行政院及所屬各機關出國報告書
（出國類別：考察）

美國專科護理師制度考察報告

出國人：

服務機關	職稱	姓名
行政院衛生署	科長	高文惠
國立台北護理學院	副教授	蔡秀鶯
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出國地區：美國
出國期間：九十年十月一日至九十年十月五日
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公 務 出 國 報 告 提 要

頁數: 250　含附件: 是

報告名稱:

參加美國專科護理師制度考察

主辦機關:

行政院衛生署

聯絡人／電話:

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高文惠　行政院衛生署　醫政處　科長

出國類別: 考察

出國地區: 美國

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分類號/目: J0／綜合（醫藥類）　J0／綜合（醫藥類）

關鍵詞: 專科護理師

內容摘要: 在美國，專科護理師制度隨著時代的演進而發揮其不同的角色功能，而目前其專科護理師制度已發展至所謂的進階執業護理師（Advanced practice nurse）的階段，即該進階執業護理師的名詞可相當廣泛地包括執業護理師（Nurse Practitioners）、合格的護士助產士（CNM ; Certified nurse-midwives）、麻醉護士（CRNA ; Nurse anesthetists）及專科臨床護理師（CNS ; Clinical specialists）等護理專業人員；他們於臨床上扮演著獨立、合作性的健康照護者身分，亦即於臨床上他們可以扮演著顧問、行政者、研究者或教育者的功能。以執業護理師（Nurse Practitioners）爲例，他們可於不同的專科領域執業，如家庭、成人、小兒科、老人科、婦女衛生（women' s Health）、學校衛生（school health）、職業衛生、心理衛生（mental health）、急診及急性照護（emergency and acute care）。其主要特色即在於他們可以評估及處理有關醫療及護理方面的問題（medical and nursing problems），故他們可以詢問病史（taking histories）、理學檢查（conducting physical examination）、開具醫囑處方（ordering）、病情診斷及檢驗判讀（performing and interpreting appropriate diagnostic and laboratory tests）、處方藥物（prescription of pharmacological agents, treatments and nonpharmacological therapies for the management of the conditions which they diagnose）等。在基層醫療及一般的急性醫療照護，執業護理師可於門診、急性及長期照護單位工作，提供一般護理服務、醫療服務給個人、家庭及團體。在執業護理師的養成教育方面，基本上是要經由碩士學制的養成及至少五百小時的臨床實習訓練，方得具備執業護理師的資格，其養成訓練課程包括（一）一般核心課程如：研究方法學、護理理論、倫理學、組織學、人類科學、健康政策、健康照護系統、健康照護財務；（二）執業護理師專業課程則包括進階健康評估、進階藥理學、進階生理病理學、

健康促進及疾病預防、以社區爲基礎的執業學科、專業角色發展、家庭理論、生長發育學、臨床決策學及其他課程；（三）執業領域中專業角色發展；（四）健康與疾病的診斷與管理。而其養成教育的評估則由全國性執業護理師團體（National Organization of Nurse Practitioner Faculties）定期予以評值，其評值項目不只包括課程內容，亦包括師資、臨床實習資源，甚或執業護理師於碩士畢業一年及第五年後的成果評值（包括考照合格率、於該專科領域的地位、工作的滿意度、對於成爲NP的滿意度等等）　執業護理師可否開具處方、醫囑、理學檢查等醫療行爲，其實是因各州規定而異，以紐約州爲例，允許執業護理師執行上開所述之醫療業務（包含部分管制藥品的處方），於實際作業上，執業護理師尚須與受聘僱之醫院、合作之醫師等共三方簽署一份有關照人照護的責任聲明書，依該聲明書所敘內容範圍，執業護理師方得從事某些業務、參加醫療責任保險，並須定期（至少一年一次）接受合作醫師的審核。至於其他各州的情況則不一，有的則須在醫師監督之下執行業務，如加州、佛羅里達州；有則由當地的護理團體定其執業範圍而不須醫師的合作或監督，如德州、奧勒岡州。各州的規定不一，其實與各州的醫療資源、保險制度有關，尤其近年來，管理式照護制度之興起，執業護理師自有其發展的空間，而其間專業團體的角力（如醫師團體與護理團體於政策上的影響）亦爲重要因素。但不管其執業範圍與我國現行制度之差別多大，執業護理師團體也訂定相關稽核制度，自養成教育至執業過程中，皆有一定的考核機制，以確保其成員的素質。

目　　錄

壹、研修行程表

Mamie Kwoh Wang Nurse-Visiting Scholars Study Group
2001
Monday, October 1, 2001

246 Greene Street, Kimball Hall-7th Floor Conference Room

8:30 am	Breakfast
9:00 - 9:30 am	*Welcoming Remarks* -- Dr. Diane O. McGivern, PhD, RN, FAAN, The Erline Perkins McGriff Professor Head, Division of Nursing
9:30 - 10:30 am	*Preparing for Advanced Practice Direct Provider Roles"*--Judith Haber, PhD, RN, CS, FAAN, Director, Master's and Post Master's Certificate Programs
10:30 - 11:30 am	*"Orientation to Informatics"* --Barbara Carty, EdD, RN Coordinator, Nursing Informatics
11:30 - 12:30 pm	LUNCH- Room 702
	-Free Time-

Mamie Kwoh Wang Nurse-Visiting Scholar Fund
2001
Tuesday, October 2, 2001

Clinical Site Visits
9:00-11:00 am

•New York University Medical Center-Tisch Hospital

1:00 - 3:00 pm

•Chinatown Health Clinic
Or
•PS 307 School- based Health Clinic

****Contact Person for possible problems/questions-Professor Naegle (212) 998-5321**

Mamie Kwoh Wang Nurse-Visiting Scholar Fund
2001
Wednesday, October 3, 2001

Clinical Site Visits

10:00-11:00 am

- The Bowery Resident's Committee Community-based care
  Or
  -Free Time-

1:00-3:00 pm

- Montefiore Pediatric Emergency Room
  Or
- Terrence Cardinal Cooke Health Center-Long Term Care Facility

****Contact persons for possible problems/questions**
am-Tanita Woodson (646) 621-7890
pm-Professor Madeline Naegle (212) 998-5321

5:00-6:30 pm **RECEPTION - 246 Greene Street, 8th Floor Conference Room**

Mamie Kwoh Wang Nurse-Visiting Scholar Fund
2001
Thursday, October 4, 2001

Clinical Site Visits
9:00-11:00 am

- Bronx VA Medical Center
  Or
- The Bellevue Hospital Center Dual Diagnosis Unit-20 East

1:00 pm

- Mt. Sinai Psychiatric Care Center

2:00 pm
- Mt Sinai Jack Martin Fund (AIDS) Clinic

3:00 pm
- Mt. Sinai Health Care Center

******Contact person for possible problems/questions-Tanita Woodson (212) 998-5317**

Mamie Kwoh Wang Nurse-Visiting Scholar Fund
2001
Friday, October 5, 2001

246 Greene Street, Kimball Hall-7th Floor Conference Room

9:00 - 10:30 am	*"Advanced Practice Nursing Practices"* -- Hila Richardson, DrPH, Clinical Professor, Director of Practice Management
10:30 - 11:30 am	*"Overview of Nursing Specialties"*-- Barbara Krainovich-Miller, EdD, RN Kathleen Kenny, MSN, RN, CPNP Beth Latimer, MA, RN, CS-GNP Sally Mendelsohn, MA, RN, CNM
11:30 - 12:00 pm	Question & Answer Session with Specialty Faculty Panel
12:00 - 1:00 pm	*Lunch:* **New York University Torch Club, 18 Waverly Place**

Jack Martin Fund Clinic at Mt. Sinai
5th Avenue and 101st Street, Manhattan

Subway Directions: Take the Lexington Avenue line, #6, train to the 96th Street Station. Walk west towards the park to Fifth Avenue. Walk north 6 blocks.

Contact person: Joe Colagreco
Tel: (212) 241-1897

New York University Medical Center
560 1st Avenue, Tisch 183
Manhattan

Subway Directions: Walk to West 3rd Street behind Shimkin Hall/Bobst library. Take the NYU trolley to First Avenue and 30th Street (Medical Center).

Contact person: Beth Duthie
Tel: (212) 263-5760

Chinatown Health Clinic
125 Walker Street, 2nd floor
Manhattan

Subway Directions: Go to ~~Astor Place~~ Canal St. and take the Lexington Avenue, #6 train, downtown to the Canal Street stop. From Canal Street make a right to Center Street. Go one block to Walker Street and make a left turn. Meet Susan Seto-Yee on the 2nd floor.

Contact person: Susan Seto-Yee
Tel: (212) 226-8866

PS 307
209 York Street, Brooklyn

Subway Directions: Take the F train to the York Street stop. Exit the station and cross York Street. You will see a mailbox and a silver fence. Walk with your left shoulder towards the fence approximately two blocks. You will then see the school.

Contact person: Sally Arbolino
Tel: (718) 834-4294

Bellevue Hospital Center Dual Diagnosis Unit
550 First Avenue at 27th Street, Manhattan

Subway Directions: Take the Lexington Avenue line, #6 train to the 28th Street Station
Walk south one block and then walk three blocks east to 1st Avenue.

Contact person: Sandra Wilson

The Bowery Resident's Committee
191 Chrystie Street, Manhattan

1 train to 42nd -> 5th Ave

Subway Directions: Walk south on Broadway to Houston Street. The train station will be on your left near the Exxon gas station. Take the F train to the 2nd Avenue stop.

Contact person: Christina Causad or Dana Palmer
Tel: (212) 533-5700

Montefiore Medical Center Pediatric ER
111 East 210th Street, Bronx

Subway Directions: Take the #4 train (Lexington Avenue Woodlawn line) to Mosholu Parkway Station. Walk north on Jerome Avenue and turn right on 208th Street. At the fork, follow 210th Street to the main entrance of the hospital at 111 East 210th Street. Once you are in the hospital ask for directions to the Pediatric Emergency Room. It is on the ground floor (silver zone).

Contact person: Kathleen Kenney
Tel: (917) 562-1714
ER #: (718) 920-5655

Terrence Cardinal Cooke Health Center
1249 5th Avenue, Manhattan

Subway Directions: Take the Lexington Avenue line, #6 train, to the 103rd Street stop. Walk west to 5th Avenue then walk north 3 blocks to 106th Street. The main entrance is on 5th Avenue.

Contact person: Jennifer Fogg
Tel: (212) 534-3331

Bronx VA Medical Center
130 W. Kingsbridge Rd., Bronx, NY

Subway Directions: Take the #4 (Lexington Avenue Woodlawn line) train to the Kingsbridge stop. Make a left turn out of the station and walk 3 blocks. Meet your contact person on the 5th floor, Rm 5A13.

Contact person: Teddi Levine
Tel: (718) 584-9000 ext. 6907

Mt Sinai Psychiatric Care Center
1425 Madison Avenue
Manhattan

Subway Directions: Take the Lexington Avenue line, #6 train, to the 96th Street stop. Walk 2 blocks uphill towards Madison Avenue. 1425 is a large building across from the Main hospital (on the corner of 98th and Madison Avenue). Once you enter the building identify yourselves to security and ask them to call Elaine Shimono on the 4th floor (East building). She will then come down to get you.

Contact person: Elaine Shimono
Tel: ext. 88780

Mt. Sinai Health Care Center
Manhattan

Subway Direction: Take the Lexington Avenue line, #6 train, to the 96th Street stop. Walk 2 blocks uphill to Fifth Avenue. The entrance is on Fifth Avenue just north of 98th Street, 1st Floor, Rm. 12. Go to the Klingenstein Pavilion. You will meet Katie Capitulo in her office.

Contact person: Katie Capitulo

貳、目的

護理人員法於民國八十九年十一月八日　修正，增訂第七條之一，明定護理師經完成專科護理師訓練，並經中央主管機關甄審合格者，得請領專科護理師證書。至此，專科護理師制度正式納入法制明文規範，而國內部分醫院亦早於該法修正施行前，即已試辦推動專科護理師制度，美國在華醫藥促進局為促進國內護理界對國外專科護理師制度之規劃有所認識，亦提供王郭煥煒女士獎學金，獎助國內護理人員出國考察該制度，2001 年亦提供六名名額部分補助赴美國紐約考察其專科護理師制度發展情形，本人亦獲甄選參加此一考察團，本次行程之目的如下：

一、參觀紐約市專科護理師制度執行現況。

二、瞭解紐約市專科護理師制度相關規範。

三、比較國內專科護理師制度與紐約市專科護理師制度之差異。

參、摘要

在美國，專科護理師制度隨著時代的演進而發揮其不同的角色功能，而目前其專科護理師制度已發展至所謂的進階執業護理師（Advanced practice nurse）的階段，即該進階執業護理師的名詞可相當廣泛地包括執業護理師（Nurse Practitioners）、合格的護士助產士（CNM；Certified nurse-midwives）、麻醉護士（CRNA；Nurse anesthetists）及專科臨床護理師（CNS；Clinical specialists）等護理專業人員；他們於臨床上扮演著獨立、合作性的健康照護者身分，亦即於臨床上他們可以扮演著顧問、行政者、研究者或教育者的功能。

以執業護理師（Nurse Practitioners）為例，他們可於不同的專科領域執業，如家庭、成人、小兒科、老人科、婦女衛生（women's Health）、學校衛生（school health）、職業衛生、心理衛生（mental health）、急診及急性照護（emergency and acute care）。其主要特色即在於他們可以評估及處理有關醫療及護理方面的問題（medical and nursing problems），故他們可以詢問病史（taking histories）、理學檢查（conducting physical examination）、開具醫囑處方（ordering）、病情診斷及檢驗判讀（performing and interpreting appropriate diagnostic and laboratory tests）、處方藥物

(prescription of pharmacological agents, treatments and nonpharmacological therapies for the management of the conditions which they diagnose) 等。在基層醫療及一般的急性醫療照護，執業護理師可於門診、急性及長期照護單位工作，提供一般護理服務、醫療服務給個人、家庭及團體。

在執業護理師的養成教育方面，基本上是要經由碩士學制的養成及至少五百小時的臨床實習訓練，方得具備執業護理師的資格，其養成訓練課程包括（一）一般核心課程如：研究方法學、護理理論、倫理學、組織學、人類科學、健康政策、健康照護系統、健康照護財務；（二）執業護理師專業課程則包括進階健康評估、進階藥理學、進階生理病理學、健康促進及疾病預防、以社區為基礎的執業學科、專業角色發展、家庭理論、生長發育學、臨床決策學及其他課程；（三）執業領域中專業角色發展；（四）健康與疾病的診斷與管理。而其養成教育的評估則由全國性執業護理師團體 (National Organization of Nurse Practitioner Faculties) 定期予以評值，其評值項目不只包括課程內容，亦包括師資、臨床實習資源、甚或執業護理師於碩士畢業一年及第五年後的成果評值（包括考照合格率、於該專科領域的地位、工作的滿意度、對於成為 NP 的滿意度等等）。

執業護理師可否開具處方、醫囑、理學檢查等醫療行為，其實是

因各州規定而異，以紐約州為例，允許執業護理師執行上開所述之醫療業務（包含部分管制藥品的處方），於實際作業上，執業護理師尚須與受聘僱之醫院、合作之醫師等共三方簽署一份有關照人照護的責任聲明書，依該聲明書所敘內容範圍，執業護理師方得從事某些業務、參加醫療責任保險，並須定期（至少一年一次）接受合作醫師的審核。至於其他各州的情況則不一，有的則須在醫師監督之下執行業務，如加州、佛羅里達州；有則由當地的護理團體定其執業範圍而不須醫師的合作或監督，如德州、奧勒岡州。各州的規定不一，其實與各州的醫療資源、保險制度有關，尤其近年來，管理式照護制度之興起，執業護理師自有其發展的空間，而其間專業團體的角力（如醫師團體與護理團體於政策上的影響）亦為重要因素。但不管其執業範圍與我國現行制度之差別多大，執業護理師團體也訂定相關稽核制度，自養成教育至執業過程中，皆有一定的考核機制，以確保其成員的素質。

肆、研修內容

Preparing for advanced practice direct provider roles

課堂摘要

唐婉如 2001/10/21

1960 年代後期 NP & CNS 角色仍處於起步階段，當時因位醫師人力的短缺所以發展 NP 角色，而 NP 多半是在醫院訓練的制度下所完成，護士接受 9-13 個月的合格訓練課程便可以成為 NP，當時大部分的 NP 服務於偏遠的鄉村社區為低收入戶人群提供健康照護. NP 提供處於各個不同發展階段的人群 primary care. 整體而言，NP 角色的推行算是非常成功因為 NP 的臨床表現非常有效率. 雖說如此， NP 正式的證照認定制度卻一直延當到 1970s 才實施.

NP 正式的證照認定制度對其角色的發展非常重要，在美國各州有不同的要求. ANA 是主要提供 NP 證照檢覆及認定的學術組織，它制定了 NP 執業的範圍和標準. 除了 ANA 之外，不同的專科學術組織也與 ANCC (American Nurse Certification Center) 合作以建立該專科 NP 的檢覆考. 舉例而言，安寧照護學會，緩和療護學會與 ANCC 共同合作，建立全國性檢覆考試使通過考試的安寧專科護理師可以在不同州執業. 在 regulatory 方面，各個不同的護理組織花費至少三年的時間和精力促使 NP 法規由原先的 “在醫師監督之下” 轉換成 “與醫師的合作之下” 在次展現護理專業自主權的提升.

因護理專業的不斷進步，目前為止，全美百分之九十以上的 NP 都是在接受過研究所層級的正式教育制度下所產生. 為了要培養真正具有臨床判斷力及照護實力的專科護理師，NYU 依據 ANA 認定的 core competencies 為不同的專科護理師碩士學程設計了一系列的共同必修 - 18 學分 (如護理理論，高級研究與統計，健康照護相關議題與趨勢，領導管理，及與特定人群相關之照護: 老人，成人，婦女，或兒童)；進階必修 - 15 學分 (如高級病理學，高級藥理

學，高級身體評估，專科護理師的角色與功能，照護策略：成人或老人)；及專科選修 - 12學分（依不同專科而定），外加 710 小時的該專科臨床實習才可取得專科護理師的碩士學位．一般而言，專科臨床實習若低於 600 小時以下會產生對臨床照護安全性的考量．所以專科護理師的養成應包含接受正式的教育訓練並配合嚴格的臨床實習以確保高水準的照護品質．

Preparing for Advanced Practice Direct Provider Roles

Judith Haber, PhD, APRN, CS, FAAN
Professor and Director, Master's Programs
and Post-Master's Advanced Certificate Programs
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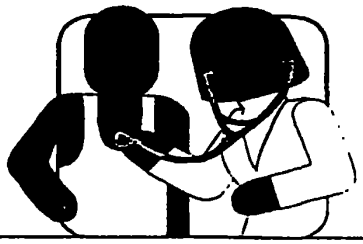
New York University

The NP vs The CNS Role



Are you the party with the worn-out paradigm?

Will The Most Effective Advanced Practice Nurse Please Stand Up!!!

Regulatory Issues

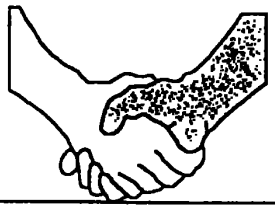
- Scope and Standards of Practice
  - ✓ANA Scope and Standards of Advanced Nursing Practice
  - ✓ANA Scope and Standards of Specialty Practice

Regulatory Issues (cont'd)

- Specialty Organization Documents
  - AACN
  - NONPF
  - NAPNAP
  - AACN
  - ONS
  - CNS

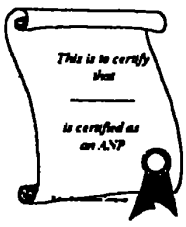
Regulatory Issues (cont'd)

- State Nurse Practice Acts
  - ✓Collaboration
  - ✓Supervision



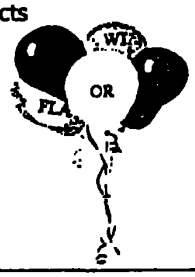
Regulatory Issues (cont'd)

- Credentialing
  - CNS Exams
  - NP Exams
  - APRN Exams

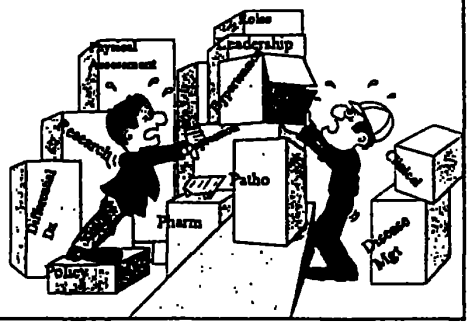


Regulatory Issues (cont'd)

- State Nurse Practice Acts
  - ✓NCSBN

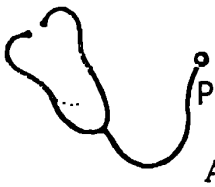


Building The APRN Curriculum



Core Competencies of the APRN Role for NPs & CNSs

- Assessment
  - ✓Mental Status Exam
  - ✓Psychosocial Assessment
  - ✓Cultural Assessment
  - ✓Spiritual Assessment
  - ✓History and Physical
    - comprehensive H & P
    - focused H & P



Physical Assessment

And

Psychiatric/Mental Health Assessment

Core Clinical Competencies of the NP & CNS Role (cont'd)

- Development of Differential Diagnosis
- Development of Treatment Plan

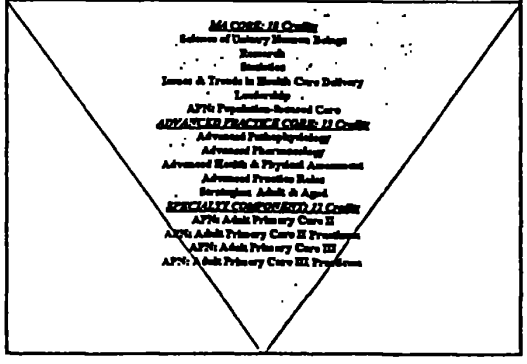
Core Clinical Competencies of the NP & CNS Role (cont'd)

- Management of Acute and Chronic Health Problems

- ✓ Health Promotion
- ✓ Preventive Interventions
- ✓ Self Care Activities
- ✓ Acute Interventions
- ✓ Health Maintenance
- ✓ Patient Teaching
- ✓ Counseling
- ✓ Case Management
- ✓ Referral
- ✓ Outcome Evaluation

To Rx or Not To Rx: That is the Question

ADVANCED PRACTICE CURRICULUM



護理資訊學

(Nursing Informatics)

蔡安津 2001/10/1

1960 年代電腦資訊時代來臨，各個行業無不開始電腦化，漸漸應用在醫學相關領域上，而心律分析是最早且最常被研究的項目。為了達到無紙化(Paperless)並消除傳統紙張病歷所帶來的不便(eg 不能同時被多人使用，需大量的空間儲存病歷……..)，結合網路系統，進而發展出醫院資訊系統(Hospital Information System, HIS)，其中包含護理資訊系統(Nursing Information System, NIS)，放射資訊系統(Radiology Information System, RIS)，檢驗資訊系統(Laboratory Information System, LIS)，…….等。相關學系相繼成立，如醫學資訊學(Medical Informatics)及護理資訊學(Nursing Informatics)。

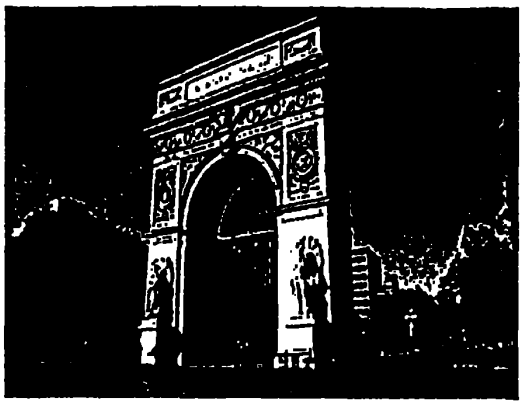
紐約大學在二年前設立了護理資訊學(Nursing Informatics)研究所，學生完成學業後可：(1)將護理資訊學的模式或理論應用到臨床實務上；(2)證明臨床資訊系統在分析、設計、實行及評估的能力；(3)提供運作、儲存及擷取護理及病患照顧資料的研究方法。此外，將實證基礎規章(Evidence-based protocols)整合入病患照顧系統。

畢業學生的方向有以下六種：(1)研究(Research)；(2)統計(Statistics)；(3)護理理論(Nursing Theory)；(4)指導(Leadership)；(5)常態焦點照護(Population-focused Care)；(6)健康照護政策及經濟(Health Care Policy and Economics)。

未來計畫促進將臨床整合入課程中，測驗額外各科跨領域的學科，促進以資訊為基礎的博士研究及論文發表，並擴展額外的課程模組至 WWW 平台，建立遠距教學。

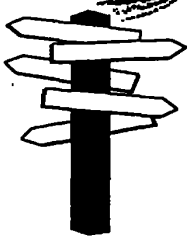
NURSING INFORMATICS EDUCATION AT NYU

Barbara Carty RN, Ed.D. FAAN
Clinical Associate Professor
Coordinator Nursing Informatics Program
New York University
barbara.carty@nyu.edu

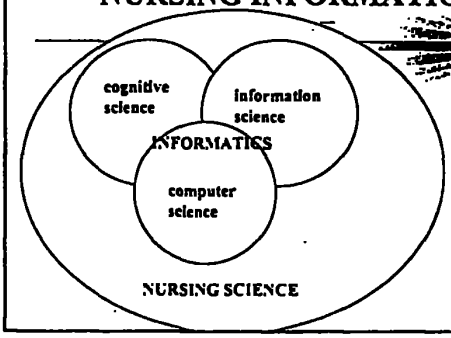


Objectives

- Introduction
  - Discipline of NI
  - Setting
  - Strategies
- NI Program
  - Course Work
  - Clinical
  - Faculty
- Employment



NURSING INFORMATICS



Credentialing

- American Nurses Association (ANA) credentials nurses specializing in informatics
- Currently developing credentialing for master level specialist role

NYU Division of Nursing

- Administratively in School of Education
- Undergraduate Program
- Master's Program
  - Informatics
  - Administration
  - Education
  - Pediatrics
  - Adult acute & Primary
  - Psychiatric Nsg.
  - Palliative Care
  - Holistic
  - Midwifery
  - Gerontology
- Ph.D. Program

NYC Health Care Delivery Systems

- Mt. Sinai, NYU Centers and affiliates
- NY Cornell and Columbia Medical Centers and affiliates
- St. Lukes and Beth Israel Medical Centers and affiliates
- Health Hospital Corporation
- Other Affiliates

Informatics Academic and Clinical Resources

- Part of major urban academic/medical center complex
- Mt. Sinai, NYUMC and affiliates including acute, primary and home care
- Other Academic Schools/Departments
  - Wagner School Public Health
  - Courant School Computer Science
  - Tisch Interactive Technology
  - Stern School of Business
  - Medical Informatics

NURSING INFORMATICS

- Established at NYU in 1998
- Two Years in development
- First class admitted in fall 1998
- Post Master Certificate 21 credits
- Generic Master 45 credits
- Current enrollment: 80 students
- Graduating Students
  - Spring 2000 6 graduates
  - Spring 2001 12 graduates

PROGRAM OBJECTIVES

- At completion of program, the students will:
  - Apply models/theories of nursing informatics to clinical practice
  - Demonstrate competence in the analysis, design, implementation, and evaluation of clinical information systems
  - Apply research methods in the processing, storage and retrieval of nursing and patient care data

PROGRAM OBJECTIVES

- Integrate evidence-based protocols into patient care systems
- Provide leadership in the area of nursing and health care informatics

Student Profile

- 80 Students
- 60 Generic Master Students
- 20 Post Master Certificate Students
- Avg. age is 36
- All have minimum of 2 years clinical experience
- Avg. yrs experience 14yrs.
- males, females

NURSING INFORMATICS CURRICULUM

- Nursing informatics major is built on six graduate core courses:
  - Research
  - Statistics
  - Nursing Theory
  - Leadership
  - Population-focused care
  - Health Care Policy and Economics

Elective Courses

- Two Elective Courses
  - Students can choose from:
    - Nursing
    - Computer Science
    - Interactive Technology
    - Health Care Management
    - Business

NI Specialty Courses

- NI Introduction
- Assessment and Analysis of Clinical Information Systems
- Decision Support in Clinical Information Systems
- Implementation, Management and Evaluation of Clinical Information Systems
- Informatics Integration

Focus: Interdisciplinary Vs Discipline Specific

- Discipline Specific
  - Nursing Domain content
  - Nursing Science
  - Nursing Theory
- Interdisciplinary
  - Systems Theory/Application
  - Medical Informatics
  - Health Informatics
  - Cognitive Science

Faculty

- Interdisciplinary
- 2 Full time nursing faculty
- Adjuncts
- Guest Lecturers
- Specialties:
  - Nursing Informatics
  - Medical Informatics
  - Management Information Systems
  - Information Technology

Integration of Theory and Clinical

- All courses have a clinical and/or lab component, total 600 clinical hours
- Class Content & Clinical Projects are related
- Clinical settings are varied and include:
  - Acute
  - Community/Primary
  - Home Health Care

Clinical Projects

- Clinical projects include:
  - Database modeling and design
  - Project development
  - System implementation & evaluation
  - Automating clinical data: incorporating vocabularies, coding
  - Decision Support: professional & patient decision making
  - QA Assessment & Evaluation of Systems

Final Integration Course

- Weekly Seminars directed by students
- Capstone Project
  - Synthesis Clinical experience
  - Student chooses an area in prior course work and produces final project:
    - Research-Based
    - Prototype Software Application and/or publishable paper
    - Clinical Focus

Evaluation Process

- Formative
- Summative
- Feedback from faculty, students, clinical agencies
- Relevance of clinical projects
- Value of clinical experience
- Follow students post graduation

After Graduation

- Clinical analyst
- Software developer
- Clinical Information System (CIS) Coordinator
- Director of Informatics
- Application specialist
- Vocabulary engineer
- Database coordinator
- Product manager
- Health Care Agencies (acute, home health, long-term)
- Enterprise systems
- Vendors
- Education
- Consultants

Future Plans

- Promote clinical dyads & integrate into curriculum
- Examine additional interdisciplinary content
- Promote Informatics-based Doctoral research and dissertations
- Expand additional course modules to WWW platform for distance learning

紐約大學護理執業模式

Academic Practice Model of New York University Division of Nursing

90.10.2 蔡秀鶯

Dr. Richardson 負責管理紐約大學護理執業模式（門診）之業務，她介紹紐約大學從 4 年前至目前之護理執業模式之種類和業務， 紐約大學護理系目前共和 15 個健康照護者、醫院或學校簽約建立護理執業模式，以執業專科護理師門診照護個案。護理執業模式之主要負責人是 Dr. Richardson，她和社區負責人共同發展和管理護理執業模式。教師執業委員會監督和協助護理執業模式，以下分項描述：

實務模式之目標

護理執業模式之目標是針對紐約市最重要的健康議題，提供（一）所有市民高品質的健康服務，特別是針對無健康保險者、特別需要團體和弱勢團體；（二）準備作為以後社區、 健康專業間和不同文化之臨床教學。護理執業模式是與社區單位或健康照護者簽訂合約，學校提供兼職或專職之執業專科護理師。合約內包括薪水（$80,000/year）、休假和行政費用（3% ）。共同與社區單位擬定執業專科護理師之角色並聘請合適的專科護理師。協助和支持專科護理師之臨床角色，提供和其他專科護理師之支持系統，和支持專科護理師之臨床教學角色。專科護理師之評值採共同評值模式，由醫師和護理相關人員共同評值。

實施執業模式之問題

紐約大學執行護理執業模式之問題有許多，其中主要包括：（一）不確定 Medicaid Manage Care；（二）支持系統之重新整合；和（三）住院醫師之缺乏。應用簽約模式之主要原因減少賠錢之風險性和減少實施護理實務模式之相關問題。

實施執業模式之成效

實施護理執業模式之成效包括在個人和家庭、社區、護理學院等方面：

個人和家庭方面：提供弱勢團體之服務，自 1999 至 2000 年看診共 16000 個案，且增加許多服務之內容及項目。

社區方面：除了提供缺乏醫療區域之服務，且擴展社會福利部門在基層醫療之服務範圍。

護理學院方面：增加護理學院在社區之知名度；提供教學和研究的單位；影響社區機構之實務。實施護理執業模式之結果不但沒有賠錢而有少許營收。雖然有一些機構無法已付行政費用，但 15 個實務模式單位仍有盈餘。

實施執業模式之挑戰

護理執業模式是一新角色的發展，極具挑戰性；在單位資料收集和研究有有限制，因執業專科護理師臨床業務繁忙，無法協助收集資料，加上收集資料之表

格或電腦資料處理的困難，因此難為研究收案之場所；管理合約上的執行常見問題，如行政費用的收取常有困難，單位常沒有能力支付。

紐約大學護理執業模式相關機構共 15 個：

1. 學校健康中心 （School-Based Health Center）
   專科護理師之職責:
   a.執行健康維護和篩檢之健康檢查
   b.健康維護之措施包括身心社會評估和提供是當的治療
   c. 篩檢門診病人
   d. 提供小兒常見慢性健康問題之照護如氣喘，並適當的轉介至醫院。
   e. 提供個人和團體的健康教育和壓力預防。
   f. 提供患者人類發展和心裡社會評估，做適當的轉介。
   g. 先穩定及處理急診患者並轉送至醫院急診。
2. 法院健康中心 Court-Based Health Center
3. 社區健康中心 Community-based Organization
4. Federation of Employment and Guidance Services
5. 漂浮醫院 The Floating Hospital
6. Pathways to Housing
7. Mount Sinai Medical Center (Clinics & Geriatric Emergency Department)
   （每一門診單位之簡介及專科護理師之職責請見附件）

The NYU Division of Nursing

Academic Practice Model

The Division of Nursing Academic Nursing Practices

The NYU Division of Nursing has 15 agency, health provider and school partners in academic nursing practices using nurse practitioners in innovative roles.

NYU Nursing

Management and Oversight of the Practices:

- **The Director for Practice Management, Hila Richardson, DrPH,collaborates with the community partners to develop and manage the academic nursing practices. She is advised and assisted by the Division's Faculty Practice Council.**

Goals of the Practices Are To:

- **Address the City's most pressing health issue of access to high quality services for all people, especially the uninsured, special needs and vulnerable populations throughout the City;**
- **Prepare the next generation of nurses in community-based, interdisciplinary and culturally diverse clinical teaching sites.**

NYU Nursing

The Contractual Model

- Contracts with community-based agencies and health providers to provide part- or full-time NP(contract covers salary, fringe benefits and administrative fee)
- Works with agencies to develop innovative role
- Recruits and hires qualified NP

The Contractual Model

- Mentors/supports NP clinical role through faculty liaison
- Provides opportunities for networking among NPs
- Supports NPs in preceptorship role
- Joint evaluation of NP performance

WHY THE CONTRACTUAL MODEL

NYC Environmental Barriers:

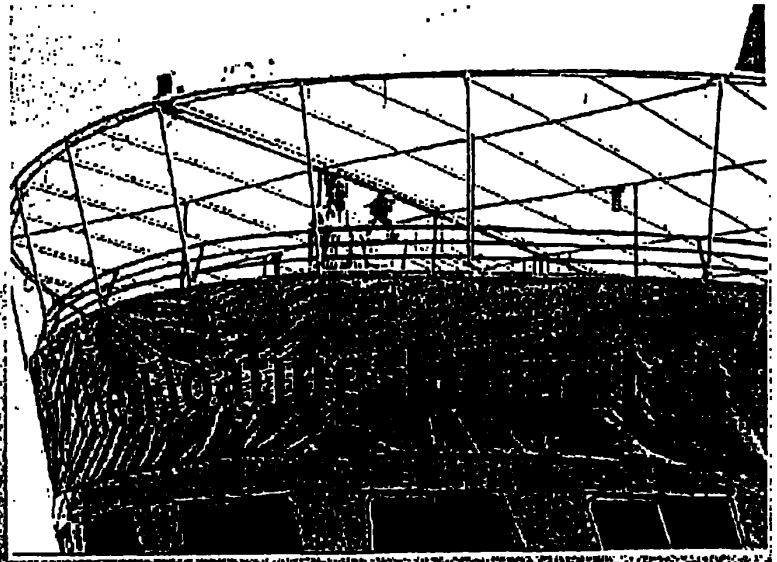
- uncertainty about medicaid manage care
- alignment and re-alignment of networks
- reduction in house staff

NYU Nursing

WHY THE CONTRACTUAL MODEL

Position of the Division Nursing:

- **inability to access equity**
- **need to minimize financial risk**
- **regulatory barriers**



NYU Nursing

OUTCOMES OF THE MODEL

Individual and Family Levels:

- **improved access to underserved: <u>16,000</u> visits (1999-2000)**
- **increased comprehensiveness of services**

Community Level

- **increased availability of primary care practitioners in shortage areas**
- **expansion of primary care in social service agencies**

NYU Nursing

OUTCOMES OF THE MODEL

Division Level:

- increased visibility in community
- innovative teaching and research settings
- opportunity for influencing practice in community agencies
- break even plus

NYU Nursing

OUTCOMES OF THE MODEL

Challenges:

- integrating new role
- data collection and research in agencies
- administrative fee structure
- management of contracts

NYU Nursing

New York University
Division of Nursing
Academic Nursing Practices
Nursing 2000

School-Based Health Centers

PS 307

The Division of Nursing has sponsored a school-based clinic at PS 307 since 1994. Through a federal grant in 1995 the Division was able to add preventive mental health services until July 1995. In addition, the Clinic has brought other services to the school: dental hygiene services through the NYU School of Dentistry, vision exams and glasses through the Kress Vision program, a tobacco prevention program through the Cancer Society and an asthma program that reduced the percentage of asthma visit of all visits to the Clinic from 33% to 3% over 2 years. The Brooklyn Hospital Center provides the license and collaborative physician to the clinic

PS 307 is part of Community School District 13 and is located in the Fort Greene section of Brooklyn. PS 307 has over 500 children in grades K-8. Almost 90% of the children are from low-income families, many of whom live in an adjacent housing project.

Nurse Practitioner Activities:

- Physical examinations for health maintenance and screening
- Health maintenance interventions that include biopsychosocial assessment and development and execution of an appropriate treatment plan.
- Triage of walk-ins, and acute care of intercurrent illness.
- Care for the common chronic illnesses of children such as asthma, with coordination of hospital services as appropriate.
- Health education (stressing prevention) in both individual and group settings.
- Developmental and psychosocial assessments of patients and families and referral for appropriate services.
- Initial stabilization of emergencies pending transport by EMS to the Emergency Room.

Court-Based Health Centers

Brooklyn Treatment Court

The Division of Nursing began providing part-time primary care services in the health clinic at the Brooklyn Treatment Center in the Spring of 1998. Full-time coverage began in January 2000. The clinic is open 2 days a week on either a walk-in or appointment basis. Funding from the Van Amaringen Foundation has made it possible to add Psychiatric Nurse Practitioner services in the clinic. The clinic also serves clients in The Treatment Readiness Program for substance abusers which is located at the Court site. The Brooklyn Hospital center provides the license and the collaborative physician for the clinic.

The Brooklyn Treatment Court, a part of the Center for Court Innovation represents an innovative approach to substance abusing defendants within the court system by providing comprehensive court-based response to the needs of nonviolent substance abusing offenders, where treatment is offered as an alternative to incarceration. The court also developed a broad network of onsite as well as community-based substance abuse treatment services.

Nurse Practitioner Activities:

- Provide physical exams and lab tests
- Diagnose and treat acute and chronic illnesses
- Prevent and detect disease early by using health maintenance strategies
- Refer to specialists at The Brooklyn Hospital Center
- Provide HIV and STD counseling and testing
- Diagnose and manage health problems
- Referrals as needed
- Health Education

Psychiatric Nurse Practitioner Activities:

- Perform comprehensive psychiatric & biopsychosocial assessment on clients referred by case manager and court staff
- Identify mental health issues in chemically dependent clients
- Advise case managers on placement to proper tax setting for clientele
- Provide crisis intervention and short term therapy
- Serve as resource to staff regarding mental health issues and concerns
- Precept mental health/psychiatric nurse practitioner student

Student Activities:

Psychiatric Mental Health Nurse Practitioner students are engaged in:

- health education groups on stress management, and smoking;
- outreach activities that include contacting clients to remind them of appointments;
- organizing databases and steamlining record-keeping
- needs assessments of clients

Community-Based Organizations

The Bowery Resident's Committee (BRC)

The Division of Nursing practice began at BRC in late 1999 with a full-time Psychiatric Nurse Practitioner. The Nurse Practitioner provides services in the Continuing Day Treatment Psychiatric Program and Adult Out Patient Alcohol Rehabilitation Program and the Reception Center.

The Bowery Residents' Committee (BRC) is a voluntary, non-profit organization addressing the needs of persons with limited resources, including the homeless, hungry, chemically dependent, psychiatrically disabled, aged and persons with HIV/AIDS in metropolitan New York City.

Services Provided by BRC include:

- Emergency shelter
- Health care
- Mental health
- Substance abuse treatment
- Geriatric services
- AIDS services
- Vocational training
- Outreach
- Transitional and permanent supported housing

Nurse Practitioner Activities:

- psychiatric, medical and substance abuse assessment;
- medication management;
- psycho-educational and supportive counseling;
- health education;
- Meditation/stress management/wellness groups

Funding:

The Psychiatric Nurse Practitioners is funded by a contract with BRC.

Faculty Practitioner:

Rhoda Berger, NPP
212.533.5700 ext 306

Federation of Employment and Guidance Services (FEGS)

The Division has a Psychiatric Nurse Practitioner at two FEGS sites, the Bronx site practice started in 1998 and the Manhattan site in 1999. FEGS is a comprehensive voluntary, not-for-profit human services organization founded in 1934. The agency has an extensive network of employment, behavioral health, family services, educational, career development, rehabilitation, residential, developmental disabilities, vocational, home care, economic development, research and corporate service programs that reaches more than 50,000 people each year.

The Bronx Site:

The F.E.G.S. Counseling Center at Jerome Avenue in the Bronx is a dynamic, diverse program serves adults, adolescents and children with a wide range of emotional problems, adjustment problems or mental disabilities. The Counseling Center provides a wide variety of treatment interventions: Individual psychotherapy, family therapy, group therapy, medication therapy and nursing. One of the Clinic's newest projects is an intensive program for children suffering from ADHD and related disorders. Support groups helping victims of childhood sexual abuse and trauma are also among the array of services.

Psychiatric Nurse Practitioner Activities:

Provides comprehensive, psychiatric nursing counseling and medication care for a panel of 150 patients including:

- performing psychiatric assessments and developing treatment plans;
- prescribing monitoring and counseling client regarding psychotropic medications
- providing psychoeducation to women's health group to help female clients assess symptoms that are part of natural hormonal fluctuations and those that are related to mental status or psychotropic medications;
- consulting with staff;
- precepting mental health/psychiatric nurse practitioner students

Student Activities:

- Learn psychiatric assessment and treatment planning skills for acute and chemically mentally ill clients;
- Assist with the women's health group;
- Learn how to prescribe and monitor psychotropic medications;
- Gain experience working with interdisciplinary teams

Faculty Practitioner

Barbara Gallo, NPP
718.881.7600 ext 438

The Manhattan Site:

Continuing Day Treatment Program-The Slaner Family Day Program
The Continuing Day Treatment (CDT) program, located in the Tribeca section, serves a population of more than 200 clients who require daily counseling for mental health and psychiatric needs. Clients attend the program daily from 8:30 AM to 2:00 PM. The program has the required structure and activities needed for the chronically mentally ill such as case management, health teaching, group therapy, psychiatric consultation and pharmacotheraphy.

- The interdisciplinary staff provide comprehensive case management for the clients.

Nurse Practitioner Activities:

- Consultation for a caseload of approximately 80 clients including pharmacotherapy on a weekly, bi-weekly and monthly basis. The Nurse Practitioner also consults with an interdisciplinary team in treatment planning.
- Pharmacological management including mental status assessment, evaluation of medication compliance, reevaluating of pharmacological treatment, laboratory analysis, referral for medical follow-up.
- Group therapy for two different groups weekly: Health Promotion for forty (40) clients at risk for non-compliance of treatment with psychotropic medication includes counseling related to diet, exercise and lifestyle habits. Data is collected and analyzed regarding medication, weight, diet and exercise and feedback is given to clients on the findings; Psycho-education which focuses on strategies for coping with mental illness, understanding their diagnosis and minimizing the side effects of medication.
- Precepting masters degree students in mental health/psychiatry

Student Activities:

The Nurse Practitioner student in mental health/psychiatry at the CDT:

- co-leads the Health Promotion group
- learns psychiatric assessment skills
- learns psychotropic medication management skills

Faculty Practitioner

Sheila Craan, NPP
212.366.8049

Funding:

Both FEGS sites are funded by contracts with FEGS.

The Floating Hospital

The Division practice started in late 1998 and continues with a Family Nurse Practitioner practicing at two different locations: The Ship which is docked at Pier 11 at Wall Street and The Auburn Assessment Center (Homeless Shelter) which is in Fort Greene, Brooklyn.

The Floating Hospital, Inc. began by taking newspaper boys on cruises around Manhattan for fresh air and sunshine over 175 years ago. The current ship has on-board facilities that include: medical and dental clinics; education centers; a theatre; playrooms and outdoor activity areas. The ship continues to sail every Friday during the summer with patients and families. Outreach sites have been established throughout the City.

Nurse Practitioner Activities:

On the Ship:

•Well-woman/primary care
•Acute care services
•School, work and sports exams
•GYN services and Sexually Transmitted Disease prevention and treatment

At the Auburn Shelter:

•Acute and episodic care for families, pregnant women and the elderly
•Health screening for shelter placement and discharge
•Management of chronic disease
•Management of anxiety, depression and substance abuse

Student Activities:

Under the supervision of the Nurse Practitioner, Adult Nurse and Pediatric Practitioner students, medical students and medical residents learn about care to high-risk populations who are recent immigrants or in transition within the shelter system. Emphasis is on:

•Understanding the goals and limitations of medical care in a traditional population
•Provision of on-site treatments and medications
•Referral to outside health and social services
•How to provide high quality care when supplies and support services are limited

Funding:

The practice is funded through a contract with the Floating Hospital.

Faculty Practitioner

Anne-Marie Uebbing, FNP
212.514.7440

Pathways to Housing

The Division practices began at Pathways in December 1999 with a family Nurse Practitioner who provides primary care services to the clients and is part of the agency's Assertive Community Treatment (ACT) team.

Pathways to Housing, Inc. (PTH) provides housing and services to homeless New Yorkers with psychiatric disabilities and/or substance abuse problems. The agency's Assertive Community Treatment (ACT) team, composed of psychiatrists, social workers, nurses, rehabilitation counselors, serves those who have been turned away from other housing programs because of active substance abuse, refusal to participate in treatment, history of violence or incarceration, or other behavioral problems. Pathways has pioneered a successful program providing immediate independent permanent housing and support services that have achieved an 85% success case at keeping tenants in housing. PTH serves 300 clients.

Student Activities:

Nurse practitioner students in the NYU mental health psychiatry program:
- make home visits with the ACT team
- practice physical and psychiatric assessment skills
- provide health education to clients and staff

Nurse Practitioner Activities:

- Comprehensive and holistic primary care, case finding, health screening, health promotion, physical and psychosocial assessment, case management, and prescripting and managing medications;
- Collaboration with other health care providers and makes appropriate referrals as needed;
- Client advocacy, specifically in accessing and navigating the health care system;
- Communication and coordination of clients' health care needs with team members;
- Teaching health promotion and illness prevention to clients and staff;
- Health care resource to clients and families/significant others;
  Precepting advanced practice nursing students

Funding

Funding is through a contract with Pathways to Housing.

Faculty Practitioner

Elisa Dunn, FNP
212.427.6877

Mount Sinai Medical Center

The Division has three practices at the Mt. Sinai Medical Center:

Jack Martin Fund Clinic (JMFC)

The JMFC is the outpatient AIDS center for the Mt. Sinai Medical Center, which is part of Mt. Sinai NYU Health. The population served comes from the surrounding area of Harlem and East Harlem. This practice is a unique joint-appointment model whereby two faculty members share a full-time nurse manager position and provide urgent and triage care to patients in the JMFC. The faculty members also maintain their full-time faculty responsibilities.

Nurse Manager Activities:

- Provides clinical leadership of nursing staff
- Assumes fiscal responsibility for clinical activities of clinic
- Serves as clinical resource to administrative and operations staff
- Participates in Care Center and hospital-wide committees as appropriate
- Participates in research on HIV/AIDS drug development
- Precepts Adult Nurse Practitioner, Informatics and Nursing Administration students

Student Activities:

- development of an interdisciplinary patient screening, teaching and documentation tool
- development and implementation of a nursing telephone triage system based upon the literature, and group dynamics between various health care providers
- data collection for clinical research on avoidable hospital readmission's
- an HIV counseling and testing initiative based on behavioral change theory, and harm reduction theory
- an evidence-based clinical pathway for tuberculosis screening

Faculty Practitioners

Carl Kirton, ANP
212.998.5334

Joe Colagreco, ANP
212.998.5315

Home Health Liaison

The practice creates a new, innovative role in the Mount Sinai Emergency Department and Home Health Agency. The practice started in late 1999 to provide a Nurse Practitioner who would be a liaison between the two areas and expedite emergency department discharge and home health admissions.

Nurse Practitioner Activities:

The adult primary care Nurse Practitioner activities include:
- diagnosing/treating patients in urgent care and asthma rooms in the emergency room;
- coordination of care for established home care patients who visit emergency department for episodic illnesses;
- case review/identification of emergency patients who are candidates for home care;
- conferencing with attending physicians regarding various services available through home care, i.e. infusion therapy, psychiatric home care, specialty programs;
- educating Emergency Room personnel regarding specific of Medicare and other insurance requirements

Faculty Practitioner

Susan Massey, ANP
212.241.0324

Geriatric Emergency Department

The Geriatric Nurse Practitioner (GNP) role in the ED was developed as a collaboration between the Division and Mt. Sinai to address issues of communication, provide more seamless care for the elderly across the continuum of the health system, and to reduce unnecessary hospitalization and emergency department visits by the elderly.

There is a high rate of admissions and re-admissions of elderly patients to emergency services and ultimately to the hospital. For example in a four month period: 41% of the patients 65 years of age and older were repeat visits to the ED and of these 90% were re-admitted. Approximately 25% of the patients were readmitted within 14 days of discharge.

Nurse Practitioner Activities:

The emerging role for the GNP in the emergency department includes:
- care coordinator for geriatric patients and their family
- resource person for other providers in the Mt. Sinai geriatric network
- coordinating and managing patient care to reduce length of stay in the emergency department
- expedite admissions to the inpatient unit, if needed
- assisting other providers in discharge planning from the emergency department
- site director for Medical Clerkship in Geriatrics
- working with frequent referral sources to the emergency department such as local nursing homes, to increase communication regarding the appropriateness of referrals and promote sharing of essential patient information
- principle investigator in a research project in the emergency department and assisting in research project done by NYU

Faculty Practitioner

Margaret Norton, GNP
212.241.1726

The Bowery Resident' s Committee Community-Based Care

參觀報告

9c.10.3

The Bowery Resident' s Committee Community 係位於 NY 舊中國城之社區性心理衛生中心，該中心主要是針對酒飲及藥影之民眾提供個別性及團體性之心理輔導、治療及社會工作之服務，。

以下簡介其服務運作方式：

一、收案來源：

接受社區或 Bowery Committee 轉介個案。其個案背景為非洲亦美國人（70%）、西般牙亦美國人（10%）……，且男性多女性。

二、服務內容：

經收案後評估，並訂定適當之輔導治療計畫。一般而言，其輔導治療計畫，依個案情況而分為復健性治療計畫（Rehabilitation）及臨床性治療計畫（Clinical）；復療計畫為每週三天，不超過三禮拜之治療性計畫。經收案後，該中心亦附帶提供早、午二餐之服務。

經由團隊合作模式，由各專業人員分別提供心理評估、職能治療、社會功能重建等治療處置，藉由逐步漸進方式，以促病人減少藥物或酒精濫用，並重返社會。甚至當病人結束治療後，尚協助其解決居住的困難。

三、工作人員之組成：

組成之工作人員包括心理師、執業專科護理師、執業護士、職能治療（例如音樂治療、藝術治療及娛樂治療等）及社會工作師等。

四、執行現況及成效：

目前共有８３位個案，其中六位為結束治療後之追蹤期（須接受三至六個月的追蹤）。

平均每年二十八人由此計畫完成治療，但也有少數病之人係再次被收案，以前二年言，６８位病人中，僅３位再度接受治療，故其成功輔導之案例可謂具相當成效。

五、與政府之關係：

該單位為一非營利性機構，每年由州政府及 OASAS 提供主要的經費來源，該機構亦須每年接受州政府之考核，其考核有其一定之標準及程序，被考核之單位亦有一書面指引手冊，藉由該標準作業手冊，可資準備接受考核，故其監督輔導關係定之位權責明確。對考核結果，州政府會給予適當之建議及處置措施，如依其服務功能及人員之素質資格，例如經考核並建議改善者，給予一年或三年不等之執

照效期，逾期未改善者，則停止補助或不發給執照，實具相當之約束效果，並藉以促進人員及服務之提供維持一定之品質。

紐約大學醫學中心-Tisch 醫院(2)

New York University Medical Center-Tisch Hospital

蔡安津 2001/10/2

參訪者：蔡秀鶯，陳幼梅，唐婉如，高文惠，林美珠，蔡安津

紐約大學醫學中心-Tisch 醫院是一所包含了 596 張急性病床和 174 張復健病床的醫院，並專長於心臟血管醫學。911 恐怖攻擊事件後，使得醫院的醫療資訊系統被破壞，兩星期後才恢復。

此醫院的執業專科護理師(Nurse Practitioner, NP)照顧的範圍包含所有的病人除了燒傷病人及骨髓移植的病人以外。Marilyn Lopez 及 Diane Maydick-Youngberg 是此次帶我們參觀的其中兩位，Marilyn 是老人醫學(Geriatric)的執業專科護理師(NP)，而 Diane 是傷口造口處理(Wound Ostomy Continence)的臨床專科護理師(Clinical Nurse Specialist, CNS)。

Marilyn 指出執業專科護理師主要工作是個案管理(Case Management)，發展護理照顧模式(Develop nursing model)，利用實證醫學(Evidence-base practice)為基礎建立標準。執業專科護理師主要是由各州頒發資格且被紐約大學醫院承認。醫師非常放心把患者交給執業專科護理師照顧。執業專科護理師的工作內容有詢問病史、身體評估、開立處方、照會其他領域的執業專科護理師及醫師、工作不被侷限於某個單位、篩選病患、提供患者更多的資源、衛教家屬……等。由醫院支付薪水，與醫師合作並簽訂共同契約。

Diane 指出傷口造口處理臨床專科護理師的主要工作是到門診探視術前病患，並在術後到病房追蹤預後，從電腦輸入傷口照顧計畫，由護士或臨床專科護理師執行。患者出院後會電話追蹤預後情形。與執業專科護理師不同的是，臨床專科護理師不開立處方。

陳副主任、唐老師和我在經過 Marilyn 及 Diane 的詳細解說對於執業專科護理師及臨床專科護理師的工作及角色上有了更深入的了解。看到她們在臨床上合作的情形及專業的態度，是我們所要加強及深思的地方。

New York University Medical Center

疼痛處置門診 (Pain Management Clinic) 參訪紀錄

90.10.2 林惠珠

Tish New York University Medical Center 疼痛處理的門診業務是由 Sally Arbolins 負責，她是一位臨床護理專家(CNS)。由她的介紹中了解其業務內容，她除了不能開處方之外，什麼都可以做，包括：

1、收集病人回診前一個月的全身狀況資料。

2、執行相關之健康評估。

3、評估 PCA 裝置的功能與殘餘劑量。

3、執行處理醫師開的處方藥物並調整劑量。

4、解答病人與家屬的各項疑問，並提供諮詢。

6、處理完之後並向醫師討論給藥情形，遇到醫師質疑給藥的劑量，能很快的演算證明無誤。

7、轉介給 Home Infusion Service。

這次她主要介紹的是永久性置入型的 Epidural Catheter，這個方法是依病人身高、體重及病情狀況設計藥物劑量，提供長期疼痛控制的服務。這類的病人大多數為不會好也不會馬上死的癌症病人。

由此次的參訪得知美國，在門診很方便就有疼痛處理這項服務、CNS 的獨立執行業務的能力、作業範圍及對人的尊重。反觀國內尚不普及，這可能是我們要加強學習的地方。

New York University Medical Center
Department of Anesthesia
Pain Management Center

Permanent Implanted Epidural Drug Delivery System

A Guide for Patients

Introduction

Patients selected for the placement of an epidural catheter are experiencing severe constant pain, usually associated with cancer. This method is considered when your current pain medications do not provide enough relief, cannot be swallowed, or you experience too many side effects such as drowsiness or nausea.

Another method to control pain is a permanent implanted epidural catheter. This method provides long term pain control with less medication. Since there is less medication, there are minimal side effects. This booklet will provide you with information about how the catheter works, how it is implanted and how to care for the catheter.

What is an Epidural Catheter?

An epidural catheter is a soft plastic tube that is inserted into your back. The pain medication is "pumped" into the area around the spinal cord called the epidural space. In the spinal cord, the pain sensation can be stopped or lessened by specific pain medications. Since these medications work directly in the spinal cord, less medication is necessary to provide pain relief.

The permanent epidural catheter allows for continuous (deliver medication all the time) and self administered "bolus" medication (extra medication). The "bolus" medications is given to yourself when you need extra medication because of increased pain. This allows you to be more comfortable and not to have periods of time with terrible pain or being too sleepy.

Advantages of the Permanent Epidural Catheter System

- ☐ Greater control over your medication
- ☐ Smaller dosages
- ☐ Faster onset and longer duration of pain relief
- ☐ Reduced undesirable effects such as nausea or sedation

- ☐ Permits greater freedom to participate in activities
- ☐ Decrease rehospitalization for pain management, resulting in reduced costs to you

Disadvantages and Potential Complications

As with all invasive procedures there are risks. However, there are few reported risks associated with implanted epidural catheters:

- ☐ Generalized infection
- ☐ Localized infection at exit site and along catheter path
- ☐ Twisting, blockage, or movement out of the correct placement of the catheter
- ☐ External portion of catheter susceptible to breakage
- ☐ Tissue scarring around epidural tip site in your back causing pain on injection

What is the permanent epidural catheter system?

There are two (2) parts of the permanent epidural catheter system:
1) the epidural catheter
2) the Patient Controlled Analgesia (PCA) pump infusion system

The epidural catheter is placed into your back and into the epidural space outside your spinal cord. The other end of the catheter is tunneled to the front of your stomach, where it is attached to the PCA pump. The place where the catheter leaves the body is called the "exit site". The PCA pump may be an internal or external computerized machine. This system can provide medication around the clock (continuous) and/or give more ("extra") medication when needed (bolus).

Medications

There are specific medications that can be given in the permanent epidural catheter system. Opioids (narcotics), such as morphine, are used most frequently. The opioid may be used alone or together with a local anesthetic, such as bupivacaine. These medications lessen pain by attaching to receptors in the spinal cord or by anesthetizing the nerve roots which block the pain sensation from being felt in the brain. Some of the side effects of the medications include:

-nausea/vomiting	-itching	-difficulty emptying bladder
-constipation	-drowsiness	-tingling/numbness around mouth
-dizziness	-blurred vision	-ringing in ears
-tremors		

If you have any of these symptoms notify the Pain Service. These effects may be from other medications/treatments you are receiving or from the permanent epidural catheter system. If these symptoms are caused by the permenent epidural system these are only for a short time and can easily be managed.

Besides having the permanent epidural, you may need additional medications which will decrease and control you pain. These may include antidepressants, anticonvulsants, nonsteroidal antiinflammatory or corticosteroid drugs.

In some special cases, if your pain cannot be managed with conventional methods, the Pain Management team may discuss enrolling you in an investigational drug protocol. Certain non-narcotic medications, which are used for specific medical problems, relieve pain when given epidurally or intrathecally.

Preliminary workup

The Pain Management team will work with your primary physician regarding your assessment and treatment. You may need to be in the hospital or Coop Care for the prescreening tests and for the temporary catheter placement.

A temporary catheter will be inserted for a short period of time, usually 24-72 hours. This temporary epidural catheter is similar to the permanent

epidural catheter except the catheter is taped to the outside of your back and over your shoulder. The temporary catheter is used to determine how much medication you need and how you are responding to the medication. If during this time, you receive improved pain control with minimal side effects, you will be considered for a permanent epidural catheter.

Before the permanent epidural catheter is implanted, you will need to sign an informed consent form. The risks and benefits of the permanent epidural catheter will be explained to you in detail by someone from the Pain Management Team. The Pain Management Team will be working with your doctor(s) and other members of the health care team to provide effective pain management.

Implantation of the Permanent Epidural Catheter

The permanent epidural catheter is implanted in the operating room or a sterile room in radiology. This ensures the catheter will remain in place and help to prevent infections. You will need local or general anesthesia during the procedure. You will have an X-ray using dye to verify the catheter's position.

The epidural catheter will be connected to the PCA pump and be used immediately. At first a bulky dressing on your abdomen will be applied. Later (after 24 hours) a less bulky sterile dressing will be applied. A sterile dressing will be on your exit site (on your abdomen) until it heals. Eventually, no dressing will be necessary over the "exit site".

You may feel some soreness or discomfort around the "exit site" and in your back from the placement of the catheter. You should tell the nurse or a member of the Pain Team if you are having pain so your medication can be adjusted.

While you are in the hospital, the Pain Management Team will adjust your medication. You will also be receiving instructions on how to care for your permanent epidural. You will also meet with the home care infusion nurse. This nurse will discuss how you will take care of the permanent epidural system at home.

Dressing Changes and Exit Site Care

The most common complications from a permanent epidural catheter is infection. This is caused by inadequate care of the catheter exit site. It is very important to follow these steps carefully.

Procedure

1. Wash hands for three minutes with warm soapy water and dry on clean towel.

2. Prepare a clean, uncluttered work area within easy reach.

3. Gather all supplies:

   - ☐ Open bag for disposal of used items
   - ☐ Bottle of hydrogen peroxide
   - ☐ Clean paper cup
   - ☐ 3 Sterile tip cotton swabsticks
   - ☐ 3 Sterile providone-iodine (Betadine) swabsticks
   - ☐ 1 package of 4x4 sterile sponge (1 package contains 2 sponges)
   - ☐ 1 Transparent occlusive dressing
   - ☐ 1 Roll of paper tape

A face mask is optional but use it if the person changing the dressing has a cold or flu-like symptoms

4. Open all supplies and place on the work area. Be careful not to touch the inside surfaces of the sterile wrappers or the tips of the swabsticks.

5. Pour hydrogen peroxide into a paper cup and recap the bottle.

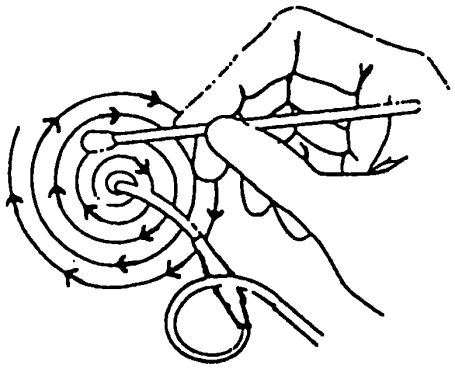
6. Tear off a piece of tape approximately four inches long.

7. Remove old dressing, holding the external catheter with one hand. Start at the top of the dressing and work from the edges downward toward the center. Touch only the outside of the dressing. Be careful not to pull on the catheter. **DO NOT USE ANY SHARP INSTRUMENTS, SUCH AS SCISSORS, AROUND THE CATHETER.**

8. Inspect exit site and along catheter track for signs of infection: drainage at the exit site, redness, swelling, increased warmth or tenderness.

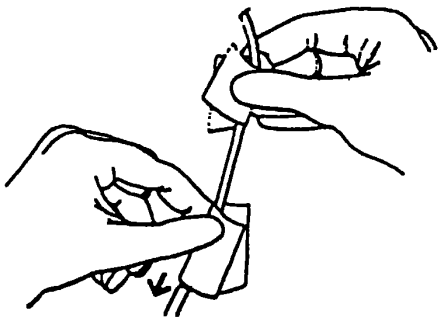
9. Wash hands again with warm soapy water and dry on a clean towel.

10. Carefully clean the exit site with sterile tip cotton swabsticks dipped in hydrogen peroxide. Starting at the exit site, wipe the skin in a circular motion. This step should be repeated two more times, using a new swabstick for each circle around the exit site, covering a distance of about two inches. Allow the area to air-dry.



11. Repeat Step 10, using Betadine swabsticks.

12. Pour some hydrogen peroxide on open 4x4 sponges. Pick up the top sponge with one hand and use the inside surface to hold the catheter away from the body near the exit site. Be careful not to touch the exit site with your fingers. Take the second 4x4x sponge in your other hand and use it to clean the exernal catheter, beginning at the exit site, by gently wiping it with the moistened sponge. Clean the entire catheter length to the connector. Be careful not to pull the catheter out.



13. Make a small upward loop with the catheter. Secure the catheter against the skin with the tape. Place the transparent occlusive dressing over the exit site and the catheter loop.

14. Discard bag of used disposable items.

15. Wash hands thoroughly.

Care of the PCA Pump Infusion System

The PCA pump infusion system consists of the PCA pump with medication cassette, tubing and a filter. The Home Infusion Service is responsible for the care of this system. The Home Infusion Service will change the medication cassette, tubing and filter approximately every seven days, or more frequently if needed. You need to be aware of any possible problems with the system. Below is a list of minor problems you can trouble shoot.

If the PCA pump alarm goes off, try to figure out the problem and follow the appropriate steps below. If you are unable to determine the problem, notify the Home Infusion Service immediately.

Troubleshooting Guide

Problem (alarm sounds):	Steps to follow:
Empty cassette	Stop pump and call Home Infusion Service immediately
Medication tubing kinked	Unkink the tubing
Catheter tubing kinked	Unkink the tubing
Low battery	Check screen in lower right corner; if battery is low, replace with fresh nine volt alkaline or call Home Infusion Service

Problem (may not have alarm sounds):	Steps to follow:
Medication leakage around connections	Tighten around connections
Disconnected tubing	Wipe both ends to be connected with Betadine swabsticks, air-dry and reconnect

Warning Signs of Potential Complications

IF YOU OR A PERSON ASSISTING YOU IN YOUR CARE NOTICES ANY OF THE SIGNS LISTED BELOW, QUICKLY CONTACT THE HOME INFUSION SERVICE OR PAIN SERVICE, AS YOU MAY REQUIRE MEDICAL ATTENTION.

- ☐ Fever higher than 100.5 degrees
- ☐ Swelling, drainage, tenderness and/or increased redness around exit site (slight redness around exit site is normal)
- ☐ Redness, swelling, tenderness and/or increased warmth along catheter track
- ☐ Leakage of medication around exit site
- ☐ Change in length of external catheter
- ☐ Severed or perforated catheter
- ☐ Pain with self-administered "bolus" injection
- ☐ Persistent headache
- ☐ Decreased pain relief with present dosage
- ☐ Decreased respiratory (breathing) rate
- ☐ Decreased alertness
- ☐ Changes in behavior noted by family/friends

Your Activities

Daily. You may continue your normal daily activities, including work, visiting friends and family, shopping etc. *Caution:* Avoid strenuous activity that might dislodge the catheter or a chance of a blow to your pump.

Baths/showers. Sponge baths only until your sutures are removed and incisions have healed. Once adequate healing has occurred you may shower. The Pain Service recommends that you put the PCA pump and filter in a plastic bag and place it outside the shower on a flat surface. Place plastic wrap over the exit site and tape edges securely. Do not direct stream of water on the exit site. After showering, remove the plastic wrap and perform a routine clean dressing change. Once the new clean dressing is in place,

remove the PCA pump and filter from the plastic bag. *Caution:* Baths are not advised.

Driving. Whether or not you can drive will depend on the medication you are receiving and your response to it. Discuss this with the Pain Specialist.

Traveling. Discuss with the Pain Specialist and your Home Infusion Nurse, so plans can be made for refilling your medication, catheter care and dressing changes. These arrangements may be made with a Home Infusion Service in the area you plan to visit. You should keep your Epidural ID card and this booklet with you at all times while traveling. You may need to present your Epidural ID card to airport security personnel for clearance through metal detectors. *Caution:* Avoid high current industrial equipment, power magnets and transmission towers and antennas. This includes MRI scans.

Other. _____

_____

_____

_____

_____

_____

Follow-Up at Home

The Pain Specialist, the Home Infusion Service and your Primary Physician will collaborate to assist you in managing your epidural drug delivery system in your home. The Home Infusion Service will be assessing your management of the epidural catheter and drug delivery system, as well as your overall status. Based on your needs, you will be scheduled for follow-up appointments with the Pain Specialist in the Pain Clinic.

Your first visit from the Home Infusion Nurse will be on:

(date)_____(time)_____

Your first Pain Clinic appointment is scheduled for:

(date)_____(time)_____

Your first follow-up appointment with your Primary Physician is scheduled for:

(date)_____(time)_____

NEW YORK UNIVERSITY MEDICAL CENTER

DEPARTMENT OF ANESTHESIOLOGY

PAIN MANAGEMENT CENTER

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ACUTE PAIN SERVICE MANUAL

JANUARY 2001

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DESCRIPTION OF SERVICE

The **ACUTE PAIN SERVICE** (*APS*) is part of the **PAIN MANAGEMENT CENTER** (*PMC*), a division of the Department of Anesthesiology, New York University Medical Center. The goal of the APS is to provide safe optimum analgesia to patients with post-operative pain. This includes epidural analgesia, and other types of postoperative analgesia when requested by the surgical team. Optimum management of postoperative pain in patients with acute postoperative pain can include indwelling epidural catheters, and intravenous PCA (patient controlled analgesia). All epidural catheters are managed postoperatively by the pain service. These catheters are initiated and managed by residents under attending supervision. In most cases, the epidural is placed by the anesthesiologist providing anesthetic management during the surgical procedure. On request from the attending anesthesiologist caring for the patient during surgery, the pain service will be available to place or assist with placement of epidural catheters. At times this may be done in the SDA area of the 6th floor. **Please contact the pain service at 263-7316 the day prior to surgery to schedule placement of the epidural by the pain service.**

Other acute pain treatments include parenteral analgesics, opioids, and adjuvant medications. Pain Management trainees treat patients and conduct invasive procedures commensurate with their knowledge and experience under supervision of the pain service attendings. At night, anesthesiology residents or acute pain service nurses are on call for the acute pain service and are under the supervision of the pain fellow and APS attending, who are available by beeper. Attending, Fellows, and Resident visit each patient under their care daily. These are teaching rounds for the housestaff and also ensure that the attending pain anesthesiologist sees each patient of the service daily. The pain nurses also make rounds on each patient on the acute pain service during each 8 hour shift or more frequently if medically indicated.

SERVICE PROVIDED

The *APS* is provided by the Pain Management Center team, which consists of residents, fellows and pain nurses under the supervision of the attendings physicians in the Pain Management Center.

I. AVAILABILITY OF SERVICE:

The acute pain service provides in-hospital availability 24 hours per day seven days per week. All inquiries should be directed initially to the pain service beeper, 866-PAIN. Calls to the pain service beeper **will be answered within 10 minutes, and the resident or APS nurse will physically be present to see the patient within 30 minutes.** To ensure availability, pain housestaff and nurses will answer calls as follows:

1) <u>6:30 a.m. - 6 p.m. weekdays:</u>

Resident/ APS Nurse -Residents rotating through the *PMC* answer calls to the APS: 6:30 a.m. until 12 noon the CA2 will answer calls. From 12 noon until 6:30a.m. the in house pain service nurse (**APS Nurse**) answers acute pain calls. If no pain procedures are scheduled, the CA2 is responsible for calls to the APS until 4 p.m

Pain Fellow and Pain Attending - Provide in-house backup and education for pain residents/nurses during the day. Fellow will be present in-house until 6pm.

2) Week nights after 6:00 p.m.:

Resident/APS Nurse - Pain Nurse or resident/fellow is in the hospital 24 hours per day 7 days per week to answer calls and see APS patients.

Pain Fellow or Pain Attending on-call and available by phone as needed.

3) Weekends and Holidays:

APS Nurse and trainees (Resident or Fellow) take in-house beeper call.

Pain Fellow and Pain Attending are also on call and available by phone as needed. All APS patients will be seen each day by the pain fellow or attending.

If an indwelling epidural catheter requires administration of a test dose (see section IV), an **MD must be present to perform the test injection and to monitor the patient for at least 20 minutes after the last test dose is given.** From 6:30 a.m. to 6:30 p.m. the pain resident or fellow will be available. At other times, test doses occasionally may be needed, and the APS nurse will contact the following individuals to perform test doses:

6:00p.m. to 10:30p.m. ---recovery room MD
10:30p.m. to 6:30a.m. , weekends, holidays---OB resident

There is always backup by telephone by the APS attending. Call Pain Clinic (37316) and operator will contact the pain attending. In house attending back-up for unusual urgent occurrences will be provided by the Recovery Room attending when in-house and at other times by the OB attending anesthesiologist.

II. LOCATION OF PATIENT CARE FOR EPIDURAL ANALGESIA

A. Placement of epidural catheters usually will be performed preoperatively in the operating room, or the 6th floor SDA. Occasionally, epidural catheters will be inserted postoperatively in the RR, ICU or patient room, but this should occur only infrequently for malfunctioning epidural or when the surgical service requests epidural placement and the APS agrees that it is indicated. Placement of epidural catheters in patients with a recent surgical incision is painful and presents technical difficulties with positioning, thus pre-operative placement of epidural catheters is preferred.

B. Patients may have postoperative epidural pca infusions in any area of the hospital.

III. GUIDELINES FOR EPIDURAL PCA PRESCRIPTION

General Considerations:

The pain team must be contacted by the attending anesthesiologist prior to initiation of postoperative epidural infusion. The prescription for the patient and guidelines for initial institution of Epidural PCA have been put onto the HIS Computer System so that appropriate selections may be made easily. Guidelines for the appropriate prescription also are included in the menu. Orders for post-operative pain management by the Pain Service must originate from the primary service (i.e. surgery). **The APS will enter the orders for epidural PCA.** A note will be written when the epidural PCA is ordered. (See APPENDIX I)

1) Post-Operative Cesarean Patients:

Orders for post-operative ceasarean patients can be found in the Obstetrical Protocol on the HIS Anesthesiology Department Epidural Screen. A single click of the pen will provide the epidural PCA orders including medications, dosage, concentrations and initial bolus dose. There are no other options for this program. In the event of any problems or questions, please refer the matter to the APS Attending or Fellow on call.

Standard Solution for OB patients:

Fentanyl 3 mcg/ml & Bupivacaine 0.015%& Epinephrine 1:2,000,000
Starting rate of epidural infusion: 15 cc/hr, Bolus dose 3 cc and lockout 10 minutes.

2) Standard Solutions for Post-Operative Patients:

In this protocol there are a choice of several solutions:

Fentanyl 2mcg/ml & Bupivacaine 0.06%
Fentanyl 5mcg/ml & Bupivacaine 0.125%
Dilaudid 0.04 mg/ml

The choice of solution is determined by the placement of the catheter in relationship to the surgical site and by the patient's age and medical condition.

Recommended guidelines for catheter placement:

Surgical Site	Epidural Placement	Rate of Epidural Infusion
Thorax	T2-T8	2-6 cc/hr with 1-5 cc bolus
Upper Abdomen	T6-L1	Lockout 15 minutes
Lower Abdomen	T10-L3	
Lower Extremity	T12-L3	

If catheter is placed at recommended level, and patient is under age 65, fentanyl 5mcg/cc bupivacaine .125% should be ordered. If patient is 65 years and older or medically fragile or hemodynamically unstable, fentanyl 2 mcg/cc bupivacaine 0.06% should be ordered.

Dilaudid 0.04 mg/cc should be used for patients with catheter placement lower in the spine than the recommended levels or for patients with inadequate pain relief despite maximization of the above regimens. **Infusion rates for dilaudid are lower: 1-3 cc/hr (can be increased to 4cc/hr as needed), bolus 1-3 cc and lockout of 30 minutes. APS attending or fellow should approve all prescriptions for epidural dilaudid.**

3) Custom Solutions:

There is an option to make a custom epidural solution under certain circumstances. These include: allergy to the above mixtures, need to add or have a higher concentration of bupivacaine in the solution, etc. These HIS screens follow the same ordering sequence as the standard solution screens. **Custom mixtures may be ordered only with the approval of the APS attending.**

IV. PLACEMENT AND CARE OF EPIDURAL CATHETER

Epidural catheters should be placed at the level appropriate for the surgery as described in section III. The length of epidural catheter in the epidural space should be 3-5 cm.

The clear Opsite or Tegaderm covering allows for easy inspection of catheter insertion site. When placing the clear dressing, no cushion or other padding should be used. The epidural site and circuit should be inspected daily to check proper securing of the catheter, and evidence of infection. If the area is wet, the dressing should be changed by *APS* personnel only. Removal of the dressing and tape should be done gently and with reassurance as patients are sensitive to this process. Document removal of the tip of the catheter in the patient chart and on the green acute pain sheets.

The catheter should be removed if infection is suspected, and C&S studies of the skin site and catheter tip sent to the laboratory.

V. ASSESSMENT & MANAGEMENT OF INADEQUATE PAIN RELIEF

1) If local anesthetics are used, check for sensory dermatomal level.

2) Check whether the catheter is dislodged or if epidural tubing is disconnected or circuit to pump has interruption. Check catheter position at skin exit site. Check for leakage.

3) Check for aspiration of blood or CSF. If CSF is aspirated, discontinue epidural.

If aspiration is positive for blood, withdraw catheter a few millimeters and re-check. Repeat until aspiration is negative for blood. Retest catheter.

4) If position of catheter tip is questionable: give 2 cc increments of 1.5% or 2% lidocaine with epi 1:200,000, at least 5 min apart, for a total dose of up to 8 cc depending upon patient's response, level of the catheter, surgery, etc. Evaluate for resultant dermatomal sensory deficit which indicates the location of catheter tip within the epidural space. Pain relief does not indicate catheter is working. The dermatome of sensory loss also must be tested and documented. Also, evaluate patient for motor block.

   An MD must be present for the test and to monitor the patient after the test. Stay with patient for 20 minutes recording respiratory and hemodynamic status. This is to prevent mishaps occurring from unintended intrathecal injection of anesthetic. If there is no dermatomal level of analgesia, discuss with the Pain Attending for possible catheter replacement or switch to alternative pain management technique.

5) In the event of misplacement of epidural catheter, repeat epidural placement of catheter under supervision of an Attending Physician if patient requires continuation of pain control.

6) **The Pain Management Center should be notified of any and all problems that may occur.**

VI. GUIDELINES FOR MANAGEMENT OF SIDE EFFECTS WITH EPIDURAL NARCOTICS

If the patient is experiencing side effects and not having pain, decrease rate of epidural infusion by 2 cc per hour.

1) NAUSEA AND VOMITING

Exclude obstructed nasogastric tube, distended abdomen, hypotension, bleeding, etc.
Compazine - 5-10 mg PO or IM , repeat every 6 hours as necessary
Zofran 4 mg IV every eight hours as necessary

2) PRURITUS

Benadryl - 25-50 mg PO or IM (may give 12.5 to 25 mg iv) - repeat if necessary.

If Benadryl is not effective after 2 doses, initiate naloxone infusion - 1 mcg/kg/hr (see Appendix II)

3) SOMNOLENCE OR RESPIRATORY DEPRESSION
(Respiratory Rate < 10 per minute; Sedation Score > 2)

Respiratory rate is highly unreliable to assess respiratory depression and sedation will be the first sign of impending respiratory depression.

FIRST---MANAGE AIRWAY IF NECESSARY

Exclude intrathecal migration of epidural catheter. If indicated, aspirate and test catheter fluid for glucose with chem strip.

Naloxone bolus: Dilute 0.4 mg of naloxone in total volume 10 cc and administer 1 cc (0.04mg) repeat q 1 min prn. Large bolus doses of naloxone reverse analgesia and may induce cardiopulmonary failure in patients at risk and therefore should be avoided.

If necessary, start naloxone infusion 5-10 mcg/kg/hr until effects of opioid overdose have dissipated.

Due to the short life of naloxone, 20 minutes, patients with signs of respiratory depression should be placed on naloxone drip in a monitored setting.

4) HYPOTENSION

Hypotension occurs in postoperative patients for a variety of reasons including dehydration, ongoing blood loss, and sepsis. Assess for etiology of hypotension. Stop epidural infusion until BP is stable. Treat BP with IV fluids and pressors as needed.

5) URINARY RETENTION

Straight-cath patient prn.
Naloxone PCA can be ordered if urinary retention is prolonged.

6) SENSORY OR MOTOR BLOCK OF LOWER EXTREMITIES

If sensory and motor weakness is observed, patients should ambulate with caution. Decrease dose by 20% until the return of function to normal in lower extremities. If block is unilateral, withdraw catheter 1 to 2 cm.

7) ONE SIDED ANALGESIA

Catheter should be withdrawn 1-2 cm and retaped. Catheter should be retested and rebolused to assess whether analgesia is improved. Patient should be reassessed 1-2 hours later. Catheter may be replaced if anelgesia not adequate

VII. OTHER POTENTIAL ISSUES FOR PATIENTS WITH EPIDURAL CATHETERS

1) ANTICOAGULATION

If a patient with an epidural catheter is to be anticoagulated, the epidural MUST be discontinued prior to starting anticoagulation. In the event that anticoagulation is started without discontinuation of the epidural, the APS attending should be notified and the following should be done:

FOR COUMADIN: The epidural can be discontinued up to 12 hours after the first dose of coumadin has been administered. If more than 12 hours have elapsed, evaluate the patient's current PT/PTT. If normal, remove the catheter. If elevated, withhold any further doses of coumadin until the PT has normalized (INR<1.4). Coumadin may be restarted after the epidural catheter is removed.

FOR DEXTRAN: If the patients coagulation is normal, the epidural catheter can be removed at any time.

FOR HEPARIN: Discontinue heparin for 4 hours and then obtain a stat PTT. If normal, remove the epidural catheter. The heparin may be restarted 2 hours after the epidural catheter has been removed.

FOR LOW MOLECULAR WEIGHT HEPARIN (LOVENOX) OR MINI-DOSE HEPARIN: One dose should be held and the epidural can be discontinued 23 hours after last dose (one hour prior to the next scheduled dose).

FOR SUBCUTANEOUS HEPARIN: The epidural can be discontinued between the 8th and 12th hour from the previous dose. The next dose of subcutaneous heparin is held for 2 hours after the epidural is discontinued.

2) FEVER

Postoperative fever spikes are frequent and do not as a rule indicate that an epidural catheter should be removed. For example, many thoracotomy patients experience fever spike due to atalectasis post op. Check epidural site. Discontinue epidural if site is infected or if patient is bacteremic. If there is no evidence of infection at site and no bacteremia, continue epidural and monitor site every 8 hours. Note that epidural abscesses are extremely rare complications of post-operative epidural pain management, especially within 5 days of placement of the epidural catheter. Other sources of infection should be sought.

3) HEADACHE

Postdural puncture headache (PDPH) usually occurs after the epidural catheter is removed. This headache is due to CSF leak after inadvertant dural puncture and is postural and often associated with nausea and vomiting.

Treatment includes:

1. Careful neurologic exam to assess for other etiologies of headache. Obtain history of any similar prior headaches. (Remember that over 20% of the population have a significant headache history, and the patient may be experiencing his or her typical headache.) Assess for fever, nuchal rigidity and focal neurologic signs. Follow-up with appropriate evaluation and treatment if necessary.

2. Conservative treatment includes abdominal binders, PO or IV hydration and caffeine.

3. Epidural blood patch can be performed by the pain service and is 90% effective for PDPH. Patients should give informed consent for this procedure and should be told that the alternative is observation and conservative treatment as the headache is usually resolved within 7 days. Caution patients that they should remain at bedrest for 24 hours after blood patch, and avoid valsalva because of possibility of reoccurrence of headache and need for 2nd blood patch.

D. NEW ONSET OF LOW BACK PAIN AND/OR RADICULAR SIGNS

Severe back pain and tenderness and neurological (radicular) signs not explained by the routine effect of the epidural should be considered a **medical emergency. Notify the pain management team immediately.** The patient should have immediate evaluation for possible epidural hematoma.

E. EPIDURAL IN PATIENTS ON PREOPERATIVE CHRONIC OPIOIDS

These patients are at risk of opioid withdrawal. Signs include anxiety, sweating, tachycardia, hypertension, metallic taste. Patients may require parenteral narcotics until they are able to take their oral medications.

F. SEDATIVES AND PARENTERAL OPIOIDS

Sedatives and parenteral opioids should be administered with caution in patients receiving epidural narcotics. These medications are to be ordered by the APS only.

G. CONFUSION AND DYSPHORIA

Patients, particularly the elderly, may experience confusion in the postoperative period. There are a number of causes, including preoperative confusion i.e., assess the patient's baseline mental status, anesthetic agents, metabolic abnormalities, sepsis and poorly managed pain. Epidural narcotics are less likely to cause postoperative confusion than

parenteral narcotics; however, be aware that fentanyl administered via the epidural route achieves significant systemic levels.

H. PATIENT SATISFACTION

This is the ultimate goal of the pain management service! The APS is committed to delivering postoperative pain management with a high level of patient satisfaction. This means that you, the clinician, are critical to our success. Your attitude and responsiveness to patient needs will be a positive and memorable part of the patient's experience at NYU.

APPENDIX I

GUIDELINES FOR EPIDURAL INITIATION AND FOLLOW-UP NOTES BY APS STAFF

INITIATION

1) Post-op analgesia has been requested by surgical service.

2) The chart has been reviewed, and the patient has been evaluated.

3) Brief significant past medical/surgical history.

4) Current surgery, intra-op anesthetic history, and level of epidural catheter placement.

5) PCEA, or IV PCA, etc. is indicated or not.

6) Your plan for pain management.

7) APS staff enters orders in HIS system. Transfer epidural orders to pain service on HIS.

8) Be sure to document PCEA prescription on green sheet and place green sheet in red book.

FOLLOW-UP NOTES

A legible note (with a **date, time, and title "Pain Management"**) should be written whenever an in-patient is evaluated or a therapeutic intervention is made. It should include current pain regimen; pertinent information about the patient's mental status (A,A,Ox3); level of pain control (pain score at rest and with movement); presence of side effects (N/V, pruritus, sedation); evidence of motor and/or sensory block; po status; bolus deliveries and demands (for PCA pumps), and your plan.

If changes are made on a PCA protocol during round, please reprogram the PCA pump, change the PCA order in the HIS computer system, document the change in the progress note, the pain book (green or white sheet), and the nursing PCA flow sheet (after discussing with the patient's nurse).

APPENDIX II

LOW DOSE I.V. NALOXONE INFUSION

INDICATIONS:

In low doses (40-200 mcg) I.V. Narcan will minimize the unpleasant side effects associated with epidural narcotics without decreasing their analgesic effect. It is indicated for treatment of generalized itching, especially itching of the face; also for nausea and vomiting. Higher doses are necessary when treating respiratory depression or over-sedation.

While Narcan is utilized in the treatment of epidural analgesia it must be given I.V./I.M. and may not be given epidurally.

PREPARATION OF NALOXONE INFUSION

PROCEDURE:

1) Naloxone (Narcan) must always be infused by a pump for a continuously regulated infusion.

2) Enter orders for Narcan IV PCA in HIS system.

3) Naloxone infusion may be required for approximately 24 hours for treatment of side effects of epidural narcotics.

4) Naloxone IV PCA has standard orders to follow in HIS. The solution consists of adding 2.4 mg of naloxone in 240 cc of NS (10 mcg per cc). Initial bolus is 80-120 mcg (8-12-cc). Naloxone rate is 1-3 mcg/kg/hr for itching, thus a starting dose for a 70 kg person is 7cc/hr with a PCA bolus of 3 cc with a lockout of 6 minutes . **For respiratory depression, do not use PCA. HIS has standard orders for Narcan drip.**

華阜健康診療所(Chinatown Health Clinic)

陳幼梅 2001/10/2

華阜健康診療所(Chinatown Health Clinic, CHC)成立於 1971 年，屬於社區門診型的健康照護機構，提供基層醫療，將預防性醫療與健康教育深入社區。

CHC 成立的起緣是一群中國人在街頭舉行義診活動，由醫師、護士、學生、社區居民發起的義診活動受到社區廣泛的迴響，因而借用教堂的閣樓成立由義工組成的華阜健康診療所。1979 年起 CHC 獲得市政府的公共衛生部門提供資助，才得以搬遷至較大空間的場所。發展至今，CHC 已成為紐約大都會區首區一指的健康照護中心，提供講中文的移民全面且經濟可以負擔的醫療服務。病人數由每年 2000 人次提升為 16000 人次，隨著移民人口數的增加，業務量可能呈倍數成長,診療所的病人來自大都會區的各地區民，其中 40%來自於 Brooklyn 區，22%來自於 Queens 區。今年底或明年初預定要搬遷至離現址不遠的新大樓，將來有六層樓的空間將可提供更多更好的服務。

CHC 提供的基層醫療服務包括內科、小兒科、婦產科、過敏諮詢、皮膚諮詢、小兒心臟問題諮詢、設備齊全的牙科手術服務、眼睛照護(例如糖尿病、青光眼篩檢)、乙狀結腸鏡檢查、癌症篩檢(子宮頸抹片、乳房攝影、抽煙防癌計畫)。

另一個 CHC 提供的整合性服務是健康教育，由於工作人員精通雙語或三種語言，不論是在社區或診療所，都能提供中文(粵語、北京話、閩南語)的健康教育，包括產前與產程衛教、產後照護、新生兒照護、家庭計畫。舉辦婦女健康、高血壓、營養、兒童安全、愛滋病等主題之社區講座。CHC 製作大量的雙語衛教單張，甚至有遠自南美洲與加拿大的機構要求提供。

診療所目前經費由聯邦政府、州政府、市政府提供的計畫經費籌措，另外也可向保險機構申請醫療給付。組織架構有董事會、執行長(Executive Director)，下設醫療主任、財務主任、發展主任，醫療主任下設有臨床主任(Clinical Director)。

此次之訪問即由臨床主任負責介紹該所業務，並引荐一位病人服務部主任(Director of Patient Service)與一位執業助產護理師(Midwifery)。臨床主任過去曾任 CHC 的護士，後來回學校修公共衛生行政碩士學位後升任目前職位，負責診療所臨床業務之協調與發展；病人服務部主任來自香港，曾任護佐(Nurse Aid)，經由工作中發現護理可以發揮的廣大空間，故回到正規護理教育完成護理學士學位並投入居家護理工作，加入 CHC 投入門診醫療工作，並完成其公共衛生行政碩士學位接手目前的工作；助產護理師移民自香港，到美國之前已執行多年的助產工作，當時僅接受過三年的訓練課程，到紐約州立大學完成其執業助產護理師的碩士學位，並加入 CHC。CHC 同時

有醫師、執業助產護理師(Midwifery)開設門診，病人可自由選擇由誰看診，許多病人仍偏好由執業護理師看診。

CHC 三位受訪的護理工作者在工作上展現無比的自信與活力，對自我的期許、對病人的承諾、以及對護理工作的自主性深深吸引我們。走出中國城的老街，同行的三個夥伴包括高科長、蔡副教授和我抬首仰望紐約城林立的高樓，不禁期待台灣護理也能走出屬於自己的一片天空

華埠健康診所
CHINATOWN HEALTH CLINIC
125 WALKER STREET NEW YORK, N. Y. 10013

THE CHINATOWN HEALTH CLINIC

The Chinatown Health Clinic is a community based ambulatory health care facility which provides primary care and emphasizes preventive medicine, health education and community involvement. The Clinic was established in 1971 as the result of a 10 day street fair during which screening tests were conducted by volunteer doctors, nurses, students and community residents. Inspired by this overwhelming response and community wide support, the Chinatown Health Clinic, staffed entirely by volunteers, provided free services out of donated space in a church and, later, a second story loft in a neighborhood tenement. In 1979, the Clinic received Section 330 funding from the Public Health Service under the Urban Health Initiative Program to operate a community health center and relocated to a small converted warehouse (3,800 square feet) at 89 Baxter Street. Today we are the leading provider of comprehensive, affordable health care for Chinese-speaking immigrants in the New York metropolitan area. Our annual patient population has catapulted from 2,000 to 16,000 patients. Immigration trends for the Chinese indicate the numbers will easily double within a few years. The Clinic's patients come from all parts of the Metropolitan area with over 40% of its patients from Brooklyn and 22% from Queens.

In the last 30 years, the Chinese population in New York City has swelled from 20,000 to over 500,000, surpassing San Francisco as the leading city for Chinese settlement in the United States. By the year 2000, it is projected that there will be close to 800,000 Chinese in New York City and close to 1 million in the tri-state area of New York, New Jersey, and Connecticut.

The Clinic remains the only health care choice for many of the Chinese immigrants in the New York City metropolitan area. Because of the Clinic's respected status in the Chinese community, it is an essential link between community residents and existing health care institutions such as New York University Downtown Hospital (formerly New York Infirmary/Beekman Downtown), Bellevue Hospital, New York Hospital and Gouverneur Diagnostic and Treatment Center.

In June of 1994, the Clinic opened its new facility consisting of 11,665 square feet and 12 examination rooms. The new space has doubled the Clinic's capacity and has provided a more comfortable patient care setting. The Chinatown Health Clinic continues to offer a full range of primary health care services in internal medicine, pediatrics, obstetrics and gynecology, as well as consultations in allergy, dermatology and pediatric cardiology. Some of the expanded services offered at the new facility are: a fully equipped three-operatory dental suite, an eye

(212) 226-8866 ADMINISTRATION
(212) 226-9339 CLINICAL SERVICE
(212) 226-1661 SOCIAL SERVICE
(212) 226-1872 HEALTH EDUCATION
(212) 226-8375 WIC
(212) 226-3888 INFORMATION & APPOINTMENTS
(212) 226-2289 FACSIMILE

care center introducing a diabetes and glaucoma screening program and a sigmoidoscopy room. The Clinic also provide cancer prevention programs, such as PAP smears, mobile mammography screening, and smoking prevention activities.

Health education is an integral part of the Clinic's services and the department has established a nationwide reputation among health providers in Chinese communities. The Clinic offers unparalleled access to health information through the use of bilingual staff, media outreach, and evening and weekend hours. Special Clinic services address problems prevalent in the Chinese immigrant community, including tuberculosis and hepatitis. The Clinic's health education staff participates in outdoor community fairs and community parent conferences, and makes presentations at schools, day care centers, youth programs, senior citizen centers and job training programs on topics such as women's health, hypertension, nutrition, child safety, and AIDS. The Clinic conducts community, worksite, and on-site health education programs, including a prenatal workshop series in Chinese on labor and delivery, postpartum care, infant care, and family planning. Ongoing health information is disseminated weekly through the Chinese media, slide presentations, and bilingual pamphlets on subjects such as cancer, AIDS, dental hygiene, parenting. This information is transmitted throughout North America and requests for our pamphlets come from places as far away as South America and Canada. Each winter the Clinic dispenses 2,000 free flu shots to senior citizens. The Clinic operates seven days a week and provides approximately 60,000 medical and dental visits in 1998.

J:admin\denise\chchis99

PS 307 參觀報告

唐婉如 10/02/01

PS 307 是代表 public school 307, 在這所公立學校中共有約 600 名學生, 年齡分佈從 3-14 歲不等. 這所公立學校的學生幾乎都來自低收入戶, 以黑人及墨西哥移民居多, 學校的教職員工亦不例外, 校長本身就是一位黑人.

七年前聯邦政府提撥一筆基金給這所學校, 外加一些私人捐獻, 於是學校成立的一個 clinic. 目前基金已被用盡, clinic 的一切營運所需就靠私人捐獻及紐約州政府提供的經費來維持. 專科護理師負責 clinic 中的一切規劃及運作, 他有一位秘書協助其執行工作. 學校專科護理師的主要工作是預防注射, 身體評估, 抽血檢查, 篩選有健康問題的學童, 轉介服務等等. 目前為止, 90% 的學童在 clinic 中建有檔案, 對於新入學的學童, 專科護理師會花 2-3 個月的時間來建立學生的檔案. 新入學的學童必須接受身心及家庭方面的評估, 紐約州所有設有 clinic 的公立學校 (189 所, ??%) 使用相同的評估工具. 評估內容除以書面型式建檔之外, 資料並輸入電腦儲存. 可惜的是學校與學校之間或學校與醫院之間並沒有建立連線制度, 所以若學生轉校或就診, 相同的資料必須再收集一次, 造成資源浪費.

這些低收入戶學童, 很多來自寄養家庭 (foster care), 沒有健康保險, 有酗酒, 青少年懷孕, 藥物濫用, 或 HIV 問題. 對於沒有健康保險的學童, 專科護理師會協助其加入 Child health plus 來給付或補助就診所需的花費. 在專科護理師來校創立門診服務之前, 38% 的學童沒有健康保險, 70% 的學童在校建有健康檔案現在只有 10% 的學童沒有健康保險, 而超過 90% 的學童在校建有檔案. 如果專科護理師發現問題學童, 他會主動與家長聯繫並視情況召開照顧委員會會議. 除了專科護理師之外, 校長, 副校長, 社工人員, 藝術治療師, 語言治療師, 及該學童的級任導師都是當然委員. 開會之前專科護理師會與學童家長會談以收集更深入的資料. 專科護理師認為除了提供學童健康照護之外, 學童家長的需求及問題亦是不容忽視. 因為學童的健康與家長的情形及觀念實

在息息相關.

目前在 PS 307 附近有5所學校沒有提供 clinic 及專科護理師的服務, PS 307 的專科護理師希望能與 NYU 護理系的教授合作向聯邦政府申請經費購買一部大型旅行車以滿足鄰近學校學童的健康需求並提供學童高品質的健康服務. 他認為這類 mobile clinic 的服務能在有限資源之下讓學校的專科護理師發揮最大的功能. 他並強調在密西根及底特律地區已有成功的 mobile clinic 經驗可循.

Montefiore 兒科急診室

(Montefiore Pediatric Emergency Room)

蔡安津 2001/10/3

參訪者：蔡秀鶯，高文惠，蔡安津

此次參觀Montefiore 兒科急診室的目的是要了解執業專科護理師在兒科急診室的角色與功能。Montefiore 兒科急診室 Montefiore 兒科急診室的成員包含三個執業專科護理師(Nurse Practitioner)(一個兼職，兩個專職)，十四個醫師(Attending Doctor)（三個兼職，十一個專職)，三個總住院醫師(Fellow)，另外還有實習執業專科護理師及社工人員。環境上包括有氣喘治療中心(Asthma Treat Center)14 床和觀察床數十張，另有隔離室及急救室，還有部分地方在整修當中。

Kathleen Kenny 是今天負責接待我們的執業專科護理師，畢業於哥倫比亞大學，目前除了在 Montefiore 兒科急診室兼職 11 年，此外也任教於紐約大學(New York University)。

兒科執業專科護理師是最先被發展出來的執業專科護理師，經過長期的奮鬥奠定了現在的制度及地位。執業護理師的工作時間只有白班，不值晚夜班。執業專科護理師與醫師的角色在 Montefiore 醫院的兒科急診室中是採獨立照顧病患模式，從評估、檢查、診斷到治療都獨立作業，每個人有不同的專門，Kathleen 的專長是心臟學，醫師與執業專科護理師可以互相討論病情，而接新病人是由執業專科護理師或醫師獨立執行，誰有空就接，並沒有固定收多少病人，視病患的嚴重程度而定，如氣喘病患則有可能收將近二十位病患，較嚴重的患者則收八位左右。有遇到較難確立診斷的個案則提出並彼此互相討論與諮詢，使病患得到更正確的治療。病患管理方面，執業專科護理師會追蹤前一天出院的病患，並把檢查結果告知病患，如須接受進一步治療則會電話中告知。85%Woodlawn 區的居民為低收入戶或非法移民，並沒有醫療保險，生病時只能到急診室接受治療，根據執業專科護理師法為了要照顧所有的人(不論是無保險或非法移民)，不管有無錢可付都一律可以接受治療。

執業專科護理師和部主任及醫院簽訂共同合約(Contract)，訂定執業專科護理師的工作範圍及規章。醫院也訂定執業標準(Practice Protocol)，各州也有各自的標準需要執行。制訂的合約依急診室的需要重新設定調整。執業專科護理師與醫師相同有處方權，如果需要麻醉用要處方則須申請麻醉執照並每年繳交 500

美元的年費。

Montefiore 兒科急診室的執業專科護理師受雇於急診醫學部，各個醫院的情況不同。醫師與執業專科護理師皆受雇於醫院，由醫院支付薪水，兩者皆包含於健康保險公司的給付名冊中，對病患所開的處方和所做的治療都可以將給付金額以她們的名字納入醫院之中。支付給執業專科護理師的薪水較醫師少，但是 Kathleen 不以為意且非常滿意現狀，因為不需要值班，也不需要做更進階的治療，承擔的責任也較少。

和蔡副教授與高科長參觀了 Montefiore 及其他醫院後，有幸看到 Kathleen 與醫師討論病情，深度真的很夠，在台灣雖然也會和醫師討論病情，但總感到沒有像她們那樣深入。也感受到執業專科護理師的專業性及受到醫師和病患對她們的尊重及信任，這一些都需要我們台灣護理界學習及跟進。

Terrence Cardinal Cooke Health Center 參觀報告

唐婉如 10/03/01

Terrence Cardinal Cooke Health Center 是一個提供長期照護的機構，機構內共有約720位住院病人外加門診病人. 醫院有員工200人，內設有專為員工健康服務的門診. 專科護理師 (Nurse practitioner, NP) 負責整個門診的運作. 她的職責在執行職前身體評估，年度正常健檢，及突發事件的處理. 平均而言 NP 一天為20位病人提供健康服務，其中包括5個身體評估，10個突發事件處理 (例如燙傷，跌倒，及生病)，和5-10個年度定期健檢. 除此之外，NP 更兼負教導者的角色. 她教導員工執行乳房自我檢查，戒煙，提倡預防注射，及執行一般婦科及前列腺檢查. 如果她發現員工有特殊狀況，NP 會適當的轉介至專科醫師.

紐約州健康防治部門遵循美國國家疾病防治中心 (CDC) 所設的照護標準來統一 NP 的臨床造護標準. 在突發事件處理的過程中，約有 10% 是跌倒相關的，大部分來自提供食物服務的員工，因廚房地板有油漬之故. 如果員工受傷，NP 會主動聯繫受傷員工以提供健康照護並持續追蹤六個月左右. NP 的薪水來自醫院而非直接由保險公司給付. 在此醫療機構中另有醫療佐理員 (medical assistant) 之設置. 醫療佐理員多半只有高中畢業接技術學校 (technical school) 所提供的短期訓練課程 (通常六個月). 醫療佐理員聽從醫師，NP，及註冊護士 (RN) 的指示行事. 在約12年前，為了使 RN 有更多時間去評估病人，故有醫療佐理員的設置來協助 RN 執行技術層面的護理工作，不幸的是卻因而增加 RN 照顧病人的數目. 經過美國護士協會 (ANA) 多次與不當醫療政策制度的反擊，如今醫療佐理員已漸漸式微.

提到 NP 與醫師助理 (Physician assistant, PA) 的最大不同其實出現在法律層面. 在紐約州的法律規定 PA 所執行的一切治療行為必須在醫師監督之下，所有紀錄要有醫師 Co-sign，而 NP 可獨立執行治療行為，不需經醫師 Co-sign.

醫師與NP的關係是合作關係而非上對下的監督關係. 但是對於NP可否獨立執業, 各州有不同的看法與法律制度. 舉例而言, 在華盛頓州NP可享有完全獨立執業的權利, 並不需要與醫師有合作的契約存在. 在紐約州NP可享有獨立執業的權利, 但需要與醫師有合作的契約存在. 而在伊利諾州根本一點也不承認NP的角色, 更何況獨立執業的權利. 雖然NP比PA接受更久的教育訓練 (full time study - 2.5 years; part time study - about 4 years), PA的薪資卻比NP來的好, 這其中有太多的政治因素存在.

大體而言, 醫院並沒有使用NP來取代醫師 (especially R1 & R2), 雖然NP的臨床表現比住院醫師好的多. 住院醫師的薪資大概只有NP的一半左右. 因NP可從主治醫師身上拿到約80%的reimbursement. 醫院可雇用NP的比率大概是 2:1 (兩個NP比一個主治醫師). 就如何評值NP的表現而言, 通常與NP簽有合作契約的醫師會每三個月隨機抽查10%左右NP所照顧病人的病歷來評量NP的表現. 如果醫師不滿意NP的臨床表現, 她/他可以隨時終止與NP的合作關係, 反之亦然.

Bronx VA Medical Center

參訪者：蔡秀鶯等六人

記錄：高文惠 2001/10/4

Bronx VA Medical Center 為一榮民醫院，此次參訪的 NP 服務於 Urgent care 及 Primary care 單位。以該院的執業管理要求而言，NP 於執業時須與醫師簽訂一份合作協議書（Collaborative practice agreement）外，另須簽署一份照護責任的聲明書(Attachment a Patient Care Responsibility)，該聲明書之共同簽署者尚包括合作之醫師、護理部門相關主管及院長等，以示該 NP 對於其執業內容權責能有明確之認知並願遵守之。於執業過程中，每二年定期更新簽署合作協議書，以隨時能保有彈性調整空間。

另就其角色責任簡介部分，該院之 NP 可獨立開具處方（有其一定之處方品項限制，例如抗生素即被限制）、檢驗及身體檢查等醫療處置，惟其紀錄須有醫師來共同簽署【此為其他醫院所沒有之特殊要求】，並每三個月定期抽審其 10% 的紀錄（由醫師及其他相關專業人員審查），以確保其執業的品質。

本次為我們介紹之 NP 共有二位，一位服務於 Urgent care 的 NP 為受聘於門診部之長期照護單位，負責脊髓損傷病人照護，除隨時處理來院病人之醫療照護外，並須提供外展服務(Outreach Care)，於訪談過程中，其對於 NP 角色所提供之功能表示滿意外，另對與醫師之分工，是否會被認為搶病人之質疑表示，經由 NP 之預先評估處置，反而能協助醫師有更大的空間，可照顧更多的病人，此顯示出經明確定義不同專業間之分工合作權責及關係，並被雙方接受後，反而能提供更有效率的照護。另一位 NP 則於門診部負責提供 primary care，其業務範圍亦如上述。一般而言，該院 NP 對於病情穩定者，可於門診以先予診視評估後即收案，再知會 clinical chief 及醫師，目前該院急之住院部門並無 NP，而門診手術室 NP 則負責疼痛控制，護理之家亦有二名 NP 提供安寧療護服務。

由於每家醫院的管理策略不同，部分醫院之 NP 可能兼具個案管理員（Case Manager）角色，或為一獨立之專業工作者角色，但此醫院之 NP 其業務功能，相較於其他醫院，則顯得保守，類似為資深之護理人員（practice nurse）的角色。故 NP 之功能角色，故然須靠其專業訓練呈現其專業能力外，另該州或該州護理團體與醫師團體對 NP 之執業範圍（如護理團體對 NP 訓練及繼續教育之要求，醫師團體對 NP 可執行業務範圍之意見），亦呈現其外在結構性的影響力。

Mt Sinai 兒童精神照顧中心

(Mt Sinai Psychiatric Care Center)

蔡安津 2001/10/4

參訪者：蔡秀鶯，陳幼梅，唐婉如，高文惠，林美珠，蔡安津

Mt Sinai 兒童精神照顧中心的成員包含註冊護士(RN)、護佐(Nurse Assistant)、執業專科護理師(Nurse Practitioner)。該中心總床數 25 床，以年齡層區分病房區域，8 床專收 13~18 歲的病患，大部分是因為父母藥物濫用、具暴力傾向而有自殺行為的受虐兒，不一定有精神異常問題，其住院日平均不超過 15 天；另外 17 床專收 5~12 歲的病患，大部分是精神分裂症(Schizophrenia)、邊緣性人格(Borderline Disorder)或重鬱症的患童。中心與學校合作請老師到院幫住院兒童上課，避免住院期間與學校課程脫節。有 4 間保護室提供較有自殘或暴力傾向的兒童暫時隔離，依其程度訂定不同的隔離措施，若患童有嚴重暴力行為發生，則需要醫師醫囑進行強制隔離。美國聯邦法律規定最長約束時間，5~9 歲為 1 小時、10~17 歲 2 小時、18 歲以上 4 小時，且每 15 分鐘必須巡視病患一次。

Halana Finnie 是該中心之護理長(Nurse manager)，未來將兼任執業專科護理師，護理長之工作可能會因此調整。未來的工作將負責照顧一定數量的病人，提供醫療照護與用藥指導(Medication Teaching)，她更分享臨床經驗發現用抗痙攣藥物(Anticonvulsant)，如 Tegretol 幫助鎮靜病患效果很好。

一般來說，執業專科護理師是由醫院雇用，但在不同的專門領域工作。Halana 擁有 2 個執業專科護理師的執照：小兒科及精神科，視與其合作的醫師擁有的專科執照來決定要簽訂幾份合約，與 Halana 合作的醫師也擁有小兒科與精神科的執照，所以只要簽一份合約就好了。合約的內容基本上依醫院為主。目前 Mt Sinai 有 160~200 位執業專科護理師。執業專科護理師在各州有公會，有的醫院有自己的公會，有的沒有。

一行人參觀了 Mt Sinai 的精神照顧中心，覺得硬體設備空間很夠也很舒適及人性化，對於執業專科護理師兼具個案管理的角色覺得非常有趣及具有挑戰性，惟此種相當獨立的專業功能，實須奠基於扎實的訓練基礎及專業人員間合作的認知，方能使執業專科護理師發揮其功能。

Mt. Sinai Health Care Center 參觀報告

唐婉如 10/04/01

Mt. Sinai Health Care Center 是紐約市最大的教學醫院，有自己的醫學院並是紐約市所有醫院中雇用 NP 最多的醫學中心，現有 NP 約 200 名（不包括 CNS 之數字). Mt. Sinai 的小兒器官移植舉世聞名，目前在全世界排名第三. 在 Mt. Sinai 的婦產及小兒部門中設有一位 case management 主任，一位 coordinator，及 20 位左右的 NP. 一般而言，多數醫院都是由 NP 的合作醫師負責 NP 的評值工作，但在 Mt. Sinai 醫學中心卻提倡每年一度的雙評值制度（NP 的合作醫師及 NP coordinator 共同負責評值工作). 雙方的評值重點不同，NP 的合作醫師負責臨床方面的考核，NP coordinator 負責 NP 行政能力的考核. 不同專業的 NP 有不同的評值標準（見附件). NP coordinator 會定期與 NP 聚會 mentor them，並加強提醒他們莫忘記自己護理的本質.

然而大部分 NP 的臨床照護仍遵循醫療模式的取向. NP 可以獨立再醫院或診所執行醫療活動. 雖然紐約州法律規定 NP 必須與特定醫師簽約並維持互相合作的關係，但如果 NP 沒有轉介的行為，醫師並不需要診視病人. 就拿這次紐約發生的恐怖活動來說，幾乎所有的醫師都出動救災，NP 肩負起照顧醫院中所有病人的責任，發揮極大的獨立功能，令人寡目相看.

剛執業的年輕 NP (1-3 years after graduation) 經驗較少能力難免受人質疑，但隨著臨床經驗的增長 (over 15 years after graduation)，NP 的能力受到肯定，醫師和註冊護士 (RN) 也變的非常信賴 NP 的臨床決策. 有些醫生甚至會以他與多少 NP 合作的量來凸顯個人卓越等級. 基本上 Mt. Sinai 的 NP 都是受雇於醫院而非醫師. 醫院也沒有因為雇用 NP 而降低雇用醫師的量，政治，權力與金錢因素實在與 NP 的角色發展息息相關. 美國醫學會 (American medicine association, AMA) 是一個非常有錢而且勢力強大的組織，他們不可能讓 NP 搶走醫師的市場. 況且 Mt. Sinai 是一所教學醫院並有自己的醫學院，

醫院當然不可能降低雇用醫師的量因為醫學院學生需要有醫師指導. 雖是如此, 在Mt. Sinai 的小兒科, NP的薪水幾乎與醫師一樣. 但NP 與RN的薪水就有所差異, 就紐約州而言, NP 的年薪約在 75000 美金左右, 而RN 約在 55000 美金左右. 在工作量方面, 視病人情況不同, 一個 NP 最少照顧 10 個病人, 最多照顧30 個病人. NP 並不固定在一個病房單位, they attach to the service.

伍、研修心得與建議

由於美國為一聯邦制國家，故各州對於專科護理師制度之規劃與管理並不一致，以此次參訪的紐約市為例，其執業護理師（ＮＰ）除其護理專業角色外，亦扮演部分第一線醫師的功能，此制度之發展實與其健康保險制度有極大的相關，藉由執業護理師之功能規劃，減輕醫師的工作負擔與保險給付之支出，惟該制度之實施，其相關的配套機制，如明確分工項目（區分醫師與執業護理師的業務範圍），醫院、醫師與護理人員間的契約訂定，良好的轉介制度，執業護理師培訓課程的設計等，亦應加以注意，才能使醫療服務的提供維持一定品質，且不會牴觸各專業人員間業務權責的運作。

在台灣此制度之推展，建議考量規劃因素：

一、強調終身學習繼續教育：其範圍可包括

（一）學校教育制度之檢討改革

（二）各專科護理人才培育

（三）終身護理教育

二、了解現況並預測規劃未來人力需求

前提：我們是為了加強訓練有能力及合標準的專科護理師來服務社會。

（一）目前應該做什麼：

1．培育有能力及合標準的師資（臨床及理論）：現在培育合標準的師資，也是在培育未來的好師資。否則，只是量的增加，將會惡化護理服務品質，進而影響全面醫療服務品質。

2．跨院際的合作：建立主訓練醫院及建教合作醫院的角色及配合功能

3．建立人力需求資料庫：除了社經環境等結構性因素外，影響民眾需求（Demand）改變的因素，亦應加緊探討，以求建立人力需求（運用）推估常模，避免浪費社會資源。

4．紮實紮根的培育計畫：包括專科護理師訓練課程綱要、專科護理師訓練機構認定標準。

審慎隨時代演進，而調整確立專科護理師角色功能，應該是較具彈性且可被接受的方向。

AMERICAN ACADEMY OF NURSE PRACTITIONERS

STANDARDS OF PRACTICE

AMERICAN ACADEMY OF NURSE PRACTITIONERS
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Revised, 1998

STANDARDS OF PRACTICE

I. Qualifications

Nurse Practitioners (NPs) are registered nurses with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary, acute and long term care settings. A Master's degree is required for entry level practice.

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
- obtains a relevant health and medical history
- performs a physical examination based on age and history
- performs or orders preventive and diagnostic procedures based on the patient's age and history
- identifies 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 a mutually acceptable cost-awareness plan of care that maximizes health potential. Formulation of the treatment plan includes:
- ordering additional diagnostic tests
- selecting 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 of care
- based on scientific principles, theoretical knowledge, and clinical expertise
- consistent with teaching and learning opportunities.

Actions include:

- accurately conducting and interpreting diagnostic tests
- prescribing 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 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.

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Revised 1998

D. Facilitation of entry into the health care system.

E. The promotion of a safe environment.

IV. Interdisciplinary/Collaborative Responsibilities

The nurse practitioner participates as a team 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.

American Academy of Nurse Practitioners

NURSE PRACTITIONER AS AN ADVANCED PRACTICE NURSE

ROLE POSITION STATEMENT

The term advanced practice nurse is a descriptor that includes nurse practitioners (NP), certified nurse-midwives (CNM), nurse anesthetists (CRNA) and clinical nurse specialists (CNS).

Advanced practice nurses make independent and collaborative health care decisions. Advanced practice nurses are expert clinicians engaged in active practice. The advanced practice nurse demonstrates leadership as a consultant, educator, administrator and researcher. An important leadership function of all advanced practice nurses is participation in legislative and professional activities to promote professional advancement and health related social policies.

The nurse practitioner is a unique health care provider within the constellation of advanced practice nurses. Nurse practitioners engage in advanced practice in a variety of specialty areas, such as family, adult, pediatric, gerontologic, women's health, school health, occupational health, mental health, emergency and acute care.

Nurse practitioners assess and manage both medical and nursing problems. Their practice emphasizes health promotion and maintenance, disease prevention and the diagnosis and management of acute and chronic diseases. This includes taking histories, conducting physical examinations, ordering, performing and interpreting appropriate diagnostic and laboratory tests, prescription of pharmacological agents, treatments and nonpharmacological therapies for the management of the conditions which they diagnose. The nurse practitioner serves as a primary care provider and consultant for individuals, families and communities in a variety of ambulatory and inpatient settings.

Email Comments, Corrections & Questions to: webmaster@aanp.org

American Academy of Nurse Practitioners

Scope of Practice

SCOPE OF PRACTICE FOR NURSE PRACTITIONERS

Professional Role

Nurse Practitioners are primary health care providers who practice in ambulatory, acute, and long term care settings. According to their practice specialty these primary care providers provide nursing and medical services to individuals, families, and groups. In addition to diagnosing and managing acute episodic and chronic illnesses, NPs emphasize health promotion and disease prevention. Services include, but are not limited to, ordering, conducting, and interpreting diagnostic and laboratory tests, and prescription of pharmacologic agents and nonpharmacologic therapies. Teaching and counseling individuals, families, and groups are a major part of nurse practitioner practice.

Nurse Practitioners practice autonomously and in collaboration with health care professionals and other individuals to diagnose, treat, and manage the patient's health problems. They serve as health care researchers, interdisciplinary consultants, and patient advocates.

Education

Entry level preparation for NP practice is a master's degree. Didactic and clinical courses prepare nurses with specialized knowledge and clinical competency to practice as primary, acute, and long term health care providers. 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 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.

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AMERICAN ACADEMY OF NURSE PRACTITIONERS

POSITION STATEMENT ON NURSE PRACTITIONER PRESCRIPTIVE PRIVILEGES

The American Academy of Nurse Practitioners advocates that nurse practitioners have unlimited prescriptive authority and dispensing privileges within their scope of practice.

Nurse practitioners are advanced practice nurses who have completed a formal educational program beyond that of the basic registered nurse. All nurse practitioners have advanced education in pathophysiology and pharmacology that prepares them to diagnose and prescribe medications and treatments within their specialty area. Nurse practitioners make independent and collaborative decisions about the health care needs of individuals, families, and groups across the life span. Three decades of research conclude that nurse practitioners, practicing within their scope of practice, provide safe, cost-effective, quality health care. Prescribing medications and devices is essential to the nurse practitioner's practice. Restrictions on prescriptive authority limits the ability of nurse practitioners to provide comprehensive health care services.

Consumer safety is provided through registration and licensure of nurse practitioners by State Boards of Nursing or other designated agencies. Nurse practitioners serve as State Board of Nursing members and on advisory councils for advanced practice nurses. This process promotes public safety and competent advanced nursing practice. The American Academy of Nurse Practitioners recommends that state boards of nursing regulate nurse practitioner practice and prescriptive authority. The American Academy of Nurse Practitioners also advocates that nurse practitioners attain 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 diverse populations across the life span.

AMERICAN ACADEMY OF NURSE PRACTITIONERS
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NURSE PRACTITIONERS

PROVIDERS OF QUALITY PRIMARY HEALTH CARE

DOCUMENTATION OF COST EFFECTIVENESS

Three decades of practice and research have provided ample evidence of Nurse Practitioners' (NPs) ability to provide cost-effective, high-quality care. NPs have often served low-income urban and rural communities. Now, the managed care environment with it's emphasis on prevention and reduced expenditures has also found NPs to be a cost effective and profitable way to meet the increasing demand for primary care providers.

Nurse Practitioners are a proven response to the evolving trend towards wellness and preventative health care driven by consumer demand, federal and state regulation, and private payers. Health promotion services increase the effectiveness of recovery and reduce the number of repeat episodes of illness.[1] NPs cost 40% less than physicians and are particularly cost-effective in preventive care with their expertise in counseling, patient/client education and case management.[2]

When productivity measures, salaries and costs of medical education are controlled, nurse practitioners are cost-effective providers of health services. Research shows that nurse practitioners manage 80-90% of what primary care physicians can do without the need for consultation or referral.[3]

The Department of Health and Human Services reported that the cost of an office visit to see a Nurse Practitioner ranged from about 10% to 40% less of the cost for comparable primary care services provided by a physician.[4]

With a changing health care system, Nurse Practitioners are in a prime position to deliver appropriate, acceptable, and cost effective health care as independent providers. A cost analysis performed at the State University of New York (SUNY) comparing the cost of providing services at a NP managed center for homeless clients with other community alternatives. The study showed earlier and less costly intervention by the NP managed center.[5]

In Tennessee's state-managed MCO, TennCare, NPs 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 rate below physicians. They wrote 42% less prescriptions than other providers. The data suggests that the NP providers demonstrated above-average performance in cost-efficiency while delivering top quality health care.[6]

Oxford Health Plans and Columbia Presbyterian Medical Center in New York are testing nurse practitioners in the formal role of primary caregivers for patients. "We already know that proactive management of patients will reduce ER and office visits", says Oxford VP. It has already found that asthma patients who work with NPs at Columbia are less likely to be hospitalized for asthma attacks.[7]

Emerging research shows nurse practitioner use plays a part in HMO's strategies to control costs. A recent survey found that when more NPs were employed in a MCO, fewer physicians were needed.[8]

A study conducted in a large HMO setting in 1994 found that adding a Nurse Practitioner to the practice could virtually double the typical panel of clients seen by a physician. an extrapolation of a typical panel size of 1352 patients was increased to a projected ideal of 2400 patients. The projected increase in revenue was $1.38 per member per month, or approximately $1.65 million dollars per 100,000 enrollees per year.[9]

Overall, when compared with the cost of MD only teams, costs of using an MD/NP team in a long–term care facility were 42% lower for the intermediate and skilled care residents and 26% lower for those with long term stays. The study also showed significantly lower rates of emergency room transfers, hospital length of stays and specialty visits for patients covered by MD/NP teams.[10]

A year long study compared a family practice physicians managed practice and a NP managed practice within the same MCO. The study found that the NP managed practice has 43% of the total emergency room visits, 38% of the inpatient days, and the NPs total annualized per member monthly cost was approximately 50% less.[11]

The long-standing cost benefits of nursing-specific interventions in a managed- care environment are substantial. It has been argued that employing nurse practitioners fully could save 20 percent of the cost of primary care. The country may be spending up to $8.75 billion dollars that could be saved by employing nurse practitioners fully.[12]

Insurance companies are now moving into team-based and independent practitioner approaches as pilot studies show financial benefits. On the federal level, the Federal 1999 Balanced Budget Act allows for Medicare to directly reimburse APNs in all parts of the country. CHAMPUS and the Federal Employee Health Benefit Program also allow for federal reimbursement of nurse practitioners. On the state level, NPs may currently be independently reimbursed, prescribe medicine and admit patients to a hospital when working in collaboration with or in many cases independently of physicians.[1]

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AMERICAN ACADEMY OF NURSE PRACTITIONERS

SCOPE OF PRACTICE FOR NURSE PRACTITIONERS

PROFESSIONAL ROLE

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Advanced Practice Models: A nparison of Clinical Nurse Specialist and Nurse Practitioner Activities

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THE PURPOSES OF this article are to present advanced practice nursing models, explore similarities and differences in roles of clinical nurse specialists (CNSs) and nurse practitioners (NPs) in South Carolina, and relate findings to the advanced practice nursing models. A questionnaire was mailed to advanced practice nurses (APNs) listed with the board of nursing, which yielded a convenience sample of 228 nurses; sixty-two percent were classified as CNSs and 30% as NPs. CNSs spent significantly less time in direct practice and more time in education, consultation, research, and administration than did NPs. Satisfaction was high for both CNSs and NPs and was related to the quality of perceived support for the role and to relationships with key staff. Respondents were engaged in a variety of revenue-generating activities and provided additional suggestions for ways in which APNs could generate additional revenue. Results support previous literature suggesting greater ambiguity in the CNS role as compared with the NP, but also suggest that differences in role are primarily related to relative emphasis on direct practice. Findings tend to support viewing CNS and NP roles as dual pathways to advanced practice or as overlapping roles, with areas of shared and unique activity.

Key Words: clinical nurse specialist, nurse practitioner, advanced practice nurse

, political, and economic factors are converging ncourage a reexamination of intra- and inter- nal boundaries in all of the health professions. ıg, this trend is reflected in discussions related ture of the CNS. Proposals have been developed gthen the administrative component of the : or to merge the CNS with the nurse manager :, 1989); to develop the CNS as an acute care ner and/or a substitute for resident physicians (Aiken, 1993; "Changing Times," 1992; Futch, 1993; Mallison, 1993); and to merge the CNS and nurse practitioner (NP) roles (DiVincenti, 1993; Hockenberry & Powell, 1991; Kitzman, 1989).

CNS roles have generated discussion and controversy almost from their origin (e.g., Baker & Kramer, 1970; Montemuro, 1987; Reiter, 1966). More recently, economic pressures have heightened interest in examination of the roles and in demonstration of cost effectiveness (Hoffman & Fonteyn, 1986; Naylor & Brooten, 1993). Boundaries between the roles of CNSs and NPs are increasingly blurred (Elder & Bullough, 1990; Forbes, Rafson, Spross, & Kozlowski, 1990), and there is discussion about the economy and appropriateness of a common educational base (Snyder, 1989) and about the possibility of common titling (Elder & Bullough, 1990; Sparacino, 1993). There is also considerable discussion about the feasibility and desirability of actually merging the roles, with some disagreement about the direction that such a merger might take (Hanson & Martin, 1990). Because the two roles emerged from different historical backgrounds and have differing philosophies and value systems (Hawkins & Thibodeau, 1989), attempts to merge the roles neces-

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sarily raise questions about the extent to which the roles are similar.

The purposes of this article are to discuss possible advanced nursing practice models, describe findings of a survey of advanced practice nurses (APNs) in South Carolina, and relate these findings to the advanced practice models and to the literature on the roles of NPs and CNSs.

REVIEW OF THE LITERATURE

Elder and Bullough (1990) surveyed a 10-year cohort of NP and CNS alumnae from a Master of nursing program in New York State. They found fewer differences than anticipated, and they concluded that there was a great deal of overlap in role functioning and opinions on key professional issues, including support for common titling. Similarly, Forbes et al. (1990) reported findings of a national survey of curricula of graduate programs that prepared CNSs and/or NPs. They found differences in clinical settings used for practice, but minimal differences in core content. NP programs provided more preparation in pharmacology, primary care, physical assessment, health promotion, nutrition, and history taking. Nevertheless, differences were minimal between NP and CNS curricula, particularly when compared within specialty areas (e.g., pediatric CNS vs pediatric NP). More recently, Forbes (1993) noted the inconsistency in clinical practice requirements of Master's curricula and certifying bodies for CNSs and NPs. NPs are required to have heavier clinical practice experiences during their Master's programs, but write the certification examination upon graduation. CNSs have more variable practice requirements during their educational experience, but must wait and accrue experience after graduation before qualifying to take clinical specialty certification examinations. Forbes expressed concern about the implications for the public in delaying practice experiences; however, there are also negative implications for the CNS in a competitive environment in which certification is often a requirement for direct reimbursement by third-party payers.

Traditionally, a major distinction between the CNS and the NP has been associated with their locus of practice. The CNS has tended to practice in acute care hospitals and the NP in primary care or ambulatory settings. Along with other differentiations, this distinction is not as clear as it once was. Case Western Reserve has described a role for an acute care practitioner ("Changing Times," 1992), and general hospitals are employing NPs to work in a variety of roles in acute care situations. Similarly, CNSs can be found in a variety of outpatient settings (Brooten et al., 1988; Cyr, 1990; Gilliam, 1991; Hilderly, 1991; Naylor & Brooten, 1993; Noble, 1988; Sawyers, 1993). Studies of the impact of the CNS on outcomes of care with several client populations argue the need for the CNS to provide care to select subpopulations across the spectrum of outpatient and inpatient services (Brooten et al., 1986; Burgess, Lerner, D'Agostino, Vokanas, Hartman, & Gaccione, 1987).

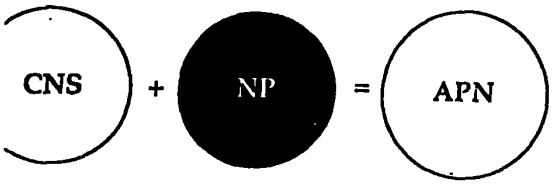
Harrell and McCulloch (1986) identified the gro the NP movement as a threat to the CNS role a gued that there is urgent need for the CNS r nursing. They pointed out that the same know base and role freedom that permit the CNS to cre solve patient and staff problems is, paradoxically the source of role stress and ambiguity. Issues r to role ambiguity and stress have concerned ma servers of the CNS role (Hamric & Taylor, Topham, 1987). In contrast, the NP role has less guity (Starck, 1987).

The importance of administrative support to ment the CNS role effectively and to secure job faction of CNSs has been widely described (Ande Hicks, 1986; Arford & Olson, 1988; Harrell & M loch, 1986; Murphy & Schmitz, 1979). Fenton (however, also noted the need for successful C generate their own support system and job satisf

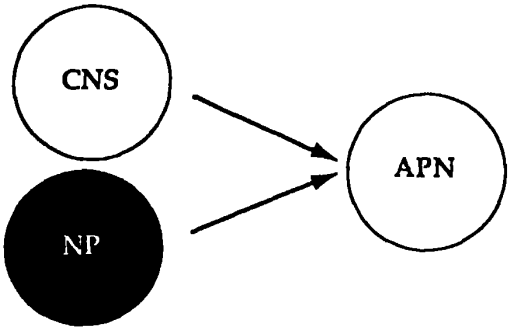
Anecdotal reports of the CNS and NP roles s that the NP role is more one dimensional and fc on practice, whereas the CNS role is more multic sional (Kitzman, 1989; Starck, 1987). No ide studies have compared relative emphasis on ad practice subroles by NPs and CNSs; however, r time spent in major CNS roles has been exami several studies (Boyd et al., 1991; Robichaud & H 1986; Tarsitano, Brophy, & Snyder., 1986). Co able variation has been reported, with a tende role emphases to shift with increasing work expe Baker (1987) developed a model of skill developm the CNS that emphasized direct care functions first 2 years of practice; however, Hamric and (1989) did not find a differentiation of emph years of practice in the CNS role. Reports of t centages of time that CNSs spend in direct p have ranged from 35% (Tarsitano et al., 1986) (Boyd et al., 1991). The research role has often r less emphasis and was not identified as a help component in interviews with co-workers of t (physicians, head nurses, and staff nurses) (1987). Nursing administrators, however, rated search component more highly than did CNSs tano et al., 1986).

All Master's-prepared nurses are facing inc pressure to demonstrate cost effectiveness and sume a greater role in generating income for t tings in which they are employed (Chicadonz & 1985; Hazelton, Boyum, & Frost, 1993; Malone. Anecdotal accounts of revenue-generating acti reported (Haddock, 1991; Hilderly, 1991); howe surveys have been identified that have examine nue-generating activities of nurses in advance tice roles. Economic pressures are contributing evolution of other new or modified roles and nur assuming roles in managed care and case m ment. To what extent these roles require ad preparation and to what extent they require preparation is still a matter of some discussion 1992).

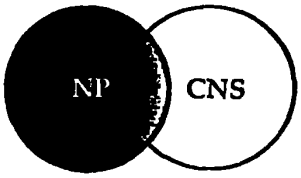
relationship of the CNS and the NP within an ad-
ced practice nursing model are inherent in relation-
ps between the two roles. Figure 1 shows five models
t depict these relationships. The models were devel-



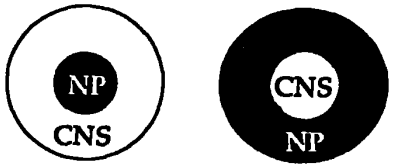
A Additive Model



B Dual Pathways



C Overlapping Roles



D One Role Subsumes Other

E Blended Role

Figure 1. Models of advanced practice nursing.

port distributed by the Southern Council on Collegiate Education for Nursing (DiVincenti, 1993) presents a model of the evolution of the advanced nursing practice role. There are similarities between the models presented here as coexisting models and those incorporated into DiVincenti's diagram of the historical development of APN roles. These similarities are discussed below.

Figure 1A describes an additive model. This model assumes that one role, most commonly the NP role, can be tacked on to the other. The additive model is used in programs that prepare CNSs as NPs through post-Master's education or through an extended Master's degree program.

Figure 1B illustrates a model in which one may achieve APN status through dual pathways. This model assumes that both CNS and NP programs prepare nurses for advanced practice and that the two types of graduate preparation are separate but equal pathways to the common goal of advanced practice. This model is reflected in certain state laws (e.g., Florida), which recognize advanced practice for both CNSs and NPs and is invoked when an NP is employed in a CNS position. It is also inherent in the materials disseminated by the American Nurses Association (1992) to describe the APN.

Figure 1C describes the NP and the CNS as occupying overlapping roles. Each has areas of unique practice and each shares areas of practice with the other. This model is reflected in curriculum plans for advanced practice, which identify core and specialty content for advanced practice.

In Figure 1D, one role is subsumed within the other. This model is being used by graduate CNS curricula that integrate practitioner skills within the CNS program and could also be used to integrate CNS content within a practitioner program.

Figure 1E describes a blended role. In this model, boundaries are so blurred that neither the CNS nor the NP can be identified separately and the roles and competencies of one blend into those of the other. This model is increasingly discussed as a curriculum option for preparation of the APN of the future. In these curricula, a common educational base prepares APNs with the skills for both roles. Either a common title would develop or graduates would select their role by their choice of position.

DiVincenti (1993) developed a model that traced the evolution of advanced practice roles. In DiVincenti's model, CNSs and NPs of the 1970s were separate entities, similar to the model presented here as dual pathways to advanced practice (Figure 1B). DiVincenti depicted the roles as overlapping (Figure 1C) in the 1980s and as evolving to a blended role (Figure 1E) in the 1990s. This conceptualization reflects the evolution from separate roles to blended role very effectively, but does not acknowledge the coexistence of several models at the present time.

STATEMENT OF THE PROBLEM

Economic and social pressures are contributing to a reexamination of the articulation between the CNS and NP roles. Role activities of CNSs and NPs have been examined separately, but with little comparison of the activities in which these two groups are involved. Several approaches to combining the two types of APN have been described; however, there has been little empirical examination of similarities and differences in role activities of CNSs and NPs.

METHODS

A descriptive survey of CNSs and other APNs registered with the South Carolina Board of Nursing in January 1992 was conducted in spring 1992. The purposes of the study were to compare the role activities and perceptions of CNSs and NPs in South Carolina and to relate the findings to several models of advanced practice.

Sample

Registered nurses in South Carolina who held a Master's degree and practiced as a CNS, an NP, or in another extended role were surveyed (n = 371). The final sample consisted of 228 nurses (61% of the population) who responded to the survey.

Instrument

The survey instrument consisted of 34 questions, most of which had specific response options and yielded categorical data. Several questions, which yielded continuous data, asked respondents to use 5-point scales to rate selected variables. These included the quality of their relationships with key staff, their perceptions of their own clinical skills, their perception of the extent to which staff nurses valued their expertise, and their perception of the amount of support they had for their advanced practice role. Open-ended questions were used to elicit information regarding respondents' ideas for entrepreneurial activity, their opinion of APNs assisting staff nurses, and their place in the administrative hierarchy.

Graduate students enrolled in a course on the CNS role and the faculty member teaching the course designed the survey in order to examine questions developed in class and identified in the literature about the activities of CNSs and NPs. In view of the current trends toward blurring of role distinctions and the difficulties of separating APNs on state board lists, the survey was extended to all Master's-prepared nurses listed as practicing as a CNS or in an extended role. The survey form was reviewed by NP faculty and by CNSs in practice for content validity and was revised on the basis of their suggestions.

Procedures

A mailing list was obtained from the South Carolina Board of Nursing of all APNs registered with the Board as of January 1992. Names of NPs or CNSs wl known to be employed in a faculty role were c After obtaining college ethics committee appro questionnaire was mailed with a stamped retur lope. The nurses were assured that their res were anonymous and no method of identifica respondents was used. No follow-up mailings we to encourage participation.

RESULTS

Of the 228 APNs who responded, 121 describe role as a CNS, 46 as an NP, and 61 as "other." I nation of the other roles of these nurses revealed nurses practiced in joint practitioner-CNS rol were practicing as case managers, 6 as nurse an tists, 16 as nurse midwives, and 3 others in practice or psychiatric liaison nursing. Recateg the midwives and anesthetists with practi yielded 68 nurses (30% of the sample) practicin; "extended role" and hereafter referred to as NPs managers, liaison nurses, and nurses in join were classified with CNSs, to create a group CNSs (62% of the sample). The nurses in join were practicing in acute care situations and, purpose of collapsing the data, they appeared more closely aligned with the CNS role than the N Because the case management role may be fil either a CNS or an NP (as well as by other nurs other professionals), these nurses were more diffi classify. Case management functions were repor both CNSs and NPs; however, those who identifie role as that of case manager were examined to i their clinical preparation, locus of practice, and c activities and classified accordingly. Although th tidimensional activities of the case manageme spondents tended to suggest that most of them practicing in a role more closely related to the CN those case managers who indicated involvemer extended roles or traditionally medical activitie: classified with NPs. The 18 "other" nurses rem were primarily administrators, educators, and co ants, and comprised 8% of the sample. The latter was deleted when CNSs and NPs were compare spondents were primarily experienced nurses; percent had been practicing as registered nurs longer than 10 years, and 58% had been practic an advanced role for more than 5 years. Neverth there was a range of advanced practice experienc the sample was fairly evenly divided among nurse had been practicing in an advanced role for less t years, from 2 to 5 years, 5 to 10 years, and more 10 years.

Respondents were asked to estimate the num hours per week they spent in direct patient care. mates ranged from zero to 55 hours per week, v mean time of 20.7 hours (SD = 14 hours), a med 10 hours, and a mode of 20 hours. When CNSs compared with NPs on direct practice hours, spent significantly less time in direct practice ((mean hours/week = 17.5; NPs: mean hours/we

30.5; $t(206) = 7.28$, $p < 0.0001$). There was no difference in hours of direct practice associated with years of practice as a CNS.

When asked to rate their confidence in their clinical skills on a 1- to 5-point scale (1 = not at all confident to 5 = extremely confident), 193 nurses responded with either a 4 or 5 (mean ± SD = 4.23 ± 0.66), suggesting that they were primarily very confident about their skills. Similarly, when asked whether they thought staff nurses valued their clinical expertise, 68% responded "Yes, very much so." There were no statistically significant differences between CNSs and NPs in how they rated their own skills or how they perceived other nurses as rating their expertise. As nurses had more experience in advanced practice, however, they felt significantly more confident about their skills and were more likely to believe that staff nurses valued their expertise.

Respondents were asked to estimate the percentage of work time they spent in selected roles. Table 1 displays estimates of CNSs and NPs, with *t*-tests of differences in mean percentage of time for each role. NPs spent significantly more time in the direct practice role than CNSs (66% vs 33%), whereas CNSs spent significantly more time in each of the other roles.

When asked to rank the relative importance of the five roles, there were no significant differences in the overall rankings, using the Wilcoxon test for nonparametric analysis of variance. Nevertheless, mean rankings for the top and bottom two roles were reversed for CNSs and NPs. Direct practice was ranked highest in importance by NPs and second highest by CNSs, whereas the educator role was most highly ranked by CNSs and was ranked second highest by NPs. Similarly, the researcher role was ranked lowest by CNSs and second lowest by NPs, and the administrator role was ranked lowest by NPs and second lowest by CNSs. The time NPs spent in direct practice was consistent with their higher ranking of that role; however, CNSs spent more time in research than NPs did, despite ranking it lower. Both NPs and CNSs ranked consultation as third in importance.

Respondents were asked about their working relationships with key staff (nurses, physicians, head nurses, and administrators) on 5-point scales (1 = very difficult to 5 = very positive). Mean scores for both groups on all relationships were 4.0 or above, suggesting very positive feelings about relationships with all categories of staff examined. Nevertheless, the full range of responses were reported for both CNSs and NPs and relationship quality appeared to be an important factor influencing satisfaction in the role. Factor analysis of the four relationship scores supported viewing them as measures of a common relationship dimension. Therefore, a summative relationship score was created, which was strongly related to satisfaction with the role and to perception of support for the role.

Respondents were also asked whether they thought the same group of key staff "see your role the way that you do." As may be noted in Table 2, a higher percentage of NPs than CNSs believed that each of the four categories of staff had a perception of their role that was similar to their own view. Chi-square tests of association, however, indicated that only responses for physicians and nurses differed statistically.

A stepwise regression equation yielded four variables that were significantly related to satisfaction and accounted for 44% of the variance in satisfaction with the advanced practice role: perceived support for the role, the dummy variable for similarity of the physician's view of their role to their own view, number of revenue-generating activities, and a positive co-worker relationship score (see Table 3). Number of revenue-generating activities contributed negatively to satisfaction.

Respondents were also asked to what extent they were involved in revenue-generating activities. There was no significant difference in NPs and CNSs on involvement in revenue-generating activity, although, as may be noted in Table 4, CNSs were significantly more likely to generate funds through workshops and community education, whereas NPs were more likely to report revenue generation through patient management or home visits. All activities, however, were reported by both CNSs and NPs. Similarly, as demonstrated in Table 5, all sources of funding were reported by both types of APNs; however, NPs were significantly more likely to report receipt of third-party reimbursement, government grants, and agency contracts.

In an effort to identify the percentage of respondents filling line versus staff positions, respondents were also asked to whom they reported and whether or not any staff reported to them. Of the 135 CNSs who responded to this question, 34 supervised someone and 101 did not, whereas 24 of the 40 NPs responding to this question supervised someone, suggesting that NPs were more likely to be in a line position. A nursing administrator was the supervisor for 48% of the CNSs and for 47% of the NPs, whereas a physician supervised 16% of

TABLE 1
MEAN PERCENTAGE OF TIME IN SELECTED ROLES

Role	CNS	NP	*df*	*t*
Direct Practice	33	63	199	7.73***
Education	29	19	200	3.38***
Consultation	18	6	191	7.56***a
Administration	16	10	192	2.06*
Research	6	3	186	3.21***a

[a]*t*-Test for unequal variance.
* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

TABLE 2
PERCENTAGE OF APNs REPORTING KEY STAFF HAD SIMILAR VIEW OF ROLE TO THEIR OWN

Staff category	CNS	NP	Chi-square
Physicians	42	69	12.24**
Nurses	57	80	10.54*
Head nurses	65	81	7.6
Administration	67	77	2.5

* $p < 0.05$; ** $p < 0.001$.

TABLE 3
STEPWISE REGRESSION OF SATISFACTION WITH THE APN ROLE ON SELECTED INDEPENDENT VARIABLES

Variable	Partial R^2	R^2	F
Perceived role support	0.2913	0.2913	54.27**
Physician view similar	0.0661	0.3575	13.48**
No. of revenue-generating activities	0.0333	0.3908	7.11*
Total positive co-worker relationships	0.0341	0.4248	7.64*

* $p < 0.01$; ** $p < 0.001$.

the CNSs and 47% of the NPs. Four CNSs and 10 NPs reported dual supervision.

In open-ended responses, nurses presented a wide range of ideas for entrepreneurial APN activities. The most common suggestions were consultation and private practice (suggested by 23% and 22%, respectively, of the total sample).

DISCUSSION

Few absolute differences were found between CNSs and NPs practicing in South Carolina, a finding that is consistent with some observations reported in the literature (Elder & Bullough, 1990). Differences in relative emphasis, congruent with the role expectations for the two groups, were found. NPs spent more time in direct practice and ranked it significantly higher than did CNSs, whereas CNSs spent more time in the indirect roles of educator and consultant. As long as CNSs continue to be employed primarily in secondary and tertiary care settings, with responsibilities for staff support and development, and NPs remain in primary care settings, with responsibilities for patient assessment and management, these differences are likely to persist. Recent trends toward role blurring, however, also include crossing of clinical boundaries, so that CNSs are increasingly found in the community and NPs are finding roles in institutional settings. If this trend continues, further blurring of the differences in roles can be expected.

TABLE 4
SELECTED REVENUE-GENERATING ACTIVITIES OF APNs BY PERCENTAGE[a]

Activity	CNSs (n = 135)	NPs (n = 66)	Chi-square
Workshops	47%	15%	19.83***
Health screenings	10%	18%	2.40
Community education	28%	15%	4.12*
Outpatient care	18%	30%	3.32
Home visits	6%	17%	5.97*
Case management	16%	14%	0.12
Patient management	23%	60%	25.66***
Consultation	24%	20%	0.41
Patient teaching	30%	25%	0.36
Contract/grant	18%	21%	0.21
Counseling/psychotherapy	9%	4%	1.21

[a] Data show percentage of CNSs and NPs engaged in each activity and are rounded to the nearest whole number.
* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

TABLE 5
PERCENTAGE OF APNs RECEIVING SELECTED FORMS OF REIMBURSEMENT FOR REVENUE-GENERATING ACTIVITIES

Funding source	CNSs	NPs	Chi-square
Patient payment	30%	52%	9.80*
Third-party payment	31%	63%	19.87**
Government grant	8%	22%	8.10*
Agency contract	10%	32%	14.18**
Other source	15%	6%	3.23

* $p < 0.01$; ** $p < 0.001$.

APNs in South Carolina are primarily a satisfied group of nurses. Although almost all nurses in the sample were either satisfied or highly satisfied with their role, satisfaction was strongly related to quality of support given to the advanced practice role and to relationships with staff nurses, physicians, head nurses, and other administrators.

Recent questions about the CNS role suggest that the role may be excessively ambiguous (Hamric & Taylor, 1989; Harrell & McCulloch, 1986). There was some support for this view in this study. NPs were significantly more likely than CNSs to describe physicians and nurses as having a view of their role similar to their own. One's role is to some extent defined by the expectations of others, and role conflict arises when one's own role perception is at variance with that of others in reciprocal roles (Singleton, 1984; Topham, 1987). Therefore, NPs could be expected to experience more role clarity and less role conflict. This greater clarity would allow NPs' to direct their emotional energy to the primary tasks of their work, rather than to role issues.

The CNSs in this study believed that they had positive relationships with nurses, physicians, head nurses, and administrators. They also believed that they were clinically skilled and viewed as such by staff nurses. There may be a need to examine the perspectives of these other groups. If the CNS role is to continue to maintain its viability, it will be important to be seen positively by other forces within the health care system. Professionals in reciprocal roles are the minimal groups with which APNs need supportive relationships.

As previous literature has suggested, minimal time was spent in the research role by both groups, and the research role was also ranked least important by both. Nevertheless, the range of time spent in research varied from zero to 70%, and pressure for APNs to be involved in research is increasing. The need for studies of advanced practice outcomes, for validation of nursing diagnoses, and for testing of clinical guidelines suggests the importance of generating interest in research on the part of Master's-prepared nurses.

Revenue-generating activities and funding sources of respondents were examined. Findings were consistent with those related to time spent in subroles and ranked importance of the roles. Activities through which NPs generated funds were more likely to be related to direct

care and were more likely to be reimbursed by patients or third-party payers. CNSs were more likely to be reimbursed for educational activities, which was also the role in which they spent the most time and the role to which they assigned the highest rank.

Open-ended responses of respondents suggested general enthusiasm about the future entrepreneurial possibilities for APNs. Nevertheless, a smaller group of respondents presented a theme of pessimism and reluctance to engage in the risks associated with entrepreneurial activity. Future studies may need to examine the extent to which Master's-prepared nurses are ready to move into more independent roles and assume increased responsibility for autonomous practice. If this attitude extends to other elements of emerging advanced practice roles, there may be implications for staff development.

The study has several limitations. As with most surveys, data tended to provide breadth of information, rather than depth. For example, respondents used their own judgment in identifying the percentage of time they spent in various roles. It can be assumed, however, that they were not all using the same definition of these roles. Direct practice, for example, can be defined very differently. Further study is needed to break down role activities into more specific elements, such as physical assessment, medication monitoring, and patient education. Another limitation was that the study was conducted in one southeastern state. There is a need to examine similar questions in a state that recognizes both CNSs and NPs as APNs.

RELATIONSHIP OF FINDINGS TO MODELS OF ADVANCED PRACTICE

Several models of advanced practice were described above (see *Models of Advanced Practice*). Findings of this study support viewing the CNS and NP roles as dual pathways to advanced practice (Figure 1B) or as supporting the overlapping roles described in Figure 1C. Although CNS and NP roles may be evolving toward a blended role (Figure 1E), this was not yet apparent in this sample. Findings here would suggest that there are areas that overlap in the functioning of CNSs and NPs that are consistent with some prior literature (e.g., Elder & Bullough, 1990; Forbes et al., 1990), but there are also differences in emphasis. If a common educational base for advanced practice develops as proposed (Sparacino, 1993), a blended role may truly develop.

In summary, this study reported a survey of 228 APNs in South Carolina. Findings indicate that NPs spend more time in direct practice and value it more highly and that CNSs spend more time in each of the other subroles. Satisfaction, perception of role support, and perceived relationships with head nurses and administrators were high and did not differ significantly between CNSs and NPs; however, NPs perceived their relationships with physicians and other nurses as significantly more positive than did CNSs. Both groups reported involvement in revenue-generating activity, although the activities for which their agencies were reimbursed differed in directions that were consistent with the time and ranked importance assigned, respectively, by CNSs and NPs to the various subroles.

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Nurse Practitioners Take on New Role in Social Agencies

Innovative NYU Program Leads the Way

by Anne Schott

America's rapidly changing healthcare system spawns both problems and opportunities. Two years ago, the Nursing Division of New York University (NYU) saw how a new role for nurse practitioners could turn a series of problems into opportunities. These were the problems:

- New Yorkers who have mental health or substance abuse problems have difficulty obtaining comprehensive healthcare services.
- Students studying to be nurse practitioners need clinical sites to develop their skills.
- Psychiatric mental health nurse practitioners need career opportunities.
- Nursing programs need to recruit qualified applicants.

To meet those somewhat disparate challenges, the NYU Division of Nursing created a faculty practice that partners with 15 community agencies in New York City to place psychiatric mental health nurse practitioners (PMHNPs) in social service agencies. Under contract with NYU, these agencies hire PMHNPs to deliver direct psychiatric nursing care. The nurses also serve as adjunct NYU faculty and supervise the clinical experiences of students studying to become PMHNPs. The success of NPs in this new role is likely to expand their career opportunities and to attract new students into the program.

Madeline Naegle, the coordinator of advanced practice psychiatric mental health nursing at NYU, conceptualized this new blended role for NPs. "The PMHNP has knowledge in mental health comparable to that of a clinical nurse specialist," she said, "but the NP also prescribes medications and provides basic health services."

Nurses prepare for this role in a graduate program that includes courses in advanced pathophysiology, pharmacotherapeutics and comprehensive physical assessment.

From Model to Reality

Hila Richardson, director of the Nursing Division's Center for Continuing Education and Community Partnerships, who organized the faculty practice, drew on her background in public and community health to actualize the PMHNP role. "I worked at the NYC Health and Hospitals Corporation, whose mission is to serve vulnerable populations," she said. "For years I worked with other agencies and community based groups, so I had a lot of contacts. I reached out to the agencies and asked, 'Do you need services?' Many agencies were looking at the option of hiring NPs, but didn't know how to go about it."

> NYU's faculty practice began in 1998 and has already placed four PMHNPs in social service agencies, where they often work with social workers, psychiatrists, and addiction specialists.

NYU's faculty practice began in 1998 and has already placed four PMHNPs in social service agencies, where they often work with social workers, psychiatrists, and addiction specialists. The PMHNP master's program now has 25 enrolled students, some of whom are gaining their clinical experience in these agencies.

Since 1998, nurse practitioner Barbara Gallo has worked at the F.E.G.S. Counseling Center in the Bronx, where she cares for 180 adult patients. She performs psychiatric assessments, develops treatment plans, prescribes and monitors psychiatric medication, and provides counseling and education. "Many of my patients have schizophrenia or depression with psychotic factors. Others have a panic disorder and have been anxious for their whole lives," she said. "Some live in a supervised residential setting and some live independently, but all are on medication."

Because Gallo treats a Medicaid population, she has to operate within narrow time limits. "I typically see patients once a month for 20 minutes. You need razor-sharp skills to be able to prescribe medications after a short interview. You have to put the pieces together quickly," she said. "But I like the independence and the challenge."

Barbara Gallo, once a clinical nurse specialist at St. Luke's-Roosevelt Medical Center, was the first psychiatric mental health nurse practitioner (PMHNP) to begin work through NYU's faculty practice.

Rhoda Berger works at three different sites for The Bowery Residents' Committee, which provides a range of services to individuals with limited resources like the homeless, the chemically dependent, and the psychiatrically disabled. At one site, the Adult Out Patient Alcohol Rehabilitation Program, many of the patients she sees have criminal histories and have been told to either attend the program and abstain from substance abuse or go to jail. "This is a tough crowd and they are originally skeptical about a woman nurse practitioner," Berger said. " Most of the patients are minority men from 20-45. I see a lot of co-morbidity and a prevalence of both physical and sexual abuse and neglect. They recognize that I'm from a different culture and often say to me, 'you don't understand.' But I don't take that personally. I tell them that each of us brings something different to the table."

In her role as a PMHNP, Berger collaborates with a physician and also works with RNs, social workers, and drug and alcohol counselors. Among the advantages of the job, she says, are the many resources available to her though NYU. "I have a lot of smart people I can call on," she said, "and I'm looking forward to doing research. "The problems my patients face afflict the minority male population significantly more than the female population. I'd like to learn why that's the case."

Sheila Craane works at the F.E.G.S. Continuing Day Treatment Program, which serves the chronic mentally ill. Patients live in a residential facility where a staff oversees their living arrangements, but they come to the treatment center every day from 8:30 a.m. to 2:00 p.m., where they receive group therapy, take part in a variety of activities like tai chi and yoga, and improve their skills in reading, math, and computers.

Craane sees 15 to 20 patients a day, manages their medication, prescribes anti-psychotic drugs, checks on their health, and refers them for medical services "My patients need to be seen every day, or they would have to be hospital," she says. "Because this population is inde they don't have other health care providers and prob often go undetected. For example, one relatively y woman had stopped menstruating and was told it probably early menopause. "But it wasn't," Craane sai was a reaction to her meds." Craane started a health pr tion group for patients who had gained 50, 60, eve pounds due to the medica They didn't like gaining we which was also causing p lems like rising glucose and lyceride levels. Many want stop taking the meds. Cr did a pilot study and found just advising patients about ferent food groups, portions and the importance of drin water and walking regul helped them lose weight.

Psychiatrist Al Ainbinder, who works Craane, finds the PMHNP helpful, particularly in di ing patients who have ong medical problems like diab hypertension, and TB. He knowledges that psychiat have "feelings about another cipline writing prescriptio but says, "I want help. I can it all myself and welcome a league, particularly some who can work as part of a te

Angela Blair is the PMI at the Brooklyn Treatment C which provides a new appro to handling non-violent stance abuse offenders. Offi ers can choose treatment ins of incarceration within a c devised framework that m tors their progress. Case ma ers identify those who have tal health problems and the referred to Blair who does a c plete assessment and evalua

"My first interview w client lasts about one hour and fifteen minutes, alth sometimes I will do short-term therapy," Blair said. process helps to place each person in the proper setting. I past, offenders went to an ordinary substance abuse prog Now we can identify the mental health aspect of the prob Drugs were often the way they dealt with that problem

Most of Blair's patients are poor, range in age from 3 39, and the majority is female. "Many of them thought needed treatment before and report being told in the past they were 'crazy.' So education is an important part o job," Blair said. " I explain that they have a disorder and can be done about it. The patients are largely receptive t services we offer."

This new role for NPs, which includes nursing aspects of psychiatry and social work, provides com hensive care to a population that often lacked it. mentally ill in state hospitals had not had basic physic 10 years," Naegle said. The nurses working in this new find it challenging and satisfying, and although there been some resistance, that doesn't surprise the prog leaders. "This is a social change process. We are neers," Naegle said. "That's why faculty provide on-g support and consultations. We work to sustain relat ships and to anticipate questions and misperceptions a result, we encounter new things all the time. This gram is a teaching laboratory."

RN

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Advanced practice nursing today

[Articles]

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Abstract

With their numbers growing nearly four times faster than doctors', nurse practitioners and nurse midwives are redefining their roles.

FIGURE 1 Family practitioner Kirby Turner loves how nurse practitioner Linda Gillespie eases his workload, taking over his routine office appointments if he's called to the ED unexpectedly. "She's added a lot to my peace of mind," says Turner, a member of the 34-doctor Kneibert Clinic in Poplar Bluff, Mo.

Figure 1. No caption available.

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· Turner, however-like many physicians-is wary of Gillespie's fast-growing profession, whose numbers are expected to outpace those of his own family practice specialty by 2005. "They're all going to want jobs," Turner says.

Turner's comments illustrate the mixed feelings doctors have about advanced practice nurses, especially NPs and nurse midwives. Yes, doctors admit, APNs do most of what primary care doctors do at one-third to one-half the pay. But, given the broadening scope of APN practice and increasing numbers, they worry that APNs will rob them of their patients and even their jobs.

Such fears seem premature, but many health policy experts think the rise of APNs does signal a long-term shift in medicine. "The professional sovereignty of doctors has come to an end," says Richard Cooper, director of the Health Policy Institute at the Medical College of Wisconsin.

In 1990, NPs numbered 28,600. Today, there are about 70,000, and Cooper expects their numbers to hit 116,000 by 2005. During the same period, the number of nurse midwives is expected to triple, reaching almost 9,800. Between 1995 and 2005, Cooper says, the fields will have grown roughly four times faster than the number of practicing physicians, excluding residents.

As physicians see it, nurse practitioners are practicing medicine: ordering and interpreting X-rays of broken bones, suturing lacerations, diagnosing illness. In most states they also prescribe medications, including Schedule II drugs.

Are docs and APNs interchangeable?

Mary O. Mundinger, dean of Columbia University School of Nursing, believes APNs can serve patients just as well as doctors. That belief is founded not just in her gut, but based on a comparative study of the care given by doctors and NPs caring for a population of 1,300 patients. "NPs' and doctors' outcomes are indistinguishable in this study, so that would suggest that they indeed are interchangeable," says Mundinger.

The patients, primarily Hispanics who sought healthcare through the emergency room or urgent care center at Columbia Presbyterian Medical Center in New York City, were randomly assigned to primary care doctors or to NPs in an independent practice with hospital privileges and prescribing authority. The NPs and physicians had identical productivity requirements. The study-whose results were published in the January 5 issue of *The Journal of the American Medical Association (JAMA)*-was the first large-scale, randomized clinical trial comparing NPs and physicians in similar practices, Mundinger says.

After six months, researchers evaluated the patients' health status and satisfaction with their care. The results: No significant differences were found in outcomes for patients with diabetes and asthma. There was a difference in patients with hypertension, however-those under the care of NPs had lower diastolic values. NPs and physicians hospitalized patients at the same rate and used the same amounts of services. TABLE 1

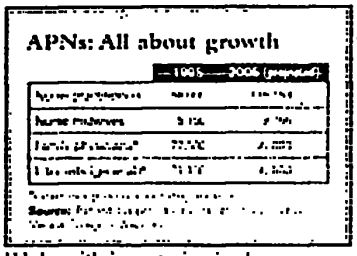
APNs: All about growth

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Table 1. APNs: All about growth

In private practice, physicians who hire advanced practice nurses benefit greatly. Patients triaged to NPs are often happier because their visits are longer and they can get same-day appointments. Without a knot of patients in their waiting rooms, physicians are less harried-and many make money on each patient the NP sees.

With the Balanced Budget Act of 1997, Medicare now reimburses for NP services at 85% of what a doctor would get in all practice settings, even if the doctor is not actually on site. If the doctor is on site, they will pay 100% if certain criteria are met. Medicare pays nurse midwives just 65% of a physician's fees if the doctor is off site.

Commercial insurers, too, are increasingly willing to reimburse APN services-generally at 80% - 100% of what doctors receive. NPs and nurse midwives have even had some success in persuading managed care plans to allow enrollees to choose them as primary care providers.

Not all physicians are happy about these changes, though. At the AMA's House of Delegates meeting last December, for example, delegates pushed for a pledge to work toward the repeal of state laws granting prescribing authority to APNs. In the end, cooler heads prevailed, and the House of Delegates voted to hold the line against *future* incursions, while studying the impact of existing state prescribing laws.

Progress is made state by state

Across the country, APNs are taking their fight for recognition as autonomous practitioners to state legislatures. In Pennsylvania, for example, Rep. Patricia H. Vance, an RN, introduced a bill during the 1999 legislative session that would, among other things, have placed all advanced practice RNs under the sole licensing authority of the Board of Nursing. As it is now, the nursing board has statutory authority over all advanced practice nurses *except* NPs, who are dually licensed under the nursing and medical boards.

Pennsylvania doctors fear the law would let APNs practice independently, while the nurses insist the bill would change nothing except the ability of APNs to sign their own prescriptions.

Although the bill didn't pass, the state's medical and nursing boards did broaden NPs' prescriptive authority-allowing them both to prescribe controlled substances, and to do so over their own signature-but they included "a lot of hoops nurses have to jump through," says NP Jan Towers, director of health policy for the American Academy of Nurse Practitioners. The state's Independent Legislative Review Commission agreed. After reviewing the regulations, the commission sent the rules back to the boards with instructions to remove some of the "hoops."

Prescriptive authority is, indeed, a key element in a move toward independent practice. (See Vital Signs, page 16.) But prescriptive authority is only one aspect of independent practice. *The Nurse Practitioner* magazine reports that NPs can work free of physician supervision or collaboration in 22 states and Washington, D.C. Nurse midwives enjoy these prerogatives in nine states and Washington, D.C., according to the American College of Nurse Midwives.

Such tallies vary, though, depending on how independent practice is defined-the degree of mandated physician involvement varies from state to state. In 10 states-California, Florida, Georgia, Idaho, Kansas, Massachusetts, Pennsylvania, South Carolina, Virginia, and Wisconsin-direct physician supervision of nurse practitioners is the law. TABLE 2

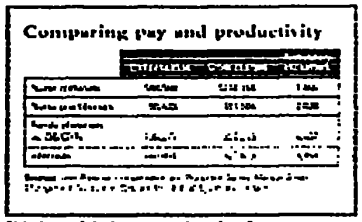
Comparing pay and productivity

Table 2. Comparing pay and productivity

[Help with image viewing]

Direct supervision of certified nurse midwives is required in 12 states: California, Connecticut, Florida, Idaho, Illinois, Louisiana, Massachusetts, North Carolina, South Carolina, South Dakota, Virginia, and Wisconsin.

One thing is clear, though, says Cooper: "However you want to define provider independence, the number of states where it exists is going up."

Increasingly, doctors' resistance toward greater autonomy for APNs is giving way to a spirit of compromise. Physicians in Colorado and Ohio seem inclined to meet nurses halfway. A new law in Colorado frees nurse midwives from the direct supervision of a physician. Instead, they will practice in accordance with the standards of the American College of Nurse-Midwives, which require a nurse midwife to consult or refer to a physician when appropriate.

"There shouldn't be any need for a patient under the care of a nurse midwife to see a physician just to satisfy an arbitrary state requirement," says Alyson Reed, a policy analyst with the college, based in Washington, D.C. "On the other hand, no midwife should practice without a system in place for the safe coordination of care with a physician and other members of the care team."

Besides giving nurse midwives more autonomy, the Colorado legislation paves the way to wider hospital admitting privileges. It also permits CNMs to be reimbursed directly for their services, rather than being paid through a supervising physician. The new law benefits

physicians, too, says Reed. "Under the old law, physicians could potentially be held vicariously liable for everything nurse midwives did. That wasn't a great incentive for them to use our services."

Following the lead of the American College of Obstetricians and Gynecologists, which endorses collaborative arrangements between nurse midwives and physicians, the Colorado Medical Society supported the bill, which was signed into law this spring.

In Ohio, the governor recently signed a bill granting APNs the authority to prescribe both controlled and noncontrolled substances without a doctor's cosignature.

The Ohio State Medical Association opposed the bill when it was introduced in early 1999, but backed off after the bill's sponsors agreed to several changes. One was that APNs be given prescribing privileges for Schedule III to V-but not Schedule II-drugs. A second was that all APNs-except those in pilot programs as of the effective date of the bill-be required to participate in a one-year externship with a physician. The bill also establishes a 3-1 ratio of APNs to collaborating physicians.

Will APNs take control of healthcare?

Pharmaceutical manufacturers certainly recognize the fact that APNs have become a force in healthcare. Their ads on TV no longer tell consumers to "consult your doctor;" instead they recommend consulting "your healthcare provider." Indeed, NPs wrote 15 million prescriptions in 1998, an increase of 66% over 1997, according to the pharmaceutical consulting firm Scott-Levin.

Although publicly, the debate over practice prerogatives like prescriptive authority is framed in terms of the quality of care, as always, economics is the subtext. NPs and nurse midwives are just two professions in a growing army of clinicians-along with optometrists, psychologists, chiropractors, and podiatrists, to name a few-who will give doctors serious competition in the pursuit of patients and income.

Right now, though, it's hard to paint NPs, CNMs, or other advanced practice nurses as usurpers. True, primary care physicians are more likely than specialists to face direct competition from APNs. Yet there are no widespread reports from physician recruitment firms that group practices are trimming payrolls by replacing retiring doctors with NPs. Instead, groups are hiring APNs to expand the practices by freeing doctors to see the more complicated cases.

In fact-and nurses considering entering graduate programs take note-the demand for NPs actually shows signs of cooling down. The percentage of NPs who have jobs lined up before they graduate from training programs slipped from 93% in 1995 to 82% in 1998, according to one ongoing survey.

Leaders of APN organizations also tell doctors not to worry-there will be enough jobs to go around. After all, an aging population with chronic illnesses galore will require more healthcare. Many places still don't have enough practitioners to immunize babies and perform Pap smears. And who's going to treat the 44 million uninsured if they become medically enfranchised? "There's room for everybody," says the AANP's Towers.

At least some doctors recognize that. As the Medical College of Wisconsin's Richard Cooper

puts it: "The world is changing. Trying to hold on to the past won't work. We can't monopolize medicine anymore."

NPs: "There are plenty of patients for all providers"

When nurse practitioner Carolyn Zaumeyer sold Women's Health Watch in Fort Lauderdale recently, she had more than 4,000 female patients ranging from age 7 to 88. "I cared for business owners, wait-resses, strippers, attorneys, and a doctor," says Zaumeyer, who is leaving her practice after seven years to run a company supplying blood products to pharmaceutical researchers. "The 7-year-old was on Medicaid, and the 88-year-old was a multimillionaire." She also marketed her practice to men who wanted confidential testing for HIV and other sexually transmitted diseases.

Patients came to Zaumeyer despite the fact that she was never on call, didn't admit to the hospital, or accept insurance. Why did they put up with the inconvenience and expense? Zaumeyer rattles off the reasons: "My patients wanted a female provider, no one ever waited more than 15 minutes, the office had a casual, friendly atmosphere, and I charged half a physician's fee for an initial visit." Some physicians, she says, sent her patients regularly.

Entrepreneurial to the core, Zaumeyer has lectured to NPs nationwide on setting up independent practices, and her book on the subject is required reading at some universities. "One physician in town was upset that I was encouraging NPs to venture out on their own. Then her NP bought my book and started her own practice," Zaumeyer laughs. She scoffs at physicians who view NPs as rivals, however. "There are plenty of patients for all providers," she says.

NP Donna Torrisi prefers to say that she and physicians are interdependent. Patients, she says, "get the best healthcare when there are multiple disciplines available to them. Physicians have to realize that they are not the captain of the ship, and that they should consult with nurses more often. The only way to meet the complex needs of patients is for providers to call upon each other and recognize our strengths and limitations. No one wins when we start fighting over territory."

Not that many physicians would covet Torrisi's turf-Abbottsford Family Practice, which employs five NPs, is in a public-housing community in Philadelphia. "No doctor would dare tell us to get out of here because they don't want the patients we serve," says Torrisi.

As a part-time clinician, Torrisi calls a physician regarding a patient problem only about once a month. The physician also visits the practice every six weeks to discuss patients the NPs have concerns about. And although the NPs do stints on call, they refer to physicians any patients who have to be admitted to the hospital. FIGURE 2

Figure 2. Kathryn Johnson, RN, and Donna Torrisi, RN, practice in a public-housing community.

[Help with image viewing]

Although five primary care physicians have offices across the street from NP Melanie Arntz's practice in Burns, Ore., she has no trouble filling her schedule with 25 to 30 patients a day. In fact, when an NP employed by one of those physicians departed, Arntz and her two NP colleagues gained some new patients who prefer to be treated by an NP. One appeal: "We schedule appropriately, so we can get patients in and out without a wait," says Arntz, a former president of the American Academy of Nurse Practitioners. Also, she and another NP in the practice were born in this rural town, which is 132 miles from the nearest medical center. "People have known us for years," she says.

Although Arntz's practice has no formal collaborative relationship with a physician, she doesn't hesitate to call one when she needs to. "Unlike many physicians," she says, "nurse practitioners are quicker to say, 'I don't know how to do this,' before they are in over their heads."

CNMs: "We don't just catch babies"

Sandra Williamson's birthing center in Orlando, Fla., had been running for four years when she and the midwives she employed applied for admitting privileges at the local hospital. That was in 1990. It took three years for the hospital to grant them, and even then with strings-Williamson would have to pay a doctor to be present when any of the midwives delivered a baby.

Only after she sued the hospital for antitrust violations and restraint of trade did Williamson gain full admitting privileges. By that time, another two years had passed. The opposition to her was purely economic, Williamson explains: "There is a glut of OB/GYNs in Orlando, and nurse midwives are seen as competition." FIGURE 3

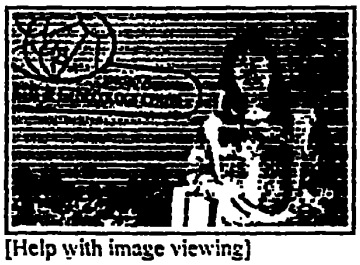

Figure 3. Nurse midwife Sandra Williamson is shown here in front of the practice she founded in the mid-'80s.

[Help with image viewing]

While Williamson was fighting for admitting privileges, Kathryn Harrod was commuting 117 miles round trip to a physician's practice in Milwaukee because no doctor in her community would hire a nurse midwife. After enduring the commute for 10 years, Harrod, who has a doctorate degree in nursing and teaches in the nurse midwifery program at Marquette University, found a job with a small, multispecialty practice owned by Aurora Health Care. The practice's OB/GYN had worked with midwives in the Air Force and wasn't threatened by them. "He actually calls me his partner on occasion," says Harrod.

Not all the area doctors were as open-minded, Harrod discovered when she applied for hospital privileges. "A few physicians told the hospital administrator that they wouldn't assist me if I had an emergency on the unit," Harrod recalls. But when she quietly delivered a teenage

mother for an obstetrician who had not yet arrived-and didn't charge for it-she earned the physicians' respect. "I had to show them that I was safe and wasn't doing crazy things," she says. "Now these doctors provide backup care for my patients."

Although her OB/GYN partner has 65% of the practice's OB patients, Harrod estimates she handles 60% of the births, since she delivers her own patients and splits call with the physician. Practicing with a doctor widens, rather than limits, her practice's scope, she says. "I'm doing things I never would have done on my own. I'm his first assist for C-sections, and I do circumcisions now, which I swore I'd never do. And instead of referring diabetic patients out, I co-manage them with the physician."

Harrod also gives public lectures about perimenopause, which brings more patients to her practice. "I allocate 50 minutes for new patients, and I spend much of that time listening to them," she says. "I've had 50-year-old women say that no one has ever listened to them so attentively before." That willingness to spend time with patients is why family practitioners refer women with difficult-to-treat yeast infections to her, as well as women who want a midwife-attended birth. (In 1997-the most recent year for which data are available-nurse midwives attended 7% of all births in the United States.)

At Williamson's Special Beginnings Birth and Gynecology Center, which does 15 - 25 deliveries a month, midwives stay with patients throughout labor, even if the mother is transferred to the hospital. "We don't rush in and catch babies at the last minute like some OBs do," says Williamson. "We also don't separate mother and baby after the delivery." Williamson boasts of a C-section rate of about 5% (in contrast to an almost 21% national rate), and equally low episiotomy and medication rates. About 16% of the Center's patients transfer to the hospital to deliver, primarily for oxytocin induction.

Williamson raves about the group of OB/GYNs with whom she and her midwives consult. "Midwives and OBs working together are a great team."

Doctors also benefit from the association. "We are a significant source of patients to physicians because we refer all our abnormal gynecology problems and surgeries to them," says Williamson.

Nurse midwives do manage to spark ire in physicians because their goal is not to duplicate what doctors do, but rather to change the birthing process. So it gives Williamson immense satisfaction that one of the OB/GYNs who led the battle to keep her out of the hospital 10 years ago is now seeking a nurse midwife for his own practice.

As for Harrod, she's happy she's finally able to realize the "gift of taking care of women in my community. This is my dream."

For information on which states allow nurse-midwives to practice without direct physician supervision, visit our Web site at www.rnweb.com .

KEY WORDS: advanced practice nurse; nurse practitioner; certified nurse midwife; independent practice; prescriptive authority; career development; professional issues

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Nursing Informatics: The Future is Now

Barbara Carty, EdD, RN

ABSTRACT

Nursing informatics is a new and evolving specialty. The potential for specialists in this area of practice to influence the nursing profession, affect healthcare delivery, and participate in the design and development of future healthcare systems is remarkable. This paper explores the nature of nursing informatics, the educational preparation, and the variety of roles within the specialty.

Health Care in the Information Age

Health care today is a swiftly changing landscape that is dominated by the rapid proliferation of information and communication technology. Health professionals and consumers are navigating new terrain as they communicate, access information, and resolve illness and healthcare issues. No longer is health care confined to the hallowed halls of brick and mortar institutions. Increasingly it is becoming a "point and click" system with leveled boundaries that promotes unfettered public access to healthcare information and untraditional communication between providers and patients.

Health care is dominated by the emergence of enterprise systems, electronic communications, including the computerized patient record (CPR), healthcare portals, and World Wide Web interactions. A recent poll conducted by Harris (2000) found that 68% of on-line adults seek health information, indicating that health care will be strongly influenced by Internet health portals and interactive health information networks. The impetus for this accelerated access to, and availability of, information has been the development and introduction of the World Wide Web into homes, offices, businesses, and healthcare settings. Internet-based healthcare networks linking caregivers and patients provide customized health tools and e-commerce to patients, thus enabling patients to monitor their health status, report health data, access disease prevention information, purchase healthcare products, and influence health outcomes.

With the move from stand-alone hospital information systems to integrated delivery networks, the availability of the types, quality, and amount of information will determine how care is distributed. As health systems move to enterprise-based organizations, the role of consumers, providers, and settings will interact to produce a more dynamic, interactive environment, which will be dominated by information and data access. This revolution will have profound effects on how health care is delivered, evaluated, and reimbursed. Nurses, who are the major providers of health care in the United States, will have to embrace the technology that is driving much of the change. The evolution of nursing informatics as a specialty has paralleled the rapid advances of information technology. However, nursing informatics continues to be a fairly unrecognized area among healthcare providers generally and nurses specifically. This article will discuss informatics within the context of nursing and present the current education and practice milieu of the specialty.

The Domain of Nursing Informatics

As with any new and evolving domain, time is needed to develop a research body to support the science and practice. Informatic

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however, is being swiftly propelled by the accelerated development of information technology and tools that allow for the rapid prototyping of data, information, and knowledge. It is these tools that the nurse informaticist uses to define, manage, and research the data, information, and knowledge of nursing and health care. This engineering and modeling of data, information, and the representation of knowledge are at the core of the informatics specialty. As early as 1989, Graves and Corcoran-Perry defined nursing informatics as the management and processing of nursing data into nursing information, and nursing data and information into nursing knowledge for the purpose of patient care. However, the inextricable association of informatics with technology has served to mystify the specialty and obscure the importance of the data, information, and knowledge concepts. An important aspect of nursing informatics is to express within systems what nurses do, the language of nursing. Brennan (1994) underscores that the distinct body of knowledge that is the discipline of nursing and nursing informatics is expressed in its language. "A discipline produces knowledge that is unique to it. The knowledge, in turn, is evident in the language of the discipline." (p.200). The discipline provides the practitioner with the language necessary to express the phenomena of its practice and differentiates it from other disciplines. As a result, there are within the domain of nursing informatics major efforts to structure the language, define concepts, and map terminology to be represented in systems (Henry, Warren, Lange, & Button, 1998; Bakken, Cashen, & O'Brien,1999; Bakken, Wade, Bain, Sklar, & Kelber, 2000; Button, Warren, Bakken, Androwich, & Mead, 20 Ozbolt, 2000).

Subsequent definitions of nurs informatics incorporate models that exp its domain to include other disciplines, s as computer science, information science, more recently cognitive science (Turley, 19 The inclusion of cognitive science has b echoed by Ribbons (1998) in nurs informatics and Patel and Kaufman (1998 medical informatics. Supporting the inter ciplinary nature of nursing informatics is American Nurses Association (ANA) de tion of nursing informatics as the speci that "integrates nursing science, comp science, and information science in iden ing, collecting, processing, and manag data and information to support nursing p tice, administration, education, research the expansion of nursing knowledge" (A

A Career Opportunity as a Nursing Informatics Specialist

by Elizabeth Phillip, RN, MSN

My career transition to a nursing informatics specialist began when, as an adult health clinical nurse specialist, I enrolled in the Post-Master Certificate program in Nursing Informatics at NYU.

The certificate program is designed for masters-prepared nurses and includes five courses. Introduction to Nursing Informatics explores the specialty as well as issues, such as data security and confidentiality associated with information management. Two courses focus on all aspects of the information system life cycle. A clinical decision support course investigates more future-oriented uses of clinical information systems. A capstone course requires students to apply and integrate learning from the program into an all-encompassing project and to explore the development of nursing informatics as a specialty. Application of learning is demonstrated in each course through a project related to information systems. The projects I completed included developing a plan for a medication data bank in a home care setting; establishing a database to measure the effectiveness of pressure ulcer assessment, prevention, and management strategies; and developing a rules-based clinical decision support program for a fall prevention program in the acute care setting. In addition to these projects, I had over 600 hours of clinical experiences. During that time, I was actively engaged in projects related to healthcare information systems in a variety of clinical settings from home care to the outpatient clinic and the acute care setting.

As a result of completing this program of study, I obtained a position as a Clinical Effectiveness and Quality (CEQ) Coordinator at the Hospital of the University of Pennsylvania. In this role, I am responsible for supporting the clinical effectiveness and quality teams in identification, data analysis, and implementation of CEQ targets. This is accomplished by designing and maintaining databases and as supporting the development of clinical pathways, disease management protocols, and educational materials to aid in their implementation. These job responsibilities reflect the nursing informatics specialist's scope of practice of aggregating clinical data to measure and communicate outcomes based on that data. I am able tc successfully combine my informatics expertise with my clinical knowledge, an important aspect of being successful in nurs ing informatics.

The Clinical Effectiveness program comprises an interdisciplinary team of professionals with financial or clinical backgrounds. In addition to the database design and management skills I acquire through the informatics program, my rol includes representing the nursing profession. This involves verifying that the da tabases contain and accurately measur data that is sensitive to nursing interven tions. Nursing knowledge is used to as sure the validity and integrity of data co lected and to verify that the correct meth odologies are applied when measuring th data. I review queries generated from th databases to make sure that they are de signed to provide the correct data th answers the clinical question being aske My informatics education has enabled m to successfully position myself in a ne and exciting role within nursing.

Elizabeth Phillip is a clinical effectiveness and quality coordinator at the Hospital of the University of Pennsylvania in Philadelphia. She completed the master certificate program in nursing informatics at NYU. The Division of Nursing at NYU also awards a master degree in nursing informatics.

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p.3, 1994). This ANA definition was an outcome of numerous efforts by national committees and study groups (National Center for Nursing Research, 1993; Graves & Corcoran-Perry, 1989; Heller & Romano, 1988) to support the development of nursing informatics as a specialty within nursing. The ANA Expert Panel on the Scope of Practice (ANA, 2000) proposed a new definition to reflect the expanded roles of informatics nurse specialists (INS) on the graduate level:

> Nursing Informatics is a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, and knowledge in nursing practice. Nursing informatics facilitates the integration of data, information, and knowledge to support patients, nurses, and other providers in their decision-making in all roles and settings. This support is accomplished through the use of information structures and information technology (p.20).

The document also outlines the recommended practice, education, roles, and responsibilities of the INS.

Education for Informatics

Based on the current literature and the nature of the practice environment, it is clear that informatics content needs to be addressed in both undergraduate and graduate curricula. The core informatics content in undergraduate programs will prepare nurses to work in a health care environment that is increasingly information- and computer-driven. The graduate specialization will prepare the developers and designers of the healthcare systems, and assure nursing's participation in a digitally dominated healthcare environment.

Undergraduate Informatics Education

In 1998, the American Academy of Colleges of Nursing released its document, "The Essentials of College and University Education for Professional Nursing." The document outlines core knowledge and skills related to technology for professional nursing education. These competencies include the ability to: (a) use information technologies to promote professional knowledge, (b) teach patients about information technologies, (c) use information and communication technologies to document and evaluate patient care, (d) adapt the use of technologies to meet patient needs, and (e) use technology to advance patient care and enhance the accessibility of care. Specific undergraduate informatics content has been outlined by Nelson (2000) and is represented in a model that incorporates computer skills, information literacy, and nursing informatics content. Computer skills include the use of a variety of software programs, such as word processing, spread sheets, and database software. Information management knowledge requires proficiency in the use of telecommunications, including email and Internet and bibliographic database searching. Basic nursing informatics knowledge includes nursing taxonomies and language, and various applications of the computerized patient record (CPR).

In addition to supporting core informatics content in basic education programs, undergraduate faculty need to develop their own knowledge, skills, and understanding of computer applications in health care and education.

Graduate Informatics Specialization

With the identification of nursing informatics as a specialty, the question arises as to how to prepare nurses for this new and evolving role. Studies indicate that graduate education programs and faculty preparation in informatics are in short supply. (Carty & Rosenfeld, 1998; Arnold, 1996). The scarcity of programs on a national level has made it very difficult for nurses to become educationally qualified for this area of practice. As a result, nurses have often had "on the job training" or have obtained graduate degrees in related fields such as computer science, business administration, management information systems, and programming (Carty, 1994; Arnold, 1996). As the roles have expanded and the demand for nurses qualified in this area of practice have increased, more educational programs are emerging. They vary in curricula design, course requirements, and clinical experience. Some graduate programs emphasize the specialist role with a concentration of informatics courses. Other programs integrate informatics content in graduate specialization programs such as advanced practice or administration (American Medical Informatics Association, Nursing Informatics Working Group, available at amia-niwg.org.) The programs that emphasize the master's specialization are the ones most appropriate to prepare the INS.

Graduate informatics education prepares a practitioner who posseses a broad scope of knowledge and skills. The expertise has been promulgated in the ANA draft on "Scope of Practice of Nursing Informatics and the Standards of Practice and Professional Performance for the Informatics Nurse Specialist" (2000, p.21). Performance areas and roles include but are not limited to:

- Employ information systems life cycle and other tools to analyze data, information, and information system requirements;
- Design, select, and evaluate information technology, data structures, and decision-support mechanisms into an integrated information system. These systems support patients, nurses, and their information management and human-computer interactions within health contexts;
- Facilitate the creation of nursing knowledge.

The informatics nurse specialist works with a variety of health care informaticists in an interdisciplinary setting that is constantly challenged by the rapid advances of technology within health care. The specialist possesses a level of clinical expertise and knowledge combined with knowledge of information and systems technology.

Credentialing for Informatics

Current credentialing by ANA for informatics specifies a minimum of a bachelor's degree, practice as an RN for 2 years, and a minimum of 2000 hours in the field of informatics or 12 credits in graduate program and 1000 hours in the field of informatics. However, the recent draft of the ANA Expert Panel on the Scope and Standards of Practice for the INS supports graduate education preparation of the informatics nurse. This position was also endorsed by the National Advisory Panel on Nursing Education and Practice (1997). The panel recommended:

- Preparation of advanced informatics nurses;
- Identification of core informatics content;
- Preparation of faculty in informatics;
- Collaboration on informatics projects.

These efforts to clarify and propose a variety of solutions to the often-confusing landscape of nursing informatics have illuminated many alternatives. Nurses who want to qualify for the advanced practice role should be prepared at the graduate level. Nurses who already have a master's degree can qualify with a post-master certificate. Practicing nurses without master's preparation can be certified as a generalist by fulfilling education and practice requirements.

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The Practice of Nursing Informatics

The paradigm shift from a traditional, provider-dominated system to an information, consumer-driven system has left many nurses confounded about the future of health care and their own professional existence. The emergence of informatics as a specialty offers nurses new opportunities in an expanding discipline. As healthcare organizations attempt to implement systems that will sustain their markets, clinicians with informatics expertise are in a win-win situation. Professional prospects abound in the area of system development and design, implementation, and evaluation. Professional opportunities can be found in the private sector as developers and consultants with vendors, in clinical settings as analysts and system designers, and in education as faculty and researchers. Career opportunities are not confined to settings but are portable, and numerous roles can be found in a variety of settings. These role titles may include: nursing information system coordinator, clinical informatics specialist, clinical analyst, vocabulary engineer, clinical database coordinator, healthcare quality improvement and outcomes manager, knowledge engineer, director of clinical information systems, consultant, educator, and researcher (Willson et al., 2000).

As an example, the role of a nursing information system coordinator may vary from setting to setting, but essentially the responsibilities are "to coordinate the analysis, design, development, planning, testing, training, implementation, maintenance, support, and evaluation of both existing and future hospital clinical information systems" (Willson et al., 2000, p.83). In some settings, nurses may function in only one or two of these areas, such as training and education or systems design and evaluation. In the latter role, they are often referred to as nurse analysts. On a more advanced level, nurses may serve as director of informatics. This role is usually found in a setting that has clearly defined the area of informatics. Nurses in this executive position provide leadership during all phases of the system life cycle, from selection to implementation and evaluation. They usually work with a group of designers and analysts and are part of a larger interdisciplinary team within the organization. Whatever the role a nurse assumes in informatics, the key to success is the clinical knowledge and experience that informs the position.

The flexibility and diversity of nursing informatics career opportunities are attractive to the nurse who enjoys a challenge, can envision novel and exciting opportunities, and is willing to create or define a position. These opportunities are a direct result of the evolution of a networked society and the intense focus on information access and knowledge engineering. Nursing informatics presents an exciting opportunity for nurses to examine their practice, articulate their language, and create new and exciting ways to position their profession.

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The Psychiatric Advanced Practice Nurse With Prescriptive Authority: Role Development, Practice Issues, and Outcomes Measurement

Carol Cornwell and Patricia Chiverton

Within the rapidly changing health care system, there is an increased need for professionals who can provide cost-effective primary health care for mentally ill patients. This article discusses the role of the Psychiatric Advanced Practice Nurse (APN) with Prescriptive Authority as a cost-effective, high-quality component of comprehensive mental health care delivery. Historical aspects of the development of the Nurse Practitioner (NP) role are discussed, as well as issues specific to the role in psychiatric nursing. The implementation of this role at Rochester is described, followed by recommendations for studying the impact of the Psychiatric NP on care delivery, including process and outcome variables.

WITHIN THE rapidly changing health care system, there is an increased need for mental health professionals who can provide cost-effective primary health care for mentally ill patients. Although hospital lengths of stay are declining and there is movement toward community-based psychiatric care, funding and resources to provide this comprehensive care is dwindling.

This article will discuss the role of the Psychiatric Advanced Practice Nurse (APN) with Prescriptive Authority (referred to as the Psychiatric Nurse Practitioner, or NP throughout this article) as a cost-effective, high-quality component of comprehensive mental health care delivery. We will first review the literature regarding the NP role in other nursing specialties. Then, we will discuss issues specific to the Psychiatric NP role, the implementation of this role in Rochester, and recommendations for studying its impact on care delivery outcomes.

LESSONS FROM THE PAST: THE NURSE PRACTITIONER ROLE IN OTHER SPECIALTIES

The NP movement began over 30 years ago in response to an increasing need for care providers in the area of primary infant and prenatal care (Ford & Silver, 1967; Ford, Seacat, & Silver, 1966). In 48 states, NPs can prescribe medications; in 20 states, they have authority to practice independently without the supervision or collaboration of a physician (Bailey, 1996). As Psychiatric APNs strive to implement the Psychiatric NP role, we may learn from the historical context within which the NP role in other specialties has evolved.

Challenges to Nursing Autonomy

Because autonomous NP practice challenges the orthodox structure of health care (Kelly, 1985), conflict often accompanies change. Christman (1987) discussed conflict around innovation in professional practice. He states that theory and science are available to all clinicians and "no one profession has a monopoly on the ability to be imaginative" (p. 385). Imagination and creativity have always been keystones to developing effective nursing care models that can meet the changing needs of patient populations.

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The NP role, with prescriptive authority and autonomy of practice, is a vital component to innovative care delivery models. Batey and Lewis (1982) define authority as the legitimate power to discharge a responsibility, and state that, as a precondition to autonomy, it "derives from at least three sources: (1) authority of the situation, (2) authority of expert knowledge, and (3) authority of position" (p. 14). Autonomy, then, is defined as the "freedom to make discretionary and binding decisions consistent with one's scope of practice and freedom to act on those decisions" (Batey & Lewis, 1982, p. 15).

Objections to increased autonomy and authority inherent in the NP role have often been tied to issues of patient safety, educational preparation of the prescriber, and overall client welfare. However, nurse practice acts, which are determined by state licensing bodies, exist to protect the safety of patients and to promote the welfare of citizens in regard to health care needs provided by Registered Nurses (RNs) (Batey & Holland, 1983, p. 88; Hadley, 1989).

There are two types of prescriptive authority that may be granted by states: (1) complementary, in which the nurse must have a collaborating physician and supervisory mechanism; and (2) substitutive, in which the nurse may prescribe medication without physician supervision (Talley & Brooke, 1992). As is the case in most states in which nurses have prescriptive authority, New York State grants NPs complementary authority. Under complementary and substitutive authority, prescribing activities can range from NP prescribing as an extension of physician authority, to prescriptive authority that is accorded formally under the RN licensure and through state recognition of certification and preparation for specialized nursing practice (Batey & Holland, 1983, p. 85). As Psychiatric NP roles are implemented, specialists must maintain the highest level of autonomy and authority that is granted within their own state's nurse practice act.

Role Blurring

Role blurring becomes evident between the Psychiatric APN who may be in independent practice providing psychotherapy and the Psychiatric NP, who is now prescribing. Historically, this has been an issue that has been a struggle for other nursing specialties, as well. Kitzman (1989) discussed issues in role blurring between Clinical Nurse Specialists and NPs, including breadth and depth of knowledge and skills, practice domain (primary, secondary, tertiary), professional autonomy, interdisciplinary collaboration, and directness of service.

Lego (1995) spoke about difficulties with the "nurse practitioner" title in Psychiatric nursing. She noted the differences between Psychiatric APN autonomous practice and Psychiatric NP roles, and raised concerns about loss of autonomy through external regulation. Caverly (1995) argues that problems with the NP title relate more to interstate differences in degrees of autonomy and authority accorded to APNs than to differences in role practice. She advocates simplifying the various practice titles and supporting the master's degree requirement for entry into practice. In psychiatric nursing at Strong Memorial Hospital, the NP role is viewed as an area of specialization that may be undertaken by the ANA Certified APN. Therefore, although all Psychiatric APNs are master's prepared specialists, they are not all Psychiatric NP's, which creates potential for role blurring. However, the concept of specialization is not new to consumers, so that education in this area may help to clarify roles and reduce blurring. Clearly, this issue needs further clarification and discussion within our profession.

Benefits of the Nurse Practitioner Role

Historically, practice and research has shown that nurses who are practicing in expanded roles need to be able to write prescriptions in order to practice efficiently (Cohn, 1984). In reviewing the NP literature (Batey & Holland, 1983; Munroe, Pohl, Gardner, & Bell, 1982; Rosenaur, Stanford, Morgan & Curtin, 1984), it is unequivocally clear that the legalization of prescriptive authority for APNs has "... increased access to primary care for many individuals and families; and allowed nurses to practice more fully to the limits of their education and training" (Talley & Brooke, 1992, p. 71).

NP practice traditionally has focused on health promotion and wellness care (Rosenauer et al., 1984). Repicky, Mendenhall, & Neville (1980) completed a national study of 341 NP and 356 Physician's Assistant (PA) participants who were employed by primary care physicians. When comparing NP with PA practice, they found that the direct care provided by NPs was more often "characterized by an emphasis on patient education, patient counseling, prevention of health prob-

lems, continuity of service, and disease management" (p. 40). In a study of 89 NPs in adult and family health, Batey & Holland (1985) found that although prescription practices were similar between NPs and physicians, the proportion of drug visits per client visit, rate that drugs were mentioned, and intensity of prescribing (prescriptions per patient) was less for NPs than for physicians. The authors note that those findings may be reflective of the NPs' greater emphasis on health teaching and prevention in primary care.

There is a paucity of literature regarding prescriptive practices of Psychiatric NPs. Saur and Ford (1995) completed a case study describing their collaborative practice model in treating a 57-year-old divorced White woman with a 23-year history of bipolar disorder with psychotic features. They reported positive clinical outcomes (decreased hospitalization, stabilization of symptoms, physical health, absence of alcohol) and positive functional outcomes (social adjustment, family relationships, financial management, quality of life). In addition, they reported positive financial outcomes in calculating the cost of care for this patient, which decreased from over $40,000 per year (average hospital cost only) with one care provider to less than $4000 per year under a collaborative practice model of care. As Psychiatric NPs begin to establish and expand their practice, research studies that can document the efficacy of this role will be essential.

Factors in Effective Collaboration

Because the quality of clinical care in any setting is highly dependent on the cooperative efforts of the team of professionals involved, collaboration emerges as vital to care delivery. Many factors have been delineated that impede and promote the development of collaborative relationships between physicians and NPs. Some barriers in the past have included APNs being resistant to the role of prescriber, feeling that they are not adequately trained, that they are unwilling to assume additional responsibility without a concomitant increase in remuneration, fear that they will become "physician extenders" and will sacrifice their skills and nursing satisfaction for the prescriptive role (Bailey, 1996; Bailey & Snyder, 1995, p. 184). Other barriers have included insurance liability issues, lack of understanding of the role by physicians and patients, stereotypes of the physician as the dominant partner in health care provider relationships, and the sociohistorical context of health care as a predominantly male-dominated culture (Bailey, 1996; Repicky, Mendenhall, & Neville, 1980).

Baggs and Schmitt (1988) identified key factors that are critical to effective collaborative relationships: coordination; open communication; sharing in and taking responsibility for problem-solving, goal-setting, planning, and decision-making; and working together cooperatively (p. 145). They also emphasize the importance of administrative support for the development and maintenance of collaborative roles.

In NP practice with complementary prescriptive authority, the use of practice protocols can be a tool that can enhance collaborative practice. Developing protocols together, the physician and NP can cooperatively make treatment decisions and discuss care philosophies, while enhancing the efficiency and quality of patient care (Cohn, 1984). Protocols should be based on a minimum safe level rather than the ideal of practice; they should be realistic and updated on a routine basis (Bailey & Snyder, 1995; Moniz, 1992).

NP PRACTICE IN PSYCHIATRIC NURSING

Psychiatric APNs are Uniquely Prepared for NP Practice

In 1994, the ANA Task Force on Psychopharmacology stated:

> "Psychiatric nurses are among the primary health care professionals working on a daily basis with the long-term management of psychiatric patients on the continuum of prevention, diagnosis, treatment, maintenance, and rehabilitation ... (and) are unique in that their training and experience enable them to assess the biological as well as psychosocial needs of patients." (American Nurses' Association, 1994b, p. viii).

Psychiatric APN preparation as a Registered Nurse includes education and clinical experience in assessment and interventions in both physical and psychological realms (Aiken, 1987; Haber & Billings, 1993). After RN training, the master's degree allows the Psychiatric APN to practice as a specialist. Subsequently, ANA Certification reflects a depth and scope of clinical practice and competency gained after substantial supervised clinical experience and a certification examination after the master's degree.

The Psychiatric NP is a highly specialized clinical nurse who has obtained education, clinical

supervision, and advanced certification and can "apply knowledge, skills, and experience autonomously to complex mental health problems" (American Nurses Association, 1994a, p. 11). Talley and Brooke (1992) discuss mechanisms of support that must be in place in order for Psychiatric APNs to practice safely in expanded roles:

> "Prescriptive authority within the psychiatric specialty sector mandates access to a full complement of therapeutic agents; methods for monitoring responses to treatment and potential side effects of therapy; access to medical facilities for the evaluation of patients who develop reactions; ethical and legal practice standards to insure the patient's emotional and physical well being; admitting privileges to inpatient treatment settings; the right to manage ones' case within that setting; and consultation and referral mechanisms to access specialized care for patients in emergency or complicated treatment situations" (p. 77).

Psychiatric APNs need to work toward attaining these goals; in many institutions, nurses do not have admitting privileges although they may admit under the privileges of the collaborating physician.

There is a lack of research documenting the effectiveness of Psychiatric APN practice. One such study by Baradell (1995) was a survey of 223 patients who had completed a course of outpatient psychotherapy in a practice of six autonomous Psychiatric Clinical Nurse Specialists (CNS). The questionnaires included measures of mood, quality of life, functional status, and patient satisfaction. Results showed that there was statistically significant improvement in the following areas: (1) clinical symptoms of anxiety, depression, anger, confusion, fatigue, and vigor; (2) quality of life, including family, social, and job; and (3) satisfaction with care provided by the CNS. The study provided evidence that psychiatric CNSs can provide care at lower cost than physicians or psychologists with equivalent or better patient outcomes.

Psychotherapeutic Issues in Treatment Triangles

There are issues regarding triangulation in the therapeutic relationship that are unique in psychiatric practice and need to be taken into consideration in collaborative practice models in which Psychiatric NPs are prescribing under complementary authority. This triangulation may occur between primary therapist, patient, and a third party that may be involved with managing psychopharmacological treatments (Beitman, Chiles, & Carlin, 1984; Bradley, 1990; Kelly, 1992).

Bradley (1990) speaks extensively about conflicting historical paradigms in psychotherapy and pharmacology treatments, providing an excellent review of the psychodynamic issues that may come into play when nonphysician psychotherapists collaborate with physician pharmacotherapists in the treatment of patients, including triangulation, transference, and countertransference issues, emphasizing the importance of being aware of these issues as powerful forces in treatment of patients by dual care providers. Kelly (1992), in a case study of collaboration between a psychiatrist and nonmedical psychotherapist, also emphasizes the importance of the collaborative relationship, as well as attending to the psychodynamic implications such relationships have to the treatment process.

Triangulation is less likely to be an impediment to practice with the NP role. Because much of the consultation and decision-making may be done between the NP and the physician, there may be a more clear boundary for the patient in regard to medication management. Psychiatrists and their professional groups have published guidelines for provision of collaborative treatment with nonmedical care providers, including clearly defining practice functions and defining what type of arrangement is in place (consultative, supervisory, or collaborative) (American Journal of Psychiatry, 1980; Appelbaum, 1991).

Practice Models in Psychiatric Nursing

Bailey (1996) and Bailey and Snyder (1995) have discussed Psychiatric APN Nurse Prescriber practice models based on the traditional relationship between supervisor and supervisee. The models are:

> "designed as a type of internship period during a relatively short period of time. The goal is for the nurse-in-training to become an independent prescriber (insofar as individual statutory regulations allow) who uses more experienced colleagues as consultants on an as-needed basis" (1995, p. 184).

To accomplish this, they recommend at least 1 hour of weekly supervision with case reviews, that the dyad develop guidelines and parameters of practice before beginning a collaborative relationship, and that there be agreement on issues such as credentialling, scope of practice, practice review, and other specifics such as emergencies and coverage before

establishing a collaborative relationship (Bailey & Snyder, 1995, p. 186).

Saur and Ford (1995), a Psychiatric CNS and physician team, in writing about their collaborative practice model, state that "Collaboration, a relationship of interdependence, requires that nurses and physicians have complementary rather than hierarchical roles" (p. 332). They describe seven characteristics that have enabled their collaborative relationship to be effective: (1) trust; (2) respect for each other's discipline and clinical skills; (3) commitment to and focus on patient-centered goals; (4) cooperation; (5) coordination of care; (6) open, honest, and respectful communication and sharing of information between nurse, physician, and patient; and (7) flexibility based on assessment of patient need (Saur & Ford, 1995, pp. 336-7).

THE PSYCHIATRIC NP ROLE AT STRONG MEMORIAL HOSPITAL

Development of the Role

The Psychiatric NP role is functional within the Psychiatric Mental Health nursing service at Strong Memorial Hospital which is based within the Department of Psychiatry. Our philosophy is that the national licensing and certification bodies for Psychiatric Mental Health Nursing should set the precedent for requirements for practice, and not the state. Therefore, we have patterned the requirements for assuming the Psychiatric NP role at Strong Memorial Hospital after recommendations of the American Psychiatric Nurses Association (APNA) Position Statement on Prescriptive Authority for Advanced Practice Psychiatric Nurses (Journal of the American Psychiatric Nurses Association, 1995), which were developed and endorsed by the American Nurses' Association, Society for Education and Research in Psychiatric Nursing (SERPN) and the APNA: (1) completion of a master's degree in nursing with major in Psychiatric Mental Health, (2) licensure as an RN in New York or other jurisdiction of the United States, (3) ANA Certification as a Psychiatric CNS and (4) NP certification in New York State. In addition, the APN must be competent in physical assessment and clinical psychopharmacology (APNA, 1995). These competencies are reflected by the requirements of New York State NP Certification, graduate coursework

⇒⇒⇒⇒⇒ CUMULATIVE OVER TIME ⇒⇒⇒⇒⇒					
	BASIC PREPARATION		PSYCHIATRIC SPECIALTY PREPARATION		SPECIALIZATION AFTER GRADUATE PREPARATION
ROLE	Registered Nurse (RN)		Advanced Practice Registered Nurse (APRN) with Independent Practice Privileges		Psychiatric Nurse Practitioner (NP) with Complementary Prescriptive Authority
EDUCATION	Baccalaureate Degree		Master's Degree with major in Psychiatric Mental Health		Coursework (pharmacology, physical assessment)
LICENSING OR CERTIFYING BODY	New York State (NYS)	American Nurses' Association (ANA)	NYS	ANA	NYS
LICENSURE/ CERTIFICATION AND REQUIREMENTS	NYS Board Examination for RN	RN Certification Examination (RNC) and supervised clinical experience	RN	Certified Specialist (CS) Examination and supervised clinical experience	NYS Certification as NP NP may also obtain DEA Number from NYS (for a fee) for prescribing controlled substances, if desired.

Fig 1. Cumulative Preparation, Licensure, and Specialty Certification of the NP in Psychiatric Nursing at Strong Memorial Hospital

in Pharmacology (including a one-credit section on writing prescriptions), and in physical assessment. A supervised clinical experience. Practice Agreement and protocols with the collaborating psychiatrist are also required. The certified Psychiatric NP may also apply for a Drug Enforcement Agency Number from New York State, which authorizes the prescription of controlled substances.

University of Rochester
Strong Memorial Hospital
Department of Psychiatry
PSYCHIATRIC NURSE PRACTITIONER PRACTICE AGREEMENT

I. INTRODUCTION

Practice agreement between_____, Nurse Practitioner and_____, Collaborating Physician

II. PRACTICE AGREEMENT
The physician(s) and nurse practitioner agree to adhere to standards of collaborative practice as described herein. Each party agrees to the conditions and qualifications imposed on their contractual relationship of this practice agreement.

III. SCOPE OF PRACTICE
To function as a psychiatric nurse practitioner in the _____ Clinic at Strong Memorial Hospital, a registered nurse must have a Master's Degree in Psychiatric Nursing and meet the qualifications of a Psychiatric Nurse Practitioner and practice within departmental parameters as stated in Chapter 257 of the Laws of 1988.

Services at the_____ Clinic consist of a broad range of outpatient mental health services for _____ including:
A. Psychosocial assessments and diagnostic evaluations
B. Individual, family, and group psychotherapy
C. Psychopharmacology consultation and intervention
As a health care provider working in collaboration with a licensed psychiatrist(s), the psychiatric nurse practitioner may assess some or all of the following: Physical and psychosocial status of patients by means of interview, history, physical examinations, review of previous evaluations and treatment summaries, diagnostic tests, and contact with the primary care physician and primary therapist. After the initial review of the findings with the psychiatrist, a treatment plan is created which the nurse practitioner carries out according to approved policies and procedures.

IV. PHYSICIAN CONSULTATION
A collaborating psychiatrist* shall be available to the nurse practitioner for consultation. Such availability shall include either on-site or telephone access. In the absence of a collaborating psychiatrist, the Nurse practitioner shall consult as necessary with other Strong Memorial Hospital Clinic Psychiatrists or Emergency Room physicians. In the absence of the nurse practitioner, appropriate coverage will be provided by _____

V. RECORD REVIEW
A quarterly review of patient records will be done by the nurse practitioner and collaborating psychiatrist according to hospital policy.

VI. PROVISION OF RESOLUTION OF DISAGREEMENTS
In the event of a disagreement in the area of medical management between a psychiatric nurse practitioner and collaborating psychiatrist, additional opinions will be sought from the Psychiatric Nursing Chief, or designee, and the Medical Director of the _____ Clinic. If this disagreement cannot be resolved, the opinion of the collaborating psychiatrist will prevail.

VII. ALTERATION OF THIS AGREEMENT
The Practice Agreement will be reviewed on a yearly basis. It may be altered or amended only in writing.

* A collaborating psychiatrist is defined by the Department of Psychiatry as a supervising (attending) psychiatrist who is ultimately responsible for the patient's care.

_____ _____

Nurse Practitioner Date Collaborating Physician Date

Fig 2. Nurse Practitioner Practice Agreement

At Strong Memorial Hospital, we view the Psychiatric NP as a specialized role that builds on the basic skills and clinical experience that the APN gains through master's preparation and ANA certification. Psychiatric APNs may or may not wish to pursue the Psychiatric NP as a specialty area for practice. Figure 1 summarizes the cumulative preparation, licensure, and specialty certification that are required for assuming the NP role at SMH in Rochester.

Talley and Brooke (1992) have emphasized the need for a proper educational and practice foundation for using prescriptive authority, and the importance for psychiatric nurse educators to retain control of psychiatric nursing specialty curricula. In Rochester, there are links between psychiatric nursing practice and the School of Nursing at the University of Rochester. The content of the graduate program in Psychiatric and Mental Health Nursing has been revised to reflect integration of new knowledge of neurosciences and psychopharmacology. However, because we view the Psychiatric NP role as one of specialization after ANA Certification, our graduate program is designed to prepare Psychiatric APNs who may, after ANA Certification, pursue prescriptive privileges, if they so desire. Therefore, our primary focus in the master's psychiatric specialty curriculum remains the APN role.

Practice Agreement

The Practice Agreement in place for Psychiatric NP practice at Strong Memorial Hospital (Figure 2) reflects standards of practice and legal requirements for collaborative practice in New York State. Because prescriptive authority for NP's in New York State is complementary, the agreement specifies that the NP shall consult with a collaborating psychiatrist, and in the event of a disagreement that cannot be resolved in the area of medical management, the opinion of the collaborating psychiatrist will prevail. This clause has been the most common issue for discussion, because it relates to ultimate legal responsibility for clinical decision-making. The agreement defines the NP scope of practice to include psychosocial assessments and evaluations, and psychological and pharmacological therapies. It specifies mechanisms for record review and consultation. A setting-specific Practice Protocol with a collaborating psychiatrist is also required for NP practice at Strong Memorial Hospital. As is common when new roles are being developed, there has been some resistance among psychiatrists within our hospital. As the role has developed, however, and collaborative relationships have matured, increasing numbers of psychiatrists are willing to collaborate. There has been administrative support for the development of these roles, which has also been instrumental in paving the way for their implementation and acceptance.

MEASURING OUTCOMES OF PSYCHIATRIC NP ROLE PRACTICE

In today's market, the importance of providing data to support the efficacy of innovative models of mental health care delivery, such as the Psychiatric NP role, cannot be underestimated. Merwin and Mauck (1995) provided a comprehensive literature review of the current status of Psychiatric Nursing outcome research. There are many opportunities for developing measures for clinical care outcomes of Psychiatric NP practice. The challenge is to identify relevant variables that measure practice activities and clinical responses to interventions. Psychiatric nurse clinicians have studied outcomes related to Psychiatric APN practice, including mood, quality of life, functional status, patient satisfaction, hospitalization, family relationships.

STRUCTURE VARIABLES	PROCESS VARIABLES	OUTCOME VARIABLES
Work group composition	Numbers of prescriptions	Self-Care Activities
Caseload size	Types of prescriptions	Symptom Severity
Administrative support	Consultations/Referrals	Functional Status
Educational preparation	Patient diagnoses	Adverse Side Effects
Practice experience	Medication adjustments	Recidivism
	Collaboration	Patient/Family Satisfaction
	Patient/Family teaching	NP and MD Satisfaction
	Patient advocacy	E.D. Visits
	Monitoring of patients	Hospitalization
		Length of Stay
		Cost of Care

Fig 3. Potential Measures for Research on NP Practice

and financial cost reduction (Baradell, 1995; Saur & Ford, 1995).

Evaluation of the impact of the NP role on care provision might be planned within the framework of a structure-process-outcome evaluation (Bloch, 1975; Donabedian, 1966). This allows examination of how setting- and provider-specific variables (structure variables) affect provider actions (process variables) and how these, in turn, may relate to changes in the recipient of care (outcome variables). Figure 3 summarizes some potential structure, process, and outcome variables for measurement when considering evaluation of the NP role in Psychiatric Nursing practice.

CONCLUSION

With changes in the health care system come innovative roles for Psychiatric APNs. We have discussed issues of role development, the implementation of the role in a large, northeastern medical center, and recommendations for studying outcome measures of Psychiatric NP practice. We must clarify, define, and educate the public about changing roles and opportunities for more cost-effective, efficient, and high quality mental health care.

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DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
BRONX, NEW YORK 10468

ATTACHMENT A
PATIENT CARE RESPONSIBILITIES

As a Registered Professional Nurse with special training and education, I request that I be granted the Patient Care Responsibilities outlined on the attached form. I certify that I have had ongoing review in the designated areas. I understand that:

(1) My responsibilities are limited to those identified in the attachment.
(2) These responsibilities will be reviewed and recertified annually by me and my collaborating physician.
(3) These responsibilities will be withdrawn if incompetence and/or negligence is demonstrated by me at anytime while exercising my privileges or if I am reassigned.

I agree to function within the guidelines of my Functional Statement and the attached clinical privileges in collaboration with the physician.

Signature:_____ DATE:_____
Employee

Signature:_____ DATE:_____
(Collaborating Physician)

CONCURRENCE:

_____ _____
Chief Nurse Date

_____ _____
Practice Chief Date

_____ _____
PCC Director Date

_____ _____
Chief of Staff Date

_____ _____
Chairperson, NPSB Date

_____ _____
Chairperson, PSB Date

Approval:

_____ _____
Medical Center Director Date

7/99

ATTACHMENT B

PATIENT CARE RESPONSIBILITIES
NURSE PRACTITIONER/PRIMARY/URGENT CARE

NP'S NAME: _____

PHYSICIANS'S NAME: _____

1. Takes comprehensive history of adult clients assigned to Primary/Urgent Care practice.

2. Performs physical examination on initial contact and assesses severity and urgency of the problems.

3. Interprets physical findings, discriminating between normal and abnormal findings, and formulates diagnostic impressions.

4. Orders, performs and interprets laboratory tests, diagnostic x-rays and procedures as indicated.

5. Prescribes new medications, and makes changes in existing medications, consulting with collaborating MD as necessary.

6. Prescribes and/or administers immunizing agents including vaccinations, inoculations and boosters.

7. Performs therapeutic or corrective measures according to practice guidelines.

8. Refers patients to appropriate physicians and/or consults. Admits patients as medically indicated following pre-admission certification guidelines.

9. Educates clients and significant other (s) in regards to the use and common potential/untoward effects of prescribed medications and/or treatments.

10. Educates clients and significant other (s) regarding health promotion and disease prevention strategies.

Signature: _____ Date: _____
NURSE PRACTITIONER

Signature: _____ Date: _____
COLLABORATING PHYSICIAN

NURSE PRACTITIONER AND PHYSICIAN COLLABORATIVE PRACTICE AGREEMENT

I. GENERAL INFORMATION
   A. Nurse Practitioner (NP)
      Name_____
      State License Number_____
      Area of Certification_____
      Certification Number_____
      Expiration Date_____
   B. Licensed Physician (MD)
      Name_____
      State Registration Number_____
      Board Certification Area_____

II. Definitions:
   A. The purpose of this document is to delineate the NP and MD Collaborative Practice Agreement (CPA) for the Primary Care/Urgent Care at the Bronx Department of Veterans Affairs Medical Center.
   B. NP may provide medical services he/she is competent to perform, and that are consistent with his/her education, training and experience; consults with a physician in a timely fashion regarding any procedure or diagnostic concern which he/she determines exceeds his/her level of competence.

   NP's Responsibilities:
   A. Takes comprehensive history of adult clients assigned to the primary/urgent care practice.
   B. Performs physical examination on initial contact and assesses severity and urgency of the problems.
   C. Interprets physical findings, discriminating between normal and abnormal findings, and formulates diagnostic impressions.
   D. Orders, performs, and interprets laboratory tests diagnostic X-rays and procedures as indicated.
   E. Prescribes medications including:
      1. Commonly prescribed medications
      2. Controlled substances
      3. Immunizing agents: vaccinations, inoculations and boosters.
   F. Performs therapeutic or corrective measures using the following publications as practice guides:
      - Hoole, Greenberg & Pickard (1988). **Patient Care Guidelines for Nurse Practitioners.** Boston, MA: Little Brown & Co.
      - Uphold & Graham (1994). **Clinical Guidelines in Adult Health.** Gainesville, FL: Barmarrae Books.
   G. Refers patients to appropriate physicians and/or consults.
   H. Patient education regarding health promotion and disease prevention strategies.

MD's Responsibilities

A. Takes over the medical management of unstable patients or designate an alternative physician to take over the management.
B. Participates with the NP in discussing therapeutic measures.
C. Be available for consultation in person or by phone.
D. Designate an alternative physician if unavailable.

III. Specific Clinical Issues

A. Chart notes and co-signatures: NP is responsible for documenting findings and plans of care. Co-signatures will be required within 24 hours for (1) new patients & new diagnosis, (2) patient's whose condition turns for the worse, and (3) patients unresponsive to conventional therapy.
B. Life-threatening emergencies: In an emergency, the patient will be transferred to the emergency room if condition permits. In the event of an arrest, cardiac arrest code will be called & CPR initiated.
C. Admission privileges: NP recommends patient admission as necessary and initiates hospital admission after collaboration with MD adhering to pre-admission certification requirements.
D. Emergency absence coverage:
   1. For Primary Care, the NP will notify the service so that patients can be notified to reschedule their appointments if possible. If the patient could not be notified and/or could not be rescheduled, patients will be distributed/assigned to the other members of the health care team. In the absence of the collaborating physician, coverage by another MD will be made.
   2. For Urgent Care, another NP and/or physician will provide coverage.
E. Ethical Considerations: Performs all interactions in a professional/ethical manner assuring client's confidentiality and security of all information and records.

IV. Legal Issues

A. Accountability: The NP is administratively/clinically responsible to the Patient Care Center Directors for Primary Care.
B. Quality Assurance: NP participates in continuing professional development including:
   1. involvement in quality assurance review on a periodic basis including systematic peer review of records and treatment plans.
   2. maintenance of current knowledge and clinical skills by attending educational programs, keeping abreast with research studies and utilizing research findings as appropriate.

3. maintenance of certification in compliance with current New York State law.

C. NP will carry NP malpractice insurance.

D. Disagreements between collaborating MD and NP regarding diagnosis and treatment will be resolved through consultation with MD from another team. If the conflict cannot be resolved, the matter will be resolved at the Patient Care Center directors level.

E. CPA Enforcement: The document will be on file in the Patient Care Center as well as in the hospital administration (in order to provide legal coverage for the NP's clinical practice). The CPA takes effect on the date it is signed by both parties coming into an agreement. The CPA is reviewed annually and remains in effect until it is deemed necessary to revise care practice.

F. Authorization:

NP's Signature_____Date_____

MD's Signature_____Date_____

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VETERANS HEALTH ADMINISTRATION
BRONX, NEW YORK 10468

ATTACHMENT A

PATIENT CARE RESPONSIBILITIES

As an Adult Nurse Practitioner, I request that I be granted Patient Care Responsibilities outlined on the attached form. I certify that I have had ongoing review in the designated areas. I understand that:

(1) My responsibilities are those identified in the Patient Care Responsibilities within the Scope of Practice for Nurse Practitioner in the Spinal Cord Injury Center.

(2) These responsibilities will be reviewed with the collaborating physician and recertified annually.

(3) These responsibilities will be submitted to disciplinary and performance appraisal process consistent with those outlined in the VHA policy.

I agree to function within the Clinical Practice Guidelines and the attached identified Patient Care responsibilities and to work with the collaborating Physician.

Signature: _____ Date: 9/8/00
Nurse Practitioner

Signature: _____ Date: 9/8/00
Collaborating Physician

Concurrence:

_____ Date: 10/2/00
Chief, Nursing Program

_____ Date: 9-28-00
Chief, Clinical Service

_____ Date: 10/3/2000
Chief of Staff

_____ Date: 10/26/00
Chairperson, NPSB

_____ Date: 10-30-00
Chairperson, PSB

Approval:

_____ Date: 10/30/00
Medical Center Director

ATTACHMENT B

Scope of Practice for Nurse Practitioners in Spinal Cord Injury
Patient Care Responsibilities

NP's NAME: Elizabeth Marrero

MD/PRECEPTOR's NAME: Victor Sousa

1. Primary Care provider for sub acute and sustaining care patients according to clinical practice guidelines.
2. Assess, diagnose, treat, and evaluate care that promotes wellness and prevents diseases and/or injury and disability.
3. Takes comprehensive medical history and performs physical examination of adults SCI clients, assessing severity and urgency of the problems.
4. Orders, conducts, and interprets, laboratory and diagnostic studies and procedures as indicated.
5. Prescribe and evaluate pharmacotherapeutic and non-pharmacotherapeutic regimes.
6. Initiates hospital admission with the collaborating physician adhering to admission requirements.
7. Consults and collaborates with physicians and other health care professional to manage complex health problems.
8. Educate and counsel clients and significant other/others regarding health promotion, wellness, and restorative treatments.

Signature: _____ Date: 9/1/00
Nurse Practitioner

Signature: _____ Date: 9/8/00
Collaborative Physician

IURSE PRACTITIONER AND PHYSICIAN COLLABORATIVE PRACTICE AGREEMENT

I. GENERAL INFORMATION

A. Nurse Practitioner (NP)
Name Elizabeth Marrero
State License Number 413495
Area of Certification NP Adult Health
Certification Number F 301755-1
Expiration Date 08/31/03

B. Licensed Physician (MD)
Name [illegible]
State Registration Number NY 105015
Board Certification Area [illegible]

II. DEFINITIONS:

A. The purpose of this document is to delineate the NP and MD Collaborative Practice Agreement (CPA) for the Spinal Cord Injury Patient Care Center at the Bronx Department of Veterans Affairs Medical Center.
B. NP may provide medical services he/she is competent to perform, and that are consistent with his/her education, training and experience; consults with a physician in a timely fashion regarding any procedures or diagnostic concern which he/she determines exceeds his/her level of competence.

NP's Responsibilities:

A. Primary Care provider for sub acute and sustaining care patients using the following clinical practice guidelines/publications:

- Department of Veterans Affairs Medical Care of Persons with Spinal Cord Injury, 1998.
- Uphold, C.R. & Graham, M.V. (1994) Clinical Guidelines in Adult Health. Gainesville, FL: Barmairae Books.

B. Assess, diagnose, treat, and evaluate care that promotes wellness and prevents disease and/or injury and disability.
C. Takes comprehensive medical history and performs physical examination of adults SCI clients, assessing severity and urgency of problems.
D. Orders, conducts, and interprets, laboratory and diagnostic studies and procedures as indicated.
E. Prescribe and evaluate pharmacotherapeutic and non-pharmacotherapeutic regimes.
F. Initiates hospital admission with the collaborating physician adhering to admission requirements.
G. Consults and collaborates with physicians and other health care professional to manage complex health problems.
H. Educate and counsel clients and significant other/others regarding health promotion, wellness, and restorative treatments.

MD's Responsibilities:

A. Takes over the medical management of unstable patients or designate an alternative physician to take over the management.
B. Participates with the NP in discussing therapeutic measures.
C. Be available for consultation in person or by phone.
D. Designate an alternative physician if unavailable.

Specific Clinical Issues:

A. Chart notes: NP is responsible for documenting findings and plans of care.
B. Admission privileges: NP recommends patient admission as necessary and initiates hospital admission after collaboration with MD adhering to admission requirements.
C. Emergency absence coverage:
    1. For Spinal Cord Injury Patient Care Center, the NP will notify the service so that patients will be distributed/assigned to the other members of the health care team. In the absence of the collaborating physician, coverage by another MD will be made.
D. Ethical Considerations: Performs all interactions in a professional/ethical manner assuring client's confidentiality and security of all information and records.

IV. Legal Issues:

A. Accountability: The NP is administratively/clinically responsible to the Patient Care Center Directors for Spinal Cord Injury.
B. Quality improvement: NP participates in continuing professional development including:
    1. involvement in quality improvement review on a periodic basis including systematic peer review of records and treatment plans.
    2. Maintenance of current knowledge and clinical skills by attending educational programs, keeping abreast with research studies and utilizing research findings as appropriate.
    3. Maintenance of certification in compliance with current New York State law.

C. Disagreements between collaborating MD and NP regarding diagnosis and treatment will be resolved through consultation with MD from another team. If the conflict cannot be resolved, the matter will be resolved at the Patient Care Center Directors level.

D. CPA Enforcement: The document will be on file in the Patient Care Center as well as in the hospital administration. The CPA takes effect on the date it is signed by both parties coming into an agreement. The CPA is reviewed annually and remains in effect until it is deemed necessary to revise care practice.

E. Authorization:

NP's Signature: [signature] Date: 9/8/10

MD's Signature: [signature] Date: 9/8/10

THE MOUNT SINAI MEDICAL CENTER
DEPARTMENT OF NURSING
APPRAISAL FORM
NURSE PRACTITIONER

Name _____

Position No. _____

Life No. _____

Date Employed _____

Department _____

Patient Population:

Neonate	
Pediatric	
Adolescent	
Adult	
Geriatric	

I. INSTRUCTIONS FOR USE

The Mount Sinai Performance Appraisal Program is based on two principles:

- Employees need to know what is expected of them and how well they are performing.
- Performance appraisal represents a significant responsibility of supervisors and managers.

This form is designed to help supervisors and managers appraise performance. To do so, follow the steps outlined below.

1. Speak with others who have significant information about the employee's performance during the year.
2. Review notes kept during the year; then prepare the performance appraisal.
3. Review the appraisal with the next-level manager.
4. Notify the employee, in advance, of the date and time of the appraisal meeting. Allow enough time for a thorough discussion.
5. Hold the appraisal discussion in a quiet place, without interruptions. Encourage the employee to ask questions and make comments.
6. Finalize the appraisal, asking the employee to sign and add any comments. Forward the original form to Human Resources (Box 1209) for filing, give a copy to the employee, and keep a copy for your files.

II. OVERALL PERFORMANCE EVALUATION

On the basis of performance against the job responsibilities as outlined in the Position Description, after completion of Sections 3 and 4, rate this employee's overall performance during the review period. This rating is not a numerical average of ratings recorded; it should recognize that some activities and skills are more important than others. Excessive absence or lateness should also be considered in determining this rating. Circle appropriate letter.

S - Superior performance. Performance in all areas far exceeded expectations, both in terms of performance of objectives/job responsibilities and how work was accomplished. Rating should be reserved for truly outstanding performance.

E - Highly effective performance. Performance of most objectives and job responsibilities exceeded expectations, and others fully met expectations. Work performed very effectively.

M - Consistently meets expectations. Performance of objectives and job responsibilities and how the work was accomplished were at level expected. Rating represents solid, competent performance.

B - Somewhat below. Overall performance generally falls some-what below level expected. Needs some improvement to meet expectations, either in the performance of objectives or job responsibilities or in how the work is performed. An improvement plan should be developed and follow-up counseling scheduled within three months.

U - Unacceptable performance. Overall performance significantly below level expected. Needs significant improvement to meet expectations, either in the performance of objectives or job responsibilities and/or in how work is performed. Requires immediate and sustained improvement. An improvement plan should be developed and follow-up counseling scheduled within three months.

III. In the section "RATING" enter appropriate letter - S, E, M, B, or U.

In the section "COMMENTS/RECOMMENDATIONS" note areas for improvement and outline action to be taken during next 12 months.

RESPONSIBILITIES	RATING
A. Clinical Practice 1. Develops and implements a collaborative practice agreement in the specific clinical area and performs a periodic review of the collaborative agreement . Comments/Recommendations _____ _____ 2. Assesses the health status of patients/families by means of comprehensive health history and physical examination. Comments/Recommendations _____ _____ 3. Initiates selected therapeutic and diagnostic procedures, consultations and laboratory examination, prescribes and alters medication regimens, interprets findings and alters plan of care according to agreed-upon collaborative practice agreement and protocols in designated area. Comments/Recommendations _____ _____ 4. Provides teaching and counseling in the areas of health promotion, maintenance, disease prevention, and management of acute/chronic illnesses. Comments/Recommendations _____ _____	

RESPONSIBILITIES (Continued)	RATING
5. Documents findings and plan of care in the patient's medical record. Comments/Recommendations _____ _____ 6. Consults with physician as established in the collaborative practice agreement. Comments/Recommendations _____ _____ 7. Initiates referrals to specialty services and fosters continuity of care. Comments/Recommendations _____ _____ 8. Participates in team meetings and conferences to enhance an interdisciplinary approach to acute/primary health care delivery. Comments/Recommendations _____ _____ **B. Professional Practice Domain** 1. Supports the mission, vision philosophy and goals of the Department of Nursing and the Medical Center. Comments/Recommendations _____ _____ 2. Demonstrate accountability for own nursing practice. Comments/Recommendations _____ _____	

RESPONSIBILITIES (Continued)	RATING
3. Advocate for patients/families and supports patients' rights. Comments/Recommendations _____ _____ 4. Considers ethical issues of professional nursing practice and adheres to the code of ethics. Comments/Recommendations _____ _____ 5. Demonstrates a humanistic, kind and caring attitude in the delivery of health care. Comments/Recommendations _____ _____ 6. Serves as a resource person to nurses and other health team members. Comments/Recommendations _____ _____ 7. Participates in peer review. Comments/Recommendations _____ _____ 8. Incorporates research findings in clinical practice. Comments/Recommendations _____ _____ 9. Participates in approved medical and nursing research studies. Comments/Recommendations _____ _____	

RESPONSIBILITIES (Continued)	RATING
10. Keeps knowledge current by self directed learning, literature review and attendance at educational programs. Comments/Recommendations _____ _____ 11. Participates in defining, maintaining, and interpreting standards of nursing practice. Comments/Recommendations _____ _____ 12. Contributes to the maintenance of a positive image of advanced practice in the medical center and in the local community by implementing programs which recognize nursing as a profession. Comments/Recommendations _____ _____ 13. Participates in departmental and interdisciplinary committees which influence and/or determine policies affecting nursing practice and patient care delivery. Comments/Recommendations _____ _____ 14. Seeks opportunities to enhance professional nursing practice and influence outcomes. Comments/Recommendations _____ _____	

Adheres to Dress Code:

☐ Always ☐ Occasionally Dresses Inappropriately ☐ Frequently Dresses Inappropriately ☐ N/A

Number of: Sick Days _____ **Unexcused Absences** _____ **Days Late** _____

Please explain any reasons for absences:_____

_____

_____

_____

Considers the age of the patients served in planning and carrying out nursing interventions:

_____

_____

IV. **WORK METHODS** - Evaluate employee's performance in each area below. If an item is not applicable to an individual's job, write NA (Not Applicable).

	RATING		RATING
PATIENT & FAMILY SERVICE		**TEAMWORK**	
Demonstrates caring, compassion	___	Coordinates work and provides information to help others do their jobs	___
Provides information to help patients take appropriate action	___	Works effectively with others	___
Responds to needs without getting defensive	___	Helps coworkers	___
Handles own and patients' emotions effectively	___	Courteous to other employees	___
		Puts aside personal problems to help accomplish unit work	___
SUPERVISION NEEDED		**SAFETY**	
Once job learned, works without constant supervision	___	Works in manner which will not harm self/others	___
Follows through and finishes work on time.	___	Knows safety codes, procedures and how to respond to emergencies	___
Follows established procedures, instructions, priorities	___	Wears protective clothing	___
Gives needed attention to details	___	Observes infection control guidelines	___
Works without disrupting others	___	Reports safety problems to supervisor/unit safety representative	___
COMMUNICATIONS		**DEVELOPMENT AND IMPROVEMENT**	
Writes legibly	___	Learns/uses new procedures within specified time.	___
Correctly interprets written and verbal information	___	Suggests ways to do work better	___
Gives clear directions, information	___	Keeps up-to-date by reading, workshops or conferences	___
Demonstrates good listening skills	___	Attends and provides inservice training	___
Keeps supervisor and others informed of work status, issues and problems	___		

V. SIGNATURES AND COMMENTS

Employee: Your signature indicates that your manager has discussed this appraisal with you and that you have read the appraisal. Your signature does not necessarily indicate agreement with what has been written. Use the space below to comment on this appraisal and note any disagreement you may have with the evaluation.

Employee:_____ Date:_____

Appraised by:_____ Date:_____

Reviewed by:_____ Date:_____

COMMENTS:

This space is provided for additional comments by the employee, appraiser or reviewing manager. Additional pages may be attached if needed.

BRONX VAMC
130 W. Kingsbridge Road
Bronx, New York 10468

INTERDISCIPLINARY AGE SPECIFIC COMPETENCY CHECKLIST

NAME: [illegible] UNIT: [illegible]

DIRECTIONS: Based on the decision-grid information, each staff is assessed at least annually for age specific competencies as it relates to their job performance standards. The PCCD or designee inserts the date and their initials under the age category for each applicable "Age Specific Element" that was observed performed. Any "No" check-mark requires remedial training Document remedial activities in the back of this form.

Age Specific Elements	Adult			Geriatrics		
	YES	NO	NA	YES	NO	NA
1. Demonstrated knowledge on specific human growth and developmental needs including communication skills.	/			/		
2. Demonstrated ability to assess and interpret age specific data.	/			/		
3. Demonstrated ability to adapt treatment interventions and the assessment of response to treatment specific to the age group, including equipment use.	/			/		
4. Demonstrated ability to provide safety needs specific to the age group being served.	/			/		
5. Demonstrated ability to involve family/ Significant others in the plan of care.	/			/		

[illegible]
Signature of Observer
Director, SCI PCC

4-15-00
Date

NP Elizabeth Marrero

BRONX V.A.M.C.

PHYSICIAN V. Sousa, MD

NURSE PRACTITONER – M.D. COLLABORATION
QUARTERLY PEER REVIEW PROCESS
CHART REVIEWS

YEAR 200 QUARTER 3rd DATE 7/1-8/30 SIGNATURE NP [signature] SIGNATURE MD X [signature] MD

ID #	HPI	PERTINENT ROS	EXAM	ASSESSMENT	PLAN	SOAP FORMAT	COORD OF CARE	CONSULTATION AND OR REFERRALS	MD IN. X
H 7032	✓	inc	✓	✓	✓	✓	✓	✓	✓
M 4704	✓	✓	✓	✓	✓	✓	✓	✓	✓
S 4690	✓	✓	✓	✓	✓	✓	✓	✓	✓
B 7887	✓	N/A	✓	✓	✓	✓	✓	✓	✓
W 1803	✓	✓	✓	✓	✓	✓	✓	✓	✓
N 4105	✓	✓	✓	✓	✓	✓	✓	✓	✓
R 0469	✓	✓	✓	✓	✓	✓	✓	✓	✓
T 0713	✓	✓	✓	✓	✓	✓	✓	✓	✓
V 2694	✓	✓	✓	✓	✓	✓	✓	✓	✓
V 2694	✓	NA	✓	✓	✓	inc	✓	✓	✓
M 3552	✓	✓	✓	✓	✓	✓	✓	✓	✓

KEY		
	NA	= NOT APPLICABLE
	√	= PRESENT
	HPI	= HISTORY OF PRESENT ILLNESS
	ROS	= REVIEW OF SYSTEM
	SOAP	= SUBJECTIVE, OBJECTIVE, ASSESSMENT, PLAN
	MD INITIALS	= INITIALS OF MD THAT REVIEWED CHARTS

COMPETENCE ASSESSMENT PROCESS REVIEW
REQUEST FORM
2000

	1	2	3	4	5	6
Name or Category of Staff*	Job Description HR.1	Verification of Current License or Registration/Certification, when Applicable HR.2	Initial Assessment of Competency including any skill/competency list(s)* HR.4	Performance Evaluation HR.5		
				Most Recent Performance Evaluation including any skill/competency list(s)**	Age Specific Competence when appropriate ***	Performance Specific skill/competency (Surveyor use only)
Maureen Elizabeth	✓	✓	✓	✓	✓	✓

*Some additional names may be added later in the survey.

*Limited to staff hired after January 1, 1993.
**Separate skills/competency lists are not required but if used in your hospital, should be provided.
***Age specific competency required for staff who routinely provide direct patient care to different patient age groups served by the hospital, e.g., neonates, pediatric and adolescent patients, and geriatric patients.

Effective 1/1/96

BRONX VAMC
BRONX, NEW YORK 10468

Program Orientation

Name of Employee

Program

A. Orientation includes review of:

1. Scope of Services	✓
2. Policies	✓
3. Procedures	✓
4. Other:	✓
B. Review of Performance Plan & Expectations	✓
C. Environment of Care Plan	✓
Nearest fire pullbox	✓
Nearest exit	✓
Oxygen shutoff valve	✓
Role in safety management	✓
D. Role in Prevention of Infection	✓
E. Performance Improvement Activities	✓
F. Other:	
	✓

I have provided orientation to the above named employee covering the above.

Print name of Supervisor

Title

Signature of Supervisor

Date: 4-4-08
NAME: Monica Eglinton
POSITION/GRADE: RN/ LVN II - 05

This portion of the checklist must be completed for all staff who have regular clinical contact with patients. Competency Assessment of such individuals must address the ages of the patients served and the success with which the staff member produces the expected results of clinical interventions.

AGE SPECIFIC APPROPRIATE CARE	VERIFICATION METHOD	COMPETENCY CODE
YOUNG ADULTHOOD (18 - 39 years old)		
Accepts chosen lifestyle and assists with necessary adjustments relating to change in health. Other age specific competencies include:		
MIDDLE ADULTHOOD (40 - 64 years old)		
Recognizes risk factors related to health. Copes with concerns expressed by patient. Provides direction and clarification as needed. Other age specific competencies include:		
OLDER ADULT (65 - 80 years old)		
Encourages physical and social activity. Explains procedures and routines. Provides reassurances and assistance whenever possible. Other age specific competencies include:		
GERIATRIC (80+ years old)		
Provides physical, intellectual and emotional assistance. Reassures and comforts patient as needed. Assists patient with self-care as required to encourage as much independent living as possible. Provides necessary safety measures. Assists patient to cope with loss, i.e. hearing, vision, death of a loved one. Other age specific competencies include:		

VERIFICATION METHOD	COMPETENCY CODE (for HPDM competencies)
OB – Observation D – Demonstration V – Verbalization T - Quiz/Test DR - Document Review O - Other (Specify)	S – Satisfactorily Meets (Area of Strength) N – Needs Review and Practice (Area for Development)

UID
Supervisor's Signature [signature] Date 4-4-08
Employee's Signature [signature]

Date: 4-11-00
NAME: Warren Elizabeth
POSITION/GRADE: [illegible] NP

COMPETENCY EDUCATION PLAN

Initial Date of Assessment	Competency	**Educational Intervention(s)	Reassessment Date	Competency Code	Verification Method

** *Examples of Educational Intervention*: course, seminar, independent study, cross-training, web-based curriculum, simulations, etc.

VERIFICATION METHOD	COMPETENCY CODE (for HPDM competencies)
OB – Observation D – Demonstration V – Verbalization T - Quiz/Test DR - Document Review O - Other (Specify)	S – Satisfactorily Meets (Area of Strength) N – Needs Review and Practice (Area for Development)

U11

Supervisor's Signature [illegible] Date 4-11-00
Employee's Signature Elizabeth Warren

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Competency Assessment
Bronx VAMC
VISN 3

Date 4/00
NAME Marcia E.
POSITION/GRADE NP II/9
SERVICE SCI CAMPUS

Technical Skills *continued* (i.e. "Position Competencies")	Verification Method	Competent
1. Physical Assessment: Demonstrates the ability to perform comprehensive physical assessment and history taking.	D	S
2. Identifying Problems and Diagnosing: Demonstrates the ability to detect acute and chronic diseases.	OB	S
3. Prescribing: Demonstrates the ability to recommend appropriate diagnostic and therapeutic interventions.	OB	S
4. Consulting and Referring: Obtains appropriate and timely consultations of collaborative physician and specialties.	OB	S
5. Age Related and Cultural Differences: Incorporates age and developmentally related variations and cultural differences of the clients in the care plan	OB	S
6. Cost Containment in Care: Demonstrates the ability to consider appropriateness and financial implications to the client, hospital and the third party payors in ordering diagnostic tests and in prescribing medications.	OB	S
7. Professional Development Issues: Maintain responsibility for ongoing professional development.		
1) Respiratory Therapy Basic (Preceptor) 7/00		
2) Pediatric Therapy Update Annual Physical - 7/00		

VERIFICATION METHOD	COMPETENCY CODE
OB – Observation D – Demonstration V – Verbalization T - Quiz/Test DR - Document Review O - Other (Specify)	S - Satisfactorily Meets N - Needs Review & Practice

Rater's Signature
Employee's Signature

Page 2

DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

COMPETENCY ASSESSMENT FOR REGISTERED NURSES
NURSE PRACTITIONER - NURSE III

SERVICE: Spinal cord PCC
RATING PERIOD: FROM: 8/1998 TO: 8/1999

EMPLOYEE: Elizabeth Marrero
TITLE Adult Nurse Practitioner

EVALUATOR Arthur Cytryn, MD
TITLE Chief, Spinal Cord Injury

KEY COMPETENCY	COMPETENCY STATEMENT	PERFORMANCE CRITERIA	COMPETENT SELF	COMPETENT RATER	METHOD OF VERIFICATION
Nursing care in the different stages of human development based on age of the patient.	Demonstrates or verbalizes knowledge of the characteristics and life style of young adults on the 18-39 years age group.	Provides health education and guidance to develop good lifestyle habits; i.e., weight control, exercise, effects of drugs and alcohol, problems related to human sexuality, family planning, and necessary adjustments relating to health.	✓	✓	
		Recognizes the client's commitment and function of competence in life	✓		
		Supports changes as necessary for health	✓		
	Demonstrates or verbalizes knowledge and skill to provide age-specific care to middle aged clients between the ages of 40-64 years old	Perform accurate assessment of risk factors related to health. Consults and collaborates with other professional and refers as needed.	✓		
		Provide counseling and assistance in planning for anticipated changes in life, i.e. balancing work with other roles, preparing for retirement, etc.	✓	✓	

KEY COMPETENCY	COMPETENCY STATEMENT	PERFORMANCE CRITERIA	COMPETENT		METHOD OF VERIFICATION
			SELF	RATER	
Nursing care in the different stages of human development based on age of the patient.	Demonstrates or verbalizes knowledge and skill to provide age-specific care to middle aged clients between the ages of 40-64 years old	Provides counseling and guidance regarding the physical changes of middle age adulthood and maintenance of health habits; i.e. adjustment to menopause, sexual dysfunction, use of over the counter drugs, use of alcohol, tobacco, etc.	✓	✓	
	Demonstrates or verbalizes knowledge of the physical and social problems of the young old group between the ages of 65 -74 years old.	Assess clients ability to participate in physical and social activities. Involve family/significant others in developing a plan to keep the client physically and socially active.	✓		
		Provides assistance and guidance in maintaining peer group interactions.	✓		
	Demonstrates or verbalizes knowledge of the psychosocial problems of the middle age group between the ages of 75 - 84 years old	Provides guidance and assistance in coping with loss; i.e. hearing, eyesight, death of loved ones, sensory loss, memory low, etc.	✓		
		Encourage clients to discuss thoughts and plans related to death and dying, i.e., advance directives, living wills.	✓		
		Implement health promotion and provide client and significant others education on the safe use of equipment; i.e., walker, crutches, wheelchair, etc.	✓		
	Demonstrates or verbalizes knowledge of the physiological changes associated with aging and the problems of the old, old group between the ages of 85 and over	Accurately assess client's ability to perform activities of daily living; i.e., feeding, personal hygiene, ambulation, exercise, etc.	✓		
		Provide guidance and assistance on client's need for independence.	✓		
		Initiate referrals to appropriate agency for placement.	✓	✓	

KEY COMPETENCY	COMPETENCY STATEMENT	PERFORMANCE CRITERIA	COMPETENT		METHOD OF VERIFICATION
			SELF	RATER	
Clinical Practice/skill	Demonstrates competence in providing primary care to adult/geriatric clients with emphasis on promotion of health, the prevention of disease, and early detection and treatment of disease.	Assess the health status, illness conditions, response to illness and health risks of the client.	✓	AL	
		Diagnose the actual or potential health problem or need based upon analysis of data collected	✓		
		Plans the therapeutic intervention jointly with the client.	✓		
		Manages wellness and illness needs using current scientific data, protocols and guidelines.	✓		
		Consults and collaborates with other professionals and refers as needed	✓		
		Evaluates process and outcome of the management plan and modifies the plan as indicated.	✓		
		Plans appropriate follow-up care and additional health care services.	✓		
		Documents findings and plan of care in the Medical Record.	✓		
Professional Practice	Demonstrates ability to support the role in health care delivery	Interprets the role to the public and other health care professionals	✓		
		Assists with the training and education of NP students by serving as a preceptor, role model and mentor.	✓		
		Joins and participates in appropriate professional associations	✓		
		Joins and participates in legislative and policy-making activities that will result in facilitating delivery of care.	✓	AL	

KEY COMPETENCY	COMPETENCY STATEMENT	PERFORMANCE CRITERIA	COMPETENT		METHOD OF VERIFICATION
			SELF	RATER	
Professional Practice	Demonstrates ability to support the role in health care delivery.	Participates in professional development program for staff.	✓	✓	
		Participates in quality assurance activities in the healthcare setting.	✓		
		Participates in peer review.	✓		
		Participates in defining, maintaining, and interpreting standards of nursing practice.	✓		
		Participates in the research process.	✓		
		Interprets and incorporates research findings in clinical practice.	✓		
		Demonstrates accountability for own practice.	✓		
Continuing Education	Assumes responsibility for maintaining competence in clinical practice	Develops educational programs to improve patient care delivery.	✓		
		Participates in a variety of educational activities in order to maintain and increase competence.	✓		
Administrative Practice	Collaborates with other health care providers in assessing, planning, implementing and evaluating care for individual veterans and target population.	Participates in departmental and interdisciplinary committees which influence and/or determine policies affecting nursing practice and primary health care delivery.	✓		
		Demonstrates ability to work effectively with others.	✓		
		Demonstrates ability to manage and coordinate a case load.	✓		
		Demonstrates ability to work within a collaborative agreements/protocols with a physician in area of practice.	✓		
Medical Emergencies	Demonstrates ability and skil to recognize emergency situations and initiate appropriate action	Correctly demonstrates Basic Life Support techniques in accordance with Medical Center protocol and AHA guidelines	✓	✓	

KEY COMPETENCY	COMPETENCY STATEMENT	PERFORMANCE CRITERIA	COMPETENT		METHOD OF VERIFICATION
			SELF	RATER	
Environmental Safety	Demonstrates knowledge and skill in the management and care of the environment which includes:	Recognizes emergency situations and takes appropriate action.	✓	✓	
	Fire and fire safety	Locates fire fighting equipment; i.e. fire alarm box, fire exits, fire extinguisher, oxygen shut-off valve.	✓		
		Identifies the acronym RACE	✓		
		Responds to appropriate drills and fires, evacuation protocol, etc.	✓		
	Safe Use of electrical equipment and appliances.	Demonstrates safe use of electrical appliances and/or equipment on clients and environment.	✓		
		Correctly identifies electrical appliances and/or equipment that are considered unsafe and are prohibited for use in the Medical Center.	✓		
	Radiation Safety	Practices the principles of time, distance and shielding	✓		
	Materials Communication/ Hazardous Materials; Use of MSDS.	Practices the Medical Center's protocol and guidelines for safe handling of hazardous materials.	✓		
		Locates MSDS Manual.	✓		
	Emergency Preparedness/ Disaster Code	Respond to all disaster drill without exception. Familiar with emergency and disaster protocol.	✓		
	Proper body mechanics and Assist-O-Kinetic techniques	Correctly demonstrates proper use of body mechanics and assist-o-kinetic techniques in moving, lifting or transfering clients/heavy load	✓		
Safety/ equipment	Maintains the client in a safe environment	Keeps client 's environment free from obstruction, hazards, water spill, etc.	✓		
		Reports broken equipment's /appliances to appropriate service/department.	✓	✓	

KEY AREA OF COMPETENCY	COMPETENCY STATEMENT	PERFORMANCE CRITERIA	COMPETENT		METHOD OF VERIFICATION
			SELF	RATER	
Infection Control	Demonstrates knowledge and integration of OSHA air and Bloodborne pathogen regulations into client care delivery	Uses appropriate universal precaution measures before and after patient care; i.e. proper hand washing	✓	✓	
		Practices proper disposal of used materials and equipment	✓		
		Uses appropriate personal protective equipment to eliminate or reduce the likelihood of contamination from blood, body fluids and air-borne pathogens; i.e. T.B.	✓		
Patient's Rights	Demonstrates ability to provide safe and secure environment for the clients	Reports any abusive behavior involving clients and/or personnel to proper authority	✓		
		Respects and fosters the client's sense of dignity	✓		
	Demonstrates knowledge and sensitivity to diverse cultural and ethnic practices	Recognizes differences in cultural and ethnic practices in the delivery of health care	✓		
		Observes/considers cultural and ethical aspects when providing patient care.	✓		
		Provides health care to clients regardless of age, sex, race and religion	✓		
Security	Demonstrates knowledge in reporting security incidents that involve clients, visitors, personnel or property	Reports to appropriate service/department security incidents that involve clients, visitors, personnel or property; i.e., theft, vandalism, accidents, etc.	✓		
Assignment Completion	Demonstrates ability to adapt to change in work load as required	Completes work assignment within tour of duty.	✓		

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VA MEDICAL CENTER
BRONX, NY 10468

NURSING PROGRAM
JANUARY 2000

FUNCTIONAL STATEMENT NURSE PRACTITIONER/NURSE II

I. Role Description: The Nurse Practitioner is accountable for primary care of a group of adult/geriatric clients assigned to primary care practice. This responsibility includes relatively independent functioning with ongoing collaboration with physician peers and appropriate members of the health care team. The specific focus of primary care is on health maintenance, disease prevention, screening, early detection of illness, and management of common acute illness and chronic long term illness. . The individual also meets the competencies with the role and responsibilities and in accordance with the High Performance Development Model.

II. General Qualifications:

A. Experience --- Education

1 year	---	Doctoral degree in nursing or Doctoral in related field and baccalaureate or Master's degree in nursing ~(NLN accredited).
2 years	---	Master's degree in nursing (NLN accredited).

B. Licensure --- Active and current license to practice as a professional nurse from a state, territory or commonwealth of the USA.

C. Physical Standards - As specified in DM&S Supplement, MP-5, Part II, Chapter 10.

III. Specific Qualifications: Successful completion of a master's degree or certificate program for Adult/Gerontological Nurse Practitioners. Certification from a national nursing accreditation organization is preferred.

He/she demonstrated knowledge of development processes as he/she provides patient care to an adult population in an age 18 to 85 plus. Performs duties of function considering the age specific needs of patients (e.g. for geriatric population the aging process and risk factors).

IV. Accountability: The Nurse practitioner (NP) is administratively and professionally responsible to the Patient Care Center Director and is clinically/medically responsible to the physician Preceptor. The Nurse Practitioner functions with ongoing collaboration with physicians, nurses, and other health care professionals.

V. FUNCTIONS AND RESPONSIBILITIES

Criteria	Outcomes
A. Clinical Practice With appropriate physician supervision.	a. With 1-2 exceptions.
1. Develops a data base on clients in the primary care practice the NP: 2. Assesses severity, urgency and nature of client problems, i.e.: a) emergent, non-emergent	

1. Communicates pertinent information to the PCCD/ Physical to include clinical trends in the client population, prepares reports and summaries as necessary.

2. Assists in the formulation and update of policies and procedures which provide the clinical guidelines for quality practice.

3. Participates in the accomplishment of goals for ambulatory care, consistent with those of agency.

4. Participates in a variety of hospitals committees nursing.

C. Education

c. With 1-2 exceptions.

1. Provides orientation to the Nurse Practitioner role for nursing staff, physicians, clients and significant others.

2. Collaborates with other disciplines to plan and implement educational programs.

3. Maintains an active involvement with professional organizations, community programs, and academic environment.

4. Assume responsibility for personal, professional and educational growth in a specialty field.

D. Research

d. With 1-2 exceptions.

1. Participates in identifying clinical concerns, and in conducting clinical investigations/research studies.

2. Reviews literature pertinent to the specialty area. Collaborates with the other disciplinarian in selectively applying research findings to the clinical area.

3. Initiates and/or participates in research which adds to the body of nursing knowledge, and makes results of investigations known.

E. Interpersonal Relationships:

e. With 1-2 exceptions.

1. Communication skills demonstrates the ability

b) acute or chronic

3. Assesses and interprets data, discriminating between normal and abnormal findings and formulates diagnostic impressions.

4. Develops, implements and evaluates initial and ongoing plans for client care.

5. Provides phsychosocial and educational measures to clients and significant others.

6. Manages treatment modalities within guidelines set forth by established protocols within the specific Patient Care Center.

7. Prescribes and/or performs selected laboratory and other diagnostic tests, treatments, referrals, medications, and consultations deemed pertinent in concurrence with individually approved clinical privileges.

8. Promotes a clinical environment which is client centered, participate and individualized, and acts as a role model in demonstrating caring, respect and dignity of primary care clients; collaborates with primary care staff in identifying and implementing means for enhancing quality of life for clients.

9. Participates in assessment, planning implementation, and evaluation of client care as part of the interdisciplinary team. Activities include collaboration with nursing colleagues, physicians, and other disciplines.

10. Reviews minutes of Therapeutic Agents and Pharmacy Committee.

11. Acts as a clinical resource in the provision of care for clients, and provides consultation to other hospital areas as requested.

12. Meets with others in order to exchange information and to define and clarify the Nurse Practitioner role in its continuing evolution.

13. Collaborates with other health disciplines to assure continuity of client care, and continuance of health maintenance plans for clients.

B. Administrative:

b. With 1-2 exceptions.

to work effectively with others, to initiate and lead groups of nursing personnel in collaboration with other health care professionals, to impact on the delivery of care by:

a) Applying the communication skills and process, such as listening, validation, restating, reporting and summarizing.
b) Using effective verbal, and written skills to give directions and provide information to others.
c) Utilizing meeting/conference format to communicate and contribute to problem resolution.
d) Seeking the assistance of appropriate resource personnel, and using communication.

2. Consistently collaborates with the professional and interdisciplinary team:
   a) Attends and participates as a member of the hospital or unit level program representative.
   b) Takes a leadership role in initiating, participating and directing interdisciplinary team meetings.
   c) Demonstrates ability to facilitate change process at the unit level.
3. Assume responsibility for the improvement of client care:
   a) Using discretion and leading others in appropriately safeguarding confidential information.
   b) Preserving the right of others while serving as client advocate.

F. Professional Contributions: — f. With 1-2 exceptions.

1. Professional and Personal Growth.
   a) Evaluates own action and needs.
   b) Develops goals and objectives for career enhancement and contributions for improvement of client care.
   c) Is self directed and accepts responsibility for own actions.
   d) Professional practice may include involvement in community or outside activities.

2. Ethical Conduct. — 2. With 2-3 exceptions.
   a) Demonstrates and promotes professional and personal integrity. Conducts self in a professional manner which reflects favorably on the Nursing Profession an the VA.

3. Adheres to Medical Center philosophies, policies and procedures and communicates and interprets same to members of the interdisciplinary team. — 3. With 2-3 exceptions.

4. Consistently performs within the Nurse Practice — 4. With 2-3 exceptions.

Act, VA regulations and Nurse Practitioner legislation.

5CUSTOMER STANDARDS: SUCCESSFUL

Providing, Direct Customer/Patient Service

1. Consistently responds to the requests of patients, families, and co-workers for assistance promptly and in a friendly and cooperative manner. 2. Routinely identifies the customer's/patient's situation properly, and performs the task required to resolve the customer's/patient's problems accurately and in a timely manner.
3. Listens to all customer/patient feedback, positive and negative; acts to resolve complaints within his or her control; and reports feedback to manager (or team leader) in a timely manner.
4. Interacts with a wide variety of staff and demonstrates sensitivity to and an understanding of their needs by taking ownership of the problem and adopting the customer's needs as his own.

Communication. Information, and Education

1. Consistently communicates with customers (e.g., veterans, family members, coworkers, the general public) in a courteous, tactful, and helpful manner. Communication, both oral and/or written, is generally provided promptly and is responsive to the customer's needs.
2. As a rule, oral and/or written information is correct, using clear and precise communication methods to ensure that customers understand.
3. Provides professional and technical advice, support, and assistance to all customers with a view towards accomplishing the service mission; personal contacts are free of legitimate negative feedback.

Contacts With Fellow Employees

1. Relationships with supervisors, co-workers, and others within the organization must be consistently courteous and cooperative in nature, and must contribute to the overall effective operation of the office. Performance must demonstrate the ability to adjust to changes or work pressures in a pleasant manner, to handle differences of opinion in a business like fashion, to follow instructions conscientiously, and to function as a team member, helping the group effort whenever possible.
2. Routinely interacts in a professional and courteous manner with managers and other employees to facilitate the accomplishment of the work of the organization.
3. Instills confidence and trust in supervisors, peers, and subordinates by providing timely and quality service and by meeting established time frames and deadlines in established area of responsibility.

1. DM & Supplements, MP5, Part II:
Chapter 2. "Nurse VA Qualification Standards" (5/18/83).
Chapter 10. "Physical Standards" (10/28/20).

2. DM & S. Part ~V:
Part V. "Professional Services-" "Nursing Services" (4/1/85).

1/04/01

Lynda Olender, RN
Nurse Executive

FUNCTIONAL STATEMENT NURSE PRACTIONER III

I. Role Description: The Registered Nurse/Nurse Practitioner possesses advanced preparation, competencies and skills in assessing the physical and psychosocial status of individuals and is capable of identifying a broad spectrum of health-illness needs. Responsibilities include relatively independent functioning and ongoing collaboration with the health care team to enhance the delivery of care to outpatients in accordance with individual patient needs. . The individual also meets the competencies with the role and responsibilities and in accordance with the High Performance Development Model.

I. General Qualifications: The nurse in this role must meet all of the general requirements of Nurse III, specifically related to:

A.	Experience	----	Education
	1 Year	----	Doctoral degree in Nursing or Doctoral degree in related field and Baccalaureate degree or Master's degree in Nursing (NLN accredited program)
	2 Years	----	Master's degree in Nursing or Master's degree in related field and Baccalaureate degree in Nursing (NLN accredited program)
	3 Years	----	Baccalaureate degree in Nursing (NLN accredited program)
B.	Licensure		Active and current license to practice as a registered professional nurse from a state, territory or commonwealth of the USA.

C. Physical standards - As specified in DM&S Supplement, MP-5, Part II, Chapter 10.

III. Specific Qualifications:

A. Successful completion of a Master's degree program-Nurse Practitioner.
B. Nurse practitioner certification from a national nursing accreditation organization.

IV. Accountability: The Nurse Practitioner is administratively and professionally responsible to the Patient Care Center Director and clinically to the physician preceptor.

FUNCTIONS AND RESPONSIBILITIES:

Criteria	Outcome
A. Clinical Practice:	
1. Performs comprehensive health history, with particular attention to client's chief complaint.	1. A health history will be elicited from all clients who call with 3-4 exceptions.

2. Assesses severity, urgency and nature of client problem/concerns & arrives at a disposition in a timely manner.	2. Identified client problems/concerns will be addressed in a timely and appropriate manner with 3-4 exceptions.
3. Demonstrates ability to prioritize patient needs.	3. Demonstrates accurate prioritization of patient needs with 3-4 exceptions.
4. Assesses and interprets lab data, discriminating between normal and abnormal findings.	4. Contacts client and/or health care provider with findings, as appropriate with 3-4 exceptions.
5. Manages treatment modalities within guidelines set forth by established protocols for Program	5. Will function within established protocols for Program with 3-4 exceptions.
6. Advises, teaches & counsels patients & significant others regarding identified health care needs.	6. Provides effective patient/SO teaching with 3-4 exceptions.
7. Collaborates with other health care providers concerning necessary treatment &/or follow up.	7. Collaboration with other health care providers will promote continuity of care with 3-4 exceptions.
8. Maintains accurate documentation disposition including chief complaint, assessment, disposition & follow up, when indicated.	8. Documents findings, including & follow up with 3-4 exceptions.
9. Utilizes approved documentation format & guidelines on progress notes & encounter forms.	9. Approved format used with 3-4 exceptions.
10. Keeps PCCD/clinical manager &/or NAC advised of incidents, issues &/or problems.	10. Supervisory personnel kept abreast incidents, issues &/or problems with 3-4 exceptions.
B. Administrative:	
1. Demonstrates understanding of professional responsibility as extending beyond the Program, to include the goals established for Program and the Medical Center.	1. Meets professional obligations & conducts self in a manner which reflects favorably on the nursing profession and the VA.
2. Identifies needs & follows through in developing new policies, procedures, standards/guidelines/protocols, as needed.	2. Participates in ad hoc committees for the purpose of problem solving &/or updating policies, procedures, standards/ guidelines/protocols, as requested.

3. Participates in the development, implementation and evaluation of goals and for the Program	3. Meets regularly with the PCCD/ clinical manager or designee to discuss update goals for the Program
4. Functions as clinical manager for Program Program in the absence of the PCCD/clinical manager.	4. As assigned.
5. Guides & evaluates performance of other staff who perform nursing care.	5. Provides guidance & direction as indicated.
6. Participates in quality improvement activities related to Program.	6. Performs audits & initiates corrective action, as indicated.
7. Uses discretion & leads others in appropriately safeguarding confidential exceptions. Information.	7. Abides by hospital policy concerning patient confidentiality with 3-4
8. Participates in own performance appraisal through regular meetings with documentation PCCD/clinical manager to apprise her of activities.	8. Meets with PCCD/clinical manager at regular intervals. Relevant submitted, as requested.
C. Research:	
1. Bases nursing practice on current knowledge/technological advances &/or research findings.	1. Applies current concepts & findings from research &/or studies to current practice to improve patient care &/or resolve patient care delivery problems.
2. Participates in research related activities relevant to Program.	2. As indicated.
D. Education:	
1. Functions as a consultant/resource person for co-workers.	1. Assists co-workers in developing effective decision making and assessment skills.
2. Participates in orientation of new or lesser skilled staff to Program.	2. As indicated.
3. Reviews findings from literature to initiate change & act as a catalyst to improve quality patient care.	3. Integrates acquired knowledge into Program Program.
4. Maintains currency by completing all mandatory annual reviews.	4. All mandatory annual reviews will be completed in a timely fashion.

5. Identifies personal learning needs & assumes responsibility for personal/ professional growth.	5. Attends at least 2 educational programs per year.

CATEGORY II

A. Interpersonal Relationships:

1. Demonstrates ability to work effectively with others & to establish relationships with professional &/or other health related groups in the community.	1. With 1 exception.
2. Collaborates with other members of the multidisciplinary health care team.	2. Participates in hospital committees/ task force, as requested.
Recognizes complex situations that with patients & other staff members & intervenes using sound judgment, a professional attitude & appropriate channels.	3. Assumes liaison role with team to resolve conflict with 2-3 exceptions.
4. Fosters good public relations when understanding interpreting philosophy, policies, procedures &/or hospital-wide goals and objectives to all personnel, patients and the public.	4. Maintains tact, courtesy & when interacting with all levels of medical center personnel, patients and/or the lic public 2-3 exceptions.
5. Submits written reports that are concise, organized, pertinent & timely.	5. With 2-3 exceptions.

CATEGORY III

A. PROFESSIONAL CONTRIBUTIONS/ACCOMPLISHMENTS:

1. Makes significant contributions to the nursing profession through: a. publication OR b. membership on task force, inter or extramural committees OR c. consultation OR d. development of media OR e. scientific inquiry	1. As evidenced by submission of documentation.

CUSTOMER STANDARDS: SUCCESSFUL

Report of the

National Task Force on Quality Nurse Practitioner Education

Criteria for Evaluation

of

Nurse Practitioner Programs

1997

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American Nurses Association
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Division of Nursing, Bureau of Health Professions, Health Resources Services Administration, Health & Human Services (BHPr, HRSA, HHS)
Audrey Koertvelyessy, MSN, RN, FNP

Task Force members are committed to ensuring excellence and stability in nurse practitioner education. We have worked in a collegial manner and have sought to build consensus in our process. Our major strength has been the desire to prepare highly qualified, competent nurse practitioner graduates. We believe that this document advances that purpose.

Acknowledgements

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External Review Panel

Other major contributors to the development of the document were the individuals who served as reviewers of a first draft of the evaluation criteria. The Task Force thanks the external review panel for the additional insight and useful recommendations for improvement to the document.

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Pilot Study Participants

The Task Force recognizes the significant contribution of the participants in the pilot study. These programs expended considerable time to complete the self-study using the evaluation criteria, and the results of the pilot study helped to shape the final document.

Catholic University
Oregon Health Sciences University
Rush University
University of Pittsburgh

Other

This document was also made possible through the assistance provided by Kitty Werner, Administrative Director of the National Organization of Nurse Practitioner Faculties.

Endorsements

The following organizations have endorsed the riteria for Evaluation of Nurse Practitioner Programs found on page 7 of this document. The scope of endorsement is defined on page 4.

American Academy of Nurse Practitioners

American Academy of Nurse Practitioners Certification Program

American Association of Colleges of Nursing

American Association of Nurse Anesthetists

American Association of Occupational Health Nurses

American College Health Association

American College of Nurse Practitioners

American Nurses Association Congress of Nursing Practice

American Nurses Credentialing Center

American Psychiatric Nurses Association

Association of Women Health, Obstetric and Neonatal Nurses

National Alliance of Nurse Practitioners

National Association of Neonatal Nurses

National Association of Nurse Practitioners in Reproductive Health

National Association of Pediatric Nurse Associates and Practitioners

National Conference of Gerontological Nurse Practitioners

National Council of State Boards of Nursing

National Certification Corporation

National Gerontological Nursing Association

National Organization of Nurse Practitioner Faculties

National League for Nursing

National League for Nursing Accrediting Commission

Oncology Nursing Society

Background

For over 30 years, since the initiation of the first nurse practitioner (NP) program, nurse practitioner educators have been dedicated and vigilant in their efforts to maintain the quality of educational programs. Ensuring that graduates met established competency levels for designated specialty practice areas fostered quality control. Specialty associations, such the Association of Faculties of Pediatric Nurse Practitioner and Associate Programs (1996) and the National Association of Nurse Practitioners in Reproductive Health, in cooperation with the Association of Women Health, Obstetric & Neonatal Nurses (1996), defined the distinctive nature of their own specialties by establishing content, standards, and competencies for graduates. More generically, the National Organization of Nurse Practitioner Faculties (NONPF) delineated the fundamental knowledge, skills, and behaviors expected of new graduates (NONPF, 1995). During the initial development of NP programs, nurse educators were successful in maintaining the quality of programs through such strategies as limited number of students, low student-to-faculty ratios, and selective admission (Harper, 1996).

In recent years, many forces have created a need to reexamine nurse practitioner educational standards. External forces such as the shift from fee-for-service to managed care, critical policy reports (O'Neil, 1993; Pew Health Professions Commission, 1995; Shugars, O'Neil, & Badger, 1991), and increased scrutiny from state regulatory agencies created educational challenges for the preparation of nurse practitioners. Internal forces such as the rapid growth of nurse practitioner programs, a growing concern regarding NP program quality, the delineation of essential components of master education for advanced practice nurses (American Association of Colleges of Nursing [AACN], 1996), and a critical study of 176 National League for Nursing (NLN) accredited master programs (Burns et al., 1993) have stimulated efforts among professional organizations to develop consensus on criteria for evaluation of nurse practitioner programs.

The immediate impetus for the National Task Force on Quality Nurse Practitioner Education was the National Council of State Boards of Nursing (NCSBN) concern about variance among educational programs, including differences in the length of programs, curricula for nurse practitioner specialty areas of practice, number of required clinical hours, and faculty qualifications. In 1995, the NCSBN asserted that member state boards of nursing were reporting major difficulties licensing NPs due to these variances. A related issue for the NCSBN was the perception of certifying examinations (e.g., criteria to sit for examinations, legal defensibility, and psychometric soundness). The certifying organizations worked cooperatively and resolved these issues in an independent process. Three meetings were held prior to the formation of the National Task Force on Quality Nurse Practitioner Education:

- In June 1995, representatives of nursing organizations met in Chicago to discuss a proposal by the NCSBN to implement an entry-level core competency exam for all nurse practitioners. The consensus of the group was that another certifying exam was neither necessary nor appropriate but that there was a need to address NCSBN concerns and to determine the extent of variability among certification groups and NP educational programs.

- In July 1995, a second meeting was held in Keystone, Colorado, co-chaired by Janet Allan and Charlene Hanson from NONPF. The meeting brought together leaders from NCSBN, the four NP certifying groups (American Academy of Nurse Practitioners [AANP], American Nurses Credentialing Center [ANCC], National Certification Board of Pediatric Nurse Practitioners & Nurses [NCBPNP/N], and National Certification Corporation [NCC]), AACN, American Nurses Association (ANA), NLN, and other interested groups. The Keystone meeting generated two agreements: 1) the four NP certifying groups would work together to describe their processes, both similarities and differences, and prepare a written response for the August NCSBN meeting; and 2) NONPF, NLN, AACN, and specialty NP organizations would develop a model for program approval which could help to determine eligibility to sit for certifying exams.

- In November 1995, NONPF and NLN co-hosted a third meeting in Washington, DC, attended by representatives of NCSBN, the four certifying bodies, specialty groups,* AACN, ANA, NLN, and the Division of Nursing, BHPr, HRSA, HHS. This meeting resulted in the creation of a task force charged with developing standardized criteria for evaluation of NP programs.

Methodology

Using funding provided by the Division of Nursing, BHPr, HRSA, HHS and facilitated by NONPF, the Task Force conducted its work between November 1995 and July 1997 (see listing of Task Force members). The Task Force established goals to 1) develop standardized criteria for evaluation of NP programs, 2) pilot test the criteria as a self-study document, 3) develop an implementation/ dissemination plan for the criteria, and 4) seek endorsement of the criteria from participating organizations and other selected nursing organizations.

* American College of Nurse Practitioners (ACNP), Certification Council of Nurse Anesthetists (CCNA), National Alliance of Nurse Practitioners (NANP), National Association of Neonatal Nurses (NANN), National Association of Nurse Practitioners in Reproductive Health (NANPRH), National Association of Pediatric Nurse Associates and Practitioners (NAPNAP)

Task Force members met face-to-face, reviewed and edited draft documents through fax and mail, and held several conference calls. The group based its work on several documents, including *The Essentials of Master's Education for Advanced Practice Nursing* (AACN, 1996); *Advanced Nursing Practice: Curriculum Guidelines and Program Standards for Nurse Practitioner Education* (NONPF, 1995); *Philosophy, Conceptual Model, Terminal Competencies for the Education of Pediatric Nurse Practitioners* (Association of Faculties of PNP/A Programs, 1996); the accreditation materials of the National League for Nursing; ANN Accreditation Task Force Draft Documents for the Council of Neonatal Nurse Practitioner Program Accreditation (NANN, 1995); and program criteria and evaluation materials from specialty and certifying organizations. Through a process of dialogue, writing, review, and revision, the Task Force came to consensus initially on a draft document in July 1996. Task Force members recommended individuals for an external review panel who reviewed the first draft in August 1996. (See cknowledgements page for external review panel members.) The Task Force considered comments received from the review panel before completing a final draft document in November 1996.

Pilot Study

From late 1996 through early 1997, the Task Force implemented a pilot study to test the Criteria document and to obtain critical feedback about the program review process: specifically, how relevant the criteria were to NP education and how workable the review process and documents were for programs to utilize. Task Force members nominated institutions to participate in the pilot. Nominated programs met one or more of the following criteria: 1) new, 2) long-standing, 3) representing a newer specialty, 4) having multiple tracks, 5) having a single track, and/or 6) having other distinctive features. From these nominations, five institutions agreed to serve as test sites. Program directors and faculty from four of the five institutions completed the self-study. (See cknowledgements page for participants.)

A subcommittee, appointed by the Task Force, reviewed the pilot study material, analyzed programs evaluative comments about the content and process, and made recommendations to the Task Force for changes in the document. At the final meeting in March 1997, the Task Force made changes to strengthen the criteria based on the subcommittee analysis.

Implementation

At the March 1997 meeting, the Task Force agreed to publicly present the document as a report of the National Task Force on Quality Nurse Practitioner Education entitled riteria for Evaluation of Nurse Practitioner Programs. Remaining Division of Nursing funds would be used to publish and initially disseminate the document to

major groups and national stakeholders without cost to these groups. Additional copies will be made available to consumers at a cost that will cover printing, handling, and mailing. NONPF agreed to facilitate the publication and distribution of the document on behalf of the Task Force.

The work of the Task Force represents substantial progress toward the development of a model for evaluating the quality of nurse practitioner programs. As such, it becomes an important resource for several vital entities that play a role in the preparation, credentialing, and licensing of nurse practitioners, including:

- universities, institutions, and consultants who strive to build new nurse practitioner programs and maintain standards for current programs
- national accrediting bodies that accredit graduate programs
- state boards of nursing that license/certify nurse practitioners and monitor nurse practitioner programs
- certifying bodies that screen candidates for national certification exams
- specialty nurse practitioner organizations that approve, accredit, and/or monitor specialty nurse practitioner programs
- Division of Nursing, BHPr, HRSA, HHS and others that fund and monitor nurse practitioner programs and work force projects
- students who plan to attend nurse practitioner programs

Endorsement

At the final March 1997 meeting, the Task Force agreed to seek endorsement of the document from a broad list of nursing organizations (see list of organizations that have endorsed the document to date). Endorsement was defined as a general philosophical agreement with the intent and content of the document. The Task Force believes the document gains strength as it is endorsed by the nursing community.

Recommendations

These evaluation criteria are intended to be applicable to basic nurse practitioner programs. The Task Force agreed that these criteria would be used in conjunction with existing criteria for accreditation of graduate programs and criteria to evaluate

specialty nurse practitioner programs. With these considerations, the Task Force recommends that the criteria should be used as follows:

- to evaluate nurse practitioner programs. The intent of this Task Force is that this evaluation be combined with other accreditation/review processes.
- as a complement to specialty criteria used to evaluate specialty content of nurse practitioner programs
- to evaluate new programs being developed
- to assist in planning new nurse practitioner programs
- for self-study by existing nurse practitioner programs.

Further, the Task Force makes these recommendations:

- Nurse practitioners prepared in the specialty area of the program under review should be members of the evaluation/accreditation team(s).
- When an institution/university has multiple-track NP programs, separate evaluation of each track should be done.
- Evaluation should be conducted more frequently than the existing formal accreditation processes (e.g., every 3-5 years) to ensure program quality.

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Criteria for Evaluation of Nurse Practitioner Programs

INTRODUCTION

The purpose of this document is to provide a framework for the review of all nurse practitioner educational programs. Nurse practitioner programs shall be housed within a graduate program in Nursing accredited by a nationally recognized accrediting body for Nursing. If it is a new program, it is assumed that it will work to meet these criteria and become accredited as soon as eligible.

This document will focus on faculty, curriculum, evaluation, and clinical resources/ experiences for NP educational programs. Although not addressed in this document, the program shall meet nationally recognized accreditation standards basic to a graduate program, e.g., philosophy, mission, program outcomes, organization & administration, student admission & progression, dismissal and grievance policies, and faculty recruitment, appointment, and organization.

CRITERION I: ORGANIZATION AND ADMINISTRATION	ELABORATION AND DOCUMENTATION
A. The NP educational component is directly coordinated by a qualified NP faculty member.	A. Submit credentials* & CV of the individual responsible for the direct coordination of the NP educational component, including a copy of current national certification. Submit a letter from the individual identified as the program coordinator, describing his/her responsibilities to that program. See Criterion V for qualifications.
B. Institutional support ensures that NP faculty obtain and maintain currency in clinical practice.	B. Attach documents that provide evidence of institutional support of clinical practice (e.g., school bylaws, letter of support from the Dean, etc.)

* This term and others are defined in the lossary found on page 25.

CRITERION II: STUDENTS	ELABORATION AND DOCUMENTATION
A. Admission criteria specific to the NP program, if present, are established by NP program faculty prior to admission.	A. List any additional NP criteria for admission to the NP program.
B. Progression criteria specific to the NP program, if present, are established by faculty.	B. List progression criteria unique to the NP program.

CRITERION III: CURRICULUM	ELABORATION AND DOCUMENTATION
A. NP program faculty members must have ongoing input into the NP track development, evaluation, and revision. Curriculum meets the following criteria:	A. Document in faculty minutes of curiculum committee that NP faculty are designing/updating/revising the curriculum.
1) The curriculum is consistent with competencies of specific areas of NP practice (e.g., pediatric, family, geriatric, neonatal, etc.)	1) Submit Curriculum Overview Data Sheet (**Form #1**). Submit program of study for master and post-master (part-time and full-time). Submit Curriculum Plan identifying where content is presented (complete **Form #2** including course objectives, etc.).
2) The Curriculum Plan evidences appropriate course sequencing.	2) Document that basic course work (e.g., advanced pharmacology and pathophysiology) is completed prior to or concurrent with beginning clinical course work. (Submit program of study and prerequisites.)
3) The instructional track/major has a **minimum** of 500 supervised clinical hours overall. Practice	3) Complete Curriculum Overview Data Sheet (**Form #1**).

areas that provide care to **multiple groups** (e.g., FNP) or prepare NPs to function in multiple care settings (e.g., primary and tertiary care) may require more than 500 clinical hours

4) Post-master students shall successfully complete graduate didactic and clinical requirements of a master NP program through formal certificate or master level NP program in the desired area of practice. Post-master students are expected to master the same outcome criteria as master NP students.

4) See 1, 2, & 3 above.

a) Courses may be waived only if individual transcript indicates that the required NP course or its equivalent has already been taken.

a) Identify the specific process for evaluation of applicants for course waiver.

b) Non-NP post-master students are required to complete a **minimum** of 500 supervised clinical hours.

b) Identify how clinical hours in the specific area of practice are documented for each student. Attach a form used.

c) Special consideration should be given to NPs expanding into other NP specialties by allowing them to challenge selected courses and experiences; however, didactic and clinical experiences shall be sufficient to allow the student to master the outcome criterion of the new area of NP practice.

c) Identify a process for allowing NPs to challenge selected courses and experiences.

CRITERION IV: RESOURCES, FACILITIES, & SERVICES	ELABORATION AND DOCUMENTATION
A. University resources, facilities, and services support the development, management, and evaluation of the NP program/track.	A. Describe student and faculty numbers and the resources, facilities, and services of the institution that relate to the specific needs of the NP program/track.
1) Faculty resources support the teaching of the didactic component of the NP program/track.	1) Describe the faculty-student ratio and provide the rationale of how the ratio meets the educational needs of students.
2) Facilities and physical resources support the implementation of the NP program/track.	2) Describe resources (e.g., models for pelvic exams, clinical simulations, audiovisual aids, computer technology, and library resources) directly available to the NP program/track.
B. Clinical resources support NP educational experiences.	B. Provide a list of clinical facilities utilized specifically for the NP program/track and site-based clinical preceptors (type, degree, & certification). Include: Name of site; type of site (e.g., community health, private practice, rural clinic); & client characteristics. **Complete Form #3.**
1) The student has experience with patient populations specific to the area of practice and sufficient in number and variability to ensure that the student will meet core curriculum guidelines and program goals.	1) Provide the form used to document individual student clinical experiences.
2) The program provides evidence of contractual agreements with agencies or individuals used for students' clinical experiences.	2) Append a sample contractual agreement.

3) The faculty/student ratio is sufficient to insure adequate supervision and evaluation. Faculty supervision can be direct or indirect. Direct supervision occurs when NP program faculty function as on-site clinical preceptors. Indirect supervision has 3 components: To supplement the clinical preceptor teaching; to act as a liaison to a community agency; and to evaluate the student progress. Faculty in direct or indirect roles are responsible for all NP students in the clinical area. NP faculty have ultimate responsibility for the supervision & evaluation of NP students and for oversight of the clinical learning environment.

a) Supervision can be shared with other clinicians serving as clinical preceptors. Clinicians can serve as preceptors if they:

i) Are authorized by the state licensing entity to practice in the nurse practitioner role and/or nationally certified in their specialty with experience and expertise in the area of specialty. ...

3) On-site faculty/student ratio **at any time** should be 1:2 if faculty are not seeing their own clients and 1:1 if faculty are seeing their own clients. Indirect faculty supervision should be no more than 1:6 **per clinical session.** Certain practice areas (e.g., acute care) may use different ratios. Document educational rationale for any differences in these ratios and attach to **Form #1.** Specify the number of site visits to each student in a semester/quarter. **Complete Form #1.**

a) Preceptors complete **Form #3** with title, discipline, credentials, licensure/approval/recognition, education, years in role, site, type of clinical supervision (e.g., pediatrics, family, adult, women health), and # of students supervised.

i) Have a copy of current authorization to practice as a nurse practitioner and national certification on file.

ii) Have educational preparation appropriate to their area(s) of supervisory responsibility with clinical experience of at least one year.	ii) Complete **Form #3.**
iii) Maintain currency in clinical practice and continue to improve their expertise.	iii) See (i) above and complete **Form #3.**
b) Evaluation of students is **cumulative** and is based on clinical observation of student performance by NP faculty and the clinical preceptor assessment. These evaluation methods can be supplemented by student-faculty conferences, telephone, videotape sessions, written evaluations, and/or clinical simulations.	b) Append forms used for preceptor and faculty evaluation of the student clinical performance. Have completed evaluations available. Document the frequency and process used for evaluation of the student clinical performance. **Complete Form #1.**
4) Preceptors are oriented to program requirements and expectations for oversight and evaluation of NP students.	4) Describe preceptor orientation and methods used for maintaining ongoing contact with programs.

CRITERION V: FACULTY & FACULTY ORGANIZATION	**ELABORATION AND DOCUMENTATION**
A. Faculty responsible for professional NP role development or clinical management courses meet the following criteria:	A. Complete Nurse Practitioner Faculty Profile (**Form #4**).

1) Faculty have authorization by the state licensing entity to practice as nurse practitioners and are currently nationally certified as nurse practitioners.	1) Have copies of national NP certification, CVs, & state licensure/ approval/recognition as NP on file.
2) Faculty have preparation and current expertise appropriate to area(s) of teaching responsibility.	2) **Complete Form #4.**
3) Faculty have demonstrated history and current practice (may include direct clinical teaching) to ensure clinical competence in the area of teaching responsibility. If a faculty member has less than 800 hours of clinical practice as a graduate NP, he/she must be responsible to a fully qualified NP faculty member.	3) Explain the faculty development plan to become fully qualified if faculty have not already had 800 hours of clinical practice. Describe relationship with fully-qualified NP faculty and designate on **Form #4** who fills this role.
B. Non-NP faculty ***must*** have expertise in the area in which they are teaching.	B. Complete **Form #5.** Document credentials in the field of expertise of non-NP faculty.

CRITERION VI: EVALUATION	**ELABORATION AND DOCUMENTATION**
A. There is an evaluation plan for the NP program/track. This plan should include the following components:	A. Submit the evaluation plan used for the NP program/track. If the graduate evaluation plan from your institution is used for the NP program/track, submit a copy of that plan and document how it is applied to the NP program/track. Please include evaluation forms, feedback mechanism for change, documentation via minutes, and process of integration.

1) Course: Evaluate courses regularly (at least once per year).

2) Faculty: Evaluate faculty competence as teachers and clinicians regularly (at least once per year)

3) Students: Evaluate student progress through didactic and clinical components of NP program/track each semester/ quarter.

4) Clinical Sites/Preceptors: Evaluate clinical sites/preceptors regularly (at least once per year).

B. Formal curriculum evaluation should occur every 3-5 years.

C. There is an evaluation plan to measure outcomes of graduates at 1 year & 5 years post-graduation.

1) Document current course evaluation process.

2) Document how faculty are evaluated (e.g., current list of certifications, student evaluations, peer review).

3) Document methods used to evaluate students throughout the program (e.g., pass rates, case studies). Submit the evaluation forms used.

4) Document how clinical sites & preceptors are evaluated.

B. Document curricular decisions based upon evaluation.

C. Document the frequency of evaluation, certification pass rates, practice/ position in area of specialty, employer/practice satisfaction, graduate satisfaction with NP preparation & other outcome measures used.

Note: The Appendix includes sample evaluation forms. These samples are provided to offer guidance but are not intended to restrict the development of evaluation forms unique to the institution.

Curriculum Overview Data Sheet Form # 1

The purpose of this form is to provide a complete overview of the program/track.

I. Credit System

1 credit hour of didactic = _____ clock hours
1 credit hour of clinical = _____ clock hours of clinical practice

II. Instruction System

1 semester = _____ weeks
1 quarter = _____ weeks

III. Estimated Total Hours - (Entire program)

Total number of graduate-core didactic clock hours: _____
Total number of NP-content didactic clock hours: _____
Total number of clinical/preceptor clock hours _____
(not including laboratory)

IV. List all national guidelines used to develop the curriculum.

_____

_____

V. Clinical Oversight of NP Students

Ratio of NP faculty to clinical students:* _____
Ratio of preceptors to clinical students:* _____
Number of site visits to student per semester: _____ per quarter: _____

List other methods to maintain contact with preceptors, adjunct faculty, and students in clinical sites. Specify type of method and frequency used.

_____

_____

VI. Describe or attach documentation that verifies student evaluation and progression:

_____

_____

* Document educational rationale for differences in ratios from standards.

Curriculum Plan for NP Program Form #2

Indicate Specialty/Practice Area of NP Program: _____	
GRADUATE CORE COURSES	**Content found in: (List course # and title)****
Research	
Theoretical Foundations of Nursing Pract.	
Organizational Theory	
Ethics	
Human Diversity	
Health Policy	
Health Delivery System	
Health Care Financing	
NP PROGRAM CONTENT	
Advanced Health Assessment *	
Advanced Pharmacology *	
Advanced Physiology & Pathophysiology*	
Health Promotion & Disease Prevention	
Community-Based Practice	
Professional Role Development	
Family Theory	
Growth Development	
Clinical Decision-Making	
LIST OTHER REQUIRED COURSES	
Professional Role Development Within Practice Area	
Diagnosis & Management of Health & Illness (List all courses)	

* Should be separate courses. (These courses constitute the APN core.)

** Submit course description, objectives, required readings, evaluation methods, topical outline, and one unit for all NP courses & indicate where content related to specialty practice is found.

Clinical Sites/Preceptors*

Form # 3

Name and Address of Site: _____

_____

Type of Site (rural clinic, private practice, public health)	Characteristics of Clients (gender, age, ethnicity)	Experiences Available

Name and Credentials of Preceptor(s) at each site	Practice Specialty	Certification *Specify: Certifying body, # (as appropriate), & exp date*	Years of Practice in Specialty Area	Previously Precepted NP students (Y/N)	*State Licensure/ Approval/ Recognition** Specify: # & exp. date*
1.					
2.					
3.					
4.					
5.					
6.					

* Separate form should be completed for each clinical site used.

** Copy on file as allowed.

Nurse Practitioner Faculty Profile

Form #4

All NP Faculty Complete This Form

Attach CV of NP who directs the track or program. CVs or resumés for other faculty available on request

Name: _____ Credentials: _____ State License/Approval/Recognition # RN: _____
APN: _____

Certification (List certification body & exp. date): _____

Attach a copy of current national certification

Academic NP Program Completed: _____ Graduation Date: _____ NP Track/Major: _____

Faculty Appointment: % of FTE in NP track: _____ % of Time in School of Nursing: _____

Clinical Teaching Responsibilities: (Include past academic year and current responsibilities)

Clinical Course	# Students	Clinical Sites	Dates

Didactic Teaching Responsibilities: (Include past academic year and current responsibilities)

Didactic Course	# Students	Dates

List Other Faculty Responsibilities: (e.g. other teaching, committee work, thesis/dissertation supervision, research, etc.)

_____

_____

Continued on reverse side

NP Practice Experience: (List last 5 years with current practice first)

_____

_____

_____

_____

_____

_____

_____

_____

Are you practicing now? ____ Yes ____ No

If yes, describe the following: Setting _____

Patient Population _____

Practice _____

Approximate current # of hours per week/month: _____

Approximate # hours last year per week/month: _____

If you have less than 800 hours of clinical practice time as a graduate NP, who is your faculty supervisor/mentor?

_____

NON-NP Faculty*

Form # 5

Complete form

Name/Credentials	Title/Position	Area of Specialty	Course Content Responsibility	Other Faculty Responsibilities

* Faculty having teaching responsibility for any courses required for graduation from a Master's NP program. This includes full-time or part-time faculty from nursing and other disciplines and major guest lecturers only.

GLOSSARY

APN (Advanced Practice Nursing) - essential curriculum content for all master degree nursing students prepared to provide direct client/patient care at an advanced level.

Assigned Clinical Session - faculty assignment to supervise student clinical experience over an academic semester or quarter.

Clinical Hours - are those hours in which direct clinical care is provided to individuals and families in the specific area of NP practice (e.g., pediatrics, etc.).

Clinical Observation - observation of the student interacting face-to-face with a real patient in a clinical setting.

Credentials - titles or degrees held by individual, indicates level of education, certification, or licensure (e.g., MSN, CPNP, RN).

Curriculum - The overall didactic and clinical components that make up courses for the program of study.

Direct Client Care - involves assessment, diagnosis, treatment, and evaluation of a real client/patient; not simulated situations.

Direct Clinical Teaching - teaching that occurs face-to-face with the student in one-on-one direct client/patient care situations (e.g., demonstration, example, role modeling, coaching).

Evaluation of Curriculum - The review process that is used yearly to review and update courses based on student evaluations and changes in health care; the process serves to ensure accuracy and currency of learning experiences. Revision of curriculum takes place every 3-5 years and is a more in-depth review, leading to substantive curricular changes as deemed necessary.

Graduate Core - foundational curriculum content deemed essential for all students who pursue a master degree in Nursing regardless of specialty or functional focus.

Master's NP Program - basic nurse-practitioner program in Nursing to prepare baccalaureate-educated nurses at the master level.

AN NP EXCLUSIVE

Annual Legislative Update

HOW EACH STATE STANDS ON LEGISLATIVE ISSUES AFFECTING ADVANCED NURSING PRACTICE

Linda Pearson, RN, FNP, MSN

The Nurse Practitioner, a resource for nurse practitioners (NPs) and advanced practice nurses (APNs) for more than a quarter century, is proud to present the thirteenth Annual Legislative Update on issues affecting APNs. Compiled each year from the generous contributions of more than 100 Boards of Nursing, State Nursing Associations, and NP organization officials, this article continues to be broadly cited and we hope, a useful reference for APNs (NPs, clinical nurse specialists [CNSs], certified nurse midwives [CNM], and registered nurse anesthetists [RNA]). Nursing leaders, health care professionals, national and state legislators, and the media can use the Annual Update to identify trends in APN practice status.

APN legal authority to practice has expanded each year, and this continues to benefit health care for our nation's citizens. APNs continue to gain autonomy through legislatively sanctioned diagnosing, prescribing, and reimbursement authority. The following pages provide a regulatory and statutory summary of APN practice by state. New this year are Web sites for each state, which are included when available. Table 1 presents a summary of legislation regarding NP legal scope of practice, except prescriptive authority; Table 2 provides a summary of NP prescriptive and dispensing authority; and Table 3 provides an estimate of the number of APNs in each state. Some officials were able to provide an official count of APNs in their state; others provided their best estimates.

APNs Who Work Together Show Their Power

Throughout the past 3 decades, APNs have struggled against organized medicine and others who wanted to require undue limitations and/or physician-supervised APN practice. Countless studies have documented that APNs provide safe, cost-effective, and patient-desired health care.

This year's Annual Update documents the continuing legislative and regulatory success of APNs. In the past year, three states have expanded legal authority for APNs (Kansas, Kentucky, and Wisconsin), and two states have expanded some aspect of APN legal authority (Illinois and Mississippi) (see Table 1).

APNs have also made legislative progress in the reimbursement area. Seven states have improved some aspect of APN reimbursement (Alaska, California, Idaho, Iowa, Massachusetts, Texas, and Washington). Six states have expanded APN prescriptive authority (Illinois, Ohio, Pennsylvania, South Carolina, Virginia, and Washington) in comparison to last year, and five other states expanded some aspect of APN prescriptive authority (Kansas, Maine, New Hampshire, New Jersey, and South Dakota).

Perhaps the most stunning success has come in allowing the dispensing of drug samples. For the first time since the journal's survey began, APNs in all 50 states (and Washington, D.C.) have the authority to receive and/or dispense drug samples according to the authorized scope of practice, statute, or rules and regulations. With the continuing yearly march toward fair and equitable practice statutes and regula-

CONTINUED ON P. 11

CONTINUED FROM P. 7

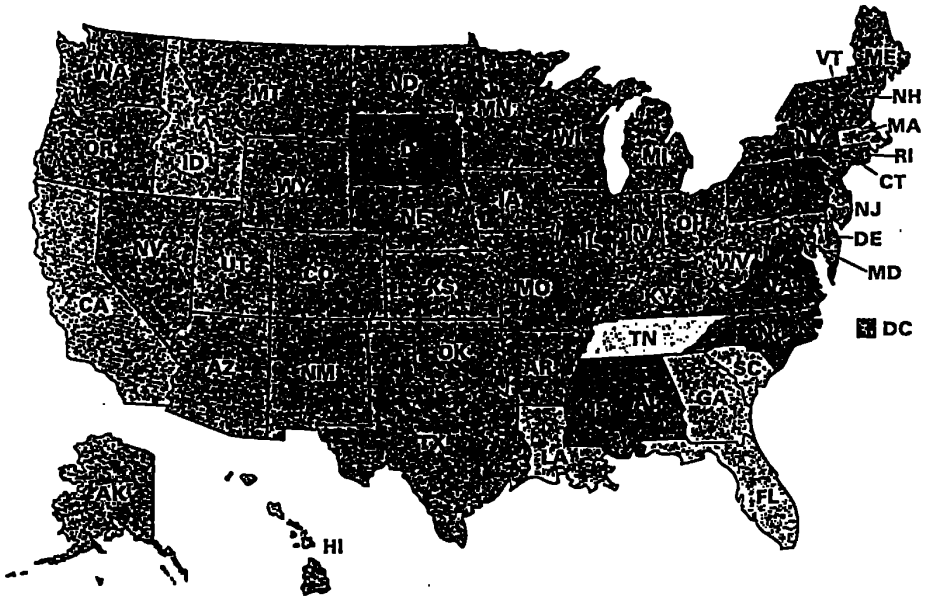
tions, APNs' authority to practice is slowly starting to match their ability. In contrast, physicians' authority to practice is often broader than their ability. While fairness may not always prevail, APNs must continue their diligence in carving out their proper legislative authority from the "health care pie." The journal will continue to report on this progress as we have for the past 13 years.

A Shift of Power and Influence

More than 25 years ago, author Rick Carlson opined that the medical profession would eventually become obsolete, partly because of the insistence on medical self-regulation, the rise of consumerism, and the corporatization of health care delivery.[1] Add to those factors the current realities of simple diagnostic technology, increased medical information availability, and consumer involvement, and one can readily see why physicians may feel threatened.

Those who want to return to the time when physicians undisputedly controlled health care are having great difficulty with today's reality. The physician's role and influence in the

Summary of Advanced Practice Nurse (APN) Legislation: Legal Authority for Scope of Practice*



- States with nurse practitioner† title protection; the board of nursing has sole authority in scope of practice with no statutory or regulatory requirements for physician collaboration, direction, or supervision: AK, AR, AZ, CO, DC, HI, IA, KS, KY, ME, MI, MT, ND, NH, NJ, NM, OK, OR, RI, TX, UT, WA, WV, WY
- States with nurse practitioner† title protection; the board of nursing has sole authority in scope of practice, but scope of practice has a requirement for physician collaboration: CT, DE, IL, IN, OH, MD, MN, MO, NE‡, NV, NY, VT, WI
- States with nurse practitioner† title protection; the board of nursing has sole authority in scope of practice, but scope of practice has a requirement for physician supervision: CA, FL, GA, ID, LA, MA, SC
- States with nurse practitioner† title protection, but the scope of practice is authorized by the board of nursing and the board of medicine: AL, MS, NC, PA, SD, VA
- State without nurse practitioner† title protection where APNs function under a broad nurse practice act: TN

KEY: * This table provides a state-by-state summary of the degree of independence for all aspects of NP scope of practice including diagnosing and treating (except prescribing). See Table 2 for a state-by-state analysis of the degree of independence for the prescriptive authority aspect of NP scope of practice.
† The information may apply to other APNs (clinical nurse specialists, nurse midwives, and nurse anesthetists). See State Survey for details.
‡ States with APRN board. [Washington, D.C. is included as a state in this table.]

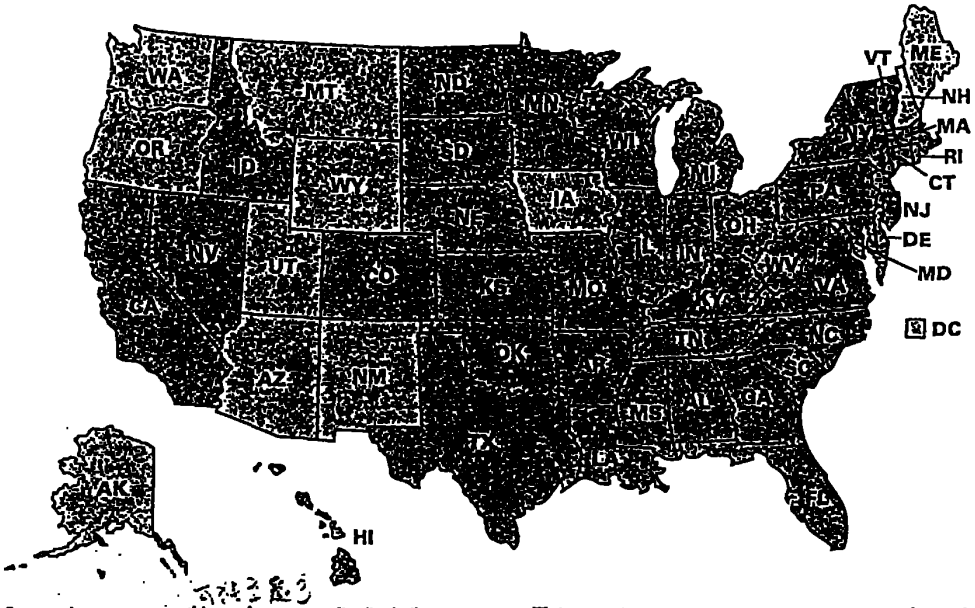
health care industry are changing, as evidenced by a number of factors:

Managed care plans will continue to use quality and financial incentives and indicators, profiling, and feedback to persuade physicians to practice in specific ways. Thus, physicians are increasingly subject to the rules of a hierarchical structure that is out of their control.

A new Internet-based system will soon allow patients to rate physicians on-line. The Foundation for Accountability (FAACT), a nonprofit coalition of corporations, government agencies, and consumer groups, has designed a way to help patients evaluate and influence physicians.[2] The FAACT program provides information on physician quality of care; whether physicians are using evidence-based standards; whether physicians are accessible, have good communication skills, and are trustworthy; and whether patients believe their symptoms are being well managed.

In the past, physicians had a sense of patient owner-

Summary of Advanced Practice Nurse (APN) Legislation: Prescriptive Authority*,†



▨ States where nurse practitioners† can prescribe (including controlled substances) independent of any required physician involvement in prescriptive authority: AK, AZ, DC, IA, ME, MT, NH, NM, OR, UT‡, WA, WY

▩ States where nurse practitioners† can prescribe (including controlled substances) with some degree of physician involvement or delegation of prescription writing: AR, CA, CO, CT, DE, GA‖, HI, ID, IL, IN, KS, MA, MD, MI, MN, NC, ND, NE, NJ, NY, OH, OK, PA, RI, SC‡, SD, TN, VA, VT, WI, WV

■ States where nurse practitioners† can prescribe (excluding controlled substances) with some degree of physician involvement or delegation of prescription writing: AL, FL, KY, LA, MO, MS, NV, TX

□ States where nurse practitioners† have no statutory or regulatory prescribing authority: (None)

[Washington, D.C. is included as a state in this table.]

KEY: * This table provides a state-by-state analysis of the degree of independence for the prescriptive authority aspect of NP scope of practice. For analysis of the degree of independence for other aspects of NP scope of practice (including diagnosing and treating) see Table 1.

† In ALL states, nurse practitioners† have the authority to receive and/or dispense drug samples according to the authorized scope of practice, statute, or rules and regulations.

‡ The information may apply to other APNs (clinical nurse specialists, nurse midwives, and nurse anesthetists). See State Survey for details.

§ Schedule IV and/or V controlled substances only.

‖ State does not have written prescribing or dispensing authority; falls under delegated medical authority.

ship because possession of the medical records was nearly synonymous with possession of the patient. Contrary to those relatively autonomous and simpler times, in today's world, patients have more to say about their medical records, especially as more Internet-based tools allow them to track, create, and edit their own health information. Empowered through information, patients, who view themselves as health care consumers, are more willing to challenge "doctors' orders."

After deliberating for 2 years, and in spite of intense lobbying by the American Medical Association (AMA), in March 2000 the Health Care Financing Administration (HCFA) announced that it would remove the federal requirement that nurse anesthetists must be supervised by physicians when administering anesthesia to Medicare patients.

■ Further Attempts to Subjugate APNs

Some physicians continue the fight against NPs. For example, the AMA has an intensive on-line advocacy campaign to help medical societies defeat state and national legislation that increases the professional autonomy of APNs and other providers. The AMA's goal is to kill legislation that does not allow ultimate physician control. As part of this plan, the AMA continually attempts to reinterpret the term *collaboration* as implying a supervisory requirement. In many states, the AMA has introduced physician antitrust legislation that includes provisions for physician control of patient care plan decisions.

CAN NPS DELIVER the same quality care as physicians? The answer is a resounding yes. Where are the evidence-based studies that demonstrate that extra years in cadaver and biology labs translate to better physician-delivered primary care? NPs must stand tall and debate those who try to imply that NPs are less qualified to provide safe care.

As part of the AMA's plan to sustain physician control over other providers, it submitted a "Citizen's Petition" to the HCFA in July 2000. Signed by 49 physician specialty organizations, the petition charges that the HCFA "has failed to uphold the intent of Congress and its duty to taxpayers and Medicare beneficiaries by encouraging advanced practice registered nurses (APRNs) to practice beyond legally authorized safeguards." The AMA petition insists that NPs and CNSs should be forced to work in "collaboration" with physicians, in addition to the individual state practice act requirements, so as to control Medicare payments.

■ Goals for Furthering APN Practice

Although countless studies have confirmed the safety, cost efficiency, and high level of patient satisfaction associated with NP care, four recurrent themes continue as national barriers to NP practice: (1) a lack of direct reimbursement, (2) prescriptive authority restrictions, (3) an inability to obtain hospital privileges, and (4) scope of practice limitations. In response to these barriers, APNs must continue to fight arbitrary, unnecessary restrictions on their practice. Often, the resistance will require out-of-the-box thinking. The following paragraphs provide examples of attitudes, goals, and debate positions that may strengthen APN positions. The Annapolis Think Tank, a selection of NP leaders convened by Carolyn Buppert, CRNP, JD, in March 2000, and many national APN organizations are to be commended for their intensive work in fighting unnecessary restrictions and barriers against APN practice.

An important article that discusses the struggle of APNs was recently published in the *Harvard Business Review*.[3] The authors believe that the health care industry is convoluted, expensive, and often deeply dissatisfying to consumers. They compare the health care industry with other businesses that have faced a similar crisis. The authors note that, because physicians and managed care organizations use flawed logic to protect the status quo, they are conducting a futile battle that will ultimately thwart economic progress. Reframing the battle for legislators and other health care industry decision makers may help speed barrier removal.

APN leaders must focus their efforts on how to achieve national standards for health care workforce regulation, education, and credentialing rather than depending on a state-by-state patchwork approach that requires untold amounts of energy to combat organized medicine's attempt to diminish APN autonomy. For example, the Pew Commission has recommended that Congress establish a policy advisory board that would develop national scopes of practice for legislature implementation. APNs should continue to support efforts that examine ways to achieve a uniform national standard. A uniform practice act would sanction APNs functioning within their area of professionally credentialed or certified practice rather than leaving the scope of practice open to political influences.

Many current players in the health care industry may not be aware of fundamental nursing principles that underlie APN practice. Physicians and other health care professionals have begun to adopt these principles as their "new philosophies." Depending on the individuals and the situation, it is likely that many physicians are encroaching on nursing practice while they claim that APNs are encroaching on physician practice. This merging of the roles ideally allows for individual practitioners to utilize their strengths in cooperation and collaboration with other team members for the patient's benefit. Those who advocate a predesignation of the physician as ultimate supervisor in all settings are opposing what is best for patients. APNs must espouse the nursing principles underlying their practice and eloquently advocate team cooperation to health care business leaders and the public.

Physicians commonly state, "Considering all the training and education physicians receive, there should be no question about who is more qualified to deliver primary care." Can NPs deliver the same quality care as physicians? The answer is

Estimate of APN Population*

	Total Number of Advanced Practice Nurses	Nurse Practitioners	Clinical Nurse Specialists	Certified Nurse Midwives	Certified Registered Nurse Anesthetists
Alabama	2,366	1,100	120	46	1,100
Alaska	584§	422	†	50	112
Arizona	2,258	1,893	36	171	198
Arkansas	815	415	80	21	299
California	14,071	10,126	1,400	1,057	1,488
Colorado	3,217	1,938	780	201	298
Connecticut	2,079	872	580	143	484
Delaware	564	315	74	21	154
District of Columbia	1,026	679	30	94	223
Florida	8,232§	5,525	†	513	2,194
Georgia	4,251	2,315	303	325	1,308
Hawaii	685	400	150	35	100
Idaho	580	298	15	17	250
Illinois	2,375	1,000	175	300	900
Indiana	862	630	30	40	162
Iowa	1,214	707	104	54	349
Kansas	1,797	961	247	39	550
Kentucky	2,005	989	120	100	796
Louisiana	2,302	686	578	39	999
Maine	1,712	1,189	138	61	324
Maryland	2,219	1,472	308	134	305
Massachusetts	6,328	4,165	921	408	834
Michigan	4,106§	1,974	†	255	1,877
Minnesota	1,353	658	118	65	512
Mississippi	1,273§	823	†	33	417
Missouri	2,667	2,053	416	81	117
Montana	546	323	30	41	152
Nebraska	738§	342	†	18	378
Nevada	490§	400	†	15	75
New Hampshire	1,064	514	100	300	150
New Jersey	3,908	1,600	1,600	250	456
New Mexico	965	522	118	130	195
New York	10,704§	8,948	†	856	900
North Carolina	4,835	1,665	1,136	166	1,868
North Dakota	421	188	30	9	194
Ohio	5,585	2,020	1,583	258	1,726
Oklahoma	1,002	462	129	33	378
Oregon	2,180	1,500	210	200	270
Pennsylvania	9,926	4,858	2,500	260	2,308
Rhode Island	632	386	30	55	161
South Carolina	2,457	603	54	70	509
South Dakota	609	240	88	15	266
Tennessee	3,958	2,102	480	139	1,237
Texas	7,857	3,666	1,659	334	2,198
Utah	1,158	792	125	95	146
Vermont	392	254	48	40	50
Virginia	4,506	2,676	441	175	1,214
Washington	2,981§	2,254	†	253	474
West Virginia	1,175	439	88	53	595
Wisconsin	1,388	689	58	311	330
Wyoming	159	55	23	21	60
Total	139,394	81,103	17,253	8,398	32,640

* Numbers provided by state authorities. Numbers are estimates only; the number of APNs identified in each state is based on the latest data, which was 1999 information in some states; the numbers may include duplicate licenses within one state or multistate licensure; and the numbers reflect state APN recognition and do not reflect employment status (i.e., part time, retired, unemployed, working in another field).

† CNSs not specialty-identified, not officially tracked by state, or estimate not available.

§ Total does not include CNSs.

a resounding yes. NPs can now respond to this question by quoting solid research. A recent study compared NPs with privileges to prescribe, consult, and refer with physicians.[4] A methodologically sound random assignment of 1,316 patients to either NPs or physicians found no significant differences in patients' health status or in health service utilization. Where are the evidence-based studies that demonstrate that extra years in cadaver and biology labs translate to better physician-delivered primary care? NPs must stand tall and debate those who try to imply that NPs are less qualified to provide safe care.

Managed care is rapidly becoming the dominant financial and delivery force for our health care industry. The preventive orientation of NPs is custom made for managed care. APNs must insist that credit be given where credit is due: There is no question that HMOs and managed care organizations are saving money when they hire APNs. Surveys must be designed that will help demonstrate to employers and insurers that patients desire care from APNs. APNs, collectively and individually, must continue to inform managed care network managers of policy barriers that limit their practice and utilization.

Artificial barriers have been erected against APNs to protect physician economic interests. One significant barrier to truthful economic statistics about APNs is the phenomenon of hiding APN productivity and prescription data. Group practices and pharmacies still have little incentive to track care provided by APNs. For example, in a capitated practice, a physician receives the same amount of capitation payments regardless of who sees the patient; many APNs are not receiving fair credit or compensation and are being exploited as invisible providers. When it is volume that counts, as is the case with HMOs, APNs must insist that accountants find a way to account for APN care for patients with difficult, time-consuming conditions. Typically, when an NP's patient volume decreases, he or she receives no credit even when, in reality, the cost savings go up. APNs must continually insist that they be recognized separately as providers and prescribers instead of allowing their productivities and prescribing habits to be hidden.

APNs must utilize the legislative and insurance regulatory process to challenge discriminatory anticompetitive practices of insurance carriers who refuse to reimburse APN practice. Nondiscriminatory primary care provider language is needed that mandates nonexclusion of all qualified licensed providers. For example, "primary care provider," which includes both APNs and physicians, means a provider who has responsibility in providing initial and primary care to patients, in coordinating/maintaining patient care continuity, and in initiating specialist referrals.

Conclusion

Truly independent providers do not exist. Different types of science-based clinicians use intricately interconnected care to help solve patient problems. The age of medicine when physicians held all the power and prestige is behind us. Organized physician groups must rethink the perspective that they are the only appropriate scientifically based clinicians to supervise patient needs. Instead, all the major players in the health care industry must move toward a system where the clinician's skill level and expertise are matched appropriately to the patient problem. The challenge for APNs will be to find the best and most expedient way to be granted full credit and recognition from insurers, employers, and consumers for their evidence-based, financially responsible, community-oriented, and patient-centered care.

ACKNOWLEDGMENT

The author thanks the following people from every state for their time, friendship, and invaluable information and perspectives: the board of nursing and state nursing associations' executive directors/legislative consultants, and chairpersons from NP special interest groups and associations. Although every attempt has been made to present the most current information possible, the Journal welcomes feedback and will print validated corrections or updates.

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Abbreviations Used in the Legislative Update

ANP	Advanced Nurse Practitioner	CRNP	Certified Registered Nurse Practitioner
APN	Advanced Practice Nurse	CS	Clinical Specialist
APRN	Advanced Practice Registered Nurse	FNP	Family Nurse Practitioner
ARNP	Advanced Registered Nurse Practitioner	GNP	Geriatric Nurse Practitioner
BC/BS	Blue Cross/Blue Shield	JPC	Joint Practice Committee
BME	Board of Medical Examiners	LVN	Licensed Vocational Nurse
BNE	Board of Nurse Examiners	NA	Nurse Anesthetist
BOM	Board of Medicine	NPA	Nurse Practice Act
BOME	Board of Medical Examiners	PCP	Primary Care Provider
BON	Board of Nursing	PNP	Pediatric Nurse Practitioner
BOP	Board of Pharmacy	PPO	Preferred Provider Organization
CFNP	Certified Family Nurse Practitioner	PT	Physical Therapist
CNM	Certified Nurse Midwife	OT	Occupational Therapist
CNP	Certified Nurse Practitioner	RNA	Registered Nurse Anesthetist
CNS	Clinical Nurse Specialist	RNP	Registered Nurse Practitioner
CPNP	Certified Pediatric Nurse Practitioner	R&R	Rules and Regulations
CRNA	Certified Registered Nurse Anesthetist	Rx	Prescription/Prescriptive
CRNM	Certified Registered Nurse Midwife	SOP	Scope of Practice
		WHNP	Women's Health Nurse Practitioner

Alabama

www.abn.state.al.us

Legal Authority

Public Law 95-263 designates the BON as the sole state authority to establish the qualifications and certification requirements through R&R for APNs (i.e., CRNPs, CNMs, CRNAs, and CNSs). The law also states that the BON and BOME shall regulate through R&R the collaborative practice of physicians and CRNPs and CNMs, and require CRNPs and CNMs to practice with protocols approved by the BON and BOME. The protocol must include a formulary of drugs, treatments, tests and procedures, a predetermined plan for emergency services, a process for referral, a mechanism for quality analysis, and a written plan for review of medical records. The protocol must be signed by the collaborating physician and any NPs practicing with those physicians. "The term collaboration does not require direct, on-site supervision of the activities of a CRNP or CNM by the collaborating physician. The term does require such professional oversight and direction as may be required by the R&R and BOME."

The joint committee (BON and BOME) does not regulate CNSs and CRNAs. CRNAs and CNSs (graduate degree required) "may not: (1) perform delegated medical acts or engage in collaborative practice as described in the act; (2) perform any of the functions of a CRNP or CNM as described in this act and the regulations adopted under this act, whether or not performed within a collaborative practice relationship; and (3) prescribe drugs of any type."

Reimbursement

The state nursing association is working with the Alabama State Employees Insurance Benefits board to sponsor a pilot project with BC/BS. The pilot project studies quality of care and cost-effective issues on NPs and CNMs. There are no legislative restrictions against APNs on managed care panels. The Alabama Medicaid Agency reimburses NPs enrolled in the Alabama Medicaid Nurse Practitioner Program. Alabama Medicaid does not reimburse for services provided in a hospital or emergency department. NPs are reimbursed through the Kids First Program. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

The 1995 act authorized a BON and BOM joint committee (composed of one CNM, one CRNP, one RN, and three MDs) to adopt R&R governing the collaborative relationship between physicians and CRNPs and CNMs and the prescription of legend (noncontrolled) drugs. The R&R (effective July 1, 1996) specify a 2:1 ratio (CRNP:MD) and a 3:1 ratio (CNM:MD or for a combination of CRNP and CNM:MD). Exemptions to this specification include public health employees and practices in place before R&R took effect. Applications for exemptions of the ratio are considered by the Joint Committee. The BON and BOM shall approve the protocols and formulary of legend drugs that may be prescribed by authorized CRNPs and CNMs. Authorization is tied to the collaborative agreement; if the CRNP or CNM changes physicians, then they must reapply. The CRNP or CNM is issued a number by the BON; the Rx pad must have the following information printed on it: (1) the MD name/address etc.; and (2) the CRNP or CNM name and his or her Rx number.

Dispensing is allowed as specified under administrative code 610-x-9-16(2)(6), which states that CRNPs and CNMs may "prescribe, administer and provide therapeutic tests...and drugs" with an approved formulary.

Alaska

www.dced.state.ak.us/occ/pnur.htm

Legal Authority

NPs have statutory authority to practice as ANPs, which include NPs and CNMs. CRNAs have their own R&R. CNSs are not licensed separately from their RN license. The statutory definition of an ANP is an RN who, because of specialized education and experience, is certified to perform acts of medical diagnosis and prescription and dispensing of medical, therapeutic, or corrective measures under regulations adopted by the BON. ANPs must have a plan for consultation and referral for their patients, but no physician relationship is required. The Alaska Native Hospital (federal) allows CNMs to admit independently; the other hospitals require an MD preceptor. Nothing in the law precludes admitting privileges for ANPs. Continuing education requirements for ANPs are 30 CEUs (eight of these must be pharmacology hours) every 2 years.

Reimbursement

There is no managed care in the state; all health care is provided on a fee-for-service basis. A nondiscriminatory clause in the insurance law allows for third-party reimbursement to NPs. However, the BC/BS (federal plan) charges patients a $200 deductible to see NPs and no deductible to see MDs. The R&R allowing CNMs, PNPs, and FNPs to receive Medicaid reimbursement were implemented in 1992; NPs receive 80% of the physician's payment. A revision is pending to reimburse all APNs under Medicare. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Authorized NPs have independent Rx authority, including Schedules II-V controlled substances. A law permitting CRNAs to prescribe was finalized in August 1992. ANPs receive their own DEA registration. In April 1993, the law was amended to allow ANPs to dispense drugs under regulations adopted by the BON.

Arizona

www.azboardofnursing.org

Legal Authority

A definition for RNPs is in the NPA statute; corresponding R&R outline their SOP. RNPs include NPs and CNMs. RNPs (statutory defined SOP) (1) examine patients and establish medical diagnosis; (2) admit patients to health care facilities; (3) order, perform, and interpret laboratory, radiographic, and other diagnostic tests; (4) identify, develop, implement, and evaluate a plan of care; (5) prescribe and dispense medications; and (6) refer to and consult with appropriate health care providers.

In 1995, separate legislation was passed to allow BON certification of CNSs. The rules contain criteria for state certification including a requirement that CNSs must have at least a master's degree in nursing or a master's degree with a specialization in a clinical area of nursing practice. CNSs are not allowed to prescribe.

Reimbursement

RNPs and other certified registered nurses receive third-party reimbursement. Enabling statute is in the Department of Insurance statutes. There is no Medicaid; the Arizona Health Care Cost Containment System (AHCCCS) contracts with primary care providers on a capitated basis. Some NPs have directly contracted with AHCCCS as primary care providers. AHCCCS reimbursement for NPs is 60% of the established physician rate. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa/gov/medicare/enrollment/contacts/.

Prescriptive Authority

RNPs and CRNAs (effective 12/99) have full Rx and dispensing authority on application and fulfillment of criteria established by the BON. The enabling statute allowing RNPs to prescribe is in the pharmacy statute, with corresponding R&R in the NPA. As of 12/99 no documentation is required of CEUs in pharmacology on a yearly basis for renewal of Rx and dispensing authority. RNPs are provided their own DEA number and may prescribe Schedules II-V controlled substances. Drugs, other than controlled substances, may be refilled up to 1 year.

Arkansas

www.state.ar.us/nurse

Legal Authority

The NPA was revised in 1995 to provide second licensure by the BON for APNs who are nationally certified in one of four categories: CNM, CNS, CRNA, or NP. R&R provide for SOP as defined by national certifying body. A consulting physician is required for CNMs only; CNMs must have an agreement with a consulting physician if providing intrapartum care. NPs not nationally certified may qualify for licensure as an RNP and practice under physician direction/protocol. Since November 30,2000, new RNP licenses are no longer be issued.

The NPA revision also provided for the establishment of an advisory committee (nursing, medicine, pharmacy) to advise the BON on Rx authority issues. All programs preparing APNs within the state must be approved by the BON.

Act 1065 of 1997 redefined the CRNA SOP to be the administration of anesthetics under the supervision of, but not necessarily in the presence of, an MD or DDS; CRNAs may order RNs to administer drugs pre- and postoperatively for any procedure that has been/will be provided. If the hospital/institution authorizes the CRNA to act as its agent under its DEA number, the orders do not have to be signed by the physician.

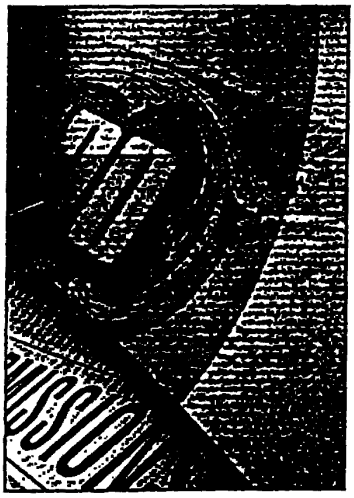
Hospital privileges for APNs are determined on a hospital-to-hospital basis according to the medical board of each hospital.

Reimbursement

The 1995 NPA mandates direct Medicaid reimbursement to APNs and RNPs. Current Medicaid reimbursement is at 80% of physicians' rate. APNs cannot be primary care providers for Medicaid in Arkansas. BC/BS will now reimburse ANPs who have a collaborative practice agreement. Services are filed under the collaborative physician's name and are paid at the physician's rate. Reimbursement is limited to H&M 99203 and 99213 and below. CNMs and some NPs are listed on managed care panels; for example, QualChoice lists CNMs by name and specialty. A statutory provision exists for third-party reimbursement for CRNAs. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

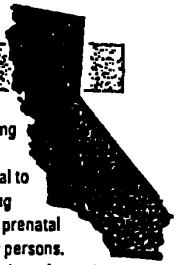
Prescriptive Authority

The 1995 NPA authorizes the BON to provide a certificate of Rx authority to qualified APNs in collaborative practice with a physician of comparable specialty/scope and using protocols for prescribing. Neither protocols nor a collaborative practice agreement with a physician is required unless the APN has Rx authority. Under R&R, an initial applicant for prescriptive authority must (1) be a certified APN with completion of pharmacology coursework of three graduate credit hours or 45 contact hours in (effective 11/00) a competency tested pharmacology course; (2) have 300 hours of precepted prescribing experience; (3) have 1,000 hours of post-APN education program experience; and (4) include a current collaborative practice agreement with a physician. This Rx authority includes Schedules III-V controlled substances after a DEA number is obtained. APNs who have fulfilled requirements for Rx authority may receive legend drug samples and therapeutic devices appropriate to their area of practice, including Schedules III-Vcontrolled substances that have been prepared in accordance with the state pharmacy laws and regulations. The BOP provides a waiver for a limited number of drugs for women's health RNPs who work for the Department of Health.



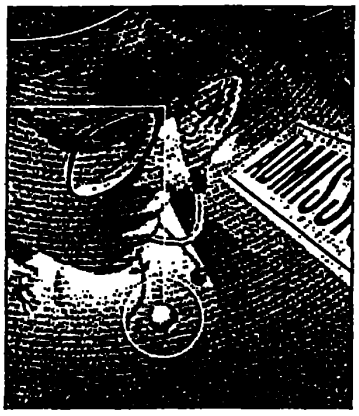
California

www.rn.ca.gov



Legal Authority

The BRN issues separate certification to NPs, CNMs, CRNAs, and CNSs. Advanced practice titles are protected (i.e., the RN must have a BRN-issued certificate to use the title). RNs function under "standardized procedures" when performing medical functions. The standardized procedures shall (1) be in writing and signed by the organized health care system personnel authorized to approve it; (2) specify which standardized procedure functions may be performed; (3) specify state requirements that are to be followed; (4) specify experience, training, and/or education requirements for performance of a procedure; (5) establish a method of evaluation; (6) specify the scope of supervision for the persons authorized to perform the procedure functions; (7) set forth the circumstances that require immediate communication with the patient's physician; and (8) specify record keeping and periodic review requirements. The standardized procedures are agency-specific and must meet specified requirements, including collaborative development by nursing, medicine, and the administration within the agency.



The level of "supervision" required is specific to the practice setting and is also specified in the standardized procedure. "Supervision" does not require the physical presence of an MD. CNMs have an additional SOP that enables them (under supervision of an MD with current obstetrics practice) to attend normal childbirth and to provide prenatal, interpartum, and postpartum care including family planning care for the mother and immediate care for the newborn; standardized procedures are not required when functioning within the CNM SOP. The granting of hospital privileges to APNs is at the discretion of the facility.

Reimbursement

Medi-Cal must reimburse FNPs and PNPs for Medicaid-covered services. BC of CA Medi-Cal Provider Directory currently lists NPs as primary care providers under their area specialty. CNMs and CRNAs may receive direct Medi-Cal reimbursement. All NPs, CNSs, and CNMs may be reimbursed indirectly (i.e., payment made to physician, hospital, or clinic). Third-party payers are required to reimburse BRN-listed psychiatric-mental health nurses for qualifying services. Participants in the state's managed care programs for specified Medi-Cal beneficiaries may select NPs and CNSs as their PCPs. Effective September 2000, NPs, CNMs, and CRNAs may be profesionally exempt from mandatory overtime in the labor code, providing the test for professional is met. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Effective January 2000, the NP may furnish or "order" drugs or devices when all of the following apply: (1) the drugs or devices are furnished or ordered by an NP in accordance with standardized procedures or protocols developed by the NP and supervising physician or dentist; (2) when furnished or ordered incidental to the provision of family planning services, routine health care, prenatal care, or to essentially healthy persons. (NPs may not furnish or order drugs in a solo practice.) The furnishing or ordering of drugs or devices by an NP occurs under physician or surgeon supervision but shall not be construed to require the physical presence of the physician. The supervision includes collaboration on the development of the standardized procedure, approval of the standardized procedure, and availability by telephone contact at the time of the patient examination by the NP. The signature of an NP on a drug order shall be deemed to be the signature of a prescriber.

Effective January 2000, pharmacists must include both the NP and physician name on the drug label. NPs may sign for receipt of pharmaceutical samples and may dispense drugs including controlled substances pursuant to a standardized procedure or protocol. No physician or surgeon shall supervise more than four NPs at any one time. Drugs and devices furnished or ordered by the NP may include Schedule III-V controlled substances. NPs authorized by the BRN to furnish or order controlled substances are authorized to register for a DEA number.

CNMs have limited prescribing privilege to furnish drugs and devices only in specified facilities and may not furnish controlled substances. The furnishing of drugs and devices must be in accordance with standardized procedures developed by the CNM and the supervising physician. CNM and NP furnishing authority is conditional on the issuance of a "furnishing number" by the BRN. To obtain the number, the CNM/NP must complete a qualifying pharmacology course and a 6-month physician-supervised experience in furnishing or ordering. CNMs cannot obtain DEA numbers.

Colorado

www.dora.state.co.us/nursing

Legal Authority

Definitions in the NPA are broad; SOP is based on the individual nurse's knowledge, skills, and abilities. Title protection is provided for APNs (NPs, CNSs, CNMs, and CRNAs); anyone using a specialty title must register with the BON. Educational requirements include master's degree in a clinical specialty area for CNSs; completion of an accredited program and certification by the respective certifying body for CNMs and CRNAs; and completion of an accredited NP program and/or certification by a nationally recognized accrediting agency for NPs. A graduate degree in the appropriate area will be required after June 30, 2008. An APN SOP is founded on the relevant educational program and core curriculum as determined by currently accepted professional standards. The education, training, and experience of the particular APN determines the scope of advanced nursing practice. While a particular function

Colorado continued

may be within the SOP of a particular APN, the individual APN must have the requisite knowledge, judgment, and skill to safely and competently perform any function that she/he undertakes. Certain functions and tasks that would otherwise be considered the practice of medicine may be performed by the APN if the functions and tasks are within that particular APN's knowledge, skills, and SOP.

Reimbursement

Third-party reimbursement is available to any RN; billed services qualify for reimbursement only if the type of service has a history of being reimbursable to other health care providers (i.e., a fiscally neutral bill). Currently, CNMs but not NPs are listed on HMO provider panels. Medicaid reimbursement, as regulated by the Department of Social Services, is available to PNPs, FNPs, CNMs, and CRNAs. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

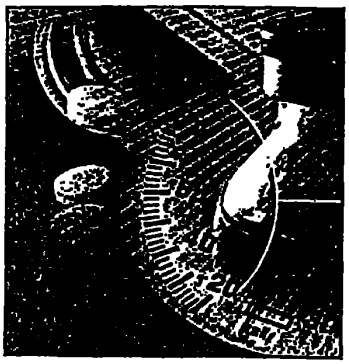
APN authority (legislated in 1995) includes Schedules II-V controlled substances and eligibility for a DEA number. To be eligible for Rx authority, the prescribing APN must be listed on the APN registry, have a graduate degree in a nursing specialty that included a minimum of 45 contact hours of advanced health/physical and psychological assessment, and have a minimum of 45 contact hours of advanced pathophysiology/psychopathology and a minimum of 45 contact hours in advanced pharmacology. (These course requirements can also have been completed post-basic professional nursing through an institution accredited by the United States Department of Education.) The APN must have satisfactorily completed education in the use of controlled substances and prescription drugs; have postgraduate experience as an APN in a relevant clinical setting of not less than 1,800 hours (in the immediately preceding 5-year period); and have a written collaborative agreement with a physician whose medical education and active practice correspond with that of the APN.

The Rx collaborative agreement shall include the duties and responsibilities of each party, provisions regarding consultation and referral, a mechanism designated by the APN to assure appropriate Rx practice, and other provisions established by the board. The APN shall provide the BON with the name of the collaborating physician; that information will also be available to the BOP, BOM, and (except for DEA numbers) the general public. The APN Rx section of law clearly states that nothing shall be construed to limit the ability of the APN to make independent judgment, require supervision by a physician, or require use of formularies. APNs may dispense or distribute drug samples that pertain to their SOP.

Connecticut www.state.ct.us/dph/

Legal Authority

The NPA was amended in 1999 to allow APRNs (NPs, CNSs, and CRNAs) to work in a collaborative relationship with physicians (instead of under their direction and according to written protocols as was in the previous NPA). R&R specific to this law have not yet been written. The collaborative agreement with respect to Rx authority must be in writing. The bill defines collaboration as a mutually agreed upon relationship between an APRN and a physician who is educated, trained, or has experience that is related to an APRN's work. The collaboration between the physician and the APRN must include (1) reasonable and appropriate consultation and referral, (2) patient coverage in the absence of the APRN, (3) a method for reviewing patient outcomes, and (4) a method of disclosing the collaborative relationship to the patient. The bill exempts CRNAs as their service is under the direction of a licensed physician.



The 1999 NPA may be further revised to clarify authority and licensing requirements in two areas: (1) Must an APRN also be a current licensed RN in the state? A recent opinion by the state's AG supports this; (2) Can RNs continue to operate under an order issued by an APRN? This is not clear under the new law. CNM SOP is recognized under a separate statute passed in 1984.

Reimbursement

CNPs, psychiatric CNSs, and CNMs are reimbursed for services under state insurance statutes. The statute affects only private insurers. Nurse providers must have a fee-for-service practice, either private or collaborative. Reimbursable services must be within the individual's SOP and must be services that are reimbursed if provided by any other health care provider. The law further states that no insurer can require supervision or signature by any other health care provider as a condition of reimbursement. Medicaid regulations govern reimbursement to APRNs under the remaining Medicaid fee-for-service programs. NPs have been recognized by the state's Medicaid managed care organizations for AFDC recipients since 1994. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/ medicare/enrollment/contacts/.

Prescriptive Authority

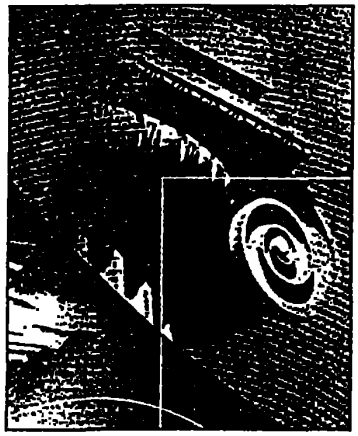
APRNs working in the collaborative relationship may prescribe, dispense, and administer medications including Schedule IV and V controlled substances and Schedule II and III controlled substances that are expressly specified in the written collaborative agreement. The prescriptive form must include the name, address, and phone number of the APRN or CNM and can include the collaborative physician's name. An APRN prescribing, administering, or dispensing controlled substances must obtain a DEA number. CRNAs can administer drugs during surgery only when the physician who is medically directing the Rx activity is physically present in the institution, clinic, or other setting.

Delaware

Legal Authority

The 1994 legislation includes four categories of APNs (NPs, CNSs, CNMs, and CRNAs). APN applicants must have a full academic year of postbasic education and national certification requirements. APNs must be nationally certified if there is a national certifying examination. If an examination is not available, APNs must be master's prepared. APNs must have a collaborative agreement with a physician to facilitate consultation and referrals, but no supervision, chart reviews, on-site MD requirements, or other restrictions exist.

The APN's SOP may be further defined: (1) If the APN does not perform independent acts of diagnosis or prescribing, the authority to practice is governed solely by the BON; (2) If the APN performs independent acts of diagnosis or prescribing in collaboration with an MD, DDS, podiatrist, or licensed state health care delivery system without written guidelines or protocols and does not write prescriptions independently, the authority to practice is governed by the JPC (approved by the BOM). Therefore, if the APN operates with guidelines or protocols and does not write prescriptions independently, then the APN practice is governed by the BON. The BON has defined these guidelines or protocols as suggested pathways to be followed by the APN for managing a particular medical problem that does not require an association with, and may be developed collaboratively with, an MD, DDS, podiatrist, or health care delivery system. The statute allows for hospital privileges for APNs.



Reimbursement

A 1991 insurance act specifies that no health insurer, health service corporation, or HMO shall deny benefits for eligible services when rendered by an APN acting within his or her SOP. Nothing prohibits APNs from being listed on provider panels, and some providers are recognizing APNs on managed care provider panels. CNMs obtained legislative authority under the Board of Health for third-party reimbursement in 1988. FNPs and PNPs also receive Medicaid reimbursement; they are reimbursed at 100% of physician payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

APNs received Rx authority in 1994. The R&R for APN Rx authority/independent practice (promulgated in January 1996) define collaborative agreement as "a true collegial agreement between two parties where mutual goal setting, access, authority, and responsibility for actions belong to individual parties and there is a conviction to the belief that this collaborative agreement will continue to enhance patient outcomes, and a written document that outlines the process for consultation and referral between an APN and licensed MD, DDS, podiatrist, or licensed Delaware health care delivery system." An APN applicant shall (1) be a BON-licensed APN; (2) submit a copy of his or her collaborative agreement to the JPC (the JPC consists of five APNs, two MDs, one pharmacist, and one public member); (3) show evidence of at least 30 hours of advanced pharmacology; (4) demonstrate how submitted CEU relates to pharmacology within his or her area of specialty; and 5) provide evidence of academic courses in advanced health assessment, diagnosis and management of problems within the clinical specialty, and advanced pathophysiology. Qualified applicants submit to the JPC for approval and then to the BOM for final approval. APNs may prescribe legend drugs (including Schedules II-V controlled substances). APNs are assigned a provider number, and they must register with the DEA to prescribe, administer, and dispense professional samples of Schedules II-V controlled substances.

District of Columbia

Legal Authority

APNs include NPs, CNMs, CRNAs, and CNSs. APN practice is defined in the 1985 Health Occupations Revision Act (HORA). 1995 amendments grant APNs authority to practice without any required collaborative agreement with a physician. The 1995 amendments drop requirements for APNs to function under protocols and drop SOP limitations for various specialties. These amendments were passed by D.C. City Council and confirmed by Congress in March 1995. The SOP for an APN is regulated by the BON. APNs may apply for hospital privileges.

Reimbursement

The 1995 HORA amendment authorizes direct reimbursement of APNs for providing drug abuse, alcohol abuse, and mental illness care; it also prohibits health care plans or institutions from discriminating against APNs with clinical privileges. There is no current legislative authority mandating reimbursement for APNs. Private third-party payers reimburse for NP services. NPs and CNMs have been redesignated as PCPs, allowing them to receive Medicaid payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

The D.C. statute and regulations provide for full Rx authority for APNs. The requirement for a collaborative agreement has been abolished. The law and R&R authorize prescribing Schedules II-V controlled substances. The statute allows dispensing; however, the rules have not yet been promulgated. The D.C. Pharmacy Board began issuing DEA numbers in 1995.

Florida

www.doh.state.fl.us/mqa/nursing/rnhome.htm

Legal Authority

ARNPs are certified by the BON and include NPs, CNMs, and CRNAs. Effective April 2000, 500 supervised clinical hours in the educational program are required for initial ARNP certification. An ARNP shall only perform medical acts of diagnosis, treatment, and operation pursuant to a protocol between the ARNP and an MD, DO, or DDS. The degree and method of supervision, determined by the ARNP and physician or DDS, shall be specifically identified in written protocol and shall be appropriate for prudent health care providers under similar circumstances.

The rules of the BOM and BON define general supervision as the ability to communicate/contact by telephone; on-site presence of the supervising practitioner is not required. ARNPs in private practice must find a physician willing to sponsor the ARNP's protocols. ARNPs must file protocols with the BON yearly, and the physicians working with the ARNP must send the statement required in the medical practice act to the BOM. A 1996 health bill (1) allows for provisional state certification of graduate NAs and CNMs who are awaiting results of the national certification examination; (2) requires ARNP applicants graduating on or after October 1, 1998, and NA applicants graduating on or after October 1, 2001, to graduate from a master's degree program to qualify for initial certification (NMs were not identified in this bill); (3) allows an ARNP, within the framework of established protocols, to order diagnostic tests and physical and occupational therapy.

Reimbursement

ARNPs receive Medicaid, Medicare, CHAMPUS, and third-party reimbursement. Medicaid reimburses ARNPs at 80% of physician reimbursement; Medicaid pays 100% only if an on-site physician countersigns the chart within 24 hours. In 1998, a bill was signed into law prohibiting managed care companies from discriminating against the reimbursement of ARNPs if based on licensure. Private insurers must reimburse NM services if the policy includes pregnancy care. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

The BON/BOM joint committee obtained privileges for ARNPs in 1988 through a rule decision; however, controlled substances were excluded. ARNPs prescribe under their protocol, which broadly lists the medical SOP and generic categories from which the ARNP can prescribe. The Rx contains the ARNP's name and license number. Currently, initiatives are underway to promulgate rules to permit ARNPs to prescribe Schedule II-V controlled substances. The BON is appealing a legislative interpretation that would require a statutory change for ARNPs to be considered as "providers" for this purpose. ARNPs who dispense (distribute medication for reimbursement) must apply for dispensing privileges. Giving out free samples is allowed and not considered dispensing.

Georgia

www.sos.state.ga.us/ebd-rn

Legal Authority

If authorized to practice by the BON, APRNs include NPs, CNMs, CRNAs, and CNSs in psychiatric-mental health. CNSs in psychiatric-mental health must have at least a master's degree to be authorized by the BON to practice. As of 1999, a master's degree or higher in nursing within the respective specialty and national certification is required for all APRNs. An APRN is authorized to perform advanced nursing functions and certain medical acts that include but are not limited to ordering drugs, treatments, and diagnostic studies by protocol. A physician may delegate to an NP in accordance with a "nurse protocol" the authority to order controlled substances from a BOME formulary and the authority to order drugs, medical treatments, and diagnostic studies. The R&R for this statute, however, have never been written nor has a formulary been developed.

"Nurse protocol" means a written document signed by the NP and physician by which the physician delegates to the nurse the authority to perform certain medical acts and provides for immediate consultation with the delegating physician. Public hospitals may (but are not required to) grant privileges to nonphysicians if they are otherwise qualified for staff privileges pursuant to the bylaws of the governing body of the hospital.

Reimbursement

Statutes mandating third-party reimbursement for APRNs do not exist. FNPs, PNPs, OB/GYN NPs, CNMs, and CRNAs are eligible for Medicaid reimbursement from the Department of Medical Assistance. NPs and CRNAs are reimbursed at 90% of a physician's payment. Since 1999, CNMs are reimbursed at 95% of a physician's payment. Some private insurers reimburse APNs but are not required by law to do so. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

A process exists that permits RNs (including APRNs) to administer, order, or dispense drugs under delegated medical authority, either as prescribed by a physician or as authorized by protocol. BON regulations governing protocol used by RNs require that the RN document preparation and performance specific to each medical act. Ordering is not construed to be prescribing nor the issuance of a written prescription. "Medication orders" may be called into a pharmacy.

Hawaii

www.state.hi.us/dcca/

Legal Authority

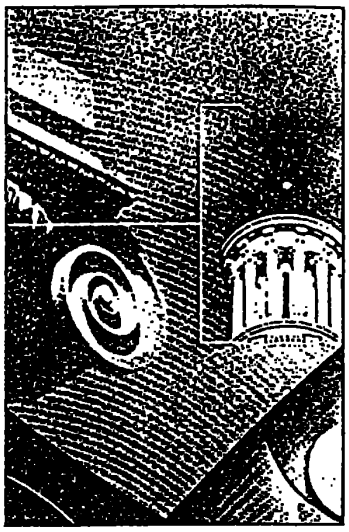
As of 1994, APRNs are defined in the NPA as either having a "master's degree in nursing as specified in rules adopted by the BON or a current certification for specialized and advanced nursing practice from a national certifying body recognized by the BON." Each APRN's (NP, CNS, CNM, and CRNA) SOP has been defined in administrative rules that were formally adopted in 1997. The BON is proposing an amendment to the NPA that would require APRNs to have a master's degree and national certification by 2005.

Reimbursement

Legislation was passed (SH 743) in 1999 that provides direct reimbursement to all APRNs. Several insurance companies are in the process of credentialing APRNs for their provider panels. Some APRNs are already listed on managed-care panels and are being directly reimbursed for their services. The rate of reimbursement has not been determined yet; it currently ranges from 85% to 100%. NPs and CNSs are also reimbursed through CHAMPUS. Medicaid reimburses PNPs, FNPs, and CNMs at 75% of physician payment. Hawaii Health QUEST, a Medicaid waiver program, defines PNPs, FNPs, and CNMs as PCPs. However, QUEST, unlike Medicaid, does not require the QUEST health care plans to include APNs as PCPs on their provider panels. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Rx authority was signed into law in 1994. Rx administrative rules became effective in 1998. After a September 1998 Rx authority public hearing, the Department of Commerce and Consumer Affairs (DCCA) forwarded the APRN Rx authority rules (with the ratio of 1 MD:2 APRN deleted) to the Governor for signature. APRN Rx authority is not supervised; however, APRN's must document with the DCCA that they have a collegial working relationship with an MD working in the same "institution" and specialty area. APRNs prescribe from an exclusionary formulary that excludes controlled substances. To prescribe from the formulary, APRNs must have a master's degree in nursing or nursing science, 30 hours of advanced pharmacology, 1,000 hours of clinical practice, and be nationally certified. Master's and non-master's-prepared APRNs can prescribe controlled substances under protocols when the physician agrees. Legislation is pending to allow master's-prepared APRNs to independently prescribe controlled substances.

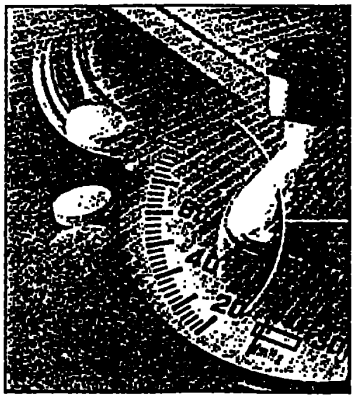


Idaho

www2.state.id.us/ibn/ibnhome.htm

Legal Authority

Effective July 1, 1998, the NPA established licensure for NPs as a category of advanced practice professional nurses (APPN), which also includes CNMs, CNSs, and RNAs. APPN licensure requires RN licensure, completion of an approved APPN program, and national certification. Practice is regulated solely by the BON and is consistent with defined national standards. NPs, CNMs, and CNSs must practice with MD supervision, consultation, collaboration, and referral. Supervision is defined as "designation of a course of action or provision of guidance and direction." RNAs practice in collaboration with MDs. Hospital privileges for APNs are neither specifically permitted or prohibited by the NPA. APNs have been granted privileges by some facilities. The issue is under discussion in other facilities.



Reimbursement

Listing APNs on managed care provider panels is neither specifically permitted nor prohibited and is currently under discussion by third-party payers. Effective November 2000, BC/BS agreed to place NPs on their preferred provider list. NPs receive their own Medicaid provider number and may choose to file independently or with a group. As of 1995, reimbursement rates are 85% of physician reimbursement. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Rx/dispensing authority is granted to APPNs who have completed 30 contact hours of pharmacology-specific formal instruction beyond basic RN education. Authorized APPNs may prescribe and dispense legend and Schedule II-V controlled substances appropriate to their defined SOP. Some dispensing restrictions apply to Schedule II substances. Authorized APPNs have their own DEA numbers and prescribe independently.

Illinois www.dpr.state.il.us

Legal Authority

In August 1998, the Nursing and Advanced Practice Nursing Act became law. CNPs, CNSs, CNMs and CRNAs are title protected and statutorily recognized as APNs. APNs may not use the title "Dr." in a clinical setting. By July 1, 2001, all new applicants must have a graduate degree in their APN specialty. APNs without graduate degrees will be grandfathered if they are currently certified or if they have been NPs for 10 years or more.

Practice is regulated by the Department of Professional Regulation's APN Board (composed of four APNs, three physicians who must be in a collaborative practice with an APN, and two public members). Draft R&R covering APN SOP and Rx authority have been written; the initial 45-day commitment period has been completed. Approval is anticipated in early 2001. CNPs, CNSs, and CNMs must have a written collaborative agreement with a physician that describes the working relationship between the APN and the physician and authorizes categories of care, treatment, or procedures to be performed by the APN. Medical direction is adequate if the APN and physician jointly develop the guidelines and periodically review them. The agreement need not describe the exact steps for a specific condition, disease, or symptom, but must specify which authorized procedures require a physician's presence. The physician's presence is not required at the site where services are rendered; however, telecommunication methods for consultation must be established, and the physician is expected to visit the site at least once a month. The services to be provided by the APN shall be services that the collaborating physician generally provides. No ratios are specified; however, the Medical Practice Act prohibits a physician from entering into an "excessive number" of written collaborative agreements with licensed APNs resulting in an inability to adequately collaborate and provide medical direction. CRNAs must enter into a written practice agreement with a physician, dentist, or podiatrist.

Reimbursement

As of July 1995, the Illinois Department of Public Aid provides direct reimbursement at 70% of physician rates to certified PNPs and FNPs who enroll independently as Medicaid providers. No statutory prohibition for third-party reimbursement to APNs exists. APNs receive direct or indirect reimbursement from third-party payers in some cases. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

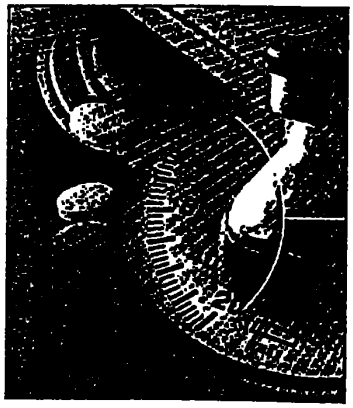
Prescriptive Authority

Delegated Rx authority is granted to APNs by their written collaborative agreement for legend and Schedule III-V controlled substances. APNs will use Rx pads with their names and their collaborating physicians' names printed on the pad, with only the APN signature required. A collaborating physician may delegate to an APN (as part of a written collaborative agreement) the Rx and dispensing legend and Schedule III-V controlled substances. APNs must obtain their own DEA number to prescribe controlled substances. Medication orders shall be reviewed periodically by the collaborating physician. An APN may sign for and accept drug samples as long as it is stipulated in the written collaborative agreement.

Indiana www.ai.org/hpb

Legal Authority

The NPA defines APN as an NP, CNM, or CNS. The BON does not issue a separate license to APNs; APNs without Rx authority may function in their advanced practice with the RN license. The BON has R&R defining APNs. APNs are required to practice in collaboration with a licensed practitioner. Collaboration must be evidenced either by a written practice agreement (WPA) or by privileges granted by the hospital medical staff. The WPA or privileges must set forth the manner in which both professionals will cooperate, coordinate, and consult with each other in the provision of health care.The NPA defines CRNAs as separate from APNs.



Reimbursement

The reimbursement law is considered an "any willing provider" statute. APNs may receive third-party reimbursement as determined by payers. NPs receive Medicaid reimbursement at 85% of a physician's payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

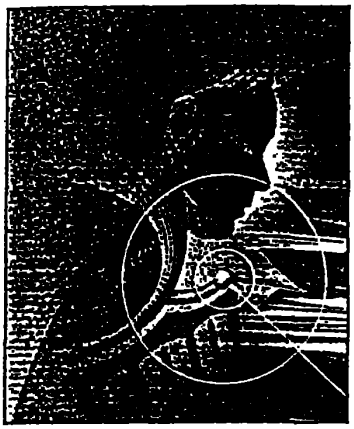
Prescriptive Authority

The BON has legal authority to establish rules with the approval of the BOM to permit Rx authority for APNs. Medical board approval (of the BON R&R for APN prescribing) became effective in 1994. The BON may issue authorization to prescribe legend drugs and controlled substances if the qualified APN submits proof of having successfully completed a graduate level pharmacology course consisting of at least 2 semester hours from an accredited college or university and submits proof of collaboration with a "licensed practitioner" (i.e., LP, DDS, podiatrist, physician, or osteopath) in the form of a WPA. The WPA sets forth provisions for the type of collaboration between the APN (for example, dispensing samples) and the LP and the reasonable and timely review by the LP of the Rx practices of the APN. An Rx authority ID number is issued by the BON; the authority limits the APN prescribing to within the APN's and collaborating physician's SOP. APNs requesting authority to prescribe controlled substances must apply for and obtain an Indiana State Controlled Substances Registration prior to obtaining a federal DEA number. CRNAs are not required to obtain Rx authority to administer anesthesia.

Iowa www.state.ia.us/nursing

Legal Authority

Advanced practice administrative rules are in the administrative code. ARNPs (i.e., NPs, CRNAs, CNMs, and CNSs) are registered by the BON in addition to their RN license. ARNPs may practice independently. Collaborative practice agreements are not required. In addition to independent functions, an ARNP may



perform selected medically delegated functions when a "collaborative practice agreement" exists. Collaborative practice agreement means an ARNP and physician practicing together within the framework of their respective SOPs. This collaborative agreement reflects both independent and cooperative decision making and is based on the preparation and ability of each practitioner. Applicants must submit evidence of graduation from an approved program and certification from a BON-approved national certifying body. A 1999 Hospital Fairness Bill adds ARNPs to the list of providers who can obtain clinical privileges in hospitals.

Reimbursement

A 1996 statute provides for payment of necessary medical or surgical care and treatment provided by an ARNP if the policy or contract would pay for the care and treatment if provided by an MD or DO. The statute does not mandate managed care organizations to offer ARNP coverage unless there is a contract or other agreement to provide the service. Under Medicaid, ARNPs who independently practice (who are not employees of a physician or facility) receive direct Medicaid reimbursement at 85% of physician payment. As of January 2000, FNP, PNP, and CNM rates are under the fee schedule established by Medicare and incorporate resource-based relative value scale (RBRVS) methodology; a CRNA fee schedule is R&R vs plus 0.7%. Medicaid R&R for ARNPs who are employees of a physician or facility authorize payment of 100% to the physician for ARNP office visits and 100% to the facility for ARNP hospital care. Because ARNPs can be listed on managed care provider panels, special efforts are being made with the state Medicaid mental health managed care provider (Merit Behavioral Corp.). A 1997 amendment to the Medicaid program telemedicine pilot project will pay for ARNP Medicaid covered services. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Authorized ARNPs are granted independent Rx authority. Registration with the federal DEA and the Iowa BOP extends this authority to controlled substances. ARNPs write prescriptions using their own Rx pads.

Kansas www.ksbn.org

Legal Authority

BON-recognized ARNP status (for NPs, CNMs, CRNAs, and CNSs) is required for RNs practicing with an expanded SOP. There is additional statutory recognition for CRNAs. Under regulations effective March 2000, a master's degree or higher in nursing will be required for new ARNP applicants after July 2002. ARNPs function in a collegial relationship with physicians and other health care professionals in the delivery of primary health care services. ARNPs make independent decisions about nursing needs of patients and interdependent decisions with physicians in carrying out health regimens for patients. ARNPs are directly accountable and responsible to the consumer. The physical presence of the physician is not necessarily required when care is given by the ARNP.

Reimbursement

A statutory requirement to reimburse all ARNPs for currently covered services in health plans was passed in 1990. The five urban counties originally excluded are included following 1993 legislation. Medicaid has expanded payment to include all covered services but will only pay 80% of physician payment (except for CRNAs and practitioners performing early periodic screening diagnosis and treatment who receive 100%). For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa/gov.medicare/enrollment/contacts/.

Prescriptive Authority

Effective April 2000, a new pharmacy law (HB 2168) permits ARNPs, except CRNAs, to prescribe pursuant to jointly adopted protocols agreed on by the ARNP and "the responsible physician." Each written protocol must (1) specify for each classification of disease or injury the class of drugs the ARNP is permitted to prescribe; (2) be maintained in a notebook or book of published protocols; and (3) contain the ARNP and physician's annual signature. The prescription order must be signed by the ARNP and include the name of the physician and ARNP on the prescription. ARNPs are eligible to apply for DEA numbers. ARNPs are permitted to receive drug samples if the drug is within their protocol.

Kentucky

www.kbn.state.ky.us

Legal Authority

State law licenses ARNPs, including NPs, CNSs, CNMs, and CRNAs. ARNPs must maintain RN licensure and be registered as ARNPs. ARNPs must practice in accordance with the scope and standards of practice of the national certifying organization as adopted by the BON. ARNPs shall seek consultation or referral in situations outside their scope of practice.

Reimbursement

The state medical assistance program reimburses ARNPs for services at 75% to 100% of physician rates (depending on the region). In October 1995, Kentucky received approval from HCFA to implement a waiver to establish capitated managed care for Medicaid recipients through Healthcare Partnerships; ARNPs are listed as PCPs. Kentucky is an "any willing provider" state. The applicable statute specifies third-party reimbursement to providers under the authority of the Cabinet for Health Services; ARNPs are included in the definition of PCP. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

As of July 1996, ARNPs may prescribe nonscheduled legend drugs pursuant to a collaborative practice agreement (CPA) that defines ARNP scope of prescribing authority and is signed by the ARNP and physician (see KRS 314.011[8]). CRNAs do not need CPAs to deliver anesthesia care. In 1997, the BON revised 201 KAR 20:057 to include definitions for "collaboration" and "CPA," and specific information that must be contained in the CPA (i.e., ARNP and collaborating physician's name, practice address, and area of practice). Any changes to a written CPA must be reported to the BON within 30 days. In prescribing, the ARNP alone signs his/her name to the Rx pad. ARNPs must complete 5 contact hours in pharmacology (every 2 years for relicensure) as part of their CE requirement. ARNPs may receive drug samples (non-controlled legend medications only) and may dispense drug samples to patients at no charge.

Louisiana

www.lsbn.state.la.us

Legal Authority

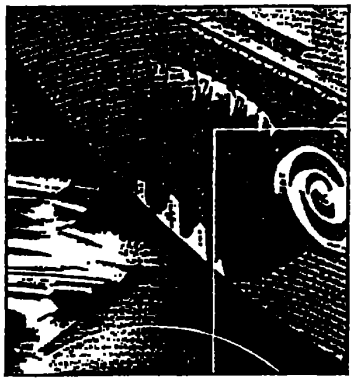
As of January 1996, Act 633 of 1995 provides for licensure and regulation of APRNs, including *NPs, CNMs, CRNAs, and CNSs. APRN licensure* is granted with a concentration in the respective APN specialty. If the APRN obtains additional education and certification, the APRN must apply for additional BON recognition. APRNs must only practice within their BON-recognized category and specialization. Minimum educational preparation is at the master's level. Specific scopes for each category are in the administrative rules. As defined in the NPA, "APRN means nursing by a CRNA, CNM, CNS, or NP, which is based on knowledge and skills acquired in a basic nursing education program, licensure as an RN and a minimum of master's degree with a concentration in the respective advanced practice nursing specialty." The APRN SOP includes "certain acts of medical diagnosis or medical prescriptions of therapeutic or corrective nature, prescribing assessment studies, drugs, therapeutic regimens and distributing drugs for administration to and use by other individuals within the scope of Act 629. Acts of medical diagnosis and prescription by an APRN shall be under the direction of an MD or DDS and in accordance with a collaborative practice agreement" (i.e., a formal written statement addressing the parameters of the collaborative practice, which are mutually agreed upon by the APRN and MD). The BON determined that the following CPT codes can be within the CNP's SOP: 32000 and 32020; and that the following CPT codes are not within the CNP's *SOP: 33210 and 93503.*

Reimbursement

General mandatory reimbursement for ARNPs does not exist. Medicaid reimbursement for CNMs and CRNAs is at the same level as physicians. Medicaid reimbursement for PNPs and FNPs is at 80%, except immunizations at 100%, of physician reimbursement. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Act 720 of July 1997 provides limited Rx and dispensing authority to approved NPs, CNSs, and CNMs in collaborative practice with physicians. The applicant for Rx authority must provide evidence of a collaborative practice agreement with a licensed physician or physician group and shall include a plan of accountability to include (1) clinical practice guidelines, (2) availability of collaborating physician, and (3) patient care coverage plans with documented review of the guidelines with the on-call physician. Act 720 created the Joint Administration Committee on Prescriptive Authority for APRNs under the joint jurisdiction of the BON and BOME. The committee accepted R&R effective July 1999. The R&R require 12 hours of advanced pathophysiology, 36 hours of pharmacotherapeutics, and 500 hours of active full-time practice prior to applying for prescriptive *authority. The Rx R&R also limit one physi*cian with no more than two APRNs, and require, with some site exceptions, that the physician visit the APRN practice site at least weekly. The Committee may grant the Rx of controlled substances by APRNs on an individual basis; however, under current interpretation of the law, APRNs cannot obtain a DEA number. The Committee is working with the Department of Health and Hospitals to change this. APRNs with Rx authority may receive and distribute drug samples appropiate to the APRN's specific area of specialization.



Maine

www.state.me.us/nursingbd

Legal Authority

Regulation of the APRN is under the BON. APRNs include CNMs, CNPs, CCNSs, and CRNAs approved by the BON. The APRN SOP includes national standards of the national certifying body and "consultation with or referral to medical and other health care providers when required by client health care needs. A CNP who qualifies as an APRN must practice for at least 24 months under the supervision of a licensed physician or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The CNP must submit written evidence to the BON upon completion of the required clinical experience." Following this 24-month period, the CNP can practice independently. CCNSs practice independently. CRNAs are responsible and accountable to an MD or DDS. Public Law 438 of 1997 allows CNPs and certified psychiatric CNSs to sign the papers necessary for emergency involuntary commitment through emergency departments. There is no statutory requirement either promoting or inhibiting the inclusion of APRNs on hospital medical staffs. The BON is considering their current interpretation, which states that once an NP has accepted delegated medical authority by a physician for services beyond that NP's SOP, all acts forward are performed pursuant to that delegation. The state association, the Maine Nurse Practitioner Association (MNPA), has requested that the BON rule that delegation is not exclusive (NPs can also work without delegation for services within their SOP). Such a ruling is important to NPs who may hold two or more jobs, only one of which involves work outside the SOP. The MNPA has filed legislation on this issue in case it is not resolved satisfactorily by the BON.

Reimbursement

A new law (LD 857) has three effects: It requires reimbursement under an indemnity or managed care plan for patient visits to an NP or NM when referred from a PCP; it requires insurers to assign separate provider identification numbers to CNPs and CNMs; and it allows managed care enrollees to designate CNPs as their PCP. However, managed care organizations are not required to credential any MD or CNP if their "access standards" have been met. Reimbursement under indemnity plans is mandated for master's-prepared, certified psych/mental health CNSs. No other third-party reimbursement for APRNs is required by law; however, some insurance carriers reimburse independent CNPs. Medicaid reimburses in full, on a fee-for-service basis, for services provided by CFNPs, CPNPs, and CNMs. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

A CNP or CNM who qualifies as an APRN may prescribe and dispense drugs or devices in accordance with rules adopted by the BON. BON rules are now in place; approved CNPs and CNMs receive their own DEA numbers. BON rules require CNPs and CNMs to have a pharmacology course and prescribe from a formulary, which includes all over-the-counter drugs, appliances, devices, and drugs related to the nurses' specialty area. Schedule I and II controlled substances are excluded from the formulary. A CNM or CNP approved by BON as an APRN may also "choose to perform medical diagnosis or prescribe therapeutic or corrective measures when these services are delegated by a licensed physician." APRNs may receive and distribute drug samples included in the formulary for Rx writing. The BON has scheduled public hearings to consider expansion of APRN Rx authority to include Schedule II controlled substances after additional pharmacologic course work has been completed.

Maryland

www.mbon.org

Legal Authority

APNs include NPs, CRNAs, CRNMs, and APRN/PMH (psychiatric mental health). NPs are certified to practice through the BON; requirements include passing a national certification examination and submitting a written agreement with a collaborating MD (the agreement is approved by an equally represented MD/NP joint committee). Once the agreement is approved, NPs may perform the functions of the agreement independently. CRNMs are certified to practice through the BON; requirements include passing a national certification examination and submitting a written agreement with a back-up physician. CRNAs are certified to practice through the BON; requirements include passing a national certification examination and submitting a collaborative agreement with an anesthesiologist, physician, or dentist. APRN/PMHs are certified to practice through the BON; requirements include a master's degree or higher and national certification as a CS in psychiatric/mental health nursing. APRN/PMHs practice independently, make mental health diagnoses, and carry out psychotherapy. No regulations address hospital privileges; APNs usually apply via the Allied health section of the medical board in the institution in which they desire privileges.

Reimbursement

Pursuant to 1986 legislation, all nurses are entitled to private third-party and Medicaid reimbursement for services if they are practicing within their legal SOP. Medicaid reimburses at 100% of physician payment. Legislation passed in 1994 allowed due process for APNs being listed on managed care panels; APNs were not to be arbitrarily denied. In 1997, the state insurance commissioner denied NPs PCP status, which would capitate NPs directly with managed care organizations. The 1115 Medicaid waiver for Maryland was activated on July 1, 1997. All Medicaid recipients have been assigned to a managed care organization. CRNPs (with the exception of neonatal and acute care) and CRNMs have been designated as PCPs and may apply to be placed on a provider panel. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/ medicare/enrollment/contacts/.

Prescriptive Authority

NPs and CNMs have Rx authority, including controlled substances. The scope of Rx authority is defined by the written agreement developed by the NP and collaborating physician. CNMs have statutory authority to prescribe based on a formulary mutually developed by the BON, BOM, and BOP. NPs and CNMs can obtain both federal and state DEA numbers. The Division of Drug Control publishes a list of newly authorized NP and CNM prescribers in their newsletter and sends a list of authorized NP and CNM prescribers to pharmacists. NPs and CNMs sign their own name on the prescription. NPs and CNMs are legally allowed in most settings (those in which pharmaceutical samples are state authorized to be distributed) to dispense medications.

Massachusetts

www.state.ma.us/reg/boards/rn

Legal Authority

As of April 1994, RNs who apply for BON authorization in advanced nursing practice (i.e., NPs, NAs, psychiatric CNSs, and NMs) must have either a graduate degree in advanced nursing practice or a certificate of approved educational program in advanced nursing practice at least 1 year in length, and certification in advanced nursing practice from a BON-approved certifying organization. Advanced practice R&R governing the ordering of tests, therapeutics, and prescribing are promulgated by the BON in conjunction with the BOM. All other areas of SOP are exclusively under the BON. All APNs shall practice in accordance with written guidelines developed in collaboration with the nurse and physician. In all cases, the written guidelines shall "designate a physician who shall provide medical direction as is customarily accepted in the specialty area." If practicing in an institution, the nursing and medical administrative staffs must approve the guidelines. If there is no nursing/medical administrative staff, the guidelines must be approved by the BON. Credentialing for hospital privileges varies according to hospital policies.

Reimbursement

Psychiatric CNSs, midwives, CRNAs, and NPs are reimbursed according to state law. This law only includes indemnity plans, not HMOs and other managed care arrangements. BC/BS will begin credentialing NPs for Phase I (NPs in private practice settings) to receive individual NP provider numbers. A new HMO protection bill (July 2000) allows "other providers" to be listed on panels; however, the law does not specifically address APNs nor does it require them to be listed as providers. FNPs, PNPs, and ANPs are reimbursed at 100% of physician payment rate in Medicaid. The Medicaid program under the Division of Medical Assistance has expanded its previous definition of an independent NP. The issue of salaried versus non-salaried NPs as a condition of independence has been deleted in private group practice settings; NPs in this setting are now being reimbursed the same as their physician colleagues. These new regulations (March 2000) do not apply to hospital-based practices when the NP is salaried by the hospital. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Under a bill implemented in early 1993, NPs, CNMs, and psychiatric CNSs have Rx authority for Schedules II–VI controlled substances. Authorized APNs must apply to the state Department of Public Health for a state DEA number; they then apply for a federal DEA number. Authorized APNs have (1) prescribing guidelines mutually developed and agreed upon by the nurse, employer, and supervising physician; guidelines need not be submitted to the BON unless requested (the guidelines pertaining to Rx practice shall include a defined mechanism to monitor prescribing practices including review with a supervising physician every 3 months); and (2) proof of 24 hours of pharmacology content in original APN program or CEU credits. The Rx has the name of supervising physician on the pad; the authorized APN signs the Rx.

Michigan

www.cis.state.mi.us/bhser/genover.htm

Legal Authority

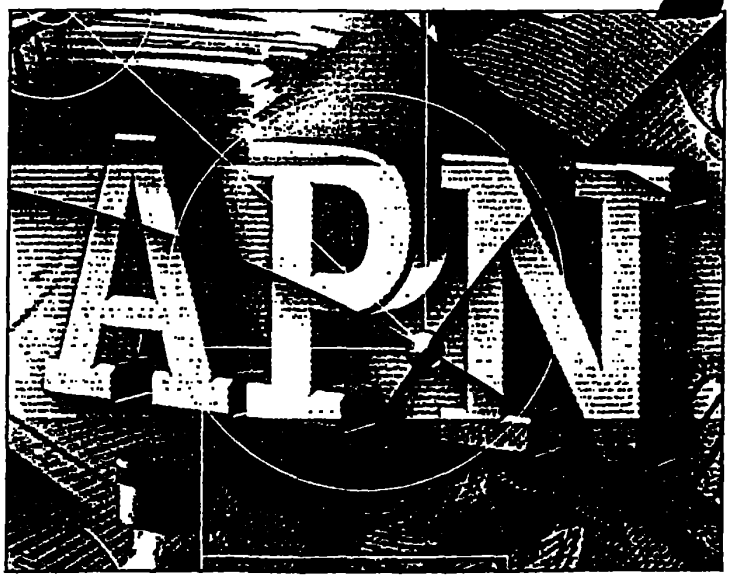
The Michigan BON grants "specialty certification" to CNMs, CRNAs, and NPs (CNSs may qualify for certification as NPs). Nurses with specialty certification require no physician collaboration or supervision.

Reimbursement

Medicaid directly reimburses all certified NPs at 100% of the reimbursement rate. BC/BS directly reimburses all NPs, CNMs, and CRNAs. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

NPs, CRNAs, and CNMs may prescribe non-controlled substances as a delegated act of a physician. NPs and CNMs may prescribe controlled substances as a delegated act of a physician. A supervising physician or DO may delegate in writing the ordering, receipt, and dispensing of complimentary starter dose drugs other than controlled substances.



Minnesota

www.nursingboard.state.mn.us

Legal Authority

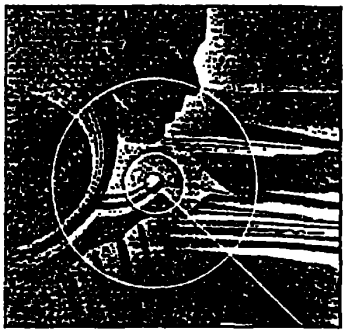
A 1999 law defines APRN as an RN certified by a national nurse certification organization acceptable by the BON to practice as a CNP, CNS, CNM, or CRNA. The BON maintains a registry of all APRNs. Collaborative management is defined as a mutually agreed upon plan between an APRN and physician(s) that designates the scope of collaboration necessary to manage the care of patients where the APRN and physician(s) have experience in providing care to patients with the same or similar medical problems. CNPs, CNSs, and CRNAs must practice within the context of collaborative management. CNMs must practice within a system that provides for consultation, collaborative management, and referral.

Reimbursement

NPs, CNMs, CRNAs, and CNSs in psychiatric health have legislative authority for private insurance reimbursement. FNPs, PNPs, GNPs, WHNPs, and ANPs are reimbursed by Medicaid at 90% of the physician rate. In 1995, it became unlawful for an insurance company or HMO to deny payment for a Rx because the prescriber is an NP, CNM, or CNS. A 1996 insurance statute made it unlawful for an HMO or private insurer to require an MD cosignature when an APN orders a laboratory test, X-ray, or diagnostic test. The medical director for United Health Care (UHC), the Medicare appointed organization for the state, had begun denying APRNs reimbursement for higher level services. Minnesota Nursing Association initiated a forum with APRNs, UHC, BON, and state and federal lawmakers to successfully resolve this issue. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/ contacts/.

Prescriptive Authority

APRNs who meet statutory requirements may prescribe and administer drugs (including controlled substances) and therapeutic devices within their authorized SOP. Each APRN must determine whether she/he meets the statutory requirements and has the knowledge and ability to prescribe safely. The BON does not grant Rx authority but will discipline the APRN if the prescribing practices are unsafe, unethical, or illegal. CNPs, CRNAs, and CNSs must have a written agreement with a physician that defines the delegated responsibilities related to the prescription of drugs and devices. The written agreement pertaining to Rx authority must be maintained at the practice site of the APRN and collaborating physician. CNMs have independent Rx authority. An APRN who has the authority to prescribe and wants to prescribe controlled substances must apply to the DEA and to the BON for a verification of compliance with a Minnesota statute form.



Mississippi

www.msnurses.org

Legal Authority

NPs, CRNAs, and CNMs are certified by the BON. The R&R are jointly promulgated by the BON and BOM and implemented by the BON. To become certified, the RN must successfully complete an appropriate NP program, be nationally certified as an NP, and submit practice documentation of a collaborative, consultative relationship with a physician whose practice is compatible with the NP. NPs must practice according to a BON-approved protocol that has been mutually agreed on by an NP and physician. CRNAs may also collaborate/ consult with licensed dentists. NP applicants graduating from an NP program after December 31, 1998, must submit official evidence of graduation from a graduate program with a concentration in the applicant's advanced practice nursing specialty. Practicing in a site not approved by the BON, with an MD not approved by the BON, or according to a protocol not approved by the BON is in violation of the NPA R&R. BON R&R adopted in 1996 provide title protection for CNSs. In 1995, the state nurses association was instrumental in expanding SOP for NPs within state law so that NPs can now sign for (1) disability verification, (2) disability license plates, (3) testing of minors for sexually transmitted infections without parental consent, and (4) proof of immunization for Medicaid. As of 2000, NPs can perform the assessment and attest to the health of a child for adoption. Prior to 1995, the BOM ruled that if an NP treats patients in a "freestanding clinic" (more than 15 miles from the supervising physician), then the physician must obtain BOM approval to collaborate with the NP. However, as of 1995, HB 1081 provides that any action taken to prohibit NPs from practicing to the full extent of their SOP is prohibited. HB 1081 also states "that any R&R that impact the practice of NPs shall hereafter be jointly promulgated by the BON and BOM."

Reimbursement

Insurance law specifies that whenever any insurance policy, medical service plan, or hospital service contract provides for reimbursement for any service within the SOP of a CNP working under the supervision of a physician, the insured shall be entitled to reimbursement whether the services are performed by the physician or CNP. Medicaid reimbursement is available at 90% of physician payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

NPs have statutory Rx authority granted by the BON; the Rx authority is based on the NP's BON-approved protocol or practice guidelines. The protocol must outline diagnostic and therapeutic procedures and categories or drugs that may be ordered, administered, dispensed, and/or prescribed for patients with diagnoses identified by the NP. NPs, CRNAs, and CNMs may not write an Rx for any schedule of controlled substance. DEA numbers are not issued. CNMs and CRNAs may order controlled substances within a licensed health care facility using BON-approved protocol or practice guidelines.

Missouri

www.ecodev.state.mo.us/pr/nursing

Legal Authority

The statutory definition of APN in the NPA, 335.016 (2) RSMo, became effective August 28, 1993. The Rule 4 CSR 200–4.100 Advanced Practice Nurse became effective June 30, 1996 and includes NPs, CNSs, NMs, and RNAs. Pursuant to the BON's application process, a "Document of Recognition" may be granted by the BON if the APN Rule requirements are met. Individuals are recognized by their specific clinical nursing specialty area as a CNS, an NP, an NM, or an RNA, which thereby delineates their particular title and SOP as APNs. When practicing outside their recognized clinical nursing specialty area, individuals must practice and title themselves as registered professional nurses (who are not APNs). Continuing recognition as APNs is accomplished through ongoing compliance with the APN Rule's requirements. Additional legislation enacted in 1993 permits collaborative practice arrangements between RNs who are not APNs or RNs who are recognized as APNs and physicians using written agreements, written protocols, or written standing orders (334.104.1 or 334.104.2RSMo). Joint rulemaking activity between the BON and Board of Healing Arts, with Board of Pharmacy input, culminated in Rule 4 CSR 200–4.200 Collaborative Practice (CP). Three areas of focus in the CP Rule are (1) geographic areas to be covered, (2) methods of treatment that may be covered by CP arrangements, and (3) requirements for review of services provided pursuant to a CP arrangement. A written CP arrangement with a physician is not needed when an APN is performing nursing acts consistent with 335.016(10) RsMo and one's skill, training, education, and competence. A CP arrangement may be indicated to perform physician-delegated medical acts within the SOP of the APN and consistent with the APN's skill, training, education, and competence.

Reimbursement

Legislation passed in 1998, 376.407 RSMo, stated that "Any health insurer, as defined in section 376.806 RSMo, nonprofit health service plan or health maintenance organization shall reimburse a claim for services provided by an advanced practice nurse, as defined in section 335.016, RSMo, if such services are within the scope of practice of such nurse." Medicaid reimbursement is made to APNs who are enrolled as Missouri Medicaid fee-for-service providers, and Medicaid-enrolled APNs associated with a federally qualified health care and/or rural health care facility. Medicaid-enrolled APNs are reimbursed by Missouri Medicaid at the same rate and with the same benefits and limitations that apply to physicians. Changes in reimbursement, benefits, and/or limitations for physician services through Missouri Medicaid apply to APNs as well. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

BON-recognized APNs may be delegated administering, dispensing, prescribing, or other medical methods of treatment authorities by a physician pursuant to a written CP arrangement. Delivery of such APN health care services shall be within the APN's advanced clinical nursing specialty area, SOP, and consistent with the individual's skill, training, education, and competence. Delegated Rx authority does not include controlled substances and, therefore, a DEA number is not available. Any joint rulemaking between the BON and the Board of Healing Arts relating to the dispensing and distribution of medications or devices by prescription or prescription drug orders is subject to approval by the BOP.

Montana

www.com.state.mt.us/license/pol/index.htm

Legal Authority

As of October 1993, APRNs, including NPs, CNSs, CNMs, and CRNAs, are recognized and allowed by the BON to practice independently after completion of specific curriculum requirements, plus successful completion of a national certifying examination by a BON-recognized national certifying body. As of April 1995, APRN new graduate applicants must have a master's degree and national certification. Hospital privileges vary according to the rules and bylaws of each hospital.

Reimbursement

BON-approved APRNs have third-party reimbursement for all of the areas and services for which a policy would reimburse an MD. However, because HMOs are not included in the indemnity insurers law, mandatory coverage for APRNs does not apply to HMOs. APRNs receive 85% of the MD payment from BC/BS. Medicaid reimbursement (at 85% of physician payment) has been available since 1986. Medicare reimbursement consistent with federal guidelines (1990) is currently in effect. Since 1997, APRNs are included as providers for worker's compensation. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

APRNs who desire Rx authority apply to the Prescriptive Authority Committee (consisting of three BON members, one BOME, and one BOP). APRNs with Rx authority can prescribe all medications, including Schedule II-V controlled substances, using their own DEA number. Authority to prescribe is not dependent on any other health professional. Prescribing APRNs must have a quality-assurance program in place with a defined process of referral. The quality assurance method must be approved by the BON prior to issuance of Rx authority. The quality assurance method must include 30 charts or 5% of all charts by the APN reviewed quarterly. Review includes a mixture of peer review and review by a physician of the same specialty. New APRN applicants must complete 15 hours of CE pharmacology (in addition to their master's degree program) before application. CE is required for Rx authority renewal every 2 years. APRNs can receive and dispense pharmaceutical samples.

Nebraska

www.hhs.state.ne.us/crl/nns.htm

Legal Authority

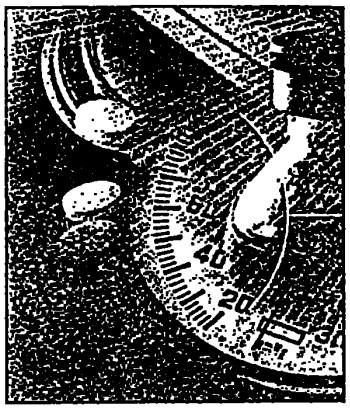
APNs are licensed as APRNs by the APRN Board, or certified as CRNAs or CNMs by the BON and BOM. The Board of APRNs consists of five APRNs, five MDs, one consumer, and one pharmacist. The CNS is not a legally expanded role but there is title protection in the statute. APRN scope is defined in statute and includes illness prevention and diagnosis and treatment and management of common health problems and chronic conditions. APRNs must maintain liability insurance ($200,000 per incident and $600,000 aggregate per year), and maintain an Integrated Practice Agreement (IPA) with a collaborating physician. The APRNs and physician shall practice collaboratively and have joint responsibility for patient care based on the SOP of each practitioner. The IPA specifies that "the collaborating physician shall be responsible for supervision through ready availability for consultation and direction of the activities of the APRN." If after diligent effort an APRN is unable to obtain an IPA with a physician, the APRN Board may waive the requirement for an IPA if the APRN has demonstrated proper course work, has a master's degree or higher in nursing, and has completed 2,000 hours under the supervision of a physician. APRNs without a master's or doctorate degree and/or at least 2,000 hours of physician-supervised practice must also have jointly approved protocols. APRNs licensed after July 19, 1996 must have a master's or doctorate degree to practice except for women's health and neonatal. CRNAs must practice with consultation, collaboration, and the consent of a physician. CNMs must have a practice agreement jointly approved by the BON and BOM that delineates delegated medical duties; CNMs function under protocols.

Reimbursement

Currently state legislation mandating third-party reimbursement for APNs does not exist; consequently, some APNs have been refused recognition as a provider. Medicaid reimburses ARNPs at 100% of physician payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Rx authority for APRNs is in the ARNP statute. The statute defines the APRN SOP as "prescribing therapeutic measures and medications" and "dispensing incident to practice only sample medications." Schedule II is limited to 72 hours and pain control only. CRNAs prescribe within their specialty practice; authority is implied in the statute. Qualified CRNAs and APRNs receive DEA numbers. CNMs may not obtain DEA numbers, as their authority to prescribe is dependent, based on the practice agreement.



Nevada

www.nursingboard.state.nv.us

Legal Authority

APN is a protected title recognized by the BON (title includes NPs, CNMs, and nurse psychotherapists with a master's degree). Applicants must submit a completed application and APN program transcripts. Applicants who graduated from an APN program after July 1, 1992, must be nationally certified or hold a BSN, or sign an agreement with the BON to make consistent progress toward the degree. A master's degree will be required after 2005. Applicants must present to the BON a signed letter of agreement with a collaborating physician (licensed in Nevada). The APN must keep written protocols at every job site along with a collaborative agreement signed by a physician. The BOME has changed a regulation, "supervision of APNs," to "collaboration of APNs" (BOME input); The BOME regulation, applicable to MDs, includes a provision that makes the physician apply for approval status and limits the number of APNs with whom any one physician can collaborate. The BON audits 5% of the APN practices each year. The BON has adopted R&R that certifies CNSs who meet educational requirement as APNs. CRNAs and CNSs function independently but may not prescribe. CRNAs are not considered APNs and do not have a collaborative practice agreement. CRNAs must have a BSN, and after 2005 they must have a master's degree.

Reimbursement

APNs and CRNAs have received third-party reimbursement since 1995. Hospital privileges are available to qualified APNs. Reimbursement from private insurance is at the same rate as the physician payment. Medicaid reimbursement is available to all APNs at 85% of physician payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

APNs may prescribe if they submit to the BON documentation (within the last 2 years) of 1,000 hours as an APN with a collaborating physician and documentation of completion of a course in pharmacology (equivalent to one semester), a list of drugs to be prescribed, and a signed competency statement from the physician. APNs must also apply to the BOP for a certificate to prescribe. If approved by the BON and BOP, the APN can prescribe any medications (excluding controlled substances) listed in the protocol (developed with the collaborating MD and updated yearly). The APN may pass a BON examination for dispensing, and, after passing the examination with BON approval, apply to the BOP for a dispensing certificate. Samples are not considered "dispensing"; APNs with Rx authority may distribute samples without having dispensing authority.

New Hampshire www.state.nh.us/nursing

Legal Authority

NPs, NMs, NAs, and psychiatric mental health CSs are licensed by the BON as ARNPs. ARNP applicants must provide (1) an official transcript of an approved educational program (including over 225 hours of theoretical nursing content, over 480 hours of clinical nursing practice including a precepted experience, and a formal pharmacology course or documentation from the program director that pharmacologic interventions have been integrated into the curriculum); (2) current national certification in the requested category; and (3) 30 contact hours of CE in a specialty area within 2 years prior to application. The ARNP has no requirement for physician collaboration or supervision.

Reimbursement

All major insurance companies, hospital service corporations, medical service corporations, and nonprofit health service corporations must by law reimburse ARNPs when the insurance policy provides for any service that may be legally performed by the ARNP, and such service is rendered. However, Cigna Healthsource, the state's largest HMO, has chosen not to recognize statewide ARNPs as PCPs. ARNPs are recognized as PCPs by several HMOs within the state. Medicaid also reimburses ARNPs at 100% of physician payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

BON-licensed ARNPs have plenary authority to prescribe controlled and noncontrolled drugs from the official exclusionary formulary determined by the Joint Health Council whose membership consists of (effective March 2000) three ARNPS appointed from the BON, three physicians appointed by the BOM who work with ARNPs, and three pharmacists appointed by the BOP. ARNPs are assigned a DEA number on request and after licensure as an ARNP. ARNPs also have dispensing authority.

New Jersey www.state.nj.us/lps/ca/medical.htm

Legal Authority

NPs and CNSs must be BON certified; effective November 1999, the certification title became *advanced practice nurse*. Advanced practice nurses now sign their credentialing title as RN, APN,C. NP and CNS applicants must be master's prepared in the appropriate specialty and have successfully completed a graduate-level credit course in pharmacology. Each certification applicant shall be required to successfully pass the highest level practice examination in the area of specialization approved by the Board. The following categories of NPs or CNSs may be certified: adult health, family, pediatric, school, gerontological, women's health; OB/ GYN, neonatal; psychiatric/mental health, community health, perinatal; maternal/child, oncology, critical care, emergency burns/trauma, medical/surgical, and rehabilitation. Other categories may be approved by the Board through the rulemaking process; any additional approved practice areas must meet nationally accepted standards. Family planning NPs have until May 2, 2002 before a master's degree is required. CNMs are regulated by the BME and have a separate authority to prescribe under the BME.

CRNAs do not have legislative recognition. However, CRNAs have BON regulations that require national certification and policies and procedures specific to the practice setting that meet nationally accepted standards.

Statutory requirements for hospital privileges do not exist; however, most hospitals have a provision in their bylaws to allow for credentialing APNs. The Department of Health and Senior Services (DHSS) is expected to adopt changes to hospital regulations to allow APNs to perform the admitting H&P, order consultations by other providers, and discharge patients from the emegency department without requiring physician cosignatures or assessments. DHSS is also reforming long-term care regulations.

Reimbursement

Private health plans in New Jersey, including Medicaid-managed care plans, are permitted to utilize APNs as PCPs according to a DHSS regulation, NJAC 8:38-6.2(c) but are not required to recognize or reimburse an APN. Consequently, many APNs are meeting barriers to reimbursement in many plans. Some plan directories list APNs as providers but many are still resistant to credentialing APNs to carry their own panel of patients. Currently, most health plans have a capitated arrangement with physician practices and allow APNs employed by the practice to care for plan beneficiaries. Medicaid fee-for-service adopted regulations in 1995 to reimburse APNs at approximately 95% of the physician rate, but the rate may vary according to procedure and setting. BC/BS must reimburse APNs directly if the reimbursed service can be performed within the APN's SOP and the APN is not an employee of a physician or an institution. The state health benefits plan covering all public employees in New Jersey directly pays some APNs. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Since 1991, APNs have been able to prescribe/order noncontrolled substances. A law effective November 1999 permits APN prescribing for Schedule II-V controlled substances, in both inpatient and outpatient settings, but only in the following circumstances: to continue or reissue an order or prescription for a controlled dangerous substance originally prescribed by the collaborating physician or to otherwise adjust the dosage of that medication, provided there is prior consultation with the collaborating physician or a physician designated by the collaborating physician; or for a patient in an end-of-life situation or as part of a treatment plan for a patient with terminal illness (when life expectancy is predicted as 12 months or less). APNs who want to prescribe controlled substances must apply for a state-controlled dangerous substances number and a DEA number. APNs prescribe/order medications using jointly developed protocols. The Division of Consumer Affairs (DCA), which oversees the BON and the BME, has established regulations that establish standards for the joint protocol between nurses and collaborating physicians. "Collaboration" means the ongo-

New Jersey continued

ing process by which an APN and a physician engage in practice, consistent with agreed upon parameters of their respective practices. "Joint protocol" means an agreement or contract between an APN and a collaborating physician that conforms to the standards established by the DCA. The joint protocol shall be (1) signed by the APN and the physician; (2) maintained on the premises of every office in which the APN practices; (3) updated and reviewed at least annually to reflect changes in the practice, skills of the APN, and reference materials containing practice guidelines or accepted standards of practice. The content of a joint protocol shall address (1) the nature of the practice, the patient population, and settings; (2) the recordkeeping methodology used in the practice; (3) a list of categories of medications appropriate to the practice; (4) specific requirements with respect to the record of medications prescribed or dispensed, dosages, frequency, duration, instructions for use, and authorizations for refills; (5) any medical conditions or findings within the nature of the practice that should require direct consultation prior to the prescribing or ordering of medications or devices; (6) identification of the means of communication between the APN and the collaborating physician can be in direct communication; and (7) identification of reference materials containing practice guidelines or accepted standards of practice. APNs can receive and dispense drug samples. No cosignatures are required for APN documentation, order, or prescription for controlled and noncontrolled medications.

New Mexico www.state.nm.us/nursing

Legal Authority

A 1991 revision to the NPA defines CNP as a PCP who can practice independently without physician supervision or collaboration requirements. BON-approved CNPs receive a CNP designation on their RN license; there is no certification designation of the specialty. A 1997 amendment to the NPA specified that the CNP must have completed a graduate program for the education and preparation of NPs (after January 2001 this must be master's level or higher for initial licensure). The BON also regulates CRNAs and CNSs. A 1997 NPA amendment specifies that after January 2001, CRNAs seeking initial licensure must be at the master's level or higher. CNSs must be master's prepared and certified by a national certifying nursing organization. Under a 1997 amendment to the NPA, CNSs can now "make independent decisions" and have "prescriptive authority" including Schedule II-V controlled substances and can distribute prepackaged drugs. CNMs are regulated by the Department of Health. Few NPs have hospital staff privileges if they have admission privileges. An MD must usually countersign within 24 hours.

Reimbursement

Statutory authority for third-party reimbursement for NPs and CNSs has been in effect since 1987 but CNPs continue to meet resistance in being listed as a PCP. FNPs and PNPs receive Medicaid reimbursement at 90% of physician payment. All three of the managed care groups contracted to provide Medicaid coverage have contracts with NPs. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa/gov/medicare/enrollment/contacts/

Prescriptive Authority

The 1991 revision to the NPA allows CNPs who have fulfilled the requirements for Rx authority to prescribe and dispense independently, including Schedules II–V controlled substances. BON prerequisites to prescribe controlled substances include experience with Rx writing, a state-controlled substance license, and a DEA number. Each CNP must maintain his or her own formulary and submit a copy to the BON. CNSs must have graduate-level pharmacology, pathophysiology, a physical assessment course, and must prescribe in collaboration with an MD, DO, or NP during a 400-hour preceptorship before they can prescribe independently. Under a 1997 law, CNMs obtained Rx authority; rule-making authority is under the Department of Health.

New York www.op.nysed.gov/nurse.htm

Legal Authority

Since 1939, NPs have been authorized to diagnose, treat, and prescribe in collaboration with a physician in accordance with a written practice agreement and written practice protocols. NPs are licensed as RNs and certified by the State Education Department as NPs. RNs are authorized to implement NP medical regimens: OTs and PTs are authorized to accept NP referrals. NPs may be granted hospital admitting privileges. NPs are considered independent practitioners; orders, prescriptions, and medical notes do not require a cosignature.

In April 1993, midwives were separately licensed to manage pregnancies and primary preventive reproductive health care, and to prescribe in collaboration with a physician with a practice agreement and protocols. Although CNMs may continue to use the title "nurse midwife," individuals do not have to be nurses to be licensed as midwives.

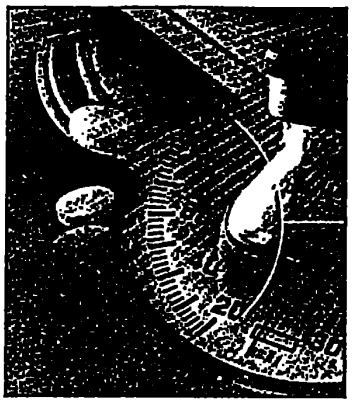
In 1999, a bill was introduced in the State Senate to define CRNA practice. It would have required medical direction of CRNAs and was opposed by many nurses in the state. The use of the term "medical direction" in the NPA would have been more restrictive for CRNAs than the wording, "collaboration with a physician," currently used for other APNs. APNs can be credentialed for hospital privileges. However, the credentialing process is through the medical staff bylaws, so barriers do appear.

New York continued

Reimbursement

NPs of all specialties may register as Medicaid providers and be reimbursed at 100% of the physician rate. Midwives and NPs are reimbursed through Medicaid.

In 1996, the Medicaid managed care law was revised. Nurses continue to be qualified providers and NPs are specifically mentioned as qualified primary care gatekeepers. A new law is in effect that regulates the practice of HMOs. All of the provisions are provider-neutral, applying equally to physician and nonphysician providers. Although there is no guarantee that APNs will have a role in managed care delivery, if they are utilized in the system their rights are assured. The law requires disclosure to patients of all benefits covered as well as processes used for utilization review and filing grievances on denial of service. The law also prohibits "gagging" health care providers, establishes due process for termination of provider contracts, allows for access to specialty providers, includes continuity of care provisions for ongoing care with providers outside of the plan, and requires the commissioner of health to determine that there are sufficient providers to meet the covered patients' needs. Nurses continue to be qualified providers and NPs are specifically mentioned as qualified primary care gatekeepers for managed care. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa/gov/medicare/enrollment/contacts/.



Prescriptive Authority

The law authorized and the state attorney general endorsed Rx of drugs (Schedules II-IV), devices, and immunizing agents without restriction. The DEA has granted individual numbers to NPs since the attorney general interpretation. NPs may order drugs, devices, immunizing agents, tests, and procedures in accordance with the practice agreement and practice protocols without cosignature. Midwives are authorized to prescribe and administer drugs, immunizing agents, diagnostic tests, and devices, and to order laboratory tests limited to the practice of midwifery.

North Carolina www.ncbon.com

Legal Authority

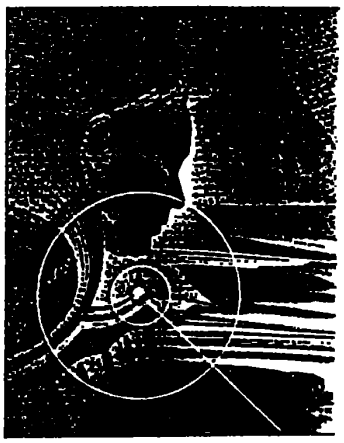
NPs apply to a joint subcommittee of the BON and North Carolina Medical Board to obtain approval to practice as NPs. Beginning January 2000, new NPs must have a master's degree. NPs may own their own practice as long as they contract with a MD. As of May 1999, the NP must have a collaborative written practice agreement with a physician for continuous availability to each other for ongoing supervision, consultation, collaboration, referral, and evaluation of care provided by the NP and documented face-to-face consultation every 6 months. NP's SOP can include those medical acts that NPs can document training for and that are included in the site protocols approved by the NP and physician. The supervising physician does not have to be on site. The NP shall be prepared to demonstrate to the BON or BOM the ability to perform medical acts as outlined in the site-specific written protocols. CRNAs are regulated solely by the BON and do not have Rx authority. CNMs have their own separate statute and are regulated by a midwifery joint committee. CNS recognition and SOP is regulated by the BON, but does not include Rx authority. CNSs with master's in psychology/mental health may practice psychotherapy independently. As of 1995, all APRNs are allowed to form corporations with MDs; however, CRNAs can only incorporate with anesthesiologists.

Reimbursement

NPs receive Medicaid reimbursement at 100% of the physician rate. CHAMPUS also reimburses NPs. Statutory authority for third-party reimbursement for NPs provides for direct reimbursement to NPs for services within their scope that are currently reimbursable to a nonnurse provider. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

NPs and CNMs may prescribe any drugs and devices, including controlled substances, that are identified in their site-specific written protocols. NPs are also authorized to compound, dispense, and procure drugs. They may refill legend drugs up to 1 year; they may not refill any controlled substances. They may write controlled substance prescriptions for 30 days. The protocols must be signed by the NP and all supervising MDs for that practice site and be maintained on site. A DEA number must be obtained, in addition to the NP's prescribing number issued at the time of approval, to practice if controlled substances are in their protocols.



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North Dakota www.ndbon.org

Legal Authority

In 1995, an extensive amendment to the NPA (NDCC 43-12.1) was enacted. APRNs (NPs, CNSs, nurse clinicians, NMs, and NAs) are regulated by the BON after demonstrated advanced education and certification. After January 2001, an APRN applicant for initial licensure must have a master's degree with a nursing focus. APRNs must maintain national certification and submit a SOP statement for review by the BON to renew their APRN license. All R&R governing APRNs were reviewed and revised by the BON in 1996.

Reimbursement

In 1987, a third-party reimbursement bill was passed giving benefits for health services provided in the scope of licensure by nurses holding advanced licensure and having mental health within their SOP. FNPs, CNMs, and PNPs receive Medicaid reimbursement at 75% and CNMs at 85% of a physician payment. In 1995, a third-party reimbursement bill was passed for APRNs practicing within their SOP. BC/BS reimburses CRNAs, CNMs, CNSs, and NPs at 75% of allowable charges.For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

A bill authorizing Rx authority for ARNPs for controlled and noncontrolled drugs was passed by the 1991 legislature. Rx practice is defined in the NPA as assessing the need for drugs, immunizing agents, or devices and writing a Rx to be filled by a licensed pharmacist. For Rx authority, the APRN must submit a statement to the BON addressing the following: methods and frequency of the collaboration for Rx practices, which must occur as client needs dictate but no less than once every 2 months; documentation methods of the collaboration process regarding Rx practices; and alternative arrangements for collaboration regarding Rx practices in the absence of the physician.

An affidavit from the physician must be submitted acknowledging the manner of review and approval of the planned Rx practices and that the APRN's SOP is "appropriately related" to the collaborating physician's specialty. The "collaborative agreement" requirement is solely for Rx authority. APRNs with Rx authority may apply for a DEA number.

Ohio www.state.oh.us/nur/

Legal Authority

Legislation (SB 154) recognizing CNMs, CNPs, CRNAs, and CNSs became effective in 1997. Each CNM, CNP, and CNS must have a collaborating physician. Each CNM, CNP, and CNS (except psych/mental health CNSs) must develop a standard care arrangement (practice agreement) with the collaborating physician. CRNAs practice with a supervising physician. Beginning in 2001, all new NPs, NMs, and NAs must have a master's degree in nursing or a related field and must hold applicable certification from a national certifying organization approved by the BON. Currently, each CNS must have a master's degree in nursing and each NP, NM, and NA must have certification from a BON-approved national certifying organization. The statute extends three pilot programs utilizing APNs at schools of nursing at Case Western Reserve University, University of Cincinnati, and Wright State University until 2010. Only qualified nurses in the pilot programs have Rx privileges per formulary. CNSs and NPs were included in 1998 legislation concerning do not resuscitate orders.

Reimbursement

The Ohio Department of Human Services (ODHS), which administers Medicaid, continues to recognize APNs employed in the pilot programs. Currently ODHS recognizes CNMs, CRNAs, and CNPs (in family, pediatric, adult, and women's health specialties) for reimbursement. Discussion is ongoing to recognize other specialties and CNSs. Some managed care organizations are including APNs on provider panels, and some commercial plans are including APNs on their panel after direct negotiation. Some APNs are receiving reimbursement as a result of direct negotiations with other payers. Some managed care organizations are including APNs on provider panels. The Worker's Compensation Bureau reimburses CRNAs, NPs, and CNSs as of July 1999. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Approximately 120 APNs in Ohio have practice-based pilot project Rx authority to prescribe according to protocols approved by a formulary committee. APNs in the pilot project may prescribe Schedule III-V controlled substances using DEA numbers. The pilot project authorization will sunset 2003. Under a law effecitve May 2000, all qualified CNPs, CNSs and CNMs are able to prescribe Schedule III-to V controlled substances. Rulemaking will be completed June 2001 with full implementation of the law by January 2002. Administered by the BON, applicants for Rx authority must be graduate-prepared (except for a 1-year grandfather period for qualified APNs), complete a 1-year externship with a physician, and have taken an advanced pharmacology course (initially 36 hours and increasing to 45 hours, which can be part of a graduate curriculum or a CE course). During the externship, the CNP, CBNM, or CNS will be able to sign prescriptions in consultation with the physician. At the end of the externship, the physician will be able to sign a letter of endorsement and the CNP, CNM, or CNS would be issued a permanent certificate to prescribe (where consultation with a physician will be up to the discretion of the CNP, CNM, or CNS). A formulary will be developed by a joint committee (Committee on Prescriptive Governess) consisting of APNs, physicians, and a pharmacist. DEA numbers will be applicable and the CNP, CNM, or CNS will be able to dispense samples (a 3-day supply or the smallest commercially prepacked units available).

Oklahoma

www.lsb.state.ok.us

Legal Authority

APNs (ARNPs, CNMs, CNSs, CRNAs) are defined in the NPA and regulated by the BON. APNs must complete a formal program of study approved by the BON and be nationally certified by an appropriate certifying body. The ARNP practices within the SOP as defined by the NPA. State regulations for the licensing of hospitals currently prohibit the admitting of patients by APNs.

Reimbursement

Legislation addressing third-party reimbursement for NPs does not exist. After Rx authority legislation passed, the state Medicaid managed care HMO added NPs as primary care managers in rural areas only. One of the major insurance companies in the state (Oklahoma State and Education Employees Insurance) added NPs as providers in 1997. Negotiation continues with other third-party insurers. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Optional Rx authority for ARNPs, CNSs, and CNMs is regulated by the BON. Physician supervision is required only for the Rx authority portion of advanced practice. Prescribing parameters include that the Rx (1) not be on the exclusionary formulary approved by the Board, (2) must be within the ARNP, CNM, CNS SOP, (3) includes Schedule III-V controlled substances if state narcotics and DEA registrations are obtained, and (4) includes signing to receive pharmaceutical samples. ARNPs, CNMs, CNSs must have 45 contact hours or 3 academic hours of pharmacology in the 3 years immediately preceding the initial application for Rx authority, and 15 contact hours or 1 academic hour every 2 years for renewal.

In 1997, CRNAs obtained the authority to "order, select, obtain and administer legend drugs, Schedule II-V controlled substances, devices and medical gases, when engaged in preanesthetic preparation and evaluation, anesthesia induction, maintenance and emergence, and postanesthesia care." Regulation is by the BON. The CRNA functions under the supervision of an MD, DO, or dentist licensed in Oklahoma, and under conditions in which timely on-site consultation by such MD, DO, or dentist is available. CRNAs must have a minimum of 15 CEUs for initial application for Rx authority and 8 CEUs for biennial renewal in advanced pharmacology related to administration of anesthesia within the 2 years immediately preceding the date of initial application and renewal, and evidence of professional liability insurance. CRNAs must obtain state narcotics and DEA registrations to order Schedule II-V controlled substances.

Oregon

www.osbn.state.or.us

Legal Authority

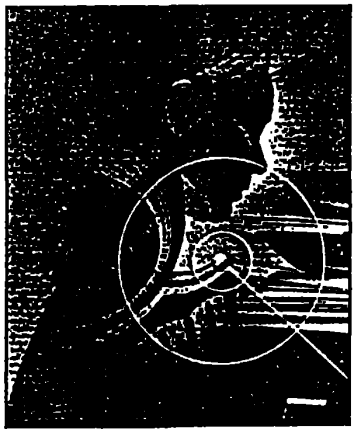
Authority for NP practice is granted through the NPA and regulated by the BON. NPs, CNMs, CNSs and CRNAs must receive a certificate from the BON to be authorized to practice. NP SOP is very broadly defined in the statute; a master's degree is required for entry into NP practice. CNS rule making for licensure is in progress. Statutes allow NPs to be granted hospital privileges; they may be refused hospital privileges, but only on the same basis as other providers.

Reimbursement

NPs are entitled by law to reimbursement by third-party payers. APNs are designated as PCPs on several HMO and managed care plans. Medicaid reimburses NPs for services within their SOP at the same rate as physicians. Numerous administrative rules and statutes include NPs (e.g., Department of Education special ed physicals; Department of Motor Vehicle chronically ill and disabled motorist examinations). For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Regulation of Rx authority is under the sole authority of the BON. The BON determines the formulary from which NPs can prescribe including controlled substances Schedules II-V. The NP formulary is based on Drug Facts & Comparisons; new drugs are added on the formulary at each BON meeting. Criteria for inclusion include the following: (1) Is the drug appropriate for NP SOP? (2) Would the NP use the drug? and (3) Is the drug FDA approved? Oregon has legislated independent or "plenary" authority for NPs to prescribe, so NPs are able to obtain DEA numbers. NPs can receive and distribute samples but they do not have dispensing authority, except NPs in college health centers have limited authority to dispense certain prepackaged medications. NPs do not have authority to prescribe under the "physician-assisted suicide" law. Medical marijuana is also not permitted to be authorized by anyone other than a physician.



Pennsylvania

www.dos.state.pa.us/bpoa/nurbd/mainpage.htm

Legal Authority

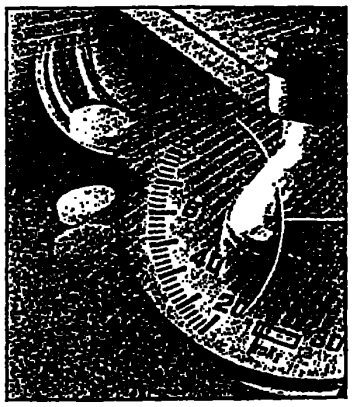
NPs are authorized to practice as CRNPs under regulations promulgated jointly by the BON and BOM. A CRNP functioning in the expanded role performs in collaboration with and under the direction of a physician. "Direction" is the incorporation of physician supervision to the CRNP's performance of medical acts in the following ways: (1) immediate availability through voice or direct communication; (2) a predetermined plan for emergency services; and (3) regularly scheduled basis for consultation, chart review, and "establishing and updating standing orders, drug and other medical protocols," and "periodic updating in medical diagnosis and therapeutics." CNSs are not specifically defined or regulated beyond the RN SOP. The BON regulates CRNAs' education and certification requirements, requires overall physician direction, and defines cooperation between the CRNA and physician or dentist. The BOM licenses and regulates CNMs. A signed written collaborative agreement between the CNM and physician is required. The PA Department of Health Regulations authorizes a hospital's governing body to grant and define the scope of clinical privileges to individuals, with advice of the medical staff. Legislative plans include seeking title recognition for CNSs and removing CRNPs from BOM control.

Reimbursement

Third-party reimbursement is available for the CRNA, CRNP, certified enterostomal therapy nurse, certified community health nurse, certified psych/mental health nurse, and certified CNS, provided the nurse is certified by the state or a national nursing organization recognized by the state BON. Medicaid reimburses CRNPs and CNMs at 100% of physician payment for certain services. The state Department of Health allows HMOs to request an exception to HMO regulations in order for CRNPs to be recognized as primary care gatekeepers. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

The CRNP R&R of the BON and BOM authorize the CRNP to "perform acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in the Commonwealth." The BON and the BOM have jointly developed proposed regulations granting CRNPs Rx writing privileges. Under the new regulations effective in 2000, a CRNP may prescribe and dispense drugs if the CRNP has successfully completed not less than 45 hours of course work specific to advanced pharmacology (either as CRNP education or Board-approved CE), and if the prescribing and dispensing is relevant to the CRNP's area of practice and documented in the collaborative agreement and not from a prohibited category of drugs. The CRNP may write a prescription for a Schedule II controlled substance for up to a 72-hour dose if the CRNP notifies the collaborating physician within 24 hours. The Rx blank must include the name and certification number of the CRNP and identification of the collaborating physician. The collaborative agreement is a signed written agreement between the CRNP and a collaborating physician and must identify the area of practice; specify the amount of professional liability insurance carried by the CRNP; specify the categories of drugs from which the CRNP may prescribe and dispense; contain attestation that the physician has knowledge and experience with the drugs that the CRNP will prescribe; and specify the circumstances and how often the collaborating physician will personally see the patient, keep the patient at the practice site, and be available for inspection. A physician may have a collaborative agreement with several CRNPs as long as the physician is not supervising more than four (with a prescribing and dispensing agreement) at any one time; a limit does not exist regarding supervising those who do not prescribe and dispense.The CNM R&R authorize the CNM to "prescribe medical therapeutic and diagnostic measures." The BOM does not interpret this to include Rx authority.



Rhode Island

www.health.state.ri.us/hsr/professions_reg.htm

Legal Authority

NP practice is covered under the NPA. A joint-practice committee (three MDs, three NPs, and one consumer) meets regularly to assess CRNP practice for the purpose of improving patient care and to review complaints. This committee reports to the BON. There are no requirements for physician collaboration (except for Rx authority). CNMs have a separate law and separate R&R not under the BON. CNSs are BON R&R defined. In 1997, H 5652 passed, which allows psych/mental health CNS (1) to practice, including prescriptive privileges and certain legend medications and Schedule IV controlled substances; (2) to prescribe from a formulary established by a formulary committee; and (3) to practice without physician collaboration except when prescribing. The psych/mental health CNS in independent practice does not have Rx privileges.

Reimbursement

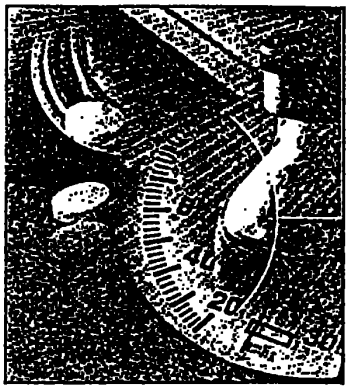
June 1990 legislation allows for direct reimbursement of psychiatric clinical specialists and CNMs. January 1995 legislation allows CRNPs and psych/mental health CNSs practicing in collaboration with or in the employ of a physician licensed under Chapter 37 of Title V to receive third-party reimbursement. The Medicaid program, implemented by the Department of Human Services, is working with PNPs and FNPs to define how NPs fit into

Rhode Island continued

coding for primary care services. The RIteCare Program (managed care program for persons eligible for Medicaid) has a contract provision that allows NPs to CNMs to serve as PCPs. Passed in 1997, H 6109 designates third-party reimbursement for CRNAs providing they provide their services under the supervision of anesthesiology MDs or CDSs. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Legislation passed in 1998 grants Rx privileges to CRNPs for legend and Schedule II-V controlled substances. CRNPs and CNSs are receiving DEA numbers. CRNPs are able to prescribe Schedule II-V legend drugs and CNSs may prescribe Class IV drugs. The CRNP and prescribing psych/mental health CNS must complete 30 hours of pharmacology within a 3-year period just prior to application for Rx privileges, and 30 hours of CE every 6 years to maintain these privileges. A six-member formulary committee appointed by the director of health recommends to the director of health what the formulary contains. The CRNP and collaborating MD or medical director write their own practice guidelines, which are kept at the practice site and updated annually. The NP signs an Rx pad that has the site identified on the pad. Pharmacies have a list of all CRNPs who have Rx privileges. Though in draft form, guidelines were written and are currently being followed "to provide guidance to licensed health care facilities relating to the proper storage, security, and dispensing of medications." The guidelines (referenced from state statutes) state that licensed practitioners with authority to prescribe medications may procure and dispense (including drug samples) legend medications and Schedule II-IV controlled substances if the practitioner has obtained the required state and federal registrations; the guidelines apply to CNMs, physicians, dentists, veterinarians, physician assistants, podiatrists, and CNSs (only for Schedule IV controlled substances).



South Carolina www.llr.state.sc.us/bon.htm

Legal Authority

The NPA (Chapter 33, 91-6) has BON R&R for NPs, CNMs, and CNSs functioning in the extended role, and CRNAs. An NP, CNM, CNS functioning in an extended role shall perform delegated medical acts pursuant to an approved written protocol between the nurse and physician. "Delegated medical acts" means those additional acts delegated by the physician that include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy under approved written protocols. NPs who manage delegated medical aspects of care must have a supervising physician and operate within the "approved written protocols." Approved written protocols means specific statements developed collaboratively by the physician and the nurse that establish physician delegation for the medical aspects of care including prescription of medications. The protocols must be reviewed and signed annually. When application is made for more than three NPs to practice in the extended role under one physician or when the NP is performing delegated medical acts in a practice site greater than 45 miles from the physician, then the BON and BOM will determine if adequate supervision exists. For official recognition as an NP, CNM, or CNS functioning in the extended role, or CRNA, new applicants to the BON must provide evidence of certification by an appropriate national credentialing organization and provide evidence of a master's degree in nursing. The BON conducts a random survey of the protocols, practitioner, and practice site.

Reimbursement

All NPs can apply for a Medicaid provider number; NPs are paid 80% of the physician payment rate. The state health and human services finance commissioner requires NPs to have current, accurate, and detailed treatment plans. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Legislation passed in June 1992 authorized NPs, CNMs, and CNSs functioning in the extended role to prescribe. Prescriptions by NPs are limited to "drugs and devices utilized to treat common well-defined medical problems within the specialty field of the NP as authorized by the physician and listed in the approved written protocols." Schedules II–IV controlled substances cannot be prescribed. Legislation passed in June 1993 allows NPs to prescribe Schedule V drugs. The BON is responsible for implementation of the new R&R within the NPA. The Board of Pharmacy has opined that "The supervising physician is not the prescriber and the NP is not working under the physician's supervision. The NP prescribes independently of the supervising physician." NPs can obtain DEA numbers from the Department of Health and Environmental Control. The BON issues an identification number to the nurse authorized to prescribe. Prescriptions are signed by the NP with the BON assigned Rx authority number, and the physician's name and address must be preprinted on the form. During August 2000, the BON approved an emergency regulation allowing the NP with Rx authority to request, receive, sign and distribute professional samples (except for Schedule II-IV controlled substances).

South Dakota www.state.sd.us/dcr/nursing

Legal Authority

CNPs and CNMs are regulated by a BON and BOM joint board. CNPs and CNMs must submit a collaborative agreement with an MD licensed in the state prior to performing the overlapping scope of advanced practice nursing and medical functions. On-site MD collaboration is required one half day per week.

CNSs are regulated by the BON. MD supervision is not required. Prior to ordering durable medical equipment or therapeutic devices, CNSs must collaborate with an MD. CRNAs are regulated by the BON. CRNAs perform acts of anesthesia in collaboration with an MD licensed in the state as a member of a physician-directed health care team. On-site supervision is not required. APNs are granted hospital privileges. In 1996, legislation was passed that permits nurses to form professional service corporations.

Reimbursement

Since the early 1980s, the insurance law has specified that CNPs and CNMs can receive third-party reimbursement. Pursuant to 58 17 54, CRNAs, CNPs, and CNMs must be reimbursed on the same basis as other medical providers assuming that the service is covered under the policy; the law requires that CRNAs, CNPs and CNMs receive reimbursement when the service is covered under the policy and they are acting within their SOP.

CNPs and CNMs receive Medicaid reimbursement at 90% of the physician payment rate. CRNAs are reimbursed at the physician rate for services provided under Medicaid.

State insurance law is silent regarding CNSs. CNSs may be reimbursed under specific plans. Medicaid reimbursement is allowed only if billed through physician's practice. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

As of January 1997, CNPs and CNMs may prescribe legend drugs and Schedule II-IV controlled drugs as authorized by the collaborating physician agreement. CNPs and CNMs have two controlled substance registration options: (1) they may seek independent state registration and independent DEA registartion in all schedules as authorized by their collaborative agreement; or (2) they may act as an agent of an institution utilizing the institution's registration number to prescribe, provide, or administer controlled substances. Controlled substance authority is granted by separate application to the Department of Health following collaborative agreement approval by the BON and BOM.

CNPs and CNMs may request and receive drug samples, provide drug samples, and provide a limited supply of labeled medications, pursuant to legislation effective July 1, 2000. Medications and sample drugs must be accompanied by written administration instructions and documentation entered in the patient's medical record. The provision of drug samples or a limited supply of medications is not restricted, with the exception of Schedule II controlled substances, which are limited to a one-time 48-hour supply. Therefore, the amount provided is at the profssional discretion of the CNP or CNM and the collaborating physician, based upon the needs of the patient. CNPs or CNMs who accept controlled substances, either trade packages or samples, must maintain a record of receipt and disposition. CNPs and CNMs who practice in licensed healthcare facilities may have to comply with additional requirements. CRNAs and CNSs do not have Rx authority. CNSs may order and dispense durable medical equipment and therapeutic devices in collaboration with a physician.

Tennessee 170.142.76.180/bmf-bin/bmfproflist.pl

Legal Authority

APRNs practice under a broad nurse practice act and a BON administrative rule that authorize the expanded role. APRNs who prescribe legend drugs must have protocols that are jointly developed by the APRN and the supervising physician. Medical board rules that govern the supervision of the NP Rx writer are jointly adopted by the BOME and the BON. The BON has the sole authority to establish the qualifications, competencies, training, education, and experience required to prescribe legend drugs. APRNs who meet the qualifications and hold a "certificate of fitness" to prescribe are recognized in the law as NPs; in TCA 63-7-123, they are called CNPs for the purpose of prescribing. CNSs, CNMs, and CRNAs are not named in the NPA. CRNAs and CNPs are defined in the hospital licensure rules. Hospital rules provide that medical staff may include nurse-midwives. CNMs are not precluded from admitting a patient with the concurrence of a physician member of the medical staff. CNPs have admitting and clinical privileges in Medicare critical access hospitals, but privileges for NPs are not addressed in other hospital licensure rules.

Reimbursement

Tennessee law mandates reimbursement of APRNs in private insurance plans. Restrictions preventing APRNs from being listed on managed care panels do not exist; however, neither is there language to specifically authorize it. BC/BS reimburses primary care NPs in the TennCare program at 100%; they also reimburse CNMs and CRNAs. Some managed care organizations reimburse APRNs and some do not. The Tennessee Nurses Association was successful recently in negotiating positive changes in a restrictive "protocol" that was a component of the contract of one HMO in middle Tennessee.

Prescriptive Authority

APRNs who have a certificate of fitness to prescribe issued by the BON (requiring a master's or doctorate in nursing, preparation in specialized practitioner skills at the master's, post-master's, doctoral or post-doctoral level, three academic quarter hours of pharmacology or its equivalent, and current certification in the appropriate nursing specialty area) currently write and sign prescriptions and/or issue legend drugs under protocols and medical board rules (0880-6) in any practice site. This authority includes prescribing Schedules II-IV controlled substances. NPs can receive and issue drug samples.

Texas www.bne.state.tx.us or www.cnaptexas.org

Legal Authority

Nurses in advanced practice (NPs, CNMs, CRNAs, and CNSs) must be recognized by the BNE as APNs. The NPA provides the BNE authority to regulate professional nursing practice, including advanced practice nursing, and authority to set the educational requirements and CE requirements for Rx authority. The APNs SOP is based on her/his educational preparation, continued experience, and the accepted SOP of the particular specialty area. The functions of the APN shall be appropriate to her/his advanced educational preparation. The APN acts independently and/or in collaboration with the health team and must utilize mechanisms that provide medical authority when such mechanisms are indicated. Hospitals may extend privileges to APNs but are not required to do so. Legislation was passed in 1999 requiring hospitals electing to extend APNs clinical privileges to provide due process type rights in granting, modifying, or revoking those privileges. Legislation was also passed that permits appropriate categories of APNs to perform and sign for physical examinations required for bus drivers and cosmetologists. Specific legislation was passed regarding CRNAs who practice in outpatient settings. The board adopted final rules for the minimum standards for provision of general anesthesia, regional anesthesia, and monitored anesthesia care by CRNAs in 2000. The BOM adopted similar rules for physicians who provide these services.

Reimbursement

The Coalition for Nurses in Advanced Practice has been successful in changing state agency regulations to be consistent with current APN practice and in recognizing APNs in the health care system. For example, the University Interscholastic League, which regulates competition in kindergarten through 12th grade, changed its constitution to allow APNs to sign their forms. All categories of APNs are eligible for direct Medicaid reimbursement at 85% of physician fees. Medicaid rules permit APN services provided under jointly developed protocols to be billed as a physician service at 100% of the physician rate. Texas does not have an "any willing provider" law except for pharmacists. Insurance plans must list which providers will and will not be recognized in each plan. HMOs and PPOs are prohibited from discriminating against APNs based solely on licensure. HMOs and PPOs are required on request to list an APN on any provider panel on which the APN's collaborating physician is listed unless the APN fails to meet previously established quality-of-care standards. Legislation was passed in 1999 that includes APNs in the nondiscrimination provision governing indemnity insurers. Actual reimbursement practices vary greatly by company and type of APN. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Rx authority for APNs does not include controlled substances and is based on a collaborative practice model utilizing protocols, standing delegation orders, standing medication orders, practice guidelines, or other physician orders for the medical aspects of patient care including noncontrolled drug orders. Law and regulations explicitly provide that protocols should be designed to promote the exercise of professional judgment by APNs commensurate with their education and experience. BME and BNE rules define protocols broadly as written authorization to initiate medical aspects of care, including prescribing. Rx authority is site specific, but APNs at most practice sites should be able to qualify. Sites qualifying are (1) sites serving medically underserved populations, (2) physician primary practice sites, and (3) facility-based practices in hospitals or LTC facilities. The APN with a valid Rx authorization number may request, receive, possess, and distribute drug samples provided protocols authorize the APN to sign the drug orders, all requirements for the APN to sign have been met, and a record of the sample is maintained. Samples must be labeled as specific in the Dangerous Drug Act and are limited to categories of dangerous drugs only.

Utah www.commerce.state.ut.us/dopl/dop1.htm

Legal Authority

APRNs include NPs, psych/mental health specialists and other CNSs. Licensing of APRNs, CNMs, and CRNAs occurs through the BON under the Division of Occupational and Professional Licensing. CRNAs are not recognized in state law as APRNs; CRNAs hold separate licensure and are regulated under the same NPA but under a different classification. CNMs are regulated by a separate practice act and LNM board. All APRNs must be master's degree prepared. APRNs licensed after July 1, 1992, must be nationally certified to obtain licensure. The APRN SOP is defined by set standards from each national professional specialty organization. Physician collaboration is required only for APRNs prescribing Schedule II-III controlled substances. All APRNs must participate in peer review.

Reimbursement

There is a nondiscrimination clause in the state insurance code, so there is nothing to prohibit reimbursement. CNMs, APRNs, and CRNAs, are reimbursed by most insurance companies. The state health department Medicaid Advisory Board has implemented certified PNP and FNP reimbursement at 100%. CNMs are reimbursed at 65% by Medicare whereas other APRNs receive reimbursement at 85%. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

APRNs and CNMs can prescribe within their SOP. For APRNs, a consultation and referral plan is only needed if prescribing Schedule II or III controlled substances. CRNAs do not require a consultation or referral plan for their practice. CRNAs are required to be involved in a quality assurance program. CRNAs may order and administer drugs, including Schedule II-V controlled subtances in a hospital or ambulatory care setting; they may not provide prescriptions to be filled outside the hospital. APRNs and CNMs receive a DEA number after passing a controlled substance exam and obtaining a state-controlled substance license. APRNs may sign for and dispense samples.

Vermont

www.vtprofessionals.org/nurses/

Legal Authority

APRNs are endorsed by the BON to perform acts of medical diagnosis and to prescribe medical, therapeutic, or corrective measures under the R&R. The APRN performs medical acts independently within a collaborative practice with a physician under practice guidelines that are mutually agreed on between the APRN and collaborating physician. Practice guidelines (1) describe the clinical site, focus of care, and category of clients; (2) index a copy of standards for clinical practice, including method of data collection, assessment, plan of care, and criteria for consultation and referral, including emergency referral or delineation of clinical privileges; (3) include the name of at least one physician who practices in the same specialty area who will be routinely utilized for collaboration, consultation, and referral; and (4) include method of quality assurance. The practice guidelines must be reviewed and signed annually, and filed at the workplace.

Current APRN R&R include (but are not limited to) the following: ANPs, PNPs, FNPs, WHNPs; CNMs, CRNAs, and CNSs in psychiatric health. The BON will endorse other CNSs if they are nationally certified and if their formal educational program, approved by the BON, included (1) a "hands-on" supervised clinical preceptorship; (2) advanced physical assessment and differential diagnosis; (3) advanced pharmacology "geared toward the nurse prescriber" with a clinical management component. CNSs in psychiatric health do not need a collaborative physician if they do not have Rx privileges.

Reimbursement

Currently, BC/BS reimburses psychiatric NPs utilizing a provider number. All NPs receive Medicaid reimbursement at 100% of physician payment. The state Medicaid program is implementing an enhanced reimbursement to physicians who care for patients covered by both Medicare and Medicaid. The medical case management fee rules do not include NPs as eligible PCPs. Although legislation requiring or prohibiting third-party reimbursement does not exist, insurance companies may reimburse NPs depending on policies. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Prescriptions, including controlled substances, may be written and signed by the APRN for medications covered in the practice guidelines. A list of BON-endorsed APRNs is made available to the BOP. NPs are receiving DEA numbers. APRNs have the same privileges as physicians in dispensing and administering drugs.

Virginia

www.dhp.state.va.us

Legal Authority

The BON and the BOM have statutory authority to regulate licensed nurse practitioners (LNPs): NPs, CNMs, and CRNAs. CSs are registered solely with the BON. The presidents of the BON and BOM each appoint three members from their boards to the Committee of the Joint Boards of Nursing and Medicine to administer the regulations governing LNPs. LNPs must be nationally certified to apply for state authorization and must practice under the medical direction and supervision of a physician. NP practice is based on education and written protocols; the NP may practice only within the SOP agreement with a supervising physician.

Reimbursement

NPs can independently bill insurers, but they are not always paid, as they are not mandated providers. CNMs (as of July 1997) and CNSs in psychiatric health now receive third-party reimbursement. FNPs, PNPs, and CNMs receive Medicaid reimbursement at 100% of physician payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa/gov/medicare/enrollment/contacts/.

Prescriptive Authority

Authorized LNPs (as designated by the BON and BOM) may prescribe all Schedule VI legend drugs. A practice agreement with the physician is submitted to the joint boards; this agreement lists the categories of drugs from which the NP will prescribe. NPs may only prescribe legend drugs if "such prescription is authorized by the written agreement between the NP and physician." The Rx can contain only the NP name, but the patient must be told in writing the name and address of the supervising physician. Rx authority legislation was changed in the 1995 legislative session to allow each physician to have a practice agreement with four NPs in both for-profit and nonprofit sites. Under a law effective July 2000, the Rx authority of NPs has been expanded to include the following: Schedules V and VI controlled substances after July 2000; Schedules IV-VI controlled substances after January 2002; and Schedules III-VI controlled substances after July 2003. The bill also removes from the BON and BOM the responsibility of developing a formulary for the specific drugs that NPs are allowed to prescribe and requires the supervising physician to develop a written agreement with each NP listing the controlled substance the NP is authorized to prescribe. In addition to the requirement of periodic site visits by physicians who supervise NPs, the joint regulations of the BON and BOM will include requirements for continued NP competency (for example, CE testing). The regulations must also address ethics, standard of care, patient safety, the use of new pharmaceuticals, and communication with patients. The Joint Commission on Health Care (with full cooperation of nursing, NP, and physician boards and societies) must study the impact of these new Rx regulations on legal, reimbursement, and safety issues and present a report of the findings to the 2004 session of the general assembly. Regulations must be enacted before this new act can be implemented; this is not likely to occur before early 2002. Until that time, NP practice agreements should only include Schedule VI drugs.

Washington

www.doh.wa.gov/nursing/

Legal Authority

Advanced practice is authorized by the Nursing Care Quality Assurance Commission (formerly the BON) for ARNPs (family, pediatric, adult, geriatric, school, neonatal, WHNPs; acute care NPs; CNMs; CRNAs; and CNSs in psych/mental health nursing). The ARNP practice incorporates the use of independent judgement as well as collaborative interaction with other health care professionals when indicated in the assessment and management of wellness and conditions as appropriate to the ARNP's area of specialization. The Commission has approved a regulation that would continue to ensure that only highly competent and appropriately educated APNs are permitted to obtain ARNP licensure. The regulation requires applicants to submit evidence that they have completed a nursing curriculum that "has as its primary purpose the preparation of nurses for the expanded nursing role as an ARNP" with a concentration of advanced nursing practice content that culminates in a graduate degree. CNSs are not listed as ARNPs by the Washington Administrative Code criteria and thus do not have ARNP status. To avoid having to adopt new rules for each new ARNP specialty, the commission is considering primarily protecting the titles ARNP, CRNA, and CNM. In a July 2000 decision, the Vehicle Services Division (under the Washington State Department of Licensing) added ARNPs to the umbrella definition of "licensed physician" so that now ARNPs can sign disabled parking permits. ARNPs can now sign patient death certificates.

Reimbursement

The insurance code bans discrimination against RNs, podiatrists, chiropractors, and certain mental health professionals. Rules governing payment to, and inclusion of, nurses prohibit artificial reductions in the level of an indemnification benefit based on a patient's choice of nursing services over those of other health providers. A difference in payment between a physician and a nurse who provide the same services must result from the "disparity of fees actually charged by medical doctors and registered nurses rather than from an arbitrary formula based on assumptions concerning the relative worth of physician-provided services versus nurse-provided services" (WAC 284-44-05). The law pertains to private insurers and health care service contractors. Medicaid reimbursement is also available to ARNPs at 100% of physician payment. ARNPs are reimbursed by Medicare following federal guidelines. The Women's Health Care Law allows women to access a women's health care practitioner of their choice directly, without referral from another provider. The law applies to all insurance carriers regulated by the insurance commissioner and includes ARNP specialists in women's health and midwifery. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

Currently, ARNPs have independent practice with Rx authority for Schedule V and legend drugs. Senate Bill 5805, effective July 2000, expands that authority to include Schedule II-IV controlled substances. The bill further directs the Washington State Nursing Care Quality Assurance Commission to create a temporary advisory committee, comprised of three ARNPs, one physician, and one pharmacist, to assist the commission in monitoring Senate Bill 5805 implementation. The committee's arrangements do not apply to CRNAs. The rules are anticipated to be completed by early 2001. The expanded scope cannot be utilized until the rules are in place. The dispensing of Schedules II-IV controlled substances is limited to a maximum 72-hour supply of the prescribed drug. Independent Rx authority entails a minimum of 30 hours of pharmacotherapeutic education within the specialty area. DEA numbers are available to ARNPs. Renewal of Rx authority requires 15 hours of pharmacotherapeutic education within the specialty area.

West Virginia

www.state.wv.us/nurses/rn

Legal Authority

The R&R defining advanced practice for RNs took effect July 1991. A licensed RN may announce advanced practice if he or she has BON-recognized national certification. As of January 1999, all ANPs must have an MSN.

A special license is not issued; the RN license shows the title granted by the approved national certifying body. ANPs include NPs, CNSs, CNMs, and CRNAs. ANP SOP includes the ability to assess, conceptualize, diagnose, analyze, plan, implement, and evaluate complex problems related to health. The ANP SOP does not require collaboration with a physician unless the ANP is prescribing. The CNM is required to practice in a collaborative relationship with a physician. CRNAs administer anesthesia in the presence and under the supervision of a physician or DDS.

Reimbursement

There is a law requiring insurance companies to reimburse nurses for nursing services, if such services are commonly reimbursed for other providers; R&R have not been promulgated. FNPs and PNPs receive Medicaid reimbursement at the same level as physicians. However, Medicaid is currently contracting with managed-care companies in a 12-county demonstration project and 1996 HMO legislation excludes NPs as PCP "gatekeepers." The impact of this legislation is that NPs under managed care cannot directly bill for their services. Instead, NPs must be reimbursed through a "gatekeeper" provider who must be on site. CNMs were included as "gatekeepers" but with several restrictions. Bills were introduced in the 1999 legislative session to amend the state insurance/HMO laws and name NPs as PCPs under managed care. Despite a massive campaign, no amendments were passed. The 1998 legislature passed SB 25 (Woman's Access to Health Care Bill), which provides for direct access at least annually to a woman's health care provider for a well woman examination; providers include ANPs (CNMs, FNPs, WHNPs, ANPs, GNPs, or PNPs). For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/ medicare/enrollment/ contacts/.

Prescriptive Authority

ANP Rx authority, including controlled substances, became effective July 1992. The 1993 R&R specify that the ANP must meet specified pharmacology education requirements and certify that they have a written collaborating relationship with a physician or osteopath (i.e., written guidelines or protocols describing the individual versus shared responsibility between the ANP and MD with periodic joint evaluation of the practice). The ANP works from an exclusionary formulary (i.e., the following Rx are prohibited: Schedules I and II; anticoagulants; antineoplastics; radiopharmaceuticals, and general anesthetics). A DEA number is issued directly to ANPs by the DEA. ANPs are authorized to sign for and provide drug samples.

Wisconsin

www.state.wi.us

Legal Authority

APN is the protected title for NPs, CNSs, CNMs, and CRNAs. Currently, NPs function under an NPA with a broad description of nursing practice. The following BON R&R cover the performance of a delegated medical act by an RN: (1) the RN must follow protocols or written or verbal orders; (2) as jointly determined by the RN and physician, the ability to perform the delegation is based on the RN's education, training, and experience; (3) the RN must consult with the physician where the delegated medical act may harm the patient; and (4) the RN can perform the delegated act under general supervision—the physician does not have to be present in the facility. For APNs who wish to have independent Rx authority (II-V), the BON grants an advanced practice nurse prescriber (APNP) designation after all criteria are met. A BON rule effective November 2000 states, "to promote case management, the APNP may order laboratory testing, radiographs, or electrocardiograms appropriate to his or her area of competence as established by his or her education, training, or experience." APNPs shall work in a collaborative relationship with a physician. The law defines collaboration as the "process which involves two or more health care professionals working together, in each other's presence when necessary, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer." The APNP and the physician must document this relationship. The laws regarding hospital privileges are permissive, not prescriptive; therefore, some hospitals extend full admitting privileges to APNs and others do not.

Reimbursement

There is 100% Medicaid reimbursement for specified reimbursable billing codes as submitted by all master's-degree-prepared NPs or NPs certified by ANCC, NAPNAP, or NAACOG. NPs are to charge their usual and customary fee; reimbursement is up to the maximum allowed for physician billing for the same service. Qualified NPs can be paid directly regardless of their employment site or arrangement. There are Medicaid bonuses for NPs working in certain areas or for certain pediatric visits. CHAMPUS reimburses NPs, and home health RNs bill under their own provider number. Third-party reimbursement has not yet been addressed legislatively, though NPs are working on this. Some managed care panels are open to NPs, but few allow NPs to be the PCP of record. For the state Medicare carrier, see the Health Care Financing Administration Web site,http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

RNs may prescribe (including controlled substances) as a delegated medical act under the NPA. APNs may receive certification as an APNP from the BON for independent Rx authority. Eligible APNs must be certified by a board-approved national certifying body as an APN, have completed 45 contact hours in clinical pharmacology/therapeutics within the 3 years preceding application, pass a jurisprudence examination for APNPs and, after July 1, 1998, must hold a master's degree in nursing or a related health field. After initial Rx authority certification, the APNP must submit CE evidence to the board of an average of 8 contact hours per year in clinical pharmacology/therapeutics relevant to the APNP area of practice. A DEA number is issued to APNPs. The APNP may prescribe Schedule II-V controlled substances and must comply with restrictions regarding prescribing amphetamines and anabolic stercids. Under a BON rule effective November 2000, "the APN shall work in a collaborative relationship with a physician. The collaborative relationship is a process in which an APNP is working with a physician, in each other's presence when necessary, to deliver health care services within the scope of the practitioner's professional expertise. The APNP and the physician must document this relationship." Samples from the manufacturer may be dispensed any time. Prepackaged doses may be dispensed independently if the nearest pharmacy is more than 30 miles away.

Wyoming

nursing.state.wy.us/

Legal Authority

The NPA gives authority for the BON to recognize APNs after demonstrated advanced education or national certification. APNs include NPs, CNMs, CRNAs, and CNSs. The APN performs advanced nursing acts and may perform medical acts including prescribing or providing prepackaged medications in collaboration with a physician or dentist in such a manner as to assure quality and appropriateness of services rendered. BON R&R specify that the APN must have a "plan of action" for referring those clients who need referral to a physician. According to a letter of advice the office of the attorney general provided the board on February 1, 1994, collaboration as it applies to the advanced practitioner of nursing (including the CRNA), does not mean a supervised/dependent form of practice. As of 1999, APNs are specified as providers on worker's compensation lists and have been added to the physical therapy statute as able to order physical therapy without a physician cosignature.

Reimbursement

The current state statute states that all PCPs should receive third-party reimbursement. In 1992, a bill passed authorizing Medicaid payments to APNs at 100% of physician payment. For the state Medicare carrier, see the Health Care Financing Administration Web site, http://www.hcfa.gov/medicare/enrollment/contacts/.

Prescriptive Authority

A 1991 law authorizes BON-approved APNs to prescribe independently legend and controlled substances (III–V). APNs must show (1) proof of 30 hours of pharmacotherapeutic education within the last 5 years; (2) a statement declaring personal or professional liability coverage; (3) a copy of their collaborative practice plan, which specifies in writing the APN's medical referral plan for critical or complicated medical situations requiring a DDS or MD; (4) evidence of at least 400 hours of practice as an APN including practice during educational program before Rx application. The BON provides a list of approved APNs to the BOP. In 1993, the attorney general ruled that APNs are independent practitioners and may apply for independent DEA numbers.