health care.

Q: Is it true that when you were young, you were more interested in a teaching career than in nursing?

Dr. Loretta C. Ford: Originally I wanted to be a teacher. But we didn't have the family resources. And at that time, you were either a nurse or you went to the convent or you were a secretary, something of that nature. But I wanted to be a teacher, and I was really too young to go to college. So when I went into nursing, I went as a nurse's aide. I graduated from high school when I was 16 or 16-and-a-half. [The nursing program] was an opportunity to learn something, so I went in as a nurse's aide. It was part of the school program. I lived with a student and read all her books, so when I went into nursing school – you had to be 18 – I was ready. And by that time, of course, I really enjoyed nursing, and that was it.

How did certification work back then? Did you come out of the program as a certified public health nurse?

Well, our school was rather unusual. It was a hospital course in public health nursing. While I wasn't qualified according to the certification requirements at that time, I did have that course, and I won a scholarship and took another course in public health nursing that was taught by a Columbia University professor. So I

Dr. Loretta C. Ford, one of the founders, in 1965, of the first nurse practitioner education program.

earned a position as a visiting nurse. The official public health nurses were different from us, because we gave direct home care. The public health nurses did mostly teaching and immunizations and didn't do the nursing procedures in the home, as we did.

Was it common practice for nurses to visit patients in their homes?

It was very common. And actually, I think the official public health nurses grew out of the movement begun a few decades earlier, with settlements like the Hull House in Chicago and the well-known New York settlement on Henry Street, started by Lillian Wald and that group. They were the forerunners of the official public health nursing movement – official meaning they were tax-supported and hired by the county or the state. But they were very few. The care was given mostly by visiting nurses.

When you joined the faculty at the CU College of Nursing in 1961, you'd been a public health nurse for more than a dozen years in Boulder County. What did you decide you wanted to change as a nurse educator?

When I joined the faculty, there was a movement in nursing to shift the focus of the master's program from a functional one – preparing supervisors and administrators and teachers – to a clinical role. It began to be recognized that there was a need for nurses who were highly prepared in clinical nursing, direct care of the patient or the group. This movement was already going on in the profession. And most of the programs prepared what they called clinical nurse specialists. They were the ones who studied intensively in their field, whether it was pediatrics or medical/surgical nursing or psychiatric nursing, so that they could deliver a higher grade of care to their group of patients.



And that was the category that I was striving for, because when you were nursing in the county, you gave a lot of care to a lot of different people, because it was a generalized service. And that meant you visited schools. You followed tuberculosis and other communicable diseases. You ran the immunization clinics. You visited elderly people in nursing homes. You made home visits to newborns. And you ran the well-baby clinics. And that was focused primarily on prevention and feeding, and growth and development

of the child, and advising the mothers how to enhance the growth of the child, and things like that. It was full service, whatever the population needed. And it was population driven and need driven.

Tell me more about how this generalized model developed into a training program at Colorado.

Well, I was working on a model of a family nurse practitioner. That was going to be the work I had to do for the changeover of the master's program to clinical content. So we were working



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Ford served in the Army Air Forces as a nurse during World War II.

on the concepts of high-level wellness and those sorts of things. And then when I talked with Henry Kempe [pediatrics chair at CU Medical Center], he advised I talk with Henry Silver, because we were both interested in children and growth and development.

Henry Silver was a pediatrician, and I was interested in pediatrics too. I'd seen children in school, in homes, in clinics. And I thought nurses could run the well-child clinics. We developed the model together, and it was a nursing model. It was what nurses would do, and what the profession says that nursing should be doing. The profession was saying nurses should be independent in their practice. They should be collaborative with, but not supervised by, physicians for all the things they did. And they should be accountable, and of course safe and competent, to do this on their own. It was a nursing model, but people didn't see it that way because, first of all, they knew very little about public health nursing. And two, working with a physician that closely raised a real concern that medicine would control nursing curriculums, and all sorts of falsehoods that weren't true at all. So it was not met on my own campus with any support, or anything but negative criticism.

Did that happen immediately, or did it happen later, when you raised the possibility of integrating the model into the school's curriculum?

It happened immediately. Most nursing faculty did not work closely with physicians. They taught students to be key members of a health care team, but the physician was always the captain. There was never any question about it.

The organization of the whole hospital system was a medical model – you know, a sick care system. Most of the nurses were in the hospitals. There were maybe a thousand public health nurses in the country – a very small number compared to the number of nurses overall. Now we have about 3.4 million RNs, and about 205,000 or more who are nurse practitioners. We're still a relatively small number in the scheme of things, but a very powerful one now.

So their main objection to the nurse practitioner model was that nurses were going to be practicing "sick care"?

No, I think they thought the nurses were going to be overtaken by medicine, that they were going to be physician assistants. They wondered whether it would be legal for nurses to practice in this way. And they thought it wasn't nursing. Most of it – I became sure of it as I began to study the problem – was fear. It was fear not only that medicine would take over, but that it would change their practice, because we expected faculty to practice and do research and teach students. So I was ostracized. I was isolated. There was gossip and backstabbing and all kinds of things, because they were afraid of change, and the new model did mean change for many of them.

And there was another problem: I was doing something in pediatrics that I supposedly was not prepared for. And this burned the pediatric faculty, because I was not a pediatric nurse *per se*, and that didn't go over well, but most of the work we did in the community was in maternal and child health. All the clinics we ran for school such as immunization, crippled children, home visits, newborns, everything, I would say 65 percent of the work that we did in the community, in prevention, was in pediatrics and family practice. But if you're a purist, it is true I was not a "pediatric nurse" – most of whom, by the way, were in hospitals. They weren't in the clinics.

We didn't know how all this would turn out, but we were sure it was going to be positive. Our students were doing so well, and were highly accepted by patients, and competent to do what we were expecting them to do, which was to make a decision about wellness. But you know, it was a long time ago and I don't hold any grudges.

What were some of the challenges the program faced in its first years?

One of the problems we had was that too many people wanted to get in who didn't qualify, or they qualified and we couldn't take them. They also, by the way, had to have a job to go to, which wasn't always easy. The Denver VNS [Visiting Nurse Service] was very good. We placed nurses in housing units. There were some community health centers that were developing. And many physicians wanted their own pediatric nurse practitioner back in their office ... so they weren't all rural. Some were in Denver or other cities.

The main problem was the lack of support for continuance in the School of Nursing. Fortunately, the director of

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continuing education in the School of Nursing, Elda Popiel, was willing to challenge that and at least carry it on as a continuing education program. But one of the major goals of the program, and why I got into it in the first place, was to test out the role before we integrated it into the curriculum. And we tested it out and knew that it was very applicable, and enhanced public health nurses' competencies in childcare.

And then we wanted to transfer it into the master's degree program for public health nurses. That's where we had the major stumbling block, because we were told by the administration that they could not support that. Well, if the chiefs don't support it, there's no future for what you're doing.

But then the [military] services picked it up. The VA [Department of Veterans Affairs] picked it up. A lot of agencies began training their own nurse practitioners. So that made a bridge, finally, to some of the schools that had the vision and recognized its value, and there began to be demand from students – if you don't have students coming into your programs, your school is in deep trouble.

There began to be outside forces demanding nurse practitioners. They were really being trained and utilized by agencies who wanted them and could see their value, like Planned Parenthood and other service agencies. And then, of course, there began to be a demand for these kinds of nurses in different specialties – school nurse practitioners, women's health, and others. Agencies themselves began to run their own programs, and that provided a bridge. And even though those nurses were not academically prepared, they deserve a tremendous amount of credit and respect for taking on the role of the nurse practitioner until it became academically offered.

So when you went to the University of Rochester to establish its nursing school in 1972, was it simply because you were frustrated?

I went to Rochester because they had a lot of things going for them, but there



Ford makes an appearance as "Super Nurse" during an AANP National Conference.

really were several reasons. One is I realized that changing the role of one professional group is not enough to change an institution or a system. If you have a system that is committed to change, then you can move in as a member of the profession. I realized that it wasn't going to change at Colorado, and that I'd have to get to a system that really was willing to change and innovate and move. There are all kinds of leaders. I'm one that likes to move.

And it was the most difficult decision my husband and I ever made. But Rochester had enough going for it that it made me think it could move, because first of all, they were preparing nurse practitioners. They were on the CE [continuing education] model, but they were willing to do that. Secondly, they had a new model of unification of nurses and physicians working together in this system, where the dean was also the director of the Strong Memorial Hospital. The

dean-and-director model then required all others in the model to pair up. The chief of surgery had a chief of nursing surgery. And the chief of medicine had a chief of nursing medicine, the chief of pediatrics had a companion chief. The physicians there were very welcoming, as was the administration. They had the model on paper. And my job – I didn't create it, they did – was to implement it. It was a huge undertaking. But I had a lot of support in accomplishing it.

Fifty years later, does the nurse practitioner role look the way you'd originally envisioned?

Well of course, I think to a certain extent it's gone through a period of medicalization. They've taken on more of the treatment than was originally designed. But you know, I began to look at treatment as prevention, because if you treat early and educate the patient and monitor the situation with him, and develop him as a partner, treatment can become prevention of secondary infections and of disabilities, all through the involvement and engagement of the patient.

I think both the needs, the terrific needs we have in this country for prevention and for involvement of people in their own health and accountability – nurses are a huge unused resource for those needs. It's such a waste of their education. And it isn't only that they should *do* more, but *be* more, and also to fulfill their goals and their desires. They want to really be good carers and teachers, and they're just not able to practice the way they've been taught. They're not able to advance, and I don't mean financially. I mean advance in the satisfaction of being real caregivers, and holistically so. It's such a fraudulent waste of talent that I get irritated myself. People say: "Well, we don't have the money. We don't have the time. We don't have this, or we don't have that." But we do have more sickness.

You've said in recent public appearances that you think the role of the nurse practitioner is more important

Ford (second from left), a 2011 National Women's Hall of Fame inductee, sits on a stage at Mynderse Academy in Seneca Falls, New York, on Sept. 30, 2011, with, from left to right, Lynne McKenney Lydick portraying 2011 inductee Abby Kelley Foster, 2009 inductee Dr. Judith Pipher, and Coline Jenkins, great-great-granddaughter of Elizabeth Cady Stanton, during a town hall-style meeting that allowed the inductees to interact with high school students in a question and answer format.



than ever. I've heard that in other places too, but it's often explained, again, in terms of numbers, in terms of shortages. You seem to view it in terms of the kind of care patients need.

I think we deliver primary health care. I think the primary care model is a medical model. And I have a lot of empathy for the doctors, by the way, because they don't have the time to apply holistic care. They don't have the time to educate patients. On the other hand, it irritates me that they don't let somebody else do it.

Why?

Politically they're stymied. There are only 21 states [and Washington, D.C.] that allow nurse practitioners to fully practice to the extent of their preparation – I don't like to say “independent practice”; we're all interdependent. I like to talk about this political situation as “statutory authority.” It's a big waste of money and time to educate nurses to the extent we're doing, and then not allow them to practice because the laws keep us from doing it. And not just the laws, but the medical society in general. And I say enough. We have a chance now through the law, which has changed the paradigm of power. And that power is going to be a real shift toward patients.

By the law, do you mean the Affordable Care Act?

Yes, but it's not the only thing shifting more power to patients. Do you know the work of Eric Topol? He's a Rochester graduate of some

years ago, a cardiologist. He's done a great deal of work in this idea of engaging the patient and involving him individually in care. He calls it the democratization of patient care, and it involves the technology of sensors that patients can wear to give them all the information they need to know – electrocardiograms, sensors that can warn of asthma attacks, these kinds of things. They're really going to change the relationship between patients and providers – nurses, nurse practitioners, and physicians.

So I'm saying I think we shouldn't kill ourselves trying to partner with physicians, because there will be bio-engineers; there's computer science; there are technologists of every kind you can imagine. And the patients are going to have access to them as well. And I'm trying to get nurses to think about prevention, innovations, queries into different solutions, imagining things differently and coming up with lots of different ideas, and going to work every day and looking for ways to change things and make them easier on the patient – to make it less costly and also to give them some satisfaction in going to work. I'm excited about it. I wish I could get other people excited about it.

How do you see the nurse practitioner role evolving along with these technological changes?

Well, I'd like to see the nurse practitioner develop the kind of role that we perceive holistically, that this will give

her or him – and hopefully more him; that's not a play on words – more ability to function as they've been taught as a consultant, as a listener, as one who really can see the holistic part of every patient and, in a sense, help the patient to see himself. Because we've made him incompetent, in many cases, by making him think we know it all. By “we” I don't mean nurse practitioners particularly, but the health professions in general.

It sounds as if you think these new technologies are already moving health care away from the “sick care” model toward the nursing model, in the way they emphasize prevention and patient-centered care.

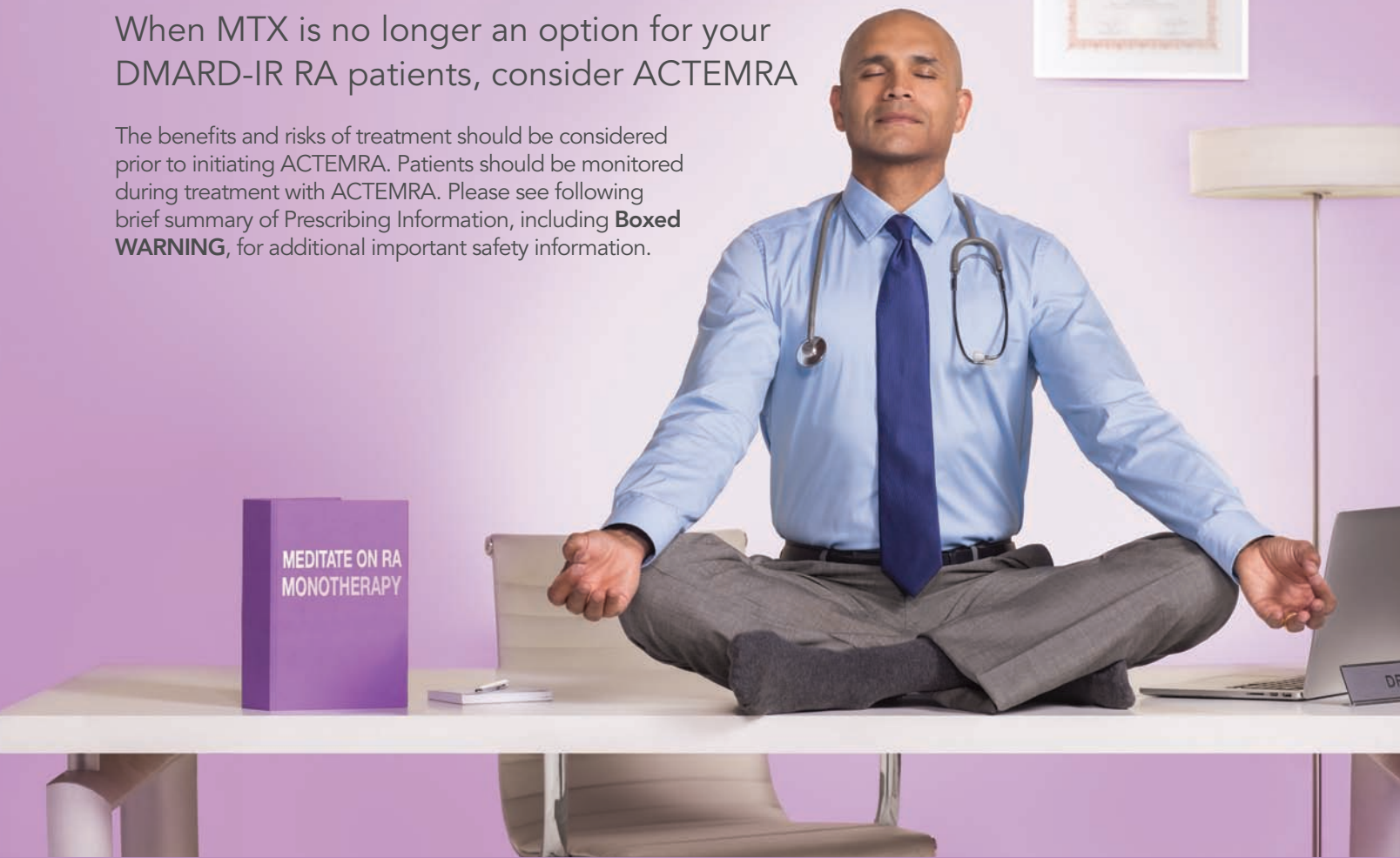
Yes, even self-care. But that's not only our model. I think physicians want to emphasize these things, too. But I think the system has been so expensive, and unnecessarily expensive, that it keeps physicians from practicing to the extent that they're able. They're paid mostly in groups now. And what they call “productivity” is moving patients in and out quickly. I don't call that productivity.

I think doctors are also penned in by some of the systems that we have today. And they've got to change. But that's the politics of it, and it's more than a problem of how we distribute people. We can prepare as many people as we want. But if we don't allow them to practice, and if there's not an overarching national health policy, I don't think we'll go anywhere as a nation.

DISCOVER A DIFFERENT STATE OF MIND WHEN YOU CAN'T PRESCRIBE MTX

When MTX is no longer an option for your DMARD-IR RA patients, consider ACTEMRA

The benefits and risks of treatment should be considered prior to initiating ACTEMRA. Patients should be monitored during treatment with ACTEMRA. Please see following brief summary of Prescribing Information, including **Boxed WARNING**, for additional important safety information.



MTX=methotrexate; DMARD-IR=disease-modifying antirheumatic drug inadequate responder.

Indication

ACTEMRA is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs).

Important Safety Information

BOXED WARNING

Serious Infections

Serious infections leading to hospitalization or death, including tuberculosis (TB), bacterial, invasive fungal, viral, and other opportunistic infections, have occurred in patients receiving ACTEMRA. ACTEMRA should not be administered during an active infection, including localized infections. If a serious infection develops, ACTEMRA should be interrupted until the infection is controlled.

Prior to initiating ACTEMRA, a test for latent TB should be performed. If the test is positive, treatment for TB should be started prior to starting ACTEMRA. All patients should be monitored for active TB during treatment, even if initial latent TB test is negative.

The benefits and risks of treatment should be considered prior to initiating ACTEMRA in patients:

- with chronic or recurrent infection
- who have been exposed to TB
- who have a history of serious or opportunistic infections
- who have resided or traveled in areas of endemic TB or mycoses
- with underlying conditions that may predispose them to infection

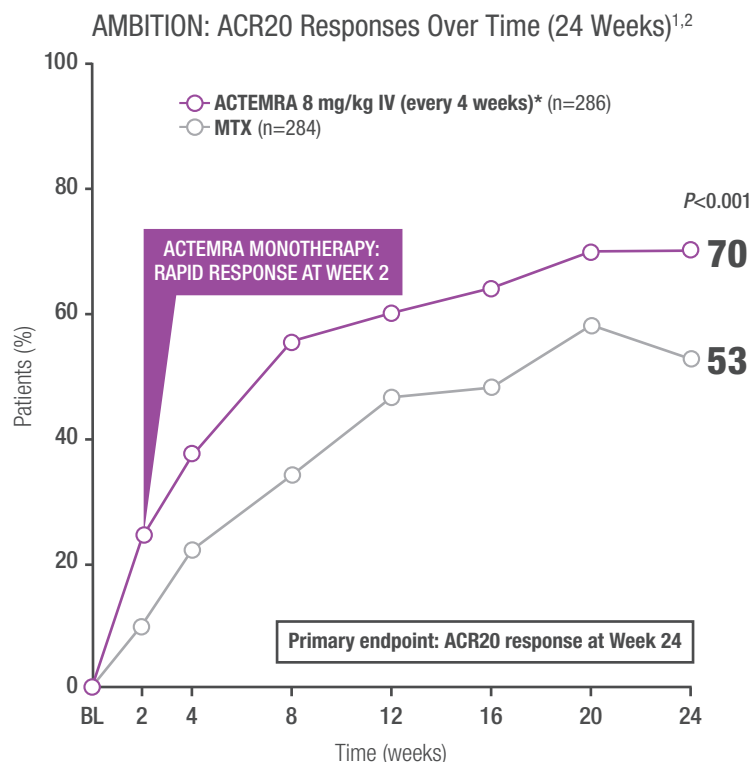
Patients should be closely monitored for signs and symptoms of infection during and after treatment with ACTEMRA.

Please see following pages for full Important Safety Information and brief summary of Prescribing Information.

WHEN MTX IS NO LONGER AN OPTION FOR YOUR DMARD-IR RA PATIENTS, CONSIDER ACTEMRA

Contact a rep at
ActemraHCP.com
for more
information

ACTEMRA DELIVERED RAPID RESPONSE AT WEEK 2 AS A SINGLE AGENT



AMBITION: Pivotal, randomized, double-blind, Phase III clinical study in MTX-naïve/-free[†] patients with moderate to severe RA. The primary endpoint was ACR20 response at Week 24. Patients were treated with ACTEMRA 8 mg/kg IV (every 4 weeks)* or an escalating dose of MTX. MTX dose was initiated at 7.5 mg/week and increased to a maximum dose of 20 mg/week within 8 weeks. The treatment period was 24 weeks.

*The recommended starting dose for ACTEMRA IV is 4 mg/kg followed by an increase to 8 mg/kg based on clinical response.

[†]ACTEMRA is not indicated for the treatment of MTX-naïve patients with rheumatoid arthritis (RA). ACTEMRA is indicated for the treatment of adult patients with moderately to severely active RA who have had an inadequate response to one or more DMARDs.

MTX=methotrexate.

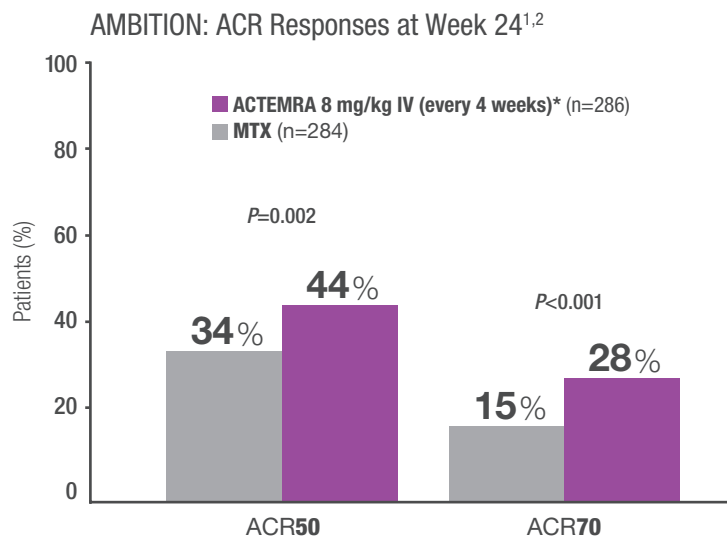
Select Important Safety Information

Contraindication

ACTEMRA is contraindicated in patients with known hypersensitivity to ACTEMRA.

Please see following pages for full Important Safety Information and brief summary of Prescribing Information.

ACTEMRA PROVIDED SIGNIFICANT ACR50 AND ACR70 RESPONSES VS MTX AT WEEK 24



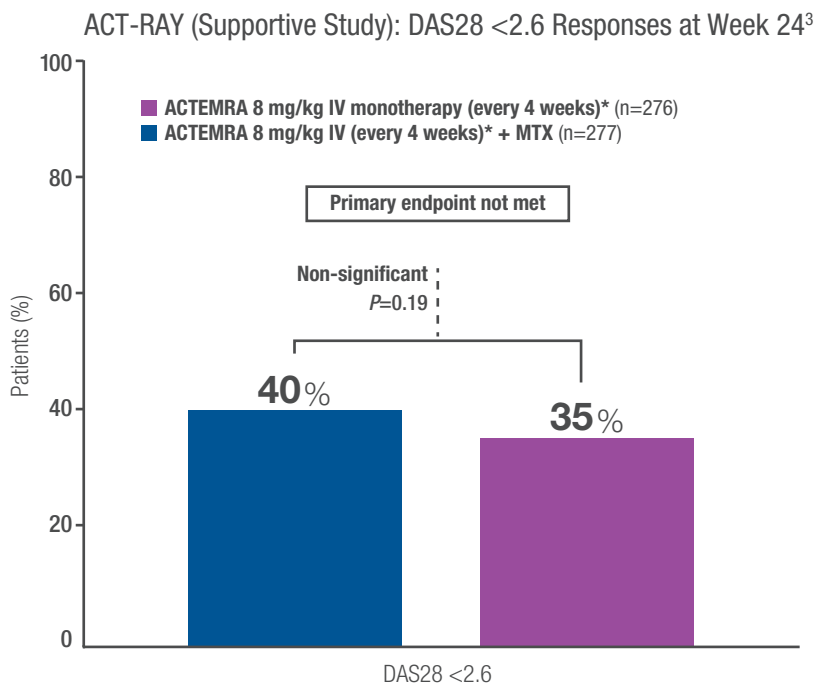
*The recommended starting dose for ACTEMRA IV is 4 mg/kg followed by an increase to 8 mg/kg based on clinical response.

Select Important Safety Information

Laboratory Monitoring

Laboratory monitoring is recommended due to potential consequences of treatment-related laboratory abnormalities in neutrophils, platelets, lipids, and liver function tests. Dosage modifications or interruptions may be required. Please see full Prescribing Information for more information.

ACTEMRA + MTX NOT SUPERIOR TO ACTEMRA ALONE



ACT-RAY: Supportive, Phase IIIb clinical trial in MTX-IR patients with moderate to severe RA. The study was designed to evaluate the superiority of combination ACTEMRA IV 8 mg/kg + MTX vs monotherapy ACTEMRA IV 8 mg/kg.* Patients received ACTEMRA IV + MTX or ACTEMRA IV every 4 weeks. The primary endpoint was the proportion of patients achieving DAS28 <2.6 at Week 24. ACT-RAY primary endpoint was not met.

*The recommended starting dose for ACTEMRA IV is 4 mg/kg followed by an increase to 8 mg/kg based on clinical response.

DAS=disease activity score.

ACTEMRA® (tocilizumab)

Injection, for intravenous use
Injection, for subcutaneous use

This is a brief summary. Before prescribing, please refer to the full Prescribing Information.

WARNING: RISK OF SERIOUS INFECTIONS

Patients treated with ACTEMRA are at increased risk for developing serious infections that may lead to hospitalization or death [see **Warnings and Precautions, Adverse Reactions**]. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. If a serious infection develops, interrupt ACTEMRA until the infection is controlled.

Reported infections include:

- Active tuberculosis, which may present with pulmonary or extrapulmonary disease. Patients should be tested for latent tuberculosis before ACTEMRA use and during therapy. Treatment for latent infection should be initiated prior to ACTEMRA use.
- Invasive fungal infections, including candidiasis, aspergillosis, and pneumocystis. Patients with invasive fungal infections may present with disseminated, rather than localized, disease.
- Bacterial, viral and other infections due to opportunistic pathogens.

The risks and benefits of treatment with ACTEMRA should be carefully considered prior to initiating therapy in patients with chronic or recurrent infection. Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with ACTEMRA, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy [see **Warnings and Precautions**].

INDICATIONS AND USAGE

ACTEMRA® (tocilizumab) is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs).

ACTEMRA is indicated for the treatment of active polyarticular juvenile idiopathic arthritis (PJIA) in patients 2 years of age and older.

ACTEMRA is indicated for the treatment of active systemic juvenile idiopathic arthritis (SJIA) in patients 2 years of age and older.

DOSE AND ADMINISTRATION

ACTEMRA may be used alone or in combination with methotrexate; and in RA, other non-biologic DMARDs may be used.

Recommended Intravenous (IV) Adult RA Dose

Patients who have had an inadequate response to one or more DMARD	When used in combination with DMARDs or as monotherapy the recommended starting dose is 4 mg per kg followed by an increase to 8 mg per kg based on clinical response
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- Reduction of dose from 8 mg per kg to 4 mg per kg is recommended for management of certain dose-related laboratory changes including elevated liver enzymes, neutropenia, and thrombocytopenia [see **Warnings and Precautions and Adverse Reactions**].
- Doses exceeding 800 mg per infusion are not recommended in RA patients [see **Clinical Pharmacology**].

Recommended Subcutaneous (SC) Adult RA Dose

Patients less than 100 kg weight	162 mg administered subcutaneously every other week, followed by an increase to every week based on clinical response
Patients at or above 100 kg weight	162 mg administered subcutaneously every week

When transitioning from ACTEMRA intravenous therapy to subcutaneous administration administer the first subcutaneous dose instead of the next scheduled intravenous dose. Interruption of dose or reduction in frequency of administration of subcutaneous dose from every week to every other week dosing is recommended for management of certain dose-related laboratory changes including elevated liver enzymes, neutropenia, and thrombocytopenia [see **Dosage and Administration, Warnings and Precautions, and Adverse Reactions**].

CONTRAINDICATIONS

ACTEMRA is contraindicated in patients with known hypersensitivity to ACTEMRA [see **Warnings and Precautions**].

WARNINGS AND PRECAUTIONS

Serious Infections

Serious and sometimes fatal infections due to bacterial, mycobacterial, invasive fungal, viral, protozoal, or other opportunistic pathogens have been reported in patients receiving immunosuppressive agents including ACTEMRA for rheumatoid arthritis. The most common serious infections included pneumonia, urinary tract infection, cellulitis, herpes zoster, gastroenteritis, diverticulitis, sepsis and bacterial arthritis [see **Adverse Reactions**]. Among opportunistic infections, tuberculosis, cryptococcus, aspergillosis, candidiasis, and pneumocystosis were reported with ACTEMRA. Other serious infections, not reported in clinical studies, may also occur (e.g., histoplasmosis, coccidioidomycosis, listeriosis). Patients have presented with disseminated rather than localized disease, and were often taking concomitant immunosuppressants such as methotrexate or corticosteroids which in addition to rheumatoid arthritis may predispose them to infections.

Do not administer ACTEMRA in patients with an active infection, including localized infections. The risks and benefits of treatment should be considered prior to initiating ACTEMRA in patients:

- with chronic or recurrent infection
- who have resided or traveled in areas of endemic tuberculosis or endemic mycoses
- who have been exposed to tuberculosis
- with underlying conditions that may predispose them to infection
- with a history of serious or an opportunistic infection

Closely monitor patients for the development of signs and symptoms of infection during and after treatment with ACTEMRA, as signs and symptoms of acute inflammation may be lessened due to suppression of the acute phase reactants [see **Dosage and Administration, Adverse Reactions and Patient Counseling Information**].

Hold ACTEMRA if a patient develops a serious infection, an opportunistic infection, or sepsis. A patient who develops a new infection during treatment with ACTEMRA should undergo a prompt and complete diagnostic workup appropriate for an immunocompromised patient, appropriate antimicrobial therapy should be initiated, and the patient should be closely monitored.

Tuberculosis. Evaluate patients for tuberculosis risk factors and test for latent infection prior to initiating ACTEMRA.

Consider anti-tuberculosis therapy prior to initiation of ACTEMRA in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed, and for patients with a negative test for latent tuberculosis but having risk factors for tuberculosis infection. Consultation with a physician with expertise in the treatment of tuberculosis is recommended to aid in the decision whether initiating anti-tuberculosis therapy is appropriate for an individual patient.

Closely monitor patients for the development of signs and symptoms of tuberculosis including patients who tested negative for latent tuberculosis infection prior to initiating therapy.

It is recommended that patients be screened for latent tuberculosis infection prior to starting ACTEMRA. The incidence of tuberculosis in worldwide clinical development programs is 0.1%. Patients with latent tuberculosis should be treated with standard antimycobacterial therapy before initiating ACTEMRA.

Viral Reactivation Viral reactivation has been reported with immunosuppressive biologic therapies and cases of herpes zoster exacerbation were observed in clinical studies with ACTEMRA. No cases of Hepatitis B reactivation were observed in the trials; however patients who screened positive for hepatitis were excluded.

Gastrointestinal Perforations

Events of gastrointestinal perforation have been reported in clinical trials, primarily as complications of diverticulitis in RA patients. ACTEMRA should be used with caution in patients who may be at increased risk for gastrointestinal perforation. Patients presenting with new onset abdominal symptoms should be evaluated promptly for early identification of gastrointestinal perforation [see **Adverse Reactions**].

Laboratory Parameters

Rheumatoid Arthritis

Neutropenia Treatment with ACTEMRA was associated with a higher incidence of neutropenia. Infections have been uncommonly reported in association with treatment-related neutropenia in long-term extension studies and postmarketing clinical experience.

– It is not recommended to initiate ACTEMRA treatment in patients with a low neutrophil count i.e., absolute neutrophil count (ANC) less than 2000/mm³. In patients who develop an absolute neutrophil count less than 500/mm³ treatment is not recommended.

– Monitor neutrophils 4 to 8 weeks after start of therapy and every 3 months thereafter. For recommended modifications based on ANC results, please consult the full Prescribing Information.

Thrombocytopenia Treatment with ACTEMRA was associated with a reduction in platelet counts. Treatment-related reduction in platelets was not associated with serious bleeding events in clinical trials [see **Adverse Reactions**].

– It is not recommended to initiate ACTEMRA treatment in patients with a platelet count below 100,000/mm³. In patients who develop a platelet count less than 50,000/mm³ treatment is not recommended.

– Monitor platelets 4 to 8 weeks after start of therapy and every 3 months thereafter. For recommended modifications based on platelet counts, please consult the full Prescribing Information.

Elevated Liver Enzymes Treatment with ACTEMRA was associated with a higher incidence of transaminase elevations. These elevations did not result in apparent permanent or clinically evident hepatic injury in clinical trials [see **Adverse Reactions**]. Increased frequency and magnitude of these elevations was observed when potentially hepatotoxic drugs (e.g., MTX) were used in combination with ACTEMRA.

In one case, a patient who had received ACTEMRA 8 mg/kg monotherapy without elevations in transaminases experienced elevation in AST to above 10x ULN and elevation in ALT to above 16x ULN when MTX was initiated in combination with ACTEMRA. Transaminases normalized when both treatments were held, but elevations recurred when MTX and ACTEMRA were restarted at lower doses. Elevations resolved when MTX and ACTEMRA were discontinued.

– It is not recommended to initiate ACTEMRA treatment in patients with elevated transaminases ALT or AST greater than 1.5x ULN. In patients who develop elevated ALT or AST greater than 5x ULN treatment is not recommended.

– Monitor ALT and AST levels 4 to 8 weeks after start of therapy and every 3 months thereafter. When clinically indicated, other liver function tests such as bilirubin should be considered. For recommended modifications based on transaminases, please consult the full Prescribing Information.

Lipid Abnormalities Treatment with ACTEMRA was associated with increases in lipid parameters such as total cholesterol, triglycerides, LDL cholesterol, and/or HDL cholesterol [see **Adverse Reactions**].

– Assess lipid parameters approximately 4 to 8 weeks following initiation of ACTEMRA therapy, then at approximately 24 week intervals.

– Manage patients according to clinical guidelines [e.g., National Cholesterol Educational Program (NCEP)] for the management of hyperlipidemia.

Immunosuppression The impact of treatment with ACTEMRA on the development of malignancies is not known but malignancies were observed in clinical studies [see **Adverse Reactions**]. ACTEMRA is an immunosuppressant, and treatment with immunosuppressants may result in an increased risk of malignancies.

Hypersensitivity Reactions, Including Anaphylaxis Hypersensitivity reactions, including anaphylaxis and death, have been reported in association with ACTEMRA [see **Adverse Reactions**] and anaphylactic events with a fatal outcome have been reported with intravenous infusion of ACTEMRA. Anaphylaxis and other hypersensitivity reactions that required treatment discontinuation were reported in 0.1% (3 out of 2644) of patients in the 6-month controlled trials of intravenous ACTEMRA, 0.2% (8 out of 4009) of patients in the intravenous all-exposure RA population, 0.7% (8 out of 1068) in the subcutaneous 6-month controlled RA trials, and in 0.7% (10 out of 1465) of patients in the subcutaneous all-exposure population. Injection site reactions were categorized separately [see **Adverse Reactions**].

In the postmarketing setting, events of hypersensitivity reactions, including anaphylaxis and death, have occurred in patients treated with a range of doses of intravenous ACTEMRA, with or without concomitant arthritis therapies. Events have occurred in patients who received premedication. Hypersensitivity, including anaphylaxis events, have occurred both with and without previous hypersensitivity reactions and as early as the first infusion of ACTEMRA [see **Adverse Reactions**]. ACTEMRA for intravenous use should only be infused by a healthcare professional with appropriate medical support to manage anaphylaxis. For ACTEMRA subcutaneous injection, advise patients to seek immediate medical attention if they experience any symptoms of a hypersensitivity reaction. If anaphylaxis or other hypersensitivity reaction occurs, administration of ACTEMRA should be stopped immediately and ACTEMRA should be permanently discontinued. Do not administer ACTEMRA to patients with known hypersensitivity to ACTEMRA [see **Contraindications and Adverse Reactions**].

Demyelinating Disorders The impact of treatment with ACTEMRA on demyelinating disorders is not known, but multiple sclerosis and chronic inflammatory demyelinating polyneuropathy were reported rarely in RA clinical studies. Patients should be closely monitored for signs and symptoms potentially indicative of demyelinating disorders. Prescribers should exercise caution in considering the use of ACTEMRA in patients with preexisting or recent onset demyelinating disorders.

Active Hepatic Disease and Hepatic Impairment Treatment with ACTEMRA is not recommended in patients with active hepatic disease or hepatic impairment [see **Adverse Reactions, Use in Specific Populations**].

Vaccinations Avoid use of live vaccines concurrently with ACTEMRA as clinical safety has not been established. No data are available on the secondary transmission of infection from persons receiving live vaccines to patients receiving ACTEMRA.

No data are available on the effectiveness of vaccination in patients receiving ACTEMRA. Because IL-6 inhibition may interfere with the normal immune response to new antigens, it is recommended that all patients, if possible, be brought up to date with all immunizations in agreement with current immunization guidelines prior to initiating ACTEMRA therapy. The interval between live vaccinations and initiation of ACTEMRA therapy should be in accordance with current vaccination guidelines regarding immunosuppressive agents.

ADVERSE REACTIONS

Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not predict the rates observed in a broader patient population in clinical practice.

Clinical Trials Experience in Rheumatoid Arthritis Patients Treated with Intravenous ACTEMRA (ACTEMRA-IV)

The ACTEMRA-IV data in rheumatoid arthritis (RA) includes 5 double-blind, controlled, multicenter studies. In these studies, patients received doses of ACTEMRA-IV 8 mg per kg monotherapy (288 patients), ACTEMRA-IV 8 mg per kg in combination with DMARDs (including methotrexate) (1582 patients), or ACTEMRA-IV 4 mg per kg in combination with methotrexate (774 patients).

The all exposure population includes all patients in registration studies who received at least one dose of ACTEMRA-IV. Of the 4009 patients in this population, 3577 received treatment for at least 6 months, 3309 for at least one year; 2954 received treatment for at least 2 years and 2189 for 3 years. All patients in these studies had moderately to severely active rheumatoid arthritis. The study population had a mean age of 52 years, 82% were female and 74% were Caucasian. The most common serious adverse reactions were serious infections [see *Warnings and Precautions*]. The most commonly reported adverse reactions in controlled studies up to 24 weeks (occurring in at least 5% of patients treated with ACTEMRA-IV monotherapy or in combination with DMARDs) were upper respiratory tract infections, nasopharyngitis, headache, hypertension and increased ALT. The proportion of patients who discontinued treatment due to any adverse reactions during the double-blind, placebo-controlled studies was 5% for patients taking ACTEMRA-IV and 3% for placebo-treated patients. The most common adverse reactions that required discontinuation of ACTEMRA-IV were increased hepatic transaminase values (per protocol requirement) and serious infections.

Overall Infections In the 24 week, controlled clinical studies, the rate of infections in the ACTEMRA-IV monotherapy group was 119 events per 100 patient-years and was similar in the methotrexate monotherapy group. The rate of infections in the 4 mg per kg and 8 mg per kg ACTEMRA-IV plus DMARD group was 133 and 127 events per 100 patient-years, respectively, compared to 112 events per 100 patient-years in the placebo plus DMARD group. The most commonly reported infections (5% to 8% of patients) were upper respiratory tract infections and nasopharyngitis.

The overall rate of infections with ACTEMRA-IV in the all exposure population remained consistent with rates in the controlled periods of the studies.

Serious Infections In the 24 week, controlled clinical studies, the rate of serious infections in the ACTEMRA-IV monotherapy group was 3.6 per 100 patient-years compared to 1.5 per 100 patient-years in the methotrexate group. The rate of serious infections in the 4 mg per kg and 8 mg per kg ACTEMRA-IV plus DMARD group was 4.4 and 5.3 events per 100 patient-years, respectively, compared to 3.9 events per 100 patient-years in the placebo plus DMARD group. In the all-exposure population, the overall rate of serious infections remained consistent with rates in the controlled periods of the studies. The most common serious infections included pneumonia, urinary tract infection, cellulitis, herpes zoster, gastroenteritis, diverticulitis, sepsis and bacterial arthritis. Cases of opportunistic infections have been reported [see *Warnings and Precautions*].

Gastrointestinal Perforations During the 24 week, controlled clinical trials, the overall rate of gastrointestinal perforation was 0.26 events per 100 patient-years with ACTEMRA-IV therapy. In the all-exposure population, the overall rate of gastrointestinal perforation remained consistent with rates in the controlled periods of the studies. Reports of gastrointestinal perforation were primarily reported as complications of diverticulitis including generalized purulent peritonitis, lower GI perforation, fistula and abscess. Most patients who developed gastrointestinal perforations were taking concomitant nonsteroidal anti-inflammatory medications (NSAIDs), corticosteroids, or methotrexate [see *Warnings and Precautions*]. The relative contribution of these concomitant medications versus ACTEMRA-IV to the development of GI perforations is not known.

Infusion Reactions In the 24 week, controlled clinical studies, adverse events associated with the infusion (occurring during or within 24 hours of the start of infusion) were reported in 8% and 7% of patients in the 4 mg per kg and 8 mg per kg ACTEMRA-IV plus DMARD group, respectively, compared to 5% of patients in the placebo plus DMARD group. The most frequently reported event on the 4 mg per kg and 8 mg per kg dose during the infusion was hypertension (1% for both doses), while the most frequently reported event occurring within 24 hours of finishing an infusion were headache (1% for both doses) and skin reactions (1% for both doses), including rash, pruritus and urticaria. These events were not treatment limiting.

Anaphylaxis Hypersensitivity reactions requiring treatment discontinuation, including anaphylaxis, associated with ACTEMRA-IV were reported in 0.1% (3 out of 2644) in the 24 week, controlled trials and in 0.2% (8 out of 4009) in the all-exposure population. These reactions were generally observed during the second to fourth infusion of ACTEMRA-IV. Appropriate medical treatment should be available for immediate use in the event of a serious hypersensitivity reaction [see *Warnings and Precautions*].

Laboratory Abnormalities

Neutropenia In the 24 week, controlled clinical studies, decreases in neutrophil counts below 1000 per mm³ occurred in 1.8% and 3.4% of patients in the 4 mg per kg and 8 mg per kg ACTEMRA-IV plus DMARD group, respectively, compared to 0.1% of patients in the placebo plus DMARD group. Approximately half of the instances of ANC below 1000 per mm³ occurred within 8 weeks of starting therapy. Decreases in neutrophil counts below 500 per mm³ occurred in 0.4% and 0.3% of patients in the 4 mg per kg and 8 mg per kg ACTEMRA-IV plus DMARD, respectively, compared to 0.1% of patients in the placebo plus DMARD group. There was no clear relationship between decreases in neutrophils below 1000 per mm³ and the occurrence of serious infections. In the all-exposure population, the pattern and incidence of decreases in neutrophil counts remained consistent with what was seen in the 24 week controlled clinical studies [see *Warnings and Precautions*].

Thrombocytopenia In the 24 week, controlled clinical studies, decreases in platelet counts below 100,000 per mm³ occurred in 1.3% and 1.7% of patients on 4 mg per kg and 8 mg per kg ACTEMRA-IV plus DMARD, respectively, compared to 0.5% of patients on placebo plus DMARD, without associated bleeding events.

In the all-exposure population, the pattern and incidence of decreases in platelet counts remained consistent with what was seen in the 24 week controlled clinical studies [see *Warnings and Precautions*].

Elevated Liver Enzymes Liver enzyme abnormalities are summarized in **Table 1**. In patients experiencing liver enzyme elevation, modification of treatment regimen, such as reduction in the dose of concomitant DMARD, interruption of ACTEMRA-IV, or reduction in ACTEMRA-IV dose, resulted in decrease or normalization of liver enzymes [see *Dosage and Administration*]. These elevations were not associated with clinically relevant increases in direct bilirubin, nor were they associated with clinical evidence of hepatitis or hepatic insufficiency [see *Warnings and Precautions*].

Table 1 Incidence of Liver Enzyme Abnormalities in the 24 Week Controlled Period of Studies I to V*

	ACTEMRA 8 mg per kg MONO THERAPY N = 288 (%)	Metho trexate N = 284 (%)	ACTEMRA 4 mg per kg + DMARDs N = 774 (%)	ACTEMRA 8 mg per kg + DMARDs N = 1582 (%)	Placebo + DMARDs N = 1170 (%)
AST (U/L)					
> ULN to 3x ULN	22	26	34	41	17
> 3x ULN to 5x ULN	0.3	2	1	2	0.3
> 5x ULN	0.7	0.4	0.1	0.2	<0.1
ALT (U/L)					
> ULN to 3x ULN	36	33	45	48	23
> 3x ULN to 5x ULN	1	4	5	5	1
> 5x ULN	0.7	1	1.3	1.5	0.3

ULN = Upper Limit of Normal.

*For a description of these studies, see Section 14, Clinical Studies in the full Prescribing Information. In the all-exposure population, the elevations in ALT and AST remained consistent with what was seen in the 24 week, controlled clinical trials

Lipids Elevations in lipid parameters (total cholesterol, LDL, HDL, triglycerides) were first assessed at 6 weeks following initiation of ACTEMRA-IV in the controlled 24 week clinical trials. Increases were observed at this time point and remained stable thereafter. Increases in triglycerides to levels above 500 mg per dL were rarely observed. Changes in other lipid parameters from baseline to week 24 were evaluated and are summarized below:

– Mean LDL increased by 13 mg per dL in the ACTEMRA 4 mg per kg+DMARD arm, 20 mg per dL in the ACTEMRA 8 mg per kg+DMARD, and 25 mg per dL in ACTEMRA 8 mg per kg monotherapy.

– Mean HDL increased by 3 mg per dL in the ACTEMRA 4 mg per kg+DMARD arm, 5 mg per dL in the ACTEMRA 8 mg per kg+DMARD, and 4 mg per dL in ACTEMRA 8 mg per kg monotherapy.

– Mean LDL/HDL ratio increased by an average of 0.14 in the ACTEMRA 4 mg per kg+DMARD arm, 0.15 in the ACTEMRA 8 mg per kg+DMARD, and 0.26 in ACTEMRA 8 mg per kg monotherapy.

– ApoB/ApoA1 ratios were essentially unchanged in ACTEMRA-treated patients.

Elevated lipids responded to lipid lowering agents.

In the all-exposure population, the elevations in lipid parameters remained consistent with what was seen in the 24 week, controlled clinical trials.

Immunogenicity In the 24 week, controlled clinical studies, a total of 2876 patients have been tested for anti-tocilizumab antibodies. Forty-six patients (2%) developed positive anti-tocilizumab antibodies, of whom 5 had an associated, medically significant, hypersensitivity reaction leading to withdrawal. Thirty patients (1%) developed neutralizing antibodies.

The data reflect the percentage of patients whose test results were positive for antibodies to tocilizumab in specific assays. The observed incidence of antibody positivity in an assay is highly dependent on several factors, including assay sensitivity and specificity, assay methodology, sample handling, timing of sample collection, concomitant medication, and underlying disease. For these reasons, comparison of the incidence of antibodies to tocilizumab with the incidence of antibodies to other products may be misleading.

Malignancies During the 24 week, controlled period of the studies, 15 malignancies were diagnosed in patients receiving ACTEMRA-IV, compared to 8 malignancies in patients in the control groups. Exposure-adjusted incidence was similar in the ACTEMRA-IV groups (1.32 events per 100 patient-years) and in the placebo plus DMARD group (1.37 events per 100 patient-years). In the all-exposure population, the rate of malignancies remained consistent with the rate observed in the 24 week, controlled period [see *Warnings and Precautions*].

Other Adverse Reactions Adverse reactions occurring in 2% or more of patients on 4 or 8 mg per kg ACTEMRA-IV plus DMARD and at least 1% greater than that observed in patients on placebo plus DMARD are summarized in **Table 2**.

Table 2 Adverse Reactions Occurring in at Least 2% or More of Patients on 4 or 8 mg per kg ACTEMRA-IV plus DMARD and at Least 1% Greater Than That Observed in Patients on Placebo plus DMARD

24 Week Phase 3 Controlled Study Population					
	ACTEMRA 8 mg per kg MONO THERAPY N = 288 (%)	Metho trexate N = 284 (%)	ACTEMRA 4 mg per kg + DMARDs N = 774 (%)	ACTEMRA 8 mg per kg + DMARDs N = 1582 (%)	Placebo + DMARDs N = 1170 (%)
Preferred Term					
Upper Respiratory Tract Infection	7	5	6	8	6
Nasopharyngitis	7	6	4	6	4
Headache	7	2	6	5	3
Hypertension	6	2	4	4	3
ALT increased	6	4	3	3	1
Dizziness	3	1	2	3	2
Bronchitis	3	2	4	3	3
Rash	2	1	4	3	1
Mouth Ulceration	2	2	1	2	1
Abdominal Pain Upper	2	2	3	3	2
Gastritis	1	2	1	2	1
Transaminase increased	1	5	2	2	1

Other infrequent and medically relevant adverse reactions occurring at an incidence less than 2% in rheumatoid arthritis patients treated with ACTEMRA-IV in controlled trials were:

Infections and Infestations: oral herpes simplex

Gastrointestinal disorders: stomatitis, gastric ulcer

Investigations: weight increased, total bilirubin increased

Blood and lymphatic system disorders: leukopenia

General disorders and administration site conditions: edema peripheral

Respiratory, thoracic, and mediastinal disorders: dyspnea, cough

Eye disorders: conjunctivitis

Renal disorders: nephrolithiasis

Endocrine disorders: hypothyroidism

Clinical Trials Experience in Rheumatoid Arthritis Patients Treated with Subcutaneous ACTEMRA (ACTEMRA-SC)

The ACTEMRA-SC data in rheumatoid arthritis (RA) includes 2 double-blind, controlled, multicenter studies. Study SC-I was a non-inferiority study that compared the efficacy and safety of tocilizumab 162 mg administered every week subcutaneously (SC) and 8 mg/kg intravenously (IV) every four weeks in 1262 adult subjects with rheumatoid arthritis. Study SC-II was a placebo controlled superiority study that evaluated the safety and efficacy of tocilizumab 162 mg administered every other week SC or placebo in 656 patients. All patients in both studies received background non-biologic DMARDs.

The safety observed for ACTEMRA administered subcutaneously was consistent with the known safety profile of intravenous ACTEMRA, with the exception of injection site reactions, which were more common with ACTEMRA-SC compared with placebo SC injections (IV arm). **Injection Site Reactions** In the 6-month control period, in SC-I, the frequency of injection site reactions was 10.1% (64/631) and 2.4% (15/631) for the weekly ACTEMRA-SC and placebo SC (IV-arm) groups, respectively. In SC-II, the frequency of injection site reactions was 7.1% (31/437) and 4.1% (9/218) for the every other week SC ACTEMRA and placebo groups, respectively. These injection site reactions (including erythema, pruritus, pain and hematoma) were mild to moderate in severity. The majority resolved without any treatment and none necessitated drug discontinuation.

Immunogenicity In the 6-month control period in SC-I, 0.8% (5/625) in the ACTEMRA-SC arm and 0.8% (5/627) in the IV arm developed anti-tocilizumab antibodies; of these, all developed neutralizing antibodies. In SC-II, 1.6% (7/434) in the ACTEMRA-SC arm compared with 1.4% (3/217) in the placebo arm developed anti-tocilizumab antibodies; of these, 1.4% (6/434) in the ACTEMRA-SC arm and 0.5% (1/217) in the placebo arm also developed neutralizing antibodies.

A total of 1454 (>99%) patients who received ACTEMRA-SC in the all exposure group have been tested for anti-tocilizumab antibodies. Thirteen patients (0.9%) developed anti-tocilizumab antibodies, and, of these, 12 patients (0.8%) developed neutralizing antibodies. The rate is consistent with previous intravenous experience. No correlation of antibody development to adverse events or loss of clinical response was observed.

Laboratory Abnormalities

Neutropenia During routine laboratory monitoring in the 6-month controlled clinical trials, a decrease in neutrophil count below $1 \times 10^9/L$ occurred in 2.9% and 3.7% of patients receiving ACTEMRA-SC weekly and every other week, respectively.

There was no clear relationship between decreases in neutrophils below $1 \times 10^9/L$ and the occurrence of serious infections.

Thrombocytopenia During routine laboratory monitoring in the ACTEMRA-SC 6-month controlled clinical trials, none of the patients had a decrease in platelet count to $\leq 50 \times 10^3/mL$.

Elevated Liver Enzymes During routine laboratory monitoring in the 6-month controlled clinical trials, elevation in ALT or AST $\geq 3 \times$ ULN occurred in 6.5% and 1.4% of patients, respectively, receiving ACTEMRA-SC weekly and 3.4% and 0.7% receiving ACTEMRA SC every other week.

Lipids During routine laboratory monitoring in the ACTEMRA-SC 6-month clinical trials, 19% of patients dosed weekly and 19.6% of patients dosed every other week and 10.2% of patients on placebo experienced sustained elevations in total cholesterol > 6.2 mmol/L (240 mg/dL), with 9%, 10.4% and 5.1% experiencing a sustained increase in LDL to 4.1 mmol/L (160 mg/dL) receiving ACTEMRA-SC weekly, every other week and placebo, respectively.

DRUG INTERACTIONS

Other Drugs for Treatment of Rheumatoid Arthritis

Population pharmacokinetic analyses did not detect any effect of methotrexate (MTX), non-steroidal anti-inflammatory drugs or corticosteroids on tocilizumab clearance.

Concomitant administration of a single dose of 10 mg per kg ACTEMRA with 10-25 mg MTX once weekly had no clinically significant effect on MTX exposure.

ACTEMRA has not been studied in combination with biological DMARDs such as TNF antagonists [see *Dosage and Administration*].

Interactions with CYP450 Substrates

Cytochrome P450s in the liver are down-regulated by infection and inflammation stimuli including cytokines such as IL-6. Inhibition of IL-6 signaling in RA patients treated with tocilizumab may restore CYP450 activities to higher levels than those in the absence of tocilizumab leading to increased metabolism of drugs that are CYP450 substrates. In vitro studies showed that tocilizumab has the potential to affect expression of multiple CYP enzymes including CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6 and CYP3A4. Its effects on CYP2C8 or transporters is unknown. In vivo studies with omeprazole, metabolized by CYP2C19 and CYP3A4, and simvastatin, metabolized by CYP3A4, showed up to a 28% and 57% decrease in exposure one week following a single dose of ACTEMRA, respectively. The effect of tocilizumab on CYP enzymes may be clinically relevant for CYP450 substrates with narrow therapeutic index, where the dose is individually adjusted. Upon initiation or discontinuation of ACTEMRA, in patients being treated with these types of medicinal products, therapeutic monitoring of effect (e.g., warfarin) or drug concentration (e.g., cyclosporine or theophylline) should be performed and the individual dose of the medicinal product adjusted as needed. Exercise caution when ACTEMRA is coadministered with CYP3A4 substrate drugs where decrease in effectiveness is undesirable, e.g., oral contraceptives, lovastatin, atorvastatin, etc. The effect of tocilizumab on CYP450 enzyme activity may persist for several weeks after stopping therapy [see *Clinical Pharmacology*].

Live Vaccines

Avoid use of live vaccines concurrently with ACTEMRA [see *Warnings and Precautions*].

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Category C.

Pregnancy Exposure Registry There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to ACTEMRA during pregnancy. Physicians are encouraged to register patients and pregnant women are encouraged to register themselves by calling 1-877-311-8972.

Risk Summary Adequate and well-controlled studies with ACTEMRA have not been conducted in pregnant women. In animal reproduction studies, administration of tocilizumab to cynomolgus monkeys during organogenesis caused abortion/embryo-fetal death at dose exposures 1.25 times the human dose exposure of 8 mg per kg every 2 to 4 weeks. The incidence of malformations and pregnancy loss in human pregnancies has not been established for ACTEMRA. However, all pregnancies, regardless of drug exposure, have a background rate of 2 to 4% for major malformations, and 15 to 20% for pregnancy loss.

ACTEMRA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Clinical Considerations

In general, monoclonal antibodies are transported across the placenta in a linear fashion as pregnancy progresses, with the largest amount transferred during the third trimester.

Animal Data

An embryo-fetal developmental toxicity study was performed in which pregnant cynomolgus monkeys were treated intravenously with tocilizumab (daily doses of 2, 10, or 50 mg per kg from gestation day 20-50) during organogenesis. Although there was no evidence for a teratogenic/dysmorphogenic effect at any dose, tocilizumab produced an increase in the incidence of abortion/embryo-fetal death at 10 mg per kg and 50 mg per kg doses (1.25 and 6.25 times the human dose of 8 mg per kg every 2 to 4 weeks based on a mg per kg comparison). Testing of a murine analogue of tocilizumab in mice did not yield any evidence of harm to offspring during the pre- and postnatal development phase when dosed at 50 mg per kg intravenously with treatment every three days from implantation until day 21 after delivery (weaning). There was no evidence for any functional impairment of the development and behavior, learning ability, immune competence and fertility of the offspring.

Nursing Mothers

It is not known whether tocilizumab is excreted in human milk or if it would be absorbed systemically in a breastfed infant after ingestion. IgG is excreted in human milk, and therefore it is expected that tocilizumab could be present in human milk. Because many drugs are excreted in human milk, and because of the potential for serious adverse reactions in nursing infants from ACTEMRA, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

ACTEMRA by intravenous use is indicated for the treatment of pediatric patients with:

- Active systemic juvenile idiopathic arthritis in patients 2 years of age and older
- Active polyarticular juvenile idiopathic arthritis in patients 2 years of age and older

Safety and effectiveness of ACTEMRA in pediatric patients with conditions other than PJIA or SJIA have not been established. Children under the age of two have not been studied. SC administration has not been studied in pediatric patients. Testing of a murine analogue of tocilizumab did not exert toxicity in juvenile mice. In particular, there was no impairment of skeletal growth, immune function and sexual maturation.

Geriatric Use

Of the 2644 patients who received ACTEMRA in Studies I to V [see *Clinical Studies*], a total of 435 rheumatoid arthritis patients were 65 years of age and older, including 50 patients 75 years and older. Of the 1069 patients who received ACTEMRA-SC in studies SC-I and SC-II there were 295 patients 65 years of age and older, including 41 patients 75 years and older. The frequency of serious infection among ACTEMRA treated subjects 65 years of age and older was higher than those under the age of 65. As there is a higher incidence of infections in the elderly population in general, caution should be used when treating the elderly.

Hepatic Impairment

The safety and efficacy of ACTEMRA have not been studied in patients with hepatic impairment, including patients with positive HBV and HCV serology [see *Warnings and Precautions*].

Renal Impairment

No dose adjustment is required in patients with mild renal impairment. ACTEMRA has not been studied in patients with moderate to severe renal impairment [see *Clinical Pharmacology*].

OVERDOSAGE

There are limited data available on overdoses with ACTEMRA. One case of accidental overdose was reported in which a patient with multiple myeloma received a dose of 40 mg per kg. No adverse drug reactions were observed. No serious adverse drug reactions were observed in healthy volunteers who received single doses of up to 28 mg per kg, although all 5 patients at the highest dose of 28 mg per kg developed dose-limiting neutropenia.

In case of an overdose, it is recommended that the patient be monitored for signs and symptoms of adverse reactions. Patients who develop adverse reactions should receive appropriate symptomatic treatment.

PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Medication Guide)

Patient Counseling

Advise patients and parents or guardians of minors with PJIA or SJIA of the potential benefits and risks of ACTEMRA. Physicians should instruct their patients to read the Medication Guide before starting ACTEMRA therapy.

• Infections:

Inform patients that ACTEMRA may lower their resistance to infections. Instruct the patient of the importance of contacting their doctor immediately when symptoms suggesting infection appear in order to assure rapid evaluation and appropriate treatment.

• Gastrointestinal Perforation:

Inform patients that some patients who have been treated with ACTEMRA have had serious side effects in the stomach and intestines. Instruct the patient of the importance of contacting their doctor immediately when symptoms of severe, persistent abdominal pain appear to assure rapid evaluation and appropriate treatment.

• Hypersensitivity and Serious Allergic Reactions:

Assess patient suitability for home use for SC injection. Inform patients that some patients who have been treated with ACTEMRA have developed serious allergic reactions, including anaphylaxis. Advise patients to seek immediate medical attention if they experience any symptom of serious allergic reactions.

Instruction on Injection Technique

Perform the first injection under the supervision of a qualified healthcare professional. If a patient or caregiver is to administer subcutaneous ACTEMRA, instruct him/her in injection techniques and assess his/her ability to inject subcutaneously to ensure proper administration of subcutaneous ACTEMRA and the suitability for home use [See *Patient Instructions for Use*]. Prior to use, remove the prefilled syringe from the refrigerator and allow to sit at room temperature outside of the carton for 30 minutes, out of the reach of children. Do not warm ACTEMRA in any other way.

Advise patients to consult their healthcare provider if the full dose is not received.

A puncture-resistant container for disposal of needles and syringes should be used and should be kept out of the reach of children. Instruct patients or caregivers in the technique as well as proper syringe and needle disposal, and caution against reuse of these items.

Indication

ACTEMRA is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs).

Important Safety Information

BOXED WARNING

Serious Infections

Serious infections leading to hospitalization or death, including tuberculosis (TB), bacterial, invasive fungal, viral, and other opportunistic infections, have occurred in patients receiving ACTEMRA. ACTEMRA should not be administered during an active infection, including localized infections. If a serious infection develops, ACTEMRA should be interrupted until the infection is controlled.

Prior to initiating ACTEMRA, a test for latent TB should be performed. If the test is positive, treatment for TB should be started prior to starting ACTEMRA. All patients should be monitored for active TB during treatment, even if initial latent TB test is negative. The benefits and risks of treatment should be considered prior to initiating ACTEMRA in patients:

- with chronic or recurrent infection
 - who have been exposed to TB
 - who have a history of serious or opportunistic infections
 - who have resided or traveled in areas of endemic TB or mycoses
 - with underlying conditions that may predispose them to infection
- Patients should be closely monitored for signs and symptoms of infection during and after treatment with ACTEMRA.

CONTRAINDICATION

ACTEMRA is contraindicated in patients with known hypersensitivity to ACTEMRA.

WARNINGS AND PRECAUTIONS

Gastrointestinal Perforations

Use ACTEMRA with caution in patients who may be at increased risk for gastrointestinal (GI) perforation. Promptly evaluate patients presenting with new-onset abdominal symptoms for early identification of GI perforation.

Laboratory Monitoring

Laboratory monitoring is recommended due to potential consequences of treatment-related laboratory abnormalities in neutrophils, platelets, lipids, and liver function tests. Dosage modifications may be required. Please see full Prescribing Information for more information.

Immunosuppression

The impact of treatment with ACTEMRA on the development of malignancies is not known, but malignancies were observed in clinical studies with ACTEMRA. ACTEMRA is an immunosuppressant, and treatment with immunosuppressants may result in an increased risk of malignancies.

Hypersensitivity Reactions

Hypersensitivity reactions, including anaphylaxis, have been reported in association with ACTEMRA and anaphylactic events with a fatal outcome have been reported with intravenous infusion of ACTEMRA. ACTEMRA for intravenous use should only be infused by a healthcare professional with appropriate medical support to manage anaphylaxis. For ACTEMRA subcutaneous injection, advise patients to seek immediate medical attention if they experience any symptoms of a hypersensitivity reaction. If anaphylaxis or other hypersensitivity reaction occurs, stop administration of ACTEMRA immediately and discontinue ACTEMRA permanently. Do not administer ACTEMRA to patients with known hypersensitivity to ACTEMRA.

Anaphylaxis and other hypersensitivity reactions that required treatment discontinuation were reported in 0.1% (3 out of 2644) of patients in the 6-month controlled trials of intravenous ACTEMRA, 0.2% (8 out of 4009) of patients in the intravenous all-exposure RA population, 0.7% (8 out of 1068) in the subcutaneous 6-month controlled RA trials, and in 0.7% (10 out of 1456) of patients in the subcutaneous all-exposure population.

Demyelinating Disorders

Monitor patients for signs and symptoms of demyelinating disorders.

Prescribers should exercise caution in considering the use of ACTEMRA in patients with preexisting or recent-onset demyelinating disorders.

Active Hepatic Disease and Hepatic Impairment

Treatment with ACTEMRA is not recommended in patients with active hepatic disease or hepatic impairment.

Vaccinations

Avoid use of live vaccines concurrently with ACTEMRA. Patients should be brought up to date on all recommended vaccinations prior to initiation of ACTEMRA therapy.

ADVERSE REACTIONS

The most common serious adverse reactions were serious infections. In the ACTEMRA-IV monotherapy clinical study, the rate of serious infections was 3.6 per 100 patient-years in the ACTEMRA group and 1.5 per 100 patient-years in the methotrexate group. The rate of serious infections in the 4 mg/kg and 8 mg/kg ACTEMRA plus DMARD groups was 4.4 and 5.3 events per 100 patient-years, respectively, compared to 3.9 events per 100 patient-years in the placebo plus DMARD group.

In the 5 Phase III clinical trials, the most common adverse reactions ($\geq 5\%$ of patients treated with ACTEMRA-IV) through 6 months were:

	ACTEMRA-IV 8 mg/kg Monotherapy (%)	Methotrexate (%)	ACTEMRA-IV 4 mg/kg + DMARDs (%)	ACTEMRA-IV 8 mg/kg + DMARDs (%)	Placebo + DMARDs (%)
URTI	7	5	6	8	6
Nasopharyngitis	7	6	4	6	4
Headache	7	2	6	5	3
Hypertension	6	2	4	4	3
Increased ALT	6	4	3	3	1

The safety observed for ACTEMRA administered subcutaneously was consistent with the known safety profile of intravenous ACTEMRA, with the exception of injection-site reactions, which were more common with ACTEMRA-SC compared with placebo-SC injections (IV-arm).

In the 6-month control period, in SC-I, the frequency of injection-site reactions was 10.1% (64/631) and 2.4% (15/631) for the weekly ACTEMRA-SC and placebo-SC (IV-arm) group, respectively. In SC-II, the frequency of injection-site reactions was 7.1% (31/437) and 4.1% (9/218) for the every other week ACTEMRA-SC and placebo-SC groups, respectively. These injection-site reactions were mild to moderate in severity. The majority resolved without any treatment and none necessitated drug discontinuation.

USE IN PREGNANCY: PREGNANCY CATEGORY C

Adequate and well-controlled studies with ACTEMRA have not been conducted in pregnant women. ACTEMRA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to ACTEMRA during pregnancy. Physicians are encouraged to register patients and pregnant women are encouraged to register themselves by calling 1-877-311-8972.

PATIENT COUNSELING INFORMATION

Advise patients of the potential benefits and risks of ACTEMRA. Physicians should instruct their patients to read the Medication Guide before starting ACTEMRA therapy. Inform patients that ACTEMRA may lower their resistance to infections and instruct patients of the importance of contacting their doctor immediately when symptoms of an infection appear. Inform patients that some patients receiving ACTEMRA have had serious side effects in the stomach and intestines and instruct patients of the importance of contacting their doctor immediately when symptoms of severe, persistent abdominal pain appear. Assess patient suitability for home use for SC injection. Inform patients that some patients have had serious allergic reactions including anaphylaxis and advise them to seek immediate medical attention if symptoms occur. Please see following brief summary of Prescribing Information, including **Boxed WARNING**, for additional important safety information.

References 1. Jones G, et al. *Ann Rheum Dis*. 2010;69:88-96. 2. Data on file. AMBITION Clinical Study Report. Genentech Inc. 3. Dougados M, et al. Presented at EULAR Annual European Congress of Rheumatology; June 6-9, 2012; Berlin, Germany. Poster THU0093.

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 **ACTEMRA**[®]
tocilizumab

NP Education Reflects 50-Year Effort to Promote Excellence

BY CHARLES DERVARICS

With more than 205,000 nurse practitioners (NPs) across the United States, NPs are a major player in the nation's health care system. They come to this work with extensive education and advanced clinical training, a background that provides them with specialized knowledge and competencies to serve children and adults across a range of settings including primary, acute, and long-term care.

"Even after 50 years, it's still a relatively young profession," said Dr. Diane Padden, vice president for research, education, and professional practice at the American Association of Nurse Practitioners (AANP). From a modest start at the University of Colorado in the 1960s to address a shortage of doctors and help manage rising health care costs, NP education has changed markedly during the past half century. Today, more than 400 colleges and universities have NP study tracks that reflect core competencies and professional guidelines, producing graduates who have at least six years of specialized training and can call on a diverse skill set to provide quality, individualized care.

"With considerable talk about a shortage of primary care providers, nurse practitioners can help fill the gap," Padden said. "And the key to that is quality education."

Building a Pathway

The educational pathway to becoming a nurse practitioner has five key components, achieved over a multi-year period. The first step is a bachelor of science degree in nursing, or BSN, a four-year degree from an accredited institution that prepares an individual to practice as a registered nurse (RN). After that point, other steps on the career pathway include:

Registered Nurse License: Bachelor's degree recipients follow the procedure in their state to become a registered nurse and obtain a license.

Graduate Nursing Education: RNs with an interest in further education enter a master's degree program or doctor of nursing practice (DNP) program. These two- to three-year programs provide additional clinical training and specialized training in areas from acute care to gerontology to women's health.

National Certification: The American Academy of Nurse Practitioners Certification Program (AANPCP) certifies adult, family, and adult-gerontology nurse practitioners through national certification examinations that prepare individuals for licensure and professional credentialing. Separately incorporated from AANP, the AANPCP offers entry-level certification in these three specialties along with practice exams to help candidates prepare for the assessment.

State NP Licensure Registration: The final step is to gain licensure within a state. State policies typically require an individual to be an RN within the state, a graduate of an accredited NP education program acceptable to the state, and an applicant for state certification.

Padden said those seeking an advanced nursing degree generally fall

into two categories – those with many years of experience as an RN and those who are fairly recent graduates of BSN programs. "In years past, you wouldn't enter an NP program without years of experience as an RN. But now you might go directly from an RN program to an NP program or pursue additional education after only a few years as a nurse," she said.

Statistics showing projected shortages of primary care physicians also are fueling interest in graduate nursing programs, as is the increased attention given to the NP profession as a vital cog in the nation's health care system, particularly as it affects underserved populations.

Data reflect the growing importance of NPs in primary care. In their master's and doctoral education, nurse practitioners continue to select primary care as a specialty area. In 2012, 80 percent of NPs were trained in primary care. At the same time, physicians increasingly are choosing specialties, as only 14 percent of physicians in 2012 focused on primary care.

Those trends provide "increased recognition of the nurse practitioner role," said Dr. Anne Norman, associate vice president for education at AANP. The number of nurse practitioners also is increasing steadily, from 106,000 in 2004 to 157,000 in 2012 and a projected 244,000 by 2025. More than 17,000 men and women graduated from NP programs alone in the 2012-2013 academic year, the most recent annual data available, according to AANP.

NPs Focus on Specialty Areas

One significant change over the past half century is in the specialty areas chosen by NPs in their



Instructor Crystal Smith, right, watches as Illinois State University (ISU) Mennonite College of Nursing student Lynnae Braker is examined by fellow nurse practitioner student Katie Merila at ISU's Nursing Simulation Lab in Normal, Illinois, on Sept. 12, 2014. By the time they are able to practice, NPs have had at least six years of specialized training.

advanced education programs. Family care and pediatrics dominated the landscape for decades, but education programs today can train students in an array of specialty areas including gerontological care, acute care, oncology, and women's health. "We don't come out as generalists," Norman said. "As part of their study, NPs declare what type of nurse practitioner they would like to be."

Overall, 54.5 percent of NPs still have some type of family care as their primary focus, the Association reports, a statistic welcomed by health policy experts concerned with a shortage of primary care providers. Yet about 1 in 5 practitioners chooses adult health care, and 1 in 4 selects other subspecialties. A breakdown of these options is in the chart to the right, along with average years of practice and mean age within these specialties.

The typical curriculum in a nurse practitioner program includes courses in epidemiology, health promotion, physical assessment and diagnostic reasoning, advanced pharmacology, laboratory/radiography diagnostics, statistics and research methods, health policy, leadership, and acute and chronic disease management. It also includes clinical rotations, depending on the chosen program and subspecialty.

AREA OF SPECIALTY, MEAN YEARS OF PRACTICE AND MEAN AGE

Population	Percent of NPs	Years of Practice	Age
Acute Care	7.5	8	46
Adult*	19.3	11	50
Family*	54.5	9	48
Gerontological*	2.5	13	53
Neonatal	1.1	16	52
Oncology	1.2	9	47
Pediatric*	5.3	15	50
Psych/Mental Health	3.7	11	54
Women's Health*	4.9	17	53

*All are based on a primary care focus.

The growth in NP and other health care programs also has led to inter-professional education, Padden said, where NP students may obtain didactic content in the same classrooms with those studying to be physician assistants or, in some cases, prospective physicians. "We're seeing more inter-professional education, and that is constructive because it

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NPs left to right: Amelie Hollier, Kathy Baldridge, Betty Vicknair, Mimi Secor, and Janis Guilbeau.

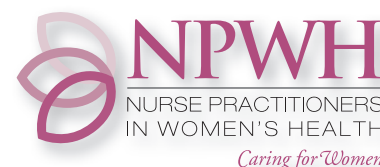
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promotes the idea of team-based care for patients,” she said. “As health care providers, we’re all working together to improve patient outcomes.”

Guiding curriculum at these colleges and universities is a set of nine core competencies developed by the National Organization of Nurse Practitioner Faculties. The competencies serve as guidelines so that, when they complete an NP program, graduates have the knowledge, skills, and abilities essential for successful independent practice. These competencies can drive curricula and programming at colleges and universities and include the following:

Scientific foundation competencies, including the ability to critically analyze data and translate research into improved practice;

Leadership competencies, including the ability to assume complex and

Clinical rotations are one component of nurse practitioner education programs.

advanced leadership roles and communicate practice knowledge effectively;

Quality competencies, such as using best available evidence to improve quality of clinical practice and applying skills in peer review to promote a culture of excellence;

Practice inquiry competencies, including the ability to apply clinical investigative skills to improve health outcomes;

Technology and information literacy competencies, such as integrating appropriate technologies for knowledge management;

Policy competencies, including the ability to analyze legal, ethical, and

social factors and to understand the link between policy and practice;

Health delivery system competencies, such as applying knowledge of organizational practices and complex systems to improve health care delivery;

Ethics competencies, such as evaluating the ethical consequences of decisions; and

Independent practice competencies, including the ability to manage the health and illness status of patients and/or families over time.

Next Steps: The Doctoral Degree

Amid growth of NPs nationwide, changes taking place across the nursing profession – fueled in part by major changes in U.S. health care – emphasized the need for additional education and credentialing. One

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significant event in 2004 was adoption of the DNP degree, a post-master's, terminal degree for advanced practice nurses. The decision to offer this degree grew out of efforts by nursing organizations to move the preparation level needed for advanced nursing from the master's level to the doctoral level.

Advocates of the plan noted that, through this action, nursing is moving in the same direction as many other medical professions including pharmacy, dentistry, psychology, physical therapy, and audiology by having a terminal degree at the doctoral level. AANP officials also have said that many NP programs already have a credit level similar to a doctoral degree.

The doctor of nursing practice (DNP) degree, a post-master's terminal degree for advanced practice nurses, was introduced in 2004. DNP advanced coursework includes such topics as biostatistics, informatics, and health policy and economics and places greater emphasis on clinical research.

The DNP includes additional advanced coursework in biostatistics, research methods, clinical outcome measures, care of special populations, informatics, and health care policy and economics. "As our health care and systems become more complex, NPs need more education," Padden said. The DNP also places even greater emphasis on clinical research. "Quality care

and improved patient outcomes are always the goal," she said. DNP programs typically take three years of full-time study.

However, AANP has made clear that NPs with master's degrees will continue to be able to practice as before. With regulation and certification left to the states, it may be many years before most states act on the recommendation. In addition, AANP is recommending that those with master's degree training continue to be part of the NP system.

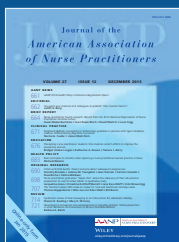
"Many of the additional courses for the DNP are in health care informatics, ethics, and evidence-based practice," Padden said. The new degree reflects changes in technology and patient care that are

adding to the complexity of health care, she added. More than 100 colleges and universities are planning to offer DNP programs, according to the American Association of Colleges of Nursing.

This trend also coincides with adoption in 2008 of the Consensus Model for recognition of advanced practice registered nurse (APRN) practice. Leading nursing organizations came together to endorse this model for licensure, accreditation, certification, and education not only for NPs but also for certified nurse anesthetists, certified nurse midwives, and clinical nurse specialists.

The Journals of AANP

The American Association of Nurse Practitioners (AANP) has two official journals, which, with their timely, scholarly content, together serve as a rich educational resource for nurse practitioners.



JAANP

The *Journal of the American Association of Nurse Practitioners* (JAANP) was first published by the Academy in 1989 as a member benefit. It was the first nurse practitioner-focused journal to be indexed in the Web of Science in 2007 and the only one to achieve an Impact Factor. Since its inception it has featured

original articles focused on clinical practice and management, health policy, research, and education, as well as other issues of concern and interest to nurse practitioners and fellow primary and acute care health providers. With the merger of the American Academy of Nurse Practitioners with the American College of Nurse Practitioners (ACNP) came a name change for the journal: the *Journal of the American Association of Nurse Practitioners*. Originally offered in print, the monthly journal is now available only online. It is free to AANP members, who can access current articles or search archived content through Wiley Online Library.



JNP

JNP: The Journal for Nurse Practitioners (JNP) was first published in 2005 as the official publication of ACNP. Today, AANP partners with health care and scientific publisher Elsevier to publish 10 issues of JNP per year. Peer-reviewed articles provide the latest clinical information and original research as well as demonstrate

the role that policy plays in shaping practice and delivering outcomes. An "AANP Forum" section in each issue includes AANP news and updates. JNP is available in print and online to more than 90,000 readers.

Continuing Education

For nurse practitioners, learning is life-long: Even after they have earned their degrees and acquired the skills and knowledge to provide care to patients, they undertake additional NP training in the form of continuing education (CE). Nurse practitioners ultimately are licensed by their states, and most certifications require renewals every three to five years. That requirement, along with the fast-changing health care system, necessitates continuing education that keeps NPs up to date on changes and advances in health care and their profession. Nurse practitioners earn CE credit toward certification by participating in online educational courses and/or in-person workshops that cover a vast array of topics.

In a fast-changing health care environment that increasingly relies on NPs for quality care, the continued evolution of nurse practitioner education will help support excellence. These diverse efforts, Norman noted, "are all focused on improving patient outcomes."

Resources for NP Students

With the steady growth in the number of nurse practitioners nationwide, the American Association of Nurse Practitioners (AANP) offers prospective students a wealth of resources to learn more about the profession and its many education options.

The Association's website includes an online search capability for prospective students to research and find NP programs. The site links to graduate and doctoral programs and includes background information on each program so students can match these programs with their professional interests.

The tool allows individuals to search through hundreds of accredited programs by state or specialty, and it includes information on traditional in-class programs as well as online and hybrid options. Information is based on data from the American Association of Colleges of Nursing and details the various specialty tracks offered by more than 400 colleges and universities in the United States.

The website also includes a Student Resource Center with a variety of information including a summary of the profession, its evolution, and its current and future opportunities as well as links with information on grants and scholarships, starting a career, and connecting with NPs in person or via social media to get the answers to common questions about the profession. The site even covers topics such as the intricacy of negotiating salaries, including whether the arrangement will be salaried, paid by the hour or day, or paid based on patient contact. Information on health care reimbursement also is included.

For more information about these resources, visit the site at www.aanp.org/education/student-resource-center.

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Interview with Sarah Thompson, PhD, RN, FAAN

Dean, College of Nursing, University of Colorado

BY GAIL GOURLEY

Please begin by describing aspects you would like to highlight about your nurse practitioner education program at the University of Colorado College of Nursing.

Sarah Thompson: We have all of the APRN [advanced practice registered nurse] roles, except for the CRNA [certified registered nurse anesthetist] and the neonatal intensive care nurse practitioner. We have robust programs in psychiatric mental health, pediatrics, midwifery, family nurse practitioner, and adult-gerontology, and we have both acute and primary care in many of these areas. We have a strong CNS [clinical nurse specialist] program, which I know is not “nurse practitioner,” but is one of the four APRN roles, and we are currently in preliminary discussion with the School of Medicine about launching a CRNA program.

We do have a strong applicant pool to all of our programs; we can't take as many as we would like. This is an estimate – because it changes a little bit here and there – but we have roughly 350 master's students and more also in our DNP [doctor of nursing practice] program. Currently, where some programs have moved to baccalaureate to DNP, we're still conferring the master's degree, but we're working on moving our advanced practice clinical programs to the BS to DNP in the near future.

One feature that makes your program unique is that your institution is the birthplace of nurse practitioner education. What other aspects would you highlight about what makes your program unique?

We did “birth” nurse practitioners. What's interesting about that is it started as an inter-professional certificate program, which I didn't realize until I read the history. It was started by a physician, Henry Silver, and a nurse, of course: Lee Ford. But they had other individuals teaching in the program – sociologists, psychologists, and others. Given the emphasis today on inter-professional

education and practice, this is quite a legacy, actually. The program started with an emphasis on extending the work of health care providers to the underserved and into the community, which also was a novel idea in 1965, because even in 1965, we were becoming incredibly acute-care focused. So it's quite unique in the way that it started.

I think what makes our program unique now is that in the early '90s, we were pioneers in distance education, making our program accessible to students in rural areas or who live at a distance. Some areas in Colorado are not easy to get to, and we try to be extremely flexible with our programming. What continues to make us unique is the fact that we offer most of the APRN roles. [And while] our program meets the needs of a very dense metropolitan area,

we also have a strong rural need and mission. Like many, we have demands in this state for primary care in rural areas that can be very isolated in the winter. So addressing the specific workforce needs in isolated areas distinguishes us as well.

Are there collaborations with other entities you'd like to mention?

We do collaborate with a variety of community-based or rural-based organizations across the state of Colorado that work to meet workforce needs. We work with our AHEC [area health education centers] organizations. We work with the School of Medicine. In addition, we have incredible acute care partners that offer opportunities for training in hospitals and primary care clinics. We have seven Magnet hospitals right here in Denver, so the opportunity for our students to train in this area and have an outstanding experience is phenomenal. We're located on a relatively new medical center campus and we have a children's hospital, a university hospital, and we'll soon have VA [Department of Veterans Affairs hospital] right here on the campus, so it makes our partnerships and our training opportunities quite good. We've had a lot of partnerships along the way, and we work with a lot of agencies to build not only our practice mission but training opportunities for students as well.

The program started with an emphasis on extending the work of health care providers to the underserved and into the community, which also was a novel idea in 1965, because even in 1965, we were becoming incredibly acute-care focused.

Are there enhancements to your program that you're currently working to institute or that you would like to see made in the future?

I think it's important, if you're educating health care professionals, to continuously evaluate your programs and make sure that not only are they in keeping with the national standards, but that they incorporate the latest evidence-based practice. So we're continuously updating and improving our programs in that regard. We listen to the students quite a bit and try to offer as much flexibility as possible in terms of where they train and under what circumstances, and again, offer flexibility so they can live in a rural area but also have a high-quality education.

Like a lot of schools, we combine state-of-the-art technology to enhance distance education with some on-site intensives where time is spent with an expert faculty member or a highly qualified preceptor. So we have a good balance in that regard, but I think we're always really looking at that and making sure that our students are leaving the program with the best [possible education].

How has the education of nurse practitioners evolved over time and is this reflective of the evolution of the nurse practitioner role?

I'm not sure it's the role per se of the nurse practitioner as much as how the health care system has changed. The need to practice using the latest evidence combined with the need to be fluent with how to gather evidence and synthesize it very quickly and incorporate it into your daily practice has changed fundamentally, and it will keep changing. I think that's one of the reasons that education has moved to the DNP level, because the skills that individuals need around informatics, evidence-based practice, leadership, how to translate research into practice, all of that – I think all of those aspects have enhanced the evolution of the NP to the DNP level.

The clinical practice environment has changed dramatically since 1965. We have a strong clinical focus like a lot of programs and more clinical hours in our specialty areas than is "mandated." I also think that there's quite a bit of business savvy that new grads need now, more than ever, and we're starting to put more of that into our program. There's a lot around billing and setting up a business, electronic health records, and just all sorts of things that, again, are very complex – far more complex than they used to be.



PHOTO COURTESY OF THE UNIVERSITY OF COLORADO SCHOOL OF NURSING

I think what makes our program unique now is that in the early '90s, we were pioneers in distance education, making our program accessible to students in rural areas or who live at a distance. Some areas in Colorado are not easy to get to, and we try to be extremely flexible with our programming.

What are the biggest challenges nurse practitioners face today, and how does your program prepare students for those challenges?

I think one of the biggest challenges is graduating a student who can walk right into a health care system that has very complex patients and is fast-paced and constantly changing. That's almost impossible, actually. You create a graduate who is able to learn continuously, and use evidence continuously, but, as with any new graduate at any level, creating a graduate who can meet all the demands of a system upon graduation is a challenge. We're looking at some "residency" options with many of our clinical partners where the new

graduate could have an experience in that first year of practice that really helps them get up to speed. I don't want to imply that graduates are dangerous or unable to function; it's more the need in today's environment to get up to speed a lot faster because of the economic models that drive practices. I think in many practices, it's the number of patients that practitioners or providers of any kind are expected to see to make a practice economically viable, and then the complexity of the patients. So it takes a bit of time for people to be able to handle that.

Providers must be able to maintain an insane workload. A commonly held belief is that a new graduate NP will cost

the practice money for about the first six months [as they are getting up to speed], and then they're able to bill enough to make money. So there's a lot of thinking right now around that transition, and about ways to maybe immerse students when they're still in their educational program or have some sort of transition as they leave [so they are prepared for the speed and complexity with which they'll have to work].

I think some of the biggest challenges will continue to be the pace at which health care changes, and what I would call the growing number of underserved – although the Affordable Care Act has, at least in Colorado, for example, definitely expanded access. [That said,] there

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are still individuals that don't have access to care, and I'm not sure that will change in the foreseeable future. And nurse practitioners have a key role in meeting that need. We offer rural rotations and we offer rotations with the underserved. We've got quite a good program here that treats the underserved. We offer students those opportunities to experience different practice arenas that are fundamentally different.

Can you elaborate on how nurse practitioners fit in with the changes that the Affordable Care Act has brought about?

They're fundamentally primary team members in accountable care organizations and some of the restructuring that we're seeing in health care delivery as a result of the Affordable Care Act. Nurse practitioners can also provide – you see different statistics – 70 percent, 75 percent, 80 percent of primary care, [as well as] health promotion, primary and secondary prevention, and then referrals to specialists. They are great team members with physicians because they can complement and provide a tremendous amount of care along with and in collaboration with physicians. You get the best of both worlds, I think.

As the Affordable Care Act has changed and is changing funding to be more outcomes-based, nurse practitioners are trained – nurses are really trained – to be patient-centered and look at patient outcomes, and we have very good outcomes. Whether, through the Affordable Care Act, nurses practice independently or with teams or within an accountable care organization, they're vital members of [the health care delivery community], and many people are beginning to realize that health care will not fundamentally change or improve without nurses having a central role. Nurse practitioners are able to fully function as team members or as independent practitioners as well. I think it's a

great time of change and tremendous opportunity for nursing in all arenas, but for nurse practitioners especially.

Do you see a growing need for increased numbers of nurse practitioners?

Oh yes, definitely. Absolutely. Everything you read would say that. It's because we can provide very good care at a lower cost. So the demand is going to be huge.

What would be your message to those considering the NP career path?

It's a perfect time. Go for it. Right now. Don't wait.

What about from the perspective of a patient? What would be your message to patients about what the education of nurse practitioners means for their health care?

Nurses have very extensive training and they have a lot of clinical preparation in their baccalaureate degree, in their master's, and their DNP – whatever type of program they go through. And again, nurse practitioners can provide 70 percent to 80 percent of primary care. Nurse practitioners are trained to view patients and their families more holistically. We're simply trained that way. We're trained to focus on education and facilitating patient-centered care and wellness in ways that other providers are not. Yet it's interesting, I think, that nurses also are trained in a way to see the value of other professions, and so I think we work well as team members and know the value of a physical therapist and physician and respiratory therapist and all of those vital team members. Patients I know that have had a nurse practitioner as their primary care provider love them.

What are your thoughts reflecting on the fact that the nurse practitioner profession is 50 years old?

It's amazing. It's amazing that we have around 205,000 nurse practitioners right now. And it's

also amazing to me that nurse practitioners will be pivotal in the future of the health care system and improving the health and well-being of people. It's an exciting time. It's just incredible to look at the history and to be here 50 years later.

Sarah A. Thompson, PhD, RN, FAAN, joined the University of Colorado College of Nursing as dean and professor on Aug. 27, 2012. She previously held a joint appointment with the University of Nebraska Medical Center as professor in the College of Public Health, Department of Health Services Research and Administration, and professor and associate dean of academic programs in the College of Nursing. She held a faculty appointment at the University of Kansas Medical Center School of Nursing.

Thompson earned her bachelor's degree from the University of Oklahoma, and her master's and doctorate degrees from the University of Kansas (KU). She completed a certificate in gerontology from KU and has done much of her research in end-of-life care in nursing homes. She held two hospice-related positions as case planners for Kansas City Hospice and St. John's Regional Medical Center Home Health and Hospice in Joplin, Missouri.

Thompson has been a reviewer for numerous research and gerontology-related journals. She is a member of the American Nurses Association, the Gerontological Society of America, the Midwest Nursing Research Society, Sigma Theta Tau International, and the Western Institute of Nursing. She became a fellow in the American Academy of Nursing in 2009.

The dean has received some impressive recognition in 2015. Based on her hard work, dedication, and passion for nursing education, Dean Sarah Thompson, PhD, RN, FAAN, has been named one of the top 30 most influential deans of nursing in the country.

An Expanding Role

Particulars of the NP Profession

BY ERIC TEGLER

Any possible debate today about the value of the nurse practitioner (NP) is purely academic; in an everyday world that has seen the number of NPs rise from approximately 106,000 in 2004 to 205,000 as of 2014, there's simply no doubt that they will be on the front lines of primary care for years to come.

As patient outcomes continue to trend positive with an increasing NP population, the most relevant discussion centers on managing details of the profession to both facilitate the work NPs do and to encourage them to continue pursuing professional growth and variety. The American Association of Nurse Practitioners (AANP) recognizes both the added dimensions the NP profession is taking on in response to unprecedented demand for primary care as well as the need for continuing education (CE) across a broader variety of specialties and delivery mechanisms than ever before.

"With the Affordable Care Act, we now have millions more Americans with insurance who need care," Dr. Diane Padden, AANP's vice president of research, education, and practice, said. "Given the reported physician shortage and additional Americans with health care coverage, nurse practitioners often provide care in rural and underserved populations, many who previously had limited access to care."

"As nurse practitioners are more widely recognized and more in the public eye, we see more [registered nurses] have a desire to go on and further their education and clinical training to become nurse practitioners," Dr. Anne Norman,

AANP's associate vice president of education, added.

Padden and Norman are family practice NPs, each with more than 20 years of experience. As AANP's associate vice president of education, Norman is in charge of overseeing the Association's continuing education and accreditation programs as well as grant writing activities. Her experience encompasses working in a variety of primary care settings including medical school health center, retail, and rural health clinics as well as college and on-site corporate primary clinics.

Padden's research department at AANP conducts surveys and analyzes workforce demographics and practice settings. She also collaborates in research with outside groups in the areas of education, practice, legislation, and policy. Along with primary care clinic experience, Padden taught in a university setting and conducted research.

Deepening Professional Competency

Continuing education has become even more important for NPs as advances in technology, medical science, and procedures have continued to accelerate over the past five years. State-by-state licensure for NPs brings with it a varied slate of requirements, often with implications for professional mobility. Many states

prescribe specific syllabi for NP license renewal and CE, most often in areas like ethics, mental health, controlled substances, and pain management. The organizations that certify NPs into different practice areas and populations also have varying requirements for the number of hours of CE necessary.

It's a complex landscape where CE and practice have mutual implications. Even when focusing on more specialized practice areas, NPs may still require broader CE than some of their primary care colleagues.

"Different from our physician and PA [physician's assistant] colleagues, nurse practitioners have to have pharmacology continuing education – a certain number of pharmacology hours, for instance," Norman pointed out.

While CE typically follows the form of an individual's chosen practice or new areas into which the NP may wish to move, there are often crossover requirements as well.

"You may work only in endocrinology and do no thyroid disease, just diabetes," Norman said. "But you would want continuing education in obesity because it crosses over into diabetic patient health."

AANP's annual conferences continue to be an important generator of CE programs, presentations, and topical information. The gatherings offer courses on a variety of subject areas for both new and seasoned NPs.

Many hands-on workshops are presented as well. Typically they're offered one full day before the conference as a pre-conference day and usually the last half-day, according to Norman. Workshops most often run for approximately



three hours. More in-depth workshops often consist of two three-hour sessions. The AANP education department develops CE programs all year and delivers them via live presentations both at the annual conference and at a number of other organization meetings. All such live programs are “endured” – recorded and made available online to AANP members.

A number of other groups and organizations in the nursing, medical, and pharmaceutical fields – many of them national organizations – have partnered with AANP in various CE programs. For example, Norman pointed to AANP’s recent partnership with the Collaborative for REMS (Risk Evaluation and Mitigation Strategy) Education, or CO*RE. The collaboration, which brings together 13 partners including AANP, seeks to further education related to the comprehensive management of pain, addiction, and their comorbidities.

Nurse practitioners take part in a continuing education session at an AANP National Conference. In an increasingly complex health care field that constantly sees medical and technological advances, continuing education opportunities are essential for NPs.

Norman serves on CO*RE’s executive committee. The collaboration has developed a three-hour CE/ CME (continuing medical education) program on pain management with extended release/long acting (ER/LA) opioid analgesics. NPs learn to reduce serious adverse outcomes (addiction, unintentional overdose, death) resulting from inappropriate prescribing, misuse, and abuse of ER/LA opioid analgesics.

While the most common CE topics relate to the clinical practice of the NP, others relate to business and regulatory facets of the profession, such as liability. AANP recognizes the importance of education on liability

and insurance and has held sessions at its annual conferences addressing liability with attorneys as well as NPs with joint degrees in law.

Obtaining liability insurance, malpractice rates, record keeping, and patient confidentiality are typical issues that AANP works to help its membership learn about and address. The liability environment for NPs is roughly similar to that for physicians, according to Norman and Padden, who pointed out that NPs often hire consultants to ensure that they’re covered for potential liabilities, that their employees are properly trained, and that they have the right processes in place.

CE development partnerships go hand in hand with the accreditation that AANP confers along with other organizations like the American Nurses Credentialing Center (ANCC).

“We’re also accrediting a lot of the physician conferences because [we] have found that so many nurse



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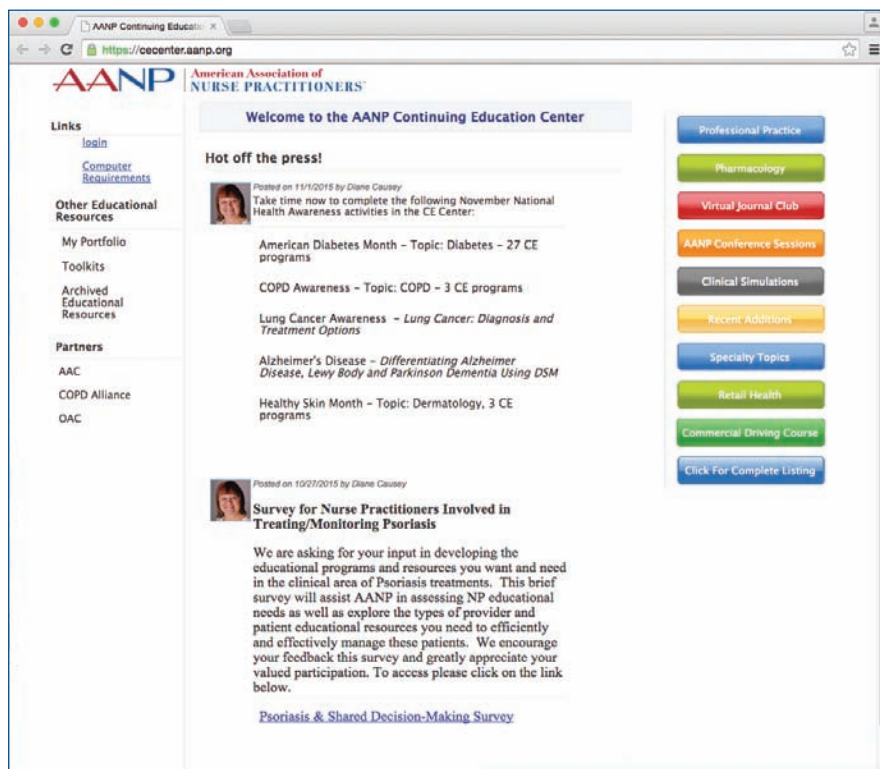
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practitioners attend them,” Norman said. The frequency with which NPs attend such conferences and programs with other primary care professionals, including registered and advanced practice nurses and physicians, makes for good opportunities to exchange interdisciplinary best practices and information.

“Pri-Med is a large provider of continuing education; they hold live conferences all over the U.S. You’ll see people from several different disciplines attending those for CE. We are certainly an advocate of inter-professional education and inter-professional care,” Norman said.

Most of the education programs that AANP produces “in house” are funded by external sources, Norman explained, typically by pharmaceutical firms. There are conference sponsorships by other organizations as well and corporate membership through AANP’s Corporate Council.

Attending conferences in person isn’t often an option, of course. On-demand CE is the logic behind AANP’s Continuing Education Center. In 2010,

AANP’s Continuing Education Center makes it possible for members to access CE content at their convenience. More than 200 programs in 10 different categories are available, as are both recent and archived CE sessions from AANP national conferences.

the online learning center offered 50 programs; today there are more than 200. The offerings are divided into 10 categories from general professional practice programs to pharmacology – even a commercial driving course.

The most recent online additions include presentations on Binge Eating Disorder, Common Side Effects of Psychiatric Medications, Diabetes Mellitus Type 1, Dizziness & Vertigo, and Down Syndrome and Dementia, to name a few. The CE programs for each range from 30 minutes to three hours. Some of AANP’s conference sessions, from the latest to those done in previous years, are available as well. Recent sessions have covered topics including Acid Base Interpretation at the Bedside, Acute Abdominal Pain in Children,

Continuing Education: By the Numbers

By Charles Dervarics

AANP’s extensive continuing education program provides comprehensive and, in some cases, even real-time training to members. Key statistics taken from the Association’s 2014 annual report showed that AANP:

- Reviewed and approved 429 applications for AANP continuing education credit for programs that vary from one-hour activities to large conferences;
- Reviewed and accredited all sessions at three AANP conferences plus 105 other internal education activities;
- Developed two professional-level video programs for the Association’s CE Center;
- Presented two live webinars on safe prescribing practices;
- Developed three non-accredited education publications on topics such as attention deficit hyperactivity disorder, diabetes, and sleep disorders;
- Increased the number of activities at the CE Center from 111 at the end of 2013 to 168 in 2014;
- Added a nine-hour Commercial Motor Vehicle Medical Examiner Training Course to the CE Center, serving 752 participants; and
- Had 149,466 viewings of CE activities, generating the issuance of more than 100,000 continuing education certificates.

and Alpha-1 Antitrypsin Deficiency, among others.

According to the Association, AANP CE credit is universally accepted by

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all state boards of nursing and nurse practitioner certifying bodies.

The online CE Center also functions as a platform for AANP surveys and data gathering. Members have the opportunity to offer input into the development of educational programs and resources for various clinical areas. Currently, AANP is surveying its membership on the details of psoriasis and tobacco dependence treatments. These brief surveys assist AANP in assessing NP educational needs in these areas as well as exploring the types of provider and patient educational resources needed to effectively manage these patients. The next major educational needs survey is scheduled in January 2016.

AANP conducts larger surveys periodically. The last such survey, in fall 2015, focused on NP compensation and benefits. Its findings included both general and detailed numbers regarding the contours of the profession. For example, the majority of respondents

Family nurse practitioner Ruth Wiley examines Elizabeth Knowles at a Walgreens Take Care Clinic in Indianapolis, Indiana. As nurse practitioners increasingly work in varied clinical settings, including their own practices, they often face challenges borne of inconsistencies across the country in full practice authority.

(74.7 percent) were salaried, while 22.5 percent were paid an hourly rate and 2.8 percent were self-employed. Approximately 85 percent of NPs had written job descriptions and 58.3 percent had an employment contract. The hourly pay rate for NPs in full-time practice was \$53.16. The mean annual base salary for NPs was \$97,083. The average yearly compensation for all respondents was \$94,050, and the mean hourly wage reported was \$46.12.

Along with the archived conference sessions and other programs, AANP offers access to AANP-developed tools and resources on the Education Tools

and Resource page of the organization's website. Designed to keep NPs informed on important health issues and to assist them in patient education, the tools include the popular AANP patient education flipcharts and additional external resources.

Broadening Practice and Authority

The increased CE content and transmission modes offered by AANP reflect a response not only to increasing numbers of NPs nationwide but the increasing diversity of practice areas and subspecialties in which they work. The trend toward increased NP specialization beyond traditional primary care practice is just beginning to accelerate, Padden said.

"What we're seeing is an expanded role for nurse practitioners. Upon completion of their main education program and certification, nurse practitioners may seek to specialize in certain areas, whether that's orthopedics, emergency care, or dermatology, for example."

Continued on page 81

The Oncology Nursing Society Celebrates **50 Years** of Nurse Practitioners

Over the last 50 years, healthcare has changed tremendously, and so has the role of the nurse practitioner. In oncology, as treatment has become more multifaceted, oncology nurse practitioners serve as direct caregivers, consultants, educators, administrators and researchers delivering the highest quality care across a diverse number of settings. We celebrate this milestone and honor the advancements and contributions in healthcare, and the impact nurse practitioners have had on patients and their families.

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NURSE PRACTITIONER SUBSPECIALTIES

AANP's Dr. Mary Ellen Roberts

Discusses the Trend Toward Specialization

By Eric Tegler

After receiving their general certifications, nurse practitioners (NPs) are increasingly choosing to specialize. The reasons lie in both demand and an individual desire to focus on one practice area, according to Dr. Mary Ellen Roberts.

Roberts has served in various positions on AANP's board of directors and is a past president. She has also served as co-chair of the AANP National Conference and presently is the chair of the American Association of Nurse Practitioners (AANP) Fellows. A doctor of nursing practice, Roberts is currently assistant professor at Seton Hall University with clinical expertise in cardiovascular disease. She practices at the Urban Health Initiative clinic, a grant-funded program for the inner city area of Newark, New Jersey.

NPs overwhelmingly work as primary caregivers, but there are more opportunities now for them to work in other settings – opportunities that are driving them to a dozen or so subspecialties.

"People like to specialize," Roberts said. "If they're not going into a general practice or primary care, then they're going to subspecialize."

She explained that when NPs go for their education and certification today, they choose one of the general NP practice categories – family, adult-gerontological, women's health, or acute care, for instance.

"They'll become certified as a family nurse practitioner, but they'll take a specialty exam to be certified as an emergency room or emergency department NP."

A variety of new subspecialty exams have sprung up in the last decade, Roberts said, in areas like neonatal, oncology, cardiology, dermatology, or emergency medicine. Such subspecialties are typically certified by

organizations associated with the particular specialty. For example, the Dermatology Nurses Association gives the dermatology exam and certification for NPs, the Board of Certification for Emergency Nursing gives certification for NP emergency care specialization, the Pediatric Nursing Certification Board does the same for pediatric specialization, and so on.

Currently, there is no particular formal structure or progression for NPs who wish to specialize, Roberts acknowledged. "There's nothing really outlined at this point as to getting your education to become a dermatology nurse practitioner or for the other subspecialties."

As such, NPs tend to go where their interests and basic practice certifications take them. You can find NPs with subspecialties in a variety of settings, for example in a physician's office, in their own practices, or in ACOs (accountable care organizations – health care organizations that tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients).

Subspecialty NPs are also increasingly present in hospitals and in specialty clinics within hospitals, like cardiology or dermatology clinics.

Roberts added that some acute care NPs are taking on roles as hospitalists, where they make daily rounds on patients in hospital settings.

Obstacles for NPs who wish to specialize are largely similar to those for the general NP population, according to Roberts.

While testing is a relatively smooth process, liability is a concern. "I think some of the obstacles include insurance companies. We're not fully accepted by all the insurers yet. It's getting better, but depending on the state you're in, you may not be fully accepted."

Full practice authority (FPA) remains an impediment to highly accomplished NPs like Roberts and those in practice with a subspecialty focus, regardless of their experience.

"I don't practice in a hospital setting," Roberts said, "but at the clinic that I work in, I haven't seen my [collaborating physician] in four years. I don't ask for permission to prescribe various drugs. I just have a collaborating agreement with him that explains what I can do. It's called a joint protocol. If I need to prescribe a Class II drug, I prescribe a Class II drug. The problem with not having that full practice authority is that I have to have that joint protocol. If I had FPA, I wouldn't need it, so it is a barrier."

Nevertheless, NPs have long had to deal with obstacles, from regulatory to reputational. The barriers have not kept their numbers from growing, and if history is any guide, they won't blunt a trend toward subspecialization.

"I think this may grow as a trend depending on what the future demand is," Roberts agreed. "The majority of NPs still work within primary care, but the nice thing about nurse practitioners is that we go where the need is."



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As NPs expand into more subspecialties and work in different clinical settings including their own practices, many inevitably run into challenges with full practice authority (FPA). FPA is the collection of state practice and licensure laws that allow for NPs to evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatments – including prescribing medications – under the exclusive licensure authority of the state board of nursing.

Currently, 21 states and Washington, D.C., have granted FPA to NPs. Even in states that have yet to grant FPA, an NP can start his/her own practice without a physician on-site, but must have a collaborating physician. In some states, that physician may need to spend a minimum number of hours per month at the NP practice or review a certain percentage of the charts.

Professionally, the lack of consistent FPA in all states can be an impediment to NPs who wish to work in underserved geographical areas, Norman said.

“Since nurse practitioners are willing to go out and work in rural areas, this can be a big hurdle. If the collaborating physician decides that he/she doesn’t want to drive the 100 miles that it takes to get out to the NP clinic and elects not be a collaborating physician, that nurse practitioner may not be able to get another in a timely fashion. Then, their patients suffer because they can’t attend to them. In those rural areas, the NP may be the only provider for miles.”

Collaborating physicians may also charge fees that make an independent practice unfeasible. As a result, NPs often move to another state where FPA is in effect.

“We’ve seen that happen in Texas. The NPs move right next door to New Mexico,” Norman said. The lack of uniformity in FPA doesn’t just affect NPs; it also hinders patient access in many cases.

A 2014 report, funded by AARP and the Robert Wood Johnson

Foundation, found that in California – which lacks FPA – adoption could yield \$1.8 billion in health care cost savings over the next 10 years, the number of NPs could increase by 24 percent, and patients in rural and underserved communities would be the major beneficiaries.

The case for extending FPA does seem to be simple common sense. Perhaps reacting to the straightforward logic that favors it, the Nebraska legislature unanimously passed a bill granting NPs such authority in the state in 2014. The bill went to then-Gov. Dave Heineman’s desk, but he vetoed it. However, in March 2015, newly elected Gov. Pete Ricketts signed into law LB 107, bringing FPA to NPs in the state. The bill made Nebraska the 20th state with FPA, a victory fueled in no small part by NPs themselves.

“As ‘the Voice of the Nurse Practitioner,’ AANP’s role is to continually educate the public, legislators, and patients on the critical role that nurse practitioners serve in providing access to care,” Padden said. “Sometimes patients are our best advocates.”

Those patients include a population often overlooked when discussion turns to issues surrounding primary care. Despite recent publicity attending their treatment by the Department of Veterans Affairs, prior service members (along with active military) are underserved in a number of regions in the United States. NPs have been a critical component of their care for many years.

Padden, who previously taught at the Uniformed Services University, explained there was an organization specifically for military NPs: the Uniformed Nurse Practitioner Association. Their annual meeting was held in conjunction with the AANP National Conference, but several years ago they made a decision to have their content incorporated into the main schedule. A military track is currently offered within the AANP conference that addresses

some of the medical, cultural, and procedural differences that military NPs face.

However, Padden remarked that the issues relevant to active-duty service members are similar to those of “citizen” soldiers. Many injured veterans, she explained, are “National Guard and Reserve members who were activated and returned with injuries and are now in our civilian and community health care system. Nurse practitioners in rural Montana need to know how to care for those types of injuries – PTSD, traumatic brain injury, amputation, hearing loss, blindness, disfigurement. Veterans are in every community.”

The community of NPs has done an admirable job of promoting itself, largely through the effective work NPs do, both Norman and Padden said. The efficacy of the primary care they deliver has been confirmed in a number of studies, none more influential than the 2010 Institute of Medicine (IOM) “Future of Nursing” report.

The IOM report not only highlighted the patient outcome and cost effectiveness of nurses including NPs, it recommended that scope-of-practice barriers be removed. The report’s authors also called for the expansion of opportunities for advanced practice nurses to lead and diffuse collaborative improvement efforts.

The recommendations signal recognition of the increasing demand for NPs and an expansion of the roles they fulfill. Such recognition has overwhelmingly seeped into public consciousness, Padden said.

“The growing number of patients choosing nurse practitioners as their provider of choice is due to increased public awareness and access to nurse practitioners in their communities. When I graduated, people didn’t even know what a nurse practitioner was. They’d call you a doctor, and you’d say, ‘No, I’m a nurse practitioner.’ Today, they have a better idea of what an NP is and seek them out for their health care.”

THE CERTIFICATION LANDSCAPE

AANPCP's Dr. Diane Tyler on NP Certification in 2015

By Eric Tegler

2015 is an interesting year in terms of certification for nurse practitioners (NPs). To start with, it is the target year for full national implementation of the Consensus Model for APRN Regulation. It's also a year in which the American Academy of Nurse Practitioners Certification Program (AANPCP) has continued to progress and accelerate the exams it gives and the certifications it issues. Further, the year has seen continuation of the trend in which NPs increasingly specialize. That trend will likely have implications for certification in the future.

Dr. Diane Tyler is AANPCP's director of certification, and she has observed not only the trends leading to the future of NP certification but the past as well, illustrated by the timeline on the facing page. Scan it and you'll note the basic contours of certification for NPs in the United States, from the first certification exam administered by the American Nurses Association to the rise of exams and certification for the six general population-based areas of NP practice currently recognized, which are neonatal, pediatric, women's health/gender specific, adult-gerontology, family, and psychiatric-mental health.

Along the way you'll note the collaboration between AANPCP and other certification bodies (now five in all), a response to the changing demand for primary care and specialization.

"Some of those areas have further specialty focus," Tyler noted. "For example, under the Pediatric Nursing Certification Board (PNCB), they launched an exam in 2011 for advanced practice nurses to become pediatric primary care behavioral health specialists. That exam was meant to deal with the competencies of nurses working with young children and adolescent populations with distinct behavioral issues."

Certification has evolved to meet the goals of the Consensus Model. Initially published in 2008, the model sought to standardize licensure, accreditation, certification, and education for all advanced practice registered nurses (APRNs). AANPCP (particularly under the leadership of its former executive director, Dr. Jan Towers, and current CEO, Richard Meadows) provided input from the outset. As it seeks to reach full implementation this year, Tyler said it has become a valued guide for the typical NP career path.

"It explains the standards for how nurses would be recognized at every level – getting their education, being eligible for certification, being recognized at the state and national level. That really needed to happen and 2015 is the targeted implementation date, so this is very timely. The last details are being addressed, and we're focusing on keeping standards unified while not excluding qualified APRNs."

AANPCP's own changes reflect the influence of the Consensus Model. Today, it certifies family, adult, and adult-gerontology NPs. AANPCP retired its gerontology certification in 2012, and in 2013 launched its adult-gerontology certification.

In 2014, the last year for which there is complete data, AANPCP had 47,379 family NPs, 8,664 adult NPs, 2,246 adult-gero NPs, and 281 gero NPs for a total of 58,570 certifications (some dual certifications are included). The number of exams and certifications has rapidly increased, Tyler said.

"We attribute much of our growth to great customer service, the rise in NP educational programs and students, and our excellent 100 percent clinically based exams. By 2010, AANPCP had issued approximately 31,000 certifications. In 2015, we're approaching 70,000, so we have more than doubled the certifications issued in five years."

AANPCP is also watching the trend toward specialization among NPs with interest. Tyler said that along with the subspecialty certification exams for pediatrics and for palliative care and oncology specialists, there is potential demand for exams in other areas, such as emergency room subspecialty certification for NPs.

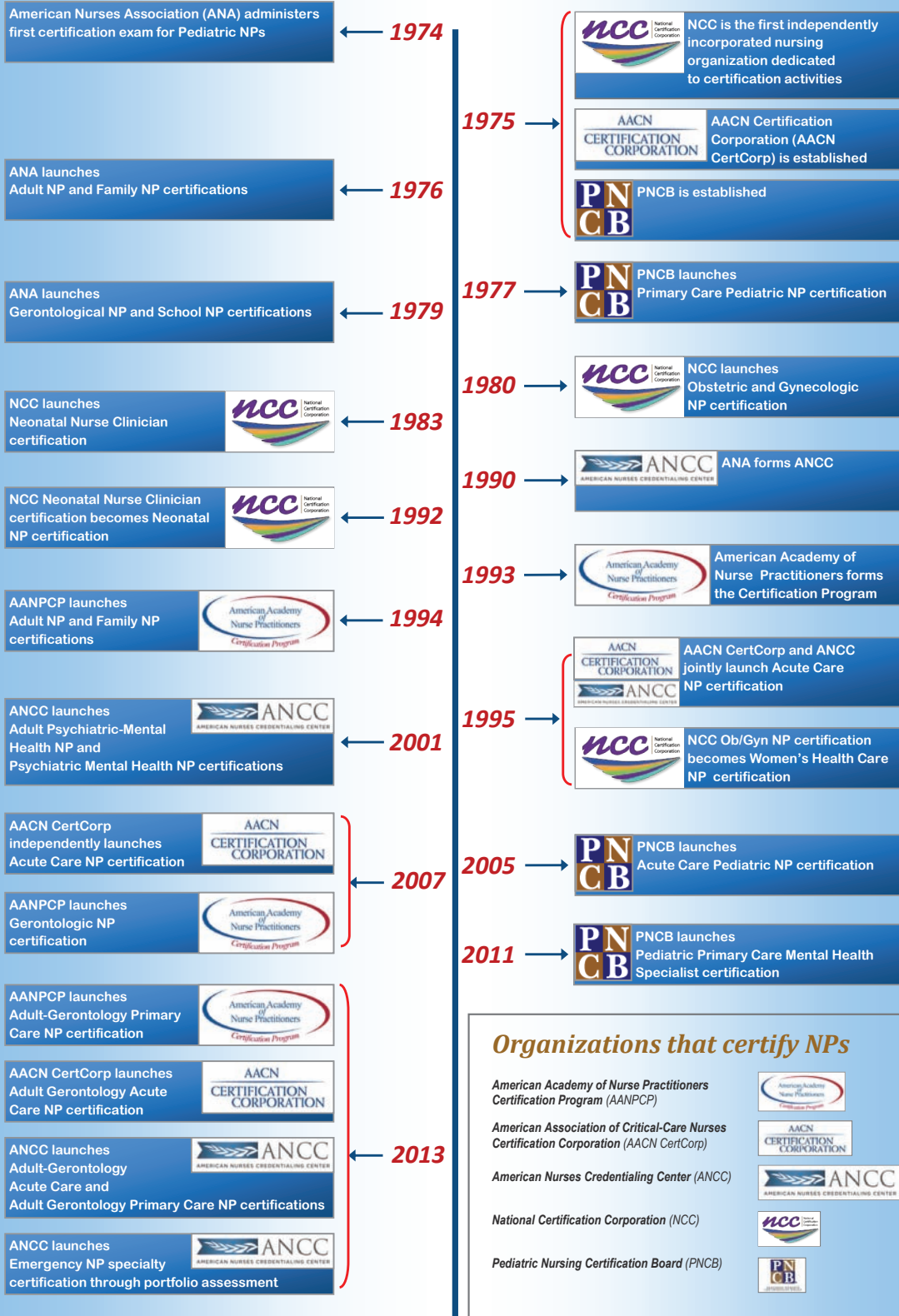
"I think there will be growth [in demand] in other areas. ANCC [the American Nurses Credentialing Center] has developed a methodology called portfolio assessment for the emergency care nurse practitioner specialty, which they launched in 2013. There are other groups that may want to distinguish their special competencies by having advanced certification for specialties and subspecialties."

Any emerging specialty exam for NPs should comply with the Consensus Model and meet the national/international accreditation standards, which include more than 21 criteria detailing the credentialing process, Tyler explained.

"There is an established process. Not every organization chooses to have an accredited certification program, but if you want your specialty recognized by state boards of nursing and other organizations, it is important for it to be accredited."

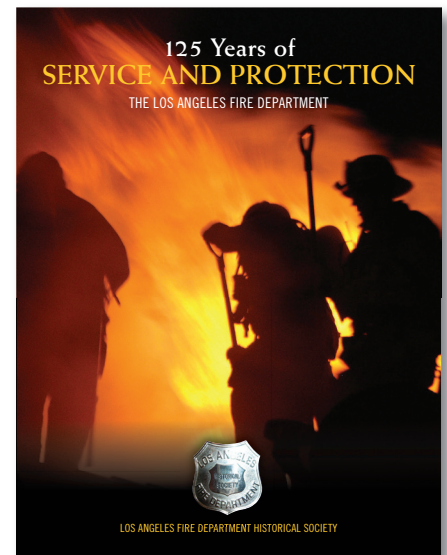
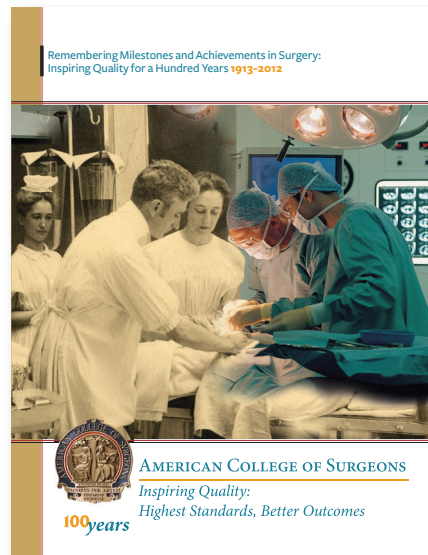
NP Certification Historical Timeline

by Diane Tyler, PhD, RN, NP-C, FAAN, FAANP, CAE





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Interview with Doreen C. Harper, PhD, RN, FAAN

Dean and Fay B. Ireland Endowed Chair at the University of Alabama at Birmingham School of Nursing

BY GAIL GOURLEY

Please begin by describing and highlighting characteristics of the nurse practitioner education program at the University of Alabama at Birmingham (UAB).

Doreen C. Harper: UAB was on the ground floor of developing nurse practitioner programs back in the late '80s, early '90s, when master's education for nurse practitioners really took off, and even before that in terms of some of the certificate work that went on in early nurse practitioner programs. I'd like to emphasize that the school, because of where it's located, has the ability to develop programs due to the rich resources we have here in the Academic Health Science Center. We offer all of the primary care specialties that exist, as well as a number of subspecialties and acute care specialties.

So when you look at the programs from the LACE [licensure, accreditation, certification and education] model that are identified – adult-gero primary care, adult-gero acute care, psychiatric, pediatric primary care, pediatric acute care, neonatal – [UAB] really covers the spectrum. And then we developed subspecialties under a number of those areas: in palliative care, in women's health, in occupational health and oncology, and the RN [registered nurse] first assist subspecialty, [which] is an RN who has additional OR [operating room] training to work and do many of the procedures in the OR. For nurse practitioners with that subspecialty, it adds a dimension to their work in acute care and gives them the skill set they need for highly specialized care.

A nurse anesthetist is its own distinct role, and we have that program also, which I think is wonderful because it gives depth to ... the APRN [advanced practice registered nurse] roles.

Approximately how many nurse practitioner students do you currently have in the program?

We have many – we have almost a thousand. We are very fortunate in that we have been able to mount a large program, and we have a large number of graduates. We graduate over 400 nurse practitioners across a myriad of populations – specific areas and specialties – a year, because we have designed a program that really allows them to move through the program in a cohort model. This cohort model requires the coordination of both clinical placements [and] competency-based testing in terms of the standardized patient testing that we do at the medical school as well as inter-professional educational programs and the clinical training models that we have set up. So there's a lot to it. It's a complex organization in terms of our educational programs, because we have a number of advanced nursing administrative tracks also.

What factors make your program unique among nurse practitioner education programs?

I think that we're distance accessible. And I like to say the words "distance accessible," not "online," because we strongly believe that our students need to be part and parcel of our campus and our clinical resources, as well as accommodating their needs to learn where they live and work. Our students come back to campus on a regular basis each semester, and we conduct competency-based testing and clinical skill development during "intensive" on-site experiences with them, because there's a lot of "hands on" in workshop and laboratory format and the faculty wants to be sure that our students develop competency in their skills and clinical decision-making.

We believe that because we are developing practitioners who must be competent practitioners that actually testing them for specific competencies is an essential part of our program. We also feel that teaching them the competency skill sets cannot all be done online. So we really have what I call a hybrid program. It's built and developed to support students in this kind of work and we actually bring them back in executive sessions, essentially. We call them intensives, but it's just like an executive program where they come back for that intensive instruction, competency development, and testing. And this came from the students. They love it; they love being with the faculty, they love being on campus, they love being able to go

We are very fortunate in that we have been able to mount a large program, and we have a large number of graduates. We graduate over 400 nurse practitioners across a myriad of populations – specific areas and specialties – a year, because we have designed a program that really allows them to move through the program in a cohort model.

to some of our own nurse-managed clinics and observe nurse-led models of care.

What collaborations with other entities would you like to highlight?

We are one of the original VA [Veterans Affairs] Nursing Academic Partnerships for Graduate Education here at UAB. And we have both the graduate education program for the development of the mental health nurse practitioner as well as a residency for mental health nurse practitioners, which is relatively novel. And it has been an amazing success. The training for our mental health nurse practitioners in graduate education is done primarily at our [VA] Medical Center as well as in the community-based outpatient centers that the VA operates across the state of Alabama. Our graduate NP students and residents are also linked to areas that support both the families and children of veterans in the community, and other areas [where] we would provide mental health and behavioral health care to veterans and their families. We have had this program in operation for the last three years. It's our third cohort as residents. They are amazing when they graduate. Not only are these residents telehealth certified, they are really delivering very complex care to a population that has very specialized needs.

Are there any enhancements to your program that you're currently working to institute or that you'd like to see made in the future?

We have developed work with several of Alabama's FQHCs [federally qualified health centers] and the nurse practitioners in our

underserved areas in the state – where there are significant health disparities – to reach out to those preceptors in these underserved areas, many of whom are not in settings where they have a lot of support. We've developed webinars for those preceptors so they can be involved in learning some of the latest clinical updates about content that is new and cutting edge. And that's been supported through the Daniel Foundation here in the state of Alabama. It's been very exciting to watch because we've developed a Graduate Nursing Education Primary Care Scholars Program for our students who are also out in these areas, and we're really recruiting students who live and work in those areas into our program with a supportive infrastructure to help them, to make sure we can help them get back to those communities.

How has the education of nurse practitioners evolved over time, and is this reflective of an evolution of the role?

Absolutely. There were truly excellent nurse practitioner programs in the early days. Lee Ford was one of my mentors, together with many of the founding nurse practitioner leaders. And one of the things that I think really happened is the explosion of knowledge and the increase in scope of practice, where nurse practitioners really are accountable from a regulatory standpoint in terms of pharmacotherapeutics, prescriptive authority, accountability for care, et cetera. The role has evolved and been articulated more clearly so that professional accountability has had to grow as that evolution of the

role has occurred. That is reflected in curriculums and they have been "stuffed" to accommodate all the content. I led the study that looked at NP curriculums and saw that we were just continuing to have this curriculum overflow. It was one of the reasons the DNP [doctor of nursing practice] became part of the model for advanced practice registered nurses. So because we found that curriculum was increasing at such a rapid pace, that programs were just adding more and more credits, and the variation in credits was so high that they were the equivalent of many doctoral practice programs, this data was used as the rationale for the development of the DNP.

What are the biggest challenges nurse practitioners face today, and how does your program prepare students to meet these challenges?

I would say the biggest challenges are the rapid pace of change in health care and the market, and, with the Affordable Care Act, the increased focus on prevention – on the triple aim, essentially; better health for lower cost and the best experience for patients and families. So part of what I think nurse practitioners have to continue to do is to really evolve their role in relationship to those three areas and be able to show the evidence of how their role meets the triple aim. We are in a health care system where there's not going to be more money, so when we look at roles, if we can accomplish better care and show that it saves money, I think the sky's the limit for nurse practitioners.

Our curriculums are constantly evolving and I think have incorporated much of the content. Again, our

master's curriculums are evolving into the DNP curriculum. That's one of the reasons we're even seeing the evolution of a residency model developed for advanced practice registered nurses, because the expectations in practice are all measured today, regardless of who you are. And we've got to really prepare our graduates to be able to work in the world that they're going to be measured in.

Looking ahead, how would you characterize the future of the nurse practitioner role, particularly with the advent of the Affordable Care Act?

I think the future for nurse practitioners and all other advanced practice nurses is bright. I think we have entered an era where this role and the value added by nurse practitioners in our health care system is not only becoming more and more evident and recognized, but we also have critical mass so that we're penetrating the health care system – we are more evident in our presence.

What surprises you the most about how the role of nurse practitioners has evolved?

It's not a surprise because I always believed in the potential. I've built my career on the potential of nurse practitioners and understanding what they had to offer, that they really offered a dimension of care that didn't exist otherwise in the health care system. So I'm not surprised. I'm not surprised that as more and more of our public begin to experience this provider and the role, they begin to see the added value in terms of the education and the time that patients have with a nurse practitioner provider. When someone talks to me about seeing a nurse practitioner, the first thing they say is, "That nurse practitioner spent more time with me." It's about the relationship and it's about person-centered care, and I think if we focus on that, the nurse practitioner role will continue to expand.



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The demand for nurse practitioners (NPs) and their primary care services has never been higher. By utilizing staffing models that include NPs, health care facilities are better able to offer patients access to comprehensive primary and preventative care services.¹

A common but challenging condition managed in primary care is pain. Perhaps more than any other condition, pain may be managed by the clinician and/or by the patient, which can compound care. For example, many patients take over-the-counter (OTC) non-steroidal anti-inflammatory drugs (NSAIDs) to manage pain, and clinicians may be unaware of OTC NSAID use. NSAIDs represent approximately 60% of OTC analgesic agents used in the United States.² In addition, approximately 5% of the US population uses a prescription NSAID.³ Although NSAID use is ubiquitous, many patients are unfamiliar with the class name and do not know which products are NSAIDs or contain NSAIDs in combination with other agents.⁴ Data on national patterns of NSAID use show that 26% to 44% of individuals are consuming more NSAIDs than they should.^{3,4} In addition to individual risk stratification, the medical literature demonstrates

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that NSAID-related adverse events are dose and duration dependent, and there are potentially serious risks associated with their improper use. For example, a British study concluded that 12% of medication-related preventable hospital admissions were related to use of NSAIDs.⁴

These facts place primary care clinicians, like NPs, at the critical intersections of diagnosis, treatment, and patient education. It is important for all HCPs,

including NPs, to educate patients about how to take NSAIDs in a responsible way that provides a therapeutic benefit while minimizing risks. This means that NPs not only need to know how to manage pain but also must make sure they ask the questions and get the information needed to make sound decisions and best educate their patients. Asking about how patients manage pain and making NSAID use a standard part of any medication history and reconciliation process can lessen the likelihood of a serious NSAID-related adverse event. Similarly, reminding patients to take one NSAID at a time at the lowest effective dose for the shortest duration of time required can help ensure the safest and most appropriate way to manage pain with OTC or prescription NSAID medications.

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It's a career for a lifetime, and I would say it's one of the most rewarding careers you can ever, ever aspire to. Working with both individual patients and populations offers both challenges and opportunities at every step of the way.

What is your message to those who are considering becoming a nurse practitioner?

It's a career for a lifetime, and I would say it's one of the most rewarding careers you can ever, ever aspire to. Working with both individual patients and populations offers both challenges and opportunities at every step of the way. And that's what makes it so interesting, because even though you work with patients who have similar conditions, there's never a configuration with [one] person that's the same as another. There's always an opportunity to be creative. And there's nothing better than seeing the patients and families that you serve grow from an experience of health. That's what it's all about.

What is your message to patients about what the education of nurse practitioners means for their health care?

I would say to patients, and I do, often: "You can really benefit from a relationship with a nurse practitioner as a patient." Because as a provider, the nurse practitioner comes with not just a medical perspective, but a nursing perspective – a point-of-care perspective, on a 24/7 basis – and a community perspective. Nursing brings that moment-to-moment experience, which really can help people cope with both health and illness and move toward a better level of health and well-being.

Is there anything else you'd like to add?

I think we often think of nurse practitioners out in the community and in clinic situations, but we need to

be reminded that we also have nurse practitioners today who are working in high acuity tertiary, quaternary health care settings [who] are really at the center of the team coordinating and keeping the patient at the center of care.

Doreen Harper, PhD, RN, FAAN, is dean and Fay B. Ireland Endowed Chair in Nursing, and director of the PAHO/WHO Collaborating Center for International Nursing at the University of Alabama at Birmingham School of Nursing. She is the fourth dean in the school's history, having served since November 2005. Harper has taught and led at all levels of nursing and medical education, including the inaugural nursing program at George Mason University, the University of Maryland School of Nursing, The George Washington University School of Medicine and Health Sciences, and the University of Massachusetts Medical School. Harper led the national program for the W.K. Kellogg Foundation's Community Partnerships in Graduate Medical and Nursing Education Initiative focused on increasing access to high-quality primary care through the development of academic-community partnerships locally and globally. Harper's scholarly work breaks new ground in joint partnerships for nursing workforce development to improve patient and population care across clinical and community settings.

Harper holds a bachelor's degree in nursing from Cornell University in New York, and a master's of science in nursing degree from Catholic University in Washington, D.C. She

earned a PhD in nursing, with a focus on primary care and gerontology, from the University of Maryland, and became a certified adult nurse practitioner.

Dean Harper has led the top-tier UAB School of Nursing in the development of new educational, practice, and research opportunities, including the Accelerated Master's in Nursing Pathway, BSN to the PhD Program, the Joint DNP Program, the Nurse Anesthesia Program, the Paul D. Coverdell Peace Corps Fellows Program, and the Clinical Nurse Leader track. Additionally, the school has more than doubled student enrollment and graduation with support to assist hundreds of minority students through grants from the Health Resources and Services Administration, Robert Wood Johnson Foundation, and Graduate Assistance in Areas of National Need. Harper has grown the research and practice enterprise substantially in the school, including the partnership with UAB Hospital and Health System, and Children's of Alabama, Veterans Affairs Nursing Academic Partnership for undergraduate and graduate education and research programs in cardiovascular, oncology, occupational and palliative care, as well as patient safety and quality research.

A distinguished leader in developing inter-professional and clinical collaborative partnerships, Harper is known for her expertise in nursing education, nurse practitioner education, policy, and nursing and health professions workforce development. Harper is a fellow in the American Academy of Nursing, and the recipient of numerous national and distinguished awards for her scholarly contributions in nursing education and health workforce research. Throughout her career, Harper has made an impact on improving patient care access and quality through developing and promoting nursing and advanced practice nursing roles.

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AANP Enhancing Its Research Capacity

By Charles Dervarics

In America's fast-changing health care system, access to readily available data is essential for policymaking and practice. With that in mind, three years ago the American Association of Nurse Practitioners (AANP) made a significant new investment in its research capacity, part of an effort to focus on the NP profession as well as its role in promoting positive health outcomes.

From surveys of its own members to partnerships with other organizations, AANP is providing detailed information about nurse practitioners, their practice environments and salaries, and their growing importance in delivering high-quality care.

"We support quality research on NPs," said Michelle Cook, the Association's associate vice president of research. "As the number of NPs grows and NPs represent one-third of the primary care workforce, NPs need to have strong representation in research."

AANP is supporting this goal through a significant expansion of its internal research capacity. When Cook was hired three years ago, there was only a research coordinator position at the Association, who was guided by the vice president of research, education and professional practice. But now the AANP research office consists of five highly trained staff who can conduct survey research and observations as well as interact with external partners and researchers seeking to include NPs in their own work. The Association's critical research work includes these activities:

Surveys – The research office surveys AANP members every three years to examine what they appreciate about their membership. They also conduct surveys every spring on either salaries and benefits or the NP practice environment. The salary survey is of particular interest not only because it generates nationwide data but also because it can help NPs during contract negotiations. "This is just one major request we receive from our members," she said.

Data Summaries – The office plays a key role in summarizing important data on the NP profession for a variety of audiences. For example, it works closely with the Association's government relations

and membership departments to design infographics, talking points, and other materials that highlight the growth of NPs and the breadth of their work. Such work is particularly critical when working with lawmakers at the state level, who determine the scope of practice for NPs. "It's important for us to work with our state and federal government affairs offices to reduce barriers to practice," Cook said.

NP Profiles – AANP-led research identifies key characteristics about NPs and their work. Recent studies have noted that NPs:

- see patients of all incomes, ages, and insurance types, with more than 75 percent caring for low-income patients as part of their practice;
- prescribe medications in all 50 states and Washington, D.C., writing an average of 19 prescriptions per day;
- have an average of 25 years of experience as a registered nurse and 11 years of experience as an NP;
- have an average age of 51, with 98.7 percent holding a graduate degree and 14 percent possessing a doctoral degree; and
- earn a mean full-time annual base salary of \$97,083.

With the number of nurse practitioners surging, the research department maintains the quality and timeliness of a national NP database. This work includes collecting extensive data on the location of the nation's nurse practitioner workforce. "To the best of our ability, we map where NPs provide services in a state," Cook said. Among other benefits, it identifies "where the major shortages of health care professionals are."

Future research is expected to continue to focus on four key areas: education, clinical practice, health policy, and workforce, Cook said. Clinical practice is particularly important as national data point to increasing reliance on NPs for primary care. One recent AANP study found that 90 percent of recorded patient visits to NPs were managed without the need for a referral to another health care provider. Another AANP study showed that, when compared with physicians, NPs were more likely to treat patients for chronic health care problems.

The Association also partners with others on research. For example, the National Nursing Centers Consortium and AANP partnered on a grant from the Center for Medicare and Medicaid Services (CMS) that will look at strategies to transform health care and educate clinicians, with NPs at the forefront. "CMS is looking to reduce costs and improve care through these practices," Cook said.

Electronic health records and information technology are two other high-priority topics. The department has a partnership with the Health Information Management Systems Society (HIMSS) to examine issues such as data storage, data interoperability, and NP use of electronic health records. Such topics are important not only for high-quality patient care but also for reimbursement from insurance companies and other carriers.

As a global nonprofit focused on improving health through information technology, HIMSS has wanted to learn more about how NPs utilize health information technology. AANP has added questions about electronic health records and telehealth services to its most recent survey.

As nurse practitioners gain more attention nationally, the profession is receiving more requests from external researchers. In response, the AANP research office serves as a liaison between these researchers and the NP community. "There's been tremendous growth in the NP profession. We get a lot of questions about this growth in states and nationally," Cook said.

The department has internal policies to review requests by external researchers, who may want to collect data at AANP conferences or survey NPs. "We want other researchers to feel they can come to us if they have a research project of interest," Cook said. Typically, an advisory panel will review external requests to contact NPs for purposes of data collection.

Overall, the expansion of AANP's research capacity has coincided with continued growth in the number of NPs and their importance in service delivery. "The NP workforce continues to grow," Cook said, "and we support AANP's mission to lead NPs in providing high-quality care."

Closing the Policy Gap

AANP's Effort to Extend the Benefits of Full Practice Authority Nationally

BY JAN TEGLER

The challenges facing America's health care system are many. From rising costs and complex regulation to an expanding, aging population, the national health care framework built in the 20th century is struggling to adapt to new realities as the second decade of the 21st century winds down.

One of the most pressing issues is a shortage of health care professionals to meet the growing needs of Americans. According to the Agency for Healthcare Research and Quality, an agency of the U.S. Department of Health and Human Services, there were 209,000 practicing primary care physicians in the United States in 2010 – slightly less than one-third of the 624,434 American physicians who devote the majority of their practice to direct patient care.

The Health Resources and Services Administration projects that America will experience a shortage of 20,400 primary care physicians by 2020 while a March 2015 report released by the Association of American Medical Colleges indicates that the nation will face a shortage of between 12,000 and 31,000 primary care physicians by 2025.

Ironically, though the annual number of graduating physicians has risen steadily over the last decade,

according to the Henry J. Kaiser Family Foundation, fewer and fewer are opting to become primary care physicians. Why? Lower prestige, high debt loads, and the knowledge that they must see an excessive number of patients per day in order to meet overhead while earning half of what specialist physicians earn discourage medical school graduates from selecting primary care as a career.

How can the United States address this workforce shortage? The American Association of Nurse Practitioners (AANP) believes a key part of the solution is America's growing population of certified nurse practitioners (NPs) – a group of dedicated primary care providers that have been serving the health care needs of Americans for 50 years. Through its offices of federal government affairs and state government affairs, AANP works to educate legislators about nurse practitioners and restrictive laws and regulations that affect their practice,

with the end goal of eliminating barriers NPs face in delivery of care and increasing patient access to NPs.

The Drive for Full Practice Authority

"Everyone is looking at how we can realign and rebalance our health care system to meet 21st century needs," said Dr. Tay Kopanos, AANP's vice president of State Government Affairs. As part of that process, states are looking to recalibrate their licensure laws to reflect the skill set of today's workforce and better meet state health care needs."

As the fastest-growing category of primary care providers in the country, nurse practitioners would seem to be an obvious part of the solution to the problem of primary care provider shortage. But obstacles in the form of restrictive state licensure laws that require physician involvement in order for an NP to provide patient care limit the ability of these primary care providers to serve the public to the full potential of their education, skill, and expertise.

An increasing number of states, however, have closed the gap between state law and the high level of care NPs can offer. Twenty-one states and the District of Columbia now grant full practice authority

Twenty-one states and the District of Columbia now grant full practice authority (FPA), the collection of state practice and licensure laws that allow for NPs to evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatments – including prescribe medications – under the exclusive licensure authority of the state board of nursing.



(FPA), the collection of state practice and licensure laws that allow for NPs to evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatments – including prescribe medications – under the exclusive licensure authority of the state board of nursing.

AANP puts the number of NPs practicing in 2015 at 205,000 nationwide, almost double the number (106,000) licensed in 2004. They are distributed across the country, but the majority of states that grant FPA are concentrated west of the Mississippi.

“Several states have had FPA for decades,” Kopanos said. “Some of the early adopters were Western states [that] recognized the skill set NPs possessed and their availability to provide more health care services

Adult nurse practitioner Jayne Mitchell, right, watches as patient Marlena Bechtel-Rysdam learns how to use an electronic monitoring device called a Health Buddy at Oregon Health Sciences University in Portland, Oregon, on Jan. 30, 2013. In an effort to reduce costly rehospitalizations, Mitchell works with patients with heart failure to give them extra education before they’re discharged. When given the chance to practice to their full capabilities and qualifications through full practice authority, NPs can not only provide high-quality health care but can also help keep health care costs down.

to more people in more places. Population need and the quality of NP care drove those early policies. But we’re now seeing access to quality care, escalating health care costs, and continued health care workforce challenges driving health policy decisions everywhere from densely

populated cities in the Northwest to sparsely populated states like Nebraska, a state that recently [in 2015] adopted FPA legislation.”

The logic underpinning AANP’s drive for FPA marries the need of meeting the health care workforce shortage with the goal of improving public access to quality health care and curbing health care costs while improving Americans’ ability to choose a health care provider.

FPA streamlines care and makes its delivery more efficient, obviating requirements for physician collaboration or protocol and providing patients with direct access to the entire scope of services NPs can provide. The elimination of duplication of services and billing costs associated with physician oversight, along with reduced repetition of orders, office visits, and

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Despite significant resistance, AANP believes the pendulum is swinging toward the adoption of FPA nationally, and Kopanos reported that AANP's board of directors has set a goal that 90 percent of states will have FPA licensure by 2020.

care services, results in savings for patients and the health care system.

AANP's State Government Affairs opened in 2010 with Kopanos as its director. At the time, 14 states and Washington, D.C., had adopted FPA. Over the last five years, seven more have changed their licensure laws to grant full practice authority, pushing the proportion of states with FPA past 40 percent. Kopanos said these additions show the trajectory is positive and that the work AANP is doing is paying off "but we'd like to see that trend enhanced."

So what are the hurdles to the adoption of FPA nationally? Kopanos explained that educating state legislators about the capabilities and track record is critical. So is overcoming opposition to FPA.

"Most disappointing is that modernization efforts continue to get opposition from the organized medical community," Kopanos said. "It's a disconnect from our colleagues whom we practice with every day, who practice evidence-based health care and principles daily but who have not yet endorsed evidence-based licensure regulation for NPs."

She maintains that "those stakeholders" – physician lobbying groups – are the biggest challenge to acceptance of FPA by the legislative community at the state level, adding that they continue to advocate against modernized licensure laws for NPs.

"At AANP, we hear from some individual physicians who are very supportive of moving to FPA. It's truly the organized physician lobby and state medical associations [that] are in opposition. As health care is changing, I think the 'Marcus Welby' idea of how medicine is practiced is also changing. There's a cultural shift occurring in the awareness

of policymakers and patients, but unfortunately, that dated hierarchy and the misinformation about what health care providers are educated and trained to do continues to be a factor in our campaign."

MaryAnne Sapio, AANP's vice president of Federal Government Affairs, agrees that opposition from "organized medicine" is a problem at the federal level as well. In addition, barriers to FPA exist within Medicare.

"We're focused on provisions that are already in the Medicare statute that we have to fix, while at the same time examining new pieces of legislation which are being introduced to ensure that they are inclusive of nurse practitioners," Sapio said. "Durable medical equipment is one issue, home health care is another."

Despite significant resistance, AANP believes the pendulum is swinging toward the adoption of FPA nationally, and Kopanos reported that AANP's board of directors has set a goal that 90 percent of states will have FPA licensure by 2020.

How will that come about? Via an ongoing campaign focused on education and advocacy, bolstered by evidence-based research, strong stakeholder support from groups like the National Academy of Medicine (formerly the Institute of Medicine), the Federal Trade Commission, the National Governors Association, and other organizations that recommend states grant NPs full practice authority.

Broadcasting the Message

"AANP works with multiple stakeholders," Kopanos said. "One

of the largest is individual NPs and nursing associations within individual states."

Health care policy is a "team sport," she explained, so NP voices in the conversation about FPA are probably the "most critical and pivotal." NPs serve at the intersection of health care policy and patient care. Every day they see where dated law and regulations interfere with efficient and timely patient care.

"Having individual NPs – our individual members – sharing their stories and highlighting to policymakers where these barriers are and how they impact patients is critical to helping states that haven't yet adopted updated licensure laws move forward. Continuing to build on the research that underscores the high-quality outcomes and cost efficiencies of NPs from FPA states is also critical. Those will be the two biggest levers in moving policy in the next couple of years," Kopanos said.

On the federal side, Sapio and her team are working to broadcast the organization's message. AANP's efforts in the federal arena mirror those at the state level, she said. Sapio explained that AANP reaches out to members of Congress on various committees to educate them about nurse practitioners as well as restrictive laws and regulations in the federal sphere and how they inhibit access to NPs.

At the state and national levels, AANP partners with larger patient advocacy groups including AARP, business groups, chambers of commerce, community health centers, federally qualified health centers, and patient rights groups such as the Mental Health Association, the Alzheimer's Association, and patient specialty associations. These

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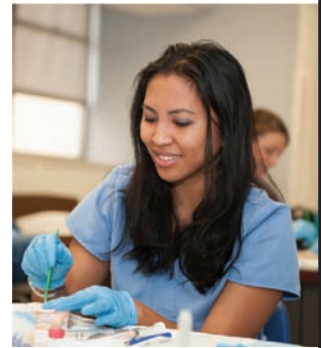
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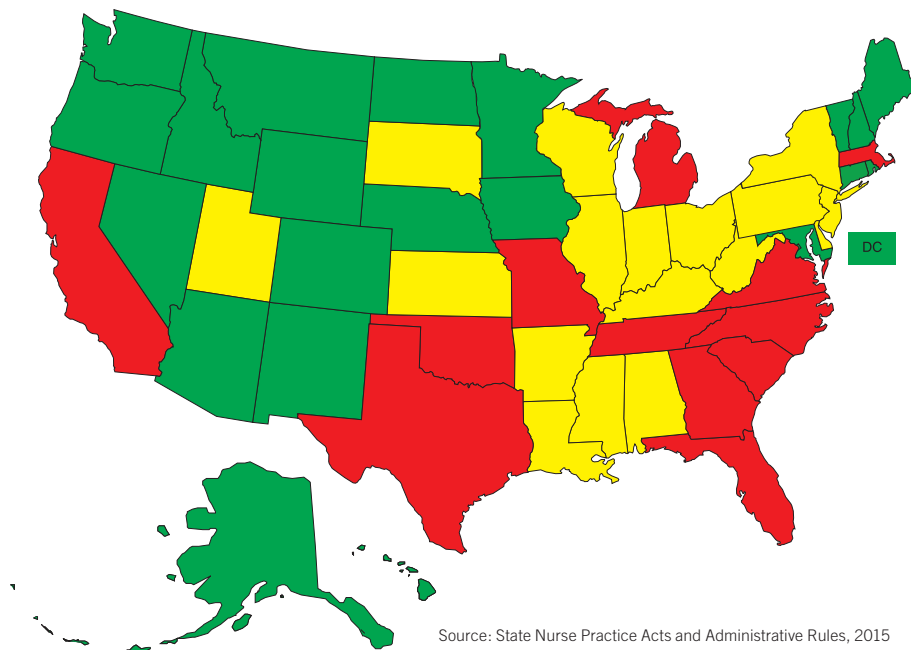
State practice and licensure law provides for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribing medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

Reduced Practice

State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care.

Restricted Practice

State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care.



Source: State Nurse Practice Acts and Administrative Rules, 2015
© American Association of Nurse Practitioners, 2015

organizations recognize that their members, beneficiaries, and families benefit from access to NPs for care on a daily basis.

AANP works with issue-based coalitions and provider-type coalitions at the federal level to amplify its voice, Sapio added.

“We work with various other health care interests in many different coalitions to advance our common goals. We are constantly endeavoring to find common ground with and work with a large swath of other organizations,” she said.

The message AANP members and others are delivering is that the NP profession has been around for 50 years and has an impressive track record of patient outcomes. While policymakers view their own states through a unique lens, they are always receptive to what has worked in other states. Highlighting the stories of success from states nearby that have adopted FPA really speaks to them.

“Policymakers see that this isn’t a new issue that has arisen in just the last five years and that NPs are not simply the latest health care provider in the field. Legislators are receptive to individual case studies and a growing body of research pointing to the benefits of nurse practitioner care,” Kopanos said. “For example, North Dakota changed their licensure laws in 2011. Since then, the state has opened new clinics and is seeing an increase in access points to health care through NPs. Sharing how North Dakotans gain increased patient choice and better quality of care by modernizing licensure helped Nebraska and Maryland legislators better appreciate how modernizing licensure laws in their states would improve health care access.”

In Congress, AANP examines a broad variety of bills that come before various congressional committees it interacts with and delivers its message via multiple

channels, including testimony before the committees.

“Several times last year, our past president testified in front of the Energy and Commerce committee,” Sapio said. “Prior to that, we had an AANP state representative testify in front of a Senate committee. We do have opportunities to testify at the invitation of members of those committees.”

Kopanos points to decades of research published comparing patient care outcomes between NPs and physicians. Recent studies highlight that states with FPA have improved outcomes of care, reduced costs of care, and lower hospital readmission rates than states with more restrictive licensure laws. She said the studies continue to confirm that NP care has continued to be either as good as or better than physician-delivered care in terms of outcomes.

“In the states that have FPA, you’re finding a correlation between those states and lower health care costs along with improved access. It’s a

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complete package of research outcomes and cost-savings, and a picture of what states that have adopted this model have done and how they've been successful with it."

Kopanos added there's evidence that states that already offer FPA are attracting NPs and that this can be a competitive advantage.

Though some nurse practitioners are migrating to states where full practice authority is the law of the land, Kopanos stressed that NPs in states where FPA is not granted are actively advocating for it. She notes that it will be interesting to see where new NP graduates end up going. NP graduates not currently embedded in a state providing care have a larger swath of opportunity these days. Students are looking for opportunities that match their education and skills and they're looking first at FPA states.

A smaller obstacle to allowing patients full access to NPs is insurance. AANP continues to see challenges with insurance companies allowing patients to choose NPs as their primary caregivers and reimbursing that service under the insurance plan.

In addition to working on licensure modernization, the AANP State Government Affairs team is examining insurance reimbursement and general policies so that patients do have the option to choose NPs as primary care providers on their insurance plans.

"We're finding that some insurance companies are credentialing NPs and paying them directly for their service. That's a trend we started seeing a couple years ago, which has continued to increase. There has also been movement in federal and state law that protects patient choice and requires insurance companies to allow patients to choose NPs as well as physicians and other providers."

The larger point is that even in states where FPA is not current law, patients are opting for NPs as their primary care providers. AANP indicates that in 2014, more than 900 million visits were made to NPs and that two out of three patients supported legislation that would give them greater access to NP services. The Association maintains that patient choice should be supported by state law and insurance.

Overall, Kopanos is positive about AANP's FPA advocacy effort. She said that AANP members and NPs in general are speaking out on the issue more and more.

A Tipping Point

The adoption of FPA nationally is AANP's ultimate aim. But with fewer than half of states having modernized their licensure laws so far, is AANP's 90 percent goal achievable by 2020?

Kopanos and Sapio believe it is.

Though some nurse practitioners are migrating to states where full practice authority is the law of the land, Kopanos stressed that NPs in states where FPA is not granted are actively advocating for it.

Shaping Health Care Policy

STATE POLICY GOALS

- Provide patients with full and direct access to NP services
- Modernize state practice laws
- Promote sustainable reimbursement policies
- Address NP signature recognition and promote NP-inclusive language in state law and regulations

FEDERAL POLICY GOALS

- Elimination of federal barriers that remain in Medicare, including ordering Home Health
- Accountable Care Organization (ACO) participation
- Appropriations for federal funding for NP education
- NP inclusive language in CMS and federal law

Policymakers are more aware than ever of the benefits of NPs and the needs of their states, and patients and stakeholders are also taking active roles in calling for legislative action in this area.

"We anticipate that we will see several states make progress in 2016 and that we will cross that 50 percent threshold with more than half of the states providing their residents with full and direct access to NP services," Kopanos said.

Sapio agrees that the trend is positive for FPA. "We look at all pieces of legislation with that same eye. We are seeing more legislation that is written in a provider-neutral tone. That's primarily because of the education we and our AANP members are doing with members of Congress. We're now seeing support for NP issues from across the country."

"We continue to see more stakeholder interest in this issue," Kopanos concluded. "We'll also see more research that bears out and reinforces what we've seen over the last five decades. NPs provide high-quality, cost-effective care to patients, and evidence-based regulation requires the modernization of nursing licensure law."

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Interview with Eileen Breslin, PhD, RN, FAAN

Dean, School of Nursing at University of Texas Health Science Center San Antonio

BY GAIL GOURLEY

Can you please describe the nurse practitioner education program at the School of Nursing at the University of Texas (UT) Health Science Center San Antonio, and highlight some of its key unique characteristics?

Dr. Eileen Breslin: Our advanced practice nursing programs have been in existence for [more than] 20 years. We have an adult-gerontology acute care nurse practitioner program, a family nurse practitioner program, a pediatric nurse practitioner program, and a psychiatric mental health nurse practitioner program.

We have done, I think, a remarkable job in making sure that we have followed the APRN [advanced practice registered nurse] Consensus Model. For instance, when they determined that all psychiatric mental health nurse practitioner programs must be across the life span, we were already there. So one of the unique features of our nurse practitioner programs is that we teach a course in mental health so all of our advanced practice nurses have a strong base in mental health; we really believe in the importance of integrating mental health concepts into all that we do.

We collaborate with the National Organization of Nurse Practitioner Faculties, the American Nurses Credentialing Center, and all the

advanced practice organizations, such as AANP [the American Association of Nurse Practitioners], and our faculty participates in projects that have led to the Consensus Model regulation and to LACE [licensure, accreditation, certification and education].

Another unique feature about our program is that it is hybrid, including face-to-face plus online course offerings. Also, we focus on the underserved and under-represented populations. We are, as a health science center, a federally designated Hispanic-serving institution, and that is unique. We have a formalized faculty practice plan, which allows all of our nurse practitioner faculty opportunities for practice, educating nurse practitioner students in practice scholarship. Also unique is that we

have a significant enrollment of active duty and Reserve military students.

One of the things that our faculty has done is to move away from a lecture-only format during class time. They really do more of a “flipped” classroom approach: putting content up before the class time and using applications and case studies. We do a very formal OSCE [Objective Structured Clinical Examination] for clinical competency. We use standardized patients on a regular basis for our nurse practitioners so that we know that they’ve got a base. We adhere to all the national standards.

We graduated 108 students this past August. Into the family nurse practitioner program, for example, we’re admitting approximately 30 students per year, many of whom return to their communities in south Texas.

What collaborations with other entities would you like to highlight?

We have a strong inter-professional learning experience for our nurse practitioner students. For instance, our family nurse practitioner and pediatric nurse practitioner programs are working with students on a

We collaborate with the National Organization of Nurse Practitioner Faculties, the American Nurses Credentialing Center, and all the advanced practice organizations, such as AANP [the American Association of Nurse Practitioners], and our faculty participates in projects that have led to the Consensus Model regulation and to LACE [licensure, accreditation, certification and education].

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research project to explore resettled refugees' health care needs in San Antonio. We have been working in collaboration with the inter-professional refugee health clinic that is student-run by our UT Health Science Center. Medical students, dental students, nursing students, and nurse practitioner students all participate, and they're very much able to care for patients from diverse cultures and languages as part of this inter-professional student team.

We have a very vibrant virtual hospital, so our nurse practitioner students participate in some of the emergency medicine simulation projects with medical students and residents.

We have had tremendous experiences in collaboration with our university hospital clinics – our UT medicine clinics and Children's Hospital San Antonio. The pediatric nurse practitioner students spend one semester in ... a clerkship [type of] experience where they're rotating through some of the subspecialty clinics. For instance, they can rotate through genetics, gastroenterology, pulmonology, cardiology, developmental, hematology, and oncology. It's a very unique program.

The students also go out in the community with a 12-member inter-professional team of dentists, dental hygienists, two resident physicians, a pediatric nurse practitioner, and pediatricians to administer fluoride to more than 200 schoolchildren. Because there's a big push for medical practices to include oral health care as part of their practice, we're really trying to adopt that component.

We also have expanded to have some family nurse practitioner students now going on an international trip to Guatemala, where they spend one week as part of a medical outreach team.

And we have had our psychiatric mental health nurse practitioner students practice in a transitional care clinic with our physician



colleagues, and have funded stipends for psychiatric mental health nurse practitioner students in order to prepare more. We've grown our psychiatric mental health nurse practitioner program exponentially. We've gone from around six students about five years ago to approximately 28 right now.

Are there enhancements to your program you're currently working to institute, or that you would like to see made in the future?

We're going to continue to strengthen our partnerships within the Veterans Health Administration, and all our community partnerships, to ensure the very best education for our students.

What are the biggest challenges nurse practitioners face today, and how does your program prepare students to meet these challenges?

One of the challenges that most nurse practitioners face is practicing to the full extent to which [they are] educated. There are 21 states nationally that have full scope of practice, and Texas happens not to be one. We do teach our students well about collaborative practice, and [make] sure that they're using shared decision-making models. We really focus on patient- and family-centered care. We focus on evidence-based practice with an emphasis on cost effectiveness, because as we know, with the Affordable Care Act, our students really need to pay attention



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to the value added and what we do in order to focus on insuring the vulnerable populations. We have integrated, for instance, the core competencies for inter-professional collaborative practice that were developed in 2011.

I think the biggest hurdle facing nurse practitioner education is for us to move to full scope of practice. We help our students become more active and involved in health policy and understand how we can effect policy change to improve health care at both the state and federal levels.

Nurse practitioner education is evolving, and the movement is to have the doctorate of nursing practice for all advanced practice nurses.

What is your message to those considering becoming a nurse practitioner, and what changes do you see in the future for the role?

Looking ahead, I see that we will be the gateway in primary care within the next five to seven years. I think that we're going to see more acute care adult-gerontology nurse practitioners working as hospitalists.

The most important thing, I think, as you look at wanting to become a nurse practitioner, is that it requires a lot of dedication and commitment to improving patient outcomes. You really are doing it to improve the health care of the patients. Nurse practitioners have been around for 50 years. We've got research going back to the '60s and '70s saying that nurse practitioner care is equivalent [to physician-provided care]. It's important that our care comes from a nursing lens.

I think the transition from being a baccalaureate-prepared nurse and then moving into an advanced practice role is very rewarding. And there's great flexibility. There is more than enough work for all of us, and it really depends on your passion. The beauty of being in a primary care practice is that you establish long-term relationships with your patients over time.

Looking ahead, I see that we will be the gateway in primary care within the next five to seven years. I think that we're going to see more acute care adult-gerontology nurse practitioners working as hospitalists.

What is your message to a patient about what the education of nurse practitioners means for that patient's health care?

Patients appreciate their nurse practitioner being completely engaged and knowledgeable in helping them navigate the health care delivery system. They can provide their primary care, they can network and make referrals within the broader community, and access a whole host of referral sources that they may need. Nurse practitioners can navigate the delivery system on behalf of the patients and also can really help provide them the education and the monitoring, the coaching and the caring – and the time.

When you reflect on the fact that nurse practitioner education has been in existence for 50 years, what surprises you the most about the evolution of the nurse practitioner role?

It's the adoption of nurse practitioners in such a variety of settings – acute care, rehab, long-term care, and primary care. It's that the nurse practitioner has become integrated as a member of the health care delivery team. There are over 200,000 of us, and we are making a difference.

Dr. Eileen Breslin received her bachelor of science degree from Northern Arizona University. She earned her women's health care practitioner certification from the University of New Mexico in Albuquerque. She earned her master of science degree in maternal-newborn nursing from the University of Arizona, and her PhD in nursing from the University of Colorado Health Sciences Center in Denver, Colorado.

Among her professional activities, Breslin has served as president of the Primary Care Fellowship Society, is a fellow of the American Academy of Nurses, and a fellow of the American Association of Nurse Practitioners. She is currently serving a two-year term as president of the Association of American Colleges of Nursing. Among many recognitions and awards, Breslin has been recognized as a Distinguished Practitioner in Nursing by the National Academies of Practice in 2000 and received the National President's Award for the National Association of Hispanic Nurses in 2010.

Breslin's career in academia spans more than 30 years. She served at Northern Arizona University as faculty, chair of the department before moving to the University of Massachusetts-Amherst to serve as dean of the School of Nursing. While at UMass, Breslin also held the position of interim dean for the School of Public Health & Health Sciences for three years. She joined the University of Texas Health Science Center at San Antonio as dean of the School of Nursing in April 2008 and has served as the interim dean of the School of Health Professions for three months. Breslin additionally holds an appointment as adjunct professor in public health in San Antonio Regional Campus at the University of Texas School of Public Health at Houston.

Breslin, whose personal career interests include women's health and public health nursing, led major initiatives during her nine years as dean at UMass. She instituted a doctoral degree in nursing practice, a clinical nurse leader program, and a dual Master of Science and Master of Public Health program – all firsts in the state of Massachusetts.

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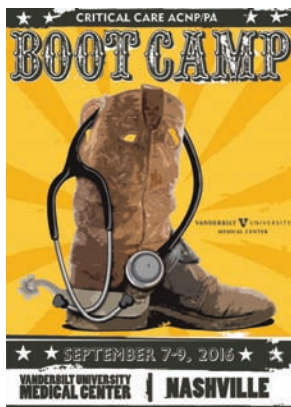
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Why I Chose to Be an NP

BY GAIL GOURLEY

The reasons why individuals choose to become a nurse practitioner (NP), and the circumstances and backgrounds, are as individual as those who make the choice. Likewise, the ways in which NPs bring those reasons to fruition in their careers can take a wide variety of paths. The one common factor, however, is that nursing's core values – advocacy, caring, and a true desire to help people stay healthy – form the central focus.

SUSAN HAGEDORN, PhD, RN, PPCNP-BC, WHNP-BC, FAANP, FAAN

As both an NP and filmmaker, Susan Hagedorn, PhD, RN, PPCNP-BC, WHNP-BC, FAANP, FAAN, has a unique perspective from which to discover reasons people choose the NP career path. “Lucky me that I was a nurse practitioner with an interest in filmmaking and storytelling,” she said. “I’ve been able to combine the two and be able to tell other people’s stories.”

Those stories, Hagedorn said, “are all of these individuals, women and men, who saw a role for themselves as making a change.”

“Almost everyone has a story that includes, ‘Now I can really do nursing as a nurse practitioner. Now I *really* can do it. Now I can do what I was taught to do, which is prevent illness, take care of illnesses earlier, help people make the decisions they want to make around the illnesses ... and I can have my own patient load and really be more autonomous in what I do.’ And that’s over and over what people say.”

For Hagedorn, the choice to become an NP developed after she attained her nursing degree. In college, she had started out as a nursing student, but her passion for storytelling was also strong. “After having an entire childhood where that was all I was going to do – be a nurse – about a month into college I had no idea why I had made that decision,” she said. “I wanted to be a poet and a writer and I dropped nursing, then ended up going back to nursing as a second degree.”



She worked at Children’s Hospital in Boston in the 1970s, and subsequently decided she wanted to practice more autonomously as an NP. “I saw that I could actually make some change in people,” she said. “I could really help kids and parents and teenagers and women make a change in their life instead of just treating them when they were acutely ill, crossing my fingers that they would get better, and then seeing them back in the hospital. I

PHOTO COURTESY OF
DR. SUSAN HAGEDORN

think a lot of people felt that way then and feel the same way now. I would say probably the No. 1 reason why nurses become nurse practitioners is because they want to see people get better and stay well.”

Hagedorn’s NP career focused on advocacy and social justice as she spearheaded the development of a school-based health clinic, the first in Massachusetts, and a mentoring program for at-risk adolescents as she earned her PhD at the University of Colorado (CU) School of Nursing, where she also taught in the NP program. Now, with her companies Seedworks Films (www.seedworksfilms.org) and Nurstory, Hagedorn focuses her filmmaking on nursing and NPs, advocacy, and social justice, successfully weaving her love of nursing with her love of storytelling.

**MARGARET FITZGERALD, DNP,
FNP-BC, NP-C, FAANP, CSP,
FAAN, DCC**

Margaret Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC, became an NP nearly 30 years ago. “I had a highly successful critical care nursing career where I had been for 15 years – in staff, leadership, and education,” she said. “One day I walked through the ICU and I looked around at all the patients we were caring for – very proud of the work we were doing – nonetheless, I looked around and I said, ‘Virtually every single person is in this ICU due to some kind of preventable disease. We are simply keeping this person from dying today, but die this person will.’ We were not prolonging life; we were, in many cases, postponing death.”

That epiphany inspired her to ask herself what she could do to keep people out of the ICU. “And that led to my deciding to become a family nurse practitioner,” she said.

Because all her nursing experience had been with adults, she intended to





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become an adult nurse practitioner, but instead reluctantly entered a family nurse practitioner program close to where she lived. Though she believed she would take care of pediatric patients and pregnant women just long enough to get through the program and then return to caring only for adults, today she continues to practice in the same Boston-area clinic she worked in as a student, a federally qualified health center in a lower-income community.

"I so enjoyed my work there that I was invited to stay on once I graduated, and I have joyfully practiced in the same community for almost 30 years," said Fitzgerald. "I see everyone that comes through the door – pregnant women, young people, old people. ... I see one five-generation family, numerous four-generation families, and countless three-generation families, and I honestly would not have it any other way. I have been privileged to take care of a second generation of women through their pregnancy. ... I have young adults, some of them in their late 20s, and I've been the only primary care provider they've known their entire life. That's very privileged work to do."

While Fitzgerald is committed to her practice, she has also expanded her NP role in other endeavors – starting a company, teaching, consulting, and writing. "All of this has sprung out of my work as a clinician," she said. "At the core of everything I do is my clinical work."

Her company, which provides NP board review and NP continuing education, among other services, stemmed from her background in speaking and nursing education beginning in her critical care days and continuing as an NP. "Quite early on, even in my novice NP role, I knew I had something that I could bring to nurse practitioners to help them move along their practice," she said. She spoke at meetings and NP continuing education forums even at a time, in the late 1980s, when most speakers at NP meetings were physicians. That has changed, she said, due to her efforts

and those of many other NPs to break down barriers, and now the majority of speakers at NP meetings are NPs.

Then, a graduate student she was precepting at the clinic made a request: "This student said to me, 'Eleven of my colleagues and I are graduating, and there's no review course around to get us ready for the NP boards. Will you help us out?'" Fitzgerald explained. "And I thought, 'I could do that.' So I literally had six people around my dining room table. It was a class of 12 – I got about 50 percent of the people to come to my home, and we conducted a series of classes where I helped them get ready for the NP board. Word got out, and the next thing I knew, I was doing a second group of about six people from another school. And that's how Fitzgerald Health Education Associates got its start, which is the industry leader in nurse practitioner board review. That was 85,000 nurse practitioners ago – we have helped 85,000 nurse practitioners achieve certification.

"My company arose out of exploiting an opportunity. Quite often, people in health care are uncomfortable with the word 'exploit.' It doesn't have to be a negatively charged word. It simply means looking around for that opportunity that no one else is seeing. I could very easily have said to that initial group of nurse practitioners, 'I'm too busy.' That would have been the easy thing to do," she said. "But what we need to do to advance our profession is to be at the table and to look around for the opportunities that you can exploit, and always have your eyes open for that."

Fitzgerald said she's surprised how varied the role of NP has ended up being. "When I first thought about becoming a nurse practitioner, I envisioned being in the exam room taking care of patients, and likely doing speaking on the side," she said. "What has really been brought forth to me is the variety of the role. ... it is an amazingly diverse group of roles that a person can fill, all under the umbrella of being a nurse practitioner."

VICTORIA ERICKSON, PhD, PNP-BC, FAANP

While Victoria Erickson, PhD, PNP-BC, FAANP, was in nursing school in the mid-1970s, she worked in hospitals as a nurse's aide and a licensed practical nurse (LPN). "That actually kind of colored my view," she said. "Part of the problem – and I still see this as a problem – is that the places that employ most nurses are hospitals and maybe some long-term care facilities. And hospitals, in particular, are very male-dominated and physician-dominated. So part of the struggle is for nurses actually to work to their full intellectual abilities [and] clinical training, and I wasn't seeing that in hospitals. All I was seeing was kind of a 'dumbed-down view.'

"I enjoyed taking care of patients," continued Erickson. "I just didn't like some of the bureaucracy, and I just didn't like the notion that everybody else was in charge of patients and nurses were there as part of the room rate and not listened to on a regular basis. And this phenomenon continues today."

Erickson explored options for nursing in non-hospital settings. The public health venue was one alternative, but didn't seem strong enough in primary care at the time. "So that was one possibility," she said, "but part of what drove me to be a nurse practitioner is that sense of, 'OK, you can have more autonomy. There's going to be more risk, so you better be good.' Part of it's feminism; part of it's just the organizational structures of the biggest employers of nurses. I really enjoy taking care of patients, but I really didn't want to be so prescribed in my role that I felt was very limiting. So even when I was in nursing school, I knew I wanted to be a nurse practitioner. I had read about it, I was real excited about it, and it was, 'OK, what's the fastest way to do this? I can't wait to do this.'"

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Erickson earned her NP certificate and began her new role at Children's Hospital in Miami, doing pre-op histories and physicals for children having procedures like tonsillectomies or dental surgery and teaching pediatric residents about normal growth and development.

Knowing she wanted to be an educator, she also began teaching

in the NP education program at the University of Miami, but soon realized she would need additional credentials if she wanted to teach as part of her ongoing career. She earned her master's and PhD, working in public health and private practice, she said, "to put food on the table."

Erickson utilized her credentials in her subsequent position at CU,

where she helped to restructure the pediatric nurse practitioner program in the late 1980s. Soon after, she and her colleagues started four faculty practices providing pediatric care – nurse-managed clinics owned by the university. Her current role is providing care and teaching in one of those clinics as part of being on the university faculty. "To me it's a perfect model," she said. "We precept all our students initially so that they get really good grounding in basic health assessment, well child care. And then our students, when they're good, when they've had several hundred hours of that, go out to private practices and other places."

Erickson has also worked with Hagedorn to create videos. In addition to her university teaching and clinical roles, Erickson said, "I'm also president of the State Board of Nursing and have been for several years. And of course, one of the struggles advanced practice nurses [APNs] have is to make sure regulatory boards 'get it.'"

Erickson said in Colorado, not unlike other states, APNs struggle against restrictions placed on the care they can provide. "We made these videos to try and educate the public, but most importantly, the legislative section of the public, about what APNs do and that they serve a critical function in delivering health care for the state."

After nearly four decades of being an NP, Erickson said the reality of her experience has largely coincided with her expectations. "If I had it to do all over again, I would do exactly the same," she said. "I have found great fulfillment in doing direct patient care as a nurse practitioner. I wear a lot of hats. I'm an educator, I'm an administrator, lots of different things. But at the end of the day, the thing that has kept me engaged in my profession and happy to do the work I do is that [patient care] part. ... At the end of my clinical day, I feel like I've done something. I feel like I've made a difference. I feel very good – tired, but good. I wouldn't change being a nurse practitioner for anything."

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**LYNN GILBERT, RN, PhD,
PNP-C, FAAN**

For Lynn Gilbert, RN, PhD, PNP-C, FAAN, the decision to become an NP stemmed from her passion for improving the health and lives of children internationally. “When I was 15 years old, I had the opportunity to go to Africa with a group of young people. That was in 1959,” she said. “As a result of that, I was given a scholarship to Stanford [University]. There were not many

kids around who had been to Africa at that time.”

Although she began her studies in international relations, she soon became aware of the school’s nursing program. “It seemed to me that in terms of my interest in becoming involved in a productive way with children in different parts of the world, that would be a good, marketable, portable skill set. So I switched from

international relations to nursing and then went to work in Africa for several years,” she explained. “I decided to become a nurse practitioner as the levels of education in nursing around the world increased.”

While becoming an NP would come years later, Gilbert had earned a master’s in public health and maternal-child health nursing from the University of California San Francisco

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following her baccalaureate degree. “Each degree gave me more credibility and a few more ways to fit in internationally,” she said. “The nurse practitioner part of it was unknown in much of the world at the time, although as it was being developed here in the U.S., it kind of coincided with my feelings that I needed to increase skills and applicability overseas. So the opportunities in what could be offered overseas in terms of child health were probably my main reasons for going on to be a nurse practitioner.”

“With what Dr. [Loretta] Ford [one of the founders, along with Dr. Henry Silver, of the first NP education program] and those who assisted her along the way were doing with that particular role, it did become, I think, an expanded and respected way to contribute in international child health,” she continued. “My boss in Nigeria while I was working there, Professor O. Ransome-Kuti, had, on a trip to the U.S., met with Dr. Ford and Dr. Silver, and when he came back from that trip, he said, ‘They’re trying to institute what we’ve had to do by default all along.’”

Gilbert added that in many parts of Africa, there are fewer health care providers, but in working alongside village health workers at the local level, she saw how the NP role could impact the day-to-day lives of children through being present in their community and understanding what factors affect their health outside of a formal health care setting. “Most of kids’ lives are not spent in clinics or hospitals, fortunately,” she said, “so that is a better way to understand what really affects health and can make a difference in their lives.”

In the late 1970s, Gilbert and her family moved from Africa to Colorado, where she entered the NP program at CU and continued her work to improve children’s health by developing a pediatric program at the free clinic in Boulder where she worked while she studied to become an NP. After 10 years at the People’s Clinic, she earned

her PhD from Union Institute in 1994 and began teaching on the faculty of the CU College of Nursing.

“I was able to teach and practice,” she said. “One of the nice things about the College of Nursing nurse practitioner programs is the linking of clinical and classroom responsibilities, so that we precepted students in clinical sites that were nurse-managed health centers or faculty practice sites. And the other thing that it gave me was the opportunity to take continuing consultations or clinical missions overseas.”

For more than a decade, Gilbert traveled annually to Haiti, making a long-term commitment to a particular area with the name *Petit Trou de Nippes*, which translates to “Little Hole in the Road.”

“We would go and, to the extent that we could, meet the health care needs on a primary care basis in the week that coincided with our being there. That was good, but there was a far greater amount that could be done if we could teach some skills and gather some resources for the villagers there in the other 51 weeks of the year.” In teaching others as another facet of her NP role, she said, “we have identified and worked with 26 women that are village health workers, some of whom actually were schoolchildren in that village when we started going to Haiti. They do things like facilitate immunizations, monitor progress in labor, and assess newborns who might need some extra help. So that is another level of involvement that, with the education of a nurse practitioner, you can feel comfortable in adapting.”

Gilbert pointed to an additional opportunity that arose in the university’s faculty practice site where they trained NPs. She explained, “I decided that there were things we needed to be doing about childhood obesity for life span health, the trajectory of health development, and there would be opportunities for us to work with families early on so that we weren’t dealing with diabetes or hypertension or obesity later on with

kids. After a particularly bad day in clinic in the early 2000s, we [Gilbert and her son, Kevin Gilbert, PhD] developed HeartSmartKids, a web-based bilingual tool that we’re using in many of our clinics, community screening, and research projects. It’s now expanding into some mental health screening efforts as well.”

Gilbert added, “That was another opportunity that we were able to develop because we were in a nurse practitioner-based clinic where you could try things out and focus on primary care.

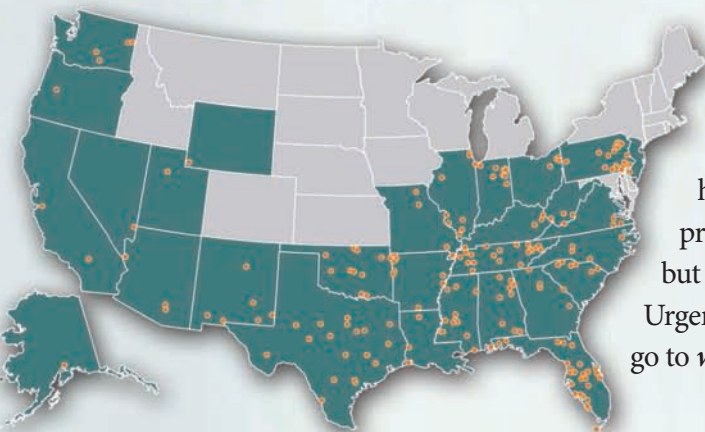
“I think the opportunities and the options available to me to work in different areas were certainly enhanced by becoming a nurse practitioner,” she continued. “It gave me a ticket and a tool kit to do what I wanted to do overseas.”

BONNIE GANCE-CLEVELAND, PhD, RNC, PNP, FAAN

Bonnie Gance-Cleveland, PhD, RNC, PNP, FAAN, was a senior in her undergraduate nursing program at CU in the mid-1970s when her desire to become an NP was initially sparked. “A guest speaker came to our pediatrics class to talk to us about the role of a pediatric nurse practitioner. I decided right then and there that’s what I wanted to do,” she said. “At that time, they wouldn’t let you go directly from your undergrad program into a master’s program. They required two years of experience, so I got the two years of experience and then applied to a nurse practitioner program. The autonomy and the ability to really work with children and families in their community, as was described to me by that nurse practitioner who visited my undergrad class, was exactly what I wanted to do.

“I was excited about the ability to make a difference,” she continued. “For me, the real appeal is providing services to children and families that

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may not have access if there's not a nurse practitioner there."

After earning her master's degree and pediatric nurse practitioner certificate, Gance-Cleveland initially worked with pediatric surgeons in their office, providing pre-op histories and physicals and consultations to families, many of whom had children with chronic conditions requiring ongoing support.

Gance-Cleveland further translated her goals to work autonomously with children and families into practice when, in 1995, she was hired by

CU to open the school-based clinic in the Sheridan School District. "We at the college still own and operate that school-based health center," she said. "We just celebrated our 20th anniversary for providing services in that community. The passion I had then is exactly what I have today, and I still practice there one day a week."

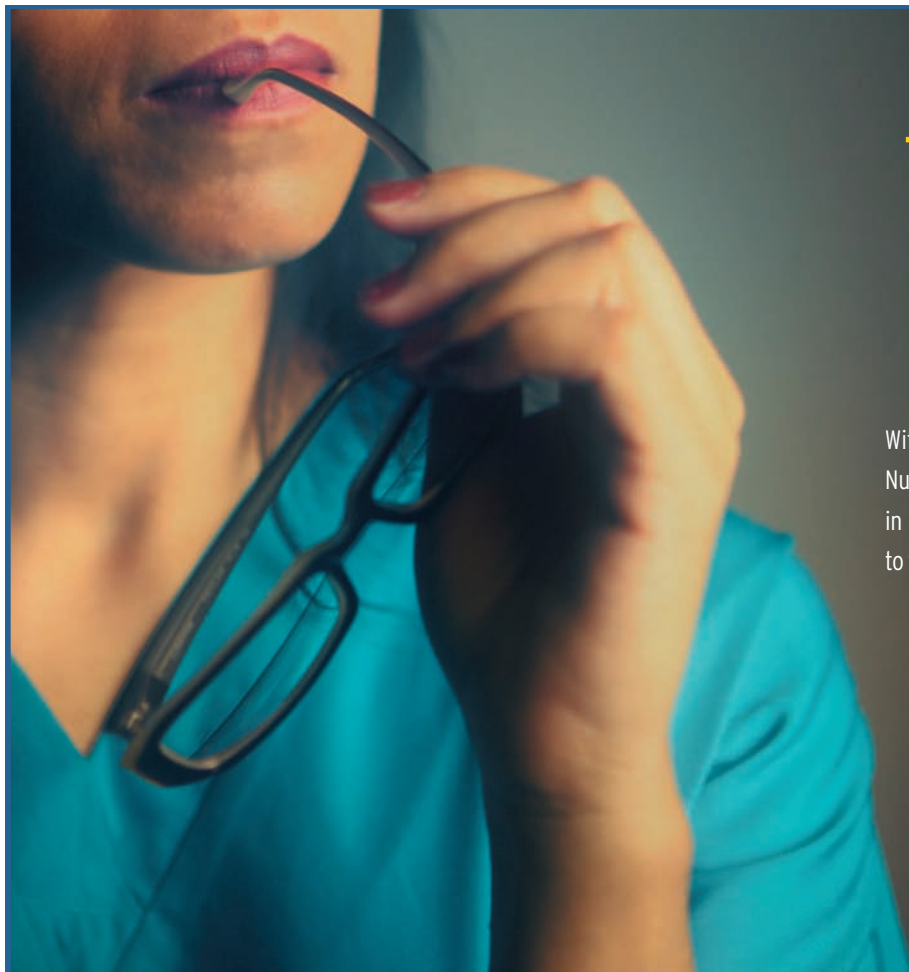
Additionally, later earning a PhD sparked her keen interest in research, she said, "and documenting what we were able to do through the research. I left the university for about 10 years to really focus more on my research

career, and that always [focused on] documenting the outcomes of nurse practitioner work."

A few years ago, Gance-Cleveland became the Loretta C. Ford Endowed Professor at the CU College of Nursing, a position that requires both practice as an NP and a funded research program. She explained, "Dr. Ford herself provided the funds but also outlined the criteria for the chair holder, and she really wanted someone who was still practicing and conducting research so the research would be grounded in practice and still relevant to a practicing nurse practitioner. She really was interested in translation research: How does the busy clinician use this in their practice? And that has indeed been the focus of my recent work in childhood obesity. How can we provide tools and education to help the busy clinician implement this in practice?"

As an example of translation research, the Agency for Healthcare Research and Quality funded Gance-Cleveland's 24-site comparative effectiveness trial looking at web-based training for clinicians in school-based health centers in six states in dealing with childhood obesity. The results of this research, which also included evaluation of the effectiveness of the HeartSmartKids interactive technology, provided results that assist clinicians in delivering more effective care.

Gance-Cleveland's relevant research and school-based clinical practice have fulfilled her passion for making a difference by providing care to children and families in their community. Reflecting on the 50th anniversary of the NP role, Gance-Cleveland said, "When we think about health care reform and the Affordable Care Act, and how we are going to provide care to everyone that needs it in the United States, I think it's this role that's the pivotal piece of the puzzle. And it was developed in our lifetime. It's just incredible to me that this amazing solution to providing care to everybody, and particularly the disenfranchised, was created by a nurse in our lifetime 50 years ago."



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**JEAN AERTKER, DNP, FNP-BC,
ARNP, COHN-S, FAANP**

Jean Aertker, DNP, FNP-BC, ARNP, COHN-S, FAANP, was a lieutenant in the Air Force Nurse Corps in 1974 when she met her roommate, a pediatric nurse practitioner. “I never saw the role before, never heard of it before, and I thought it was pretty awesome that she could see her own caseload of patients, that she worked in the clinics independently under the pediatrician but had her own patients and families that she took care of,” said Aertker. “I was caught up on the nurse practitioner role because I thought it was something I would like to do, and when my circumstances changed and I left the Air Force, I decided that I really needed to find a role that was more of what I wanted, so I started my career path to try to become a nurse practitioner.”

Aertker added, “I loved the education part, I loved the public health part of nursing and just thought it was going to be great. And definitely it was.”

Aertker visualized a specific path to incorporate those aspects into her career. “When I got into the school for nurse practitioners – when I finally got my bachelor’s finished and then I got my master’s – it was a role that was identified as working alongside the physician and there was not that much emphasis on owning your own practice. But I always envisioned someday I would own my own practice. That’s what I strived for. And that’s what I do now; for the last 18 years, I’ve had my own practice.”

While Aertker’s NP career evolved to attain that goal, it began differently. “When I first graduated and went seeking jobs, leaving the hospital arena, I had to find three jobs to make a living. The role was not there; the money wasn’t there; so I negotiated. And it was kind of like I built my own, if you will, ‘residency,’” she said. For the next two years, she worked

with family practice and orthopedic physicians in their office, learning diagnostic skills and perfecting her proficiencies as an NP.

Following that, she accepted a position with the University of South Florida, where she was the first NP to train physician students at a Tampa clinic. “I helped to bring that role so that we could have both nurse practitioners and physician students learning together at a free clinic,” she said. “It was called the Public Sector Medicine Program, and this was a novel training program within the medical school.” The multidisciplinary health care team included an NP, a pharmacist, a social worker, family physicians, a pediatrician, and early medical students for their first experience seeing patients.

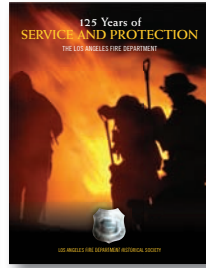
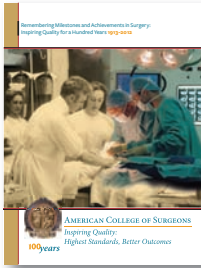
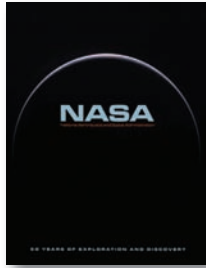
“As soon as I got there, I brought nurse practitioners in, and then

we had inter-professional training going on at the same time. It was awesome,” she said. “We like the inter-professional role. If we’re both learning how to listen to heart sounds [and other skills], it made sense to share the patients and learn together, and then take nursing’s input and medicine’s input so you can see how to take care of the patient better. It’s a great role, and that program still goes on today. ... Since 1985 I’ve been continuing to volunteer and interact with the students that are there.”

Following 10 years of teaching at the university, Aertker seized an opportunity to help one of the local hospitals start an occupational health program. “I was interested and had taken courses in occupational medicine at the university,” she said. “This was a hospital-based clinic and I developed, with the medical director, four nurse



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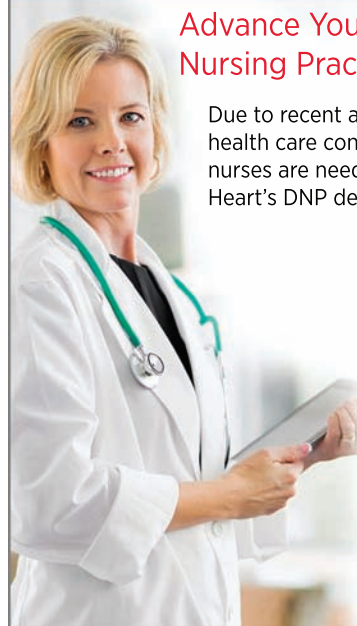
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practitioner-managed clinics around our community.”

Eight years later, when the hospital decided to close the clinics, Aertker fulfilled her vision to own her own practice and opened Tampa Occupational Health Services.

Aertker also continues to volunteer in the community at the free clinic once a week. She said, “That’s to give back, because I do miss family practice. I do miss being there to treat and diagnose patients, so I keep my skills up by doing that.”

Aertker believes that the nurse practitioner role has continually evolved for the better. Referring to the profession’s public health origins and the idea that NPs can make a big impact helping people stay well, she said, “That’s where I see the nurse practitioner role – helping people stay healthy.”

“But now we see it goes the whole spectrum,” Aertker continued, referring to acute care NP roles. “I think that’s the biggest thing that amazes me – how much depth and growth this profession has undergone in 50 years; and how necessary, too. I think that their role in hospitals in seeing critically ill patients, doing procedures, is needed because health care has been changing, and there are so many people that still need to get health care.”

Aertker also pointed out that while the NP role has become attractive to many, much effort has been made over time to create positive change. “Many of us struggled for many years to change laws that are very outdated, that were created long before the profession was popular,” she said. “Fifty years is a very short time frame to be a profession, and cutting down outdated thinking, outdated laws, has been a real struggle for us who were the ‘early birds.’”

She concluded, “I think that if we keep nursing at the core of what we do, we’re going to continue to be successful and people are going to accept more and more nurse practitioners as being their provider.”

ANGELA GOLDEN, DNP, FNP-C, FAANP



For Angela Golden, DNP, FNP-C, FAANP, the decision to become a nurse practitioner came 20 years into her varied and successful nursing career. Having worked in multiple environments from intensive care, emergency, and trauma nursing to home health, school nurse, and flight nurse, the turning point came as she planned a move to a rural Arizona community.

Describing her career to that point as mostly “high tech,” Golden said her decision to go back to school to become a family nurse practitioner stemmed from her desire to do a different type of nursing. “I wanted to be more involved in the community and caring for the community,” she said. “I looked around and realized that a family nurse practitioner has that opportunity to really be part of the health care system of a community.”

That opportunity would come, but prior to relocating and after graduating from her NP program, Golden initially worked at a private

prison. “It was actually my very first job as an NP,” Golden said. “There was a lot of learning there in that first year.”

Golden then did relocate, where she began working at a “tobacco tax” clinic, a small community health center funded by tobacco tax revenues, in a nearby town. “I did that for a couple of years and then realized that I could open my own practice in my own small community,” she said. She did just that, and 14 years later, she continues her own practice there.

When considering her reasons for becoming an NP, Golden acknowledged they would be the same today, and even more so. “Having had the opportunity to truly be part of caring for my community, providing health care for my community, providing health care for the people that I’ve come to know as neighbors and friends ... really has been one of the great honors of my nursing career,” she said.

Additionally, Golden, who had always gravitated toward education



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roles, began teaching in the NP program at Northern Arizona University, an institution she described as “a smaller university with a lot of one-on-one opportunities with graduate students.”

Golden said, “The vast majority [of students] lived in rural communities. It was their goal to stay in their rural communities and care for the people there. So the whole picture was just a perfect fit for me. I lived in a rural community, I opened my own private practice there, and taught at a university that was very rurally focused in the nurse practitioner program, and so I was able to work with graduate students who were also living in rural communities and wanted to stay in those areas to care for their own communities.”

In addition to teaching and running her private practice, Golden also became deeply involved with AANP. “I said that one of the great honors of my nursing career has been being able to be in a small community and provide health care in my own community,” she said, “but one of my greatest professional honors has been serving my profession through the American Association of Nurse Practitioners.”

Early in her NP career, Golden ran for state representative to the American Academy of Nurse Practitioners, and then mentors suggested that she go on to the board of directors. She described herself as “hooked” at the idea of serving her profession through what the board of directors did for the profession in areas of health policy, advocacy for strong education and continuing education, and working hard “to make sure that people knew what nurse practitioners were. I was just so passionate for what this organization works so hard to do for our profession,” she said. “So I ran for secretary serving on the executive committee, and then ran and was elected as the president-elect. During my presidency, the

merger of the American Academy of Nurse Practitioners and the American College of Nurse Practitioners was completed, making for a stronger national organization.”

Having just completed her term on the board of directors of the American Association of Nurse Practitioners in June 2015, Golden said, “To have been a part of all that the Association has accomplished and to be a part of being able to advocate for nurse practitioners at that level really has been one of the most amazing honors I’ve ever had.”

Golden said she feels particularly gratified about how well-received nurse practitioners as a profession have become, something she expected because of the work that’s been done to raise awareness about the role of the NP. “Five to seven years ago, everywhere I went, I had to have my ‘elevator speech’ – that 30 seconds about what a nurse practitioner is – ready to go. I can’t remember the last time I had to do it,” she said. “It’s wonderful to know that just about everybody knows at least what a nurse practitioner is.”

When summarizing her thoughts about the role of NPs, Golden referred to Dr. Loretta Ford’s vision in 1965. “Nurse practitioners are not a fill-in; we’re not filling in a gap for another profession,” she asserted. “When Dr. Ford saw the opportunity for nurses to provide a new level of care that was needed, she said, ‘Let’s create the educational system so that they’re ready to provide that health care.’ Today America is giving us another opportunity. We have a broken health care system and nurse practitioners have an opportunity to step up and be that solution, at least part of that solution, to the crisis that our health care system is in.”

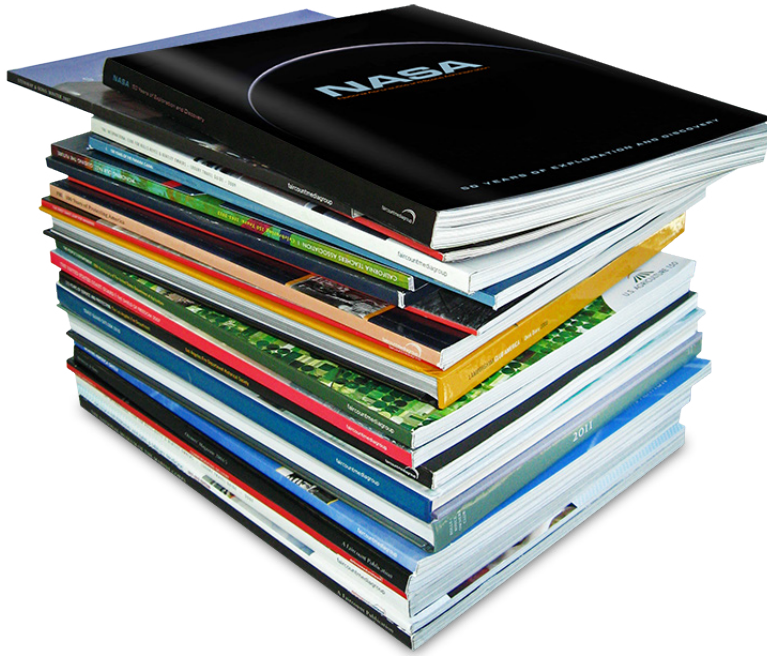
With nursing as the solid basis, Golden believes that nurses and NPs can function as change agents to help create a better health care system. “I challenge all of us to continue to look for ways to do that,” she concluded.

CAPT. JAMES DICKENS, DNP, RN, FNP-BC, FAANP

“I’ve always been a caretaker, a caretaker at heart – whether that was in athletics, my personal life, or professional life,” said Capt. James Dickens, DNP, RN, FNP-BC, FAANP, a nurse practitioner and a commissioned officer in the U.S. Public Health Service. And providing care – whether directly in a clinical capacity or indirectly by working to improve patient access to care – has been the focus of his career.

Dickens’ desire to enter the nursing field took hold in high school, when he cared for his mother, who suffered from breast cancer. “That’s when I really got a taste for the nursing profession, to understand how crucial it was and how important it was as well,” said Dickens. With the goal of becoming a nurse in mind, he joined the Air Force after graduation, became a surgical technician, and underwent “training that led up to other things – the EMT, all the field medical readiness for wartime scenarios.” While still in the Air Force, stationed at Langley Air Force Base in Virginia, Dickens enrolled in nursing school at Hampton University, a historically black college and university in Virginia. Two instructors, Johnnie Bunch and Kathy Block, impressed with the clinical skills he’d honed in the Air Force, took an interest in him and became his nurse mentors.

After he finished nursing school, he sought advice from them on how he should move forward professionally. “As a nurse, I thought I was just going to get my nursing degree and then move on and perhaps go back at some point to get a master’s in nursing education to potentially teach,” Dickens said. But having noticed his clinical acumen, his mentors “really encouraged me to go with the advanced practice role,” he said. “They preached advanced practice, they preached being a part of your professional organization. ... They both believed that the market



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was going to shift toward the advanced practice providers.” He returned to Hampton University and earned his master’s degree in nursing, graduating as a primary care nurse practitioner.

Since then, Dickens has put his education and clinical skills to work for government agencies: the Department of Veterans Affairs in Virginia, and the Federal Bureau of Prisons as a civilian clinician at a federal medical center in Fort Worth, Texas. Now in Dallas, he is a commissioned officer in the U.S. Public Health Service (USPHS), a uniformed federal agency overseen by the Surgeon General with the mission to promote, protect, and advance the health and safety of the nation.

As a USPHS officer, Dickens currently serves as the Region 6 senior public health advisor for the Office of Minority Health within the Office of the Secretary of the Department of Health and Human Services (HHS). In this role, he works with providers, schools of nursing, state and federal agencies, nongovernmental organizations, and others to develop and implement programs and policies aimed at improving the health of ethnic and racial minorities in his area of responsibility, which includes New Mexico, Oklahoma, Texas, Louisiana, and Arkansas – and, therefore, two-thirds of the U.S.-Mexico border. This presents particular bi-national issues such as the increasing number of unaccompanied minors crossing the border and both the index case

for H1N1 and a virulent strain of tuberculosis that spread from Mexico into Brownsville, Texas. “Anything that disproportionately affects minority populations or disparate populations falls under my purview,” Dickens said. “We work with a variety of groups – where we see a need or a gap – to assist. And a lot of times they call us in because they recognize that they have a gap or they recognize that there’s been a shortcoming of some sort. So we get pulled into a lot of activities for technical assistance, particularly when they’re developing policies and procedures as to how to address patient care activities.”

The nature of Dickens’ USPHS commission is such that, in addition to his work assignment with the Office of Minority Health, he can be deployed at any time to places around the world in need of health care-related assistance, whether clinical or technical. Dickens provided care in field hospitals for Hurricane Katrina evacuees in Houston, Texas; he spent a couple of years in a clinician role at Rabia Balkhi Women’s Hospital in war-torn Kabul, Afghanistan, as part of a women’s health initiative; and he was deployed with an HHS hospital assistance team to Saipan in the Northern Mariana Islands, where he primarily gave technical assistance, but also provided care to patients because of staffing shortages.

Most recently, Dickens led a 76-member team – one of four teams dispatched by USPHS – to treat Ebola patients in Monrovia, Liberia. Of the four team leaders, Dickens was the only nurse practitioner. It was an intense experience that began with a week of training stateside to learn how to use the personal protective equipment and to get acclimated to what it would be like to work in a real Ebola treatment unit. On his team, Dickens said, “We had multiple disciplines. It was just a complete inter-professional team: nurses, docs, epidemiologists, logisticians – you name it, we had it on the team. I think we realized we had everything but a podiatrist and a dentist.”

While challenges in the NP profession remain – lack of nationwide full practice authority is foremost in Dickens’ view – it’s the instances in which NPs take on nontraditional roles and excel at them that Dickens finds most rewarding about being a nurse practitioner. “Seeing those folks in the profession that are stepping up to be in nontraditional situations, meaning seeing nurses on boards that you never thought a nurse would be on, seeing a nurse run for an office that you never thought a nurse would run for, seeing nurses in positions of authority ... seeing nurses in places and spaces that have traditionally been reserved for others – and I wouldn’t even say physicians, but for others – that’s what I get my biggest enjoyment out of,” he said. “I was the only nurse in charge of a team going to Liberia: The Public Health Service took four teams over and I was the only nurse in charge of a team. Doing things that are totally different and people don’t expect you to do, and occupying spaces that nurses and nurse practitioners have never occupied before – that’s what gives me the greatest joy that I’ve seen. And not letting a glass ceiling get in your way and breaking barriers.

“That’s what I see with AANP,” Dickens continued. He’s been a member of the organization since the 1990s, and has served on various committees – again heeding the advice of his nurse mentors, who encouraged the idea of being involved with one’s professional organization. “The nurse practitioners who are running AANP – our president, Cindy Cooke, and others, our Fellows – these folks are trailblazers and trendsetters, so they’re not resting on their laurels. They’re trying to take it a step further in this 50th year. I think most of us are trying to build on what Loretta Ford has done. So we’re standing on the shoulders of a small giant. She is small in stature, obviously, but she is a giant in the nursing profession and certainly in the role as the nurse practitioner. So we’re standing on those shoulders.”

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Demand for Nurse Practitioners at an All-Time High

BY JEFF WADDILL

On the 50th anniversary of the first nurse practitioner (NP) education program and establishment of the NP role, demand for nurse practitioners is reaching an all-time high and the needle continues to point upward.

In its 23 years of nationwide temporary healthcare staffing experience, Staff Care has never seen demand for a particular type of healthcare professional grow so quickly. In 2011, we received next to no requests to staff NPs. Last year, by contrast, NPs accounted for approximately 10 percent of all staffing requests we received, trailing only primary care physicians, psychiatrists, and hospitalists on our list of most in-demand professionals.

Similarly, our sister company, Merritt Hawkins, which places physicians and other healthcare professionals on a permanent basis, also has seen an explosion in demand for NPs. In 2014, NPs were the firm's fifth most requested type of search assignment, whereas in 2011 NPs were not among its top 20. Average annual salary offers to NPs tracked by Merritt Hawkins have increased accordingly, from \$95,000 in 2011 to \$107,000 this year.

What is driving the surging demand for NPs? Seven key factors come into play, including:

The physician shortage. In its 2015 physician workforce study, the Association of American Medical Colleges (AAMC) projected a deficit of up to 90,400 physicians by the year

2025. The study's authors noted that the deficit would be considerably greater if not for the increasing volume of care being provided by NPs and by physician assistants (PAs). As physicians continue to be in short supply, demand for NPs will accelerate.

Multiplying sites of service. As little as five years ago, traditional acute care hospitals and private medical groups were the primary recruiters and employers of NPs. Today, a growing number of NPs are self-employed and they are targeted for recruitment by a wide range of organizations, including urgent care centers, retail clinics, federally qualified health centers (FQHCs), ambulatory surgery centers, large employers, insurance companies, academic medical centers, accountable care organizations (ACOs), and others. As the types of suitors proliferate, demand for NPs will increase.

The rise of convenient care. Among the rapidly multiplying sites of service that employ NPs, those that offer "convenient care" may be growing the fastest. There are more than 9,300 urgent care centers in the United States seeing 160 million patient visits a year. Of these, 40 percent expect to expand or add a new site and 85 percent expect to see

new patient growth (*Becker's Hospital Review*, August 2013). The number of retail clinics is expected to more than double from about 1,600 today to more than 3,000 by the end of 2016. NPs and PAs are the primary caregivers in these settings, which are locked in an increasingly heated competition to staff the professionals they need.

Scope of practice. In 21 states and the District of Columbia, NPs enjoy a full scope of practice, evaluating patients independently, ordering diagnostic tests, managing treatments, and prescribing medications under the authority of the State Board of Nursing. Several states have legislation pending that would allow NPs autonomous practice. As NP scope of practice increases, so will demand for their services.

Patient acceptance. In a 2013 study published in *Health Affairs*, about half of patients surveyed said they would prefer to see an NP or PA than see a physician, or had no preference, while the majority indicated they would rather see an NP or PA than wait to see a physician. Other studies have revealed the positive patient outcomes and high patient satisfaction scores achieved by NPs. Growing patient acceptance is driving down any hesitation employers may have had about recruiting NPs.

Team-based care/population health management. The Affordable Care Act and a variety of market-based

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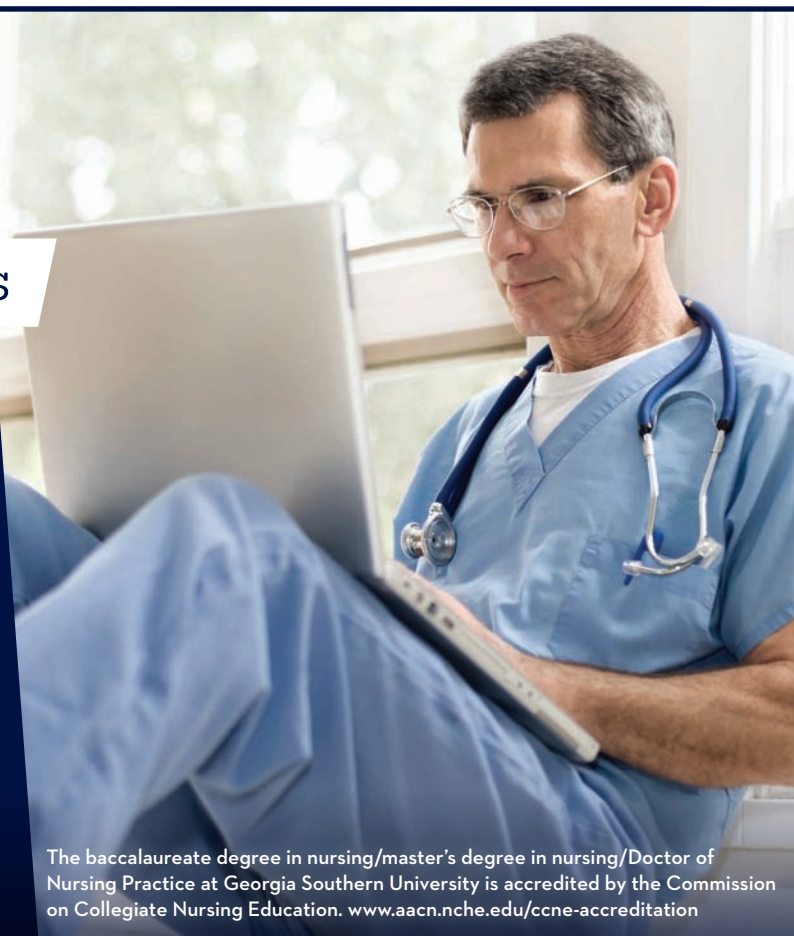
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The 50th anniversary of the NP role is an ideal time to look back and reflect on how far the profession has come.

Jeff Waddill, Divisional Vice President of Staff Care. Staff Care has seen an increase in staffing demand for nurse practitioners.

factors are driving the adoption of team-based care in which groups of healthcare professionals provide comprehensive care for large populations within a defined, capitated budget. The team typically is led by a primary care physician, but NPs are playing a critical role in care delivery and coordination. As this model spreads, it will significantly increase demand for NPs.

Cost effectiveness. As healthcare providers operate within fixed budgets, cost effectiveness will become a

greater priority. NPs can perform the majority of the tasks physicians perform while maintaining quality, yet they are paid significantly less. In addition, NPs can be critical to increasing patient access and satisfaction, providing patient education, improving outcomes, and avoiding readmissions, all metrics by which healthcare professionals and healthcare facilities will be paid as reimbursement shifts from volume to value.

The 50th anniversary of the NP role is an ideal time to look back and reflect

on how far the profession has come. Given the factors cited above, it's an even better time to look forward to the exciting places it is going.

Jeff Waddill is Divisional Vice President of Staff Care, a leading locum tenens staffing firm and a company of AMN Healthcare (NYSE:AHS), the largest healthcare staffing organization in the United States and the innovator of healthcare staffing solutions. He can be reached at jeff.waddill@staffcare.

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The Military, Veterans, and the Expanding Role and Need for Nurse Practitioners

By Chuck Oldham

The ability of nurse practitioners (NPs) to provide primary care to a diverse population enables them to work in a variety of practice settings. One of the most vital of those settings is in the military health care system. Nurse practitioners serve in all five branches of the armed forces, and the military has found NPs to be a critical part of the military health care system. As such, their roles and numbers are growing as demands increase. Nowhere is the demand for care increasing more than in the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA), which has seen an increase in demand for health care services – including mental health care due to the large numbers of younger veterans entering the system as a result of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) – as well as the expanding needs of a large number of aging veterans from World War II, the Korean War, the Vietnam War, and the Gulf War. Historically, the VA has been a leader in employing nurse practitioners within its system, beginning with 43 NP positions in 1973. The importance of NPs in the VHA has only increased in the intervening years, according to VHA Chief Nursing Officer Donna Gage, who emphasized this point in a recent interview.

"They play a very critical role for us here in the VA. I can tell you that we have over [5,000] nurse practitioners practicing and working here in the VA currently," said Gage. "What's important about them and their role is that they really help provide care to our veterans. The majority work in primary care, but also specialty care. Many nurse practitioners have specialized in different areas of care, and so they have been providing those specialized services to our veterans both in the medical centers and in our clinics as well."

"VA's Veterans Health Administration (VHA) operates one of the largest

integrated health delivery systems in the United States, delivering comprehensive care to approximately 8 million veterans through a network of health care facilities," said Penny Kaye Jensen, a past president of the American Academy of Nurse Practitioners. She is the National APRN Health Policy Liaison for the Department of Veterans Affairs Office of Nursing Services. Jensen has served 21 years in the Veterans Health Administration, and has practiced as a nurse practitioner in the Outpatient Primary Care Clinics at the Salt Lake City Veterans Affairs Healthcare System for the past 18 years.

"Similar to other health care organizations, the VA health care system has experienced ongoing pressure to reduce costs and expand primary care services," Jensen said. "VA policy has addressed these issues by endorsing resource shifts toward primary care, and, as part of this shift, endorsing NPs as primary care providers. In 1994, the VA issued a directive requiring all its facilities to develop primary care programs, and in 1996, undertook a strategic plan approved by the U.S. Congress to transform its facilities into an integrated delivery system based on ambulatory and primary care. Leadership within the VA anticipated a shortage of primary care physicians would pose a major challenge to primary care implementation, and included a mandate to involve more NPs in primary care as part of the reorganization plan.

"Primary care within the VHA has changed significantly over the past seven years," Jensen continued. "The number of NPs within the health care system has continued to increase, and as of October 2015, VHA employs 5,068 NPs, with the majority working in the primary care setting. Primary care is now delivered using a team-based medical home model, branded as PACT [Patient-Aligned Care Teams] in VHA.

PACT teams consist of multidisciplinary clinical and support staff that deliver all primary care and coordinate the remainder of patients' needs, including specialty care. NPs lead PACT teams and provide care to an assigned panel of patients. NPs working in primary care clinics represent 23 percent of the primary care workforce."

Both Gage and Jensen see the demand for nurse practitioners increasing in the Veterans Health Administration.

"I actually see the nurse practitioner role helping with our access issues and the demand with our veteran population and, also in the private sector, the demand and the need for health care as our population continues to age," said Gage. "There is increasing demand due to, as we know, the graying of America, with the baby boomers retiring, and with the implementation of the Affordable Care Act. There is, as well, the projected shortage of primary care physicians. All of these factors will overburden our nation's health care system and the VA will experience many of the same issues. So, the nurse practitioners really are part of the solution to assisting with our shortage of clinicians in providing primary and specialty care services and meeting the rising demand of our health care needs for us in the VA and as a nation.

"Often, nurse practitioners very much want to and enjoy practicing in rural health care settings, and in particular if they come from a rural setting, they really want to stay or go back home to their hometowns and enjoy providing care to their neighbors, back in the rural setting, so I really do see nurse practitioners as part of the solution," she said.

In addition, Jensen also foresees a change in the roles of the NPs within the system. "I believe NPs will be utilized much more in specialty and acute care settings as the demand for health care



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Korean War veteran John Brinson has his throat checked by nurse practitioner Rebecca Clanton during a physical at the G.V. (Sonny) Montgomery Medical Center, in Jackson, Mississippi. Nurse practitioners represent a growing number of the health care providers within the Veterans Health Administration.

services increases,” Jensen said. “I also expect to see an increased number of NPs enter the primary care and mental health clinical arenas. The VHA has established NP postgraduate training programs, which are currently funded through the Office of Academic Affiliations (OAA) as part of our Primary Care Centers for Excellence. These programs have been an excellent recruiting tool for new graduate NPs who want to continue working in the primary care setting.

“To address our need for increased access to health care for the nation’s veteran population, VA is proposing the authorization of full practice authority (FPA) for APRNs [advanced practice registered nurses] without regard to their individual state practice acts, except for the applicable state restrictions on the authority to dispense, prescribe, and administer controlled substances,” Jensen said. “This proposed regulatory change to nursing policy would permit all APRNs to practice to the full extent of their education, training,

and certification. FPA would standardize APRN practices throughout VA’s health care system, and thereby decrease the variability in APRN practice that exists as a result of disparate state practice regulations. Implementation of FPA also would increase VA’s capacity to provide timely, efficient, and effective primary care and other related health care services. This would increase veterans’ access to needed VA health care, particularly in medically underserved areas, and decrease their waiting time for patient appointments. The proposed FPA also would be an efficacious use of available VA health care resources.”

The VHA has in many ways led the charge for full practice authority for NPs, and is perhaps its most important institutional advocate.

“We are making progress,” Gage said, but it has been an ongoing effort that began in 2009.

“The most challenging aspect of my current assignment as the Liaison for APRN National Policy is leading the VA

APRN Full Practice Authority initiative,” said Jensen. The 2010 Institute of Medicine (IOM) landmark report, “The Future of Nursing: Leading Change, Advancing Health,” recommended the removal of scope-of-practice barriers to allow APRNs to practice to the full extent of their education, training, and certification. IOM’s recommendation prompted VHA to propose this policy. “Many VHA nurses have been involved in this FPA initiative throughout the years. However, this journey would not have begun without the vision of the former Chief Nursing Officer, Cathy Rick. Her leadership will have historic impact on VA advanced practice nursing for many years to come. The process of working toward achieving FPA within VHA gained national attention as well as [created] controversy. The proposed policy received both positive and negative attention from Congress, professional organizations, media, and even VHA staff.

“As I have worked to develop the APRN FPA draft regulation with the Office of Regulatory Affairs and Office of General Counsel, I have often become frustrated with the long and arduous rule-making process, but I pause to remind myself that the overarching goal is to provide safe, cost-effective, and timely health care for our nation’s veterans.

VHA’s draft regulation is consistent with IOM’s recommendation to remove scope-of-practice barriers. This change parallels other federal agencies including the Department of Defense and the Indian Health Service, as well as many institutions in the private sector. A significant number of states have approved FPA for NPs with many VA medical centers successfully utilizing NPs to the full extent of their education and training. The draft regulation will be published in the *Federal Register* as a proposed rule for notice and comment.

“The most rewarding part of my job is that every day is Veteran’s Day. I am honored and privileged to be able to serve those who have served us and have fought for the freedoms we enjoy each day.”

The Future of NP Education and Practice

BY CHARLES DERVARICS

With a physician shortage looming and a steady supply of nurse practitioners (NPs) ready to fill the void, the future looks bright for the nation's NPs. Yet rapid changes in health care – driven by new government policies, technology, and an aging U.S. population – promise to bring challenges as well as opportunities for NP education and practice in the years to come.

“We see many signs that point to increased recognition of the role of nurse practitioners,” said Dr. Anne Norman, associate vice president for education at the American Association of Nurse Practitioners (AANP). One of the many bright spots is projected job growth in the profession, which the U.S. Bureau of Labor Statistics has pegged at 34 percent through 2022. However, with this visibility also comes the need for additional education to keep up with health care’s fast moving trends.

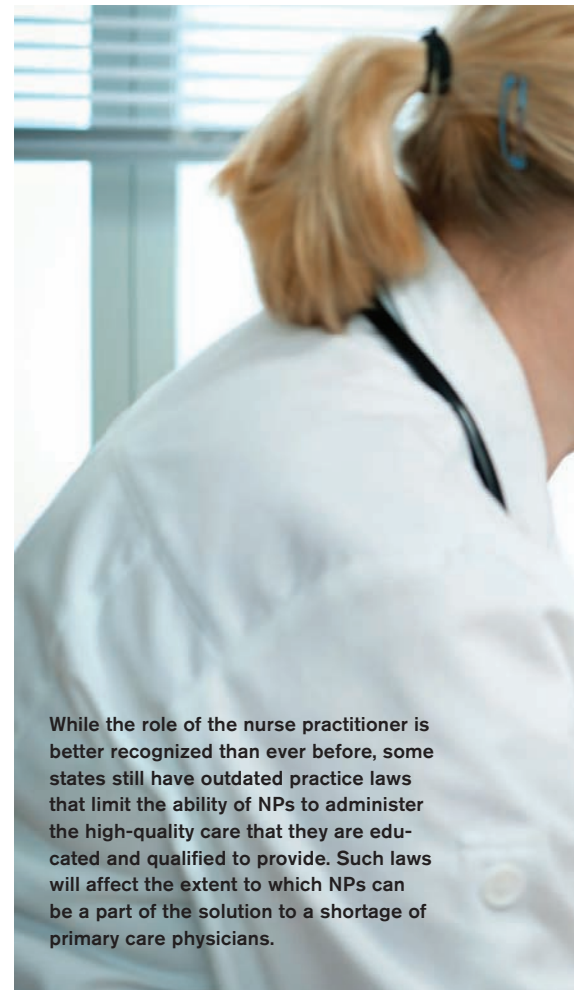
“What sets NPs apart from other providers is their strong emphasis on the health and well-being of the whole person,” Norman said, but challenges remain, including the need to convince more states to grant full practice authority to NPs. “There is now greater attention and more talk about how NPs can fill these roles,” Norman said. “It’s essential to help fill the gap in primary care ahead.”

Full Practice Access

With certification and licensing left to the state level, one key to the future is having more NPs attain full practice status, or a designation that allows them to assess, diagnose, interpret diagnostic tests, and prescribe

medications independently without physician supervision. Currently, 21 states and the District of Columbia have awarded NPs with full practice status. In addition to allowing them more latitude as primary care providers, full practice status allows NPs to operate independent practices much like those of physicians. “In many states, there is an increased recognition of the nurse practitioner,” Norman said, and this respect and recognition is reflected by granting this status.

In other states, however, NPs face limits with either reduced or restricted practice status. Reduced practice status means NPs can diagnose and treat patients but must have physician oversight to prescribe medications. In restricted access, NPs require physician oversight to prescribe, diagnose, and treat patients. States in the southern U.S. are most likely to have restricted practice. An AANP research brief notes that restrictive policies may undermine health care access and quality of care. “There is a disconnect between the higher level of care that nurse practitioners are prepared to provide and the limited level of care that outdated state practice laws will allow them to deliver to patients,” it stated.



While the role of the nurse practitioner is better recognized than ever before, some states still have outdated practice laws that limit the ability of NPs to administer the high-quality care that they are educated and qualified to provide. Such laws will affect the extent to which NPs can be a part of the solution to a shortage of primary care physicians.

Overall, however, the number of states granting full practice authority is on the upswing. Seven states have joined the ranks of full practice states in the past four years, including recent additions such as Connecticut, Maryland, Minnesota, and Nebraska. Maryland’s legislation was signed into law in May 2015, ending a previous law that required NPs to maintain agreements with physicians as a condition of their practice and discouraged NPs from working in rural and underserved areas, according to AANP.

“The legislative leadership we’ve seen in states like Maryland illustrates how lawmakers are increasingly rallying behind nurse practitioners as essential providers, especially equipped to meet the health care needs of constituents,” said Ken Miller,



AANP past president, in May 2015. Such moves also increase access to health care, reduce costs, and promote patient choice.

While full practice authority is generally a state issue, AANP has sought additional changes at the national level. One example is the Frontlines to Lifelines Act, a proposal in the U.S. Congress to grant NPs full practice authority within the Veterans Health Administration (VHA). The change would affect about 4,000 NPs and take significant steps to address access to care among the nation's veterans, many of whom face lengthy waits for service. "The current policy of limiting nurse practitioner practice in the VHA impairs veterans' access to care, risks lengthening delays in health care delivery, increases health care costs, and fails to promote

patient safety," said AANP President Cindy Cooke.

These state and federal government issues will have an impact on the ability of NPs to fill the void left by a shortage of primary care physicians nationwide. According to the American Association of Medical Colleges, the nation will face a shortage of primary care physicians by 2025 as the nation ages and the number of physicians remains flat. Simply put, as family doctors and internists retire, there are increasingly fewer young physicians stepping in to fill the void. Moreover, many of today's medical students are choosing more lucrative specialties such as cardiology or gastroenterology, where some earn double or triple what they could receive in primary care.

Amid these trends, AANP wants to make sure that NPs have an

increasingly strong role in meeting the shortage of primary care providers. "We now have more and more evidence that NPs improve access, especially to underserved populations," said Dr. Diane Padden, vice president for research, education, and professional practice at AANP. Moreover, NPs are well suited to work on health care teams that include a cross section of other health care personnel. "We're seeing more team-based care," Padden added. "The NP may take the lead, or the physician or the social worker."

In addition, with their main focus on helping patients, NPs may be better positioned to respond quickly to changes in the health care sector, particularly as they affect primary care. "As nurses, NPs are very caring individuals," added Norman. And while nurse

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practitioners simultaneously contend with issues that affect the profession outside the clinical setting – such as inequalities in reimbursement rates – improving patient outcomes remains at the center of their work.

With these trends in mind, the Health Resources and Services Administration (HRSA) at the U.S. Department of Health and Human Services also has identified the future potential of NPs to provide primary care. The supply of both NPs and physician assistants (PAs) is “projected to grow rapidly and could mitigate the projected shortage of physicians if NPs and PAs continue to be effectively integrated into the primary care delivery system,” the agency said. But there remain obstacles to making this a reality. “For this integration to occur, patient and health system acceptance is necessary and the dissemination of more effective models of workforce deployment must continue,” HRSA noted.

Dr. Curtis Armstrong, left, trauma nurse practitioner Andy Betz, center, and nurse Stephani Noretto work together to insert a catheter into a patient in Columbus, Ohio, to help monitor the pressures of the heart. NPs are invaluable members of health care teams, and, given the trend in graduate education of NP students studying alongside students in other health care disciplines, they are well suited for such team-based care.

Overall, the number of primary care NPs is expected to increase by 30 percent this decade, from 55,400 in 2010 to 72,100 in 2020. If fully utilized to their potential in primary care, NPs and PAs could reduce the projected shortage of 20,400 primary care providers in 2020 by more than two-thirds, to just 6,400, the agency said.

Aging Population Offers Opportunity

Another major demographic trend affecting NPs is the aging of the baby boomers and the resulting impact on

the health care sector. The role of NPs in senior care will increase following legislation signed by President Barack Obama earlier in 2015. This bipartisan Medicare reform measure, often referred to as the “doc fix” because it would halt reimbursement cuts, has major implications for NPs as well. By repealing the sustainable growth rate formula for Medicare Part B, this law means that NPs also are spared significant reimbursement cuts.

The new law was “imperative to the growing ranks of nurse practitioners, highly educated and clinically trained health care providers who deliver vital services to diverse patient populations, including seniors,” AANP said in an analysis of the law. The reform measure also supports an expanded role for NPs in senior citizen care through a variety of other provisions. For example, the new law:

- Includes NPs in the first year of Medicare’s merit-based incentive payment system;



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“The explosive growth of the nurse practitioner profession is a public health boon, considering our nation’s skyrocketing demand for high-quality, accessible care,” Miller was quoted in a January 2015 press release. “The challenge now will be right-sizing state and federal laws such that all patients will have full and direct access to nurse practitioners, and these expert

President Barack Obama signs bill H.R. 2 “Medicare Access and CHIP Reauthorization Act of 2015,” also known as the “doc fix,” in the Rose Garden of the White House in Washington, D.C., on April 16, 2015. The new legislation opens the door to an expanded role for NPs in providing care for the growing number of senior citizens.

and dedicated clinicians will be able to provide care to the top of their education and clinical training.”

The role of NPs also will continue to evolve as a result of the 2010 Affordable Care Act, known to many Americans as “Obamacare.” In expanding health insurance coverage to more Americans, the bill will lead millions of Americans to seek primary as well as specialty care with significant impact on NPs. In addition, the law authorized \$50

million to support nurse-managed health clinics and gave NPs a significant role in a demonstration program to serve patients via primary care teams working as part of a medical “home.” Another provision authorizes demonstration grants to help family nurse practitioner graduates transition to the workplace.

Education: Change on the Horizon

Another area that continues to undergo change is in NP education. During the past decade, nurse education experts have introduced the doctor of nursing practice (DNP) degree as the terminal degree for advanced practice nurses, including NPs. Advocates for the change note that most NP master’s programs, in length and rigor, are more like

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The University of Maryland Medical Center has established a **leadership model** for **nurse practitioners**. Within this collaborative framework, **nurse practitioners** provide oversight and development of NP teams, which includes recruitment, hiring, onboarding and complex orientation that assures new graduate competency, mentoring, program support and human resources guidance to monitor NP practice and outcomes.

We also have an **APRN Professional Advancement Model** that rewards NPs who support the values of the AANP: clinical expertise, research, scholarship and advocacy. We support our NP staff to obtain DNP education: More than 20 are currently enrolled at the University of Maryland School of Nursing, where we participate in an extraordinary partnership that supports education, training and clinical practice.

In 2013, we began a **critical care and trauma post-graduate nurse practitioner fellowship** — a 9-month program that immerses new-graduate NPs in critical care specialties across the organization. These graduates are prepared for independent practice to care for high-acuity patients.

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doctoral programs than master's programs. They also note that many other medical professions, including pharmacy, physical therapy, and audiology, now use doctoral-level training as the terminal degree.

DNP programs generally require nine semesters of full-time study or approximately 12 semesters of part-time study. Students can enter with either a BSN or MSN degree. Depending on the university, DNP programs also are available in various NP specialty areas such as acute care, adult/family care, neonatal care, pediatrics, psychiatric-mental health, and women's health. The DNP includes additional advanced coursework in biostatistics, care for special populations, informatics, and health care policy so that graduates have detailed training in clinical research as well as health systems.

DNP programs are expected to undergo significant additional growth, and the Commission on Collegiate Nursing Education, the leading accreditor of baccalaureate and higher degree nursing programs, already has provided 158 DNP programs nationwide with accreditation. Dozens of other college and university programs also are in the accreditation pipeline for approval.

While the degree provides additional education, however, students may incur costs of about \$30,000 over a multi-year period. AANP has sought to address this issue – and costs in other graduate education programs – by launching a scholarship program in 2014. During this first year, it awarded \$76,000 in grants and scholarships to 36 Association members.

Still another education option is the doctor of philosophy (PhD) degree in nursing. This degree focuses largely on nursing research and nursing education compared with the DNP, where most of the attention is devoted to clinical practice.

With such far-reaching changes in education, AANP also wants to ensure that practicing NPs with master's degrees can continue to perform their

work as they currently do. It may take years for states to amend regulation and certification rules, they note. Yet when state laws are changed to require the DNP, they should be written in such a way that NPs who were certified and licensed before the transition will be able to continue their practice without needing an additional degree.

In fact, some changes are taking place in master's degree education as well. One new trend is the availability of "executive style" education programs, Padden said. Similar to executive programs available in business and other graduate specialties, those in an executive NP program can better balance professional nursing work and study as classes are concentrated into a series of weeks or weekends during the year. "These programs are developed specifically for working nurses," she added.

Another trend in graduate education is for NP students to study alongside students in other disciplines. "In the classroom, you may see NP students with medical residents and those studying to be physician assistants," Padden said. All of this is positive, she said, in that it promotes the concept of "team-based care" that many believe is the future of U.S. health care.

There also is no "one size fits all" definition of the student in advanced practice nurse education programs. "Years ago, a registered nurse might work for 10 to 15 years and then go to graduate school. Now you might go directly from an RN program to a DNP program," Padden said.

Faculty Help Needed

Despite the surge in advanced nursing education, the university faculty needed to train future NPs are in increasingly short supply, national data show. On average, nurses with the PhD degree are 60.5 years old, the American Association of Colleges of Nursing (AACN) reports. For nurse faculty with master's degrees,

the average ages for professors and associate professors are 57.1 and 56.8 years, respectively, the association says. As the age of faculty increases, there is an increasing need to replace these educators as they retire and leave the system.

Not surprisingly, experts forecast a 25 percent increase in demand for such nursing faculty in the years to come, according to nursejournal.org, a social community website for current and prospective nurses. "This demonstrates the incredible need for highly educated nurses, who will be able to take over the roles of educators in the very near future," this analysis concluded.

Even more striking is data from AACN on nurses who want to pursue education but are denied due to faculty shortages. According to a recent association report, *2014-2015 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*, U.S. nursing schools could not accommodate 58,938 qualified applicants from bachelor's and master's programs due to insufficient faculty.

Yet despite these potential challenges in educating nurse practitioners, all signs are pointing to at least moderate increases in NP salaries for the near future – a strong incentive to seek this additional training. NPs who worked 35 hours or more per week posted a 10 percent gain in total salary income from 2011 to 2015, AANP reported in its *2015 National Nurse Practitioner Compensation Survey*. Average annual income for an NP in 2015 was \$108,643.

This rising pay, plus the likely primary care physician shortage, are two concrete indicators of the bright future ahead for NPs. "We want more patient-centered care, and NPs are already doing that," Norman noted. With their focus on health education and counseling, NPs may help patients lower their out-of-pocket health care costs. Yet most importantly, she said, with their emphasis on prevention, "NPs help patients make smarter choices."

Interview with Julie Marfell, DNP, APRN, FNP-BC, FAANP

Dean of Nursing, Frontier Nursing University

BY GAIL GOURLEY

What are some aspects you'd like to highlight about your nurse practitioner education program at Frontier Nursing University?

Julie Marfell: A family nurse practitioner program was established at Frontier in 1970. At that time, it was a traditional face-to-face certificate program where the students were here for three terms, nine months. The initial program educated nurses to become family nurse-midwives.

Since 1939, when the Frontier Graduate School started, the nurse-midwives were educated to do primary care within a public health model, which focused on caring for the entire family and the community. The community referred to the nurse-midwives as “the nurses,” specifically as “the nurses on horseback.” Mrs. Breckinridge [Frontier Nursing Service founder] knew that if you wanted to take care of a child, you had to take care of the entire family, because there are so many things that intertwine within the health of the child. But you had to focus on that child and make sure that they got through their first hurdle, if you will, which was birth. Then she specifically emphasized those first five years and how important they were “for their health and for their loving heart.”

So the nurses took care of the family, and when Dr. [Loretta] Ford in 1965 started the pediatric nurse practitioner [education program], [the school] started to look at what they could do better to provide a more formal education for the nurse-midwives. We were teaching all the skills [of the nurse practitioner role], but until then there was not a title. So we applied for

a grant in 1970 and started a family nurse practitioner program.

As the need for a master's degree grew stronger, Frontier looked for innovative ways to provide that opportunity to their students. In 1989, the nurse-midwifery program went “distance” and the family nurse practitioner program closed. Frontier and the Frances Payne Bolton (FPB) School of Nursing at Case Western Reserve formed an affiliation agreement for Frontier students to obtain a master's degree in nursing (MSN).

The FNP program was closed for 10 years before it was brought back to life in 1999. Students could complete their FNP certificate at Frontier at the same time as an MSN from FPB School of Nursing. At the same time, Frontier started putting all of the courses online. We did the same community-based model of education as had been done for the nurse-midwifery students 10 years earlier, but technology was at a point in 1999 where the Internet could be used more effectively for educational purposes. There was always a plan to restart the FNP program, but it was important to evaluate whether or not the community-based model worked for the nurse-midwives.

What are the key features of your current program?

Frontier Nursing University has a family nurse practitioner track and a women's health nurse practitioner track, all online. Students come twice to campus. They come at the beginning of the program because we're building a community of learners. We want the students to get to know each other as well as the university. And we really want them to understand the history and the mission to care for women and children and families in rural and underserved areas. So it is important to bring them together to build that community, and it's amazing what can happen in a period of three days when you bring a group of like-minded people together. That community really develops. We bring in the tradition and the history that we have because we bring them right back to Hyden, Kentucky, where it all started with the Frontier Nursing Service and Mary Breckinridge and the nurses on horseback. We really make sure they understand where the roots are, that they're really part of the Frontier Nursing Service, and that they're out there doing the work that Mrs. Breckinridge did in supporting the mission of caring for mothers, babies, and families in rural and underserved areas.

The students complete all their coursework in an online setting – community-based is what we call it, because the community is the classroom. The didactic portion of the program is delivered via an online learning system. As technology has

evolved, the learning environment has become more interactive for students and faculty. Frontier utilizes video conferencing so the students and faculty can see each other via Google Hangout and Skype.

When the students have completed all of their didactic work, they come back to campus for a week for what we call “Clinical Bound,” which is a skills intensive that is completed right before they start their clinical practicum. I always say Clinical Bound is when we make sure that the knowledge students have in their head they can get into their hands. We run patient simulations, have a physical assessment checkoff, and teach basic procedures that are needed for practice.

After Clinical Bound, the student goes back into their community with a preceptor we have met and credentialed. We have specific faculty that are called Regional Clinical Faculty (RCF), and they follow the student while they’re in the clinical practicum. The RCF completes a pre-clinical site visit to meet the preceptor and assess the clinical site. They then follow the student from the start to the finish of their clinical rotations, including an additional site visit.

Where are these clinical sites located?

These are all over the country. That’s another unique part of our program – we have students in all 50 states and most times in several foreign countries.

Approximately how many nurse practitioner students are enrolled?

Currently there are about 750.

You’ve pointed out some distinctive features of your program. Are there other aspects that make your program unique?

What makes it unique is our history. The spirit of Mary Breckenridge and the nurses on horseback is always present for our students. Another important part is the ability to keep students in their communities so they do not have to leave for their



education. That’s our goal: to keep students in rural and underserved areas. It’s been documented in the literature that if a student goes to school in their community, they stay in their community.

We also have a business component in our curriculum,

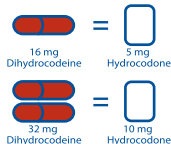
meaning that we teach students the business of health care, not just how to care for patients. Students are taught how to open a practice. We’ve had a very strong emphasis on business all along so that students understand those business elements, because if they don’t have any place

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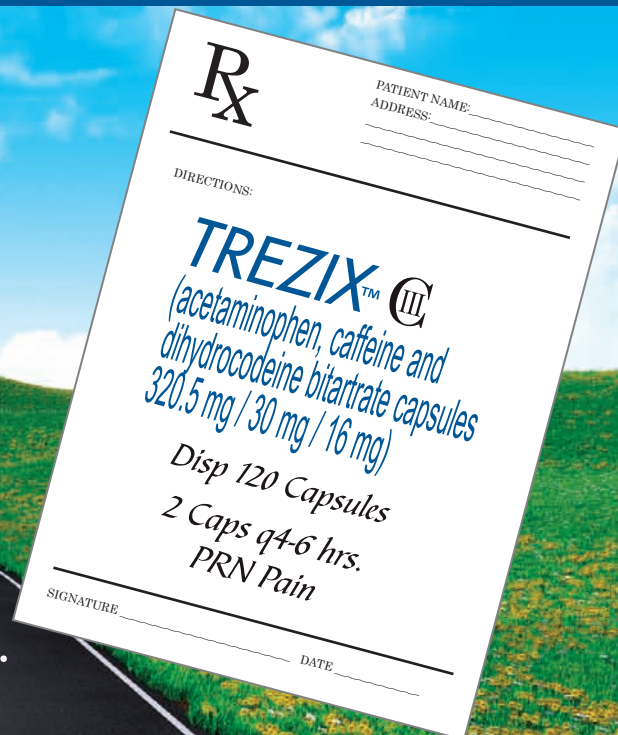
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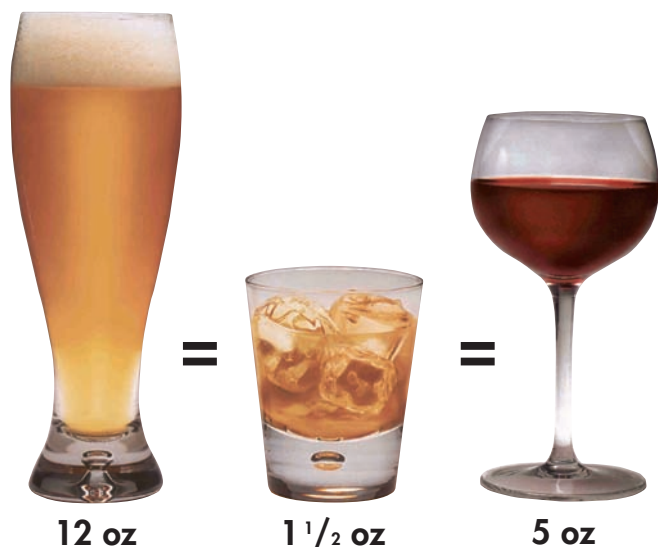
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to work in their community, they need to establish a practice.

You mentioned collaborations with preceptors in all 50 states. Are there collaborations with other entities you'd like to highlight regarding your nurse practitioner program?

We collaborate with lots of people. FNU has many clinical sites and we collaborate with every one through our credentialing process and the student's education during clinical practicum. Our RCF collaborate with the preceptors in the clinical sites to ensure the best possible experience for the student, the preceptor, and the clinical site.

We've been doing inter-professional [IP] collaboration with the University of Pikeville, with their osteopathic medicine program as well as their nursing program and social work program. We also have the opportunity via this collaboration to work with the Appalachian College of Pharmacy. We have been working with both universities to bring students across disciplines together during their education experience to understand the teamwork and the knowledge and skill the members of an IP team do to improve patient experiences and outcomes.

Are there enhancements to your program that you would like to see in the future or that you're currently working to institute?

We're going to be starting a psychiatric-mental health nurse practitioner program in 2017. We're excited about the program because there is a big need for psych-mental health services. There are not enough psychiatric-mental health nurse practitioners – not enough psychiatric-mental health providers, period. Being able to add this specialty for our students' education is going to be very important for those individuals that are cared for by our alumni. The addition of the psych-mental health nurse practitioner specialty track will

That's another unique part of our program – we have students in all 50 states and most times in several foreign countries.

help alumni in rural and underserved areas provide really important services.

We're really planning a big innovation initiative. We want to be able to get better and better at doing patient simulations online. It's one thing to be able to bring students into the lab [to do simulations], but it's another thing to be able to do that with them while they're in a different state. So we've been working very hard to provide those opportunities to FNU students. We're doing case presentations now. We're doing a lot either via Hangouts or via phone, but we just want to get better and better at it. So that's something we're really pushing forward in the next upcoming year.

There's so much informational content out there, but how do we teach our students how to use that content? Students need to be able to access and evaluate information and really base their care on evidence. That is our big push to be able to do that, and determine what skills the students need to accomplish that goal.

What are the biggest challenges that nurse practitioners face today and how does your program prepare students to meet those challenges?

I think policy as it relates to licensure and scope of practice continues to be a big challenge. Nurse practitioners still cannot practice to the full level of our education in many states. It's getting better all the time, but that's still a challenge for us. And we're still not paid the same level as physicians for the same work. So it's being able to help [students] understand how important it is to make sure that they can articulate the issues so that we can change policy, and to know how to work with their legislators so they can help make things happen.

It's a challenge to keep up with the clinical information because there is so much of it. There are a lot of challenges. Those are the big ones.

Are these challenges addressed in your curriculum?

Absolutely. We cover business. They understand where the money comes from, how the money comes in, and how the money goes out. They understand how to improve practice processes so they can be more efficient in their practices. We also emphasize understanding policy as it relates to health issues and scope of practice. A lot of our faculty are involved in policy work, and our faculty are all over the country, so [students] have the opportunity to work with faculty in their states if there are things that we're lobbying. We make sure in the curriculum that they know who their legislators are and how to contact them. We take them to the AANP [American Association of Nurse Practitioners] website so they understand how to use the legislative policy part of it. We get students involved at the state and local levels and we help them understand that it's really important to be involved in health policy, especially as it pertains to practice and patient advocacy. Students are taught to be aware of local legislative issues because if you're not, you could turn around and not be able to practice the same way you did the year before because something changed in the legislation.

Things are bright for nurse practitioners. I've said for years that we just have to keep working at it and it continues to get better in terms of scope of practice issues. If you look at the number of states that have better practice authority than they used to, we're on our way, but the students

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One thing that I've seen as the ACA has happened is most of the physician practices in our area have been incorporated into larger hospital systems.

need to realize that this is something they can't just take for granted. This is their responsibility.

Looking ahead, how would you characterize the future of the nurse practitioner role, particularly with the advent of the Affordable Care Act (ACA), and how is that reflected in your program?

I think we're going to have to really understand how systems work even more so than we have in the past. One thing that I've seen as the ACA has happened is most of the physician practices in our area have been incorporated into larger hospital systems. So it's the system around you that you need to understand and [that] you need to be able to work with so that you can really take care of your patients. Students really need to understand the workings of the business in this big system with the changes that have been brought about with the ACA.

I think we're at the forefront, because we need more people to be able to care for these individuals. We're there on the ground to be able to help them figure out what kind of services they need, and if we can't get the services to them, then we need to figure out what our network is so that we can make sure that they get locked into the services they need. If I need to make a referral to a specialist, I need to be able to do that and I need to understand how to do that. And I need to understand how to report to that specialist so that my patient doesn't get tests that they don't need, and that their records go with them – all those pieces to make sure that they go in ready to be seen, and they don't have to restart that whole diagnostic process.

What is your message to someone considering becoming a nurse practitioner?

My message is that becoming a nurse practitioner is a very rewarding career, and it's challenging in a way that will continue to make you think and grow and evolve with the time. But at the heart of it, you've got to realize that the most important person in all of this is that individual that you're caring for – that individual, that family, and then I would broaden it out to even think about the community. So what you do for that individual will affect all of those things [just] as all those things affect that individual. It's a great career, the door's wide open and it's challenging, and it's going to make you grow and think.

What is your message to patients about what nurse practitioner education means for their health care?

Nurse practitioner education means that they have an individual caring for them with a graduate degree that is a leader in nursing [who is] prepared to address their problems, to provide resources – whether it be prescriptions or referrals – and [who has] the ability to collaborate and consult with other disciplines to provide the very best care for that individual, whether it's making sure they're sent out to a specialist or caring for them right there. And it's not just about when they come in sick; it's about making sure that they understand how they don't come in sick, how to care for themselves. It's making sure that they understand that they're in charge of their health, so it's [about how we can] help them understand how to make changes to be healthier. At the same time, if they're chronically ill, it's how [we can] help them manage that illness so that they maintain a good quality of life.

When you reflect on the fact that nurse practitioner education originated 50 years ago, what are your thoughts?

My thoughts are that we stand on the shoulders of those who have come before us. Nurse practitioner education has continued to evolve because someone was always pushing the envelope, and they were always pushing the envelope for their patients. Now those are the pieces we have to concentrate on and make sure that our students are educated to know – that they need to keep pushing it forward so that we continue to grow in our profession, and have the skills that we need to answer the call, no matter what it is, so that we can continue to help [our patients and clients]. That's what education needs to do. It needs to continue to evolve as the system evolves, but still keep that caring and that nurse component to it. We always have to keep the patient right there in the center, because that's where it started, at the needs of the patients.

***D**r. Julie A. Marfell, DNP, APRN, FNP-BC, FAANP has been a family nurse practitioner (FNP) and nursing educator for 18 years. She graduated from Barnes Hospital School of Nursing with her RN in 1980, and from Rush University with a BSN in 1990 and a doctor of nursing (ND) (now the doctor of nursing practice – DNP) in 1994. Marfell became the Dean of Nursing at Frontier Nursing University in 2013. She has been at Frontier since 1999 and led the implementation of the Community-based Family Nurse Practitioner Program. Marfell has presented and published on multiple topics related to nurse practitioner practice. She has served as a member on both state and national boards including the National Organization of Nurse Practitioner Faculties. Marfell continues to care for families as an FNP in a primary care setting.*



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AANP Conferences

By Ana E. Lopez

As the largest NP organization in the country, the American Association of Nurse Practitioners (AANP) represents the interests of the more than 205,000 nurse practitioners in the United States. Conferences are one way AANP provides support to the community of NPs and helps to sustain the high quality of care they provide, thereby strengthening the NP profession as a whole.

Currently, AANP holds three different conferences every year: a national conference, a health policy conference, and a specialty and leadership conference. These gatherings offer opportunities for NPs to network with colleagues and share the latest news affecting their field. Additionally, given the increasingly complex health care environment and constant medical and technological advances, the conferences present chances for NPs to engage in essential continuing education (CE) sessions.

The annual National Conference is the largest of AANP's conferences and the largest national conference for NPs of all specialties. The schedule for the National Conference includes general sessions, podium and poster presentations of the latest evidence-based practice information, lunchtime CE and non-CE industry presentations (referred to as CE symposia and non-CE product theaters), regional meetings, and interest forums. All of these session types and more take place in an environment that fosters opportunities for national and international networking and discussions of legislative, regulatory, and practice issues affecting the NP profession at the national, state, and local levels. Additionally, a wealth of CE opportunities are offered across a variety of tracks, so NPs are able to increase their knowledge and skills in several areas over the course of the conference. Finally, an exhibit hall



features products and services of interest to NPs and NP students; more than 300 exhibitors are expected at the AANP 2016 National Conference, which will take place at the Henry B. Gonzalez Convention Center in San Antonio, Texas, from June 21-26, 2016.

A Health Policy Conference features panel discussions, presentations, and educational sessions – at which attendees can earn CE credit – that focus on policy issues that affect NPs and how they deliver care. One day of the conference is designated “Capitol Hill Day,” during which conference attendees meet with members of Congress to advocate for legislation that improves patient access to NP health care. In 2015, nearly 200 such lobbying visits were scheduled on Capitol Hill Day. The AANP 2016 Health Policy Conference is scheduled for March 20-22 at the Hyatt Regency Washington on Capitol Hill in Washington, D.C.

At AANP's Specialty & Leadership Conference, NPs attend presentations

Nurse practitioners take part in a continuing education workshop at the AANP 2015 National Conference. All of AANP's conferences provide opportunities for NPs to earn CE credit.

across a handful of featured tracks, where they can earn CE and network with professionals within – or outside – their specialties. A Business & Leadership track that aims to help NPs improve leadership and management skills is offered every year, while the other tracks may change from conference to conference. Recent specialty tracks have included Cardiovascular & Pulmonary, Convenient Care & Urgent Care, Orthopedics & Sports Medicine, and Dermatology. Conference speakers are experts in their respective fields and share the latest evidence-based information with session attendees. The next Specialty & Leadership Conference will take place Sept. 22-25, 2016, at the Hyatt Regency O'Hare in Rosemont, Illinois.

Nurse Practitioners Mark 50 Years with a Celebration of the Past and a Look to the Future

BY DAVID A. BROWN

Numbers aren't everything, but stats can play a key role in telling important stories – like that of America's nurse practitioners celebrating their profession's momentous milestone.

Fifty years have passed since pediatrician Dr. Henry K. Silver and public health nurse Dr. Loretta Ford established the first nurse practitioner training program at the University of Colorado (CU). Significant, of course, but American Association of Nurse Practitioners (AANP) Vice President of Communications Nancy McMurrey points to a particularly relevant number, one befitting this duly exuberant celebration.

"Just take the fact that, when the nurse practitioner program was developed at the University of Colorado, they graduated one person in that first class," McMurrey said. "And now, approximately 17,000 NPs graduated in the recent academic year.

"I think going from one person to about 17,000, and to know that now there are more than 205,000 nurse practitioners licensed in the country, that's amazing growth for this role that just started in 1965."

Since then, the diligence and determination of those who blazed the early trail has come to fruition by way of several significant developments in the nurse practitioner role. Topping the list is that currently in 21 states and the District of Columbia, patients have direct access to NP-delivered care. Furthermore, the number of people taking the nurse practitioner certification exam (part

of the American Academy of Nurse Practitioners National Certification Program) increased 36.8 percent from 2013 to 2014, with 13,270 exams administered.

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This is, indeed, a time worthy of celebration, and that theme resonates deeply in recent anniversary events.

Broadcasting the Message

In honor of the profession's half-century mark, AANP launched a multimedia campaign aimed at boosting awareness among the public and policymakers of the NP's critical role in providing high-quality, comprehensive, patient-centered health care to millions of Americans.

Central to the message broadcast through television and radio spots is a call to action that encourages consumers to visit NPFinder.com. Here, prospective patients can locate a nurse practitioner in their community.

"Nurse practitioners are leading the charge and growing the nation's access to patient-centered, accessible, high-quality health care," AANP Chief Executive Officer Dave Hebert said in an AANP release. "We want every American to understand the commitment, education, and

clinical training these outstanding professionals have. AANP will continue to encourage legislation that removes barriers to nurse practitioner-delivered health care services."

Capitalizing on the momentum that a 50th anniversary brings, the campaign leveraged earned media; placed broadcast television spots on programs such as *CNN New Day*, *Fox and Friends*, *CNBC Squawk Box*, *Today*, *Good Morning America*, and *Ellen*; and incorporated talk radio and in-person events.

The Grand Gatherings

Each year, the AANP National Conference delivers a much-anticipated time of learning, networking, and encouragement for NPs nationwide. This year's event, which took place June 9-14 in New Orleans, Louisiana, set a high bar with an affair befitting this historic period.

This year's conference featured several special events, 260 educational sessions, 40 skill-enhancing workshops, engaging speakers, and tremendous opportunity for professional interaction. In addition, the Exhibit Hall featured more than 300 vendors offering products and services tailored to the needs of NPs and NP students.

Dr. Ford, a highlight of the morning general session, attended the ribbon-cutting that opened the 50th anniversary celebration area in the Exhibit Hall. Also on hand for the opening general session and

ribbon-cutting was Grammy-winning country music superstar Naomi Judd, who delivered the keynote speech. A nurse prior to launching a stellar entertainment career, Judd shared how a nurse had played a key role in helping guide her through her experience as a teen mom. That level of caring and competence, she said, is what inspired her pursuit of a nursing job.

Following Judd's address, a New Orleans jazz ensemble cranked up the Mardis Gras vibe by leading attendees – many donning festive masks – in a spirited New Orleans procession from the opening ceremony to the Exhibit Hall, where the 50th anniversary festivities officially kicked off with a rousing reception.

As reported in the *Conference Call*, the official newsletter of the AANP National Conference, Ford's address included poignant comments blending encouragement with a call for awareness of the coming demographic changes and technological advances that will continue to challenge nurse practitioners. These challenges, Ford said, will reward diligence with an increasing level of opportunity.

"Congratulations on our 50th anniversary. It has been a half-century of struggle for respect, recognition, enumeration, and statutory authority," she said during her comments at the session. "I am the ghost of our historical and hysterical past, and you are the present and our future for the next century."

Sue Hagedorn, a nurse practitioner and retired associate professor at the University of Colorado, now runs Seedworks Films, a company she founded that produces films that focus on nursing and social justice. She agrees with Ford's remarks and said that this year's National Conference reflected a rising tide of enthusiasm and opportunity within the discipline.

"The number of people there was phenomenal – over 5,000," Hagedorn said. "It's unbelievable that there are so many of us. Even in the interminable lines at Starbucks®,"

Dr. Loretta Ford speaks at the 2015 AANP National Conference, where attendees celebrated the 50th anniversary of the nurse practitioner role.



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people were really passionate about our profession.”

Notable events contributing to the energized atmosphere were:

- **Recognition:** Recipients of the 2015 AANP State Award for Excellence were honored at the Salute to the States event. Founded in 1991, the award recognizes an NP in each state who demonstrates excellence in practice.

Additionally, the State Award for Nurse Practitioner Advocate, added in 1993, recognized the efforts of individuals who have had a significant impact on the awareness and acceptance of NPs.

Two awards for national leadership are presented each year as well. The Towers Pinnacle Award is presented annually to an individual who, through policy, practice, or education, has made outstanding contributions that resulted in increased recognition of NPs and increased opportunities for NPs to provide care to patients. The Sharp Cutting Edge Award annually recognizes an individual

Conference attendees participate in a continuing education workshop. More than 260 education sessions were offered at the 2015 National Conference.

who, through innovative services, technologies, or advocacy activities, has advanced NP practice and patient care.

- **Support:** Continuing its tradition of facilitating member education and development, the association honored the 2014 Corporate Council Grants and Scholarship program recipients during the Corporate Council Luncheon. The program awarded \$60,000 in scholarships and grants to 18 AANP members.
- **Storytelling:** The Closing General Session included the presentation “50 Years of the Nurse Practitioner: The Past, Present and Future,” an enlightening summation of how the discipline has developed throughout the past five decades.

Where It Started

In early October, the University of Colorado held a celebration of its own: a 50th anniversary gala complete with a formal dinner, dancing, and celebration. Honoring the birthplace of their discipline and those responsible for its creation and development, nurse practitioners toasted their role in modern health care and the amazing strides the past five decades have seen.

“The gala event was successful way beyond CU’s expectations,” Hagedorn said. “They sold out immediately and I bet they could have had twice as many [attendees].”

Recognizing Ford and Silver, the event was produced in partnership with AANP. Corporate support, Hagedorn said, was impressive.

“Children’s Hospital bought three tables; University Hospital bought a table,” Hagedorn said. “So we’re talking major health institutions in town buying big tables because they knew they wanted to be there.

“I used to teach in the pediatric and women’s health care nurse practitioner



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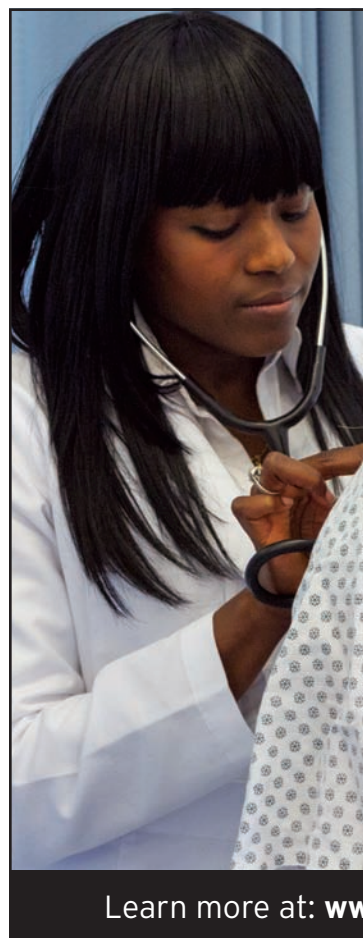
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A media skills seminar at the National Conference aimed to teach NPs how to effectively communicate both the history and current issues of nurse practitioners.

programs. So to see Children's Hospital – where many of our pediatric nurse practitioners [work] – sponsor those tables was really rewarding. It's rewarding to see that they get it – that nurse practitioners who are educated at the university are as important as they are."

The event's list of distinguished attendees, Hagedorn said, included many of the program's earliest alumni, many of whom proudly wore the bronze medals that, at one time, were presented to graduates.

"We had graduates from the mid-'60s there really wanting to be heard and wanting to celebrate this year," she said. "There were so many people so proud of being among those early nurse practitioners."

"To have Loretta Ford there, to have Dr. Richard Krugman, who was the former dean of the School of Medicine, speak, to have early graduates speak, and to show two of my films about the history of [the nurse practitioner program] was really special."

Hagedorn said she was particularly happy to have Susan Stearly-Ripley, the first graduate of that inaugural nurse practitioner program, highlighted in the films. Stearly-Ripley had passed away in August, so presenting her image and insight to those in attendance added a bittersweet yet historically necessary element.

LOOKING BACK

Along with the celebratory elements, the focus on this 50th anniversary also spawned introspective thoughts – reflections of sorts – with regard to where the nurse practitioner role found its roots as well as the nurturing efforts that made it grow. Instilling a sense of historical relevance – that was one of McMurrey's aims.



"Today's nurse practitioners are standing on the shoulders of those who went before them and made their current role possible," McMurrey said. "We are all so fortunate to have Loretta Ford leading the way. After all, she is the reason we have a 50th anniversary."

For her part, Hagedorn strives to educate by channeling her nursing background into her second career in media production. Among her 20-plus films on nursing and social justice, one of the most enlightening is a piece called *Legacy of Innovation: A History of the University of Colorado College of Nursing*. In describing the inspiration behind launching a nurse practitioner program and the struggles early NPs faced, Hagedorn stresses the need to honor this 50th anniversary with continued fervor.

"Know your history and know where the struggles were," she said. "Know [those who challenge you] and always continue to advocate. Never think that you're 'there' now. Our fear is that, because very little history has been taught to newer nurse practitioners, those who've come up in the last 15 to 20 years don't know the struggles."

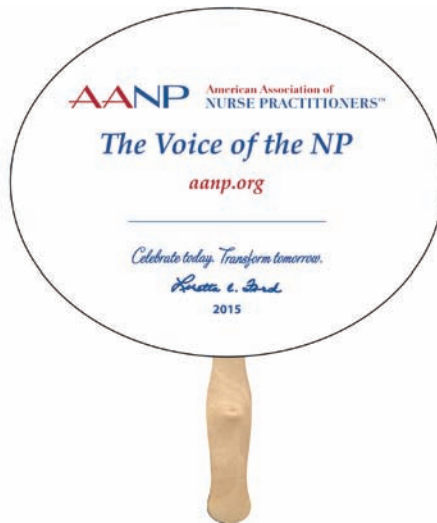
Hagedorn said that a recent decision to document the nurse practitioner discipline will help steer the ship in a different direction, at least in terms of historical awareness.

"The [AANP] Fellows decided that we need to develop an archive, so now we have an Archive Committee that will pull together documents and images of the history of the nurse practitioner."

"We never thought this would be a movement, and when we were in it [during the early years of developing the nurse practitioner role], we didn't think to document it."

Committed to helping solidify public perception of the nurse practitioner role, Hagedorn said that gathering and formally organizing all available elements of the discipline's history not only honors the last 50 years, it helps chart a course for the next half-century.

"If you don't know your history, you are very vulnerable to not only making the same mistakes, but also not understanding how much advocacy is needed to maintain what you have," she said.



The front and back of the fans created for the 2015 National Conference. The commemorative fans included the powerful message “Celebrate today. Transform tomorrow.”

LOOKING AHEAD

In her farewell address, reported in the *Conference Call*, AANP Immediate Past President Angela Golden described what she saw as an encouraging light emanating from the 50th anniversary momentum.

“The future is just so remarkable right now. Nurse practitioners are so well positioned to make such a difference in the health care landscape in the future,” she said. “Patients recognize what we bring to them, and are clamoring for it. Health policymakers understand what we bring to people – great service and cost-effective health care, which is what everybody wants.”

AANP President Cindy C. Cooke shared some thoughts in *Conference Call*: “This is a remarkable time for nurse practitioners because so many opportunities have opened for us. It is an exciting time for celebration, and also an opportunity to take care of the patients we are honored to serve. ... We must honor our pioneers and those who came before us while finding ways to energize the new NPs for the future.”

Continue the celebration, most agree, but let it serve as motivation. Stagnation serves no productive purpose. In that vein, Hagedorn

presents this charge to nurse practitioners: “Don’t rest on your laurels. Don’t think it was always like this. We weren’t just born into this role. There was 50 years of struggle. We need to own the legacy.

“Some say that the challenges are bigger now than they ever were because now we have a lot of economic power. The more economic power we have, the more other disciplines may and are challenging our ability to be an economic force in health care.”

McMurrey points out that because she herself is not a nurse practitioner, she can look at this picture from a different perspective.

“I can see it from the patient side. In order for people to make an intelligent decision about who to choose as their health care provider, they need to have the best information,” she said. “They need to know about nurse practitioners.”

This, according to McMurrey, is why media relations comprise such an important element to the growth of the nurse practitioner role. In this digital age, the potential to tell the story is ever present.

Hagedorn’s take: Media-savvy nurses and nurse-savvy media. In other words, leveraging media attention to convey the significance of all that this 50th anniversary represents requires a smart, heads-up strategy. NPs must

be able to blend historical knowledge with current issue competency when participating in interviews or producing their own content for various media outlets.

To address this objective, one of the AANP National Conference seminars focused on media skills. Stressing the need for message consistency among Association leadership, the seminar paired attendees for mock interviews in front of a microphone or camera. Subsequent feedback from their partners and media experts like seminar facilitator and multimedia host Barb Dehn helped dial in the key elements of effective communication.

A MOVEMENT CONTINUED

One of the most profound messages linked to the 50th anniversary of the nurse practitioner discipline was found in the most unlikely of places: the 50th anniversary commemorative fan McMurrey created for conference-goers. It was subtle but undeniably powerful: One side displayed the 50th anniversary logo; the other, the AANP logo and Loretta Ford’s signature below the quote “Celebrate today. Transform tomorrow.”

Fifty years – that’s definitely a voyage worth celebrating. And the successes of those five decades can serve to drive transformation in the years to come.

“There are still challenges out there in terms of patients having direct access to nurse practitioner-delivered health care, but a tremendous amount of work has been accomplished,” McMurrey said. “The more states that grant full practice authority to NPs, the more accessible the NP will be to prospective patients.

“There’s never been a better time to be a nurse practitioner.”

Like, Share, and Spread the Word: AANP and Social Media

BY ANA E. LOPEZ

It began with 140 characters or fewer. On Nov. 19, 2009, AANP began its foray into the world of social media with Twitter, and shortly thereafter established a lively Facebook presence. In the years since, AANP has become active on LinkedIn, YouTube, Pinterest, Instagram, Google+, Wordpress, Tumblr, and the NP-dedicated ENP Network and Generation NP.

The power of social media to connect people and spread information quickly and effectively was clear to AANP and its members early on. "AANP is fortunate to have members who were early adopters of social media and forward-thinking leadership who recognized the importance of embracing new technology as a means of engaging in meaningful dialogue with AANP members, patients, legislators, and others," said Michelle Karns, communications and social media specialist at AANP. "AANP's social networks attract diverse audiences, so we have adopted a multifaceted strategy that incorporates multiple goals and is tailored to each platform."

Indeed, education is a key reason that AANP harnesses the impressive reach of its various social media channels (as of press time, the association has 48,000 Facebook fans, 11,700 Twitter followers, and 13,450 LinkedIn group members). "AANP shares information that increases awareness of the NP role and highlights the variety of therapeutic areas and clinical settings that make NP practice so unique. AANP uses the hashtag #NPsLead to emphasize the fact that nurse practitioners are leading the charge and growing the nation's access to patient-centered, accessible, high-quality health care," said Karns. "The organization uses social networks to advocate for NPs and their patients and raise awareness of legislative barriers that negatively impact the ability of NPs to practice to the full extent of their education and clinical preparation. By creating a positive and professional culture for online communities, AANP aims to celebrate the contributions NPs make to the health of our nation and encourage a healthy dialogue about ways to improve the current practice environment."

While the association actively posts educational and awareness-raising content via its social media channels, its members take up the charge by sharing that information. And not only are they disseminating AANP's updates, news, and content, they are using social media to make and maintain personal and professional ties online. According to Karns, Facebook and LinkedIn are the most

popular networks NPs currently use to create and sustain such relationships, but "for those willing to try something new, Twitter has the potential to help NPs connect with individuals, organizations, and knowledge resources quickly and efficiently. Used correctly, it can be a powerful time-saving and connection-making tool." NPs also use social media for a variety of professional purposes, such as engaging with e-patient communities; gathering news, information, and cutting-edge research; promoting their businesses; discussing important health-related topics; and advocating for the NP role, their patients, and their practices, Karns said.

The impact of AANP's social media efforts – and those of its members and other NPs – was illustrated during the 2015 National Nurse Practitioner Week, or NP Week. NP Week is an initiative that aims to raise awareness of the NP role and celebrates the significant contributions NPs make to the health of the nation. "During NP Week 2015, AANP's messages reached more than 5.2 million people on Facebook, and the #NPWeek hashtag reached more than 11.2 million people on Twitter," Karns said. "Other hashtags were used, so AANP's reach was even more broad than those numbers reflect. Nearly 5,000 new Facebook fans were earned during that week, which is approximately the same number of fans earned by AANP from 2009 to 2012!" This social media activity combined with the efforts of AANP state representatives and other NPs resulted in the NP Week proclamation activity garnering signatures from at least 39 governors, as well as a State Senate resolution in Pennsylvania, according to Karns. She added, "This exceeded the record of 34 states set in 2014. The participation, reach, and number of proclamations gathered each year has grown dramatically since 2012, when eight states received signed proclamations."

Since that first tweet in 2009, AANP's social networks have seen remarkable growth, which suggests that NPs are embracing social media as a valuable tool to make their voices heard. "Three words sum up the progress NPs have made in recent years: They have become more *participatory*, *positive*, and *professional* in their use of social networks," Karns said. "We are encouraged by their enthusiastic participation in discussions, the initiative they take in support of the nursing profession and patients, and the positive and professional way they engage with large and diverse audiences as they represent the NP role."

Snapshot of AANP's Social Media Channels

Michelle Karns described what information you'll find on AANP's different social networks:

TWITTER

"Twitter is a useful tool for NPs to quickly gather and disseminate the latest information. It is also a good place to connect with colleagues and engage with e-patient communities to learn more about specific challenges or successes patients are encountering. Twitter is where NPs will find current studies, important chats about specific diseases, and government initiatives to improve the health of the nation."

FACEBOOK AND LINKEDIN

"NPs interested in learning more about AANP activities and discussing current topics of interest with their peers will benefit from becoming a fan of AANP's Facebook page and joining AANP's LinkedIn group. Facebook boasts the largest audience, with more than 48,000 fans. These networks are convenient places to connect, since many NPs already use these platforms in their personal and professional lives."

YOUTUBE, PINTEREST, AND INSTAGRAM

"Need graphic content? AANP is active on YouTube, Pinterest, and Instagram. Our YouTube library includes videos that educate the public about the NP role, share attendee experiences from AANP conferences, and celebrate more than half a century of NP excellence. Graphics that promote nurse practitioners and the exceptional care they provide are easy to share from Pinterest and Instagram."

WORDPRESS AND TUMBLR

"Wordpress is where AANP publishes its *Spotlight on NPs* blog and other articles of importance to NPs. Content from the blog may also be found on Tumblr."

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Historical Timeline

1960s

- In 1965, Dr. Loretta Ford and Dr. Henry Silver develop the first nurse practitioner (NP) program at the University of Colorado.
- Boston College initiates one of the earliest master's programs for NPs in 1967.
- Directed by a nurse and physician team, the Boston-based Bunker Hill/Massachusetts General Nurse Practitioner Program begins in 1968.

1970s

- By 1973, more than 65 NP programs exist in the United States.
- National Association of Pediatric Nurse Practitioners (NAPNAP) is established in 1973.
- In 1974, the American Nurses Association develops the Council of Primary Care Nurse Practitioners, helping legitimize the role.
- There are approximately 15,000 NPs in the United States by 1979.

1980s

- More than 200 NP academic programs or tracks are available by 1980.
- By 1983, there are approximately 22,000 to 24,000 NPs in the United States.
- In 1985, the American Academy of Nurse Practitioners (AANP) is established. AANP has 100 members at the end of its first year.
- Ninety percent of NP programs are either master's degree granting programs or post-master's degree programs by 1989.

1990s

- The AANP State Award for NP Excellence is established in 1991.
- Beginning in 1992, AANP actively works with nursing associations, such as the Royal College of Nursing UK, to develop the role of NPs internationally.
- AANP forms the American Academy of Nurse Practitioners Certification Program (AANPCP) in 1993 as a separately incorporated entity.
- In 1995, the American College of Nurse Practitioners (ACNP) is formed.
- By 1999, there are approximately 68,300 NPs in the United States.

2000s

- In 2000, AANP initiates the Fellows program, hosts the first international NP conference in the United States, and creates the AANP Political Action Committee.
- The AANP Network for Research (AANPNR) is created in 2002, the first national practice-based research network exclusively for NPs.
- National Nurse Practitioner Week, held annually in November, is recognized in a proclamation by the U.S. Congress in 2004.
- By 2009, there are approximately 130,000 NPs in the United States.

2010s

- AANP celebrates its 25th anniversary in 2010.
- On Jan. 1, 2013, the American Academy of Nurse Practitioners and the American College of Nurse Practitioners join to form the American Association of Nurse Practitioners.
 - In 2014, AANP surpasses 50,000 members and there are more than 192,000 licensed NPs in the United States.
 - At the close of 2015, AANP has more than 65,000 members and more than 205,000 NPs are licensed in the United States.
- AANP celebrates the 50th anniversary of the nurse practitioner degree program in 2015.



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There are more than 205,000 nurse practitioners (NPs) licensed in the U.S. ¹

- An estimated 17,000 new NPs completed their academic programs in 2013-2014 ²
- 98.7% of NPs have graduate degrees ³
- Nearly all NPs (99.3%) are nationally certified ³
- 86.5% of NPs are prepared in primary care ⁴
- 84.9% of NPs see patients covered by Medicare and 83.9% by Medicaid ⁵
- 44.8% of NPs hold hospital privileges; 15.2% have long-term care privileges ⁵
- 97.2% of NPs prescribe medications, and those in full-time practice write an average of 21 prescriptions per day ⁵
- NPs hold prescriptive privileges in all 50 states and D.C., with controlled substances in 49
- In 2015, the mean, full-time base salary was \$97,083, with average full-time NP total income at \$108,643 ³
- The majority (69.5%) of NPs see three or more patients per hour ⁵
- Malpractice rates remain low; only 2% have been named as primary defendant in a malpractice case ⁵
- Nurse Practitioners have been in practice an average of 10 years ⁴
- The average age of NPs is 49 years ⁴

Distribution, Mean Years of Practice, Mean Age by Main Specialty ⁴

Population	Percent of NPs	Years of Practice	Age
Acute Care	7.5	8	46
Adult+	19.3	11	50
Family+	54.5	9	48
Gerontological+	2.5	13	53
Neonatal	1.1	16	52
Oncology	1.2	9	47
Pediatric+	5.3	15	50
Psych/Mental Health	3.7	11	54
Women's Health+	4.9	17	53

+Primary care focus

Sources:

1. AANP National Nurse Practitioner Database, 2014
2. Fang, D., Li, Y., Arietti, R., & Trautman, D.E. (2015) 2014-2015 *Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington DC: AACN.
3. 2015 AANP National Nurse Practitioner Compensation Survey
4. 2013-14 AANP National Nurse Practitioner Practice Site Census
5. 2012 AANP National Nurse Practitioner Sample Survey

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PRIMARY CARE SETTING

NPs are choosing primary care more than physicians and physician assistants. In 2012, more than 80% of NPs were prepared in primary care programs, while only 14.6% of physicians entered a primary care residency.

PRACTICE IN AT LEAST ONE
PRIMARY CARE SETTING

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OR MORE
PATIENTS P
HOUR

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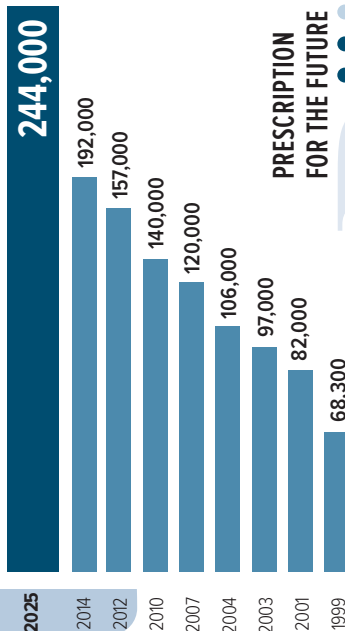
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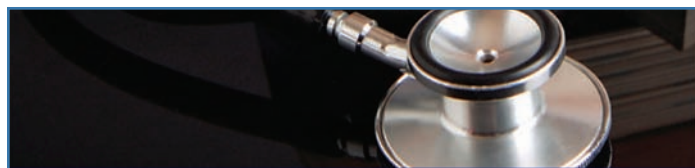
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94% accept Private Ins
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Scope of Practice for Nurse Practitioners

Professional Role

Nurse practitioners (NPs) are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers. Nurse practitioners assess, diagnose, treat, and manage acute episodic and chronic illnesses. NPs are experts in health promotion and disease prevention. They order, conduct, supervise, and interpret diagnostic and laboratory tests, prescribe pharmacological agents and non-pharmacologic therapies, as well as teach and counsel patients, among other services.

As licensed, independent clinicians, NPs practice autonomously and in coordination with health care professionals and other individuals. They may serve as health care researchers, interdisciplinary consultants, and patient advocates. NPs provide a wide-range of health care services to individuals, families, groups, and communities.

Education

NPs are advanced practice registered nurses who obtain graduate education, post-master's certificates, and doctoral degrees. Educational preparation provides NPs with specialized knowledge and clinical competency which enable them to practice in various health care settings, make differential diagnoses, manage and initiate treatment plans and prescribe medications and treatment. National NP education program accreditation requirements and competency-based standards ensure that NPs are equipped to provide safe, high-quality patient care from the point of graduation. Clinical competency and professional development are hallmarks of NP education.

Accountability

The autonomous nature of NP practice requires accountability to the public for delivery of high-quality health care. NP accountability is consistent with an ethical code of conduct, national certification, periodic peer review, clinical outcome evaluation, and evidence of continued professional development.

Responsibility

The patient-centered nature of the NP role requires a career-long commitment to meet the evolving needs of society and advances in health care science. NPs are responsible to the public and adaptable to changes in health care. As leaders in health care, NPs combine the roles of provider, mentor, educator, researcher, and administrator. NPs take responsibility for continued professional development, involvement in professional organizations, and participation in health policy activities at the local, state, national and international levels. Five decades of research affirms that NPs provide safe, high-quality care.

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Revised, 1998, 2002, 2007, 2010, 2013, 2015
Reviewed and Revised by the AANP Fellows at the Winter 2015 Meeting

Quality of Nurse Practitioner Practice

Nurse practitioners (NPs) provide high-quality primary, acute and specialty health care services across the life span and in diverse settings, including patients' homes, community-based clinics, schools, colleges, prisons, hospitals, and long-term care facilities. All NPs have advanced clinical training and competency to provide health care beyond their initial registered nurse preparation. NPs have graduate education, with masters or doctoral degrees, and they bring a unique perspective to health services in that they emphasize both care and cure. NPs diagnose, treat, and manage acute and chronic illness. NPs focus on health promotion, disease prevention, and health education and counseling, guiding patients to make smarter health and lifestyle choices. Since the NP role was created in 1965, over 50 years of research has consistently demonstrated the excellent outcomes and high quality of care provided by NPs.

The body of literature supports the position that NPs provide care that is safe, effective, patient-centered, timely, efficient, equitable and evidenced based. Furthermore, NP care is comparable in quality to that of their physician colleagues. Patients under the care of NPs have higher patient satisfaction, fewer unnecessary hospital readmissions, potentially preventable hospitalizations, and fewer unnecessary emergency room visits than patients under the care of physicians. This paper summarizes a number of important research reports supporting the quality of nurse practitioner practice. These references are listed as an annotated bibliography.

Annotated Bibliography

Avorn, J., Everitt, D.E., & Baker, M.W. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurses. *Archives of Internal Medicine*, 151(4), 694-698.

A sample of 501 physicians and 298 NPs participated in a study by responding to a hypothetical scenario regarding epigastric pain in a patient with endoscopic findings of diffuse gastritis. They were able to request additional information before recommending treatment. Adequate history-taking resulted in identifying use of aspirin, coffee, cigarettes, and alcohol, paired with psychosocial stress. Compared to NPs, physicians were more likely to prescribe without seeking relevant history. NPs, in contrast, asked more questions and were less likely to recommend prescription medication.

Bakerjian, D. (2008). Care of nursing home residents by advanced practice nurses: A review of the literature. *Research in Gerontological Nursing*, 1(3), 177-185. doi: 10.3928/00220124-20091301-01.

Bakerjian conducted an extensive review of the literature, particularly of NP-led care. She found that long-term care patients managed by NPs were less likely to have avoidable geriatric complications such as falls, UTIs, pressure ulcers, etc. They also had improved functional status, as well as better managed chronic conditions.

Borgmeyer, A., Gyr, P.M., Jamerson, P.A., & Henry, L.D. (2008). Evaluation of the role of the pediatric nurse practitioner in an inpatient asthma program. *Journal of Pediatric Health Care*, 22(5), 273-281.

Administrative and electronic medical record data from July 1, 2009, to June 30, 2010, was retrospectively reviewed from the Children's Hospital of Colorado's inpatient medical unit as well as inpatient satellite sites in the Children's Hospital Network of Care. This study evaluated cost and pediatric patient outcomes between a pediatric nurse practitioner (PNP) hospitalist team, a combined PNP/MD team, and two resident teams without PNPs. Adherence to clinical care guidelines was comparable, and there was no significant difference in length of stay between the PNP, PNP/MD teams or resident teams. The direct cost of the PNP patient care was significantly less than the PNP/MD team and resident teams.

Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. *Nursing Research*, 44(6), 332-9.

A meta-analysis of 38 studies comparing a total of 33 patient outcomes of NPs with those of physicians demonstrated that NP outcomes were equivalent to or greater than those of physicians. NP patients had higher levels of compliance with recommendations in studies where provider assignments were randomized and when other means to control patient risks were used. Patient satisfaction and resolution of pathological conditions were greatest for NPs. The NP and physician outcomes were equivalent on all other outcomes.

Carter, A., Chochinov, A. (2007). A systematic review of the impact of nurse practitioners on cost, quality of care, satisfaction and wait times in the emergency department. *Canadian Journal of Emergency Medicine*, 9(4), 286-95.

This systematic review of 36 articles examines if the hiring of NPs in emergency rooms can reduce wait time, improve patient satisfaction and result in the delivery of cost-effective, quality care. Results showed that hiring NPs can result in reduced wait times, leading to higher patient satisfaction. NPs were found to be equally as competent as physicians at interpreting x-rays and more competent at following up with patients by phone, conducting physical examinations, and issuing appropriate referrals.

Congressional Budget Office. (1979). Physician extenders: Their current and future role in medical care delivery. Washington, D.C.: US Government Printing Office.

As early as 1979, the Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.

Cooper, M.A., Lindsay, G.M., Kinn, S., Swann, I.J. (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial. *Journal of Advanced Nursing*, 40(6), 771-730.

A study of 199 patients randomly assigned to emergency NP-led care or physician-led care in the U.K. demonstrated the highest level of satisfaction and clinical documentation for NP care. The outcomes of recovery time, symptom level, missed work, unplanned follow-up, and missed injuries were comparable between the two groups.

Ettner, S.L., Kotlerman, J., Abdelmonem, A., Vazirani, S., Hays, R.D., Shapiro, M., et al. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner (MDNP) model. *Medical Decision Making*, 26, 9-17.

A total of 1207 patients were randomized to a standard treatment group or to a physician-NP treatment model in an academic medical center. The physician-NP team achieved significant cost savings during the initial inpatient stay and during post-discharge compared to the control group while the outcomes between the treatment and control group were comparable.

Gracias, V. H., Sicoutris, C. P., Stawicki, S.P., Meredith, D. M., Horan, A. D., Gupta, R., Schwab, C.W. (2008). Critical care nurse practitioners improve compliance with clinical practice guidelines in "semiclosed" surgical intensive care unit. *Journal of Nursing Care Quality*, 23(4), 338-344. doi:10.1097/01.NCQ.0000323286.56397.8c

This study examined adherence to clinical practice guidelines in a critical care setting by an NP team and a non-NP team. Critical care patients were prospectively assigned to a NP or non-NP team, and findings indicate that clinical practice guideline adherence was significantly higher among patients belonging to the NP team.

Horrocks, S., Anderson, E., Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal*, 324, 819-823.

A systematic review of 11 randomized clinical trials and 23 observational studies identified data on outcomes of patient satisfaction, health status, cost, and/or process of care. Patient satisfaction was highest for patients seen by NPs. Comparisons of the results showed comparable outcomes between NPs and physicians. NPs spent more time with their patients, offered more advice/information, had more complete documentation, and had better communication skills than physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of diagnostic studies ordered and interpretations of x-rays were identified.

Kuo, Y., Chen, N., Baillargeon, J., Raji, M. A., & Goodwin, J. S. (2015). Potentially Preventable Hospitalizations in Medicare Patients With Diabetes: A Comparison of Primary Care Provided by Nurse Practitioners Versus Physicians. *Medical Care*, 53(9), 776-783. doi:10.1097/MLR.0000000000000406

Potentially preventable hospitalizations of Medicare beneficiaries with a diagnosis of diabetes were analyzed between patients of physicians and NPs. Several statistical methods demonstrated that receipt of care from NPs decreased the risk of potentially preventable hospitalizations. These findings suggest that NPs are exceptionally effective at treating diabetic patients.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews*. 2006, Issue 1. CD001271.

This meta-analysis included 25 articles relating to 16 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or other advanced practice registered nurses) and physicians. The quality of care provided by nurses was as high as that of the physicians. Overall, health outcomes and outcomes such as resource utilization and cost were equivalent for nurses and physicians. The satisfaction level was higher for nurses. Studies included a range of care delivery models, with nurses providing first contact, ongoing care, and urgent care for many of the patient cohorts.

Lenz, E.R., Mundinger, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. *Medical Care Research and Review* 61(3), 332-351.

The outcomes of care in a prior study described by Mundinger, et al. in 2000 are further described in this report, including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients, one seen by NPs, and one seen by physicians. No differences were identified in health status, physiologic measures, satisfaction, or use of specialist, emergency room, or inpatient services. Patients assigned to physicians had more primary care visits than those assigned to NPs.

Lin, S.X., Hooker, R.S., Lenz, E.R., Hopkins, S.C. (2002). Nurse practitioners and physician assistants in hospital outpatient departments, 1997-1999. *Nursing Economics*, 20(4), 174-179.

Data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to identify patterns of NP and PA practice styles. NPs were more likely to see patients alone and to be involved in routine examinations, as well as care directed towards wellness, health promotion, disease prevention, and health education than PAs, regardless of the setting type. In contrast, PAs were more likely to provide acute problem management and to involve another person, such as a support staff person or a physician.

Martsof, G., Auerbach, D., Arifkhanova, A. The Impact of Full Practice Authority for Nurse Practitioners and Other Advanced Practitioners in Ohio. Santa Monica, CA: Rand Corporation, 2015.

The researchers identified three high-quality studies addressing the impact that more favorable NP practice environment laws could have on health care access, quality, and costs. Informed by this review of literature, the authors describe the potential effect of removing state practice law restrictions for APRNs in the state of Ohio. Their review of the literature and effect estimates demonstrate that granting APRNs full practice authority would likely increase access to health-care services for Ohioans, with possible increases in quality and no clear increase in costs.

Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association*, 283(1), 59-68.

The outcomes of care were measured in a study where patients were randomly assigned either to a physician or to an NP for primary care between 1995 and 1997, using patient interviews and health services utilization data. Comparable outcomes were identified, with a total of 1316 patients. After six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values, indicating positive trends in blood pressure for NP patients. Health service utilization was equivalent at both 6 and 12 months, and patient satisfaction was equivalent following the initial visit.

Naylor, M.D. and Kurtzman, E.T. (2010). The Role of Nurse Practitioners in Reinventing Primary Care. *Health Affairs*, (5), 893-99.

This meta-analysis of studies comparing the quality of primary care services of physicians and NPs demonstrates the role NPs play in reinventing how primary care is delivered. The authors found that comparable outcomes are obtained by both providers, with NPs performing better in terms of time spent consulting with the patient, patient follow-ups, and patient satisfaction.

Newhouse, R. et al (2011). Advanced practice nurse outcomes 1999-2008: A systematic review. *Nursing Economics*, 29(5), 1-22.

The outcomes of NP care were examined through a systematic review of 37 published studies, most of which compared NP outcomes with those of physicians. Outcomes included measures such as patient satisfaction, patient perceived health status, functional status, hospitalizations, emergency department visits, and bio-markers such as blood glucose, serum lipids, blood pressure. The authors conclude that NP patient outcomes are comparable to those of physicians.

Office of Technology Assessment. (1986). Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis. Washington D.C.: US Government Printing Office.

The Office of Technology Assessment reviewed studies comparing NP and physician practice, concluding that, "NPs appear to have better communication, counseling, and interviewing skills than physicians have," and that malpractice premiums and rates supported patient satisfaction with NP care, pointing out that successful malpractice rates against NPs remained extremely rare.

Ohman-Strickland, P.A., Orzano, A.J., Hudson, S.V., Solberg, L.I., DiCiccio-Bloom, B., O'Malley, D., et al. (2008). Quality of diabetes care in family medicine practices: Influence of nurse-practitioners and physician's assistants. *Annals of Family Medicine*, 6(1), 14-22. doi:10.1370/afm.758

The authors conducted a cross-sectional study of 46 practices, measuring adherence to American Diabetes Association clinical guidelines. They reported that practices with NPs were more likely to perform better on quality measures including appropriate measurement of glycosylated hemoglobin, lipids, and microalbumin levels and were more likely to be at target for lipid levels.

Oliver, G. M., Pennington, L., Revelle, S., & Rantz, M. (2014). Impact of nurse practitioners on health outcomes of Medicare and Medicaid patients. *Nursing Outlook*, 62(6), 440-447. doi:10.1016/j.outlook.2014.07.004

The relationship between nurse practitioner practice environment and state-level health outcome measures was analyzed. The authors gathered findings from existing publications on potentially avoidable hospitalizations, hospital readmissions, and nursing home resident hospitalization of Medicare and Medicaid patients. Significant differences existed for all three state-level outcome measures between states with and without full practice authority. Results showed that states with full practice authority have decreased hospitalizations and better overall health outcomes. There were no significant differences in the state-level outcome measures between reduced and restricted states, which suggests that any limit on NP practice may negatively impact patient outcomes.

Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. *Nurse Practitioner*, 5(4), 28-32.

The authors reviewed 26 studies comparing NP and physician care, concluding that NPs scored higher in many areas. These included: amount/depth of discussion regarding child health care, preventative health, and wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and follow-up on history findings; completeness of physical examination and interviewing skills; and patient knowledge of the management plan given to them by the provider.

Ritsema, T. S., Bingenheimer, J. B., Scholting, P., & Cawley, J. F. (2014). Differences in the delivery of health education to patients with chronic disease by provider type, 2005-2009. *Preventing Chronic Disease*, 11E33. doi:10.5888/pcd11.130175

This original Centers for Disease Control and Prevention (CDC) research paper utilizes a large sample of more than 136,000 adult patients with select chronic conditions drawn from the National Hospital Ambulatory Medical Care Survey (NHAMCS). Across all conditions, the study finds that nurse practitioners provide health education to patients more frequently than physicians.

Roblin, D.W., Becker, R., Adams, E.K., Howard, D. H., & Roberts, M.H. (2004). Patient satisfaction with primary care: Does type of practitioner matter? *Medical Care*, 42(6), 606-623.

A retrospective observational study of 41,209 patient satisfaction surveys randomly sampled between 1997 and 2000 for visits by pediatric and medicine departments identified higher satisfaction with NP and/or PA interactions than those with physicians, for the overall sample and by specific conditions.

Sackett, D.L., Spitzer, W. O., Gent, M., & Roberts, M. (1974). The Burlington randomized trial of the nurse practitioner: Health outcomes of patients. *Annals of Internal Medicine*, 80(2), 137-142.

A sample of 1,598 families were randomly allocated, so that two-thirds continued to receive primary care from a family physician and one-third received care from a NP. The outcomes included: mortality, physical function, emotional function, and social function. Results demonstrated comparable outcomes for patients, whether assigned to physician or to NP care.

Safriet, B. J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. *Yale Journal on Regulation*, 9(2).

The full Summer 1992 issue of this journal was devoted to the topic of advanced practice nursing, including documenting the cost-effective and high quality care provided, and to call for eliminating regulatory restrictions on their care. Safriet summarized the U.S. Office of Technology Administration study concluding that NP care was equivalent to that of physicians and pointed out that 12 of the 14 studies reviewed in this report which showed differences in quality reported higher quality for NP care. Reviewing a range of data on NP productivity, patient satisfaction, and prescribing, Safriet concludes "APNs are proven providers, and removing the many barriers to their practice will only increase their ability to respond to the pressing need for basic health care in our country."

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, M., Gent, M., Kergin, D.J., Hackett, B.D., & Olynich, A. (1974). The Burlington randomized trial of the nurse practitioner. *New England Journal of Medicine*, 290(3), 252-256.

This report provides further details of the Burlington trial, also described by Sackett, et al.. This study involved 2,796 patients being randomly assigned to either one of two physicians or to an NP, so that one-third were assigned to NP care, from July 1971 to July 1972. At the end of the period, physical status and satisfaction were comparable between the two groups. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician".



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Stanik-Hutt, J., Newhouse, R., (2013). The quality and effectiveness of care provided by Nurse Practitioners. *The Journal for Nurse Practitioners*, 9(8). doi:10.1016/j.nurpra.2013.07.004

Evidence regarding the impact of nurse practitioners (NPs) compared to physicians (MDs) on health care quality, safety, and effectiveness was systematically reviewed. Data from 37 of 27,993 articles published from 1990-2009 were summarized into 11 aggregated outcomes. Outcomes for NPs compared to MDs are comparable or better for all 11 outcomes reviewed. A high level of evidence indicated better serum lipid levels in patients cared for by NPs in primary care settings. A high level of evidence also indicated that patient outcomes on satisfaction with care, health status, functional status, number of emergency department visits and hospitalizations, blood glucose, blood pressure, and mortality are similar for NPs and MDs.

Traczynski, J., Udalova, V. (2013). Nurse Practitioner independence, health care utilization and health outcomes. Retrieved from http://www.lafollette.wisc.edu/research/health_economics/Traczynski.pdf.

The authors examined how state practice laws impact health care utilization and patient outcomes. In states that have fewer unnecessary practice restrictions on NPs, the frequency of routine checkups and preventive health exams increases. More favorable practice environments also were associated with higher patient-reported health status, and less emergency room visits by patients with ambulatory sensitive conditions.

Virani, S. S., Maddox, T. M., Chan, P. S., Tang, F., Akeroyd, J. M., Risch, S. A., & ... Petersen, L. A. (2015). Provider Type and Quality of Outpatient Cardiovascular Disease Care: Insights From the NCDR PINNACLE Registry. *Journal of the American College of Cardiology*, 66(16), 1803-1812. doi:10.1016/j.jacc.2015.08.017

Quality of coronary artery disease (CAD), heart failure, and atrial fibrillation care was compared for care delivered by physicians versus NPs or physicians assistants (PAs) for outpatient visits during a one month period. Quality measures were comparable among both groups, and smoking cessation screening intervention was higher among the NP / PA group for CAD patients.

Wright, W.L., Romboli, J.E., DiTulio, M.A., Wogen, J., and Belletti, D.A. (2011). Hypertension treatment and control within an independent nurse practitioner setting. *American Journal of Managed Care*, 17(1), 58-65.

A cross-sectional, retrospective study of 1,284 propensity score-matched patients with hypertension, one-half of whom were treated by NPs and the other half by physicians, found comparable controlled blood pressure rates among the comparison groups.



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Use of Terms Such as Mid-Level Provider and Physician Extender

The use of terms such as “mid-level provider” and “physician extender” in reference to nurse practitioners (NPs) individually or to an aggregate inclusive of NPs is inaccurate and misleading. The American Association of Nurse Practitioners opposes the use of these terms and calls on employers, policy-makers, health care professionals and other parties to refer to NPs by their title. In 2010, the IOM developed a blueprint for the future of nursing. A key recommendation of this report is that NPs should be full partners with physicians and other health care professionals.¹ Achieving this recommendation requires the use of clear and accurate nomenclature of the nursing profession.

NPs are licensed, independent practitioners. Nurse practitioners work throughout the entirety of health care from health promotion and disease prevention to diagnosis that prevents and limits disability.¹ These inaccurate terms originated decades ago in bureaucracies and/or organized medicine; they are not interchangeable with use of the NP title. The terms fail to recognize the established national scope of practice for the NP role and authority of NPs to practice according to the full extent of their education. Further, these terms confuse health care consumers and the general public due to their vague nature and are not a true reflection of the role of the NP.

The term “mid-level provider” implies an inaccurate hierarchy within clinical practice. Nurse practitioners practice at the highest level of professional nursing practice. It is well established that patient outcomes for NPs are comparable or better than that of physicians.² NPs provide high-quality and cost-effective care.

The term “physician extender” originated in the physician community and was related to the extension of physician services by other providers. The NP role, however, evolved in response to identified health care needs across populations. NPs continue to meet the current and evolving future needs within a complex health care system. NPs are independently licensed, and their scope of practice is not designed to be dependent on or an extension of care rendered by a physician.

In addition to the terms cited above, other terms that should be avoided in reference to NPs include “limited-license providers,” “non-physician providers,” and “allied health providers.” As it would be inappropriate to call physicians non-nurse providers, it is similarly inappropriate to call all providers by something that they are not. Similarly, the usage of the term “allied health provider” has no clear definition or purpose in today’s environment.

When it is necessary to group providers for policymaking or other purposes, more appropriate terms may instead be: primary care providers; health care providers; health care professionals; advanced practice providers; clinicians; and/or prescribers. AANP stands with the IOM, the National Council of State Boards of Nursing³ and other nursing associations to recognize nursing’s role in the health care system and only endorses the term nurse practitioner. Best practices call for clearly informing patients and referring to each health care provider by their individual title to recognize their unique but overlapping roles. Now is the time to eliminate outdated terms to ensure clarity and public understanding of the title of nurse practitioner.

1. Institute of Medicine (2011). *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academic Press.
2. Stanik-Hutt, J., Newhouse, R.P., White, K.M., Johantgen, M., Bass, E.B., Zangaro, G., . . . Weiner, J.P. (2013). The quality and effectiveness of care provided by nurse practitioners. *Journal for Nurse Practitioners*, 9(8), 492-513.
3. National Council of State Boards of Nursing (2008). *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*.

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Reviewed and Revised by the AANP Fellows at the Winter 2015 Meeting

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Nurse Practitioner Prescriptive Privilege

The American Association of Nurse Practitioners (AANP) advocates that nurse practitioners (NPs) have unrestricted prescriptive authority, including dispensing privileges, within their scope of practice.

Nurse practitioners are independently licensed, advanced practice registered nurses who have advanced training and education that prepare them to work in the NP role. Nurse practitioners have graduate education in pharmacology, pathophysiology, physical assessment, and clinical diagnosis and treatment that prepares them to diagnose and prescribe medications and treatments. Nurse practitioners make both independent and coordinated care decisions about the health care needs of individuals, families, and groups across the life span.

Five decades of research concludes that nurse practitioners provide safe, cost-effective, high-quality health care. Prescribing medications, devices, treatments, and modalities is a central component of the NP role and essential to practitioner practice. Restrictions on prescriptive authority unnecessarily limit the ability of nurse practitioners to provide comprehensive health care services.

AANP recommends that NP prescribing authority be solely regulated by state boards of nursing, and in accordance with the NP role, education and certification. This process of license and regulation exclusively by the nursing board promotes public safety and competent practice. Nurse practitioners serve as members of state boards of nursing and are competent to appropriately regulate nurse practitioner prescribing. AANP advocates that nurse practitioners be nationally certified.

The ability of nurse practitioners to prescribe, without restriction, legend and controlled medications, devices, health care services, durable medical equipment, and other equipment and supplies is essential to providing cost-effective, quality health care for the diverse populations they serve across the life span.

Resources:

- Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. <http://iom.nationalacademies.org/reports/2010/the-future-of-nursing-leading-change-advancing-health.aspx>
- National Governors Association. *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*. <http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html>
- National Council of State Boards of Nursing. *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*. <https://www.ncsbn.org/736.htm>
- Federal Trade Commission. *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*. <http://www.ftc.gov/policy/reports/policy-reports/commission-and-staff-reports?title=Nurse>

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