

25 American Academy of Nurse Practitioners

Celebrating 25 Years as the Voice of the Nurse Practitioner



A Silver Anniversary Tribute

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June 2010

In 1985, a group of dedicated nurse practitioners, with diverse specialties and geographies, realized the need for a national organization that would represent the interests of all NPs. After forming a steering committee, these like-minded NPs met at the Pennsylvania farmhouse of Jan Towers - and under an apple tree, drafted bylaws for a national NP organization. Thus, the American Academy of Nurse Practitioners (AANP) was born.

From this auspicious beginning to the present day, AANP has been dedicated to supporting our members with access to practice resources, continuing education, up-to-date information, professional services and expertise. As a member-focused organization, we seek feedback from our members and respond to suggestions on ways to enhance their professional lives. We value the ideas and suggestions and have implemented many products and services for our members based on the information we have received.

The past few years have presented many challenges and opportunities. With health care reform at the top of the national agenda and the economy in a crisis, this has been an extremely critical time for all. AANP has been instrumental in advocating for NPs and the NP role, assuring that the NP voice is heard in national congressional committees, with U.S. House and Senate members and regulatory agencies, as well as in partnership with other organizations - everywhere that health care decisions are being made. We thank our members for their support as we continue to work on behalf of nurse practitioners and their patients.

This 25th Anniversary Book provides an up-close and personal look at many facets of our members and their practices. We are grateful to everyone who shared their experiences for the anniversary book and applaud all our members for their dedication in providing the high-quality, comprehensive, personalized and patient-centered health care that brings recognition to the NP role.

Sincerely,

Dee Swanson, MSN, NP-C, FAANP

President

Penny Kaye Jensen, DNP, APRN, FNP-C, FAANP

President-Elect

Tim "TK" Knettler, MBA

Chief Executive Officer

American Academy of Nurse Practitioners

Celebrating 25 Years as the Voice of the Nurse Practitioner

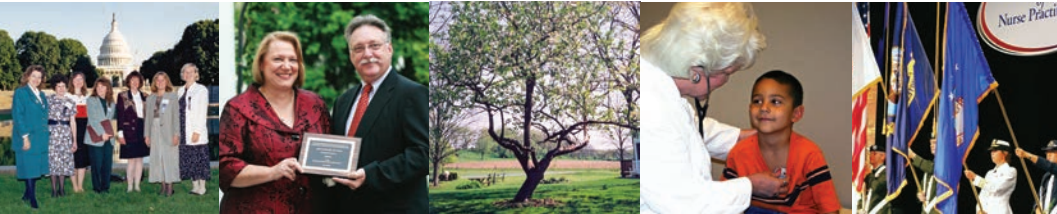


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AANP: CELEBRATING 25 YEARS

By Craig Collins

The date most often cited as the launching point for the nurse practitioner role in the United States is 1965, a culminating year for a number of social trends that had been shaping American health care for years. Throughout the 1950s and 1960s, American physicians increasingly began mentoring and collaborating with nurses who had clinical experience. At the same time, increasing specialization in the medical field led many physicians out of primary care.

The dwindling supply of primary care providers, especially in rural areas, was one of many seismic changes in American society at the height of the Civil Rights era. In 1965, the creation of the Medicare and Medicaid programs provided health coverage to low-income women, children, the elderly, and the disabled, and the sudden availability of coverage further increased demand for primary care services.

As physicians were unable to meet the demand themselves, many nurses - intelligent, capable, compassionate, and growing increasingly dissatisfied with their "handmaiden" role in the provision of health care - 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 the physician.

One nurse eager for change was Loretta Ford, who, in partnership with a physician named Henry Silver, envisioned a nurse-based solution to the challenges facing America's health care system. At the University of Colorado, Ford and Silver created the first training program for nurse practitioners, a certificate program with a curriculum that focused on health promotion, disease prevention, and the health of children and families.

While Ford and Silver led the way, their colleagues throughout the United States likewise wanted to move the nursing profession forward into an expanded role with its own philosophical orientation emphasizing wellness. Additional NP education programs began to proliferate around the United States, with curricula that reflected this shared vision. In the early years, NP certificate programs



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

The nation's first nurse practitioners - often referred to as "the pioneers" - 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 quite make it as physicians, or couldn't get into medical school, 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 medical care they received from nurse practitioners. According to Dr. Jan Towers, one of the founders of the American Academy of Nurse Practitioners, who continues to serve as the organization's director of health policy, there were also 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 post-graduate certificate programs, some of the first master's-level programs were opening their doors. The role continued to evolve into other specialty areas, including adult, family, 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 access to care for poor and low-income families in rural areas, 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.

The Founding of AANP

Such rapid progress did not occur without some growing pains. The profession evolved so quickly that laws and regulations did not keep pace. While the outcomes and curricula of NP educational 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.

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 backyard, they drafted a set of bylaws for a national organization. The organization's name - the



Opposite page: The founders of the American Academy of Nurse Practitioners drafted the bylaws of the organization beneath this apple tree at Dr. Jan Towers' farmhouse in Pennsylvania. **Above:** Dr. Jan Towers, one of the founders of AANP and the organization's director of health policy.

American Academy of Nurse Practitioners - was unveiled later that year at another national meeting of nurse practitioners in Chicago, Ill.

By all accounts, the Chicago debate was energetic and animated. "There was consternation about forming this new group," recalls Towers. "One of the comments 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, Mass., 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 nurse practitioner in Austin, Texas, took on the task of developing a database of information about the nation's nurse practitioners. She began by contacting the 50 state boards of nursing. "But at that point," she says, "many of the states had not even started up a recognition process for nurse practitioners. For the first years we reached out to state and local organizations and universities where programs existed to try to find and identify where the NPs were." Within the first year, she had developed a list of more than 15,000. To date, AANP's national database, which includes information on the nation's 135,000 NPs, is the only database of its type in the United States.

Given the contentious debate surrounding AANP's formation, says DeMarchi, 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, says DeMarchi. "In the very first year, we had people asking about forming chapters with AANP. We were very concerned," she says. "If we formed chapters, we thought it would just be more divisive, making people decide yet one more time who they were going to join." 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 135 of these group members.

While DeMarchi began assembling a national NP database, Towers began investigating ways that AANP could exert some influence on national health policy. "As soon as the organization was formed," Towers says, "we started finding out about the meetings of national organizations, and we 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 involved?' And the answer was: 'Send somebody to the Hill.' So that's what we did." From the start, Towers and the AANP lobbyists (Hurdis Griffith and then later, Carole Jennings) made regular visits to Washington to impact health care legislation representing the concerns of the nation's nurse practitioners, often giving testimony to Congress and the White House.

The early efforts of AANP 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. "The three carriers who were providing nursing liability insurance woke up one day and realized what nurse practitioners really were doing," says DeMarchi, "and decided immediately that we were too high-risk, and that they were withdrawing coverage. We were able to go in and challenge with data from our survey, which showed less than 1 percent have been named in any malpractice case. We don't get sued like physicians do, because we're more comprehensive. We have relationships, and we partner with our patients in designing the care they're getting, so they're part of the decision making. The whole concept of how we work with patient care ensures a very low malpractice rate." The carriers were unable to refute AANP's data, and within just a few weeks of the crisis, nurse practitioners around the country, thanks to the work of AANP and others, had their insurance re-established at a reasonable rate.

In Washington, the efforts of Towers' team, in conjunction with their industry and lobbying partners, were paying off as well, winning several legislative victories that increased the number of circumstances in which NPs would be reimbursed directly by the federal government. By 1990, AANP and its partners had secured direct Medicare reimbursement for rural area NPs, Medicaid payments to family and pediatric NPs, and long-term care



Founding member Zo DeMarchi started AANP's national NP database, which currently contains information on more than 135,000 NPs. It is the only database of its type in the United States. DeMarchi is AANP director of association services.

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 1989, AANP had grown to between 1,200 and 1,500 members. In that year, the organization began publication of its scholarly, peer-reviewed journal, the *Journal of the American Academy of Nurse Practitioners* (JAANP), and also held its first national conference for AANP members in Philadelphia.

The JAANP has always been a member benefit since its inception. The founding editors, Drs. Towers and Nativio, envisioned that this new peer-reviewed publication would begin a dialogue among NPs with a sharing of ideas, clinical experience, and research. After 11 years of publication, Dr. Charon Pierson became the editor-in-chief of JAANP in January 2000, taking over a well-established journal that had grown from a quarterly to a monthly publication. Along with this growth came the expectation of publishing online, which began in 2005 when Blackwell (now Wiley-Blackwell) began publishing JAANP.



Publication of the *Journal of the American Academy of Nurse Practitioners* began in 1989. JAANP has been an AANP member benefit from the start.

Publishing a quality, peer-reviewed journal for the members is a goal shared by the founding and current editors, editorial board, peer-reviewers, the organization, and the publisher. Recognition of that ideal came in 2008 when JAANP was one of several nursing journals to finally receive an Impact Factor. After 21 years of providing members with peer-reviewed articles of relevance to NP practice, and as a result of the recognition of the quality of JAANP, the number of submissions has more than tripled, and changes in NP practice and education have created a climate of increased scholarship that directly affect the impact of NP literature on nursing and health sciences. Expansion of the NP role around the globe is seen in the number of international submissions and increases the impact of NPs on the health of people around the world. Although JAANP has long been considered one of the core NP journals, it is the contribution to evidence-based practice that NPs make that will influence population health and the relevance of JAANP in the years ahead.

Beyond the Tipping Point

1989 was also the year that AANP moved its headquarters to Austin, where DeMarchi became the organization's first paid staff member. As executive secretary,

she began to build administrative support. "The organization had grown to a point that if we didn't stop and try to build infrastructure to support it, we'd start folding in on ourselves and shrinking," says DeMarchi. Within a few years, AANP was hiring additional support staff and was occupying its own office space in Austin. In 1996 - when DeMarchi became director of association services - AANP hired its first executive, Judith Dempster, who served as executive director for more than a decade.

For nurse practitioners, the early 1990s are often described as "the tipping point" - defined by popular sociologist Malcolm Gladwell in his 2000 book, *The Tipping Point: How Little Things Can Make a Big Difference*, as the level at which the momentum for change becomes unstoppable. It was during these years that NPs spiked in number, formed influential partnerships among themselves and within the health care industry, and further defined their own 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, NPs struggled with the tendency to assign them “in-between” status, an identity pegged somewhere between handmaiden and physician. NPs, rather, 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, (in collaboration with the NP community, including AANP) 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.

In 1993, AANP extended its influence over the education of NPs by establishing its own certification program, in response to a growing demand from members for family and adult competency-based certification with a strong clinical focus. As the educational expectations for NPs evolved from a post-RN certificate to a master's degree - and later to a post-master's or clinical doctorate - AANP endorsed the American Association of Critical-Care Nurses' Essentials of Master's Education for Advanced Practice Nursing, participated in and endorsed the National Organization of Nurse Practitioner Faculties' Master's Essential and Competencies for Family, Adult, Pediatric, Gerontology, Women's Health, and Acute Care NP education, as well as the essentials for nurse practitioner DNP programs.

For years, AANP has offered continuing education (CE) courses and seminars at its national conferences, and these offerings have expanded in recent years to include an online CE center with more than 50 offerings for self-study, free to AANP members. In 2010, the organization offered its first separate continuing education seminars, delivering 16 hours of intensive education in one of three specialty areas: cardiology, orthopedics, or dermatology.

Of all AANP's achievements, the one in which its founding members take perhaps the most pride is the achievement of nurse practitioners' federal reimbursement status. From the profession's earliest days - during which NPs were paid primarily as employees of physicians or hospitals, often under rules that reimbursed their activities under the physician's provider number - nurse practitioners have recognized 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. The constant presence of Towers and AANP lobbyists on the Hill led to the nurse practitioner provisions of the Balanced Budget Act of 1997, which granted provider status to NPs 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,” says Towers, “because we worked directly with the legislator who put it in.” Today, as the growth of managed care organizations have broadened the responsibilities of non-physician clinicians, many private insurers have followed suit, allowing patients to choose a nurse practitioner, rather than a doctor, as their primary care provider.

Meanwhile, AANP continues to serve its members and advance the profession. Its earliest directories, first compiled over the telephone in DeMarchi's Austin home, have evolved into NP Finder, an electronic tool for nurse practitioners to refer patients to NPs in other parts of the country. Its Fellows program, established in 2000 to develop leaders in the national nurse practitioner community, continues to encourage excellence in the nurse practitioner profession and its continued movement beyond the social and cultural barriers that have held NPs back in the past.

AANP continues, also, to mentor other NP organizations, both in the United States and abroad, building on a relationship it established with NPs in the United Kingdom in the mid-1990s. Madrean Schober, AANP's international relations liaison, has visited NPs all over the globe in recent years, in locations such as Hong Kong, Pakistan, and Europe, helping colleagues to develop the nurse practitioner role. AANP also lends support to the International Nurse Practitioner/Advanced Practice Nursing Network (INP/APNN), which is headquartered in Geneva, Switzerland, and aims to support NP and APN roles as they emerge worldwide.

Today, when she looks back on the growth of AANP, a nonprofit organization launched in 1985 with very little backing, DeMarchi can't help but be a little amazed at how quickly the organization has grown. With more than 50 staff members working in Austin and Washington, D.C., an increasing array of services offered to its members, and a growing influence on the development of the NP role around the world, AANP has probably exceeded the expectations of most of its founders. “We were a grassroots, member-driven organization,” says DeMarchi, “developing out of the resources provided from that membership.”

Not that achieving such growth and influence has been easy, says Towers. “A lot of it was just putting things down, brick by brick, and expanding our roles over time. If you think of what we were doing 40 years ago, and look at what we are now - AANP certainly was one of the most influential entities out there dealing with those things, and we had the cooperation of legislators, policymakers, professional organizations, and people on boards of nursing who agreed with us. Part of our job has been to try to pull all that together and keep it all moving in the right direction. And I think we've been pretty successful.”

FOUNDER OF THE FIRST NURSE PRACTITIONER PROGRAM: DR. LORETTA C. FORD

By Vera Marie Badertscher

Born in New York City, Loretta Ford spent her childhood in New Jersey, where she dreamed of becoming a teacher. But she could not afford to go to college, and, she says, “The choices women had at the time were teaching, nursing, or secretary work.” Pausing, she adds with a smile in her voice, “Or, of course, there was always the convent.” She chose to attend a nursing school and says, “It was a wonderful choice because I ended up teaching nursing.”



Dr. Loretta C. Ford enlisted in the Army Air Force as a nurse in World War II.

Her dream of teaching finally would come true, but it took World War II and the GI Bill to make her college education possible.

Like many young women in the early '40s, she watched her fiancé go off to war. Then the devastating news came: He had been killed in a naval battle in the Pacific. She had worked as a Red Cross nurse, and her personal tragedy plus watching her brothers and friends join the war effort persuaded her to enlist in the Army Air Force as a nurse.

Ford could not serve as a flight nurse because she wore glasses. Instead, her duties in Maine and Miami involved taking care of men and women returning with injuries from the Pacific or European theaters.

She traces her interest in advanced practice for nurses to her jobs after graduation from college on the GI Bill. “I did work for a year in the Visiting Nurse Service, so I really had a great deal of experience, not only in home care, but in independence in nursing. When I went back to school and worked in a health department, we were the Lone Rangers. We were the county nurses, ran all the clinics, did home care, visited the schools, visited the nursing homes, ran the infectious disease clinics as well. We were it,” she says. And she realized that this kind of independence and clinical decision-making required better preparation. Those experiences led directly to her groundbreaking work at the University of Colorado with Dr. Henry Silver.

Ann Noordenbos Smith, one of Ford's first nurse practitioner students at the University of Colorado, came to the same realization. “I could have done a better job as



Ford is one of the co-founders of the first nurse practitioner program.

a rural county nurse if I had only known more and could do more. Many practices in the field I simply had learned on my own or from an informal colleague mentor."

Smith studied as an undergraduate with Dr. Ford, and then returned to UC to work on a master's degree. She says, "We heard that Dr. Ford was supporting a Commonwealth Fund grant project with the School of Medicine and that our fellow student, Susan Stearly, was working with her, but I did not give it much thought at the time. Following graduation, in the fall of 1965, Dr. Ford invited me to join the first Pediatric Nurse Practitioner Program. That was when I started paying attention to the notion of an expanded role in nursing."

By then, Ford had the responsibility for developing educational goals in her specialty, which was community health nursing. "The specialty of community health nursing required nurses in various ambulatory settings - it could be a home, it could be a clinic - and nurses had to do in-depth assessments of what was before them," Ford explains. "In schools lots of times, we would be doing the screening and realize a child had some serious problem - a scoliosis, or a child that has a mental problem." That required follow-up with in-depth scientific knowledge as well as thinking about the family of the child.

"The nursing process is a diagnostic process," Ford says. "It's

"The nurse practitioner concept and role development created the most important change in the nursing profession in my lifetime."

— Ann Noordenbos Smith

assessment, it's review of data, it's recognition of the holistic needs of patients, coming to a clinical decision about what to do - either to take care of it yourself if your prep allowed or to refer. The nursing process was the basis for which we were developing the ability to take on the extended role of the nurse. It was also based on the data - social and family data that we [gathered]. It might be not only a health problem, not just a clinical problem, but a family problem."

In addition to the academic requirement of setting goals in her specialty, by the mid-1960s, Ford saw nursing organizations proposing training to meet qualification standards, and job descriptions based on the nursing process.

"I worked with a pediatrician, Dr. Henry Silver," Ford says. "[We] were partners in the development of this [NP education]. The first name we had was the Public Health Nurse, Pediatric Nurse Practitioner. Well that's pretty long, so we chose the PNP [pediatric nurse practitioner]."

At that time, Ford continues, "Advanced degrees of master's and above were almost all functional preparation [to become a] supervisor or administrator ... Clinical meant really direct care people making clinical decisions.

"When the profession said the center of our advanced practice at the master's level should be clinical expertise, every specialty in nursing



Ford, a pediatric nurse practitioner, is pictured in 1973 with a student in a pediatric unit at Strong Memorial Hospital (SMH), University of Rochester Medical Center. At the time, Ford was the dean of the University of Rochester School of Nursing and director of nursing at SMH.

- like maternal and child health, medical/surgical nursing - all had to come up with what is the clinical focus for their practice. Of course in public health nursing the focus is family, and also the kind of settings we went into," Ford says.

"[In those settings, nurses] didn't have all the resources you might have in a hospital, and it didn't have the focus

because it was so generalized - working with all ages. And out of that [PNP], other specialties grew. The school nurse NP grew out of that, the women's health NP, the family NP," Ford says.

Although many suggest that nurse practitioners came about to solve the problem of not enough doctors in rural areas, Ford disagrees. "What that provided us was an

opportunity to become public health nurses in a much more in-depth way. The fact that there was a shortage of physicians, particularly in the rural areas, gave us an opportunity. But as a nurse, my job is not to substitute for physicians; my job as a nurse educator is to prepare nurses for advanced nursing roles. I had problems of my own in nursing to solve, and I'm not about to think that I could solve the medical problems."

Rather than welcoming the new in-depth training of nurses, however, physicians resisted the concept.

The University of Rochester, already developing advanced training for nurses, recruited Ford to be the founder of the new School of Nursing, and she and her husband, Bill, made the tough decision to leave their Colorado home. Nancy Boyer studied with Loretta Ford, whom she calls "this wonder woman," at Rochester, after Ford left Colorado, and is an example of how the Ford philosophy spread.

Boyer pioneered the role of NP nursing home care, but that came about because her career hit the rocks early on. After graduation from Rochester's NP program, she was asked to leave the ICU of the hospital where she worked and get certified as a physician's assistant, then work in the adjoining nursing home. While there, she began teaching RNs physical assessment skills. That teaching model was recognized and replicated at the hospital and she went back, but now as vice president of Patient Care Services.

Boyer says of the early days, "MDs were up in arms and unified in their belief that nurses could not ever function as MDs. However, soon they realized that the intent was NEVER to replace the MD, but only to offer patient care at a level that would benefit them and the patients."

Ford echoes these thoughts and says, "[Nurse practitioner training] is [about] what were the health needs of people - the medical needs and how advanced nursing could meet those needs." She continues, "A lot of those needs are on the basis of prevention and promotion of health ... so patients themselves would be well-informed and they would also be empowered to make their own decisions. So it is a matter of educating the patients. But you need to educate the nurses as well as the patients. You know what you know, and you know what you don't know, and you know who knows what you don't. You can only see what you know to see. If you see something and you have no context or information - it may be there but you don't see it."

Because of the growing interest, the idea spread very rapidly, but not without controversy.

"Most educators were not very accepting of it at the time," says Ford, and adds, "and that's the kindest thing I can say about them. My colleagues ... thought I was a heretic ... They were concerned that medicine would control nursing education. They did not believe it was nursing. The worst thing that came out of it was that most educators did not take ownership of the role."

"... years later I sent her [Ford] a thank you note letting her know that she had kept thousands of nurses in patient care because of the enhanced practice and respect that was finally ours."

— Nancy Boyer

When asked what word comes to mind to reflect that period, Boyer says, "Combative. Bordering on cruel." Smith, a 26-year-old student at Colorado at the time, says she was enthusiastic about her studies, and sailed through the sea of controversy focused on learning new skills.

"Dr. Ford and her collaborator, Dr. Henry Silver, handled the conflict while, at the same time, they opened doors for nurse practitioners to have new sites to demonstrate the new nursing roles," Smith says. "We found new roles and nursing practice sites in neighborhood health centers, private pediatric offices, rural health departments, and with the Colorado migrant worker stream. We nurse practitioners were free to do what we did best: engage with children and families for primary care, while Ford and Silver cleared the path."

Ford gives credit to those who helped, saying, "The best thing was that some agencies - military, Veteran's Administration, specialized clinics [like Planned Parenthood] - were very eager to get these kinds of nurses ... They wanted the nurse practitioners. So when educators didn't respond and universities didn't develop the programs fast enough, many agencies, including some medical schools, took on the model that we had and developed it in their own programs.

"One of the problems was that agencies had no academic standard requirements and that resulted in an academically diverse group of NPs," Ford says. "So we had NPs from a variety of educational backgrounds with no standardization of the program. In a way, these nurses were exploited," she adds. "Now they [the agencies] deserve a tremendous amount of credit because they kept the movement alive and eventually the university faculty came into it. It took almost a decade or more before the universities began to assume responsibility."

Even the nursing profession was reluctant to accept the new model. Smith says, "I never viewed the transition to practitioner work as 'leaving regular nursing.' Neither did Dr. Ford; I have always believed we were on the same wavelength on this point and continue to be to this day. It was surprising when colleagues would introduce me saying, 'She used to be a nurse,' and later there were



Ford and her husband, Bill.

worse introductions, in the vein of being a pariah to the profession."

Smith continues, "I viewed the practitioner program as a logical progression of nursing competence and was delighted to be the second student in the program [at the University of Colorado]. But the professional flack over the expanded role had already started by late 1965 and continued over many years."

Ford characterizes the attitude of most nurses, including the ANA, as extremely conservative toward nurse practitioners. "AANP and the College of Nurse Practitioners came into being because they couldn't get the attention from the other organizations, so they built their own organizations. 'We have these organizational needs and we'll build our own,' and they built a very strong organizational base."

Although Silver and Ford pioneered the academic programs, others were working on similar challenges in various specialties - at Mass General, in Peoria (home nursing), Missouri (chronic illness), and Yale (pediatrics).

Looking back at her career, Ford has much to be proud of, but some things still frustrate her.

"It surprises me how long it takes to make institutional change when the data are obvious. It is just amazing how slow social changes occur. It also surprises me, I guess, how people respond to change so negatively sometimes. Welcoming change is not a common attribute," Ford says.

Ford asks basic questions: "What is best for people? Not what I will get out of it because I can do anything eventually. Why are we doing this? Is it really going to help people? What is it going to take? It seems a rather simple way to look at it, I suppose, but it is amazing how long it takes."

She looks at the numbers and wonders, "We're talking now about 44 years since '65. 150,000 NPs, 260,000 advanced practice nurses ... and yet we still come up against

"That is what I am most proud of – what has happened to nurse practitioners themselves."

– Dr. Loretta C. Ford

some of the basic things as back 44 years ago. Surely society can do better than that. I'm impatient, of course. But going on half a century?"

Boyer is more blunt: "The ability to do advanced practice nationwide is still not a reality, and that is a travesty."

But nevertheless, Ford continues to be positive. "Nurses, I think, have had so much within them all this time that hasn't really been tapped. In many ways, through education, we authorize them to do this. We said, 'You can do this' despite the legal system and all that. You don't need legal things to make these decisions. You can make them.

"It is just like tapping something within them. At first it is a little scary for them. We've been doing this at 3:00 a.m. for centuries almost. At 3:00 a.m. we make the decisions. We are there. Who do you think makes them at 3:00 a.m.? We do. And people depend on us to do it. And we do it very well. We could do it better, of course. That's what it is all about."

And the best changes have happened to the nurses themselves, Ford says. "Nurse practitioners are on their own, they see the change within them. They are fully united with the role. They are full of enthusiasm. They are competent ... That is what I am most proud of - what has happened to nurse practitioners themselves."

Dr. Ford's Abbreviated Bio

Dr. Loretta C. Ford, professor and dean emerita of the University of Rochester School of Nursing, Rochester, N.Y., is an internationally known nursing leader and co-founder of the first nurse practitioner program. Dr. Ford is a Charter Fellow of the American Academy of Nursing, an Honorary Fellow of the American Academy of Nurse Practitioners, and senior member of the Institute of Medicine of the National Academy of Sciences.

Dr. Ford holds seven honorary degrees from prestigious universities in the United States.

In her long leadership career of caring for patients, supervisory and administrative positions in service and academe, and university teaching, she has received national and international recognition. In 1990, Secretary of the U.S. Department of Health and Human Services Dr. Louis Sullivan presented Dr. Ford with the Institute of Medicine's prestigious Gustav O. Lienhard Award for outstanding achievement in improving health care in America. Recently, the University of Rochester School of Nursing dedicated a new "Loretta C. Ford Educational Wing" in her honor.

AANP PRESIDENT DIANA “DEE” SWANSON, MSN, NP-C, FAANP

When Diana “Dee” Swanson began working as a hospital nurse, shortly after earning her bachelor’s degree from Indiana University in 1978, she liked working with patients, but soon felt constrained. “I expected the RN role to be more of a nurse practitioner role,” she says, “and when I learned it wasn’t, I realized I needed to move forward.”

As an RN, Swanson was an ambitious professional - she was an assistant director of nursing at the hospital and taught nursing students at both a local vocational college and at the university - and she soon pursued advanced degrees. She earned a research master’s degree from Indiana in 1988, and became a nurse practitioner after finishing a post-master’s program at the university in 1991.

From the start, Swanson worked to advance the profession. Within a year of becoming a nurse practitioner, she had become Indiana’s state representative to AANP, where she served three terms before becoming AANP’s Region 5 director. She was also active at the state level, a founding member and first elected president of the Coalition of Advanced Practice Nurses of Indiana (CAPNI). For several years she was CAPNI’s legislative chair, developing relationships with the state legislature, regulatory agencies, and other professional organizations.

All the while, Swanson maintained her full-time nursing practice, first at a multispecialty internal medicine practice at Bloomington Hospital. In 2004, she helped establish Salt Creek Family Practice, a clinic in rural Nashville, Indiana. As her involvement with AANP strengthened - she served as treasurer and recording secretary and performed item writing, test construction, and task analysis for the AANP Adult and Family Nurse Practitioner certification tests - she was involved in starting a Volunteers in Medicine Clinic in her home county of Monroe and served as a volunteer primary care provider on a monthly basis.

“I’ve wanted to be a nurse for as long as I can remember,” says Swanson. “I’m an empathetic person. I enjoyed the science a lot, and the personal aspect of it - I really like taking care of people. Nothing makes me feel happier than actually having a patient in my office who is really



sick - not with anything serious, maybe a nasty flu bug or something - and I can take care of everything. I can bring them a blanket. I can get the IV in. I can draw blood and check their electrolytes and their blood count, and I can prescribe their medication for them. It just feels really good to be able to do everything for the patient, from the most basic to the most sophisticated.”

Swanson knew, in 2007, that AANP was on the brink of seismic changes - for one thing, given the pending retirement of Dr. Judith Dempster, AANP’s first executive director, it would be searching for a new chief executive. “I knew we’d probably have new leadership at some point during my presidency,” she says. “And that’s actually one of the reasons why I ran, because I figured I knew the

organization pretty well. I was also very much invested in the usual issues of autonomy and independent practice, and having a bigger voice at the state level and national level. I was looking for new opportunities to build on what other people had done in those areas, but my primary goal was to transition the organization with a new leader into the next phase.”

Swanson sees her tenure as a time of metamorphosis for AANP, the beginning of “Phase Two” for the organization. “I think we’ve grown up a little bit. We were kind of a mom-and-pop organization for many years, which is natural, and I think we recently came to the point where we had done about all we could do with our current model and structure.” The activities undertaken by AANP in the past two years have already allowed AANP and their partners to leverage their strengths: The organization has hired a public relations firm to help nurse practitioners articulate an identity that will be understandable to the public, which has been a struggle from the profession’s

first days. AANP also positioned itself to become more influential by hiring Tim Knetter – an executive with valuable experience in the issue of licensure and regulation – as its new CEO.

“We’re expanding our work at the state level,” says Swanson. “We’ve just hired a new director of State Government Affairs, so we’re going to be able to provide a lot more energy and help to our states. And we’ve gotten a much bigger profile in Washington, D.C. – not just because of me, of course, but because of our CEO and Jan Towers, and because it was just a good time for certain things to happen.”

Swanson looks back on her presidency as one of the most rewarding times of her career. “It’s been very stimulating and exciting,” she says. “I’ve enjoyed having a sort of transitional presidency. I’ve enjoyed being involved in a time of really rapid change. I’ll be glad to hand the baton to the upcoming president, but I feel like I really have accomplished a lot.”

AANP PRESIDENT-ELECT PENNY KAYE JENSEN, *DNP, APRN, FNP-C, FAANP*

Dr. Penny Kaye Jensen began to understand the need for improved access to health care early in life – she grew up on a Wyoming ranch homesteaded by her Danish great-grandparents in the 1800s. “Health care services were still very limited in our small mountain valley during my youth,” Jensen says. “Many elderly individuals wouldn’t have access to health care if NPs were not practicing independently in these remote areas. Twenty percent of Americans live in rural areas, but only 9 percent of our MDs are found in these areas. Another problem for our elderly population residing in rural areas is the limited number of physicians who will accept Medicare patients. In many of these areas, NPs are often the only providers who will accept Medicare patients into their practices. We are already filling a void that most people, including policymakers, do not fully recognize,” Jensen says.

Jensen’s effort to help influence the development of the nurse practitioner profession was launched before her career had even begun: She became involved in AANP while she was a nurse practitioner student at Brigham Young University in Provo, Utah, where she earned a master of science in nursing as a family nurse practitioner in 1997. Prior to earning her MSN, she received a bachelor’s



degree in nursing from Westminster College in Salt Lake City, Utah, in 1987. She earned a doctorate in nursing practice (DNP) from the University of Utah in 2009 - while working full-time as a nurse practitioner and remaining very involved in AANP. She was in the first cohort of DNP students in the University of Utah's College of Nursing and was the first DNP student to be a University of Utah Hartford Center of Geriatric Nursing Excellence Scholar. She received a graduate certificate in gerontology along with her DNP.

Jensen has practiced for 16 years at the George E. Wahlen Department of Veterans Affairs Medical Center (VAMC) in Salt Lake City, where she is the primary care provider to a panel of internal medicine patients in one of the new community outbased clinics (COBC). The Salt Lake City VAMC is located in Veterans Integrated Service Network (VISN) 19, which spans a geographic area of 470,000 square miles across nine states and is the largest VISN in terms of geographic area in the 48 contiguous states. It is estimated that more than 700,000 veterans reside within VISN 19's geographic region. "This VISN also has the largest number of World War II veterans in the nation, which accounts for a complicated patient population with multiple comorbidities," Jensen says. "Nurse practitioners in Utah are independent practitioners. Within the VA system NPs manage panels of 800 to 1,000 patients. We have been doing this successfully for years, with excellent patient outcomes."

Jensen is also an assistant professor in the Acute and Chronic Care Division at the University of Utah College of Nursing; she is part of the VA Nursing Academy (VANA), which was one of the first in the nation. The Salt Lake VA Medical Center and the University of Utah's College of Nursing were selected for a special partnership initiating the VA Nursing Academy. The five-year initiative, valued at over \$3.5 million, began in 2007 and supports increased student enrollment, recruitment of VA nurses and staff into university nursing programs, and collaboration that will improve practice, research, and education.

Jensen served as AANP's Utah representative before being elected to the board of directors, where she has served for the past six years. She has also served as commissioner of AANP's Political Action Committee, representing the Northwest Region, and in various positions at both the regional and state levels - including the past president of the Utah Nurse Practitioners (UNP) and Sigma Theta Tau, Gamma Rho Chapter. She continues to be active on various regional and state committees.

Prior to the 2002 Winter Olympic Games in Salt Lake City, Jensen was one of six nurse practitioners chosen to staff the Main Media Center Medical Clinic (MMC) at the Salt Palace Convention Center. The decision to use NPs in this venue was founded upon evidence-based practice outcomes presented to representatives from the International Olympic Committee. "In other venues

NPs functioned as RNs," Jensen says. Physician assistants (PAs) from other states were slated to serve as medical volunteers in the MMC. "I saw the opportunity to showcase independent NP practice and after many long discussions, we were granted approval because we were not required to have a supervising physician." Mike Noyes, MD, and Diane Kendall, FNP, served as co-directors of the MCC and were both strong supporters of NPs practicing to their full scope. "Our venue was used by 9,000 accredited news reporters from around the world. When fully operational, it had a staff larger than most Utah cities. The MMC was the only venue credentialed to use nurse practitioners as providers. This was the first time in history NPs were ever utilized in an Olympic Games. We were open 24 hours a day and busier than expected, averaging 75 patient visits per day. It was a wonderful experience and well received by the media. It also proved to be a terrific place to promote NP practice," Jensen says. "The biggest challenge was not in providing care specifically, but in dealing with the occasional language barrier. Translators were available but were not always familiar with medical terminology. Trying to sort out medications in Russian, German, and Czechoslovakian proved challenging."

Jensen has received numerous awards for her nursing practice, including the AANP 2003 Utah State Award for Excellence, the University of Utah College of Nursing Excellence in Clinical Practice Award in 2004, and the Sigma Theta Tau International Honor Society of Nursing Excellence in Leadership Award in 2008. In 2006, she was inducted as a Fellow of the American Academy of Nurse Practitioners, an honor held by fewer than 1 percent of the nation's NPs. Most recently, Jensen was named the 2009 Outstanding Doctor of Nursing Practice from the University of Utah College first graduating DNP cohort.

Jensen is routinely asked to speak on the subject of health care reform, especially regarding the issues of access to care and health policy. She has participated in the development of several position papers and white papers on health care and professional topics, and in May of 2009 was invited to speak at a health care reform briefing before the U.S. Senate that focused on the primary care role of nurse practitioners. The event was sponsored by the Nurse Practitioners Roundtable (AANP, ACNP, NAP-NAP, and NONPF), and the American Nurses Association. "Events such as this," says Jensen, "improve the visibility of NPs and the unity of all our organizations; it also sends a powerful message to policymakers."

As Jensen assumes the presidency of AANP in June 2010, she commends all the leaders who have come before her and helped to grow AANP into the largest full-service national organization for NPs of all specialties. She says, "I look forward to continuing growth and furthering interest in our organization, while setting the stage for NPs in the future."

AANP CHIEF EXECUTIVE OFFICER TIM “TK” KNETTLER, MBA

To Tim “TK” Knettlar, it doesn't seem that his interest in health care was learned; rather, it's as if he were born with it. His parents were missionaries in China and Taiwan, and TK, who spent the first 12 years of his life in Taiwan, watched them establish several medical clinics. “My exposure to that,” he says, “fueled my interest in health care, and in seeing people who had a critical need receive quality care to live a healthy and fulfilled life.”

The American Academy of Nurse Practitioners' chief executive officer, Knettlar has been with the organization since March 2009. Knettlar has over 20 years of health care and professional association experience, most recently eight years with the Federation of State Medical Boards (FSMB) of the United States and the FSMB Research and Education Foundation. Knettlar brings a well-rounded background in the management of nonprofit health care organizations to his CEO role.

Knettlar is a strong advocate for advancing health policy and collaborating with state, national, and international organizations to help ensure AANP a seat at the table in important health care discussions. He brings strong business expertise with proven ability to improve the quality and delivery of existing services and the development of new ones. He is well-known within the health care field and among policymakers and is recognized for his research and analytical abilities. Knettlar received his BA in psychology from Oral Roberts University (ORU) and his MBA with a marketing emphasis from the Cox School of Business at Southern Methodist University (SMU) in Dallas.

In the '90s, Knettlar held positions of executive vice president/chief operating officer and regional director/unit president of two health care organizations where he was able to further his passion for access to and delivery of quality health care. In the early '90s, he worked with the director of nursing at long term care and assisted living facilities. That experience and his many association committee activities gave him the understanding that nursing and the directors were where the “rubber meets the road” in health care. In the mid-90s, with the help of a nurse practitioner, he established a state nurse practitioner program for a large health care company that became a model for the rest of the country. This experience heightened his appreciation for nurse practitioners, and the value they brought to the health care community.

While not a clinician, his experience in health care, association management, licensure, and regulation



helped him to develop a comprehensive understanding of how states confront the scope of practice issue. Knettlar's eight years of experience at the FSMB gives him a unique understanding of how to address the primary care provider shortage from a state licensure and regulation perspective. This experience and perspective will provide an edge on how AANP can make additional strides to reduce barriers and to further enhance and promote the tremendous value of nurse practitioners.

Looking ahead, Knettlar is focused on the strategy and messaging that will place the nurse practitioner profession in the minds of the public, legislators, and health care community as the best answer to health care delivery and health care reform. Also, these audiences need to know that nurse practitioners are the future of health care as a profession and are the best quality and patient-focused provider today. The first 25 years of AANP were exciting and the next 25 years will enhance that excitement by further gaining the recognition that NPs so well deserve as the solution to the many health care challenges that face our country and world today.

AANP'S PAST PRESIDENTS

- Carole Kerwin-Kain • 1985-1986
 Jan Towers • 1986-1987
 Bob Smithing • 1987-1988
 Jan Towers • 1988-1989
 Irene Bjorkland Ricciuti • 1989-1990
 Barbara Berner • 1990-1991
 Barbara Sheer • 1991-1992
 Judith Dempster • 1992-1994
 Melanie Harris Arntz • 1994-1996
 Peter Coggiola • 1996-1998
 Marie-Eileen Onieal • 1998-2000
 Elias Provencio-Vasquez • 2000-2002
 Denise Laine • 2002-2004
 Mary Ellen Roberts • 2004-2006
 Mona Counts • 2006-2008
 Diana "Dee" Swanson • 2008-2010

The American Academy of Nurse Practitioners has had several different leaders over the course of its 25 years. What follows is a selection of these past presidents' recollections of their terms: what the membership was like, the biggest changes or accomplishments, and their fondest or most poignant memories.

Carole Kerwin-Kain

"I began my work with the initial core group of 37-50 nurse practitioners from around the country that formed the



Carole Kerwin-Kain

'AANP Steering Committee' in 1984. I served as acting chair of the Steering Committee and as first president of the organization from 1985-1986.

"The biggest change I saw during my term of office was the organizational transition, in approximately one year, from an impassioned concept held by a few dedicated, hard-working nurse practitioners throughout the United States to a fledgling but fully functioning membership organization that represented over 600 nurse practitioners throughout the nation. That development has continued to grow and AANP is now a mature organization representing 27,961 individual members.

"I have two very vivid mental pictures that capture the intensity, commitment, devotion, and belief of those working together to create AANP.

"The first is of the organizational meetings in Kansas City and Washington, D.C.

"In the beginning, with no money or budget to secure meeting space or have a formal gathering, we would meet in the evenings in a centrally located steering committee member's room in the hotel we were all staying. My mental picture is one of 50 people sprawling, sitting, standing, leaning on walls, sitting on beds and the floor in order to take part in the often heated discussions about what type of national NP organization was needed, how it should be structured, what its activities should be, and who should run it. It was truly participatory political action at its best. The meetings were long, impassioned, and exciting!

"The second is from an Executive Board meeting held in Philadelphia, Pa., in conjunction with the 1989 AANP National Education Conference that I chaired. Marie-Eileen Onieal had worked with the National Parks Service and secured permission to have



Bob Smithing

our Executive Board meeting in Independence Hall. Our officers and state representative were allowed to 'step beyond the velvet ropes' and sit at the replica desks of our countries' founding fathers and hold our meeting. I am still stirred by the mental image and personal comparison of our initial members and officers, my friends and colleagues, as activists and rabble rousers in an important and worthy cause - the creation of an organization to support the rights, responsibilities, and privileges of all nurse practitioners."

Jan Towers

"We were a fledgling organization at that time, so our work was focused on establishing the organization and a professional presence.

"The most common specialties at that time were Family, Pediatrics and Women's Health. Adult and Gerontology were becoming established.

"Recognizing that we could have an impact on health care as a professional organization [is my most poignant memory]."

Bob Smithing

"My presidential term was two years after the founding of AANP. The major accomplishment was laying the groundwork for a viable

organization, developing a network of NP groups, and working on legislative issues.

"The entire organization was evolving. It was a grassroots volunteer organization with no paid staff. The biggest change was the evolution of the organization and increase in membership.

"[My fondest or most poignant memory] is of the May 1985 conference where we announced the formation of AANP, of being told that we could not form AANP, and assertively pointing out that not only could we, we had done so. Twenty-five years later it is nice to see we were right."

Irene Bjorkland Ricciuti

"I remember driving to Jan's farmhouse in Gettysburg with Marie-Eileen Onieal from Connecticut for my first meeting.

"We were still in the process of getting organized, building membership and trying to decide on a logo.

"The most outstanding thing I remember is being invited as president to attend a luncheon meeting with national nurse leaders hosted by Barbara Bush. Each one of us had a picture taken shaking hands with Mrs. Bush."

Barbara Berner

"I do remember that we were growing rapidly and the informal nature of the initial organization was [in need of] a more structured approach just because of our growth. It was a difficult time of having to let go of some of the old ways of doing things toward a much more formal approach.

"I still remember our quarterly meetings that were held in Jan's dining room. We were squeezed into the room for all-day meetings and we were a very close (both in minds and physically) group. I still remember Jan's husband, Barry, cooking us lunch and baking wonderful bread for us while we worked on our plans for the organization."



Barbara Berner

Barbara Sheer

"Membership grew to 2,096 members. The majority of the members were FNPs.

"A policy and procedure manual was developed and revised bylaws were adopted. The scope of practice document was completed, and standards of practice were in the final approval process. Four additional position papers were pending, and there was a request for position papers on health care reform.

"On the national level, Medicare and Medicaid bills were introduced. There were six to eight visits to the Hill a week. Over 300 congressional visits were completed during the



Barbara Sheer

year. I had the opportunity to make several visits to the Hill with our lobbyist, Carol Jennings, and Jan Towers. Carol and Jan met with nurse staffers monthly. A Washington, D.C., address and phone number were established.

"A discussion regarding the first international nurse practitioner conference in the U.K. occurred. AANP became a sponsor of the U.K. conference held in London and continued with supporting the international movement through support of other conferences. Later the international conferences evolved into the International Council of Nurses Nurse Practitioner/Advanced Practice Nursing Network (ICN-NP/APNN), which was launched in the year 2000.

"My most memorable moment was at the national conference in Washington, D.C. At the award session we requested that the State Award for Excellence winners briefly state the reason they were selected. Each story was more compelling than the previous story. It was a wonderful expression of how nurse practitioners make a significant difference in health care and reach out to underserved populations.

"At the end of the session, Robert Hall, a corporate sponsor representative from Proctor & Gamble, said we should have videotaped the session for all the members of Congress. He wanted to assist AANP with corporate sponsorship. This was a pivotal moment that moved the AANP conferences into the next level of corporate sponsorships. AANP continued to grow into the organization that it is today."

Judith Dempster

"The organization's bylaws were changed in 1991 to increase the term of the presidency from one to two years. I was the first person to serve a two-year presidency.

"Without a doubt, the biggest change was proactive leadership in the area of health care policy and legislation. AANP was a very visible



Judith Dempster

and respected NP leader in the efforts related to Clinton's health care reform platform during this time. The AANP National Health Care Reform Position Paper was developed and published in 1993. In addition to health policy activities, other very positive changes included expanding and enhancing member services; increasing activities to serve as a vehicle for communication among NPs at the national/state/local levels; acting as a resource center for research, education, and standards of practice for NPs; providing a forum for continuing education for NPs; aggressively marketing and promoting the image and the roles of NPs; developing, revising, and disseminating multiple position papers and fact sheets; developing the first Spanish version of the NP brochure; increasing publication of the JAANP from four to 12 issues a year; providing leadership and support for the newly developing international arena for NPs; launching a national certification exam program for FNPs; and beginning development of a national foundation to support NPs and health care delivery.

"My fondest and most poignant memory from my term as president is how dedicated the team of AANP staff and board members were to



Marie-Eileen Onieal

being advocates for NPs of all specialties and for the quality health care NPs deliver. Working as a team, much was accomplished to advance the image and roles of all NPs and their health care delivery expertise."

Melanie Harris Arntz

"We started talking about the Foundation and the beginning groundwork was started. The foundation did not become a reality until the year after my term ended. The growth of the annual conference and membership were always a point of pride for the entire board.

"During those years the ACNP developed and wanted AANP to disband or join them and only have one group to represent NPs. I remember a meeting in February of 1995 when I was asked by a member of ACNP board if all of the AANP board would resign to form one group."

Marie-Eileen Onieal

Accomplishment: "Establishment of Fellows of the AANP."

Membership: "I do not remember the number of members we had, but I do recall that attendance at our national conferences grew so much that we had to move to conference centers."

Photo courtesy of Judith Dempster

Photo courtesy of Marie-Eileen Onieal



Mary Ellen Roberts

Memory: "Having a flag flown over the Capitol building on the anniversary of the founding of AANP and arranging a flag presentation ceremony at the annual AANP meeting in Washington, D.C. Members of the Uniformed Nurse Practitioners Association, representing the United States Air Force, Army, Navy, and Public Health Service, participated in the ceremony."

Denise Laine

"Family and adult were the largest groups [within the AANP membership,] although geriatric and acute care specialties were growing to significant size. Our membership was approaching 20,000.

"It is impossible to share just one thing since I was active on the board of directors for many years and the changes developed over those years. During that time, we began having our own annual educational conference, which grew from 157 participants to several thousand, developed our own certification exams, began our Foundation and PAC [Political Action Committee]. We went from an organization where our "office " was under the president's kitchen table to a large office complex with many staff members. The growth that took place over those years was amazing and gratifying for all of us serving on



Mona Counts

the board. It was an opportunity to 'grow up' twice: once personally and once through AANP."

Mary Ellen Roberts

Accomplishment: "Our PR initiatives and the 20/40 Celebration."

Membership: "Our goal was to achieve 20,000 members during our 20th anniversary year, which we did. Adult and Family NPs were the most common."

Memory: "Our 20/40 celebration and reaching our membership goals, [as well as] the increased visibility of the PAC and record numbers at our conferences."

Mona Counts

"My actual term of office as AANP president was 2006-2008. However, I held multiple elected AANP offices prior to that time. I was West Virginia state representative from 1994-1998, Region 3 director from 1999-2002, and treasurer of the board of directors from 2003-2005.

"[A major accomplishment of the term is that all] the major NP organizations have worked together on policy statements, with all logos utilized - 'Speaking with One Voice.'

"The increase in membership was phenomenal. The addition of professional staff to address the multiple components allowed the organization to truly grow. The corporation and inclusion of special interest groups paved the path for increasing specialization recognition.

"Expanding membership, professional staff, mentorship, transparency of operations, and national searches for leadership progression [were the biggest changes to the organization during my term].

"The opportunity to see NPs across the nation continue to expand knowledge and skill sets has been remarkable. The knowledge base of NPs regarding health policy and politics gives hope for the future."

Diana "Dee" Swanson

"The primary accomplishment of my presidency has been conducting a national search for a CEO to replace our original CEO. That was a fascinating experience and one that helped the organization coalesce our staff and board of directors, and renew our commitment to our mission and vision for the organization and the profession. Our CEO, TK Knetler, has been a dynamic leader and manager. Within the year that TK has been with us, we have made rapid movement in multiple directions and are becoming more visible and influential than we have ever been.

"Since becoming the president under a new CEO, we have expanded our health policy office and now have a Director for State Government Affairs, Dr. Tay Kopanos. Dr. Kopanos joins our warrior, Dr. Jan Towers, who has been leading policy for over 25 years.

"We have recently hired the PR firm of Weber Shandwick to assist us in pushing the message of the NP and quality health care and are doing a media blitz.

"I have had many memorable moments during my presidency, the most memorable being shaking President Obama's hand in the East Room of the White House after his speech on health care reform that turned the tide in getting the bill passed. My other moment of excitement was participating in a White House Stakeholders discussion on primary care. AANP was a very vocal presence and a very positive one."

OUR MEMBERS AND THEIR PRACTICES

By Christopher Prawdzik

Tim Flynn started working as a registered nurse in 1984, and since 2002, he has been a family nurse practitioner (FNP). His practice, Capital Health Services, however, is perhaps a little different from most FNPs.

His location makes his practice unique, as he is the nurse practitioner at the state capitol in Austin, Texas.

"It's the only clinic in a state capitol building, and I serve the Texas Legislature and their staff and all the people that work for legislative support agencies," he says.

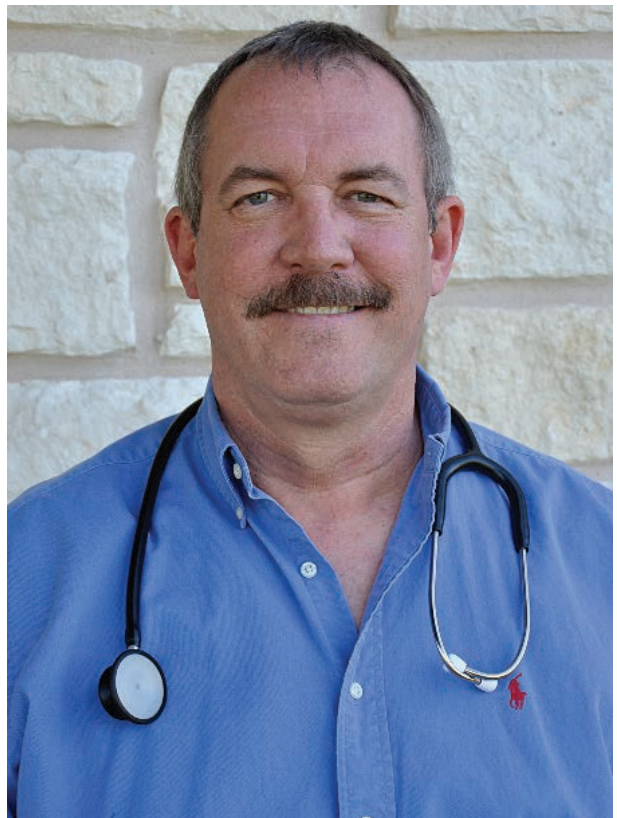
"It used to be like being the school nurse for the Texas legislature," he says about his transition from RN to NP. As an RN at the capitol, he could handle a lot of things with over-the-counter medications and basic nursing interventions, but he recognized his patients needed more than he was licensed to provide. They needed things like prescriptions and lab work - things he couldn't do.

With so many officials from out of town, they were medically underserved, he says. And it was increasingly difficult to find doctors at the last minute for some of these legislators.

"I was speaking with the Speaker of the Texas House of Representatives one day, and I said I could do a whole lot more if I was a nurse practitioner," Flynn says. "I explained it's a two-year master's degree program, and then, interestingly enough, the legislature passed a bill that allowed the state to pick up the tab for graduate education for certain state employees as long as it benefitted the population they served."

Once his schooling was completed, Flynn says his practice grew exponentially. People started coming to his office instead of going to their own doctor - and not just those from out of town. He was seeing people who worked at the capitol year-round.

"We realized pretty quick that this was a win-win situation, because the way the health insurance program is set up for state employees, the state picks up the tab," he says. "If I see a patient in my office, it probably saves the



Tim Flynn

state about \$75 to \$100 each time they're seen in my office instead of going to their doctor."

Flynn says he doesn't typically treat chronic illnesses; he focuses more on things such as sinus infections, strep throat, and bronchitis. What this has done, however, is put his growing practice in the spotlight for other states.

"We've got[ten] a lot of attention from all over the country," he says. "A lot of states are looking at doing the same thing that I'm doing here."

Key to his practice, Flynn says, is that it's similar to retail clinics staffed by nurse practitioners. He doesn't schedule appointments, so members just come in and get treated when they need it, and he sees about 20 patients a day. There's no co-pay and he says the whole process is pretty expeditious.

"Because the population I serve here at the capitol is pretty well educated and involved in their own health care," he says, "I can't just say 'Do this.' I have to explain why they need to do it."

He notes that with the great deal of education involved, it allows him to do what nurse practitioners are known for doing: patient education, health promotion, and disease prevention.

By the Numbers

As of 2008, more than 125,000 NPs worked in the United States. These advanced practice nurses have graduate degrees and additional training and education, in addition to their registered nurse qualifications. They can operate in a variety of settings, diagnosing and treating health problems across the board. According to the American Academy of Nurse Practitioners, an NP stresses "care and cure" in addition to disease prevention and other well-being practices.

Duties range from diagnosis to diagnostic test interpretation and treatment of chronic illnesses to prescribing medication and counseling patients about their medical needs and requirements.

More than 90 percent of NPs maintain national certification. And while licensed in every state and Washington, D.C., each NP is governed by the laws of his or her particular state. For example, Flynn's collaborating physician must come in once every 10 business days to examine charts. But it can vary greatly among different states.

Coast to coast, states provide a variety of different settings in which practitioners work. Most practitioners see up to four patients an hour and most (66 percent) practice in a "primary care" facility, such as a clinic, inpatient, or urgent care facility. But up to 20 percent of NPs operate in rural or "frontier" settings, according to AANP. Females make up nearly 95 percent of all practitioners.

Specialties among NPs are also quite numerous - and many variances actually exist within specific specialties.

FNPs make up nearly 50 percent of NPs. Adult care practitioners make up about 18 percent of NPs; other specialties include pediatric (9.4 percent), women's health (9.1 percent), acute (5.3 percent), gerontological (3 percent), neonatal (2.3 percent), psychiatric/mental health (2.9 percent), and oncology (0.8 percent).

A number of sub-specialties also exist, including dermatology, cardiovascular, occupational health, sports medicine, and urology, among several others.

The demand for the skills of highly trained nurse practitioners, regardless of specialties, is growing every day, and that translates to NPs working in facilities and locations as varied as the patients they treat. And with each different practice come different challenges.

Another Family

It might appear a far cry from treating legislators at a state capitol, but Diane Kendall also is a family nurse practitioner, and she just received her doctorate of nursing practice (DNP).

She works at the North Temple Clinic in Salt Lake City, Utah. The walk-in urgent-care clinic is part of Intermountain Healthcare, a nonprofit organization of medical facilities throughout Utah and parts of Idaho, and is designed to serve people without insurance. According to Kendall, the clinic is set up to see people on a sliding fee, based on individual needs, and it's one of several walk-in clinics in Utah that works on that scale. Although she says that primary care clinics often operate the very same way to see the uninsured, they often refer patients to these clinics when necessary.

Kendall's DNP project looked into barriers people must endure to access primary care, so her job at the clinic is a good fit for her recent training.

"We do see the appropriate people with urgent care needs," Kendall says. "We see quite a few people who



Diane Kendall (in green) with colleagues from the North Temple Clinic.



Above: The North Temple Clinic. Right: Chris Singer



have either recently lost jobs or recently lost insurance, who have not been able to get back to their primary care, who have been off their chronic illness medication."

Of the patients she sees, 72 percent are Hispanic, 22 percent are non-Hispanic white, and 2 percent are non-Hispanic black. Of them, less than 11 percent are privately insured, and 77 percent have no insurance at all.

One of the challenges is that many patients are from other countries, because their family lives in the Utah area. "A lot of times they'll come for a visit for six months ... and not come with enough medication, so they'll come in and ask for a refill of their chronic medication," she says.

Oftentimes this could include a follow-up for the patient at a primary care clinic. With such a high population of individuals from other countries, communication and cultural differences can provide a particular challenge when dealing with someone's chronic illness.

"Sometimes it's very frustrating to see the same patient come back, because we label them as 'non-compliant,' but in reality, what I've learned over 10 years is to have a better cultural understanding," Kendall says. "This is their culture; this is their idea about health care."

But these cultural differences can pose dangers for the patient. For instance, she says, patients who must take medicine for chronic diseases, such as diabetes, sometimes think when they're done with a prescription, they believe they're cured. The result is often a return to the clinic in several months with a variety of complications.

"They know about diabetes; their family members have diabetes, but they don't understand what the lifetime illness means," Kendall says. "So we do spend a lot of time educating them sometimes."

But most rewarding, she adds, is when as a practitioner, she knows she's right on a patient's history and her diagnostic skills get patients to the right place.

Vast Frontier

Chris Singer, a DNP and family nurse practitioner, can relate to Kendall in many ways, but again, his practice

takes him to lengths and provides challenges many other family practitioners only read about.

Singer works primarily at the Monument Valley Community Health Center, operated by Utah Navajo Health System, Inc.

"I think the classification is 'frontier medicine.' The people that we work with, I think their median annual incomes [are] about \$9,000 a year, so very poor," Singer says. "I'd have to guess that somewhere around 50 percent of the people we serve probably don't have running water and or electricity in their homes."

These individuals turn on lanterns when the sun goes down - if they have them, he adds. Running a clinic amidst such primitive conditions provides its own set of challenges, and he says one of the primary ones is to continue to think ahead, particularly with some specific, chronic health problems among the Navajo population.

"On the Navajo reservation, the prevalence of diabetes is around 30 percent, which is more than twice the national average," Singer says. "Unfortunately, they're starting to see it into the high school."

As with Kendall, cultural challenges are always at the forefront, and it's instructive to learn about these cultures in order to perform as an NP in these situations.

Singer notes that it's tough to encourage the youth to leave the reservation for education, because of the Navajo culture and the struggle of family members back home.

"It's not uncommon for somebody to even do well in high school and get scholarships ... go away to school and then something happens in the family and they get a phone call that they need help at home, and kids will leave school and go home and end up staying," he says.

For his doctoral project, Singer focused on education and overcoming culture and communication barriers -

not just with diabetes, but with other health issues that arise on the reservation. He wanted to focus on better ways to communicate to residents about medication and lifestyle and encourage physical activity for better health.

"Even with the native speakers who work with us in the clinic, a lot of times there's no direct translation of terms or verbiage in the English language directly to the Navajo language," Singer says. "People have a hard time, even though they work in health care, trying to sit down, especially with the middle-aged to the older Navajo folks, and put terms that we're using in English into Navajo."

The challenges can go further than that, however. Even convincing an individual to take insulin can be tough because they may have cultural objections or they may not have a refrigerator or electricity at home to store the medication properly.

But he still feels a connection to the population, and what began as a 30-day assignment, so to speak, has turned into five years of work with the Navajo population.

"One of the biggest things I've learned in practice - and I work with other groups ... when you're dealing with chronic disease, no matter whether you're in a rural setting or in an urban setting, it's a personal thing to people," Singer says. "We have to let them own it, and sometimes become more of a coach to helping them and educating them more than just throwing medications at them and saying 'Do this; do that.'"

Burn Center

Lee Moss, family nurse practitioner for the University of Utah School of Medicine, works at the University Hospital Burn Center. He's a most poignant example of the evolution of the nurse practitioner, particularly as the need for NPs grows across the country.

Moss started as an RN in the burn center about 22 years ago, and when he completed his NP degree 15 years ago, he took over the role of provider for the Burn Outpatient Clinic at the University Hospital.

"We've never had that model of a practice here before, and so I developed the model of this NP-run practice, and it started out with just myself and a health care assistant in 164 square feet [of space]," he says.

At that time the clinic saw up to 1,800 patient visits a year. Over the years, however, it's gotten busier as the state's population has increased, according to Moss.

"Now we're up to about 5,000 visits a year, and up until last year, it was myself, an outpatient services specialist, and a health care assistant," Moss says. "A year-and-a-half ago, I actually finally got a partner, a second nurse practitioner."

He sees most of the patients from the burn trauma intensive care unit after they're discharged - about 350



Lee Moss

patients a year - plus patient visits from those with less-serious wounds who are referred by others.

It's a matter of freedom with some effectiveness that's allowed Moss to really progress in the burn center.

"As a nurse practitioner in Utah, we're licensed independent practitioners," he says. This freed the doctors up to do more surgery. Approximately one-third of the burn surgeries are now done on an outpatient basis.

"My role in the clinic allowed us to discharge people sooner because they could come back and see me. Patients go home sooner, decreasing costs," he adds.

"Just having me in that role just changed how we flowed."

This specialty practice is one where a person really gets to know patients. About half, Moss says, are children, and most of those are toddlers. The challenge there is that it's often difficult to explain to children why they have to perform certain procedures.

In addition to wound care and pain management, he provides the full range of nurse practitioner services as his patients come to the Burn Clinic with their full range of medical problems.

"What I've discovered over the years is I can do a better job with pain management by finding better dressings than by giving more drugs," Moss says. "Anything I can do to decrease the number of dressings that parents or patients have to change means the less pain they experience."

Like many other NPs, he has to deal with a variety of sometimes-tragic circumstances, but Moss says it's a lot different than many people think.

"I've taken patients as children who now are adults, and they still come back sometimes for touch-up procedures," he says. "Unlike the medical ICU right next door to us, my patients are mostly young, healthy people who go home as young, healthy people, [and] if I do my job well, they go on and live a full life, which certainly most of them do. Burn survivors are a special breed and it is an honor to care for them."

Higher Acuity

As Moss notes, a medical ICU can be a bit different. This difference often requires the services of a particular nurse practitioner, focused specifically on acute care.

Ruth M. Kleinpell, director of the center for clinical research and scholarship at Rush University Medical Center in Chicago, says that most acute care nurse practitioners work in hospital settings and don't have independent practices.

In fact, it's the latest nurse practitioner specialty area, with national certification beginning in 1995, she says.

"Since that time, there's probably about 6,000 that have national certification as acute care nurse practitioners," Kleinpell says. "The role evolved out of several demands for having a practitioner working in hospital settings or acute care environments."

One of the main reasons acute care has grown so much is because of a decrease in medical residents and the hours in which they're allowed to practice. Currently, residents can't work in a clinical setting more than 80 hours a week, and new guidelines could drop that number to just 60 hours a week. In addition, patients actually spending time in hospitals have a higher acuity across the board.

"Nowadays if you're in the hospital, you're pretty acutely ill," she says. "They just needed an advanced practitioner to help manage patients in conjunction with the physician team."

The settings range from intensive care units to step-down units and telemetry. Kleinpell adds that there's also been an increase in acute care practitioners working in sub-acute facilities, urgent care, and even clinic settings. They often have specific specialties, such as cardio care only.

This gives them an advantage to not only follow the patient while they're in the hospital, but they also help them with their discharge instructions and also follow them after they're discharged.

"The roles sort of vary in terms of what they're doing, but definitely it's focused on patients who are acutely ill and need to have oversight of an advanced practice nurse in addition to the medical team," she adds.



Ruth Kleinpell

With the increased complexity in the condition of patients admitted to hospitals, Kleinpell says that acute care practitioners are that addition to the team that not only help manage patients but provide teaching and education to patients and families. They also serve as liaisons between physicians and staff nurses to advance the continuity of care for all patients.

Education Foundation

No matter the environment in which an NP works, the ability to practice at all begins with education. Those doing the teaching often have the experience in a variety of practices to pass on that knowledge to their students, furthering two careers.

Michael Zychowicz, DNP, associate professor and director of the Adult Nurse Practitioner Program at Duke



Michael Zychowicz

University, recently moved to North Carolina from New York, where he split time between teaching nurse practitioners and seeing patients in an orthopedic practice. An orthopedic NP for about 12 years, he's taught for 10 of them.

After living this dual-hatted existence as a clinician and professor, he began to look for teaching opportunities at larger universities, larger schools with more resources, and settled on Duke University.

"When I first came out of school I think the general public had some kind of general ... understanding of what a nurse practitioner was, but certainly it would be a process in clinical practice where I'd have to explain multiple times per day what it is I do," he says. "I've seen over the last several years a slow and steady evolution of a greater understanding of what nurse practitioners are - more of an acceptance by the general public for our ability to take care of health problems."



Margaret Bobonich

What he can do at Duke, however, is take the students who don't have a full understanding of the depth and breadth of what a nurse practitioner does and show them the ropes.

"I think the NP students don't understand the magnitude and responsibility of the professional role until they really start getting into clinical rotations where they've got to make the decisions, figure out what the person's diagnosis is, and write the prescriptions," he says.

Zychowicz earned his DNP from the Frances Payne Bolton School of Nursing at Case Western Reserve University (CWRU) in Cleveland, Ohio, just as nurse practitioner Margaret Bobonich did. Bobonich is an FNP from Cleveland, Ohio, where she began specializing in dermatology five years ago. "It was really tough starting in the specialty because there weren't many educational



Margaret Bobonich with two young patients.

opportunities for NPs to learn dermatology knowledge and skills," she says. Most dermatology NPs had to rely on on-the-job training with collaborating physicians and direct their own learning without a standardized curriculum. This is changing.

There is a growing need for more nurse practitioners in dermatology. "As the population ages, skin cancer has become the most common form of cancer and totals more cases than breast, prostate, lung, and colon cancers combined," says Bobonich. Early recognition and treatment of skin cancer means better patient outcomes. This increased demand for care, however, has also been affected by changes in the aging workforce, which includes the retirement of dermatologists. She notes the gap is being filled with nurse practitioners.

In fact, she cites a survey by the American Academy of Dermatologists that showed a 43 percent increase in the use of NPs and physician's assistants between 2002 and 2007. Dermatologists anticipate that 36 percent of practices will employ one of these providers in their practice this year. "What that means for us, as nurse practitioners,

is that we have an integral role in dermatologic care," says Bobonich.

Bobonich left private practice to join the Department of Dermatology at University Hospitals Case Medical Center and returned to the Frances Payne Bolton School of Nursing at CWRU to complete her DNP. Her goal was to establish a formal dermatology NP residency. She notes, "The concept was to create an interdisciplinary program to promote effective and efficient collaborative practice, which is the reality of today's health care." Research from Bobonich's thesis provided evidence for the NP Society (NPS) of the Dermatology Nurse's Association to develop their core curriculum.

In the past five years, dermatology NP education has expanded under the guidance of NPS through national conferences and online didactic programs and resources. CWRU is one of only three post-master's programs that now offer formal interdisciplinary education for dermatology NPs. In 2008, the Dermatology Nursing Certification Board offered the first national certification for dermatology NPs.

AANP MEMBERSHIP

By David A. Brown

A membership in the American Academy of Nurse Practitioners is designed to promote growth, achievement, and professional excellence. It's more than the variety of goods and services provided to members, although preferred pricing on professional liability insurance is a big plus. And it's not just items like the AANP-branded PDA with essential health care software - no doubt, a very helpful tool.

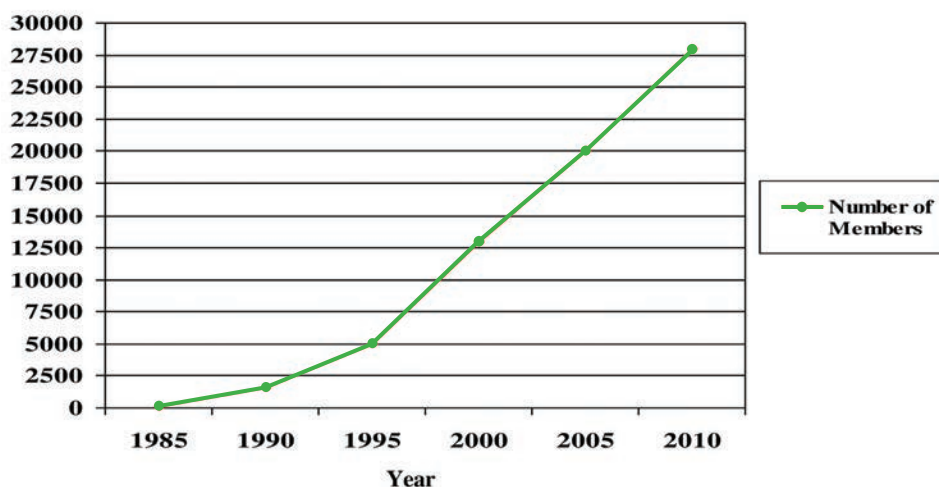
Indeed, AANP embraces, empowers, and emboldens its members with exemplary commitment to the individual as well as the profession. AANP nurtures and supports its members, who, in turn, validate this organization through their superior delivery of health care to all segments of the population.

Central to this concept is the AANP health policy staff and Washington lobbyists whose proactive approach to advocacy ensures that the membership's concerns and positions are clearly conveyed at the state and federal levels. From occupational classification and prescriptive authority to NP recognition as primary care providers in Medicaid Managed Care Programs, AANP members take comfort in knowing that they are not overlooked on issues of professional importance.

AANP Director of Communications and Member Services Nancy McMurrey says: "The benefit that members receive from our legislative and regulatory leadership is of tremendous value. The health policy office makes sure that the NP voice is heard."

Lee Moss works in the Burn Center at the University of Utah's Department of Surgery. As Utah's AANP state representative, he's intently focused on local and national matters affecting his profession. For him, the AANP health policy office serves an invaluable role for members.

AANP Membership Growth 1985-2010



"They make sure that we are treated fairly in legislation," Moss says. "I would pay for a membership just for that benefit. All of us work for a living and we can't look at every piece of legislation, so it's good to know that our lobbyists are doing so on our behalf."

"It's peace of mind knowing that someone is out there trying to protect my practice. And I hope that it gives my state constituents peace of mind to know that I'm doing my part on the state level."

Sheila McGuckin, a family nurse practitioner in Tulsa, Okla., says the AANP's legislative and regulatory efforts address real-world aspects of her job and thereby enable her to focus on the work to which she has

dedicated herself. "I am not someone who enjoys politics, but knowing that the organization has people looking out for legislative issues that are going to affect me is comforting. I don't have to worry about my job going away because AANP is out to make our profession more secure and to give us more capability to do what we need to do."

For those seeking direct participation, the AANP Political Action Committee (PAC) provides members a venue for joining the organization's legislative objectives by supporting national candidates whose beliefs align with the organization's purpose, principles, and mission. PAC involvement allows

closer interaction with congressional legislators through sponsorship of meals and social events. Through such participation, members can help advance the positions essential to the NP profession.

AANP further promotes member involvement through the invitational Health Policy Leadership Fellowship gathering in Washington, D.C. This prestigious event centers on meetings with legislators for the purpose of discussing important industry issues. Participating members also spend time with their state's elected officials to delve deeper into the specifics of key topics.

At the community level, AANP encourages members to promote their profession through National Nurse Practitioner Week - held the second full week of November. AANP facilitates this annual spotlight opportunity by providing resource guides that help members plan and execute an effective campaign that builds awareness of the high-quality, cost-effective health care available through nurse practitioners. Also AANP provides sample proclamation text that members can present to their state leaders with the suggestion of honoring the NPs in their state during National NP Week.

Learning and Development

In addition to AANP's legislative and regulatory service, McGuckin says she also values the organization's commitment to member development through the Continuing Education program. A requirement for maintaining certifications, CE courses are cost-free for AANP members and the CE Calendar provides up-to-date details on programs that are accredited/offered by AANP, AANP partners, and approved providers.

Diversity is the key, as AANP enables members to complete their CE requirements through traditional lecture formats during the annual conference, or through a variety of self-study options such as online programs, CD-ROMs, monographs, publications, and the Virtual Journal Club Series - CE activities built around articles from the *Journal of the American Academy of Nurse Practitioners* (JAANP).

Streamlining the continuing education process, CE Center - AANP's online CE portal - offers access to Web-based activities and testing, program evaluations, and a handy system for immediately generating certificates upon completion of program requirements. Through CE Center, members can track their progress and maintain an organized, easily accessed file of their program record and certificates.

"Through an extensive series of needs assessments, the CE Center and the conference are able to offer our members what they want," McMurrey says. "That's how these activities have grown and evolved - by the feedback from our members. People learn in different ways and they absorb information in different ways, so we try to respond to what works best for our members."

Pennsylvania State Representative Sue Schrand has been a member since 1999. That membership, she says, has served as a continuation of her professional education beyond her formal graduate school experience. "My affiliation with AANP has increased my professional confidence, enabling me to better negotiate my worth and to define my contributions to the health care system as an NP."

Cementing the organization's commitment to members and their career field, AANP established its namesake Foundation in March 1998. An independently incorporated 501(c)(3) philanthropic nonprofit organization, the AANP Foundation exists to advance the nurse practitioner's role by supporting education, research, and practices that improve public health. Practicing NPs and student NPs are eligible for the AANP Foundation Scholarship & Grant Program, which provides scholarships for doctoral, post-MS NP, and MSN-NP education and grants for industry-related research projects. For grant applications by members and articles about the organization, the AANP Research Department provides pertinent data, along with surveys, studies, reports on past research projects, and links to additional resources.

AANP student members include recognized NPs returning to school for post-graduate work and individuals studying to become NPs. McMurrey says both groups are essential to the organization's future.

"Student members absolutely are our future, as they are in any organization," McMurrey says. "A lot of our student members have been an RN for many years before going back to school to become an NP. Through their clinical experience as an RN, they bring ideas and expertise to the NP role."

Approximately 8,000 new NPs were prepared in the United States last year. With a new expanded membership category for NPs who are returning to school for post-graduate work, AANP will be working to enhance and expand products and services for these members as well as for students in NP programs.

"Our membership continues to grow in all categories, with more than 28,000 individual members and about 140 group members [as of April 2010]," McMurrey says. "We are deeply appreciative of our members, many of whom have been with us for years - some since we first became an organization in 1985. We encourage dialogue with membership, and a number of our products and services have developed from member suggestions, making us a true member-focused organization."

Essential to NP development is the advice and direction of those who have successfully walked the path. Such tutelage often comes from the Fellows of the American Academy of Nurse Practitioners (FAANP) - a system of recognition for NPs who have made significant contributions in the areas of research, practice, education,

and policy. The FAANP Mentoring program enables these established professionals to guide and coach novice NPs or more experienced NPs with specific career goals.

Connection and Interaction

Recognizing the inherent value of professional networking, AANP invests a tremendous effort into producing annual conferences that combine intense educational components with ample time for interaction with fellow members, health care vendors, and representatives from other industry groups. The AANP group membership category furthers this objective by providing a venue for nurse practitioners, nurse practitioner educational programs, and other nurse practitioner groups to interact for networking, advocacy, and mutual support.

For events, issues, and other industry happenings, AANP keeps its members well-informed with a diverse array of communication tools starting with the daily electronic newsletter, *AANP SmartBrief*. Delivered Monday through Friday via e-mail, *SmartBrief* compiles relevant news items from various national sources and delivers succinct summaries with links to additional news venues. Members are encouraged to include *SmartBrief* links in their Facebook, LinkedIn, and Twitter postings.

Membership in AANP also includes a subscription to the monthly peer-reviewed journal, *JAANP*. Additional communication comes by way of the AANP Annual Report, the organization's position papers/reports outlining AANP views on a broad range of topics affecting NPs, and the weekly E-Bulletin providing members with the most current information about AANP initiatives.

And when it comes to communicating with potential employers and patients, AANP provides helpful tools for these tasks. The Web-based job placement service *CareerLink.com* helps members search for the right career opportunity while providing job candidate profiles for prospective employers. *NPFinder.com* allows members to enter details of their practice so patients can locate an NP by name, specialty, and/or location.

Beyond the benefits, Schrand says an AANP membership bespeaks a deep commitment to not only a job, but a career. "Belonging to the organization demonstrates that I am an engaged and informed professional," Schrand says. "It has opened so many doors for me in my role as state representative for Pennsylvania and in my participation in the Fellows Mentoring program. By being a member and volunteering for AANP, I have had the pleasure of meeting amazing NP leaders from around the country, and it makes me really proud of our body of work as health care professionals."

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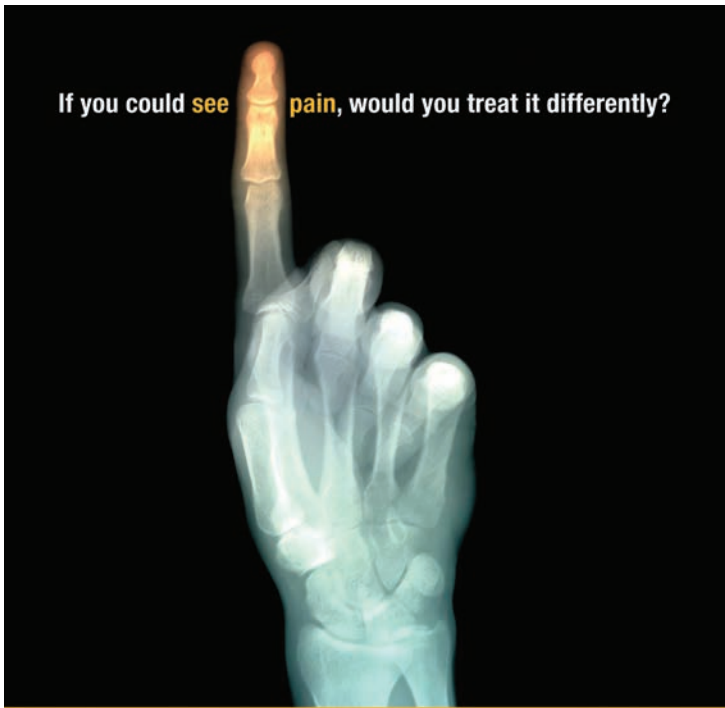
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AANP NATIONAL CONFERENCE

Educating and Enriching Through Program Diversity

By David A. Brown

There's no questioning the clear social value of catching up with colleagues and making new acquaintances, but "see and be seen" just isn't a fair summary of the AANP National Conference. Indeed, this much-anticipated event delivers a serious dose of education steeped in professional development and seasoned with the enriching awareness spawned by interaction with like-minded individuals.

A masterful blend of style and substance, the conference serves nurse practitioners at a level unmatched anywhere in the health care industry. No one knows this better than Zo DeMarchi. As AANP director of association services, she oversees the planning, coordination, and production that goes into pulling off "THE" event for nurse practitioners.

"No other event gathers NPs to the extent that ours does. When you get that size and diversity of professionals together, it's quite dynamic," she says. Mary Ellen Roberts and Yvonne Moragne-Coon, AANP national conference co-chairs, agree. As longtime conference committee members, both reminisced on the growth of the conference. "From our first national conference in 1989 to the present, we grew exponentially, rapidly becoming the largest conference for nurse practitioners in the world," reports Roberts. "I have experienced the growth and changes as they occurred with both the social networking opportunities and expert professional sessions. The conference has expanded as the profession expanded to offer something for everyone." Moragne-Coon remembers the days when the conference committee had to arrive early to help compile the attendee notebooks. She appreciates that "technology has allowed us to be 'high tech' so that all that is available to our attendees online, making it possible for them to pick and choose what they want to print and bring to the conference."

The organization is committed to a well-rounded conference. As the event draws a diverse body of attendees with a broad range of needs and interests, AANP spares no effort in designing a program with far-reaching appeal.

"We have continued to expand the number of breakouts to address the needs of everyone attending our conference," DeMarchi says. "There's something for the student



Dr. Loretta C. Ford makes an appearance as Super Nurse at the 2006 AANP National Conference.



Left: Mona Counts and Mary Ellen Roberts at the 2008 AANP National Conference. Right: The exhibit hall at the 2006 conference.

and novice NP, as well as NPs who have been in practice for 10 to 15 years or more. We strive to have something for everyone and that's not only in terms of experience, but also in terms of specialty area."

A Time to Learn

Consistently a major attraction for conference attendees is the rich schedule of clinical sessions and workshops that offer NPs ample opportunity to complete continuing education (CE) hours necessary for their certifications. Included in the conference fee, the CE benefit starts with the right lineup of topics and AANP takes its cues from the folks who matter most – the members.

Membership and post-conference surveys determine the subject areas of greatest importance and the AANP Conference Department and conference co-chairs analyze each year's data to identify any shifts in CE needs. Marrying this with a stringent process of speaker selection ensures a stellar assemblage of educational offerings.

"When you look at the presentations that are included, it is reflective of our members' needs for their specialty areas," DeMarchi says. "Our conference is driven by feedback from our members, so we review [their preferences] and secure the top-level speakers to make these presentations. We have a rating system of 1 to 5 and all of our speakers are in the 4 to 5 range. That means we're inviting the best as defined by attendees and that allows us to bring our conference presentations up to a very high level."

Cindy Cook, a family care NP from Huntsville, Ala., has attended eight conferences in her 12 years of AANP

membership. Averaging about 30 CE hours at each conference, she said the event offers a can't-miss opportunity to complete a large block of requisite learning in a concentrated period of time.

"I think AANP does an excellent job of securing the best speakers available," Cook says. "It's very important because it doesn't really help me a lot if I don't get [current] information. Medicine is constantly changing so it's important for me to get up-to-date, evidence-based information to bring back to my own practice."

Vermont representative Deborah Wachtel has been an NP since 1986, first in women's health and then as an adult nurse practitioner practicing in internal medicine with a specialty in endocrine disorders. She also has a master's of public health in international health services, so the conference's broad array of CE courses helps her with work beyond her domestic practice.

"For my professional development, this conference offers a wide variety of options for the educational sessions including many hands-on workshops," Wachtel says. "For instance, this year I am focusing on medical language skills to enhance the work I have been doing in the Dominican Republic and Haiti. I am also trying to improve my suturing skills and other diagnostic abilities that I have needed for this recent medical relief work."

Growth Through Interaction

From casual lobby chats to regional group meetings and Interest Forums, the AANP Conference affords numerous networking opportunities for attendees. Some attendees may come to the conference with specific points



Above: Attendees of a workshop at the 2007 conference. AANP strives to include clinical sessions and workshops that its members will find relevant to their own careers and practices. Right: Attendees view posters during AANP's 2003 conference.



of interest, while others find spontaneous conversation rewarding. At any level, interaction equals growth.

"I get multiple levels of professional development from the conferences," Wachtel says. "It's an opportunity to meet with the other state reps and AANP staff to work on national health policy issues. AANP's strength is encouraging leadership skills among its members. The conference is also a tremendous opportunity for networking with my peers, especially those who are working on policy issues."

A common catch-up point is the exhibit hall filled with a variety of pharmaceutical companies, medical supply and equipment companies, computer and business support companies, recruiters, and publishing houses displaying the latest in goods and services of interest to nurse practitioners.

To ensure attendee access, AANP maintains booths featuring the various AANP departments and services as well as fundraising and informational activities for the AANP Political Action Committee, AANP Foundation, and AANP Certification Program. Booths are also

featured for AANP Partner services. For example, AANP members looking for career opportunities and employers seeking the right NP can coordinate some conference face time through *AANP CareerLink* - the organization's online career center.

DeMarchi says the AANP Conference is designed to have "all the formal networking systems with informal networking opportunities." Wachtel appreciates how the event's atmosphere fosters communication.

"Networking is the key to any professional development," Wachtel says. "None of us can work in isolation and talking to colleagues and vendors helps us stay connected to the world and open to other - and new - ways of doing things."



Conference attendance has grown tremendously in the last couple of years, which speaks not only to growth in numbers of NPs but also to the event's well-respected reputation.

Noting the value of interacting with NPs from all over the country, Cook says the AANP Conference has rewarded her with new friends as well as business contacts. Exposure to a tapestry of thoughts and ideas, she says, improves her professional abilities.

"I think it's important for each of us to reach beyond our areas," Cook says. "Different parts of the country do things differently so it's important to interact with other NPs to learn other ways of doing things that can benefit our patients. And that's our ultimate goal - to provide the best patient care that we can."

Maximize the Experience

DeMarchi offers this description of the AANP Conference schedule: "It's relaxed but busy. It's a 4 1/2-day-full conference so there are long hours. We encourage people that if it's too tiring to divide their day up with some rest time."

Clinical sessions are typically scheduled in three-hour blocks and interspersed with general sessions and industry-sponsored events, produced collaboratively between

corporate sponsors and third-party education companies. To keep up on the event schedules and details, attendees need only consult the *AANP Conference Call* - the official daily newspaper of the AANP Conference. For personal convenience, a cybercafé provides the Internet connection attendees may need to coordinate with other NPs via e-mail or peruse AANP's daily electronic newsletter, *SmartBrief*.

Between the heavy list of educational sessions, industry events, and a lot of walking in the exhibit hall, time and energy management are key strategies for conference attendees. Prioritization and balance are key components of a productive conference plan.

"I think you have to plan well and there are times you have to decide between [multiple opportunities]," Cook says. "It's important to make sure that you are going to CE courses that will benefit your practice, as well as learning about new topics that can expand your knowledge."

Wachtel prefers a mix of short talks and longer workshops with hands-on activity. Dynamic programs that involve moving around are important for staying

sharp and alert, but she also suggests taking the opportunity to relax and socialize with friends and colleagues.

"That is critical to being able to tolerate the intense amount of information you'll receive at an AANP Conference," Wachtel says. "Your mind has to be clear to absorb, and playtime, which includes exercise, is the key. Also, meeting with colleagues after hours gives you an opportunity to talk about some of the information to put it in perspective and hang onto it mentally. I hit the fitness center every day at the conference if I am not able to get outside for some serious activity."

DeMarchi said that each successful conference serves as motivation to reach higher the following year. This policy of improvement has yielded big results, as members who've attended conferences are typically inclined to return the following year, while word of another rewarding event entices new attendees.

"This has led to some pretty phenomenal growth," DeMarchi says. "We went to 3,000 attendees for several years and in 2009, we had a little over 4,500 attendees. Part of that is the growth of the profession and the organization, but it's also the attraction of a dynamic conference. That's nice feedback. It's good to know that we're on track. During a time when most groups saw a decline in attendance due to the economy, ours grew."



Then-U.S. Surgeon General Richard Carmona is pictured with uniformed NPs at the 2006 conference in Dallas, Texas.

The conference co-chairs agree. Roberts expresses pride in being a major part of this annual educational endeavor for nurse practitioners, and Moragne-Coon notes, "For our 25th anniversary, this will be our best conference yet."

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AANP PARTNERSHIPS

By Christopher Pawdzik

Organizational success for an institution such as the American Academy of Nurse Practitioners does not stop at the doors of the establishment. That success, along with physical and institutional growth, is often directly related to AANP's ability to reach beyond its walls, to collaborate with other health care organizations, and to establish connections. This allows members to expand their reach and increase their own visibility within the health care delivery system.

At AANP, these collaborations, which fall along a variety of lines, create a web of partnerships that contribute to the growth and success of the organization.

While many AANP partnerships flourish on a variety of levels, at the core exist a few building blocks on which nurse practitioners can enjoy an individual connection to the organization and, in turn, connect themselves to other health care outlets, opportunities, and support that help advance their own individual success.

Nancy McMurrey, AANP director of communications and member services, says three partnerships, in particular, point directly at member benefits.

Liable to Join

For starters, Marsh Consumer, an insurance provider connected to Seabury & Smith Inc., joined AANP in June 2008 to give members a liability insurance option.

"It's the first time we've ever actually partnered with a provider of professional malpractice liability insurance," McMurrey says. "In addition to having competitive rates, our members may qualify ... for an additional 10 percent premium credit."

(McMurrey notes that most members qualify for this credit.)

Regarded as a "pro-liability" program, the insurance option serves as medical malpractice protection. Members are covered up to \$4 million every year, with each incident garnering up to \$2 million in coverage. Other discounts also are available. According to background information on the plan, it's an "occurrence" coverage plan. A nurse practitioner covered at the time of a specific incident maintains that coverage, regardless of a claim filing date.

The success of the program is evident in standardization efforts that began April 1, 2010, as Liberty Insurance Underwriters Inc. became the plan's underwriter. An important change this brings is that nurse practitioners, regardless of the state in which they practice, will maintain the same rates.

"Because it's on a Web portal, they can go online to do their policy renewals; they can ask questions online," McMurrey says about the plan's 24/7 access. "It's a very comprehensive program for malpractice insurance."

But the program doesn't stop there. With nurse practitioners an ever-growing presence in health



Marsh Consumer partnered with AANP in June 2008 and was a presence at the 2008 conference.

care, AANP now is able to offer insurance protection to nearly 4,000 student members who are not yet full-fledged nurse practitioners.

"Those are [registered nurses] who are in programs to become nurse practitioners, and they also need liability insurance," she adds. "Marsh has a plan to offer them a very, very low rate to have liability insurance during their tenure in the NP program."

Career Paths

With the recognition of students and their importance through insurance options, AANP also provides a bridge that can take them from student status right into the profession itself, particularly through AANP's

center for job opportunities, *CareerLink*, the organization's online career center.

Nearly a decade ago, AANP partnered with HealthECareers Network, which provides an effective and easy pipeline between practitioners and their future. It's a two-way street, as the network provides several benefits, first allowing employers seeking practitioners to simply provide job opening information. At the same time, candidates may post résumés and search for jobs.

"*CareerLink* brings a continuous stream of job seekers and employers to our site," McMurrey says. "They've added a lot of new opportunities on that site ... everything from how to write a résumé, how to send the right type of cover letter, and then they also have things like the ability to store different résumés and different letters that you would target for different types of positions you're going after."

The service allows NPs to search for jobs using a variety of criteria, from job location to specialty, and it even allows them to search particular companies. The system also has a mechanism that allows members to receive job alerts via e-mail.

"On an average, 600 job postings were on there every month [in 2008] and over 400 people had monthly responses to the job postings," she says. "So it's a very robust type of member benefit."

Not only does this benefit reveal job openings, it provides a connection between potential employers and potential employees, allowing those searching for jobs to set up onsite interviews at the AANP annual conference.

"Whether they're exhibitors or attendees, [this allows them] to perhaps make a connection at the conference and talk more about opportunities for that particular position," McMurrey says.

Career Information

It might be protection for practitioners through insurance, or the reassurance that AANP members and students have access to the best job availability nationwide through a job bank. But in addition to these benefits, one particular partnership that helps all members is the AANP *SmartBrief*, a daily e-newsletter that provides the most up-to-date news and information about health care. Now with strong legs since the partnership was formed in 2003, *SmartBrief* is a collection of relevant news from hundreds of print and online publications from around the country.

"It goes to more than 32,000 subscribers, but we know it has a further reach," McMurrey says. "[*SmartBrief's*] staff searches the top electronic news bureaus and other sources to pull, in our case, the most pertinent information related to health care."

Free to AANP members, the newsletter saves them time in that they do not have to sift through the mounds of information available on the health care field; it gets members the information directly. *SmartBrief* is also designed to integrate with social networking sites such as Facebook, Twitter, and LinkedIn.

The professional liability program, *CareerLink*, and *SmartBrief* help nurse practitioners find the right coverage, help employers locate the right nurse practitioner, and also provide very comprehensive content for NPs to further their careers.

"These are partnerships that directly impact the individual member and they're available to all of our members," McMurrey says. But that's just one component of partnerships AANP has established.

Other Partners

Some other partnerships might not be directed at every individual member, but instead they're directed at groups among individual members.

According to AANP Director of Research and Education Mary Jo Goolsby, EdD, MSN, NP-C, FAANP, many collaboratives involve staff or volunteer representation on behalf of the rest of AANP members.

For example, she says, AANP representatives sit on programs at the National Institute of Health, including the National Kidney Disease Education Program, the National Diabetes Education Program, and the National Center for Education in Maternal and Child Health.

"We participate as liaisons to our organization so that we can help push out messages to them," Goolsby says.

Other collaboratives include a partnership with the American College of Chest Physicians (ACCP) that began almost three years ago, when ACCP invited AANP to participate in several educational programs devoted to insomnia and sleep disorders, she adds.

"Throughout that collaborative, we've formed a pretty strong relationship, so now we're working with them on a similar series of educational programs related to COPD [chronic obstructive pulmonary disease]," Goolsby says. Together with ACCP, [we] formed something called the 'patient safety collaborative' ... that includes not only ACCP and AANP, but [physician assistants], the Infectious Disease Society, the Society of Hospital Medicine [SHM], and a few other organizations."

In addition, she says the SHM partnership has led to an entirely different set of collaboratives and partnerships.

Both ACCP and SHM are primarily based with physician members, she says. Both have a strong regard and interest in working with nurse practitioners. So for instance, Goolsby explains that through the partnership

with the Society of Hospital Medicine, as well as the American Academy of Physician Assistants, this year AANP will be collaborating on the implementation of a "boot camp" for nurse practitioners and physician assistants. This is the second year for this very intensive program, for NPs and PAs engaged in a hospital practice.

The partnership process goes beyond specific initiatives, as the organization participates in joint activities to ensure that dialog continues among the partners.

"It helps us keep informed and be able to tell our members about what's going on in the broader health care arena," Goolsby says. "We're able to bring back information to other staff and our leaders and our members from those collaboratives. I think one of the main things is that we have a nurse practitioner presence there; they can see that we're active participants [and] we make a commitment to these particular partnerships."

Through these collaboratives, AANP representatives have the ability to constantly contribute, emphasizing the work ethic and expertise of the NP. Such contributions establish a presence that makes a positive impression on other organizations.

"When you're looking organization to organization, sometimes we're at odds over certain regulatory kinds of issues," Goolsby says. "So when we're at the table for something that's really a clinical or a broader-based initiative ... we all tend to be collegial in those types of partnerships."

Research and Development

Goolsby also notes AANP's breadth and scope of research ability that has connected the organization to partners at the highest level.

In particular, she notes that AANP maintains the only comprehensive

database of all nurse practitioners in the United States, and has done so since 1986.

Also, AANP's robust research program ensures that the organization knows where nurse practitioners are practicing and validates that the people in the database are truly nurse practitioners. As a result, AANP is often called upon as the top resource for information on the nurse practitioner workforce.

"It's also by virtue of the information we have about nurse practitioners that we're in high demand, because nobody has the quality of data that we have," Goolsby says.

McMurrey agrees. But they both emphasize the thrust of the organization is always to work in its members' best interest, regardless of the partnership. This can include serious research efforts to determine the best route for the organization, providing information to officials for their high-level hearings, and presentations and even testimony about the health and well-being of nurse practitioners around the country.

If anything, these partnership efforts - whether through protection and liability insurance, an employment boost from *CareerLink*, or the latest news and information from the daily *SmartBrief* - are all designed to improve the knowledge, understanding, and connection of nurse practitioners to the health care community as a whole.

Add the abundance of special partnerships in which AANP represents nurse practitioners to the rest of the health care community - participating in decision-making, management of issues surrounding health care in the 21st century and, frankly, representing the importance and the necessity of nurse practitioners everywhere - and they meet the needs of AANP members and also serve their partners as crucial components of the entire health care community.

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FOR LIFELONG LEARNING: AANP CONTINUING EDUCATION

By Barbara Stahura

Whether the subject is H1N1 inoculations for children, how to accurately read a chest X-ray, or dealing with post-infectious gastroparesis, the continuing education program offered by the American Academy of Nurse Practitioners has it covered. According to JoEllen Wynne, AANP associate director of education, the education department supports AANP in its three-part mission: to promote excellence in NP practice, education, and research; to shape the future of health care through advancing policy; and to build a positive image of the NP role as a leader in the national and global health care community.

Continuing education (CE) is an integral part of any sort of health care provider's role, including nurse practitioners. "NPs must maintain a high level of competency based on keeping abreast of new and current therapies," explains Wynne. "Excellence in NP practice is promoted by providing each individual NP with educational opportunities. In addition, as an organization providing that education, AANP promotes the positive reputation of nurse practitioners and their credibility, along with its own."

Even though the now-burgeoning business of CE was still in its infancy a quarter-century ago when AANP was created, the organization began offering accredited CE almost from the start, with presentations delivered at its first conference. At that time, CE was not even required for licensure in many states. Yet a major reason for offering it was that NPs wanted high-quality CE.

"NPs also wanted to hear from speakers who share their approach to patient-centered care, who are respectful to them as health care providers, and who really had NPs in mind for the target audience," says Wynne. "Some educational courses provided by physician-centric organizations often made NPs feel like second-class citizens. As a way to continue to promote excellence in practice and to encourage an NP-centric view, AANP began to develop its own programs for continuing education."

Continuing education specifically developed for and by NPs is vital. They provide services that include a mix of medicine and nursing, so CE offered for either one of those two disciplines alone often does not work for NPs, for several reasons. While NPs are able to prescribe medications and are responsible for patient outcomes, just as physicians are, their overall focus and approach is somewhat different. Furthermore, NPs who participate in CE provided by medical societies such as the American

Medical Association receive a "certificate of attendance" rather than a CE certificate. This kind of separate-but-equal arrangement, says Wynne, may not fulfill mandatory state requirements for ongoing education throughout their careers. Because NPs have those physician-level responsibilities, classes provided for other nurses who are not practicing as independent providers are not adequate or comprehensive enough for NPs. In contrast, classes offered or accredited by AANP are taught by NPs or by others who fully understand the responsibilities of NPs and so teach from that perspective.

A Continuing Education Accrediting Body

AANP has long been a continuing education accrediting body, which means that in addition to offering credits for the programs it develops and presents, AANP also serves as an approval authority for programs from other educational providers, ensuring that those programs meet AANP's high standards and are educationally sound, relevant to NP practice, and consistent with all AANP CE requirements. All CE offered through AANP must meet evidence-based standards, and all CE approved by AANP is universally accepted by all NP certifying and regulatory bodies. (Each state has its own requirements for CE among NPs, and may vary widely.)

As have other areas of education, AANP continuing education has changed and evolved greatly over the last two decades. AANP CE has become much more comprehensive, with a higher level of content, mostly out of necessity. NPs specialize in areas ranging from family practice to psychiatry and from neonatal health to gerontology, along



Conference attendees earn continuing education credits every year.

with many sub-specialties. Health care itself is expanding and becoming more complex almost daily, producing detailed information that NPs must learn and put to use. This information includes clinical advances, new pharmaceuticals, new treatment modalities, as well as how to run a practice, how to code for reimbursement, and how to understand Medicare laws. These are a fraction of the knowledge required by today's NPs.

Increasingly, a number of other industries and organizations in the medical, nursing, and pharmaceutical fields want to partner with AANP in its CE programs. Just as the provision of health care is collaborative, so is providing CE that supports this provision of care. AANP participates in multiple partnerships with multiple disciplines and includes programs with pharmacists, PAs (physician assistants), nurse practitioners, and physicians.

Whether it is an AANP-developed program or a program that receives accreditation by AANP, all conflict of interest must be resolved. Accredited CE operates on very clear standards regarding the role of pharmaceutical companies and other manufacturers in funding of programs. Both the increasing collaboration and the clearly defined standards have evolved greatly over the last 25 years.

Education in Many Forms

AANP delivers its CE in a variety of forms. Much of its CE in the early years took place at the annual conference, and a good deal still does. This large gathering offers courses on a wide variety of subjects, ranging from

Spanish for health care providers to hands-on workshops in critical care that are offered at levels appropriate for NPs all the way from the novice to the seasoned. In 2010, at the request of many members, AANP also began offering immersion workshops in sub-specialty areas at the advanced level. These run for 16 hours over a long weekend, and the initial response and evaluations have been extremely positive.

Another example of both format and partnership is the ongoing series of chronic obstructive pulmonary disease (COPD) programs presented across the country, developed in partnership with the American College of Chest Physicians. This is a series of 20 daylong, hands-on workshops that include NPs, pulmonologists, and family practice physicians as faculty. These provider groups were all instrumental in collectively developing a program that will educate primary care providers regardless of the discipline.

In 2007, AANP began offering CE through the online learning center on its Web site. Initiated with five programs, today the online portal offers more than 50; all are password-protected and most are available only to AANP members. Current titles range from "To Err is Human ... Steps to Safer Prescribing" to "Soy and Health" to "A Comprehensive Review of the 2009-2010 Recommendations for Seasonal and H1N1 Influenza Vaccination in Infants, Children, Adolescents, and Adults." The online learning center also offers the AANP Virtual Journal Club, which requires CE participants to read select articles from the peer-reviewed *Journal of the American Academy of Nurse*



Practitioners (JAANP) and then answer questions and complete the program evaluation before earning credit.

Online programs are a clear example of the evolution in the provision of continuing education for nurse practitioners. The programs currently available in the AANP CE Center include programs with multiple disciplines, with class activities ranging from reading a monograph and answering questions online to various interactive activities to watching videos or listening to podcasts. The online programs are developed by AANP, either alone or with an educational partner, and must be created or presented by an NP. An important resource for program development is the AANP pilot group. In late 2007 a group of NP members were recruited to review and provide feedback on programs prior to completion. These program suggestions are then incorporated in the final program prior to posting on the CE Center. The input of more than 1,000 NPs is vital to program development.

Class Creation and Funding

In 2006, AANP began sending an annual survey to members asking about their educational needs. The survey typically lists more than 300 potential topics, which members rank. This, in conjunction with the pilot group, truly makes AANP CE a member-driven process. The 15 topics heading the rankings are the primary focus for education funding and development. However, should a new, important topic arise - such as H1N1 - it will also be added to the program priority list.

CE programs come from various sources. As already mentioned, members of the AANP CE staff create some of the programs. In another instance, an AANP member who was completing her doctoral program created a

Continuing education developed specifically for and by NPs is essential because NPs provide services that bridge medicine and nursing.

final project, complete with extensive visual content, that teaches NPs how to interpret chest X-rays; she donated it to AANP. This program has been highly rated by learners. Other programs come from collaborations with organizations such as the Agency for Healthcare Research and Quality and from the American Pharmacists Association. Early in 2010 a request for proposals went out to AANP Fellows in the hope they would assist in creating CE programs.

Programs are developed based on needs assessments, which involve using the educational-needs survey, review of the literature, and often verifying the more detailed focus that members really want within a topic.

Wynne says one example of the detail focus is COPD. AANP members have consistently ranked this illness as a topic of significant interest in the educational needs survey. During program development planning, a targeted survey was sent to select AANP members to determine which specific areas within the broad category of COPD members want more information about. A list of related knowledge areas was provided, and members were asked to rank them by importance. "This level of information supports the need for education and specifies exactly what AANP members want," explains Wynne.

AANP has become very successful in obtaining funding for CE. For instance, AANP recently obtained a grant from a pharmaceutical company that will support the development of 10 educational modules on non-clinical topics, such as legal issues, practice management, and practice ethics, among others. Not all attempts to secure funding are successful. Oftentimes no commercial funding is available, or only a portion of the requested funds is approved.

Continuing education is mandatory for all NPs, although the number of hours per year or other time period varies among the 50 states and certification bodies. AANP understands how crucial it is to meet the requirements for licensure and certification. In addition, NPs know it is important to demonstrate the ability to provide high-quality care to the public.

"NPs are lifelong learners who consistently reach out and seek to gain as much knowledge as possible," says Wynne. "Because AANP members consistently rate continuing education as an important element of their membership, the AANP CE staff continually seeks opportunities to enhance the range of topics available to meet the needs of AANP's increasingly diverse membership."

AANP RESEARCH PROVES THE WORTH OF NURSE PRACTITIONERS

By Barbara Stahura

Since nurse practitioners were first given that title in 1965, they have had to stand up to their critics, some of whom claimed NPs were practicing medicine without adequate qualifications and others who believed they were nothing more than uppity nurses who didn't know their place in the medical hierarchy. Today, however, NPs are accepted as mainstream health care providers and, particularly in rural areas, are often the major providers.

One avenue by which nurse practitioners and their roles have become accepted and welcomed is through numerous research studies. This research has given NPs consistently high marks on their quality of care, the cost-effectiveness of that care, and patient satisfaction and acceptance. In its role as an advocate for nurse practitioners, the American Academy of Nurse Practitioners has conducted this kind of research since shortly after its creation in 1985. According to AANP Director of Research and Education Dr. Mary Jo Goolsby, the importance of having detailed information about nurse practitioners was recognized early on. AANP created the National NP Database in 1986 and still maintains it today, using it as a resource for large-scale surveys of NPs. A number of AANP departments are involved in the ongoing maintenance of this critical resource, including staff from the research, IT, and operations departments, among others.

"This is the only comprehensive database including the universe of all NPs recognized to practice in the U.S., with details on their clinical specialty, practice settings, and so on," she explains. "This is a very rich resource that has grown consistently over the years. It is a resource for policymakers and others for details regarding the NP workforce and it actually allows us to immediately reach out to the body of NPs if needed and to include them in research, for example."

Over time, AANP research has played a significant role in the ways the organization lives up to its three-part mission:

- to promote excellence in NP practice, education, and research;
- to shape the future of health care through advancing policy; and

- to build a positive image of the NP role as a leader in the national and global health care community.

Goolsby explains the role of the research department and resources, saying, "Clearly, the research conducted by AANP contributes to the first part of our mission because in addition to collecting the data, we encourage others to do research."

The research department has a number of other resources available to promote high quality research by others. The datasets from prior AANP research projects are available to qualified researchers for secondary analysis. For instance, a number of variables from a study including over 16,000 participants was shared with a health economics doctoral student. There is also a process through which researchers can apply to survey AANP members either by disseminating survey invitations by mail or to attendees of AANP's national conference. Other resources are provided through the mentorship program of the Fellows of the American Academy of Nurse Practitioners and the grant program of the associated AANP Foundation.

Goolsby explains how the AANP data is available to help describe what NPs are doing and how they've contributed to their communities over time, providing a solid foundation to support and promote a positive image of nurse practitioners. "Regarding our second mission, we have data that can be used in talking to legislators and policymakers and helping them understand our role," according to Goolsby. "We're able to give very solid and specific statistics and show trends and consistencies over time so they're able to understand what a nurse practitioner contributes." This information is critical to



support the work of AANP health policy staff, as well as volunteer leaders such as AANP's state representatives.

Why Conduct Research on NPs?

AANP research on NPs has revealed some significant facts. For instance, says Goolsby, a major finding is that just as 20 to 21 percent of the population lives in rural areas, 20 to 21 percent of nurse practitioners practice in rural areas, in contrast to other disciplines with smaller percentages serving these underserved areas. Another trend demonstrated over the past 25 years is that malpractice rates have remained very low for nurse practitioners, a finding that supports the high quality and safe care provided by NPs, regardless of setting.

A critical item borne out by AANP research will become even more significant if health care reform occurs during this time when fewer physicians are becoming primary care providers. In February 2008, the Government Accountability Office (GAO) produced a document titled "Primary Care Professionals: Recent Supply Trends, Projections, and Valuations of Services" (available at www.gao.gov/new.items/d08472t.pdf). The opening section states: "Health professional workforce projections that are mostly silent on the future supply of and demand for

primary care services are symptomatic of an ongoing decline in the nation's financial support for primary care medicine. Ample research in recent years concludes that the nation's over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient. At the same time, research shows that preventive care, care coordination for the chronically ill, and continuity of care - all hallmarks of primary care medicine - can achieve improved outcomes and cost savings."

The GAO included data from AANP in this document because AANP was prepared with the necessary information. "They really do scrutinize your data," says Goolsby. "You have to show them how it's collected and the reliability." The data used in this report to Congress identified that the numbers and percentages of NPs in primary care per capita are steadily increasing, compared to the number and percentages of primary care physicians and physician assistants, which are either decreasing or stagnant. With health care reform, presumably huge numbers of people who currently do not have medical insurance will suddenly be added to the rolls. With more patients needing to be seen and nurse practitioners becoming more visible, Goolsby believes that nurse practitioner services will become more in demand. There are already too few primary care givers, and this is going to potentially become a greater issue. Recently, the

AANP issued a statement on the role of NPs in health care reform, which recommended that, "Health care reform in this country include the recognition and utilization of NPs as primary care providers."

AANP research also shows that nurse practitioners spend an average time of 20 to 21 minutes with a patient, which Goolsby says is longer than physicians and physician assistants spend and which can lead to improved outcomes – a healthy development for any practice.

Practice-based Research

In addition to research about nurse practitioners themselves, AANP is beginning to conduct practice-based research through its American Academy of Nurse Practitioners Network for Research (AANPNR). Created in 2002 and directed by Goolsby, it is the first and only national nurse practitioner-specific practice-based research network (PBRN). All AANP members are eligible to join and to participate in projects that will engage them in "reflective inquiries about practice, and produce scientific information that is externally valid and easily assimilated into practice," according to the AANPNR call for membership.

As formally stated in the call for membership, the purpose of the PBRN is "to encourage and facilitate creative, investigator-initiated research designed to increase understanding of primary care practice." It has four long-term goals: to conduct practice-based research relevant to NPs and their patients; to facilitate translation of research to practice; to improve the practice of primary care by NPs; and to improve the health of primary care patients.

This network came out of AANP's desire to promote practical research, says Goolsby, in which its members – most of whom are primary care providers – could demonstrate their outcomes. Because nurse practitioners are busy health care providers and may not feel confident to conduct projects alone, an intent of the PBRN is to pull members together to collaborate and to provide them with necessary resources to achieve project goals more readily.

PBRN projects are usually designed to be practical tests in clinical settings. While large, randomized clinical trials that test drugs, for instance, involve being able to control what the subjects do, in order to minimize the variables, this kind of control is not often possible with or does not relate to patients in an NP's practice. With practice-based research, NPs can apply information learned through a large randomized trial and then implement their own studies with a panel of patients who may have different living circumstances or resources in order to determine how practical it is. It has taken some time to get this PBRN up and running, according to Goolsby, as they have focused on projects designed to develop the descriptions of thousands of NP primary care patients required to set the

stage. This descriptive research has included understanding the types of patients seen by nurse practitioners, who is funding their care, and why they seek care from NPs. The goal is that with these data gathered, the PBRN members can move toward outcome projects, which was the vision in creating the PBRN to begin with. Goolsby also believes that as more nurse practitioners earn the doctor of nursing practice degree (a practice-based rather than research-based doctorate), they will increasingly want to participate in AANPNR projects over time.

Partnering for Research

AANP sometimes conducts research in partnership or in association with other organizations. A few years ago, it participated in the National Diabetes Education Program (NDEP) sponsored by the National Institutes of Health (NIH) and the Centers for Disease Control (CDC) to conduct a survey to learn how nurse practitioners educate their patients about diabetes, the types of diabetes, and issues related to the disease that they are seeing in their practices.

AANP also partnered in a study recently with the Institute for Nursing Centers (INC). INC members are nurse-managed programs and health care clinics and systems run mostly by NPs. This recent collaborative study compared these nursing centers, which are strong NP models often affiliated with an academic health center, with small one- and two-person NP practices. The idea is to discover the similarities and differences between the two kinds of operations. The results are not yet compiled. Goolsby says AANP has plans with INC for future studies of practice-based research, for which the two groups will collaborate and share resources.

At times, AANP will partner with a pharmaceutical company for a research project. However, explains Goolsby, "We maintain control of the survey. We have control over the final decision on the questions, and we're the ones who analyze the data and draft the report." These studies have identified details on how NPs make decisions regarding antibiotic selection for adult and pediatric patients, as well as how they approach patients with common conditions such as sleep disorders.

The view of nurse practitioners held by the public and the rest of the health care community has evolved in an increasingly positive direction over the last 45 years, thanks in large part to the research done by AANP. Goolsby sees a positive future for NPs and for the AANP research program, with the focus being on applying recommendations in a nurse practitioner practice and identifying the outcomes. AANP will also continue to collect data on patient satisfaction with nurse practitioners as an outcome. She says, "It is vital to the profession to be able to demonstrate over time that the quality of our care remains really good."

AANP'S INTERNATIONAL FOCUS

By Vera Marie Badertscher

"We learned from the experiences of Madrean Schober, Loretta Ford, and Rosemary Good-year ... that we are not alone fighting the battle for APN/NP development!" says Alice Tso of Hong Kong.

Tso's experience in Hong Kong shows that despite different cultures and different governmental structures, nurse practitioners/advanced practice nurses around the world have much in common and much to share. "I am happy to network with APN/NP overseas other than nurses in China and Hong Kong for the benefit of advancing APN practice here locally," she says.

Retired after 40 years of nursing, teaching, and supervising, Tso served as the chair of the Policy/Standards/Regulations Subgroup of the International Council of Nurses-International Nurse Practitioner/Advanced Practice Nurse Network (ICN-INP/APNN) for six years. She now consults on health business in China.

From its beginning 25 years ago, the American Academy of Nurse Practitioners had a strategic plan to work with other countries to strengthen the role of the nurse

explains, "INP/APNN is a voluntary network and participation is free to anyone practicing in, or interested in, nurse practitioner or advanced practice roles as well as interested others such as policy makers, regulators, and health planners. If an individual is a member of a national nursing association belonging to ICN you can indicate that relationship on the membership form. It is not necessary to belong to any professional organization to become a member of INP/APN Network."

Members of subgroups post papers on their subjects: Education, Practices Issues, Health Policy, and Research. The Communications subgroup posts newsletters, press releases, and announcements. Additionally, a Bulletin Board does what the Internet does best, and allows individuals to form a community where they can ask and answer questions and provide support to others.

At www.icn-apnetwork.org, an NP or APN can learn about the progress in other countries, see studies being done to determine the state of NPs around the world, and learn about conferences they may want to attend.

practitioner, but the formal APN/NP network was created just 10 years ago. The birth of the Internet made worldwide communications much easier, and the INP/APNN takes full advantage of the Internet. Although conferences and meetings remain an important part of the international network, someone who cannot travel can stay in touch and up to date by going to the Web page. At www.icn-apnetwork.org, an NP or APN can learn about the progress in other countries, see studies being done to determine the state of NPs around the world, and learn about conferences they may want to attend.

If a member has a question about a specific area, the heads of subcommittees are listed, and by clicking on their pictures, anyone can ask a question of a specific person. Another page explains membership, and the application form can be filled out on the Web site. Similarly, one may volunteer as a resource person. As the site

The innovation with the very long name (ICN-INP/APNN) emerged one fortuitous link at a time as individual nurses connected and communicated. For instance, Madrean Schober, who is now the international relations liaison, had organized an AANP project called the Asthma Training Program. One of the new NPs in the United Kingdom happened to be a respiratory nurse. Sue Cross, from Britain, and Schober, from the United States, worked together to provide the educational program to AANP. That collaboration helped start conversations about starting an international network.

In an e-mail, Judith Dempster, first CEO/executive director of AANP, recalled the network's first steps.

"Opportunities began emerging in the early 1990s with the development of the nurse practitioner role in the U.K. In 1992, some NPs from the U.K., who were presenting at an NP conference in Colorado, met with representatives of AANP and the University of Colorado. The outcome was



Chin Yee, one of Madrean Schober's nurse practitioner students in Hong Kong, converses with a patient. As AANP's international relations liaison, Schober works to advance NP and APN practice around the world through teaching, consulting, and curriculum development.

an agreement to work together to share common interests to benefit development of the NP role internationally. A steering committee emerged over the next few years that Madrean [Schober] chaired and I was actively involved in, and ultimately the INP/APN Network [International Nurse Practitioner and Advanced Practice Nurse Network] was created to be housed under the ICN [International Council of Nurses, headquartered in Geneva]. AANP was integral in all aspects of the creation of the network and has hosted their Web site since it was launched and became operational in 2000."

The purposes of the network are listed on the Web site:

- > To serve as a forum for exchange of knowledge;
- > To serve as a resource base for the development of advanced practice/nurse practitioner roles and the appropriate educational underpinning;
- > To serve as a vehicle for ICN to harness specialist expertise;
- > To help ICN more effectively meet its mandate as the global voice of the profession;
- > To provide a mechanism to promote and disseminate information from any of the network members and ICN; and
- > To act as the base for future international collaboration around advanced practice and the nurse practitioner role, including international conferences beyond 2000.

Originally consisting of Great Britain, the United States, and Australia, the network has grown to include about 70 countries.

Schober, the founding chair of the INP/APN Network and AANP's international relations liaison since the role was formalized in 2000, works as an international consultant to governments, NGOs, and health and educational institutions. She currently teaches and develops APN curricula at the National University of Singapore.

"I was used to being exposed to the world as my husband was an internationally known mathematician," Schober says, adding, "My current life partner - my husband died 19 years ago - is also an international consultant and we thrive on the international life." Being exposed to other cultures, she was appalled at how little NPs were aware of the rest of the world, "... thus began my quest to provide an opportunity [for] international opportunities to AANP NPs to travel to international conferences and to access more information re: global health."

Many of her early concerns are now being addressed by AANP. Schober says, "The San Diego conference launching the network was hosted and funded by AANP. AANP is usually represented at network international conferences. The organization from the beginning of the network and up to the present day provides the server and related tech service free of charge for the network Web site." She adds, "The organization has periodically supported humanitarian healthcare missions and provided information for NPs interested in these activities."

One of the challenges facing nurse practitioners from the United States is to realize how different another country's concepts may be.

For instance, Tso explains that in Hong Kong, a former British colony, "we inherited the culture of 'medical dominance' ... people of HK, the doctors and even nurses themselves were skeptical on the capabilities of APN/NP and their competencies when the subject was first brought to public attention before 1997. ... We faced indifference and even resistance from the policy makers who kept asking us, 'Are you nurses really ready?'"

This despite the fact there were already 1,500 APN/NPs in Hong Kong working mostly within hospitals and institutional settings. That is why it is so important to the advanced practice nurses/nurse practitioners of Hong Kong to be reassured by support from fellow nurses within the APN Network.

In the Netherlands, Schober says, "roles developed first because of shortages of doctors to staff hospital units ... but due to needs in chronic illness is moving to primary care."

Petrie F. Roodbol, director of the Educational Institute of the University Hospital of Groningen in the Netherlands, is also a professor of nursing and a member of the board of the nursing professional organization. She introduced the use of NPs in her hospital in 1997 by inviting Phyllis Zimmer, then-chair of ACNP, to speak.

Roodbol writes in an e-mail that although there was a lot of interest in NP practice from nurses and from physicians, "Of course we met some resistance as well. But many physicians knew the function from visits in the U.S. Not every nurse adopted the function immediately, however, they accepted it."

After NPs were introduced in the hospital, interest in the nurse practitioner role grew. "On our request, the university of applied science near our hospital developed a master study ANP. And eight other universities followed in the next years. The government still gives funding for 250 students each year," Roodbol notes.

Roodbol spoke at the San Diego meeting in 2000, and because the Netherlands had such an enormous waiting list to see physicians, she called her talk "Nurse Practitioner in the Netherlands; a Boy Who Puts His Finger into the Dike."

Roodbol stresses the importance of the network's Web site. "Without a Web site we do not exist. ... We connect nurse practitioners so they can share information." Echoing Tso, Roodbol says, "Because I started the nurse practitioners more or less as an individual, I needed support. I received this from the network; for me it was very important." Roodbol now serves as chair of the ICN-INP/APN Network.

Schober and Fadwa Affara wrote the only book thus far that has studied nurse practitioners and advanced practice nursing roles on a global scale, *Advanced Nursing Practice*. They found that problems include poor role clarification, differing educational requirements, scope

of practice conflicts, and variability in standards and quality of education. Even the terminology differs from country to country. A 2008 survey conducted by the ICN-INP/APNN identified that among 18 countries, 14 different titles existed for the APN role. Majority (75 percent) had formal recognition of the APN role, 58 percent had formal APN education programs, and 52 percent had licensure requirements, showcasing developing acknowledgement of the APN as an official advanced role for nursing practice.

No one understands the need for international understanding and cooperation more than Schober, who consults on health care and has taught in universities in Pakistan, Hong Kong, and currently in Singapore. Schober says of her international lifestyle, "I am frequently amazed at how much I continue to grow and learn about people as well as my idiosyncratic behaviors/lifestyle and myself."

She said, in a recent talk, that creation of her personal Web site with the help of her brother, an artist, made her focus on career development, much of which was accidental. "Events pulled and pushed me in directions that supported my fascination with the complexities of world events. Only incrementally did a mindset that originated in a small rural community develop into a global view."

She now also helps nurse practitioners and students who want to work outside the United States and answers queries from people from other countries who want to study in the United States as well as making sure the content on the network Web site stays fresh.

So what does Schober want new nurse practitioner members of AANP to know about international work? Because Americans are known for jumping in and taking charge, she hopes that they will first take time to learn about other ways of doing things and develop sensitivity.

She suggests three steps:

1. Access the ICN INP/APN Network Web site www.icn-apnetwork.org to become acquainted with the international NP/APN context.
2. Attend one of the international APN/NP conferences – the next one is in Brisbane, Australia, in September. It provides a good opportunity to present papers and network with the international community.
3. Develop strategies to become a sensitive ambassador of NPs in the United States. Imposing the U.S. version is not so popular even though many initiatives are patterned after some of our models.

And she would like everyone in AANP to be proud.

"Members need to know and be proud of AANP's consistent involvement in international activities," she says.

ENHANCE AND ADVANCE

The AANP Foundation: Funding the Development of Nurse Practitioners

By Jan Tegler

Just about halfway through the quarter-century history of the American Academy of Nurse Practitioners, AANP realized that it could do more to advocate on behalf of nurse practitioners. In addition to providing a national network for NPs of all specialties, the leaders of AANP wanted to materially support members in their pursuit of AANP's goals - education, research, and practice improvement.

Thus, in 1998, the AANP Foundation was formed as an adjunct to AANP with a philanthropic mission. It would be the organization's goal to provide financial support to AANP members seeking to improve themselves or their practice. Dr. Kay Todd, the Foundation's current executive director, describes the organization as a resource for AANP members.

"We're celebrating our 12th year as a member benefit for AANP members," Todd explains. "We were created to provide scholarships and grants so that more people might be able to afford to go to school to become NPs and enhance the field. The grants we give can be for practicing NPs or for NPs doing their dissertation. That's the focus of our efforts. We only give money to AANP nurse practitioner members. That's a benefit to belonging to AANP."

Appointed this past January, Todd is just the second executive director. Her predecessor, Dr. Judith Dempster, served both as CEO of AANP and executive director of the Foundation and left an impressive legacy, increasing the Foundation's financial awards to NP members substantially over her tenure.

"In 1998 there were five awards for \$5,000," Todd notes. "In 2009, we gave 41 awards for scholarships totaling \$110,000. Our biggest year for scholarships was 2008, when we gave out \$124,500. In total, over the 12 years of our existence, we've given out \$659,650, including 252 scholarships and 109 grants. Our goal is to expand on that number and give out more."

Providing increased financial support for NPs via scholarships and research grants is not only a vital mission for

the Foundation, says Todd, but more broadly meaningful as the importance of nurse practitioners to the national health care system has grown since the inception of the field in 1965.

"There's a very high regard for NPs and the health care they provide," the executive director maintains. "That regard continues to grow, particularly due to the variability of health care plans and the shortage of doctors. There are fewer and fewer physicians outside of cities. NPs are a critical part of the national health care system."

To build on Foundation support distributed in 2009, the organization will have to surpass the number of scholarships and research grants it offered during the year. Twenty-eight scholarships were offered in three categories: Master of Science in Nursing-Nurse Practitioner (MSN-NP), post-MSN-NP, and Doctoral-NP. A total of 14 research grants were available in four grant categories including Practicing NP Project, Practicing NP Research, Student NP Project, and Student NP Research.

In 2009, scholarships the Foundation funded ranged from student scholarships in pediatric and family medicine to post-MS-NP scholarships focused on mental health and foreign service. Examples of grants for research included awards for projects involving women's heart health, chronic obstructive pulmonary disease (COPD), NP mentoring, and nutrition.

Support for practice improvement through research is just as important as educating students to become NPs, says Todd. As she indicates, the Foundation's support for research projects that advance the field is diverse.





The AANP Foundation Store, set up at the AANP National Conference, is one of the ways the AANP Foundation raises funds.

"Research that we fund could include a dissertation that someone who's a practicing NP may be writing. Some unique, innovative projects have been comic books that might be very simple and visual in languages that help people understand better certain aspects of their health care. NP researchers might be doing a pilot study on a mobile van to go out and offer some health care screening or other projects. These are the kind of projects we've been looking at funding for our members, either students or practicing NPs."

Funding for scholarships and grants is currently raised via donations from private individuals, individual AANP members, and corporate AANP members. A portion of the AANP dues paid by corporate members support scholarships, but further contributions through the Foundation's Nurse Practitioner Corporate Partner Council (NPCPC) are especially important, according to Todd.

Four tiered membership categories - benefactors, patrons, supporters, and contributors - allow corporations and organizations to offer financial support at different levels. Participants currently include well-known corporations such as Boehringer Ingelheim Pharmaceuticals, Lilly, Novartis, and Proctor & Gamble.

"The Nurse Practitioner Corporate Partner Council came under the purview of the Foundation in 2006, and it has really helped the program to grow," Todd makes clear. She explains that corporate members receive a number of significant benefits including enhanced exposure at AANP's annual national conference.

"If they're a member of our corporate council there are points which we award them," she explains.

"These are tallied with other activities they've done to earn points through AANP. Among many things, it gives them the benefit of exhibit space choice at the AANP conference and aids them in other ways when they're looking to be an exhibitor at the conference. The exposure they get to our 28,000 members is beneficial for both the corporations and our membership. We've concentrated on raising money to this point from sponsorships at the conference and NPCPC memberships."

Increasing Foundation funding going forward will be a new challenge, but it's one the organization's new director is equal to. Todd has more than 20 years of experience in not-for-profit management, including leadership positions with the American Lung Association, the American Association of Petroleum Geologists, and the Oklahoma Thoracic Society. Moreover, she has been a consultant to more than 40 not-for-profit organizations.

Corporate partners will, as in the past, be sought out for funding, but, according to Todd, a creative new array of funding initiatives will be rolled out as well. "We're going to look at where we can go for grants for NP research. Can we look to different large foundations like the Robert Wood Johnson Foundation, NIH, or CDC? We may look to them to help us fund some of the research we want to do. We think we have an audience for grant funding that these foundations have not really accessed yet.

"We're also going to implement major gifts from individuals," she continues. "They might be current members who want to see NPs making more of a difference in the

Funds raised through AANP Foundation efforts are used to provide financial support to AANP members striving to improve themselves (through education or research) or their practice.

health care sector. We're looking at planned giving as well, searching for people who might put us in their bequests. In addition, we're evaluating the institution of an endowment fund. All of those things are on the table to diversify our fundraising."

Co-located with AANP at its National Administrative Office in Austin, Texas, the Foundation coordinates closely with AANP, working in conjunction with AANP divisions such as its research department.

"We do get involved in some joint projects with them," Todd affirms. "They might develop a research project that they want to do and we might join them in going to potential funders talking about the technical aspects of that research and how the Foundation works as a recipient of that funding and then funds the research."

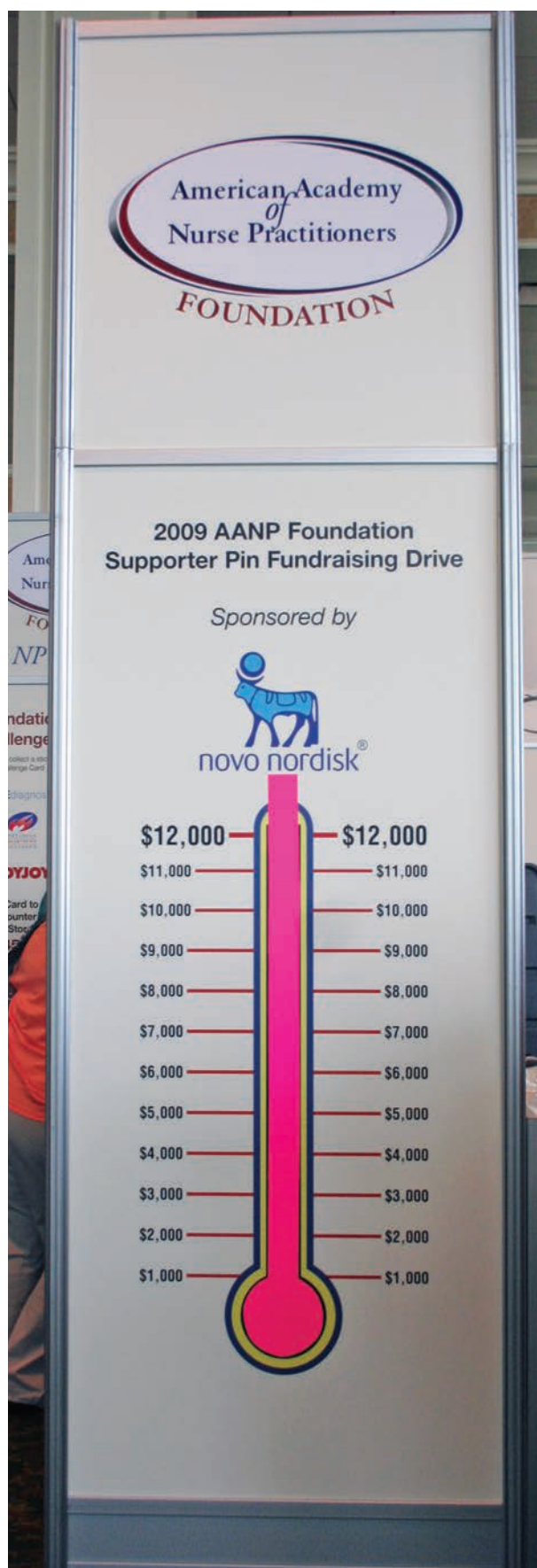
That coordination is helping the executive director put processes in place to develop a new strategic plan for the Foundation.

"We've started work on a strategic plan that is broken into four areas. The first is to advance NP education and support research funding. That's what we've been doing and what we want to grow and expand in new ways. We also want to support innovative NP practice, helping people do new things in their practice to serve the client. That may be as unique as an idea that an individual NP has who's out there practicing. Maybe they see a new opportunity for improvement and submit that to us for funding a study?"

The Foundation is also evaluating means to promote its humanitarian initiative. "In that regard we would offer opportunities for NPs to be involved in efforts like relief in Haiti for instance," Todd says. "Humanitarian efforts could include disaster relief or outreach in rural areas and inner city areas."

Though still relatively new to the AANP Foundation, Todd well understands that NPs are a key factor in the current and future quality of public health. She looks forward to leading the Foundation in the coming years to promote the role of nurse practitioners.

"There's a great depth of medical knowledge in NPs as with physicians, but there's also the nursing side of it. NPs have a closer relationship with patients often, understanding where they're coming from a bit better perhaps than physicians who are not trained the same way. It's a much more intimate relationship. It's my personal goal that every American know and appreciate the unique value of NPs."



CERTIFICATION

AANPCP: Ensuring Nurse Practitioner Competency

By Eric Tegler

Health care professionalism demands standards. We expect our health care providers to meet minimum benchmarks of proficiency and to maintain their skills as they practice. The growth in demand for and the supply of nurse practitioners has made guaranteeing uniform levels of basic competency more important than ever. Ensuring that nurse practitioners meet a well-defined professional threshold is what the American Academy of Nurse Practitioners Certification Program (AANPCP) does year in, year out.

"The public health benefit of the certification program is that it gives the public a psychometrically sound and legally defensible way to identify individuals as competent to practice as entry-level nurse practitioners," Richard Meadows, AANPCP executive director and nurse practitioner, affirms.

AANPCP identifies NP competency by testing for it, specifically by giving examinations reflective of nurse practitioner clinical knowledge and expertise in three population foci: family, adult, and gerontologic nurse practitioner. Candidates who successfully pass the examination become certified and are qualified to use the initials NP-C to indicate their certification status. As importantly, they are able to practice in U.S. states and territories that require national certification for licensing. Similarly, NP certification is required to practice in and bill to the federal sector. AANPCP is recognized in all 50 states and the District of Columbia, as well as by Medicare, Medicaid, the Department of Veterans Affairs, and private insurance companies.

Nurse practitioner is a title that encompasses specific areas of advanced practice nursing, recognizing nurses who have additional medical and advanced nursing preparation that expands their role beyond that of a registered nurse. It originally started back in the 1960s when programs for registered nurses were developed to fill a need for increased primary care services left in part by a shortage of physicians. The term nurse practitioner evolved from a number of different nomenclatures: child health associate, nurse clinician, etc. NPs practice autonomously in areas as diverse as family practice, pediatrics, adult, geriatrics, and women's health. They diagnose and treat



patients with undifferentiated symptoms as well as those with established diagnoses. NP care stresses health promotion, disease prevention, health education, and counseling, as well as clinical diagnosis and the management of acute and chronic disease.

The American Academy of Nurse Practitioners Certification Program is not a part of AANP. Incorporated separately, it is affiliated with AANP, but membership in that organization is not a requirement for certification. However, AANP does give AANPCP candidates a significant break on application fees, which is recognized as a significant membership benefit for AANP members.

AANPCP certification is offered to graduates of approved master's, post-master's, and doctoral level family, adult, and gerontologic nurse practitioner programs.

The certification program was founded by AANP under the direction of Dr. Jan Towers, current AANP director of health policy, in the late 1980s. Towers has served as a health policy consultant for multiple government and private programs and agencies,

including the national advisory committee for primary care initiatives grants sponsored by the Robert Wood Johnson Foundation and the Joint Commission on Accreditation of Healthcare Organizations, and was a National Commission for Certifying Agencies (NCCA) commissioner for six years. The author of numerous publications related to nurse practitioner practice, she headed AANPCP until April 2009 and was instrumental in crafting certification standards for the organization.

Towers helped to craft guidelines for the National Task Force for Quality Nurse Practitioner Education, Meadows explains. "Those guidelines have been endorsed and adopted by the nursing accreditation agencies. They are the criteria that those organizations use to accredit graduate-level programs that produce nurse practitioners."

The certification examinations are co-developed by the Professional Examination Service (PES) and AANPCP. Meadows explains that a minimum of four individuals per exam type (FNP/ANP/GNP) work on construction of the tests. So, 12 AANPCP certificants work on putting together the exams. All are practicing NPs. In addition, panels of content experts from representative work and academic environments and geographical areas assist in all phases of the development of the examinations.

Major components of the exam development process include role delineation, test specifications, test construction, and passing point determination. The certification examinations are specific to each role area (FNP, etc.) and each consists of 150 multiple choice items that include 15 pretest questions that are not counted toward an individual's score. The pretest questions, Meadows says, are sample questions included for evaluation purposes to see if they are appropriate for inclusion on future examinations. All items that appear on the examinations have been reviewed at least four times for each test construction.

Each examination administration is different, including a distinct combination of items from the item bank. Passing point determination hinges on test construction, and minimum passing scores are established using the credentialing industry-standard modified Angoff method. The rigor of the entire development and administering process is intended to ensure quality competency-based certification examinations.

The certification program application and test reporting processes have recently experienced some streamlining in order to accommodate candidates and expedite reporting of examination results. According to AANPCP's director, applications are processed as soon as the day after they are submitted. As of January 2010, NPs can apply for the examination online and provide all the necessary documentation except for the official transcript from their degree-conferring institution.

"We require a hard copy of a university or college transcript because we have to be able to verify the source



of that information," Meadows confirms. "AANPCP gives the states a guarantee that we actually see the document from the university."

Given a complete application, which includes an official final transcript showing the degree or certificate conferred, test results are e-mailed to candidates approximately one week after the examination and a hard copy certificate is sent within two weeks. Prior to that, each candidate is given a preliminary pass or fail response at the testing center so success is generally evident right away.

The need to maintain competency is recognized and reinforced by AANPCP's certification renewal program. NP recertification is required every five years, a process AANPCP strives to make efficient and flexible, Meadows maintains.

AANP requires at least 1,000 hours of clinical experience in five years, and 75 hours of continuing education credit. The 1,000-hour minimum requirement is sufficient for faculty who teach NPs full-time and thus have limited clinical practice opportunity to qualify for re-certification based on clinical practice and continuing education. Full-time NPs typically accumulate 10,400 hours of clinical experience in a five-year period.

Feedback on the certification program comes largely from analysis of examinations and test items in particular. The fact that the tests are based on role delineation studies sometimes referred to as task analysis and that those who develop and construct the certification tests are practicing NPs means that they change over time as medical science, practice, and process change. The finer technical aspects of various testing domains are regularly updated and items touching on contemporary clinical developments are included, Meadows says.

The AANPCP is fully accredited by the NCCA, the gold standard for accrediting certifying programs in the United States.

THE VOICE OF EXPERIENCE

Fellows of AANP Help Educate and Develop

By David A. Brown

Knowledge is power, but knowledge shared empowers many. Upon this premise, the Fellows of the American Academy of Nurse Practitioners (FAANP) have built a firm foundation from which to benefit those who follow in their footsteps, bolster their career field, and assist myriad groups with links to, or interests in, the health care field.

Founded in 2000, FAANP recognizes nurse practitioner leaders who have made outstanding contributions to health care through NP clinical practice, research, education, or health policy work. Held in their profession's highest regard, Fellows of the AANP stand committed to the global advancement of high quality health care delivered by nurse practitioners. To this end, they invest great thought and effort into grooming imaginative and creative nurse practitioner leaders of tomorrow, while developing strategies to enhance their roles in the health care industry.

FAANP candidates must be members of AANP and sponsored by two current Fellows. Those considered for selection must show evidence of their contributions and leadership in at least two of the four areas: Candidates are scrutinized based on the significance and scope of influence of their efforts; their continuing commitment and leadership in NP clinical practice, research, education, and/or health policy; and their potential for contributing to the AANP mission and to FAANP initiatives.

The application process begins each fall and new Fellows are inducted each June at the AANP National Conference. New inductees have been announced in the *Journal of the American Academy of Nurse Practitioners*, FAANP Web site, and from hereon will be announced in *FellowsGram*, the quarterly newsletter of the FAANP, as well as AANP publications.

FAANP Chair Dr. Judith Berg was inducted as a Fellow in 2003. Retired from an associate professor post at the University of Arizona, Berg now provides consulting services for the health care industry. She says the strict requirements for FAANP acceptance ensure that those recognized are truly the *crème de la crème*.

"Clearly, being selected as a Fellow of the AANP signifies an individual who has made stellar contributions at local, national, and international levels," Berg says.

"Our founding members in 2000 were visionary leaders in the NP field and each class that has been inducted has lived up to that standard."

Pass It On

In the animal kingdom, creatures of fur, fin, and feather operate largely on instinct – survival skills imprinted in one's DNA. Humans, depending more on cognitive development, rely on learning, training, and abilities borne of experience. Ideally, those with knowledge help those seeking it, and this is the essence of the FAANP Mentoring program.

Established in 2006, this program pairs a nurse practitioner with a Fellow mentor whose background best fits the mentee's career course. The yearlong term creates a relationship that's part teaching, part counseling, and 100 percent focused on helping the mentee maximize their potential as a nurse practitioner.

"A big part of our mission is to mentor, nurture, and prepare the leaders of the future," Berg says. "The collective wisdom and the pool of knowledge among the Fellows are unbelievable. We want to share [these resources] and prepare our young nurse practitioners to replace us."

The mentor-mentee relationship varies case by case, however, common threads exist. During an FAANP think tank in 2006, the Fellows identified mentoring needs that typically arise for three groups of nurse practitioners:

Students: adapting to the student role; functioning in the clinical role; developing professional skills, such as creating poster and podium presentations; managing information overload; juggling student and family/personal responsibilities; and reducing stress and preventing burnout.

New Graduates: time management and productivity; managing caseloads of patients; developing clinical





Alvita Nathaniel receives her AANP Fellows induction plaque from Dr. Nick Burnett.

skills; expanding professional skills at writing abstracts for poster or podium presentations at professional meetings; disseminating knowledge by publishing in professional journals; overcoming fear and anxiety; dealing with isolation; grasping the business aspect of practice; and balancing clinical practice with personal responsibilities.

Seasoned Professional: network for communication; dealing with burnout; desire for further self-development (education, research, publishing); need for change; keeping up skills; and need to be a mentor.

Although not every Fellow will necessarily participate in the FAANP Mentoring program, all readily share their knowledge and experience with those who seek it. Berg, for example, has not officially mentored an NP within the Fellows Mentorship Program but has served in a mentoring capacity for many master's and doctoral students. She also delivers frequent lectures to AANP members on various professional skills such as making a 10-minute podium presentation, preparing an effective poster presentation, and learning to write an abstract that will be accepted for presentation at a professional meeting.

Success Story

Like sun and water to a vineyard, the FAANP Mentoring program expands AANP's vine of professional knowledge and ability. Each time one career bolsters and benefits another, the tendrils of improvement grow farther into the nurse practitioner field. Appropriately so, the fruit of this vine is better service for those who depend on nurse practitioners for their health care.

Exemplifying the potential impact a successful mentorship can have on a nurse practitioner's career, AANP Pennsylvania state representative Sue Schrand recalls accomplishing one of her career objectives as a result of her July 2006-June 2007 mentorship with AANP Director of Health Policy Dr. Jan Towers. A founding member of AANP, Towers has spent several years in

Washington, D.C., diligently working to advance the role of the nurse practitioner. Her insightful perspective proved instrumental in helping Schrand achieve the growth she sought.

"Although I had been an NP for a number of years [prior to the mentorship], I had no experience in health policy and legislative issues," Schrand says. "My goal was to become more politically active in my profession, to learn more about legislation, policy, and to ultimately become

a nurse educator. Having the opportunity to partner with one of the pioneers of our profession to learn the ropes was invaluable."

Building on the lessons of her mentorship, Schrand served two terms as her state's AANP representative and will begin her third term in June 2010. Her professional growth has included the role of executive director for the Pennsylvania Coalition of Nurse Practitioners. Both positions have given Schrand the opportunity to make a difference in her career field.

"I think my experience working with Dr. Towers has shown me the power of impacting professional practice through policy," Schrand says. "This program positively impacts our profession in so many ways. I love that it is not just for a new graduate - rather, it is for both novice and seasoned [NPs] who want to take on a project that will help them grow professionally. It is also an excellent networking opportunity. I met other people in the program from around the country, doing a variety of projects."

Towers says a successful mentorship can deliver dual rewards. "You never stop learning, even as you're mentoring. As [mentor and mentee] work on things together, there's always the potential for growth for both individuals."

Schrand's advice to other NPs entering a mentorship: "Take risks and really challenge yourself to grow. Be open in your communication with your mentor, and let them know what areas you need support in; but also be open to their analysis and feedback of how to meet your goals."

Mechanics of Mentorship

As with any productive relationship, the structure and dynamics of an FAANP mentorship weigh heavily on its outcome. Mentors, Towers says, must know when to lead, when to advise, and when to simply provide support for their mentee's development.

"An effective mentor has to be willing to listen and help the individual grow at their own speed, but with guidance," she says.

Berg adds, "An effective mentor is one who has a lot of wisdom and expertise but who will also take the time to groom their mentee and allow them to fly and become independent. There are ways to educate and foster development that do not require an individual to be totally dependent. You provide a system of principles and then let them operate on their own."

Flexibility is important, especially in sectors of the industry given to perpetual motion. Schrand saw this firsthand during her mentorship with Towers.

"Health policy is always evolving so you learn based on what is happening in the world at that particular time," Towers says.

For any mentorship to yield positive results, the mentee's commitment must include clear communication with the mentor and a clear plan of what they wish to accomplish. Written agendas detailing prioritized objectives, timelines, and measurement goals are essential.

"The mentor-mentee relationship becomes more than a talking head giving information," Berg says. "It fosters development and growth in whatever area an individual wants to [pursue]."

The pillars of this process are deadlines. Mentorships, Berg says, need schedules with intervals that produce predetermined goals. Following such a road map greatly increases the mentee's likelihood of reaching the long-term objective. Along the way, frequent communication and honest assessments between mentor and mentee help keep the plan on course.

"The deadlines set at interval points are important, but so are the relationships," Berg says. "The best relationships are those when both [individuals] have clear expectations."

Prudent planning, diligent follow-up, and realistic outlooks can lead to a mutually beneficial experience that epitomizes FAANP's mission of sharing knowledge. Although the lines of mentor and mentee should remain clear, valuable information flows in both directions.

"The outcome becomes more than the process," Berg says. "There's an enrichment that can happen. The mentor gains a great deal in knowledge because the person they are mentoring will be talking about a variety of things. It really is a two-way exchange."

A Broad-reaching Resource

In addition to mentoring NPs, Berg says the mission of the Fellows is to export their knowledge and expertise to stakeholders who are involved in, or otherwise affect, health care. From educational institutions that prepare health care providers to national and international organizations - both private and governmental - that set health

policy or provide health care, many of these stakeholders turn to FAANP for advice and consultation.

"We consider ourselves the go-to organization," Berg says. "If you need information on a wide range of topics, you can contact us. Within our group there is likely at least one Fellow, and more likely many, with knowledge and interest in the issue at hand. These individuals will speak eloquently and knowledgeably on that particular topic."

Dr. Nick Burnett, a family nurse practitioner from State Center, Iowa, is a past FAANP chair and was inducted as a Fellow in 2001. As he notes, the Fellows are available for speaking engagements, political events, for validating research, and anywhere else they are needed. However, this willingness to serve extends past the organization.

"[AANP] itself exists for the betterment of the profession, and we take that very seriously as Fellows," Burnett says. "We want to be available for NPs to help make them as effective as possible; and we want to help the politicians to better understand what NPs do so we can expand our role and make health care more affordable and available for all patients."

In addition to personal presentations, the Fellows have assembled writing groups that prepare and provide relevant health care information to stakeholders. These documents also serve to benefit Towers' efforts in Washington, as well as the work of other politically active members like Burnett. A former U.S. Public Health Service National Primary Care Policy Fellow representing AANP, Burnett has served on the AANP Political Action Committee and continues to work locally on policy issues affecting nurse practitioners. Burnett finds that his inclusion in FAANP affords him strategic connections that help fuel his political efforts.

"Being recognized as a Fellow has had an impact on my ability to meet with other Fellows and discuss topics relevant to my political activities," Burnett says. "Because the Fellows function at such a high level in everything they do, this gives me a valued resource. It gives me access to lots of [individuals] who provide me with data to validate my presentations for success in the political arena."

For this and all applications of FAANP resources, Berg says that utilization depends on awareness. Her hope is that more stakeholders will turn to the Fellows for data, consultation, and speaking engagements. Every occasion for a Fellow to share what he or she has learned is an opportunity to enhance AANP and the health care field.

"The more people know about us, the more opportunities we will have to share our expertise and wisdom because that's what we're about," Berg says. "Whatever goal and mission we embrace, it will complement the goals and mission of AANP."

PARTNERS IN CRISIS, PARTNERS IN HEALTH

Nurse Practitioners Respond to Disasters

By Michael A. Robinson

Audrey Snyder was in the Caribbean just a short flight away from Haiti when the killer earthquake struck the island nation in January, killing more than 250,000 residents.

Despite her proximity in St. Kitts, her status as a nurse practitioner, and experience in planning for natural disasters, Snyder knew better than to drop everything and go rushing to Haiti to help.

The irony was not lost on Snyder. She is after all an assistant professor at the University of Virginia School of Nursing and the clinical nurse advisor for community outreach at the University of Virginia Medical Center in Charlottesville.

Moreover, she was in the West Indies to teach a graduate course on disaster preparedness with a special emphasis on dealing with the challenges that such catastrophes pose for island communities. Having worked in both India and El Salvador, she had experience providing medical care in distant locales.

But as a leading member of the American Academy of Nurse Practitioners, Snyder had already learned that without being part of a prepared team that could operate with its own supplies in the hard-hit region, she would be more burden than help.

"If you have teams who are pre-put together and who are used to working together, they can go into an area and be self-sufficient," Snyder explains. "You need a team that can take care of themselves for the time period they are there, and that means not only your medical supplies but your food and your lodging."

Upon returning to Charlottesville, Snyder volunteered to go to Haiti. She ended up working with a group sponsored by the Lutheran Church Missouri Synod, arriving three weeks after the earthquake hit but in plenty of time to help hundreds of injured Haitians.

She raves about the religious group's organizational skills, indicating that nurse practitioners use this as a guide in what to look for in a host agency.

"I was very impressed," Snyder says. "Within two hours of volunteering, I had an itinerary. I had pictures of everything I needed to have pictures of. I had all the details of who I would meet, the rest of my team, what would be expected of me when I got there.

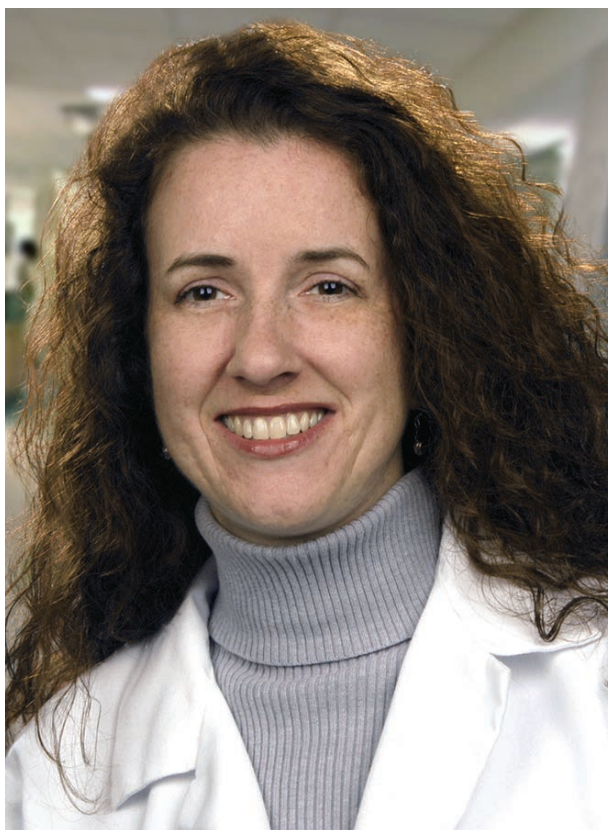
"They really made a good impression on me because they did have the partners on the ground and all the details worked out. It flowed just like clockwork. Everything they said is just what happened. That is what's so important when you are going to volunteer with a group."

Snyder advises other nurse practitioners who want to help in times of disaster, whether that is the aftermath of a local tornado, or a major calamity like an earthquake, to be prepared for privation.

Indeed, she says she teaches her students at the University of Virginia to be ready to deal with a standard of medical care that is well below the norm in the United States. That was certainly true in Haiti, an impoverished nation with a high infant mortality rate and a shortage of doctors and nurses.

"Most of what we were dealing with were wounds that were three weeks old and infected, patients who had more minor injuries who had not been treated yet," she says. "We were working with medical illnesses that come from exposure to the elements.

"And we were also seeing common diseases that had received no care because the norm is minimal or no access to health care. I worked with patients who had



Clockwise from top left: Audrey Snyder. Makeshift housing in the aftermath of the January earthquake that devastated Haiti. Snyder examines a young patient in Haiti after the earthquake. Snyder volunteered with a well-organized group to give aid in Haiti.



malaria, who had dengue fever, who had severe scabies. We had lots of patients with pneumonia with respiratory infections. In Haiti, they are very much antibiotic and pain medicine naive."

Although disasters often occur with little or no warning, advance planning often proves crucial for those who want to volunteer, says Dr. Jan Towers, director of AANP's health policy office in Washington, D.C.

In particular, she says, federal agencies are becoming more selective in accepting volunteer help. For that reason, Towers, who has her doctorate degree from the University of Pennsylvania, advises nurse practitioners to contact relevant government and nonprofit agencies long before disaster strikes to get on the list of approved personnel.

"You can't go to a disaster area, wander in and pitch your tent, and start doing things," Towers says. "We are involved in coalitions where we look at guidelines for preparedness that include health care providers like nurse practitioners. And it is ongoing.

"Our role [at the national level] is to guide people to where they can be most effective in helping in whatever disaster comes up. We also serve in an advisory capacity to government agencies and committees that set standards for this sort of thing. What we do is serve as a catalyst."

When disaster does strike, Towers adds, AANP will post relevant information on the group's Web site. AANP also makes suggestions for courses at the undergraduate



Scharmaine Lawson-Baker returned to her home health care practice in New Orleans in October 2005 after evacuating to Texas in September.

and graduate levels that can help members be better prepared to help in times of great emergency.

"Our guidelines are incorporated into educational curricula," Towers says. "That way, everyone gets some disaster training."

It's a good thing for the people of New Orleans that Scharmaine Lawson-Baker didn't succeed in Nashville as a trumpet player. Sure, she had a great time playing her instrument in the nation's music capital. But her "day job" as a nurse practitioner not only pays a lot more, it also has allowed her to help hundreds of New Orleans residents cope with their medical challenges in the aftermath of Hurricane Katrina.

Lawson-Baker's outreach to her native community stems from her successful business devoted to home medicine with a special focus on making house calls for patients who received government-subsidized health care.

Along the way, she has become something of a media sensation. In 2007, Lawson-Baker convinced CBS News to do a follow-up report on the health care crisis in New Orleans. The result was a 4-minute package from anchor Katie Couric that highlighted Lawson-Baker's work.

She then received a standing ovation at AANP's subsequent annual conference. In the fall of 2008, Sen. John

Kerry, D-Mass., mentioned her in a national conference on e-prescriptions. A few weeks later, the trade journal *ADVANCE for Nurse Practitioners* named her Entrepreneur of the Year.

Lawson-Baker doesn't seem to put too much emphasis on the media attention beyond what it might mean for improving the lives of her patients. She's got too much work to do.

"I would venture to say we would be just as busy without Katrina because of the need," she explains. "It takes a special person to want to go into the home. It takes a special person to want to deal with the impoverished. Before the storm I was the only one down here doing it."

"We haven't even begun to tap the real need. It is just so vast. Home health care, whether that is MDs or nurse practitioners, is really needed. It's going to grow because the baby boomers are getting older."

She opened Advanced Clinical Consultants in March 2005 and started making house calls. Six months later, Hurricane Katrina smashed into the Gulf Coast, forcing the evacuation of much of New Orleans.

With her neighborhood under five feet of water, Lawson-Baker evacuated to Texas. Sensing her services would be needed, she returned to New Orleans a few weeks later in October.



She now works with more than 1,000 patients and also has opened a non-profit agency that provides financial assistance to the medically indigent. Lawson-Baker says dealing with victims of a natural disaster did more than just build her business. It sharpened her instincts as a nurse practitioner.

"On a professional level," she says, "what it taught me was that you can't just focus on getting the person their blood pressure medicine or their insulin and focus on a textbook type of scenario for a plan of treatment. You have to think outside of the box as far as their social needs.

"Being able to work in the patient's home, to work outside of a controlled environment, takes a whole other set of skills and awareness of things. You go into someone's home and you know you have to look in the refrigerator for a diabetic [to check on insulin]. You know you have to look in the cupboard to see if they have food, not only that but what kind.

"You are looking for electricity wires that run over to the neighbor's home to see if they have their own electricity or if they are sharing it. You are looking for holes in the floor.

"You are looking for rats, all kinds of things that affect the person's overall health care. I'm going to catch things that someone who only works in a clinic might not catch. That's why I love my house-call practice so much. It's not textbook."

For James Dickens, the possibility of being assigned to help with a disaster in the United States is a very real possibility. As an officer in the U.S. Public Health Service, the former Air Force surgical technician is part of a rotating rapid deployment team that could be sent just about anywhere to help with medical emergencies.

During the crisis in Haiti, for instance, some of his colleagues were in fact called up and served aboard the USS *Comfort* off the coast of Port-au-Prince.

By making house calls, Lawson-Baker gets a more complete picture of what affects her patients' overall health.



Top to bottom: James Dickens (right) at the U.S. Embassy in Afghanistan in 2009. Dickens shares a meal while in theater in Afghanistan. Dickens in surgery in Afghanistan.

Located in suburban Dallas, Dickens has experience in both domestic and overseas disasters. He provided medical assistance in Texas for victims of hurricanes Katrina and Rita. He also served two stints as a nurse practitioner in Kabul, Afghanistan.

Before joining the Public Health Service, Dickens spent 14 years in the Air Force, eight of them active duty and six of them in the Reserves. That background gave him great training for the Public Health Service because it is a uniformed federal agency, though members do not carry weapons nor answer to the Pentagon. Moreover, in support of an Air Force fighter wing, he got plenty of practice establishing and maintaining field hospitals.

Events came full circle for Dickens in the fall of 2005 when the Public Health Service set up two field hospitals for evacuees from Hurricane Katrina in the Houston area as Hurricane Rita bore down on Texas.

"I am originally from North Louisiana," Dickens explains. "These were my people, not necessarily my relatives but these are people from my home state. So, I felt an automatic connection.

"I really cut my teeth in the Air Force operating rooms, making do with the instruments we had and trying to be

quick on your feet, to outthink your surgeon. I already knew what to do if we didn't have the right equipment or if a piece of equipment malfunctioned.

"For a lot of folks that kind of situation takes them out of their comfort zone. But with Katrina-Rita, I just reverted back to all the things I learned in the Air Force - making do, improvising, and just doing without in some instances."

Since Katrina and Rita, Dickens has traveled to Kabul. Each time he stayed at the American Embassy and worked in the operating room of Rabia Balkhi Women's Hospital, which is also located downtown.

The commander says he never came under direct fire though several nearby buildings were either bombed or had car bombs go off in front of them. But Dickens focused on the job at hand - saving the lives of mothers and their babies in a country with a high death rate for both.

"We understand that a mother in danger is a community in danger, is a state in danger, is a nation in danger," Dickens adds. "Over time, you have an epidemic in which the population will decrease and at some point become extinct if we don't do something to stop these trends.

"There were always bombings going on. Any time the State Department got intel [reports on possible attacks] we governed ourselves accordingly. But taking all things into consideration, being in a war zone and all the inherent dangers, I couldn't imagine not being a part of that opportunity to help these mothers, to help their babies."

At deadline for this article, Dickens was hoping to hear that he would soon be returning for another stint in Kabul. He suggests that other nurse practitioners should volunteer as often as practical to help with local, state, and national emergencies and disasters.

"You are seeing the emergence of more nurse practitioners [participating] in emergency medicine and disaster planning," he says. "Nurse practitioners need to take every opportunity to get involved because we have finally been brought to the table. It's our time to shine."

Meanwhile, it would be difficult to find a nurse practitioner with more direct military training for disasters than Jacqueline Rhoads. In her 30 years of experience as a U.S. Army nurse, both active duty and in the Reserves, Rhoads served in Vietnam as well as the First Gulf War.

Indeed, she received the Army Commendation Medal 11 times. The medal is awarded to any member of the U.S. military other than general officers who distinguish themselves by heroism, meritorious achievement, or meritorious service.

As an active duty nurse during the Vietnam War in 1970 and 1971, she helped treat thousands of wounded soldiers. For her actions, Rhoads received the Bronze Star for meritorious achievements during armed conflict.

She also appeared on the CBS News program *60 Minutes* regarding military nurses who served in Vietnam. Moreover, she co-authored an oral history book published by Texas Monthly Press and titled *Nurses in Vietnam: The Forgotten Veterans*.

Thus, it should come as no surprise that Rhoads believes nurse practitioners should be prepared for a disaster to strike at any time.

"We practiced and drilled so much we began to dream about drills," she recalls. "We were even tested to make sure we knew how to fire a weapon. We learned how to load, reload, and unjam a weapon.

"I guess the reason I value my military training so much and why it played such a role in my interest and career in disaster nursing is because it prepared me for triage and helped to ensure I was personally prepared for any disaster.

"We had so many mass casualties in Vietnam. Most of the time it was just a steady stream of people coming in. But boy, when there was some sort of offensive somewhere, you knew you would be busy. Just from one offensive we had 350 casualties.

"This one offensive in particular that I am thinking about was an ambush. The [Army] convoy just drove straight to the hospital because they had so many wounded. One of the vehicles was on fire. I'll never forget that. All these people were inside. We had to evacuate them and get them into safety."

Today, Rhoads serves as a professor at the University of Texas Medical Branch School of Nursing in Galveston. She had been on the job for just a few weeks when Hurricane Ike barreled down on the Texas coast in September 2008. She stayed on Galveston Island during the storm and helped the American Red Cross provide volunteer medical services.

Before that, she taught at Louisiana State University and was there when Hurricane Katrina struck in September 2005. She originally evacuated to neighboring Mississippi but returned a few weeks later to volunteer her nurse practitioner services.

She helped form a group of volunteers that also included emergency medical technicians and physicians affiliated with Doctors Without Borders. Among other things, the volunteers established a free clinic at Odyssey House, a behavioral health care provider specializing in addiction treatment.

"We made some handwritten pamphlets and dropped them off on the streets and nailed them to telephone poles so the people in New Orleans could come and receive needed medical aid," Rhoads says.

"We saw things like brown recluse spider bites. We saw diabetic comas, diabetic shock. We saw fractures. We saw burns. We saw head injuries. Nurse practitioners fill in the gaps [in medical care]. We've always done that. So, I just want to say that NPs are definitely prepared to respond to natural disasters."

NURSE PRACTITIONERS ADD LATEST TECHNOLOGY INTO PRACTICE

By Charles Dervarics

Back in 1993, Dr. Thomas Mackey had a vision: to store patient information electronically in easy-to-find computer files that offered medical history data in seconds. Seventeen years later, the family nurse practitioner from Texas is bringing along other converts as the NP field gets firmly behind the idea of electronic medical records (EMRs).

"I felt electronic medical records would be a big part of the future back in 1993," says Mackey, PhD, NP-C, FAAN, FAANP, associate dean for practice and director of the University of Texas Health Services-Houston. "I didn't know how true that would become."

Mackey runs UT Health Services, a nurse-managed health care center that opened in 1991. NPs from the University of Texas School of Nursing at Houston direct the health center, which sees 10,000 to 12,000 patients a year with a focus on primary care and occupational health.

Mackey believes he was the first director of nursing to have electronic medical records, beginning in 1994. He acknowledges, however, "I'm not an IT expert." Rather, what drew his interest was the goal behind EMRs - the ability to assemble and review many years' worth of patient information at the touch of a button.

"We were the first nurse-managed center in the country to have EMRs," he says. "For years," he notes, "I was a lone ranger on this. But that is changing now."

When the center first started using electronic records, their system was based on the old DOS system - one of the most elementary of computer programs. "In health IT, that was a long time ago," he says.

The facility now uses Practice Partner® software developed by a Seattle-based company and currently owned by McKeesson. While an NP can look up the record of a patient during an office visit, there also are benefits to the service. PPR Net, or the Practice Partner Research Network, also aggregates information across

several practices, allowing the center to benchmark against other practices and follow patient outcomes over time.

"What makes us unique is that with Practice Partner, we can look across 2,000 to 3,000 patients," he says. As a result, the system can identify patients who may need check-ups or diagnostic tests. For example, through a query to PPR Net, the center can identify which female patients ages 25 to 65 are due for a mammogram but have not yet received one.

First, the system will identify those patients ready for a mammogram. Then it will generate a label and a letter so the practice can notify the patient.

In a similar way, the practice can generate letters or notices about flu shots or about issues for those with asthma, diabetes, or other diseases.

"We receive quality reports that show us how our care processes and outcomes stand in relationship to other practices throughout the country. Typical outcome measures are blood pressure control, aspirin therapy for specific indicated disease states, or even lab values for diabetics," he says.

Patients are registered for the system up front during an initial visit. A nurse will enter basic patient information that is updated as needed. The system's current functionality is robust: It allows the reporting of many common medical tests - including electrocardiograms, pulmonary function tests, and audiometry exams - directly into the patient's electronic medical record. Results of other tests are scanned into the system.



The system also notes drug interactions to ensure the best link between patient and medications. "The system is more sophisticated in the information it provides and the information it can take," he says.

The system relies on a computer station in each exam room that looks much like a traditional desktop computer. An NP can examine individual patient records, seeing a history of vitals, medications, and notes about patients.

The center serves University of Texas employees, students, families, and retirees, plus many members of the general community. The facility also provides education and research opportunities for university faculty and students.

When first launching electronic records, he says, staff training lasted a half-day. Now there is a longer learning curve as staff members become acclimated to the system, but the real-time access yields significant gains.

Mackey is far from the only NP with a long track record on electronic health records. JoEllen Wynne, RN, MSN, FNP-BC, implemented EMRs at a large practice in Oregon and later in her own smaller NP-led practice.

"I remember there were a lot of late nights initially to learn the system," says Wynne, who is now AANP's associate director of education. "It can be intimidating at first, but it saves a lot of time. It makes records transportable in a simple way."

The key, she says, is that electronic records become more than just data entry and collection. "It's about pulling data and using it in a proactive way to promote wellness and preventive services."

For example, she used the system to query a list of individuals who have gone 10 years without a colonoscopy but are in the target age range for regular tests. Similar queries also can identify women who are overdue for mammograms.

On a more regular basis, Wynne would use the system to e-mail herself a 10-day reminder if she had not received or reviewed blood tests or other lab tests ordered for a specific patient.

"It really helped me stay on track with my patients," she says. Systems even can be configured to provide pop-up alerts and reminders. **Continued on pg. 99**



THE TRANSFORMATION OF HEALTHCARE THROUGH IT:

An Interview with Dr. Harry Greenspun, Chief Medical Officer of Dell Services

Q: Healthcare reform is a high-profile political issue. How does health IT fit into the big picture of healthcare reform?

A: While much of focus in Congress is on insurance reform, a major factor is finding ways to improve quality while controlling costs. Health IT is at the center of these efforts, starting with programs initiated by the stimulus package (ARRA) last year to incentivize healthcare providers and hospitals to adopt electronic health records.

Q: With all this momentum around health IT, what benefits can be derived for both providers and patients?

A: The biggest gains are around quality and safety. With electronic health records connected by health information exchanges, providers will have access to the most up-to-date and accurate patient information at the point of care. In emergency situations, this can mean the difference between life and death. Beyond that, by linking providers, we can better coordinate care, emphasize prevention, and get patients more engaged.

Q: Why has widespread health IT adoption taken so long? What are the major barriers and what is being done to alleviate them?

A: While some segments of healthcare, such as academic medical centers and large group practices, have been early adopters, the typical community hospital and smaller practice have lagged behind. There are many reasons, including financial constraints, lack of technical resources, and concerns about loss of productivity or disruptions to workflow. Government incentives remove some of the financial barriers, and the creation of Regional Extension Centers helps to provide training and workflow redesign. Similarly, IT vendors have created new

ways of hosting applications remotely so that practices don't need their own technical expertise and charge a monthly subscription fee so there are no large up front expenses.

Q: What about patient privacy concerns?

A: With the rise of electronic health information, patients' concern about privacy breaches and medical identity theft grows. It is imperative that this sacred trust be maintained. The good news is that the move to electronic records actually affords a much higher degree of security, because access can be rigorously controlled (through biometrics and other means), activity can be monitored and audited, and the data itself can be encrypted and maintained in offsite, secure locations. In addition, patients can have greater control over how their information is shared and under what circumstances. A key challenge, though, will be to effectively communicate this to our patients.

Q: What role can we as nurse practitioners play?

A: The important thing to keep in mind is that health IT is not the answer to our country's healthcare problems. It is, however, a crucial ingredient to solving them, and adoption of EHRs is the first step in transforming how we deliver, coordinate, and evaluate care. This means potentially radical changes in how we work together as clinical teams and interact with our patients. Nurse practitioners have always been at the forefront of innovative care models. We need to draw on their expertise to build the healthcare delivery system of the future, enabled by technology, to serve our patients in dramatically better ways.

Continued from pg. 95

Wynne has used several systems, including one requiring a large desktop computer. But that system often required her to turn her back to a patient in order to review records. Her favorite is one from her time in Oregon that utilized a portable tablet computer where information could be added quickly and efficiently.

“Oregon was already ahead of the curve in electronic health records, so that helped considerably,” she says of her own experiences to master the technology. “It was the way you did business there.”

More nurse-managed centers are getting into the act. The Institute for Nursing Centers (INC), a partnership of organizations including NPs, has a program to encourage the growth of EMRs in nurse-managed health centers.

The INC Practice Management/Electronic Health Record initiative offers cost-effective software as well as a data warehouse (without personally identifiable components) to aggregate trends. The software helps clinicians in decision support, online clinic order entry, referral management, patient education, and medication safety. It also offers support for nurse-managed centers on issues such as training, workflow redesign, and optimization of the technology – as well as a critical mass in the field to help technology-adept nursing centers interact with vendors.

As INC notes, investing in EMRs is “not possible” for most nurse-managed centers. Costs are a major issue, and they include software license purchase and maintenance fees, implementation, and ongoing costs and expenses to support Internet connections. In fact, Wynne notes, high-end systems may cost up to \$30,000 for installation plus a licensing fee for each user.

Yet INC works with the Alliance of Chicago, a network of community health centers, to deploy technology and provide advice on choosing cost-effective components. One common theme is outsourcing, as the Alliance takes on some of the most challenging components of data management, eliminating the need for health centers to acquire servers, database managers, and associated support.

Other participants in the INC program include:

- Wayne State University Campus Health Center in Detroit, Mich., a nurse-managed center serving students, faculty, staff, and children;
- Community Health Mission in Savannah, Ga., a nurse-managed health center for uninsured adults not eligible for Medicare or Medicaid;
- North Georgia College and State University’s Appalachian Nurse Practitioner Clinic in Georgia, which provides basic health care for uninsured individuals and families in rural northern Georgia;
- Glide Health Services in San Francisco, Calif., which serves the uninsured and homeless among other low-income populations;



Dr. Thomas Mackey

- Arizona State University in Phoenix, where the College of Nursing and Health Innovation has five nurse-managed health centers that serve a variety of ages and ethnicities;
- The Governor’s Wellmobile Program in Maryland, a University of Maryland School of Nursing mobile clinic that provides primary care services, health education, and health screenings; and
- North Central Nursing Clinics in Lafayette, Ind., in which Purdue University operates two family health clinics in rural areas with large immigrant populations.

There also is the promise of more government funding to support such activity. Legislation included in the 2009 economic stimulus bill, the American Recovery and Reinvestment Act, has funding to expand electronic medical records. NPs are seeking to access some of these dollars at the state level.

In the meantime, proponents of increased technology use are spreading the word that NPs and other clinicians like to hear – that electronic records ultimately can improve patient care.

“The toughest thing to appreciate is that you spend so much time up front and it takes a while to see the payoff,” Wynne notes. Since NPs have an average age of 47, she acknowledges, the adjustment to electronic records can be challenging. But she says that shouldn’t dissuade practitioners and clinics from jumping right in.

“It’s worth it,” she says. “It’s wonderful technology that improves patient care.”



NURSE PRACTITIONERS: THE SOLUTION TO THE PRIMARY CARE SHORTAGE

By Charles Dervarics

At a time when the nation is embarking on health care reform, the statistic is striking: Within the next 15 years, the United States faces a shortage of up to 45,000 primary care physicians. Given an aging population with growing health care needs plus more attention to the uninsured, one question on experts' minds is how the nation can provide high-quality care in a cost-effective manner.

The answer, increasingly, is to rely on the quality care provided by nurse practitioners, whose ranks are growing substantially and whose experience and training already are meeting patient needs in acute care, chronic care management, and health promotion.

As the American Academy of Nurse Practitioners marks its 25th anniversary, signs of growth are everywhere. More than 70 percent of NPs work in primary care settings nationwide, says AANP Director of Research and Education Dr. Mary Jo Goolsby.

During the past five years, the number of NPs also has grown by 25 percent to 30 percent, AANP reports. That translates into another 8,000 individuals per year for a field that currently (in 2010) has well over 135,000 NPs.

"This is unlike other disciplines, where fewer professionals are going into primary care," Goolsby says. "There are more and better career opportunities. More consumers are aware of nurse practitioners and are seeking us out."

The Primary Care Challenge

At a time of intense debate about the government's role in health care, players on all sides can agree on one issue: With fewer primary care physicians likely in the future, NPs represent one solution to the challenge.

"Too many patients simply can't get access to timely primary care," Goolsby says. "That's where NPs come in."

According to the American Association of Medical Colleges, the nation will face a significant 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 physicians stepping in to fill the void. Experts say many of today's medical students also are choosing specialties such as cardiology or gastroenterology because they are more lucrative - with some earning double or triple what they could receive in primary care.

NPs are a likely answer to the challenge. Now 135,000 strong nationwide, NPs offer a promising solution to the primary care shortage.

"NPs continue to demonstrate an interest in working in primary care," Goolsby says. In addition, unlike other disciplines, she adds, "We have more people going into primary care."

Increased reliance on NPs is consistent with the goals of many health care experts. Back in 2001, the Institute of Medicine (IOM) declared that the "American health care system is in need of a fundamental change." One ingredient of that change is a "patient-centered" system that, IOM says, "is respectful and responsive to individual patient preferences, needs and values" in guiding clinical decisions."

Since that time, organizations such as the American College of Physicians and American Academy of



Pediatrics have called for a "patient-centered care" model that includes: enhanced access; coordinated and integrated care; quality and safety; a personal provider; and an orientation toward the whole person. While physicians envision doctors serving as the personal care provider, AANP leaders note that nurse practitioners have always used the principles of this model:

- Personal provider: NPs help diagnose and manage acute episodic and chronic illnesses, with an emphasis on health promotion and disease prevention - in comparable quality to physician care. "We're good at it, and we have an excellent track record," said Dr. Jan Towers, director of health policy for AANP.
- Whole person orientation: NPs can coordinate patient care with other qualified health care professionals to help patients through acute and chronic illnesses and varied stages of life. Like much of nursing care, NP practice is "whole person oriented and grounded in the concept that individual patients should be viewed within the context of their family and community," AANP says.
- Coordinated, integrated care: NPs "practice in an environment that welcomes collaboration and communication with all health care providers and patients," AANP notes. As a result, there is a "culture of care" that values collaboration.



Q: Do you know that there are 125,000 Solutions to the Primary Care Shortage?

A: Yes, Nurse Practitioners

Dear President Obama and Members of Congress:

As leaders in primary and acute healthcare, the 125,000 nurse practitioners (NPs) in the U. S. today are highly qualified to participate in the planning and implementation of healthcare reform programs as they are considered by your administration and must be a vital part of the prescription for increasing access to high-quality healthcare.

NPs have been providing primary care in the U. S. for more than 40 years. They are graduates of master's, post-master's or doctoral NP programs, with advanced clinical preparation to provide primary, acute, and chronic care to patients of all ages and walks of life.

A large body of research has established that NPs provide high-quality, cost-effective, comprehensive, personalized patient-centered healthcare with excellent outcomes. In addition to diagnosing and managing acute episodic and chronic illness, NPs place a strong emphasis on health promotion and disease prevention. They are skilled clinicians who include teaching and counseling individuals, families and communities as a major part of their practice.

NPs practice autonomously and collaboratively with healthcare professionals and others to assess, diagnose, treat, and manage the patient's health problems and needs. They serve as healthcare researchers, interdisciplinary consultants and patient advocates.

The American Academy of Nurse Practitioners and the undersigned organizations, on behalf of the 125,000 NPs licensed to practice in the United States, offer our extensive resources to your administration as you work to bring healthcare to all.



Since NPs also are nurses, they are accustomed to listening to patients and taking their needs into account. "It's something," Towers says, "that comes from the nursing approach to care."

Within primary care, NPs operate most frequently in private physician offices. However, NPs also may have their own practices. NPs also play a major role in rural health care, where physicians often are in short supply. While 20 percent of U.S. citizens live in rural areas, only 10 percent of physicians practice there. Yet about 20 percent of NPs work in these more remote locations.

"You will see an NP pretty much anywhere you might see a physician," Towers says.

As advanced practice nurses who provide high-quality health services, NPs diagnose and treat a wide range of health problems. They can order, perform, and interpret diagnostic tests such as blood tests and x-rays. With a combination of nursing and medical care, their goal is to both care and cure.

"We treat everything - diabetes, asthma, coronary disease," Goolsby says. In addition, NPs can refer patients to physicians or even other NPs. "We recognize that health care is a team sport."

After completing a bachelor's degree in nursing, a nurse may become an NP through a master's degree in nursing. These programs generally last 18 to 24 months and include specialty areas such as family practice, acute care, adult health, pediatrics, women's health, psych/mental health, child health, emergency care, geriatric care, occupational health, and oncology. Yet primary care - the front lines of health care - remains a dominant focus for practitioners.

Research over the past three decades also has illustrated the beneficial effects of NPs in primary care. Way back in 1981, the U.S. Office of Technology Assessment (OTA) found that NPs provided equivalent or improved medical care at a lower cost than physicians. The report also concluded that NPs could manage up to 80 percent of adult primary care and 90 percent of pediatric primary care needs. But the study also considered costs. Its conclusion: NPs also had the potential to cut the cost per patient visit by as much as one third. Five years later, a follow-up study by OTA confirmed the study's main findings.

In England recently, a randomized control trial and observational studies compared care outcomes and patient outcomes for patients treated by NPs and physicians. Overall, patients were more satisfied with care by NPs and no differences were found in health outcomes. Among other findings, NPs had longer consultations with patients than physicians did. "Quality of care was in some

ways better for nurse practitioner consultations," a study summary concluded.

Other recent research has confirmed many positive findings:

- A 2004 study showed that costs per visit and total labor costs per visit were lower at practices employing NPs and physician assistants to a greater extent.
- A 1994 study in a large HMO setting concluded that adding an NP could double the number of patients seen by a physician.
- A 2005 study of an NP practice for 4,000 employees and their dependents found that NP care saved \$800,000 to \$1.5 million over past practices.
- At one hospital, a collaborative NP/physician team cut hospital readmission and mortality rates and decreased costs and length of patient stays, according to a 2006 study.
- A randomized trial in a 2000 study by M. O. Munding on primary care outcomes in patients treated by nurse practitioners or physicians showed by after six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values.



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Opposite page: This open letter to President Barack Obama and Congress originally appeared in *Roll Call*.



"Health care systems recognize that NPs are cost-effective," Towers says. "Through their clinical emphasis on health promotion and disease prevention, illnesses are caught earlier, preventing expensive hospitalizations and emergency room visits. By combining our nursing skills related to educating and counseling patients with our medical skills of diagnosing and treating illnesses, we are able to provide both high-quality and cost-effective care to our patients."

From 1994 to 2005, the number of nurse practitioner educational programs increased by 61 percent - from 213 to 342 programs. Predictably, enrollment also has increased. The number of students graduating from these programs jumped by more than 150 percent.

With these trends, the federal government is increasingly acknowledging the role of NPs in primary care. Perhaps the strongest example is in health care legislation moving through Congress. AANP and other nursing

groups have a set of principles to bolster the role of NPs through health care reform, including:

- full recognition and use of nurse practitioners as primary care providers in all health care systems and models;
- full recognition of NP practices in coordinated care models, such as medical homes;
- full participation of NPs in chronic care and transitional care models; and
- authorization of NPs to certify patients as eligible for a variety of health care services.

While details are still under negotiation, AANP is pleased with the results to date. "We have won many important victories so far," Towers says. As a result, nurse practitioners are gaining an unprecedented role in primary care.

"NPs are the fastest-growing group of primary care providers," she says. "We're also the primary care providers of the future."

POLICY OFFICE OFFERS STRONG VOICE ON MAJOR ISSUES

By Charles Dervarics

When the American Academy of Nurse Practitioners opened its doors 25 years ago, one issue high on the priority list was to build a strong Washington, D.C., presence so NPs had a voice in the corridors of Congress.



“The organization started because we felt we needed to have some say in policy discussions,” says Dr. Jan Towers, director of AANP’s health policy office. “People told us we needed to get on Capitol Hill and talk about our work, and that’s what we did.”

Today, the association’s Washington-based health policy office has staff members with years of experience in the halls of Congress and the Department of Health and Human Services. But there were challenges in building this operation, beginning with the basic goal to educate lawmakers and their staffs about the beneficial work of NPs. There also were a string of notable successes over the past two decades as dedicated AANP staff worked to elevate the profession in the eyes of policymakers who, as a result, gave NPs a greater role in Medicare, Medicaid, federal employee health plans, and countless other areas.

“It’s been an ongoing process,” Towers says. “But we are dedicated to getting things done.”

Early Days and Early Victories

Early on in AANP’s history, when the association had its headquarters in Massachusetts, talk of representation in Washington, D.C., was a high priority. AANP spent much of its early years in the nation’s capital trying to educate lawmakers about what an NP is and how they operate in the nation’s health care system.

Opposite page: A letter of recognition from Pennsylvania Governor Edward G. Rendell on the occasion of AANP’s 2008 conference. Working to ensure that Congress and the general public understand and recognize the important role nurse practitioners play in health care delivery is just one responsibility of AANP’s health policy office.



COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR
HARRISBURG

THE GOVERNOR

GREETINGS:

It gives me great pleasure to join with the American Academy of Nurse Practitioners (AANP) in welcoming everyone gathered for the 23rd annual 2008 AANP National Conference in National Harbor, Maryland.

Nurse Practitioners are advanced practice nurses who provide high-quality healthcare services similar to those of a doctor. They diagnose and treat a wide range of health problems and stress both care and cure. Nurse Practitioners are true partners in the healthcare of their patients—focusing on health promotion, disease prevention, health education, and counseling, guiding patients toward better health and lifestyle choices as well as providing clinical services.

I am grateful for AANP's unwavering dedication to promoting the highest level of excellence in health care and supporting the efforts of your members to advance their knowledge and expertise. It is this passion for quality care and professional support that distinguishes you and offers our citizens the greatest range of options for comprehensive care.

This conference will serve as an opportunity to meet with congressional members and their key legislative staff, and provide expert faculty presentations of current, practical and clinically oriented evidence-based practice information in specialty areas. It will also provide state-of-the-art skills enhancement workshops, an opportunity to discuss current national, state and local legislative, regulatory and practice issues affecting nurse practitioners and will provide national and international opportunities for collegial networking.

As Governor and on behalf of all Pennsylvanians, I welcome everyone in attendance to the 2008 AANP National Conference. I offer my best wishes for a productive, successful conference and great success in the coming year.



Edward G. Rendell

EDWARD G. RENDELL
Governor
June 26-July 1, 2008

Even with its out-of-town headquarters, “We’ve had a Washington presence since the beginning,” Towers says. Yet the challenge was a significant one. “Our first job was telling them who we are,” she notes.

In 1986, AANP launched a concerted effort to impact pertinent national legislation. That year, and in 1987, the association claimed one of its first victories, passage of legislation providing reimbursement to NPs through the Federal Employers Health Benefits Program. As a result, NPs had a greater role to play in the health care of federal employees.

The next goal was to build the visibility of NPs within Medicare, reflecting the increasing levels of work that nurse practitioners were providing in these settings. To solidify the NPs’ role in this sector, the goal was for NPs to receive reimbursement for care provided across a variety of senior settings. In the late 1980s, a critical victory by earning reimbursement for NPs providing Medicare primary care services in long-term care facilities and in rural areas, with reimbursement available either directly or indirectly, was won.

Since NPs care for far more than seniors, reimbursement for other types of care also was a priority. In one



Pictured from left to right: Secretary of the Department of Health and Human Services Kathleen Sebelius, AANP Past President Mona Counts, PhD, CRNP, FNAP, FAANP, and Nancy-Ann Min DeParle, who heads the White House Office of Health Reform, are pictured while at the White House on March 3, 2010, to hear President Barack Obama explain his vision for health care reform.

In recent years, the office has launched a number of innovative features to help educate AANP members.

significant victory in the early 1990s, AANP successfully urged policymakers to allow Medicaid payments for family and pediatric nurse practitioners, whether or not they provided those services under the supervision of a physician.

The policy office also played a major role during an insurance crisis two decades ago, when a major insurance carrier dropped coverage of NPs. AANP and its policy experts participated in helping nurse practitioners locate other affordable options.

But most significant was the passage of legislation (in the Balanced Budget Act of 1997) authorizing direct Medicare reimbursement for nurse practitioners across all settings.

“Here we crossed a threshold,” Towers says, in terms of acceptance and understanding by members of Congress and their staffs. “That was significant, and it raised the visibility of nurse practitioners.”

Current Priorities

Today, in Washington, D.C., the seven-person AANP health policy office includes a director and a registered lobbyist. While working with the House of

Representatives and the Senate, the office deals with a veritable alphabet soup of federal agencies including: the Center for Medicare and Medicaid Services, the Health Resources and Services Administration, the Department of Veterans Affairs, the National Health Services Corps, and many other offices.

A typical week may find the policy staff attending hearings on Capitol Hill, drafting letters and responses to legislation and regulations, or presenting to industry or health care groups. They also may advise on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy issues or monitor budget allocations for workforce development programs under the Public Health Service Act.

In recent years, the office has launched a number of innovative features to help educate AANP members. “We have more tools now,” according to Towers. Members can sign up for regular policy updates on key legislation, and the association Web site tracks key developments. There also is an easy-to-use application that allows members to send letters to members of Congress on specific issues. In addition, the office has developed several leadership policy programs and fellowships for nurse practitioner leaders and students.

"We have become more sophisticated in our approach, using technology to help inform our members," she notes.

The health policy office also helps ensure there is AANP representation on and in a variety of federal and national advisory councils and coalitions. These councils may focus on specific issues such as chronic care, rural health care access, health promotion, and wellness. Another major responsibility is to track Medicare and Medicaid regulations at the Department of Health and Human Services and to provide input on issues of importance to NPs. The health policy office also has played a role in creation of the Political Action Committee. Another role of the office is to work with other nurse practitioner and health care professional organizations on mutually beneficial initiatives.

The stamina of the office was tested in 2009 and 2010 as the House and Senate devoted months of work to a comprehensive health care bill. During this lengthy debate, AANP advanced many causes - including a goal that the health care reform bill recognize the utilization of NPs as primary care providers. Specific goals included:

- using the U.S. Institute of Medicine definition of primary care - which would include NPs - in all proposed legislation and regulation related to providing primary care;
- recognizing NP practices and nurse-managed clinics as medical homes and/or advanced primary care practices;
- paying special attention to safety net providers who care for patients who may not otherwise have access to care; and
- promoting prevention and management of chronic diseases, with NPs included in the design and development of all health care reform models.

The mammoth bill approved by both houses of Congress and signed by President Barack Obama in March provides many hard-fought gains. Among other provisions, the legislation has a substantial increase in funding for community health centers. An estimated 20 million Americans receive care at these clinics, and the new funds could double that number.

As the legislation would, over time, extend care to an estimated 30 million uninsured Americans, NPs will play a pivotal role in meeting primary care responsibilities. NPs are "in a position to be part of the solution to the primary care shortage," says Dee Swanson, AANP president.

Yet the new law will require many new rules and regulation for implementation, and NPs can expect that the federal policy office will be at the table working hard to advance the cause of nurse practitioners.

In addition to the mammoth health care bill, the health policy office keeps track of developments on other issues such as federal funding for health professions and nurse education grants and traineeships. Legislation



Nurse practitioners and their supporters traveled to Tallahassee from around the state of Florida in March 2010 to advocate for adequate access to affordable, comprehensive, and quality health care for all Floridians and to seek passage of two controlled substance bills. They are pictured here in the gallery of the House of Representatives.

to expand these programs also gets a high priority. Implementation of last year's economic stimulus bill, the American Recovery and Reinvestment Act, is another priority, since the law has funding for community health centers and electronic medical records, among other initiatives.

When appropriate, the office also has sponsored and co-sponsored congressional briefings on issues of interest to advanced practice nurses. In addition, the office can provide information and assistance on state-level issues affecting NP practice. At the state level, key topics for NPs can include guidelines for writing prescriptions and rules related to the interaction of NPs and physicians.

Still, most of the work remains at the federal level, where AANP can cite many accomplishments. As new legislators are elected each term, however, there remains an ongoing effort to educate lawmakers and their aides, who may have little understanding of how NPs work. "There are times when we face the same questions we did 25 years ago," Towers notes. "It's an ongoing process." But she adds that much has changed in the last quarter-century as AANP has made tremendous gains in visibility. "We have made many inroads on Capitol Hill. But it's important to continue educating them about the important work of NPs."

NP EDUCATION REQUIREMENTS SET TO INCREASE

While federal policy on primary care and reimbursement rates tends to command the most attention, one important topic for AANP leaders is the education required for nurse practitioners (NPs) – a process that is undergoing major changes.

By 2015, the terminal degree for advanced practice nursing will move from the master's degree to a doctor of nursing practice (DNP) degree. As a result, future NPs prepared after 2015 will need the doctoral degree to practice, and educational efforts are under way to prepare for the transition. Others who will encounter the new requirement include nurse midwives and clinical nurse specialists.

"The proposed goal is fast approaching," says Mary Jo Goolsby, adult NP and director of research and education at AANP. Yet she says the move makes sense for many reasons. "Health care is becoming much more complex and for that reason, a doctor of nursing practice reflects the changing environment," she says.

"It's also recognition that NPs are playing a vital role as important health care providers."

The issue dates back to 2001, when the National Organization of Nurse Practitioner Faculties created a task force to examine NP education. The transition began in earnest after October 2004, when the American Association of Colleges of Nursing (AACN) published a position paper on the issue of moving to a doctor of nursing practice degree for all advanced practice nurses.

AANP notes that advanced practice nursing is one of only a few health care disciplines that currently require master's rather than doctoral-level education. By comparison, other licensed

independent practitioners such as podiatrists, psychologists, optometrists, pharmacists, and osteopaths – as well as physicians and dentists – prepare candidates at the clinical doctoral level.

Nonetheless, the amount of time spent in a master's program for future NPs is often equal to the training in clinical doctoral programs. According to AACN research, many master's programs for future NPs exceed 60 credits and take more than three years to complete.

In a discussion paper on the doctor of nursing practice, AANP says a detailed road map is essential to help in the changeover. "The transition to the new title must be handled smoothly and seamlessly so that there will not be a negative impact on NP practice and sound patient care and that parity will be maintained."

While the change has drawn some interest and concern in the profession, AANP says the long lead time to implement the new requirement is a major help.

The DNP requirement will apply only to those who are not yet licensed or not in practice as advanced practice nurses. Current NPs with a master's degree will be able to continue practicing.

"This type of change doesn't occur in a vacuum. It's one that involves extensive discussion," says Dr. Jan Towers, a family nurse practitioner and AANP director of health policy. She also says the change has merit given the increasing importance of NPs and the already rigorous level of master's degree training. "NPs are the fastest growing group of primary care providers," she adds.

LOOKING AHEAD

The Future of the NP Profession and AANP

By Craig Collins

AANP President Dee Swanson has identified her years in office as a time when the organization entered "Phase Two" - a transformational period of rapid growth in AANP's influence and in the sophistication of its operations. The year 2010 is poised to go down in history as a time when America's health care system undergoes an equally dramatic transformation.

As AANP's president-elect, Dr. Penny Kaye Jensen, points out, "the nation is currently experiencing a shortage of primary care providers. As recently as 2008, less than 10 percent of graduating medical students chose careers in primary care, while the primary care setting was the practice area of choice for over 70 percent of NPs. These numbers suggest changes in the health care system are inevitable - and that, in whatever system emerges from the current reform efforts, nurse practitioners will continue to play a dominant role in improving Americans' access to primary care."

The exact nature of that role, however, remains uncertain. In order to ensure that the NP role is established and codified in a way that meets the needs of patients, AANP and its leaders continue to develop and implement a multi-part strategy to promote their vision for the future of the nurse practitioner profession.

Expanding Influence in Policymaking

Since its inception, AANP recognized the importance of maintaining a presence in Washington, D.C., in order to have a voice in the laws and regulations that touch the lives of NPs and their patients. AANP Director of Health Policy Dr. Jan Towers and her staff have worked tirelessly to form coalitions and partnerships on the Hill. In appealing directly to the White House and legislators, they have won significant victories and earned greater autonomy for nurse practitioners. Now that health care reform has moved into the next phase, AANP is already making plans to increase its influence at the national level, regardless of the legislative reform implementation outcome.

One of the concepts being discussed is the "Medical Home Model" of health care delivery, which promotes whole-patient wellness and disease prevention by developing partnerships between patients and a team of health care providers. The concept of team-based care is not new. The Institute of Medicine highlighted the importance of the concept in its 2001 report, "Crossing the Quality Chasm: A

New Health System for the 21st Century." Others have been promoting team-based care for even longer. The challenge has historically been implementation of a team-based approach. "Since the inception of the NP role 45 years ago, NPs have followed this type of practice model. Thus, NPs are uniquely positioned to absorb the increasing demand for primary care services, and AANP and its leaders are actively promoting NPs as a natural choice to assume leadership of medical home teams," says Jensen.

"The inclusion of NPs in medical home legislation is critical," says Jensen. "This model strives to deliver coordinated primary care directed by a single health care provider. Inclusion of NPs in the medical home should not threaten other professions, but will strengthen the foundation for the medical home. Historically, NPs work collegially and well with physicians and other health care providers. We too are trying to answer the challenge of keeping pace with the demands for quality health care for everyone."

AANP CEO Tim Knettlter has a unique understanding of how a national association can leverage its relationships in the states and in Washington, D.C., to achieve positive results. In order to heighten AANP's communication with legislators and to better maintain these relationships, Knettlter wants AANP to increase its presence on the Hill. "Building on our existing relationships with national organizations and Washington, D.C., will solidify the great work we have already done and move us further and faster to positive outcomes for everyone," he says.

Expanding Membership and Support to Existing Members

Of course, one strategy for increasing the organization's influence among nurse practitioners themselves is to attract more members into the organization and to improve the number and quality of services AANP provides to its membership. Jensen has expressed a desire to increase both individual and group memberships with-



NPs traveled from around the state of Florida to Tallahassee to advocate for access to affordable, quality health care for all Floridians; some of the NPs who came to Tallahassee are pictured here with State Representative Matt Hudson. AANP has taken steps to provide more support to its state representatives to address such issues.

in the organization. "Increased membership will give us an expanded voice for NPs around the country and help bring more awareness to the NP role," she says.

"We are the largest organization in the country for NPs of all specialties," says Knettlar, "and through our individual and group memberships, we represent the interest of the approximately 135,000 NPs practicing in the United States today. We want to continue to build strong relationships with the other nurse practitioner organizations, with a goal of being inclusive, and fostering AANP's involvement in supporting their missions and to engage those organizations in fostering support of AANP."

According to Knettlar, AANP is in the process of devising a strategy for increasing individual memberships: "We are in the analysis stage right now," he says. "And we will be putting a plan together this year to look at our membership structure and how we might either improve existing services or add new services to increase membership."

The issue of increasing membership is integral to AANP's effort to influence national policy. In the organization's view, better legislation would mean more NPs working to the highest extent of their educational preparation and improved access to quality care. "Each year, U.S. nursing schools prepare 7,000 to 8,000 NPs," says Jensen, "but must turn away approximately 6,000 qualified applicants due to faculty shortages and lack of funding. Improved funding for nursing faculty, loan repayment programs, nurse-managed centers, and the initiation of graduate nursing education funding, if

passed, would increase the number of highly qualified NPs available to provide care and to educate future NPs."

While working to increase the supply of nurse practitioners, AANP is also supportive of the doctorate of nursing practice (DNP) as the future standard entry level into NP practice, superseding today's master's-level requirement. "Schools are encouraged to convert to the DNP model by 2015," says Swanson. "It's an issue of parity with other health care professionals. Pharmacists have doctoral degrees. Optometrists have doctoral degrees. Psychologists have doctoral degrees. Physical therapists have doctoral degrees. Why would we be the only providers not earning doctorates? Nurse practitioners have long been under-credentialed. The academic rigor of nurse practitioner programs has never been adequately acknowledged, following a historical pattern of the undervaluing of nursing altogether. Movement toward the DNP is a critical factor in supporting academic credentialing more representative of the work that we do, academically and in subsequent practice."

Encouraging Awareness of the NP "Brand"

The age-old struggle against undervaluation lies at the heart of the NP's professional challenge. After 45 years of professional practice, most Americans do not understand what an NP is, what health care services an NP provides, or that NPs are experienced health care providers.

Under the leadership of Knettlar and the board of directors, AANP recently hired a public relations firm as one component in a campaign to address these issues.

"In our 25 years we have never had a national PR firm represent us," says Swanson, "because we were always watching our pennies, using them wisely but not really taking the great big leap forward. The national PR firm we are working with is the same company that branded Susan G. Komen for the Cure and worked on their 25th anniversary, marketing Susan G. Komen and affiliates around the country - and everybody knows what a pink ribbon means."

The early results of consumer surveys undertaken by the PR firm have confirmed a frustrating truth long known to nurse practitioners, says Knettler: "Half the population surveyed did not know that NPs can prescribe medications, or diagnose and treat patients without a supervising physician."

The message that will ultimately be transmitted through AANP's PR campaign will emerge from two sources: the results of consumer surveys and the results of a "brand audit" compiled from in-depth interviews with NPs, patients, physicians, and other members of the health care community about perceptions of the NP role. In the meantime, Knettler and other AANP leaders keep in touch with members of local and national media, composing letters and other communications that correct misconceptions about the role of NPs.

Breaking Down Barriers at the State Level

Confusion over the role of NPs has led to state laws and regulations governing the work of nurse practitioners. Although many of the barriers to independent practice have been removed, a number of barriers still remain; while many states grant full independence to NPs, there are still states in which NPs are not working to the degree for which they are prepared academically and experientially, and those states continue to require NPs to work under the direct supervision of a physician.

AANP's leaders recognize the inconsistency of state regulations as one of the most significant impediments to full practice autonomy for NPs. When Knettler first began working for AANP in March 2009, he says, "I started seeing e-mails and listserv messages from some of our state representatives regarding the legislative issues they were experiencing. I realized that we did not have sufficient personnel to provide them with timely information, or the type of legislative support they were requesting. Our director of health policy, Dr. Jan Towers, and her staff have accomplished so much at the federal level, we wanted her to devote all of her time and efforts to make further progress in this area."

To sharpen its focus on delivering information and support to state representatives, Dr. Tay Kopanos recently joined the health policy team as director of Health Policy/State Government Affairs. She will be working with

AANP state representatives and others on NP issues and initiatives, such as the removal of barriers to effective health care delivery and improving patients' access to health care.

Towers believes that creating an organizational structure that distinguishes between state and federal issues is an important evolutionary step. "Changes related to scope of practice take place at the state level," she says. "At the federal level we are looking at national policy focusing on health care, reimbursement, third-party payment, workforce authorization and payment, antitrust, patient and provider protections, health IT, and other policy and professional issues that impact nurse practitioners and their patients across the nation."

In the near future, Jensen would like to sharpen AANP's focus at the state level even further. "In order for NPs to be integrated as a critical component of health care," she says, "the state statutes must allow for independent practice. I would like AANP to concentrate increased efforts on the removal of practice barriers in all states."

What Really Matters

As they have worked to devise the organization's strategies for resolving each of these complex issues, AANP's leaders have remained true to the ethos, professionalism, and care outcomes of NPs - their focus on the health and wellness of patients and their families. "This mixed bag of existing regulations," says Swanson, "is an impediment. It keeps us from being able to focus on issues that really matter. Having to deal with issues that keep us from doing what we do best is very frustrating to me. That would be something I'd like to see forever changed."

Swanson envisions a future in which state laws are uniform and barriers to independent practice have been removed - in which the work of AANP can turn solely to patient-related issues. "I'd like to see us expand research on patient-care outcomes," she says. "I'd like to see us heighten a research emphasis on nurse practitioner outcomes, generally focusing more on patient care issues. I just want to be unfettered and move in logical directions."

In 2009, at his speech at AANP's 24th National Conference in Nashville, Knettler envisioned the number of nurse practitioners doubling to meet the demand for primary, acute, and specialty care. He recounted the story of a patient who had been compelled to discontinue physician visits because she could no longer afford them. "The person said that having access to an NP saved her life," he says, "because the NP discovered certain complications that otherwise would not have been found in time. And that's the kind of story that really exemplifies NP practice and is the message that AANP will work to share with the general public."



FACT SHEET

AANP Membership

For information on AANP membership benefits or to join or renew online, visit the Member Center section at www.aanp.org.

Note: There are now two student membership categories. Details available in AANP Member Center.

AANP Contact Information

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Austin, TX 78711
Phone 512 442-4262
Fax 512 442-6469
Email admin@aanp.org
Website www.aanp.org

Office of Health Policy:

PO Box 40130
Washington, DC 20016
Phone 202 966-6414
Fax 202 966-2856
Email dcoffice@aanp.org

Formed in 1985, AANP is the largest and only full-service professional membership organization in the United States for NPs of all specialties. AANP has steadily expanded services to:

- * Promote excellence in NP practice, education and research;
- * Shape the future of healthcare through advancing health policy;
- * Build a positive image of the NP role as a leader in the national and global healthcare community.

MEMBERSHIP AANP has more than 27,500 individual members and 153 NP group members. AANP represents the interests of the over 135,000 practicing NPs in the U.S. Members of current group member organizations receive a \$10 discount on AANP individual full membership dues. Group members are listed on the back of the Fact Sheet.

BOARD OF DIRECTORS & STATE REPRESENTATIVES AANP is governed by an elected Board of Directors comprised of a 5 member Executive Committee and 11 regional directors who set policy for the organization. Elected state representatives in every state serve as liaisons for AANP members and other NPs at the state and local levels.

OFFICES & STAFF AANP has two offices. The AANP National Administration Office is located in Austin, TX and houses membership, finance, communications, conferences/meetings, education/CE, research, publications, information technology and administrative operations for the organization. The AANP Office of Health Policy is located in the Washington, DC area and is a major resource for health policy, legislation, regulatory, political action committee (PAC) activities and practice issues affecting NPs. Between these two offices, the AANP currently employs 50 staff members to serve the needs of members, other NPs and healthcare consumers.

NATIONAL CONFERENCE Make plans now to attend the 25th AANP National Conference, June 23 - 27, 2010, in Phoenix, AZ. In addition to expert clinical sessions and workshops, plenty of networking opportunities, and a great exhibit hall, the conference will feature special activities to showcase AANP's Silver Anniversary. Don't miss the excitement and experience of the 25th anniversary conference. More information will be available at aanp.org as plans are confirmed. (Last year's national conference in Nashville set an all-time record with more than 4,500 NPs in attendance - the largest gathering of any NP conference to date.) We look forward to seeing you in Phoenix.

EDUCATION & RESEARCH A comprehensive nationwide list of NP programs of all specialties is available on the AANP website. AANP members receive free CE activities through a variety of resources and formats. AANP provides continuing education approval and accreditation for hundreds of meetings and continuing education materials each year. Qualified groups may apply to receive AANP CE Provider designation. AANP maintains the only national NP database of all practicing NPs and conducts national surveys gathering critical data about NP demographics, workforce, practice and prescribing. The AANPNR, created in 2002, is a national practice based research network of NPs.

PUBLICATIONS Publications include AANP SmartBrief, a daily e-newsletter highlighting cutting-edge news impacting NPs (sign up at www.aanp.org), a monthly peer-reviewed Journal of the American Academy of Nurse Practitioners (JAANP) and the NP brochure, Your Partner in Health - The Nurse Practitioner, available in English and Spanish languages. Nurse Practitioners - Celebrating excellence in healthcare, practice, education and research, a commemorative booklet, chronicles the first 40 years of the nurse practitioner role. A companion video, The First 40 Years (DVD format) presents an overview of the nurse practitioner role as seen through the eyes of a myriad of healthcare professionals. A variety of position and policy papers are also available.

MARKETING & COMMUNICATIONS AANP markets and advocates for NPs extensively through multiple activities such as publishing position statements and position papers, providing legislative testimony and pro-actively participating in numerous partnerships, alliances and coalitions. AANP is active in supporting collaborative agreements with government agencies, organizations within nursing and other disciplines, and with healthcare industry members. AANP exhibits at numerous international, national, regional, state, and local conferences.

WEBSITES & INTERNET AANP's re-designed state-of-the art comprehensive website (www.aanp.org) is visited regularly and provides valuable up-to-date information. Alerts with extensive links direct the user to informative healthcare-related websites. Visit the newly launched AANP Social Networking site at my.aanp.org.

INTERNATIONAL AANP has a rapidly increasing international presence, welcoming international members and participating in international activities. The AANP is a founding member of the International Nurse Practitioner/Advanced Practice Nursing Network (INP/APNN). The past chair of the INP/APNN core steering group is the AANP International Liaison.

FELLOWS OF THE AANP (FAANP) The FAANP Program was established in 2000 to recognize NPs who have made outstanding contributions in healthcare practice, research, education and/or policy and to facilitate leadership within the NP profession. An FAANP top priority is the development of mentorship and leadership programs for NPs.

National Group Members

<p>American Assembly for Men in Nursing American Association of Critical-Care Nurses American Association of Diabetes Educators American College of Chest Physicians American Diabetes Association Association of Asthma Educators</p>	<p>Association of Nurses in Aids Care Dermatology Nurses Association Gerontological Advance Practice Nurses Association National Association of Pediatric Nurse Practitioners National Association of Nurse Practitioners in Women's Health Nat'l Kidney Fndtn, Council of Nephrology Nurses & Technicians</p>	<p>National Organization of Nurse Practitioner Faculties Oncology Nursing Society Preventive Cardiovascular Nurses Association Wound, Ostomy and Continence Nurses Society</p>
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State Level Group Members

<p>ALABAMA: Ida V. Moffett Schl of Nursing-Stamford Univ North AL Nurse Practitioner Association Nurse Practitioners Alliance of AL Wiregrass NP Association</p> <p>ARIZONA: Arizona Nurse Practitioner Council</p> <p>ARKANSAS: Northeast Arkansas Nurse Practitioner Assn</p> <p>CALIFORNIA: California Association for Nurse Practitioners National Assoc of Pediatric NPs-LA Chapter</p> <p>COLORADO: Colorado Society of APNs DNA #30 Regis University</p> <p>CONNECTICUT: CT Adv Practice Registered Nurse Society The NPs of ProHealth Partners</p> <p>DELAWARE: Delaware Coalition of Nurse Practitioners</p> <p>DISTRICT OF COLUMBIA: NP Association of the District of Columbia</p> <p>FLORIDA: Association of NPs in Business Inc. Central FL Adv Nursing Practice Council Florida Nurse Practitioner Network Florida Nurses Association Manatee Area Council for Adv Nursing Prac North Central Florida APNs Northeast Florida Advance Registered NPs NP Council of Collier County NP Council of Palm Beach County Polk County Adv Prac Nurses Association Sarasota Council for Adv Practice Nursing South Florida Council of APNs, Inc Southern Gulf Coast NP Council Tallahassee Area Council of APNs Tampa Bay APN Council Volusia-Flagler Adv Practice Nursing Council</p> <p>GEORGIA: Atlanta Chapter/United APNs of GA Augusta Area United APNs Cowetafayette United Adv Reg Nurses of GA Chap Northeast GA AP Registered Nurses Assn United APRNs of Georgia United APRNs of GA, Central GA Chapter United APRNs of West Georgia Wellstar Primary Care NP Prog Kennesaw State Univ</p> <p>HAWAII: Hawaii Association of Professional Nurses</p> <p>IDAHO: Intermountain Advance Practice Nursing Nurse Practitioners of Idaho</p> <p>ILLINOIS: Illinois Society for Adv Practice Nursing</p> <p>INDIANA: Coalition of APNs of Indiana Coalition APNs of Indiana Region 4</p> <p>IOWA: Iowa Nurse Practitioner Society</p> <p>KANSAS: Great Plains Nurse Practitioner Society Kansas Alliance of ANPs Wichita State Univ Graduate Nursing Prog</p>	<p>KENTUCKY: Frontier Schl of Midwifery & Family Nursing Kentucky Coalition of NPs & NMs</p> <p>LOUISIANA: Louisiana Assn of NPs Univ of LA at Lafayette, College of Nursing</p> <p>MAINE: Maine Nurse Practitioner Association Maine Nurse Practitioner Coalition</p> <p>MARYLAND: Maryland Coalition of Nurse Practitioners Nurse Practitioner Association of Maryland</p> <p>MASSACHUSETTS: Massachusetts Coalition of NPs Simmons Coll Grad Prog-PHC Nurs Faculty Univ of MA Boston, Univ Health Services</p> <p>MICHIGAN: Michigan Council of Nurse Practitioners Northern Advanced Practice Nurse Network</p> <p>MINNESOTA: Minnesota Nurse Practitioners</p> <p>MISSISSIPPI: Mississippi Nurses Association</p> <p>MISSOURI: FNPs of MO-KAN Minute Clinic Four State APN Association</p> <p>MONTANA: Great Falls Nurse Practitioners</p> <p>NEBRASKA: Lincoln NP Journal Club Nebraska Nurse Practitioners</p> <p>NEVADA: Nevada Nurses Association APG</p> <p>NEW HAMPSHIRE: New Hampshire NP Association</p> <p>NEW JERSEY: Forum of APNs of New Jersey VA NJ Health Care System APN Council</p> <p>NEW MEXICO: Lea County Nurse Practitioners New Mexico NP Council</p> <p>NEW YORK: NP Journal Club of Huntington Nurse Practitioner Assn of Long Island Nurse Practitioners of New York The NP Association of New York State</p> <p>NORTH CAROLINA: Metrolina Coalition of Nurse Practitioners North Carolina Nurses Assn</p> <p>OHIO: Case Western Reserve Univ Schl of Nursing Northeast Ohio Nurse Practitioners Group Ohio Assn of Advanced Practice Nurses</p> <p>OKLAHOMA: Oklahoma Nurse Practitioners</p> <p>OREGON: Nurse Practitioners of Oregon</p> <p>PENNSYLVANIA: Berks County NPs Blair Regional Nurse Practitioner Assn Buxmont NP Group Ches-Mont NP-PA Association Laureal Highlands NP Assn NP Assn of Southwestern PA</p>	<p>PENNSYLVANIA: (continued) NPs of Central Pennsylvania NPs of NE Pennsylvania NPs of RevolutionCare in SE PA NW PA NP Association Pennsylvania Coalition of NPs Philadelphia Area NP Group Pocono Assn of Nurse Practitioners Southern Chester County NP Coalition Tri County NP Association</p> <p>RHODE ISLAND: Rhode Island State NP Council</p> <p>SOUTH CAROLINA: Upstate Nurse Practitioner Assn</p> <p>SOUTH DAKOTA: NP Association of South Dakota</p> <p>TENNESSEE: Chattanooga Area Nurses in Adv Prac Greater Memphis Assoc of APNS Middle Tennessee APNs TLC NP Retail Hlth Networking Group Union University School of Nursing</p> <p>TEXAS: APNs of the Permian Basin Austin Advanced Practice Nurses Brazos Valley Nurse Practitioner Assn Central Texas Nurse Practitioners Coalition for Nurses in Adv Practice East Texas NP Association Galveston Coalition of APNs Heart of Texas Nurse Practitioners Houston Area Nurse Practitioners Laredo Advanced NP Association North Texas Nurse Practitioners North Texas NPs Metroplex West Panhandle NP Association San Angelo Coalition of Nurs in Adv Prac Texas Nurse Practitioners Univ of TX at Arlington - SON Valley Advanced Practice Nurse Assoc</p> <p>UTAH: Utah Nurse Practitioners</p> <p>VERMONT: Vermont Nurse Practitioners Assoc</p> <p>VIRGINIA: Virginia Council of NPs</p> <p>WASHINGTON: Area Hlth Education Ctr of Eastern WA ARNPs United of Washington State Columbia River NP Association Nurse Practitioner Group of Spokane Yakima ARNPS</p> <p>WEST VIRGINIA: The APNs of the Upper Ohio Valley WV Nurses Association APN Congress</p> <p>WISCONSIN: Viterbo University MSN Program</p> <p>WYOMING: WY Council for Adv Practice Nursing</p>
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[Updated as of 05/11/2010]



Nurse Practitioner Facts

There are over 135,000 nurse practitioners (NPs) practicing in U.S.

NP Facts

- Approximately 8,000 new NPs were prepared in 2009
- 88% of NPs have graduate degrees
- 92% of NPs maintain national certification
- 39% of NPs hold hospital privileges; 13% have long term care privileges
- 96.5% of NPs prescribe medications and write an average of 19 prescriptions/day
- NPs hold prescriptive privilege in all 50 states, including controlled substances in all but 3
- NPs write approximately 556 million prescriptions annually
- The 2008 mean full-time NP base salary is \$84,250 across all specialties and settings
- Average full-time NP total income is \$92,100
- 62% of NPs see three to four patients per hour; 12% see over five patients per hour
- 20% of NPs practice in rural or frontier settings
- 66% of NPs practice in at least one primary care site; 31% practice in at least one non-primary care site (such as inpatient, emergency, surgical, or specialty practice)
- Malpractice rates remain low; only 1.4% have been named as primary defendant in a malpractice case
- Average NP is female (94.6%) and 48 years old; she has been in practice for 10.5 years as a family NP (49%)

NP Distribution, Mean Years of Practice, Mean Age by Specialty

Specialty	Percent of NPs	Years of Practice	Age
Acute Care	5.3	7.0	45
Adult	17.9	10.9	50
Family	49.2	9.5	48
Gerontological	3.0	11.6	52
Neonatal	2.3	12.3	47
Oncology	0.8	8.3	47
Pediatric	9.4	13.3	49
Psych/Mental Health	2.9	8.5	52
Women's Health	9.1	14.7	49

Sources:
 AANP National NP Database, 2009
 AANP National 2008 NP Practice Site Survey
 2008 AANP NP Compensation Survey
 2004 AANP NP Sample Survey

Additional information is available at the AANP website www.aanp.org.



Timeline for NPs and AANP

1965

- Dr. Loretta Ford and Dr. Henry Silver develop the first Nurse Practitioner (NP) program at the University of Colorado

1967

- Boston College initiates one of the earliest master's programs for NPs

1968

- Directed by a nurse and physician team, the Boston-based Bunker Hill/Massachusetts General Nurse Practitioner Program begins

1971

- One of the first family NP programs, PRIMEX, opens its doors at the University of Washington

1973

- More than 65 NP programs exist in the U.S National Association of Pediatric Nurse Practitioners (NAPNAP) is established

1974

- The American Nurses Association (ANA) develops the Council of Primary Care Nurse Practitioners, helping legitimize the role
- The *Burlington Randomized Trial Study* finds that NPs make appropriate referrals when medical intervention is necessary

1975

- The University of Colorado offers its first continuing education symposium for NPs

1978

- The Association of Faculties and Pediatric Nurse Practitioners (AFPNP) is established and begins developing PNP curriculum

1980

- More than 200 NP programs or tracks are available to students and 15,000-20,000 NPs are practicing
- Nurse Practitioner Associates for Continuing Education (NPACE) is established
- *Guidelines for Family Nurse Practitioner Curricular Planning* is published after five years of development at the University of New Mexico

1984

- A steering committee forms to study the need for an organization representing an estimated 24,000 NPs nationwide

1985

- The American Academy of Nurse Practitioners (AANP) is established
- AANP initiates development of national NP database
- AANP has 100 members at end of first year

1986

- AANP begins a concerted effort to affect pertinent national legislation

1987

- \$100 million has been spent by the federal government on NP education

- AANP conducts member survey regarding NP professional malpractice liability insurance coverage, assisting NPs in reestablishing affordable malpractice insurance

1989

- Ninety percent of NP programs are either master's degree granting programs or post-master's degree programs
- Publication of the *Journal of the AANP* begins
- The first official AANP National Conference is held in Philadelphia with 158 attendees
- AANP moves headquarters from Massachusetts to Texas and hires first part-time paid staff position
- AANP releases results of first AANP National NP Sample Survey, collecting data on a range of NP preparation and practice characteristics

1991

- The AANP State Awards for NP Excellence is established

1992

- AANP actively works with nursing associations such as the Royal College of Nursing UK to develop role of NPs internationally
- Barbara J. Safriet writes in *The Yale Journal on Regulation* supporting the NP role

1993

- AANP forms Certification Program as separately incorporated entity

1994

- Munding publishes "Advanced Practice Nursing - Good Medicine for Physicians" in *The New England Journal of Medicine*, further supporting facts that NPs are cost-effective and quality primary health care providers

1995

- AANP initiates the Corporate Advisory Council (ACAC) to enhance communications and interaction with industry leaders

1998

- The AANP Foundation is established as a separately incorporated 501(c)(3) organization and is the first foundation operating to benefit NPs in all specialties

- The AANP Foundation Scholarship and Grant program is initiated and makes first awards to AANP members

1999

- AANP conducts National NP Sample Survey comparing results reported in 1989 survey
- *Estimated 60,000 NPs in the U.S.*

2000

- AANP initiates the Fellows program, hosts first international NP conference in U.S. and creates the Political Action Committee (PAC)

2001

- September 11 - AANP enlists support of hundreds of NPs to offer aid in NYC and D.C.
- *Estimated 87,000 NPs in the U.S.*

2002

- In lieu of forming own organization, acute care NPs join AANP
- The AANP Network for Research (AANPNR) is created, the first national practice-based research network exclusively for NPs

- AANP conducts Practice Site Survey

- AANP has 13,500 individual members and 70 group members

2003

- *AANP SmartBrief*, a daily electronic newsletter with cutting-edge health care related news culled from the top 300 electronic news sources, is implemented

- AANP Membership Survey is conducted

- AANP has 14,500 individual members and 74 group members

- *Estimated 97,000 NPs in the U.S.*

2004

- National Nurse Practitioner Week, held annually in November, is recognized in a proclamation by U.S. Congress

- The American Association of Colleges of Nursing (AACN) publishes position paper on Doctorate of Nursing Practice

- AANP conducts National NP Sample Survey

2005

- AANP celebrates 20 years as the oldest and largest national organization for NPs of all specialties
NPs celebrate 40 years of practice
- AANP conducts Practice Site Survey
- AANP has 20,000 individual members and 115 group members
- *Estimated 106,000 NPs in the U.S.*

2006

- Receive three highest awards for PR excellence from the Texas Public Relations Association for the 2005 *Celebrate 20/40* campaign, booklet and documentary
Increase participants in the AANP CE Provider Program to 16 approved providers
- Conduct AANP Membership Survey
- Conduct AANP Educational Needs Assessment Survey
AANP Fellows (FAANP) launches the Mentorship Program

2007

- Conduct 2007 AANP National NP Income Survey
Launch *NPFinder.com* - an online Web-based site for NPs to register their practices where new patients are being accepted so that consumers can locate an NP in their community
- AANP conducts NP Compensation Survey
- Develop and distribute paper on *AANP Standards for NP Practice in Retail-based Clinics*
- Launch AANP CE Center for online access to continuing education activities and credits

2008

- Join with AANP Foundation for restructuring of our Corporate Partner Council (NPCPC) housed under the AANP Foundation
- Initiate development of online CE tracking
- AANP conducts Practice Site Survey, Compensation Survey and Educational Needs Assessment Survey
- Enhance and increase presence of AANP as a major advocate and leader for all NPs through lobbying and direct communication with policy makers
- Create petition urging pharmaceutical companies and other suppliers of health care products to use provider-

neutral language in consumer print and broadcast advertisements

2009

- Distribute "Did You Know?" AANP video showcasing the role of the NP. Video is distributed to public television stations in all 50 states, airs 400 times in many of the top 200 markets on networks such as CNN, Fox News, Discovery, MSNBC, and is distributed internationally to Voice of America with a daily viewing audience of 96 million people airing in 200 cities and 127 countries.
- Conduct AANP Membership Survey, National NP Sample Survey and Educational Needs Assessment Survey
- Launch *E-Bulletin*, a weekly communication e-mail to all members
- Launch *Webnp.org*, a social networking site for AANP members
- Produce advertorial/open letter to President Obama and Members of Congress highlighting NPs as primary care providers. The letter runs in *Roll Call* publication that is distributed to elected officials in D.C.
- *Estimated 125,000 NPs in the U.S.*

2010

- AANP health policy activities center predominantly on Health Care Reform, CMS regulations, Medicare payment, Appropriations, Medical Home and state and local issues of importance to NPs and their patients
- AANP participates at a meeting with White House Office of Health Reform to review the primary care perspective on preventive care, access, coordinated primary care, quality of care, payment and the need to recognize all primary care providers as solutions to the health care crisis
- AANP attends President Obama's White House briefing on Health Care Reform legislation
- AANP holds first Specialty Conference offering 16 contact hours in cardiology, dermatology or orthopedics
- AANP celebrates 25th anniversary
- AANP Fellows (FAANP) celebrates 10th anniversary
- AANP has 28,000 individual members and 151 groups (as of May 2010)
- *Estimated 135,000 NPs in the U.S.*

HONORING NATIONAL NURSE PRACTITIONERS WEEK

(House of Representatives - October 06, 2004)

Mr. BILIRAKIS. Mr. Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res. 500) honoring the goals and ideals of National Nurse Practitioners Week.

The Clerk read as follows:

H. Con. Res. 500

Whereas there are more than 106,000 licensed nurse practitioners in the United States providing high-quality, cost-effective health care;

Whereas nurse practitioners are registered nurses, with advanced education and advanced clinical training, most with master's or post-master's degrees;

Whereas nurse practitioners diagnose acute and chronic conditions, prescribe medications, treat illnesses, and counsel patients on health care issues, in coordination with physicians and other health care providers;

Whereas the excellence, safety, and cost-effectiveness of the care provided by nurse practitioners has been established;

Whereas nurse practitioners provide health care to people of all ages and in diverse health care settings, such as private office practice, hospitals, long-term care facilities, schools, State and local health departments, and managed care facilities;

Whereas more than 20 percent of nurse practitioners practice in rural settings with populations of less than 25,000, and of the 62 percent who work in cities with populations of more than 50,000, more than 39 percent work in inner-city areas; and Whereas the American Academy of Nurse Practitioners has designated the week of November 7-13, 2004, as National Nurse Practitioners Week in recognition of the many contributions that this dedicated group of health care professionals makes to the health and well-being of the people in the communities they serve in this great country: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That the Congress--

(1) honors the goals and ideals of National Nurse Practitioners Week; and

(2) offers sincere support to nurse practitioners around the country as they continue to provide high-quality health care to many Americans.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. Bilirakis) and the gentleman from Ohio (Mr. Brown) each will control 20 minutes.

The Chair recognizes the gentleman from Florida (Mr. Bilirakis).

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the House Concurrent Resolution 500.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H. Con. Res. 500, honoring the goals and ideals of National Nurse Practitioners Week, introduced by the gentleman from Texas (Mr. Burgess).

The American Academy of Nurse Practitioners has designated the week of November 7 through 13, 2004, as National Nurse Practitioners Week in recognition of the many contributions that this dedicated group of health care professionals makes to the people and well-being of the people in the communities they serve in this great country.

Currently, there are more than 100,000 licensed nurse practitioners in the United States providing high-quality, cost-effective health care. These nurses have advanced education and advanced clinical training, most with Master's or post-Master's degrees. Every day they, in coordination with physicians and other health care providers, diagnose acute and chronic conditions, prescribe medications, treat illnesses, and counsel patients on health care issues.

I urge my colleagues to offer their support to nurse practitioners around the country and to help us support H. Con. Res. 500.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, nurse practitioners play a critical role in meeting our Nation's medical needs. Working hand-in-hand with other professionals, nurse practitioners improve the flexibility and responsiveness and efficiency of our health care system. Because of their focus on primary care, disease prevention, and counseling, nurse practitioners serve as health care

first responders for many American families. From weight management, blood pressure, dangerous infections, injuries, nurse practitioners have the frontline view of health care in our country.

Nurse practitioners also improve the health care system's ability to reach underserved populations. As we all know, primary health care is desperately needed in many urban and central city communities.

As this resolution notes, nurse practitioners have been there to help meet this need. Twenty percent of nurse practitioners serve in rural areas. Forty percent who serve in metropolitan areas work in central city settings.

In this age of double-digit health care cost inflation, nurse practitioners help to improve the cost effectiveness of American health care. By improving patient choice of provider and by promoting competition, nurse practitioners help to moderate spiraling health care costs.

Nurse practitioner training programs were first developed some 40 years ago. A shortage of doctors forced State governments to innovate, and a few nurse practitioners were certified, mostly, in those days, initially in pediatrics. From that modest beginning, the nurse practitioner profession has grown to fill an important and vital role in America's health care system. There are now more than 100,000 nurse practitioners serving the American public.

I join my colleagues in urging the House to agree to this concurrent resolution celebrating those 100,000 nurse practitioners and marking the goals and ideals of National Nurse Practitioners Week.

Mr. Speaker, I reserve the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I yield such time as he may consume to the gentleman from Texas (Mr. Burgess), the writer of this bill, a gentleman who is a medical doctor, who certainly has practical real-world experience in the world of nurse practitioners.

Mr. BURGESS. Mr. Speaker, I thank the chairman for allowing this bill to come to the floor. I am aware that there are many of pieces of legislation that could have filled these hours this week.

Mr. Speaker, nurse practitioners fill a vital role in America's health care system. As the gentleman from Ohio pointed out, there are over 106,000 nurse practitioners providing high-quality care around the Nation, and they are especially important in rural and underserved areas.

These health care professionals are critical in my district, especially in areas of Fort Worth, Texas. John Peter Smith, the public hospital system in Tarrant County, maintains 23 clinics for low-income and indigent patients around the county.

Nurse practitioners are able to enhance the services provided in many of these health care clinics. By utilizing nurse practitioners, John Peter Smith is able to see significantly more patients in an outpatient setting and to do so on a finite, fixed taxpayer-funded budget. John Peter Smith and the patients served by the health system could not do without the dedicated corps of nurse practitioners.

And on a personal note, Mr. Speaker, I have worked with nurse practitioners both in a training program at Parkland Hospital and I have had several come through my private practice in Lewisville, Texas, who trained there and stayed on with me to work in private practice, Lori Driggs and Jenny Andrews, and certainly I learned a great deal more from them than I was ever able to teach them.

Mr. Speaker, on November 7 through 13, 2004, the American Academy of Nurse Practitioners will recognize National Nurse Practitioners Week to honor the dedication and commitment of these health care professionals. I rise to commend nurse practitioners for the contribution they make to the health and well-being of our country.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentleman from Illinois (Mr. Davis).

Mr. DAVIS of Illinois. Mr. Speaker, I simply rise in strong support of H. Con. Res. 500, honoring the goals and ideals of National Nurse Practitioners Week. I also want to commend the gentleman from Florida (Chairman BILIRAKIS), chairman of the subcommittee, and the gentleman from Ohio (Mr. Brown), ranking member, for the tremendous work that they do on health and health-related issues.

A great deal of my personal health care is provided by a nurse practitioner, and I simply commend her and all of the other nurse practitioners throughout the country who make up an integral part of our health care delivery system. And I would urge agreement to this concurrent resolution.

Mr. BROWN of Ohio. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. Bilirakis) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 500.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

END

Scope of Practice for Nurse Practitioners



PROFESSIONAL ROLE

Nurse Practitioners are licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. According to their practice specialty they provide nursing and medical services to individuals, families and groups. In addition to diagnosing and managing acute episodic and chronic illnesses, nurse practitioners emphasize health promotion and disease prevention. Services include, but are not limited to ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, and prescription of pharmacologic agents and non pharmacologic therapies. Teaching and counseling individuals, families and groups are a major part of nurse practitioner practice.

As licensed independent practitioners, nurse practitioners practice autonomously and in collaboration with health care professionals and other individuals to assess, diagnose, treat and manage the patient's health problems/needs. They serve as health care researchers, interdisciplinary consultants and patient advocates.

EDUCATION

Entry level preparation for nurse practitioner practice is at the master's, post master's or doctoral level. Didactic and clinical courses prepare nurses with specialized knowledge and clinical competency to practice in primary care, acute care and long term health care settings. Self-directed continued learning and professional development beyond the formal advanced education is essential to maintain clinical competency.

ACCOUNTABILITY

The autonomous nature of the nurse practitioner's advanced clinical practice requires accountability for health care outcomes. Insuring the highest quality of care requires national certification, periodic peer review, clinical outcome evaluations, a code for ethical practice, evidence of continuing professional development and maintenance of clinical skills. Nurse practitioners are committed to seeking and sharing knowledge that promotes quality health care and improves clinical outcomes. This is accomplished by leading and participating in both professional and lay health care forums, conducting research, and applying findings to clinical practice.

RESPONSIBILITY

The role of the nurse practitioner continues to evolve in response to changing societal and health care needs. As leaders in primary and acute health care, nurse practitioners combine the roles of provider, mentor, educator, researcher and administrator. Members of the profession are responsible for advancing the role of the nurse practitioner and insuring that the standards of the profession are maintained. This is accomplished through involvement in professional organizations and participation in health policy activities at the local, state, national, and international levels.

I. Qualifications

Nurse Practitioners are licensed independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long term care settings. They are registered nurses with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long term care settings. Master's, post master's or doctoral preparation is required for entry level practice.

(AANP 2006)

II. Process of Care

The nurse practitioner utilizes the scientific process and national standards of care as a framework for managing patient care. This process includes:

A. Assessment of health status

The nurse practitioner assesses health status by:

- obtaining a relevant health and medical history
- performing a physical examination based on age and history
- performing or ordering preventive and diagnostic procedures based on the patient's age and history
- identifying health and medical risk factors

B. Diagnosis

The nurse practitioner makes a diagnosis by:

- utilizing critical thinking in the diagnostic process
- synthesizing and analyzing the collected data
- formulating a differential diagnosis based on the history, physical examination, and diagnostic test results
- establishing priorities to meet the health and medical needs of the individual, family, or community

C. Development of a treatment plan

The nurse practitioner, together with the patient and family, establishes an evidence based, mutually acceptable, cost-awareness plan of care that maximizes health potential.

Formulation of the treatment plan includes:

- ordering and interpreting additional diagnostic tests
- prescribing/ordering appropriate pharmacologic and non-pharmacologic interventions
- developing a patient education plan
- appropriate consultation/referral

D. Implementation of the plan

Interventions are based upon established priorities.

Actions by the nurse practitioners are:

- individualized
- consistent with the appropriate plan for care
- based on scientific principles, theoretical knowledge, and clinical expertise
- consistent with teaching and learning opportunities

Actions include:

- accurately conducting, supervising, and interpreting diagnostic tests
- prescribing/ordering pharmacologic agents and non pharmacologic therapies
- providing relevant patient education
- making appropriate referrals to other health professionals and community agencies

E. Follow-up and evaluation of the patient status

The nurse practitioner maintains a process for systematic follow-up by:

- determining the effectiveness of the treatment plan with documentation of patient care outcomes
- reassessing and modifying the plan with the patient and family as necessary to achieve health and medical goals

III. Care Priorities

The nurse practitioner's practice model emphasizes:

A. Patient and family education

The nurse practitioner provides health education and utilizes community resource opportunities for the individual and/or family

B. Facilitation of patient participation in self care.

The nurse practitioner facilitates patient participation in health and medical care by providing information needed to make decisions and choices about:

- promotion, maintenance, and restoration of health
- consultation with other appropriate health care personnel
- appropriate utilization of health care resources

C. Promotion of optimal health

D. Provision of continually competent care

E. Facilitation of entry into the health care system

F. The promotion of a safe environment

IV. Interdisciplinary/Collaborative Responsibilities

As a licensed independent practitioner, the nurse practitioner participates as a team leader and member in the provision of health and medical care, interacting with professional colleagues to provide comprehensive care.

V. Accurate Documentation of Patient Status and Care

The nurse practitioner maintains accurate, legible, and confidential records.

VI. Responsibility as Patient Advocate

Ethical and legal standards provide the basis of patient advocacy. As an advocate, the nurse practitioner participates in health policy activities at the local, state, national and international levels.

VII. Quality Assurance and Continued Competence

Nurse practitioners recognize the importance of continued learning through:

- participation in quality assurance review, including systematic review of records and treatment plans on a periodic basis
- maintenance of current knowledge by attending continuing education programs
- maintenance of certification in compliance with current state law
- applying standardized care guidelines in clinical practice

VIII. Adjunct Roles of Nurse Practitioner

Nurse practitioners combine the roles of provider, mentor, educator, researcher, manager and consultant. The nurse practitioner interprets the role of the nurse practitioner to individuals, families, and other professionals.

IX. Research as Basis for Practice

Nurse practitioners support research by developing clinical research questions, conducting or participating in studies, and disseminating and incorporating findings into practice.

Position Statement on Nurse Practitioner Prescriptive Privilege



The American Academy of Nurse Practitioners (AANP) advocates that nurse practitioners have unlimited prescriptive authority (this includes dispensing privileges) in their scope of practice.

Nurse practitioners are licensed independent advanced practice nurses who have completed a formal educational program beyond that of the registered nurse. Nurse practitioners have advanced education in pathophysiology, pharmacology and clinical diagnosis and treatment that prepares them to diagnose and prescribe medications and treatments in their specialty area. Nurse practitioners make independent and collaborative decisions about the health care needs of individuals, families, and groups across the life span.

Over four decades of research conclude that nurse practitioners provide safe, cost-effective, high-quality health care. Prescribing medications and devices is essential to the nurse practitioner's practice. Restrictions on prescriptive authority limit the ability of nurse practitioners to provide comprehensive health care services.

Nurse practitioners are regulated by state boards of nursing or other state designated agencies. Nurse practitioners serve as members of state boards of nursing and advisory councils for advanced practice nurses. This process promotes public safety and competent nurse practitioner practice.

AANP recommends that state boards of nursing regulate nurse practitioner practice and prescriptive authority. AANP also advocates that nurse practitioners be nationally certified and obtain annual continuing education credits in pharmacology.

The ability of nurse practitioners to prescribe, without limitation, legend and controlled drugs, devices, adjunct health/medical services, durable medical goods, and other equipment and supplies is essential to provide cost-effective, quality health care for the diverse populations they serve across the life span.

Position Statement on Nurse Practitioner Curriculum



INTRODUCTION

The American Academy of Nurse Practitioners *Scope of Practice for Nurse Practitioners* (2010) describes nurse practitioners (NPs) as licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. According to their practice population focus, NPs deliver nursing and medical services to individuals, families, and groups.

The completion of a formal graduate educational program and a commitment to life-long learning and professional self-development assures society that NPs acquire and maintain the theoretical knowledge and clinical skills appropriate for their scope of practice. Formal graduate education also enables NPs to achieve and maintain professional certification and statutory recognition.

GRADUATE NURSING EDUCATION

Entry-level preparation for NP practice is a graduate degree. While most NP programs currently award master's degrees and/or post-master's certificates, an increasing number of NP programs award doctoral degrees. In 2004, the American Association of Colleges of Nursing recommended that a shift in preparing all advance practice nurses, including NPs, to the doctoral level by 2015, with the degree title of doctor of nursing practice, or DNP (AACN, 2004; AANP, 2010).

NP education provides theoretical and evidence-based clinical knowledge and learning experiences for role development as an NP. The emphasis in a graduate NP program is on the development of clinical and professional expertise necessary for comprehensive primary care and specialty care practice in a variety of settings. The NP curriculum should be designed to prepare graduates to qualify for national certification in their anticipated area of population-focused practice. Additionally, NP programs cultivate advanced skills in the roles of educator, counselor, advocate, consultant, manager, researcher, and mentor.

Faculty members who maintain NP clinical expertise, licensure, and national certification in an NP population-focus practice area should implement the clinical portion of the NP curriculum. Non-NP faculty members should understand the NP's scope of practice and have the necessary preparation, knowledge, and skills appropriate to their content areas. Preceptors should have preparation and at least one year of clinical experience in their areas of clinical supervision. (National Task Force on Quality of NP Education, 2008)

IOM Committee of the Health Professions Education Summit participants (IOM, 2003) specify that "all healthcare professionals should be educated to deliver patient-centered care as members of an interdisciplinary teams, emphasizing evidence-based practice, quality improvement approaches, and informatics" (p. 48). Entry-level core NP competencies have been identified to guide the development of NP curricula. The skills and knowledge competencies are essential to all NPs, regardless of population focus. The competencies are organized in seven content domains. The NP content domains are: Management of Patient Health/Illness Status, The Nurse Practitioner-Patient Relationship, The Teaching-Coaching Function, Professional Role, Managing and Negotiating Health Care Delivery Systems, Monitoring and Ensuring the Quality of Health Care Practices, and Culturally-Sensitive Care (NONPF, 2006). DNP competencies have also been identified (NONPF, 2006).

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Quality of Nurse Practitioner Practice



Nurse practitioners (NPs) are high quality health care providers who practice in primary care, ambulatory, acute care, specialty care, and long-term care. They are registered nurses prepared with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of settings. A graduate degree is required for entry-level practice. The NP role was created in 1965, and for 45 years, research has consistently demonstrated the high quality of care provided by NPs. The body of evidence supports that the quality of NP care is at least equivalent to that of physician care. This paper provides a summary of a number of important research reports supporting the NP.

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.

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 geriatric syndromes such as falls, UTIs, pressure ulcers, etc. They also had improved functional status, as well as better managed chronic conditions.

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.

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.

Significant cost savings were demonstrated when 1207 patients in an academic medical center were randomized to either standard treatment or to a physician-NP model.

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. The health status data and quality of care indicators were too heterogeneous to allow for meta-analysis, although qualitative comparisons of the results reported showed comparable outcomes between NPs and physicians. NPs offered more advice/information, had more complete documentation, and had better communication skills than physicians. NPs spent longer time with their patients and performed a greater number of investigations than did physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of studies and interpretations of x-rays were identified.

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.

This meta-analysis included 25 articles relating to 16 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or advance practice 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 the study described by Mundinger, et al. in 2000 (see below) are further described in this report including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients. 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., Lens, 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.

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. Health service utilization was equivalent at both 6 and 12 months and patient satisfaction was equivalent following the initial visit. The only exception was that at six months, physicians rated higher on one component (provider attributes) of the satisfaction scale.

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." (p. 19) 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.

The authors conducted a cross-sectional study of 46 practices, measuring adherence to ADA 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.

Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. *Nurse Practitioner*, 1(1), 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.

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. The only exception was for diabetes visits to the medicine practices, where the satisfaction was higher for physicians.

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 1598 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. Details from the Burlington trial were also described by Spitzer, et al (see below).

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 OTA 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, and data on nurse midwife practice, 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" (p. 487).

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. (see above). This study involved 2796 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. The NP group experienced a 5% drop in revenue, associated with absence of billing for NP care. It was hypothesized that the ability to bill for all NP services would have resulted in an actual increased revenue of 9%. NPs functioned alone in 67% of their encounters. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. Prescriptions were rated adequate for 71% of NPs compared to 75% for physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician" (p. 255).

Cost-Effectiveness



Nurse Practitioners (NPs) are a proven response to the evolving trend towards wellness and preventive health care driven by consumer demand. For 45 years, the body of evidence has supported NPs as cost-effective providers of high-quality care.

Nearly three decades ago, the Office of Technology Assessment (OTA) (1981) conducted an extensive case analysis of NP practice and reported that NPs provided equivalent or improved medical care at a lower total cost than physicians. The authors determined that NPs could manage up to 80% of adult primary care and 90% of pediatric primary care needs at that time. NPs in a physician practice were found to have the potential to decrease the cost per patient visit by as much as one third, particularly when seeing patients in an independent, rather than complementary, manner. Since 1981, continued reports have supported ongoing cost-effectiveness of NP practice. When OTA later re-examined the role of NP practice, the positive analysis was confirmed (OTA, 1986).

In 1981, the hourly cost of an NP was one-third to one-half the cost of a physician (OTA). In 2009, the median total compensation for primary care physicians ranged from \$198,000 (family) to \$205,000 (internal medicine) (American Medical Group Association, 2009). The mean 2009 total salary for NPs across all specialties who practiced full-time was \$90,200 (American Academy of Nurse Practitioners [AANP], 2009). NP preparation currently costs 20-25% that of physician preparation (American Association of Colleges of Nursing, 2000). A recent study of 26 capitated primary care practices with approximately two million visits by 206 providers determined that the practitioner labor costs per visit and total labor costs per visit were lower in practices where NPs and physician assistants (PAs) were used to a greater extent (Roblin, Howard, Becker, Adams, and Roberts, 2004). When productivity measures, salaries, and costs of education are considered, NPs are cost effective providers of health services.

NPs practicing in Tennessee's state-managed MCO, TennCare, delivered health care at 23% below the average cost of other primary care providers with a 21% reduction in hospital inpatient rates and 24% lower lab utilization rates compared to physicians (Spitzer, 1997). Jenkins and Torrisi (1995) performed a one-year study comparing a family practice physician-managed practice with an NP-managed practice within the same managed care organization. The NP-managed practice had 43% of the total emergency department visits, 38% of the inpatient days, and a total annualized per member monthly cost that was 50% that of the physician practice.

A study conducted in a large HMO setting found that adding an NP to the practice could virtually double the typical panel of patients seen by a physician. The projected increase in revenue was \$1.28 per member per month, or approximately \$1.65 million per 100,000 enrollees per year (Burl, Bonner, and Rao, 1994).

Chenowith, Martin, Pankowski, and Raymond (2005) analyzed the health care costs associated with an innovative on-site NP practice for over 4000 employees and their dependents. Compared with claims from earlier years, the NP care resulted in significant savings of \$.8 to 1.5 million, with a benefit-to-cost ratio of up to 15 to 1. In a later analysis, Chenowith, Martin, Panowski, and Raymond (2008) tested two additional benefit-to-cost models, using 2004-2006 data for patients receiving occupational health care from an NP. The later models further supported cost savings for NP care, demonstrating a benefit to cost ratio ranging from 2.0-8.7 to 1, depending on the method. Time lost from work was lower for workers managed by NPs, compared to physicians, as another aspect of cost-savings (Sears, Wickizer, Franklin, Cheadie, and Berkowitz, 2007).

A cost analysis comparing the cost of providing services at an NP managed center for homeless clients with other community alternatives showed earlier and less costly interventions by the NP managed center (Hunter, Ventura, and Keams, 1999). Coddington and Sands (2009) reviewed the literature regarding cost and quality of care for nurse managed centers where APNs, namely NPs, were responsible for patient care. Well-established NMCs with higher patient volumes operated at per patient cost lower than other options, with significant savings. The patients had fewer emergency visits and hospitalizations in several of the reports reviewed, further contributing to cost-effectiveness.

Chen, McNeese-Smith, Cowan, Upenieks, and Afifi (2009) found that NP-led care was associated with lower overall drug costs for inpatients. When Paez and Allen (2006) compared NP and physician management of hypercholesterolemia following revascularization, they found patients in the NP-managed group had lower drug costs, while being more likely to achieve their goals and comply with prescribed regimen.

A number of studies have documented the cost-effectiveness of NPs in managing the health of older adults. When comparing the cost of physician-only teams with the cost of a physician-NP team in one long term care facility, the physician-NP team's cost were 42% lower for the intermediate and skilled care residents and 26% lower for those with long-term stays. The physician-NP teams also had significantly lower rates of emergency department transfers, shorter hospital lengths of stay, and fewer specialty visits (Hummel and Pirezada, 1994). Intrator (2004) found that residents in nursing homes with NPs were less likely to develop ambulatory care-sensitive diagnoses that would then result in hospitalizations. In fact, the odds ratio for preventable ambulatory care-sensitive hospitalizations of long-stay residents was lower (0.83) for facilities with NPs than for facilities with more physicians on staff (odds ratio 1.14). Bakerjian (2008) reviewed articles regarding NP care of nursing home residents. She summarizes a review of 17 studies comparing nursing home residents who are patients of NPs with others, demonstrating lower rates of hospitalization for the NP patients. Seven studies of cost outcomes of NP care consistently demonstrated lower cost of care than control or comparison groups. The potential for NPs to control costs associated with the healthcare of older adults has been recognized by United Health (2009), which recommended that by providing NPs to manage nursing home patients, \$166 billion in healthcare savings could be realized.

A collaborative NP/physician team was associated with decreased length of stay and costs and higher hospital profit, with similar readmission and mortality rates (Cowan et al., 2006; Ettner et al., 2006). Larkin (2003) cites a number of studies supporting decreased costs, complication rates, and lengths of stay associated with NP-managed care. For instance, he cites University of Virginia Health System's 1999 introduction of an NP model in the area of neuroscience, resulting in over \$2.4 million savings the first year and a return on investment of 1600 percent. The NP model has been expanded in this system, with similar savings and improved outcomes documented. A one-year retrospective study of 1077 HMO enrollees residing in 45 long term care settings demonstrated a \$72 monthly gain per resident, compared with a monthly \$197 loss for residents seen by physicians alone (Burl, Bonner, Rao, and Kan, 1998). Boling (2009) cites outcomes documented by Smigelski et al. for an intensive short-term transitional care NP program, through which healthcare costs were decreased by 65% or more after enrollment. Another example cited includes an NP model introduced at Loyola University Health System's cardiovascular area, with a decrease in mortality from 3.7% to 0.6% and over 9% decreased cost per case (from \$27,037 to \$24,511).

In addition to absolute cost, other factors are important to health care cost-effectiveness. These include illness prevention, health promotion, and outcomes. See Documentation of Quality of Nurse Practitioner Practice (AANP, 2010) for further discussion.

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Discussion Paper: Doctor of Nursing Practice



The concept of a practice or clinical doctorate has been under discussion within the nurse practitioner (NP) community since before 2001 when the National Organization of NP Faculties (NONPF) established a task force to examine the issues from the NP educational perspective. In October 2004, the American Association of Colleges of Nursing (AACN) published a position paper focusing on the issue of converting the terminal degree for advanced practice nursing from the Master's to the Doctor of Nursing Practice (DNP) by the year 2015. AACN convened two task forces consisting of AACN members to identify the "Essentials for the DNP", similar to the "Essentials" currently in use for NP Master's Programs, and the "DNP Road Map" to propose a process for smoothly accomplishing this goal by 2015. The American Academy of Nurse Practitioners (AANP) and the American Academy of Nurse Practitioners Certification Program participated in these activities as they have unfolded. In 2008, AANP facilitated the Nurse Practitioner Roundtable, a coalition of NP organizations, to consider the current issues surrounding the DNP movement. The coalition published "Nurse Practitioner DNP Education: Certification and Titling: A Unified Statement" in June, 2008. In July 2008, the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee published the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education*, a document which establishes a framework for the processes identified in the title and which continues to broadly define APRN at the graduate level.

The rationale for the shift in the academic preparation of nurses in advanced practice focuses on several issues, including the observation that advanced practice nursing is currently one of only a few health care disciplines that prepare their practitioners at the master's rather than the doctoral level. Most licensed independent practitioners (LIPs) such as podiatrists, psychologists, optometrists, pharmacists, osteopaths, medical doctors and dentists are prepared at the clinical doctoral level. Current master's and higher degree NP programs fully prepare NPs to be accountable for health promotion, as well as the management of patients with undifferentiated problems and those with acute, complex chronic, and/or critical illness. However, it is clear that the course work currently required in NP master's programs is equivalent to that of other clinical doctoral programs. It is important however, that the transition to clinical doctoral preparation for NPs continue to be conducted so that master's prepared NPs will not be disenfranchised in any way.

The following issues, therefore, will need to be addressed to ensure that the preparation of NPs at the clinical doctoral level further develops in a logical and equitable fashion.

1. The quality of the preparation of current master's and post-master's NP programs must not be compromised. NPs have demonstrated skills in providing high quality care to their patients regardless of gender, age or socioeconomic status. The evolution of NPs programs to offer a doctorate in nursing practice does not change that fact. NPs provide safe, high quality care in all specialties and practice sites in which they are involved.
2. The transition to the new title must be handled smoothly and seamlessly, to avoid negative impact on NP practice and sound patient care, and to maintain parity.
3. Additional requirements, if any, made in the DNP programs should reflect areas where evidence supports need for increased depth to enhance NP practice.
4. Skilled clinical practice must be maintained as the foundation of all NP educational programs.

5. Issues related to parity must be addressed, to include providing reasonable methods for currently prepared NPs to obtain the DNP, if desired, and preventing discrimination in reimbursement.
6. Programs must be developed based upon agreed upon standards and guidelines.
7. Accreditation standards must be maintained to ensure the preparation of safe, highly qualified clinicians who can be certified and recognized in the regulatory arena.
8. Programs should remain accessible and affordable to qualified applicants, in order to maintain an adequate number of highly qualified NP clinicians to contribute to the health of their communities.

The evolution of existing master's programs to practice doctorate programs can add strength to programs, to NP practice and recognition in the health care arena. The development of such programs must be conducted in a manner that allows for smooth transitioning.

AANP is dedicated to and continues to address these issues as steps are taken to implement activities that would lead to the further development of DNP NP educational programs in the future.

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Standards for Nurse Practitioner Practice in Retail-Based Clinics



It is the position of the American Academy of Nurse Practitioners that primary care nurse practitioners (NPs) can play a significant role in making retail-based clinics (also known as convenient care clinics) a viable health care option to patients who might not otherwise receive needed care in a timely manner. To do this, a number of standards must be met to assist the NP in maintaining the high quality of care that NPs provide. Multiple studies have demonstrated that NPs provide health care that is equal to, or superior to that of physicians providing the same care for the same problems. Likewise, patient satisfaction ratings for NPs are found to be very high.* The combination of high quality nursing and medical care provided by NPs is an effective model for care in retail-based clinics.

Recognizing that primary care NPs are advanced practice licensed independent practitioners, the following standards should be maintained in retail-based clinics utilizing NPs as their primary providers of care:

1. NPs utilized in retail-based clinics must meet all regulatory requirements for certification and education and be recognized to practice as an NP in the state in which the clinic functions.**
2. NPs must be consulted regarding the development of retail-based primary care clinics, their policies, practice guidelines and operational procedures.
3. NPs must be an integral part of management activities in establishing and running retail-based primary care clinics.
4. The functions of the clinic should be based on the NP's full scope of practice and should not limit the ability of NPs to conduct appropriate assessments and provide appropriate evidence-based treatments and referrals to other health care providers, institutions and agencies.
5. The NP must be provided with resources to maintain appropriate health/medical records for all patients seen in the clinic, and provide appropriate information to other health care providers within the framework of HIPAA regulations.
6. The facility must be adequately equipped to appropriately provide primary care services including but not limited to the provision of patient privacy, and the maintenance of OSHA, CLIA and ADA standards.
7. NPs must be permitted to establish an ongoing program for quality assurance through appropriate peer review and established quality measures.
8. NPs must be able to maintain high standards of professionalism in all activities undertaken in the retail-based clinic environment.
9. NPs employed by retail-based clinics must receive competitive salaries or equivalent payment for services and benefits, including opportunities to attend professional meetings and continuing education activities.

The implementation of these standards will facilitate the provision of high quality primary care services to patients seen by NPs in the retail-based clinic setting.

Summary

Retail-based clinics are a potentially viable resource for the provision of necessary primary care services in many communities throughout the United States. In order to facilitate their functioning at the highest quality level, NPs must be involved in all aspects of forming and running these clinics.

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Use of Terms Such as Mid-Level Provider and Physician Extender



The American Academy of Nurse Practitioners (AANP) opposes 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. NPs are licensed independent practitioners. AANP encourages employers, policy-makers, healthcare professionals, and other parties to refer to NPs by their title. When referring to groups that include NPs, examples of appropriate terms include: independently licensed providers, primary care providers, healthcare professionals, and clinicians.

Terms such as “midlevel provider” and “physician extender” are inappropriate references to NPs. These terms originated in bureaucracies and/or medical organizations; they are not interchangeable with use of the NP title. They call into question the legitimacy of NPs to function as independently licensed practitioners, according to their established scopes of practice. These terms further confuse the healthcare consumers and the general public, as they are vague and are inaccurately used to refer to a wide range of professions.

The term “midlevel provider” (mid-level provider, mid level provider, MLP) implies that the care rendered by NPs is “less than” some other (unstated) higher standard. In fact, the standard of care for patients treated by an NP is the same as that provided by a physician or other healthcare provider, in the same type of setting. NPs are independently licensed practitioners who provide high quality and cost-effective care equivalent to that of physicians.^{1,2} The role was not developed and has not been demonstrated to provide only “mid-level” care.

The term “physician extender” (physician-extender) originated in medicine and implies that the NP role evolved to serve an extension of physicians’ care. Instead, the NP role evolved in the mid-1960’s in response to the recognition that nurses with advanced education and training were fully capable of providing primary care and significantly enhancing access to high quality and cost-effective health care. While primary care remains the main focus of NP practice, the role has evolved over almost 45 years to include specialty and acute-care NP functions. 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”. These terms are all vague and are not descriptive of NPs. The term “limited license provider” lacks meaning, in that all independently licensed providers practice within the scope of practice defined by their regulatory bodies. “Non physician provider” is a term that lacks any specificity by aggregately including all healthcare providers who are not licensed as an MD or DO; this term could refer to nursing assistants, physical therapy aides, and any member of the healthcare team other than a physician. The term “allied health provider” refers to a category that excludes both medicine and nursing and, therefore, is not relevant to the NP role.

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- For more information, visit www.aanp.org