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Public Policy & Practice News of
The Nurse Practitioner Association New York State

- Capitol Report
- NPA Risk Management / Self-Assessment
- The Doctor of Nursing Practice: The Perspective of New York State Nurse Practitioners
- The Changing State of Health Care: New Standards for Practice and Competency

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Message from President

Jeanne Martin, MS, ANP

Dear Colleagues,

I'd like to share with you my reflections of 2013 as it quickly approaches its end. In serving as your President this year, I have had many wonderful opportunities to represent you and this great organization to legislators, public servants, healthcare industry leaders, students and to the public at large. Although I have been a practicing nurse practitioner for over 16 years and have been fortunate enough to work among other providers who truly understand, support and respect us for what we do and the role we play in delivering healthcare, I'm still amazed at how much of the public still does not entirely understand who and what we are. It made me realize the importance of the need for us to keep our message going, and going, and going……..

In case you're wondering if it's all worth it, it most definitely is. We have made great inroads this year with the Governor's office as he not only included the importance of nurse practitioners having full practice authority in his State of the State speech he also recognized and declared November 10th – 17th as Nurse Practitioner Week in NYS (and we have the Proclamation to prove it!). We have worked very hard to lobby our legislators and educate them on the need to remove the artificial barriers that currently exist and impede nurse practitioner practice. We reinstituted "Capitol Day" (formerly known as "Lobby Day" in years past) and had a very successful turnout. Although we were disappointed that our NP Modernization Act did not come out of committee this legislative session, we are not deterred. Even though the legislative session has ended, we have continued to meet with our legislators in their home offices as part of an "education tour". This has given us the opportunity to really assess what they know about our profession and why the current statute is a real barrier to our practice and to access of healthcare for their constituents.

Persistence has also paid off in reaching out to nurse practitioner students and other nurse practitioners that were not members of The NPA. Our current membership is up almost 15% for this year alone and membership retention is at an all time high. I must give credit to our NPA staff that has worked tirelessly to meet our members' needs and to innovate and create new member benefits. Hopefully, you have noticed the increase in communication efforts including the monthly NPA Insights column sent electronically, the content-filled triannual JNPA, and timely blast emails that are sent to help keep our members abreast of what is happening not only in our association but in healthcare as well. Of course, we continue to have a presence on social media (Facebook and Twitter) and hope to continue and expand that avenue of communication in the future. A large part of this year has been spent in engaging members to continue to support our organization's efforts and in turn, inspire them to become more active in our endeavors.

I have also had the pleasure of getting to meet so many of you throughout our association. This has been my greatest joy! I am constantly impressed as to how diverse and encompassing our practices are. New York is truly a mosaic of urban, suburban and rural patient populations and needs. However, they all have one thing in common: all of these settings have greatly benefitted from nurse practitioners serving their healthcare needs. It has strengthened my resolve to continue to press on in the fight for us to gain full practice authority in New York State. There is still much to do but we are as close now as we have ever been. I hope you will join me as we head into 2014 and continue to build upon our successes of the past as we forge a great future for the practice of nurse practitioners. I wish you all the best in this upcoming holiday season and thank you for allowing me to represent all of you as your President. It has been an honor!

Message from Executive Director

Stephen Ferrara, DNP, FNP-BC, FAANP

Welcome to the Winter, 2013 issue of The JNPA. The first thing you may notice in this issue is the length – 48 pages! Forty-eight pages of meaningful information is a testament to the bevy of action that is underway within The NPA. From an unprecedented increase in membership to a new record of Annual Conference attendees, The NPA is now soaring to new heights. None of this is possible or sustainable however, without the dedication and commitment of each and every NPA member. Whether you are a chapter secretary, a student transition member, or a general member renewing your annual membership, the Association simply does not exist without members.

The next thing you may notice is our brand new logo that was officially unveiled at the 29th Annual Conference in October 2013. The vibrant and bold logo now features 2 colors and takes a contemporary rendering of the geographic outline of New York State – to visually represent The NPA as the only state-wide association for nurse practitioners. In addition, the familiar QRS complex is retained from the prior logo now along with the letters "NPA." It is my hope that the logo captures the vibrancy of the members that is alive within the NPA today.

This issue of The JNPA also features two peer-reviewed articles and continues the very popular "Member Spotlight" where we learn a little more about the professional and personal lives of two members. We encourage you to submit research, quality improvement projects and/or literature reviews that you are conducting along with "member spotlights" of your colleagues or yourself (see our website for author guidelines http://www.thenpa.org/associations/1031/Author%20Guidelines%20May%202013.pdf).

We have much to reflect on as 2013 draws to a close. We also have our work cut out as one of the major provisions, the "individual mandate," of the Affordable Care Act becomes the law of the land in 2014. This has the potential of making an already difficult to navigate health system even more problematic as access to providers will bottleneck. Of late, there have been countless studies and stakeholder recommendations providing evidence to support "full practice authority" for NPs. As set forth by the Board of the Directors of The NPA, we will continue our resolve of eliminating every arbitrary and outdated practice barrier for nurse practitioners in New York State while enhancing the NPA membership experience to become the model association for nurse practitioners everywhere. As always, I welcome your comments and suggestions. Feel free to send them to me: sferrara@TheNPA.org

I wish everyone a joyous and healthy holiday season.

2014 Incoming NPA Board of Directors

At The NPA's General Membership meeting held on October 24, 2013 at the Saratoga Hilton, Saratoga Springs, NY the membership elected the following candidates running for Office for The NPA Board of Directors:

President-elect – Kit Veley, FNP-C, IBCLC
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*Region 7 Director – Peg O'Donnell, ANP, FNP

We would also like to thank our outgoing board members for their dedication and service to The NPA. They are:

Immediate Past President –
Rebecca Rigolosi, DNP, ANP-BC
Region 1 Director –
Michael Ackerman, DNS, ACNP
Region 4 Director – Arlene Pericak, DA, FNP

**appointed by The NPA board of directors to fill vacancies*

WELCOME NEW

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NPA's 29th Annual Conference – Record Breaking Attendance!

The NPA's 29th Annual Conference was held October 24th - 27th, 2013 at the Saratoga Hilton, Saratoga Springs, NY. It is wonderful to see so many Nurse Practitioners coming out to support our organization along with NP practice. This year, we had record breaking attendance with 586 attendees. The 2013 program included 65 educational sessions, 56 vendors in the Exhibit Hall, and 17 NPA-member poster presentations.

Here are some highlights from this year's conference:

- Our keynote speaker Donna Frescatore, Executive Director of the New York Health Benefit Exchange, kicked off the conference on Friday morning with her presentation, "An Update on the New York Health Benefit Exchange."
- The Legislative Update allowed members the opportunity to ask questions of our Legislative Team. Contributions raised during the conference for the Nurse Practitioner of New York State Political Action Committee (NP of NYS PAC) totaled $5,673! Thank you for contributions.
- Friday afternoon's featured speaker was Patricia Bomba, MD, FACP with her topic of "Partnering to Build New York's eMOLST Registry."
- Saturday morning began with The NPA Annual Membership Meeting and Awards presentation.

Awards were presented to the following NPA members:

- Natalya Fazylova, DNP, FNP, Liliana Lopez, DNP, FNP, and Marie-Carmel Garcon, FNP, DNP – First Place Poster Presentation, "The effectiveness of web-based programs on the reduction of childhood obesity in school-aged children: A systematic review."
- Nancy Cherosky, DNP, FNP-BC - 2013 Distinguished Contributor to NP of NYS PAC
- Jeanne Martin, MS, ANP - in recognition of her contribution and service during 2013 as outgoing NPA President
- Michelle Gellman Appelbaum, PhD, FNP, PNP - 2013 NP of the Year
- Cheryl Lyon, ANP-S - 2013 Student NP of the Year

Congratulations to all award recipients!

- Saturday afternoon's featured speaker was Michael Loughran, President of Aon Affinity Insurance Services in the Healthcare Division. His topic presented was "Nurse Practitioner Malpractice Exposure: A Contemporary View."

Thank you to all the chapters and individuals that donated items for the Silent Auction. Proceeds totaling $2,312 from the Silent Auction went into The NPA Legacy Fund.

The Conference Committee would like to extend a special thank you to everyone who volunteered this year to help introduce speakers/be a room monitor, work at the registration desk, and The NPA store. Your time and effort was greatly appreciated.

As we begin to plan for next year's conference, we welcome any suggestions for topics and/or speakers which should be directed to Sue Hubbard at shubbard@TheNPA.org.

On behalf of The NPA Leaders and our Conference Committee, we would like to thank everyone for their participation in making this a memorable conference. We look forward to seeing an even more robust attendance next year for The NPA's 30th Annual Conference, 30 Years of Wisdom: A Commitment to Excellence, at the Saratoga Hilton, Saratoga Springs, NY October 22nd – 26th, 2014.












CAPITOL REPORT

Update on New York State's Implementation of the Affordable Care Act (aka Obamacare)

In the last edition of The NPA Journal we focused on the implementation of New York's Health Exchange – more commonly referred to as the "New York State of Health" or "the marketplace." Additionally, at The NPA's annual meeting, Donna Frescatore, the Executive Director of the New York State of Health presented an overview of the New York Exchange. Among other things, Frescatore noted that the State expects 1.1 million New Yorkers to enroll in new health insurance plans within the next three years. In fact, since the launch of the New York site in October, approximately 50,000 New Yorkers have signed up for insurance through the Exchange, approximately 50% of whom were eligible to receive Medicaid. After explaining the State's expectations, Frescatore was asked whether the implementation of the Exchange will lead to an increased need of primary health care providers in New York. She acknowledged that this is an issue that the State had been studying, and that even though previously uninsured New Yorkers often still received some form of healthcare services, there will be a greater need for access to primary care as a result of the new law, and that NPs can play a vital role in closing that gap.

The NPA has been expressing this concern for a while. At least in part to help close this gap, we have been diligently working with the Governor's healthcare team, the Department of Health and the State Education Department to find ways to eliminate barriers that make it unnecessarily difficult for New Yorkers to access primary care services offered by nurse practitioners. Specifically, the association has been investing a lot of time and resources to eliminate the statutory requirements that a nurse practitioner maintain a written collaborative agreement with a physician.

The Governor is expected to release his 2014-2015 Executive Budget Proposal in mid-January. The NPA is working hard to attempt to address the Nurse Practitioner Modernization Act as part of the budget negotiation process, again reiterating the important role that NPs play generally as well as the assistance they can provide in ensuring that all New Yorkers have access to quality primary care.

In the meanwhile, it is important that all NPA members continue to educate their local legislative representatives of the role of the NP and why autonomy is necessary in order to provide patients with the greatest access to quality care.

Effective January 1, 2014 New NYS Hepatitis C Testing Law

Refer to NPA website www.TheNPA.org for Frequently Asked Questions

What are the key provisions of the law?

• A hepatitis C screening test must be offered to every individual born between 1945 and 1965 receiving health services as an inpatient of a hospital or receiving primary care services in the outpatient department of a hospital or in a freestanding diagnostic and treatment center or from a physician, physician assistant, or nurse practitioner providing primary care.

• If an individual accepts the offer of the hepatitis C screening test and the screening test is reactive, the health care provider must offer the individual follow-up health care or refer the individual to a health care provider who can provide follow up health care. The follow-up health care must include a hepatitis C diagnostic test.

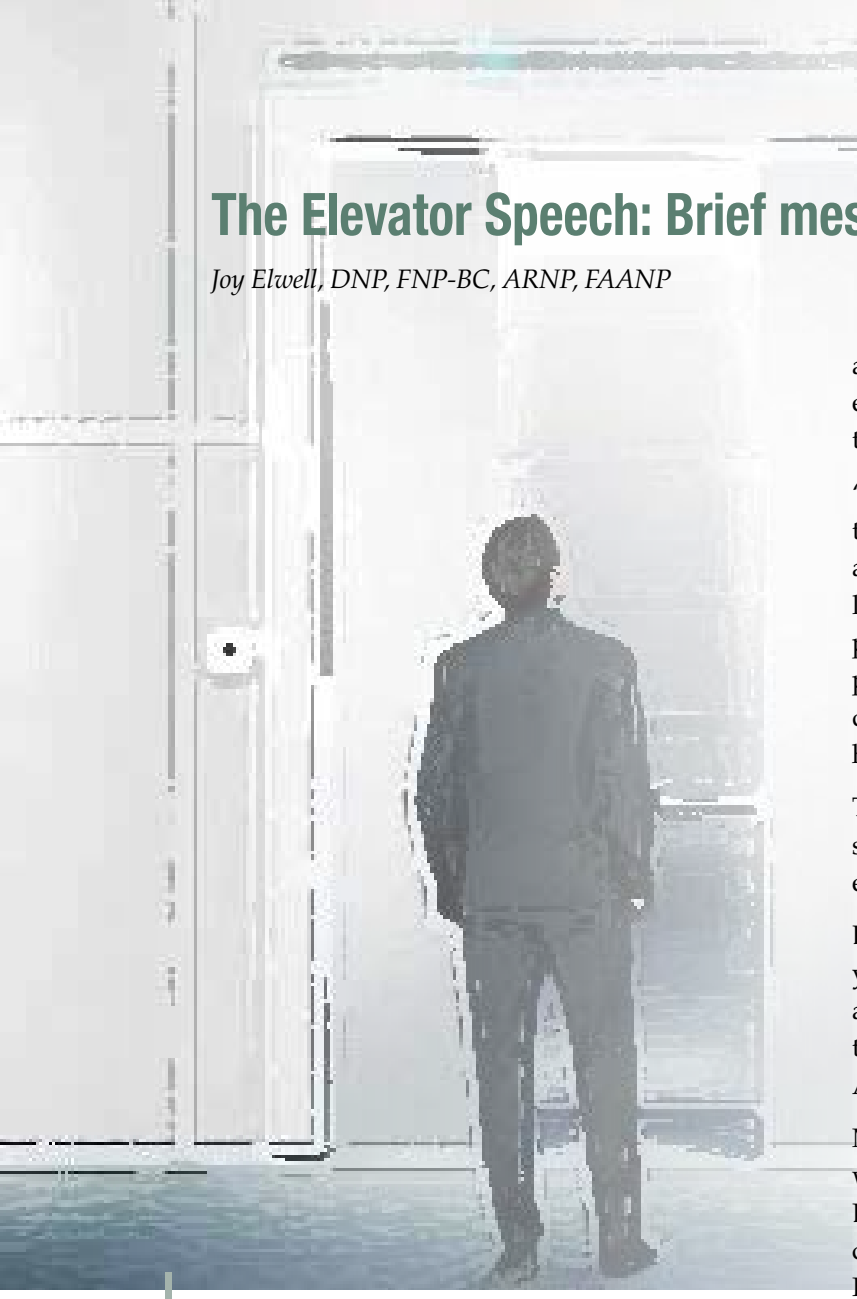
•The offer of testing must be culturally and linguistically appropriate.

Blast Emails from The NPA

The NPA will never release any of your personal information to a third party. During the course of the year, some members choose to opt-out of our blast e-mail messages. These messages include our monthly e-newsletter, NPA Insights, our Career Center job postings, and other important timely messages. If you opt-out, you will miss out on these messages. Also, be sure to add info@TheNPA.org to your contact list to continue receiving our e-mail communications.

The Elevator Speech: Brief message – strong impression

Joy Elwell, DNP, FNP-BC, ARNP, FAANP



Imagine you are waiting for the elevator at an office building. The doors slide open, revealing your local state senator. Recognizing the senator, you step into the elevator, quickly extend your hand and introduce yourself as a nurse practitioner (NP). The senator smiles politely, but blankly, perhaps asking, "How nice. You're a nurse-what?" This is your opportunity. It should be clear, from the response, that the legislator knows little, and possibly nothing about your profession. And, you have about 1 minute – the amount of time it takes for an elevator ride - to clearly, yet concisely convey the message. Does this seem intimidating? It doesn't have to be. What you need is an elevator speech – a statement, lasting under a minute, giving an overview of what a NP is, and does. If you do it correctly, you will even have enough time to request a follow up meeting. Memorize it, and no matter whom it is you meet on that elevator, you will be ready to make an effective pitch for your profession. Here is an example of an elevator speech which I developed and have used with legislators, regulators, the public, and the media:

"A nurse practitioner is an advanced practice nurse - a registered nurse with advanced education and training, prepared at the master's and doctoral levels. Nurse practitioners are licensed and authorized in all states to diagnose, treat, and prescribe, and deliver primary and specialty health care to all populations across the lifespan. Every quality study done to date supports nurse practitioners as high-quality, cost-effective health care providers."

This elevator speech is 3 sentences long and takes about 30 seconds to deliver. There are a few key points to an effective elevator speech:

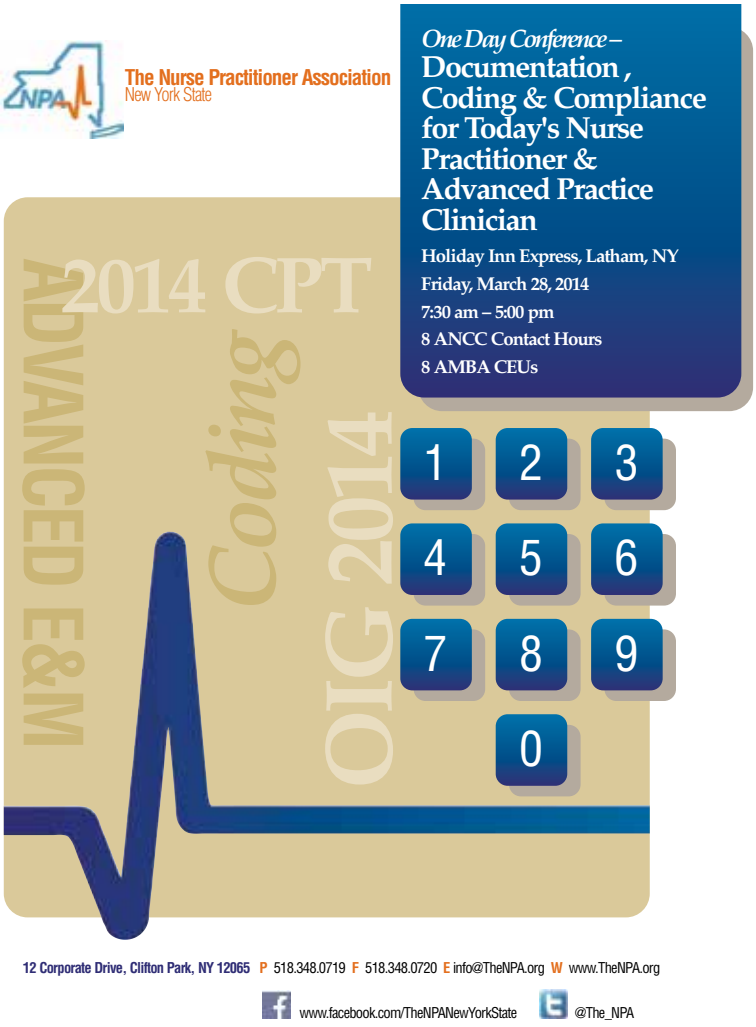
Brevity: You have less than 1 minute. But, that doesn't mean you have to rush. The speech above incorporates talking points about NP educational preparation, scope of practice, populations served, quality outcome studies, and cost-effectiveness. And, without rushing, it takes well under 1 minute to say.

Memorize and practice: It is possible you will encounter a well-known celebrity news personality. Imagine meeting Matt Lauer, from NBC's The Today Show, while waiting in line for a cup of coffee. Intimidating? Perhaps. But, what an opportunity! Having practiced and memorized the elevator speech, you are able to deliver it without having to search for the right words.

Make a request: What is it you want? Support for important legislation? A follow up meeting to discuss the issues in more depth? An interview? Ask for it – and ask for their business card, and say you will call for an appointment. Have business cards of your own to give in return. If your employer doesn't provide them, or if you are a student, buy them on your own. They are inexpensive and make a good impression.

Wrap it up: The elevator has arrived. The latte is delivered. Whatever brought you two together is over. Don't drag it out. End your brief meeting on a positive note by thanking them for their time and reminding them you will be calling their office for a follow up meeting.

A significant percentage of the public is still poorly informed about NPs. Having an elevator speech ready and delivering it in a pleasant, yet professional manner will empower you to educate influential stakeholders on the role of the NP.



Documentation, Coding & Compliance for Today's Nurse Practitioner & Advanced Practice Clinician

Who should take this course?

NPs, PAs, medical billers and anyone involved in the revenue cycle

Why should this course be taken?

One of the most challenging aspects of clinical practice is the medical coding process following each and every patient encounter. A poor understanding of the process and/or an over-reliance on electronic health records leaves the clinician vulnerable to lost revenue and increased audit potential. Finally, as the transition to ICD-10 looms (October 2014), major changes in the coding process are on the horizon. This session is geared to provide necessary guidance in terms of:

- Evaluation and management (E&M) service reporting
- Proper documentation techniques
- "Incident to" and shared visits
- Overall compliance for 2014
- Overview of ICD-10 and the significant contrasts between ICD-9-CM and ICD-10-CM coding guidelines and convention
- Discussion and clinically relevant exercises to essentially cross-walk common ICD-9-CM codes to ICD-10-CM equivalents

Participants will be provided with the tools they need to understand the importance of the medical decision making and the interpretations of NYS Medicare Administrative Contractors (MAC) and National Government Services (NGS).

Registration sign-in is from 7:30 am – 8:00 am

Session begins at 8:00 am

8 ANCC Contact Hours

8 AMBA CEUs

AMBA CEU Approved

Registration Fee:
Includes morning refreshment and lunch

NPA Member Rate: $200

NPA Student Member Rate: $125

Non-Member Rate: $300

Register online – www.TheNPA.org

How did I make that mistake?

Using an electronic prescription system, an advanced practice nurse (APN) orders penicillamine for a 9-year-old patient with a positive test for Streptococcus. The APN meant to order penicillin, the antibiotic, not penicillamine, the chelating agent. The error wasn't caught for 2 days when it was noticed the patient wasn't improving.

This true example could easily occur with a busy APN. An example of one way it might have happened is that when the APN reviewed the order before signing off, he or she misread the name of the drug. In that case, a likely contributing factor might have been "inattentional blindness," which refers to the failure to see something that is unexpected. In the penicillin example, the APN wasn't expecting an incorrect drug name, so didn't see it.

It's challenging to reduce the risk of inattentional blindness because it tends to be involuntary, but knowing that it can happen and addressing factors that contribute to it could keep you from making an error that results in your being sued and, more important, avoids patient harm.

The "invisible gorilla"

In a classic 1999 experiment of inattentional blindness, researchers asked students to watch a video of two teams passing basketballs. The students had to silently count the number of passes made by members of the team dressed in white shirts and ignore the number of passes made by those in black shirts. Halfway through the 1-minute video, a student wearing a gorilla suit walks into the scene, stops in the middle of the players, faces the camera, and thumps her chest before walking off. Amazingly, about half of the students failed to see the gorilla. They were concentrating on their task—to count the number of passes made by those in white shirts—and missed the unexpected appearance of a gorilla. Furthermore, the students couldn't believe they missed the gorilla, expressing amazement when they saw the video again. (To see the invisible gorilla video, go to www.theinvisiblegorilla.com/videos.html.)

In a recent variation of this study, radiologists viewed computed tomography (CT) scans of five patients to screen them for lung cancer. The first four patients' scans (about 1,000) were normal. But in 239 images from the fifth patient, researchers had embedded consecutive scans where a cartoon gorilla gradually appeared and then disappeared. Only 4 of the 24 radiologists looking at the CT scans noticed the gorilla.

What happened to the students and radiologists? The problem is that we're confident we'll notice unexpected events even when we are concentrating on something else. The gorilla studies illustrate what researchers Christopher Chabris and Daniel Simons call the "illusion of attention." In essence, we don't process as much of what we experience as we think we do.

Think of inattentional blindness another way: We see what we expect to see. Consider the APN who examines a patient who frequently comes to the clinic with physiological complaints that seem to be based more on an overactive imagination than any real physical changes. The APN listens to the patient's heart and lungs, fully expecting to hear no problems, as has been the case for the past year. Unfortunately, this time the patient has a slight heart murmur that the APN overlooked because he wasn't expecting it. Another example is selecting a protocol that brings up the wrong dose of a drug. The APN expects to see the correct dose, so that's what she sees.

Awareness of what factors contribute to inattentional blindness is a first step toward reducing it. Researchers who focus on the impact of human factors on errors point to four factors: capacity, conspicuity, expectation, and mental workload. Here's a closer look at each of these, including how healthcare professionals like you might use them to reduce errors.

Capacity. Drugs, alcohol, fatigue, stress, and age can affect your capacity to pay attention and notice important events. In a healthcare system where sleep deprivation among APNs is common, fatigue is a particularly important consideration. It's one of the primary arguments against mandatory overtime and one of the primary arguments for taking care of yourself by eating healthy and getting enough sleep.

Conspicuity. The two types of conspicuity are sensory and cognitive. Sensory conspicuity refers to the physical properties of an object, with the most important being contrast of the object

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to the background. We also notice objects that flicker or move, such as a railroad crossing sign. Drug labels that provide clear contrast between the important information, such as doses, and the background help key information "stand out" and reduce errors. Another example is the use of "Tall Man" lettering to distinguish drug names; that may have helped avoid the penicillamine order error.

Cognitive conspicuity refers to how you notice something that has relevance to you. A simple example is how you will overhear your name being mentioned by someone else, even in the middle of a noisy room. You can avoid this type of distraction by examining patients and ordering medications and treatments in quiet areas where you won't hear background discussions.

Expectation. Our past experiences play a role in what we notice. Equipment alarm fatigue, for instance, is a safety challenge for APNs who work in acute care. In this case, too many times alarms sound when nothing is actually wrong, so there is a tendency to start to ignore them.

Even our expertise can sometimes work against us when it comes to expectations. For example, an APN may become highly accomplished at using a particular electronic prescribing system. When a new system appears, the APN might inadvertently fail to double-check the selected drug and dosage, missing an error that occurred when changing to the new system.

Another example is ordering antibiotics. An experienced APN in family practice routinely sees patients with acute bronchitis respond well to antibiotics that he or she might miss an unusual patient reaction that a novice APN might pick up because the novice APN, who is less familiar with the expected patient outcome, is paying more attention to details.

Confirmation bias is another aspect of expectations. We are drawn to evidence that supports a belief or expectation and tend to ignore or dismiss one that doesn't. If you have grabbed a particular type of drug sample for a patient from the second desk drawer four times in the past week, you might not notice when the fifth time you grab the drug sample, it's the wrong one—someone reorganized the samples without telling you.

Mental workload. You are more vulnerable to inattentional blindness if your attention is diverted to a secondary task. For example, you may be talking to a radiologist on the phone and fail to notice your patient is looking about the exam room in a confused manner.

Like most APNs, your day is probably filled with multiple tasks that need attention. Our profession—like our society—highly values the ability to multitask. Yet studies show you

are more effective and efficient if you sequentially focus on one task at a time. When you perform that complex assessment, for example, focus on what you are doing and not on the list of tasks yet to be accomplished. Interestingly, inactivity, a problem not many APNs encounter, can contribute

to inattentional blindness because we tend not to pay attention to routine tasks in this situation.

"Invisible gorillas" in healthcare

You can help protect your patients from errors and yourself from litigation by considering factors that contribute to inattentional blindness. Being aware of this risk can help you minimize errors and increase patient safety.

Avoiding gorillas in healthcare

The problem of inattentional blindness still occurs even when people are cognizant of it, but by taking these actions, based on contributing factors, you can help protect yourself and your patients.

- Be alert for drug labels that look similar. Notify the pharmacy and drug manufacturers of potential problems.
- Lower the noise level to reduce distractions.
- Consider putting in place a system to avoid interruptions when you are doing key tasks such as ordering tests and medications.
- Take special care with what you consider "routine" procedures and assessments. Keep in mind that errors tend to occur when new or unusual combinations of circumstances occur in a familiar setting.
- Increase your critical thinking skills by taking a class or reading about it. Critical thinking can help you avoid confirmation bias.

- Don't ignore technology such as automatic warnings on documentation systems, but don't over-rely on technology, either. Technology is not a panacea for stopping either inattentional blindness or medical errors.

Resources

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Grissinger M. Inattentional blindness: What captures your attention? P&T. 2012;37(10):584-585.

Hughes V. When experts go blind. *National Geographic*. 2013. http://phenomena.nationalgeographic.com/2013/01/31/when-experts-go-blind

McGann E. Medication error prevention: A shared responsibility. Medscape Medical News. Jun 14, 2011. http://www.medscape.com/viewarticle/744546

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Risk Control Self-assessment Checklist for Nurse Practitioners

This checklist is designed to help nurse practitioners evaluate risk exposures associated with their current practice. For additional nurse practitioner-oriented risk control tools and information, visit www.cna.com and www.nso.com.

Self-assessment Topic	Yes	No	Actions Needed to Reduce Risks
Clinical Specialty			
I work in an area that is consistent with my licensure, specialty certification, training and experience.			
My competencies (including experience, training, education and skills) are consistent with the needs of my patients.			
I understand the specific clinical risks of caring for patients within my clinical specialty.			
When I am asked to cover for another practitioner, I ensure that my competencies and experience are appropriate for the assignment.			
I am provided with or require and obtain orientation whenever I work in a new or different clinical setting.			
I obtain continuing education and training as needed to maintain my competencies in my clinical specialty.			
I decline an assignment if my competencies are not consistent with patient needs.			
Scope of Practice			
I know and comply with my state Nurse Practice Act and read it at least once per year to ensure that I understand the legal scope of practice in my state.			
I decline to perform requested actions/services if they are outside of my legal scope of practice.			
I know and comply with the requirements of my state regarding other regulatory bodies, such as the Board of Medicine (if applicable).			
I know and comply with the requirements of my state regarding physician collaborative or supervisory agreements and I review and renew my agreements at least annually.			
I collaborate or obtain supervision wit a physician as defined by my state regulations and as required by the needs of my patients.			
Assessment			
I obtain, document and consider an appropriate patient clinical and relevant social history.			
I obtain, document and consider a current list of the patient's prescribed and over-the-counter medications including vitamins and holistic remedies.			
I document any patient allergies and adverse reactions to medications.			

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Self-assessment Topic	Yes	No	Actions Needed to Reduce Risks
I perform a physical examination to determine the patient's health status and to evaluate the patient's current symptoms/complaints.			
I elicit the patient's concerns and reasons for the visit and address those concerns with the patient.			
I ascertain the patient's level of compliance with currently ordered medications, treatment and care, medication regimens and lifestyle.			
I determine if the patient's current health status requires immediate medical treatment and refer the patient to an emergency department if needed.			
I adhere to facility documentation requirements related to the assessment findings.			
Diagnosis			
I utilize an objective, evidence-based approach through the application of organization-approved clinical guidelines and standards of care to determine the patient's differential diagnosis(es).			
I consider the findings of the patient's assessment, history, and physical examination and expressed concerns in establishing the diagnosis.			
I order and timely obtain and document appropriate diagnostic patient testing (laboratory, radiography, EKG, etc.) to arrive at the patient's diagnosis.			
I request (and if necessary facilitate) and obtain appropriate consultations to timely achieve the correct diagnosis(es).			
I consult with my collaborating/supervising physician as required and as needed to establish the diagnosis(es) and document all such encounters.			
If the patient unstable, acutely ill and in need of immediate diagnostic testing and/or consultation, I refer them to hospital emergency care. I facilitate this process if needed.			
If a diagnostic test or procedure involves patient risk, I carry out and document an informed consent discussion with the patient and obtain their witnessed consent.			
I proactively obtain, document and respond to the results of diagnostic tests/procedures and provide necessary orders.			
I obtain, document and respond to the results of consultations with physicians and other healthcare providers.			
I establish the diagnosis(es), establish a treatment plan, document the clinical decision making process, and order and implement the treatment and care plan.			
I comply with the standard of care and my facility's policies, procedures and clinical and documentation protocols.			
I discuss the clinical findings, diagnostic test/procedure results, consultant findings, diagnosis, proposed treatment plan and reasonable expectations for a desired outcome with the patient and ensure their understanding of their responsibilities in participating in their treatment. I document this process and note the patient's response.			
For persistent non-compliance with needed diagnostic testing and consultation, I counsel the patient regard the risk of non-compliance to them and to me and my practice. If non-compliance is potentially affecting the safety of the patient and regular counseling has been effective, I consider discharging the patient from the practice.			
I inform the patient to seek immediate emergency treatment if they experience severe adverse effects from treatment.			
I discuss the diagnosis and treatment plan with the collaborating/supervising physician as required .			
If I work in a state with autonomous nurse practitioner authority, I regularly seek peer review to assess my diagnostic skills and expertise and to identify opportunities for improvement.			
If the patient is uninsured or unable to obtain the diagnostic and consultative procedures necessary I refer them for financial assistance or payment counseling and for free or low cost alternatives.			
Treatment and Care			
I educate the patient regarding their diagnosis, treatment plan and the need for compliance with treatment, medication regimens and screening procedures.			
I prescribe clinically indicated treatment and care and appropriate health screening for the patient.			
I discuss the patient's treatment plan and ongoing response to treatment with my collaborating/supervising physician as required and appropriate.			
I inform the patient to obtain emergency medical treatment if they experience unexpected adverse symptoms or effects from treatment.			
I perform and document an informed consent discussion with the patient for any aspect of the treatment plan that involves potential risk.			
I schedule follow-up visits to monitor the patient's response to treatment.			
I obtain regular monitoring tests and consultation as needed to appropriately manage the patient's healthcare.			
I inform the patient of test and consultation results (both normal and abnormal findings) and			
I adjust the patient's treatment plan as needed and appropriate.			
I ensure patients are reminded of regular appointments and screening tests and that reminders and contacts are documented.			
I ensure patients are contacted after missed appointments for re-scheduling and that contacts are documented.			
I counsel the patient regarding their responsibilities in participating in their treatment plan and the need for compliance with on-going testing, medication regimens and lifestyle patterns affecting the outcome of the treatment plan.			

Self-assessment Topic	Yes	No	Actions Needed to Reduce Risks
If the patient is non-compliant to the point of endangering themselves or creating a liability risk for me or my practice, I counsel them that termination from the practice may be necessary and document that interaction.			
I terminate from treatment persistently non-compliant patients, assist them in transitioning to another healthcare provider and document actions taken and support provided.			
I counsel the patient regarding their responsibilities in participating in their treatment plan and the need for compliance with on-going testing, medication regimens and lifestyle patterns affecting the outcome of the treatment plan.			
Prescribing Medication			
I prescribe medications in compliance with the stated Nurse Practice Act , state prescriptive authority for nurse practitioners, my collaborative/supervisory agreement(s), and employer policies and protocols.			
I consult with my collaborating or supervising physician regarding medication orders.			
I provide the full name of the medication, the dose, the frequency and the route and include the purpose of the medication ordered to prevent prescribing and dispensing errors.			
I ensure the patient's health information record clearly reflects any drug allergies or adverse reactions.			
I check all computerized medication orders to protect against inadvertent entry errors.			
I address any computerized prescribing warning screens and never override warning screens without considering identified contraindications or identified interactions.			
I ensure prescription pads are safely stored to prevent theft or misappropriation.			
I consult with a pharmacist for medication questions, clarification or questions.			
I avoid look-alike sound-alike medications and verify the correctness of orders for such medications.			
I use caution when prescribing anticoagulants, antibiotics, psychoactives and known toxicity-prone drugs and order and follow up with all indicated monitoring tests			
I monitor control drug usage by patients and refer chronic pain patients for pain management therapies.			
I consult with physicians, pharmacists or evidence-based resources as needed to identify and mitigate any additional risks related to off-label use of a drug.			
I educate my patients regarding their medications (both brand and generic names, dose or strength, route, frequency and times), realistic expectations for results, potential side effects, signs of adverse reaction, and symptoms that warrant immediate medical attention.			
I educate my patients regarding their responsibilities for compliance with medication regimens including dietary and lifestyle modifications and the risks of non-compliance.			
I carry out an informed consent discussion prior to prescribing investigational or experimental medications or any medication with significant risks and obtain the patient's consent prior to initiation of the medication or medication protocol.			
I assist patients in obtaining financial assistance for their medications when appropriate.			
I counsel non-compliant patients regarding the risks to them and/or to my practice.			
I terminate from treatment persistently non-compliant patients; assist them in transitioning to another healthcare provider and document actions taken and support provided.			
I limit telephone refills to a maximum of one refill for routine medications pending a patient visit.			
I limit telephone refills of high risk medications on a case by case basis and ensure a rapid appointment is provided.			
I utilize drug samples with caution and ensure the lot number and serial numbers of the samples are recorded.			
I do not maintain or provide samples of controlled drugs.			
Competencies			
I obtain and participate in continuing education and training in compliance with state licensing regulations and as needed for the care and treatment of my patients.			
I remain current regarding clinical practice, medications, treatment and equipment utilized for the diagnosis and treatment of acute and chronic illnesses and conditions related to my clinical specialty.			
I consult regularly with my collaborating/supervising physician to ensure my competencies are appropriate.			
I participate in peer review and/or quality review in my organization/practice.			
I participate in quality improvement and patient safety committees/initiatives in my organization/practice/professional organization to enhance my clinical and patient safety awareness and competencies.			
I contact my Board of Nursing and/or Board of Medicine to identify learning opportunities in my state.			
I contact my professional organizations to identify national learning opportunities.			
Patient Care Equipment and Supplies			
I check to be sure that emergency and required patient care equipment is readily available and in good working order.			
I check all equipment before each use to ensure it functions properly.			
I report broken/malfunctioning equipment, remove it from use and obtain an appropriate replacement.			

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Self-assessment Topic	Yes	No	Actions Needed to Reduce Risks
I sequester broken/malfunctioning equipment that was involved in a patient incident to preserve its condition at the time of the event.			
I provide oral and written reports of broken/malfunctioning equipment to all appropriate parties.			
Professional Conduct			
I speak to patients, families and staff in a respectful and professional manner.			
I refrain from personal relationships with patients/families.			
I explain procedures and treatments to patients, including what touching they can anticipate during assessment, monitoring and treatment processes, and I obtain their permission before proceeding.			
I include a chaperone when indicated if intimate touching is required for the patient's treatment.			
I respect the patient's rights throughout the episode of care.			
I refrain from harsh physical touching or movement with patients at all times.			
I monitor the patient care environment to ensure a safe patient environment.			
I maintain patient privacy and confidentiality.			
I share patient protected information only with written authorization from the patient or legal representative.			
Other Documentation Practices			
I document contemporaneously and never make a late entry unless it is appropriately labeled and is necessary for the safe continued care of the patient.			
I never remove any portion of the patient's health information record.			
I never alter a record in any way.			
I refrain from subjective comments, including comments about patients, colleagues and other members of the patient care team.			
I do not remove patient health records (paper or electronic) from the patient care location, and I do not make entries from home or other inappropriate locations.			
If provided with a laptop, electronic pad or electronic PDA, I do not allow any other person access to that equipment, never share my passwords/access codes, and maintain the equipment safely.			
I immediately report lost or stolen paper health information records or electronic patient healthcare recording or storage devices.			
If I have documentation concerns, I contact the risk manager or hospital counsel for assistance prior to making an entry about which I am unsure.			

Claim Tips:

The following concepts and behaviors can help reduce nurse practitioner professional liability risks. Also included are steps to take if you believe that you may be involved in a legal matter related to your practice:

1. **Practice within the requirements of your state Nurse Practice Act**, in compliance with other professional boards, organizational policies and procedures, and within the standard of care.

2. **Document your patient care assessments, communications, clinical decision-making process, diagnosis, treatment plan and patient care actions** in an objective, timely, accurate, complete, appropriate and legible manner.

3. **Never alter a record for any reason or add anything to a record after the fact unless it is necessary for the patient's care**. If it is essential to add information into the record, properly label the addition as a late entry, but never add any documentation to a record for any reason after a claim has been made. If additional information related to the patient's care emerges after you become aware that legal action is pending, discuss the need for additional documentation with your collaborating/supervision physician, the organization's risk manager and/or legal counsel to determine appropriate action.

4. **Immediately contact your personal insurance carrier if you become aware of a filed or potential professional liability claim asserted against you**, receive a subpoena to testify in a deposition or trial, or have any reason to believe that there may be a potential threat to your license to practice nursing. Keep in mind that allegations involving failure to diagnose, delays in diagnosis, deaths and infection/abscess/sepsis are most likely to result in litigation.

5. **If you purchase your own professional liability insurance policy, report possible claims or related actions to your insurance carrier**, even if your employer advises you that he or she will provide you with an attorney and/or will cover you for a professional liability settlement or verdict amount.

6. **Refrain from discussing the matter with anyone** other than your defense attorney or the professionals managing your claim.

7. **Promptly return calls from your defense attorney and the claim professionals assigned by your insurance carrier.** Contact your attorney or claim professional before responding to calls, e-mail messages or requests for documents from any other party.

8. **Provide your insurance carrier with as much information as you can when reporting real or potential legal situations**, including contact information for the organization's risk manager and for the attorney assigned to the litigation by your employer.

9. **Never testify in a deposition without first consulting your insurance carrier** or, if you do not purchase your own professional liability insurance policy, without first consulting the organization's risk manager or legal counsel. In addition, do not testify in a deposition without having had specific deposition preparation by your attorney.

10. **Copy and retain any summons and complaint, subpoena or attorney letters for your records** and to share with your attorney and professional liability insurer.

11. **Maintain signed and dated copies of any employer contracts, including past agreements.**

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Increasing Adherence to Best-Evidence Guidelines: A Quality Improvement Initiative

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Donna Marie McCourt, BSN, RN

Abstract

Objective: *This quality improvement project aimed to increase adherence to clinical guidelines, thereby decreasing unnecessary risk of adverse events and conserving costs for a specific clinical issue-- blood transfusions.*

Background: *In an environment of affordable care demands, value-based purchasing, and cost-conservation, advanced practice nurses must lead efforts to enhance adherence to best-evidence clinical guidelines. We identified a local need to increase adherence to hemoglobin-based transfusion guidelines for inpatient orthopedic surgery patients as blood transfusions are costly with potential adverse reactions.*

Methods: *Interventions included a standardized order set and creating a new position for an acute care nurse practitioner on one orthopedic unit. Administrative databases were reviewed. Data were analyzed using descriptive statistics, Chi Square, and logistic regression.*

Results: *The odds of guideline adherence increased with our quality improvement interventions. Increasing patient age was associated with decreased odds of criteria adherence.*

Conclusions: Addition of a standardized order set and acute care nurse practitioner increased clinical guideline adherence on a 42-bed unit within an academic hospital. An extrapolated cost conservation, for a one year period, was an estimated $88,200.

In the contemporary healthcare environment, nurse practitioners (NPs) are challenged to enhance quality of care and decrease the risk of adverse patient events, while conserving costs. In the United States, less than 55% of adults receive best-evidence recommended care, which creates financial waste, unnecessary risk to patients, and clinical inefficiencies (McGlynn & Brook, 2001). As the Affordable Care Act progresses to state-level rules and implementation, organizations that deliver accountable care are in the process of being defined and measured. Linking payment to quality has been implemented through value-based purchasing and this system is expected to expand to additional measures (U.S. Department of Health and Human Services, 2012). The "implementation gap" between best-available clinical evidence and system-wide practices demands action and decision-making at all levels of healthcare (Institute of Medicine, 2010; Straus, Tetroe, & Graham, 2009).

Nurse practitioners can and must take the lead in the identification of opportunities to conserve costs and enhance quality by identifying specific clinical opportunities for improvement within their organizations. Nurses must also be poised to respond to payment incentives that will be increasingly tied to quality outcomes based on the adherence to best-evidence clinical practice guidelines (Garber, 2005; Institute of Medicine, 2010). This paper describes our quality improvement efforts to enhance accountable care delivery, cost conservation, and adherence to best-practice clinical guidelines for a specific clinical problem--inpatient blood transfusions. This study provides an example of how clinician-led quality improvements are an essential consideration for accountable care and cost conservation.

The Local Problem and Organization

In the organization described in this quality improvement project, a local problem was noted regarding blood transfusions. Our organization is a hospital system that includes a total of five hospitals, with two medical-surgical, post-operative orthopedic units. The first, Unit A, did not have a nurse practitioner on staff in the beginning of the quality improvement study period and was located in a teaching, academic hospital. Unit B, which was in a community hospital, had 7-day a week nurse practitioners on staff for approximately 10

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years, but no resident physician coverage. Unit A contained 42 beds, and Unit B had 37 beds. Both of the units staff one registered nurse for 5-6 patients, and one unlicensed assistive personnel for each 10 patients. The patient population in both units consisted of total hip and knee joint replacement patients, with general and neuro-surgery overflow patients. Overflow patients were not included in the quality improvement data collection.

The nurse manager on Unit A noted that a significant number of ordered blood transfusions in the organization did not meet the hemoglobin criteria and evidenced-based guidelines in facility policy as outlined by the hospitals' transfusion service department. While clinicians might have utilized blood products appropriately based on hemodynamic instability or blood loss, nursing and medical leadership identified a potential overuse of blood and blood products in our institution. Routine chart review for blood utilization, ongoing from 2010-2011, by the nurse manager revealed a discrepancy in clinician ordering behaviors based on a suspected individual physician preference and practice habit rather than evidenced-based decisions.

During the planning phase of this quality improvement project, the role of the NP was identified as crucial to enhance adherence to blood transfusion guideline criteria. NPs are essential to delivering quality, cost effective care, including team adherence to clinical practice guidelines (Institute of Medicine, 2010). However, NPs were only practicing in one of the two orthopedic units in our organization. Therefore, a new NP was hired into Unit A to round on all orthopedic patients on weekdays. The NP was affiliated with all orthopedic surgeons who placed patients on Unit A. This newly hired NP did not take call, and off hours were covered by resident physician staff.

The intent of the quality improvement project described in this manuscript was to increase adherence to best-evidence clinical practice guidelines, thereby decreasing unnecessary risk of adverse events and conserving costs. The intervention included the creation of a nurse manager-led standardized transfusion order set and the addition of a unit-based acute care NP. The study question of this quality improvement project was: What is the relationship between implementing a standardized order set along with the new hiring of an NP on adherence to hemoglobin transfusion criteria for blood transfusions?

The Clinical Issue

Clinically, the rate of whole and red blood transfusions in the United States is 48.8 per 1,000 people, for a total of 15 million transfusions annually (U.S. Department of Health and Human Services, 2011). Recent research studies indicate many transfusions administered in clinical care are superfluous or unjustified (Bennett-Guerrero et al., 2010; Carson et al., 2012). The cost for each unit of blood products is rising, while the Centers for Medicare and Medicaid only reimburse for approximately 80 % of the cost (U.S. Department of Health and Human Services, 2011). National quality goals include the need to adhere to clinical guidelines (Carson et al., 2012), reduce the proportion of patients who develop adverse events from a blood transfusion (U.S. Department of Health and Human Services, 2010), and to ensure a safe and adequate blood supply.

Adverse patient events that may result from a blood transfusion include: infection, reactions to mismatched blood, allergic reaction, hemolytic reaction, and transfusion related acute lung injury (TRALI), all of which could lead to shock and/or death (America's Blood Centers, 2001; American Red Cross, 2010; Knippen, 2006; Scarlet, 2006; Stainsby et al., 2006). While the adverse events are minimized by safe blood processing and administration guidelines, the risks assumed by the patient for unnecessary blood transfusions could lead to devastating, but ultimately avoidable, consequences.

Specific clinical guidelines on transfusion criteria of red blood cells (RBC) for hospitalized, hemodynamic stable patients should be guided by patient symptoms as well as (Carson et al., 2012);

1. Restricting transfusions unless hemoglobin is 7 g/dL or less
2. Restricting transfusions unless hemoglobin is 8g/dL or less in post-operative or patients with pre-existing cardiovascular disease with the following symptoms (chest pain, orthostatic hypotension, tachycardia unresponsive to fluid resuscitation, congestive heart failure).

Exceptions to these guidelines include patients hospitalized for acute coronary syndrome due to the limited quality of the research evidence in this population. We hypothesized that the addition of an NP, with nurse-led standardized order set creation, would enhance adherence to these best-evidence clinical practice guidelines.

Methods

This quality improvement project took place in two medical surgical units, with orthopedic surgical specialty focus, housed within one hospital system. Unit

Table 1. Logistic Regression of Variables that Increase Adherence to Blood Transfusion Hemoglobin Guidelines in Unit A (N=477)

Variables	B	SE(B)	Wald	Df	P	OR	95% CI
New NP on Duty	.67	.23	8.46*	1	.004	1.95	1.24-3.05
Hip Surgery	-.10	.20	.25	1	.617	.90	.61-1.34
Female	-.26	.22	1.41	1	.234	.78	.51-1.18
Age	-.03	.01	10.32*	1	.001	.98	.96-.99

*p<.01, NP=Nurse Practitioner

A was located in an urban, teaching hospital and cared for 452 total hip replacement patients and 569 total knee replacement patients during 2011. Unit B was located at a suburban, community hospital and cared for 243 total hip replacement patients and 654 total knee replacement patients during 2011. Patients on Unit A were routinely covered by attending physicians and orthopedic physician residents. Patients on Unit B were routinely covered by attending physicians and nurse practitioners during daytime weekday and weekend hours.

As a part of a larger quality improvement initiative to increase adherence to clinical guidelines and increase patient satisfaction, this paper describes a project to improve ordered blood transfusion adherence to hemoglobin criteria. The intervention for this quality improvement project included the unit nurse manager-led development and implementation of a routine order set for blood transfusions and the addition of a nurse practitioner to the medical coverage on Unit A during weekdays.

Education about and introduction of the standardized blood transfusion order set and addition of the unit-based NP were implemented in September of 2011. The standardized order set was developed by a multidisciplinary team, consisting of orthopedic surgery, nursing, pharmacy, and transfusion services and was reviewed by medicine and nursing administrative committees before approval. Before this quality improvement project, the provider ordered a blood transfusion by freely scripting the order. The standardized order set for this quality improvement project was developed specific to the orthopedic patient with both transfusions orders and specific patient indications, with the expectation that all post-op orthopedic blood transfusion orders be place on the new standardized order set. The project was evaluated by monitoring the amount of ordered blood transfusions that complied with hospital hemoglobin criteria for patients who had undergone elective total knee and total hip surgery.

The outcome measured for this study was if the organization's transfusion order criteria was met or unmet (1=met, 0=unmet). The intervention was measured, by proxy, as transfusions administered weekdays during the fourth quarter of the year at unit A (when the newly hired NP was on duty) compared to transfusions administered on other days of the year. Other variables included age (all patients were adults), gender, type of surgery, pre-hemoglobin level, and post-hemoglobin level. Data were analyzed using descriptive statistics, chi square, and logistic regression.

Results

A total of 1,577 units of blood product were administered on the two study units during 2011. When analyzed by type of surgery, 477 transfusions were administered to hip or knee replacement surgery patients on Unit A, and 165 were administered on Unit B. Only 42 percent (n=270) of these transfusions met the organization's criteria. On Unit A, the percent of transfusions that met criteria was 50 percent when the NP was on duty (n=54) compared to 36 percent (n=133) on other days of 2011. On Unit B, the percent of transfusions that met criteria was 42 percent (n=18) during weekdays in the 4th quarter of 2011, compared to 53 percent (n=65) on other days of 2011. Forty percent of the transfusions were administered to total hip replacement patients (n=259), and 60 percent to total knee replacement patients (n=383). Seventy three percent were administered to female patients (n=469).

To test for baseline differences in characteristics of the patients receiving the transfusions when the new NP was on duty and other days of the year, an independent samples t-test was performed for patient age, pre-hemoglobin, and post-hemoglobin levels and a $\chi 2$ test was performed for gender and type of surgery (knee or hip). Patients receiving transfusions on Unit A during the days the NP was on duty in 2011 were significantly older (M=68, SD=13.2) than patients receiving transfusions on Unit A during other days of the year (M=64, SD=11.6, t(160)=3.04, p=.003) There were no significant difference for Unit A for gender, type of surgery, pre-hemoglobin, or post-hemoglobin levels (p>.05). There were no significant differences in any patient characteristics for Unit B (p>.05).

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Next, to determine if there were differences in meeting the organization's transfusion criteria, the outcome variable was tested on each unit, with the days the new NP was on duty as the independent variable. The new NP was rounding on all patients and utilizing the standardized order set in addition to addressing the overall post-operative needs of the patient. The new NP role augmented and enhanced the surgical/medical coverage and accessibility when surgeons were typically busy in the operating room. There was a significant difference in transfusions that met the organization's hemoglobin criteria for transfusions administered during the new NP's on-duty days at Unit A, compared to transfusions administered on other days in 2011 ($\chi^2(1)= 6.3$, p=.012). More transfusions met criteria when the NP was on duty. This difference was not replicated on Unit B where there had been no change in nurse practitioner coverage year-round ($\chi^2(df=1)= 1.7$, p=.198).

A logistic regression examined the impact of the addition of the new acute care NP to Unit A on predicting adherence to transfusion criteria, with several independent variables included; type of surgery, patient age, and patient gender. The model for Unit A accounted for 5.3 percent of the variance in meeting transfusion criteria with an acceptable model fit (non-significant Hosmer-Lemeshow test). Table 1 displays the results for Unit A. The addition of the newly hired NP increased the odds of transfusions that adhered to criteria (OR=1.9, 95% CI=1.2-3.0). Increasing patient age slightly decreased the odds of transfusions that adhered to criteria (OR=.98, 95% CI=.96-.99), possibly due to increasing co-morbidities and/or decreasing physiologic reserve and response to fluid resuscitation. Type of surgery and gender did not change the probability that the transfusion adhered to criteria. As expected, none of the variables in the equation were significant predictors for the adherence to transfusion criteria in Unit B.

Limitations

As a quality improvement project, this study was limited to one organization and should not be generalized. First, no data was gathered on blood loss or hemodynamic instability, which would affect the clinician's judgment to administer blood products outside of the hemoglobin level guidelines. Because transfusion is the unit of analysis for the outcome criteria, not all of the cases analyzed were independent, violating the assumptions of the statistics used. For example, if two transfusions were administered to the same patient, the patient's characteristics (age, gender, type of surgery) were represented in the sample twice. The specific surgeon and ordering provider information was not included in data analysis. During data screening, it was noted that many patients in the sample received one transfusion that met criteria, and a second that did not meet criteria. Therefore, for the purposes of this project, they were treated as independent events and observations. Future and replication studies with larger sample sizes may statistically nest transfusions within patients to avoid this limitation.

Discussion

This quality improvement project addressing one specific clinical issue demonstrates the quality-added potential of an NP with nurse manager-led efforts to standardize orders sets. In this project, the intervention increased the probability that ordered transfusions adhered to clinical guideline. In our quality improvement measurement, transfusions given were nearly twice as likely to adhere to standardized hemoglobin criteria. In addition, transfusions administered to older patients were slightly less likely to adhere to criteria, potentially due to the complexity and enhanced potential for cardiovascular co-morbidities. Evidence from this quality improvement project supports the growing body of evidence about the central importance of the NP role to reduce costs and increase quality of care (Institute of Medicine, 2010).

To project the potential cost conservation of an NP and standardized order set, we measured the baseline and post-intervention proportion of transfusions that adhered to clinical guidelines. We then estimated the cost conservation of the difference between the proportions and extrapolated the estimate to an annual estimate. In our organization, the cost of a unit of packed red blood cells, processing, and transfusion equipment is estimated at $700 each. The total number of blood product administration on these two medical-surgical orthopedic floors was 1,577 units. If we infer the rates of compliance to guidelines for all procedures are similar to total knee and hip surgeries investigated in the project (baseline of 42% meets criteria yields n=662) and the standardized protocols and NP can increase the percent that adhere to clinical guidelines to 50 percent (estimated 788), ***126*** unnecessary transfusions could be eliminated. This estimate translates into an extrapolated total cost savings of $88,200. In the organization described in this manuscript, the return on investment from the reduction in overall transfusions supported the NP position on the unit for continued quality improvement and cost reduction. Meanwhile, the NP role is also leveraged for additional quality improvement and cost savings, and the entire impact of the role continues to be measured. Future quality

improvement initiatives, to which the NP is central, include venous thromboembolism prophylaxis, hospital acquired urinary tract infection, and antibiotic utilization.

Collaboration among unit nurse manager and NP-led quality improvement is essential to enhanced quality and cost-savings (Institute of Medicine, 2010). In our project, a nurse manager identified a specific clinical issue wherein there was low adherence to the best-available evidence. The nurse-led quality improvement project demonstrated a reduction in the risk of adverse events to patients in addition to a significant potential reduction in cost by adhering to clinical practice guidelines. Leveraging the role of the NP and standardized order sets, we guided this orthopedic surgical unit towards higher quality, cost-effective care. The central role of the NP to hospital unit quality and cost-effectiveness should continue to be investigated. The results of this study suggest that NPs can enhance accountable care, reduce the risk of adverse events, and actualize cost conservation.

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Keywords: transfusion, orthopedic surgery, nurse practitioner, quality improvement, standardized order set, clinical guideline adherence, logistic regression, APRN

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The Doctor of Nursing Practice: The Perspective of New York State Nurse Practitioners

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Abstract

The Doctor of Nurse Practice (DNP) is a clinically focused doctoral degree which has been recommended by the American Association of Colleges of Nursing (AACN) (2004) to be the terminal practice degree and minimal educational standard for advanced practice nurses by 2015. The intention of the DNP candidate is to fulfill the needs of the looming physician and nursing faculty shortages, provide medical care for the anticipated increase of millions of people who will have access to healthcare under the new healthcare plan, meet the needs of the underserved populations, and address the issues of today's increasingly complex healthcare environment. This doctoral program was established to create parity with other doctorally prepared healthcare professionals. This mandate has been the subject of much discussion and debate, focusing on issues such as title confusion with other disciplines. While the mandate was published in 2004, there is little research on this topic among practicing nurse practitioners. Therefore, this study surveyed the knowledge, attitudes and beliefs of 392 New York State NPs regarding this doctoral degree. It was found that while NPs are aware of the AACN mandate for doctoral education, slightly less than 50% of practicing NPs indicated they have no intention in pursuing a DNP degree. Practicing NPs identified barriers to return to school when already in clinical practice. NYS NPs consider this degree desirable for those wishing to maintain a clinical focus in obtaining another educational degree, as well as offering a positive alternative pathway for those NPs who desire to become employed in academia. Further research is needed to ascertain the full impact of the DNP degree on clinical practice and within nursing academic settings.

Introduction

The increasing complexity of healthcare has created a demand for advanced competencies in nursing practice, faculty, and leadership roles (McCreery, 2011). In response to this demand, the American Association of Colleges of Nursing (AACN) endorsed a pathway for advanced practice nurse (APN) preparation from the master's level to the doctoral level by 2015 (Loomis, Willard, & Cohen, 2006; AACN, 2004). The AACN position paper cited the need for a higher level of knowledge and skills to function adequately in the current complex healthcare environment (AACN, 2004). After the AACN posted its Position Statement on the Practice Doctorate in Nursing (2004), the controversy and interest regarding the DNP exploded (Hathaway, Jacob, Stegbauer, Thompson, & Graff, 2006). Subsequent endorsement of this statement was given by the Commission of Collegiate Nursing Education (AACN, 2012).

Background

Justification for the practice doctorate is to address the increasing complexity of healthcare, to establish parity with other disciplines, to integrate the continuing explosion of knowledge into NP practice, and to fulfill the pressing need for more nursing faculty. The DNP satisfies the goals of the NP interested in pursuing an advanced degree to meet the complexity of professional practice by furthering their formal education (Boland, Treston, & O'Sullivan, 2010; AACN, 2013a). While licensure requirements for NPs granted by individual state boards of nursing, vary considerably from state to state, boards of nursing reached a consensus that existing NPs will be grandfathered in their current practice if the DNP degree becomes mandatory (Smith, 2006). The DNP is not required for licensure as a NP, nor does it qualify the recipient for an additional license. There is not a separate certification exam for those who obtain this degree. DNP graduates may take optional specialty exams, designed to recognize their added knowledge without changing their scope of practice (Boland et al., 2010).

As of 2013, there has been significant growth of the DNP programs with 217 colleges currently enrolling students nationwide, with an additional 97 in the planning stages (AACN, 2013b). Questions exist as to what will happen to the 200 current advanced practice programs in institutions that do not offer the doctorate transition by providing a doctoral degree (Chase &

Pruitt, 2006). Tuition costs, running as high as $80,000 to $100,000 for this doctoral degree, need to be considered as these costs may be a detriment to recruitment of students. Additional considerations include what are to be the appropriate credentials of the faculty who teach in DNP programs, and whether there will be sufficient faculty to do so.

Statement of Problem

A larger number of providers will be needed to meet the demand for a larger aging population and for the estimated 32 million additional Americans that will gain health insurance coverage as of 2014 under the new healthcare law (Bachmann, 2011). The idea exists that DNPs will fill the gap that is left by the on-going physician shortage (Thrall, 2003). While it would seem that the timing of changing the level of preparation for advanced nursing practice from the master's level to the doctoral degree by 2015 by AACN is appropriate, the emergence of this particular doctoral degree has been described as a disruptive innovation, presenting many challenges (AACN, 2004; Hathaway et al., 2006).

Concerns regarding the DNP degree focusing on title issues have been expressed. The American Academy of Family Physicians (AAFP) has expressed concern that the DNP program will not adequately train NPs to replace physicians in primary care (AAFP, 2010; McCreary, 2011). The American College of Physicians (ACP) also expressed concern regarding the professional designation of the DNP and confusion of the public in regards to those entrusted with their healthcare. Their concern arises over conceptions and confusion by patients of the use of the prefix "Doctor" or "Dr." by NPs who have mastered this doctorate program (ACP, 2009). An American Medical Association survey in 2010 found that 35% of Americans thought a DNP practitioner was a physician, with another 19% uncertain that a DNP practitioner was a physician (Bachmann, 2011). However, due to the differences in the breadth and depth of clinical training for the DNP as compared to physicians, it has been asserted that the salutation "Doctor" may not be correctly understood by consumers.

Others within the profession have expressed differing opinions. Perspectives raised include new DNP graduates who may lack clinical experience outside of their education programs in clinical practice (Pulcini & Hart, 2007). It is postulated that conflicts could arise over the DNP candidate being considered for positions over the more experienced NP counterpart who may hold a lesser degree. Pulcini and Hart (2007) question whether the NP will feel pressure to enroll in the DNP program even though it is not a current requirement for practice.

The cost of the DNP degree may not be offset by the increase in salary offered to practicing NPs and may be a deterrent to the NP to return to college for this doctoral degree (McCreary, 2011). The 2012 Bureau of Labor Statistics data show that individuals with doctoral degrees have median weekly income $324 higher over a candidate with a master's degree (U.S. Department of Labor, 2013). A national survey conducted in 2009 found that the average annual salary for an NP was $89,392 while a DNP's annual salary was $97,080 (Rollet, 2009). There is concern that an anticipated shortage of NPs, along with an increased demand for primary care providers, might ultimately reduce the number of practicing NPs due to the length of the DNP program (McCreary, 2011). It is anticipated that with this added value of a doctoral education, the DNP candidate may encounter more job opportunities, be offered improved positions, and gain more professional respect than a clinically practicing NP (Boland et al., 2010).

Literature Review

Surveys have attempted to elicit professional opinions on the DNP degree. A survey of Massachusetts's nurses identified barriers to the DNP degree including time and cost, along with family constraints and career disruption as barriers to obtaining the DNP degree (DeMarco, Pulcini, Haggerty, & Tang, 2008). A statewide survey conducted by the University of Southern Maine (USM) found that approximately one-third of registered nurses surveyed indicated an interest in pursuing the DNP degree (Kirschling, 2006). Interest in returning to school for the DNP degree was somewhat higher (75%) when alumni were surveyed by the Department of Nursing at Missouri State University (MSU) (MSU, 2011). A 2008 study conducted by The California State University (CSU) found that nursing directors would hire those with a DNP degree as faculty (CSU, 2008). The University of Washington School of Nursing found that some schools decided not to establish this program due to the lack of faculty or administrative support (Brown & Kaplan, 2011). An internet-based survey, sent to DNP students at schools of nursing, found that reasons to pursue the DNP degree were increased intellectual knowledge, career advancement, and eligibility as nursing faculty, with this doctoral degree cited as an advantage (Cohen, 2007). To date, no surveys have addressed the perspectives of the NP regarding the practice doctorate.

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Research Purpose

The viability and practicality of the DNP program through cost efficiency and flexibility continue to be factors to explore (DeMarco, Pulcini, Haggerty, & Tang, 2008). The goal would be to identify whether there is interest in pursuing this doctoral degree, define the career advantage to this advanced education, and identify barriers prohibiting NPs from obtaining their DNP. Understanding these factors will help ascertain if the DNP is the future of NP education. Therefore, the purpose of this study was to focus on examining the level of knowledge of the NP surrounding the DNP degree, attempting to elicit the positive and negative perceptions about this advanced preparation that may impact NP's pursuit of the DNP.

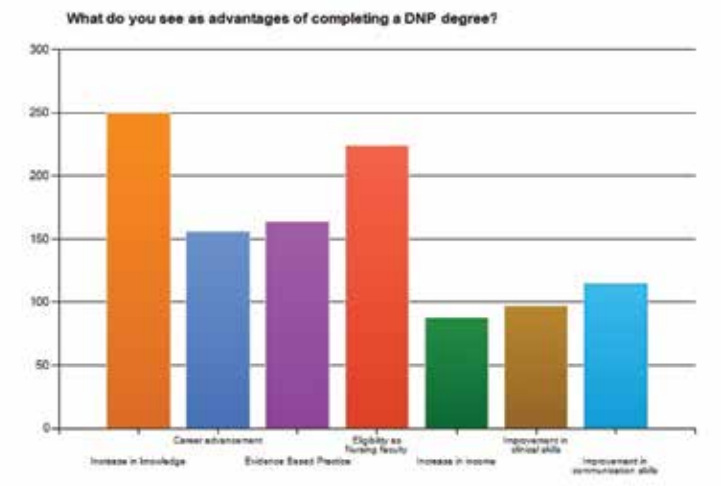
Design

The study utilized a non-experimental, descriptive design quantitative survey design. The survey queried licensed and retired NPs belonging to the Nurse Practitioner Association New York State (NPA) utilizing SurveyMonkey's online survey service. Consent to perform this research was obtained from the Human Subjects Research Review Committee at Daemen College. An NPA designee sent a blast email to licensed and retired NPs belonging to this organization. The email directed the NP to a link to SurveyMonkey's secure website for survey completion.

Data Collection Tool

A 33 question survey was created to survey study participants. Demographic questions were included to ascertain participants' characteristics. A combination of true-false statements, as well as statements reflecting attitudes and beliefs about the DNP degree were also included. Additional items were adapted from tools used in similar research studies by the University of Southern Maine and the CSU System (USM, 2005; CSU, 2008).

Table 1: Identification of Advantages of Completing a DNP Degree by NYS NPs (n=365)



Results

The survey was sent to 3321 NPA members, either licensed or retired. A two-week time period was established for the NPs to respond. While there was a total of 389 surveys returned (12 % response rate); not all respondents answered all questions, resulting in a varying n per statement/question.

Demographic questions indicated that most respondents were female (92.08%; n=381). Most respondents, 88.06% were Caucasian, with African Americans following with a response rate of 5.31% (n=377). The majority of those surveyed were between the ages of 50-59 years at 40.90%, with ages 40-49 years following at 22.43% (n=379). A majority of the respondents listed hospitals as their work location at 32.19%, followed by primary care clinic with a response rate of 21.64% (n=379).

Ninety two percent of respondents answered true to the first statement, "The American Association of Colleges of Nursing (AACN) endorsed a pathway for NP preparation from the master's level to the doctoral level by 2015". Survey question 2 asked their knowledge of the grandfathering clause exempting NPs already practicing in the state from the new requirements set forth by the AACN that the DNP will be the sole professional doctorate for accreditation. The majority of those surveyed (87.73%) were aware of this proposal. For item 3 which asked about the average annual salaries for an NP with a Master's degree versus a DNP degree, 52.2% of respondents correctly agreed that the DNP salary was approximately $10,000 more annually as compared to NPs with a master's degree. When asked if the respondent agreed with the theory that the DNP program may cause PhD programs to dwindle in enrollment resulting in a smaller pool of nursing faculty, 44.53% respondents disagreed with this statement, 25.78% agreed, and 29.69% stated uncertainty (n=384).

Survey question 5 asked the participant the advantages to completing a DNP degree. NPs ranked highest an increase of knowledge followed by eligibility as nursing faculty (see Table 1). An increase in income ranked the lowest choice for completing a DNP at 24.11%. When queried in survey question 6 whether the NP envisioned graduates of the DNP program to improve health care quality and contribute to reducing health

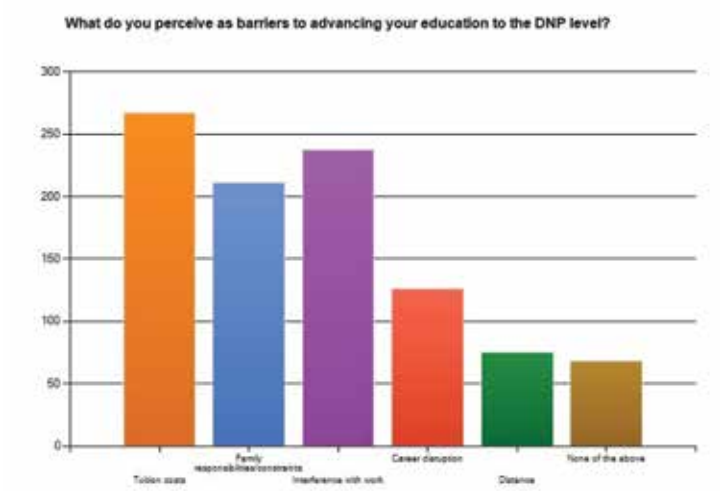
care disparities, there was minimal differentiation in the responses. Whereby 39.32% responded positively that the DNP graduate would improve health care quality and help reduce health disparities, 34.11% responded negatively, with 26.56% uncertain (n=384). Survey question 7 asked what advanced practice educational programs the participant completed, responses were NPs 99.72%, followed by Clinical Nurse Specialists at 12.5%, Clinical Nurse Midwife at 56% and Certified Registered Nurse Anesthetists at 28% (n=360).

Of all survey respondents, 11.95% responded that they were enrolled in a post-master's program (n=385). Of those enrolled, the majority, 68.42% responded that they were in a DNP program (n=57; item #9). Survey question 10 asked how strong their interest is in pursuing the DNP degree; half of those surveyed (48.65%), responded that they had no interest in pursuing the DNP degree, with only slightly greater than 3% citing a definite interest in pursing this doctoral degree (n=370). Of those pursing this education, 46.88% plan to pursue the DNP within 3 years and 33.75% responded within 5 years (n=160). The respondents largely endorsed a curriculum offering part-time study (78.91%), with 7.27% interested in a full time curriculum (n=275). Over 175 respondents, 47.18%, indicated no interest in teaching (n=373) in an academic program.

When queried on their feelings toward the DNP degree in survey question 14, ambivalence rated highest with 48.16%, followed by 35.53% advocating for the degree and 16.32% expressing antagonism toward the DNP (n=380). Question 15 asked the NP if they felt that the DNP is the next logical step in the evolution of education for NP; only slightly more NPs felt that the DNP is the next logical step.

With regard to the feeling that the DNP will lead to more job opportunities, improved positions, and increased professional respect identified in item question 16, the NPs responded negatively at 46.19%, with 29.66% responding positively about the DNP degree's future potential (n=381). Item 17 revealed that respondents did not feel the DNP threatened PhD programs 57.55 %. Survey question number 18 indicated that tuition costs ranked highest with a 71.77% response rate as their number one barrier to the DNP, and interference with work ranking as the second perceived barrier at 63.71% (see Table 2).

Table 2: Perceived Barriers of NYS NPs to Advancing Education to the DNP Degree (n=372)



Questions 19 and 20 inquired if tuition reimbursement would entice NPs to return to school. While 41.4% (151) NPs replied that their employer offered reimbursement, only 31.4% (51) replied that this would be important in the decision to return to school for the DNP degree, with 14.2% (24) being uncertain on this issue. When queried in question 21 whether the NP felt their ability to practice would be restricted if the DNP becomes the required educational preparation for NP licensure, NPs responded negatively; 59.95%, that they did not feel as though the DNP would affect their ability to practice as an NP (n=377), nor did the respondents feel that the DNP would create a conflict with currently practicing NPs, 46.49%, as asked in survey question 22 (n=385).

Survey question 23 asked if the NP felt the DNP credential would confuse the general public into believing that they were being treated by a physician or doctor of osteopathy. Responses were yes, 47.12%, versus no, 37.43%, with 15.45% responding that they were uncertain of this potential confusion (n=382). In response to question 24 on whether the DNP would cause animosity with physicians, over 53.93% responded affirmatively. Yet, responses to survey question 25 on their feeling that the DNP will cause more nurses to enroll in a PA (non-doctorate) program, 43.64% responded negatively, and 32.21% responded positively with an uncertainly response rate of 24.16% (n=385).

When asked which incentives would influence the NP's decision to return for the DNP, scholarships ranked highest (74.19%), and employer tuition reimbursement followed (73.84%) as the greatest incentives for the NPs to return for their doctoral degree. Traditional financial aid was ranked as the lowest incentive at 30.47% response rate (n=279). Regarding factors that would influence their decision to return for the DNP, program length at 80.62% was the favorable response

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with full or part-time options following at 76.82%. Factors which had least importance in returning to school which included distance from home (49.13% of respondents), and finding their own clinical preceptor (33.22%) were ranked lowest(see Table 3).

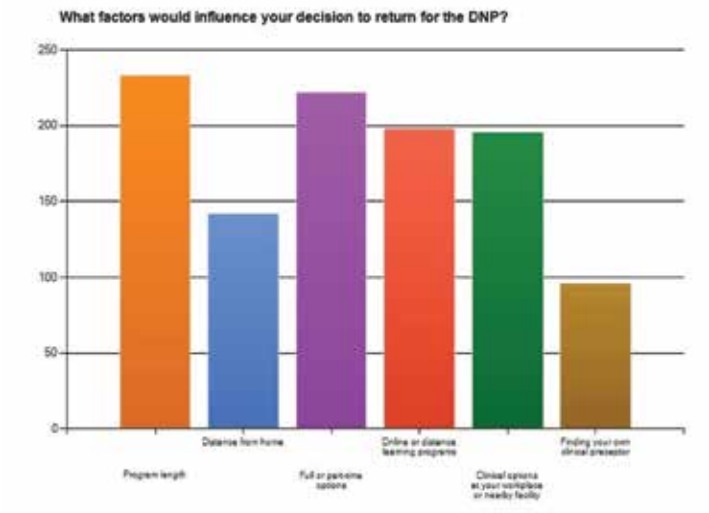
Discussion

Results of the data analysis indicate that there is knowledge among those surveyed of the AACN's position statement on the DNP and of the grandfathering clause exempting currently practicing NPs. The respondents were optimistic in their responses that the DNP would not negatively affect PhD enrollment possibly affecting future nursing faculty or cause an influx in enrollment to the non-doctoral PA programs. While clinical education is the focus of the DNP, a low response rate was given when asked what the NPs thought as an advantage to DNP degree, responding that improvement in clinical skills was not listed among the top 7 choice advantages but ranked second last. Goals set forth by the ACCN (2006) in the essentials of doctoral education for advanced nursing practice places the DNP focus on the improvement to healthcare quality and contributing to the reduction of health disparities, yet responses indicate that they may be unaware of these essential guidelines written by the AACN.

Less than half surveyed indicated no interest at all in pursuing the DNP degree, different than the intention previously cited in other surveys (CSU, 2008; DeMarco et al., 2008; MSU, 2011; USM, 2005). Over 51% indicated interest ranging from mildly interested to planning to earn a DNP degree. The majority of respondents expressed ambivalence toward the DNP degree, with only approximately one-third of those surveyed advocating for the DNP. There was little difference in the response to the question whether the DNP was the next logical step in the evolution of education for NPs and the majority did not feel that the DNP would lead to more job opportunities, improved positions or increased professional respect.

Identified barriers to attending a DNP program were tuition costs followed by interference with work and then family responsibilities, which was similar to previous findings (DeMarco et al, 2008). Likely these identified barriers are similar to barriers to attending any type of educational program. Despite tuition reimbursement from their employer, the responses indicated that this would not entice NPs to pursue this doctoral degree. It is not clear why this is a prevailing opinion, though it could be postulated that phase of career and age of the NP could be influential in this decision. NPs responded that they anticipated there would be no restriction on their ability to practice should the DNP become the required educational preparation for licensure, and that they did not expect the DNP to cause conflict with existing NPs. NPs also responded overwhelmingly that the DNP will cause animosity with physicians, while NPs responded negatively that they did not feel the DNP would cause nurses to enroll in the non-doctorate PA program. The majority cited scholarships and employer tuition reimbursement as the top incentives to pursue the DNP, with traditional financial aid ranked lowest as an incentive to pursue the DNP. Lastly, NPs cited program length and full or part-time options as the top factors that would influence their return for the DNP. Distance from home and finding your own clinical preceptor were negative factors that were least influential in the decision to return to school for this degree.

Table 3: Percentage of Responses of Factors Influencing NYS NPs Decision to Return for the DNP (n=289)



Implications

It would appear that the NPs in this study offered only modest support for the DNP degree requirement for NPs, despite having an accurate knowledge of the AACN's position statement, grandfathering clause for existing NPs, and salary comparisons. Many schools of nursing are offering the DNP with more colleges gaining accreditation to offer this program. This study indicated the need for program options that are flexible and cost efficient with choices for course delivery including on-line classes, distance delivery and/or weekend yearlong classroom. Meeting these goals will make the DNP a viable option for the NP looking to advance their educational goals.

Limitations

As many colleges across the country have already instituted the DNP programs (AACN, 2013b), the resultant data may be late and ineffective to already developed programs without concern for curriculum formats, financial incentives, or accommodations for NPs. Insight from those who have completed the DNP degree, as well as the opinions from other professionals outside the profession were not explored; this insight may be valuable in how to integrate those with the DNP into the current multidisciplinary milieu.

Recommendations for Future Study

Many of the questions in this NYS survey could be posed to those who have already obtained their DNP to query their views on impacting clinical practice. Exploration of NPs' perspectives from other parts of the country, as well as the perspectives of other disciplines, such as physicians, could be investigated.

Summary

It is postulated that the DNP degree will increase the workforce to include accountable, quality, healthcare providers and clinical leaders who will keep pace with the new demands of the ever-changing complex healthcare environment. But the results of this survey of NPs in NYS indicate that there is ambivalence towards this degree within the NP profession. While DNP degree appears it will support clinical advancement, development of leadership, parity with other healthcare professionals, and enhancement of scientific knowledge to ensure high quality patient outcomes, programs must not only accessible but cost effective to practicing NPs to enhance enrollment in these programs.

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The Changing State of Health Care: New Standards for Practice and Competency

Blake T. Andersen, PhD, President & CEO, HealthSciences Institute

Assessing the Current State of Health Care in the U.S.

For years we have been warned that the rate of spending on health care in the U.S. is unsustainable. As practitioners and consumers we have also witnessed the intended and unintended consequences of stopgap health care cost containment steps such as cuts to provider payments, managed care and utilization management, shrinking provider networks, consumer-directed health care, carve out disease management services, among others. However, these steps have failed to make health care costs any more sustainable. At the same time, health care delivery has failed to keep pace with the leaps in quality and innovation that we've seen in other fields. In particular, health care has failed to evolve with changing consumer needs and preferences. The biggest health challenges facing most individuals are related to lifestyle practices and the care and self-management of chronic conditions. However, health care delivery, as well as the training and continuing education of health care practitioners, is based on the acute model of health care.

There are signs that health care has reached a tipping point—that costs have finally met or exceeded the ability to pay and that many of our health care routines and roles are not optimally suited for improving patient-level outcomes. At the same time, some employers have cut health plan benefits to the extent that they bear little resemblance to health insurance at all. Minimed policies such as those offered to hourly workers at McDonalds have been capped at $2,500 to $10,000 in annual benefits[1]—limits that would be wiped out by a single hospital stay—the type of limited benefit plans targeted by the Affordable Care Act (ACA) of 2010 (Obamacare). To understand how health care is changing, we have to first recognize why it is changing—and the new opportunities that change brings for not only sustainable costs, but also better quality and health care value.

A Snapshot of Health Care Spending

In a detailed analysis of health care spending, Boston Consulting Group's Hamilton Moses, MD—former COO of Johns Hopkins Hospital—and his colleagues, published an economic analysis of health care in the U.S. in the November 13, 2013 issue of The Journal of the American Medical Association.[2] Among their findings:

- In 2011, health care costs doubled as a percentage of the U.S. GDP to 17.9% or $2.7 trillion from 1980. While yearly growth has decreased since 1970, especially since 2002, at 3%, it still exceeds that of other industries and overall GDP.
- Since 2,000, increases in service costs (not demand for services or increased need due to the aging population) are responsible for 91% of health care cost increases. These include a 4.2% increase for hospital charges, 3.6% for professional services, 4.0% for drugs and devices, and 5.6% for administrative costs during this same period.
- Personal out-of-pocket spending on health care has decreased from 23% to 11%.
- Chronic illness account for 84% of costs overall.

What are the primary factors responsible for rising costs? Moses and his colleagues identified the top three: 1.) Provider consolidation with fewer general hospitals; more single specialty hospitals and physician groups; 2.) Costs for information technology, and 3.) The patient as consumer trend, whereby patients choose care or drugs based on influence from online sources, informal social networks, etc.

In Search of Health Care Value

Health care costs tell only half of the story. It is also necessary to examine patient outcomes achieved by dollars spent, or health care value. While value in health care is often unmeasured and misunderstood, it can, however, be determined by assessing the impact of a treatment or service, on a specific condition(s) or episode of care, relative to the patient-level outcomes achieved. By focusing on value first, we can work much more strategically to provide the best care for dollar spent. We can also move beyond arbitrary cost-cutting to address the primary causes of unsustainable health care costs and quality gaps.

As we will see, a number of the new health care service delivery and reimbursement models being implemented by employer and government purchasers—the Accountable Care and Bundled Payment Models are two good examples—are based on the notion of value measurement and improvement. Harvard's Business School's authority on business strategy,

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Dr. Michael Porter, has been a vocal proponent of value measurement in health care, having served as an advisor to health care buyer groups and the Centers for Medicare and Medicaid.[3] Value determination and measurement will continue to be a key focus of health care in the U.S. Practitioners who understand how value is being measured by payers—and can deliver it—will be well poised for the new health care environment. Learn more about value in health care at: http://www.hbs.edu/centennial/businesssummit/healthcare/value-based-health-care-delivery.html.

Gauging the Value of Health Care in the U.S.

The U.S. spends about twice what most other developed countries spend on health care. From a value perspective, we would expect that health care in the U.S. is twice as good as that in other developed countries. Is this the case? To make this determination, we can refer to the annual Commonwealth Fund International Health Care Survey. Each year Commonwealth asks 20,000 patients about their experience with their native health care system. This comprehensive, nonpartisan evaluation of access, quality and patient-level outcomes is used to profile that state of health care in twelve nations: Australia, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland. According to the 2013 survey:[4]

- The U.S. spends $8,508 per person on health care—nearly $3,000 more per person than Norway, the second-highest spender.
- In 2013, more than one-third (37%) of U.S. adults went without recommended care, did not see a doctor when they were sick, or failed to fill prescriptions due to costs, compared with as few as 4 to 6 percent in the United Kingdom and Sweden.
- About 40 percent of the insured and uninsured spent $1,000 or more out-of-pocket during the year on medical care (in addition to health insurance premiums).
- About 25 percent of U.S. adults either had serious problems paying medical bills or were unable to pay them, compared with fewer than 13 percent of adults in the next-highest-spending country, France, and 6 percent or fewer in the U.K., Sweden, and Norway.
- U.S. insurers spent $606 per person on administrative costs, more than twice the amount in the next-highest country. These costs stem primarily from our complex, fragmented insurance system.
- Seventy-five percent of U.S. adults stated that the U.S. health system needs to undergo fundamental changes or be rebuilt completely.

Shifting the Focus from Cost to Value

Judging from the data in the Commonwealth Survey, not only does the U.S. spend nearly twice what other developed countries spend on health care, its outcomes are generally poorer, not better. These facts underscore why attempts to fix the health care that focus only on costs (or quality alone) will be insufficient. What is needed is a basic transformation in how health care is delivered and reimbursed. Since most health care spending is attributed to chronic conditions, it will require a shift from an acute care-oriented health care system, to one focused on better chronic care—reducing the risks of chronic diseases and chronic disease-related complications. Practitioners will also need to be enlisted as partners in change—sharing in the risks and rewards across care silos. Patients and family members will need to be engaged, as most daily health care is provided by the patient—with our without the assistance of family members. Change will also require integration and coordination across health care settings to reduce duplication and waste, and the bundling of payments for episodes of care. Fortunately, these are the aims of many of the improvement and demonstration programs currently being implemented and tested by health plans, employer purchasers and the Centers for Medicare and Medicaid (CMS).

The Affordable Care Act (ACA)

One of the most significant developments in health care since the 1965 Medicare Amendment to the Social Security Act is the 2010 Affordable Care Act (ACA). Limited access to affordable health care is a serious problem in the U.S.5 and a primary objective of the ACA is to make health insurance and health care more affordable for Americans through various strategies including: 1.) Increasing income limits for Medicaid eligibility, making the program accessible to many of the working poor. 2.) Providing the uninsured access to regional health insurance exchanges where they can shop for competitively priced plans; 3.) Elimination of higher premiums due to pre-existing conditions; 4.) Exclusion of lifetime limits on benefits; 5.) Mandates for basic, no-cost preventative care services to be included in all health plans; and, 6.) Allowing children up to the age of 26 to be covered by a parent's health insurance plan.

While the Centers for Medicare and Medicaid (CMS) are primarily responsible for implementing the ACA, most of the nation's 37 Blue Cross-Blue Shield (BCBS) affiliates—who write the largest share of individual

and group plans for small businesses—offer coverage via the exchanges. The BCBS affiliates are also implementing a number of strategies in their regions based on ACA provisions, such as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs). In Michigan for example, BCBS of Michigan has been helping transition primary care clinics to the PCMH model. They have also worked internally to retrain telephonic wellness, disease management and care management staff in evidence-based member engagement, self-care support and lifestyle management skills and interventions to better serve their employer and government purchasers. In 2011, BCBS of Michigan required Chronic Care Professional (CCP) Health Coach certification for over 250 of their population health improvement program nurses and continues to provide incentives for primary care practices in the State to complete training in patient self-management via CCP and approved national training programs in evidence-based health coaching such as HealthSciences Institute's Motivational Interviewing (MI) Intensive program. (The online CCP program has been selected for staff at nearly 30 of the 37 BCBS affiliates nationally). More health plans and purchasers are either requiring or recommending that primary care providers complete CCP or Registered Health Coach (RHC)® given these are the only two programs nationally recognized and linked with better patient-level outcomes.

While early enrollment numbers have been disappointing due to challenges with the Healthcare.gov website, it is anticipated that eventually anywhere from 15 to 30 million of the nearly 50 million Americans without health insurance will join the ranks of the insured through the ACA. However, better access will not solve many of the issues that the U.S. health care system faces. In addition to unsustainable and escalating health care costs,6 serious safety and quality gaps disproportionately affect certain segments of our population;7 lifestyle risks and lifestyle-related health conditions greatly increase the prevalence of often poorly managed chronic conditions in the U.S.;8 and an acute care-oriented health care delivery infrastructure and culture are poorly aligned with both the long-term needs of consumers and the objectives of health care purchasers.

Many consumers enter the insurance market under the ACA have likely delayed or avoided medical care in the past, having only sought it when absolutely necessary though an emergency department, urgent care or retail clinic. A large number have likely not had any preventative care screenings—or any continuous medical and self-care support for their chronic conditions. If the health delivery system is not reconfigured and the health care workforce retooled to provide more proactive, continuous and efficient chronic care, there is a risk of a triage effect whereby primary care will be overburdened by caring for patients with most severe, urgent and complex health care issues—limiting their capacity to offer the more proactive chronic disease care and self-care support services that reduce chronic disease-related complications and crises.

Individuals between 45 and 64 years of age who could not afford health insurance given prior limits on pre-existing conditions and were too young to qualify for Medicare, will also be entering the health care system through the new health care exchanges. Many of these individuals are affected by one or more chronic diseases (which are increasing in prevalence among individuals 45 years of age and older).[9] Recent studies find that up to one-in-five individuals 45 to 64, and nearly one-in-two 65 and older, are affected by two or more chronic conditions.[10] These data underscore the challenges that lie ahead for health care practitioners at a time that many care settings, like primary care, are already stressed from ever-increasing pressures for productivity. Many in primary care recognize that the time has come for changes that will make primary care and even better, more affordable health care center for people—and a job site that is preferred by nurses, advanced practice nurses, physician assistants and physicians, among other team members.

The Nurse Practitioner Will See You Now

As Medicaid expands, many more individuals from minority cultures or ethnic groups who have traditionally been at high risk for health care disparities will enter the health care system,[11] as well as individuals with more chronic, complex conditions. Primary care providers will be challenged to engage and support good chronic care and lifestyle management in these high-risk patients. At the same time the newly insured are entering the health care system, many physicians are leaving and fewer primary care physicians will be available to serve them. According to Deloitte12 there is approximately one PCP for every 1,500 people in the U.S. Come 2020, there will be about 70,000 fewer physicians available to consumers as a direct result of the law. The 2013 Deloitte primary care physician survey found 57% physicians view changes in the industry under health-care reform as a threat, and six in 10 physicians report it's likely that many will retire earlier than planned in the next two to three years, fueling the shortage.

Others do not consider the physician shortage issue problematic. They believe that we need to focus on building capac-

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ity from a primary care system that is poorly organized and misaligned with the needs of its most frequent consumers (patients with one or more chronic conditions). Chronic care authority and primary care physician Thomas Bodenheimer and President & CEO of the California Healthcare Foundation, Mark Smith, argue that the most pressing problem is the mismatch between primary care demand and capacity.[13] Primary care practices could greatly increase capacity by reallocating clinical roles and responsibilities to nonphysician members of the health care team and to patients to meet the demand—similar to how banking institutions have shifted simple banking transactions to self-service ATMs and online banking centers. We will continue to see a strong demand for advanced practice nurses and physician assistants with leadership and practice skills in chronic care improvement.

The CMS Innovation Center

Many innovations in future health care delivery will be guided by the experiences and outcomes of participants funded through the CMS Innovation Center. The ACA allotted $1 Billion in funding and testing new health care payment and service models through the center. Models that prove effective will be adopted by CMS (and will inevitably be adopted in some measure by other federal and state purchasers, employer purchasers and health plans). Hundreds of health care provider organizations around the U.S., large and small, are participating in these demonstration programs. While complete details are available at the innovation center web site at: http://innovation.cms.gov/, the innovation models are divided into seven categories:

1. **Accountable Care Organizations (ACOs)**
   ACOs provide incentives for health care providers to become accountable for a patient population and to invest in a variety of infrastructure improvements and redesigned care processes that support coordination, quality and efficiency. These include the Medicare Shared Savings program, Advanced Payment ACO model and the Pioneer ACO model. Learn more about ACOs at: http://innovation.cms.gov/initiatives/ACO/.

2. **Bundled Payments for Care Improvement**
   Rather than Medicare making separate payments to various providers for services delivered to the same beneficiary for a single illness or course of treatment (an episode of care), bundled payments offer providers a single payment for an episode of care. This encourages joint provider accountability and opportunities to share in cost savings.

3. **Primary Care Transformation**
   Advanced primary care practices (or medical homes) utilize a team-based approach, while emphasizing prevention, health information technology, care coordination, and shared decision making among patients and their providers. The Patient-Centered Medical Home (PCMH) incorporates a number of population health improvement (wellness, disease management and care management) components.

4. **Medicaid and CHIP Initiatives**
   There are a number of initiatives underway that aim to improve quality and achieve cost savings for the Medicaid and the Children's Health Insurance Program (CHIP). These are administered by participating states.

5. **Dual Eligible Enrollees Initiatives**
   CMS is funding a number of pilot initiatives to improve the quality and efficiency of care delivered to individuals who are enrolled in both Medicare and Medicaid. These individuals have traditionally accounted for a disproportionate share of the programs costs.

6. **Initiatives to Speed the Adoption of Best Practices**
   The CMS Innovation Center is partnering with a broad range of health care providers, federal agencies professional societies and other experts and stakeholders to test new models for disseminating evidence-based best practices and significantly increasing the speed of adoption.

7. **Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models**
   In addition, CMS is supporting a number of innovations being spearheaded by local communities and leaders to speed adoption of promising practices.

New Reimbursement Models: Bundled Payments

Most of us who have been in the health care field for a while, have seen a number of pilots and demonstration programs that have improve care quality or reduce costs. However, there are usually few incentives for putting these innovations into practice: When innovative practices do achieve cost savings, they only benefit payers. Bundled payments are one way that payers are incentivizing providers to save money. In this arrangement, a hospital and group of physicians assume the financial risk for delivering all care for one price for one patient episode over a 30, 60, 90 or 120 day period. Most bundled payment programs today are for acute care episodes, such as hip or knee replacement or spine or cardiac surgery.

We are seeing more health plans using bundled payments to providers for patients with asthma, diabetes, cancer and other chronic conditions. In these cases, the episode of care is usually for one year. A 2013 survey by KPMG LLP an audit, tax and advisory firm, found that more than 60% of health care providers believed that bundled payments could save money and improve health care quality.14 In the KPMG poll of 190 healthcare providers, largely represented by hospitals and health systems and large scale physician groups, 38 percent said they are "already working with bundled payments," while 24 percent responded "Not yet, but we plan to." Thirty-six percent remain undecided on developing and only two percent stated that they had no intention to offer bundled payment plans.

Adopting New Standards of Practice, Building New Competencies

We have shared the daunting challenges facing health care in the U.S. We have identified a number of resources to help practitioners redesign care to improve health care value—and maintain and build market position during this critical transition period. While the pace of change will vary according the practice location and local health care market dynamics, innovations being implemented nationally are filtering down to local providers in most all markets. In this section we will touch briefly on the most popular health care improvement models and steps that are creating new standards of practice—as well as critical new practitioner competencies and credentials—that support improved health care value, as well as new employment and leadership opportunities for clinicians.

Strategy, Process, Technology & People

To prepare for health care market changes, hospital and physician groups are planning and implementing new strategies, processes, information technologies, and workforce development steps—that are better aligned with the new health care environment. Overarching strategies include population health management (wellness, disease management, case management or care coordination), or advanced models for primary care or chronic care like the PCMH. Process changes may involve offering group visits to patients with diabetes or leaving 20% of appointments open for same-day scheduling. Information systems may include patient registries that identify, deliver and track care to patients with diabetes or electronic medical records that help bring health care into the twenty-first century. People or workforce factors may entail building new staff competencies in chronic care or health coaching, using primary care technicians who extend the reach of primary care physicians, or building real interdisciplinary teams. The Institute for Healthcare Improvement offers a number of case studies and tools for practice change. Learn more at: http://www.ihi.org or http://www.urac.org.

The Chronic Care & Patient-Centered Medical Home Models

The Chronic Care Model15and the Patient-Centered Medical Home (PCMH) model[16] are two primary care-based models that feature specific strategies, processes, information technologies, and people and workforce components to improve patient-level outcomes—particularly for patients at risk of, or affected by, chronic conditions. The CCM and PCMH models are guideposts for improvement that must be adapted and localized by individual practices. They also entail important changes to the "culture" of primary care—often the most difficult and crucial transformation. For these models, patient-centered care is much more than a motto, it is a way of providing care that relies on excellence in customer service and engagement by front office staff, as well as formal, evidence-based, patient-centered communication strategies and steps for practitioner-patient partnering, shared medical decision-making, and patient disease self-care and lifestyle management support. Many state medical and health care associations are providing support for practices making this transition.

Engaging the Health Care Team and Patients as Partners in Change

Like any team or organization change initiative, success is often more determined not by the strength of the model, but by the team leaders and members implementing the change. At the provider level, acceptance of the urgency for change and the development and demonstration of new skills are key to success. Many primary care and health care organizations make the mistake of trying to drive change with technology, or assume that telling staff what to do differently will work. However, organization change experts have long emphasized that building staff awareness, knowledge and critical new competencies to support success in the new environment best facilitates change. Staff need to understand why change is necessary, how it will be implemented and how it will impact day-to-day roles. Recognition and rewards provide critical incentives for change. International organization change authority and Harvard Business School Professor Dr. John Kotter, who has studied organization change process for decades, has determined that sense of urgency for change is the single most important determinant of change success.[17]

The patient also determines the success of change and he or she is at the center of the PCMH model. However, patient-

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centeredness must be more than a motto or a vision, but a standard of practice to be measured, benchmarked and improved like any other health care service. Patient satisfaction measurement is often considered a proxy for patient-centeredness. However, satisfaction surveys usually measure some mix of customer service, convenience and likeability domains. This is a necessary, but not sufficient, component of care quality. Likeability factors can be very subjective and may not predict better health care outcomes. For example, some patients who are not well engaged in their care may be very satisfied with a highly directive practitioner because this is what he or she is most comfortable or familiar with. However, a traditional interaction between an active practitioner and passive patient is not a patient-centered interaction. In patient-centered care, the patient's agenda is surfaced, the importance of change or confidence in making health-related changes explored, information or advice not offered unsolicited, and barriers to change addressed. Care is patient-centered when it is effective for fulfilling the patient's priorities and clinical outcomes. Patient-centered care is more than a consumer care initiative. As we will describe, it is a highly effective, formal approach for engaging patients and supporting change in the health-related behaviors that are responsible for most avoidable health care costs.

Health Care Workforce Development: Preparing Health Care Practitioners

A major reason why change has been so slow in coming to health care is that most practitioner training and continuing education programs—from the medical to the behavioral health fields—are cemented in the acute care-oriented, find it and fix-it model. This model values technical knowledge and invasive interventions over behavioral approaches that engage or activate the patient, improve the relationship between the practitioner and the patient, or, support lifestyle change, treatment adherence and self-care. While the acute care model permeates health care delivery and reimbursement in the U.S. (and most developed countries), nearly all of the current and pending changes to health care delivery and reimbursement in the U.S. reference care quality characteristics such as patient-centered, whole person, team-based care; new and enhanced roles for members of the health care team; and chronic care improvement—though little guidance is provided as to what exactly these terms mean, or, how these qualities or characteristics are achieved or measured.

The leading health care policy journal, *Health Affairs*, devoted their November 2013 issue to *Redesigning the Health Care* Workforce. In the lead article,[18] Ricketts and Fraher observe:

"There is growing consensus that the health care workforce in the United States needs to be reconfigured to meet the needs of a health care system that is being rapidly and permanently redesigned…The focus of health system innovation, however, has largely been on reorganizing care delivery processes, reengineering workflows, and adopting electronic technology to improve outcomes. Little attention has been paid to training workers to adapt to these systems and deliver patient care in ever more coordinated systems…training and education should be connected more closely to the actual delivery of care."

Preparing health care providers for the new health care environment translates to improved outcomes. Organizations like Kaiser Permanente have successfully prepared interdisciplinary teams of physicians, pharmacists, advanced practice nurses, case managers, nurses, rehabilitation therapists and behavioral health staff for medical home-oriented diabetes and coronary artery disease care programs through the new generation of interdisciplinary training and certification programs such as HealthSciences Institute's Chronic Care Professional (CCP) health coach program.[19] Clinical studies show that providing staff, including case managers, in evidence-based approaches such as motivational interviewing and patient activation is linked with improved clinical and utilization outcomes.[20] Using formal self-care support models and clinical education guidelines also support the successful implementation of the Chronic Care Model.[21] Among physician residents, even with the use of self-care support job tools often fail to demonstrate basic self-care support goals such as choosing a measurable goal for self-management, without formal training.[22]

Interdisciplinary Competency Models for Better Health Care

Whether it is in primary care, specialty care or inpatient care, in today's health care environment, the most frequent consumer in most health care settings is affected by one or more chronic conditions. Further, the health care services that are most costly and associated with the highest level of burden to patients and their families—particularly hospitalization and rehospitalization—are most frequently related to acute complications of a chronic disease that can usually be avoided by: 1.) Delivery or adherence to evidence-based medical care; 2.) Effective and routine self-care; 3.) Lifestyle management, e.g., healthy diet, regular physical activity. Yet few health care practitioners ever receive for-

mal training in brief, practical and effective strategies for addressing these factors. Most rely on intuition and experience—which introduces significant variance in skill and outcomes.

There have been several efforts to identify the new interdisciplinary team competencies that crosscut professional disciplines and care settings, and supplement discipline-specific skills. While each member of the health care team plays a different role—and brings his or her own specialized skills and expertise—unless the health care team shares a common vision and competency platform, it is very difficult to work in a coordinated, efficient manner to achieve better patient-level results. While this may be counterintuitive to health care practitioners who expect that their training and continuing education programs be tailored to their specialty (rather than the needs of the consumer) it is routine in most other fields outside of health care. Common training and common competencies support teamwork and a single focus on the patient—not the specialty or the professional. This is not unlike a customer service organization's workforce-wide focus on consumer satisfaction or a research organizations focus on innovation.

The Institute of Medicine's 2002 Health Professions Education Summit generated consensus recommendations for a shared competency model of this type for the 21st Century health care workforce. The summit was attended by over 50 leaders and experts from the various health professions, education, regulation policy, advocacy, quality and industry. The panel concluded that unless we reform health care professional training and continuing education to "retool" the health care workforce, it will not be possible to implement significant change to health care delivery. Summit participants identified five core competency areas:

- Delivering patient-centered care
- Working in an interdisciplinary team
- Practicing evidence-based medicine
- Focusing on quality improvement
- Leveraging information technology

Learn more about the IOM's recommendations for training and continuing education in health care at: http://www.iom.edu/Reports/2003/health-professions-education-a-bridge-to-quality.aspx. In 2005, the World Health Organization (WHO) called for a similar transformation of health care workforce training and continuing education to better meet the needs of patients with chronic conditions.

The Importance of Patient Engagement & Health Behavior Change Support

Among these new competencies, the ability to engage patients, deliver a patient-centered care experience, and support health behavior change are particularly crucial given that an estimated 85% of avoidable health care costs are due to behaviors, e.g., lifestyle, treatment adherence, disease self-care. As health care payers shift from paying for services and procedures to paying for better patient-level outcomes, the patient's health behaviors will be a key determinant of health care outcomes and reimbursement. Savvy primary care providers are making patient engagement and health coaching core competencies.

Like medical care, engaging patients and facilitating health behavior change requires evidence-based approaches. However, many practitioners are unfamiliar with the science and best practices of health behavior change support—instead relying on the legacy patient education-based approaches that they learned during their training which can not only be ineffective, but counterproductive when used as a health coaching approach. Alternatively, they may apply life coaching approaches from corporate or fitness coaching settings that blend positive psychology, self-actualization, or self-efficacy principles or techniques that in addition to not being evidence-based as described, may not be well suited for patients from more collectivist non-Western cultures that emphasize "us" over "me."

Investigators and clinicians in the fields of medicine and nursing, as well as specialists in behavioral medicine, medical psychology and health psychology have been evaluating the efficacy of interventions for improving patient engagement and activation, lifestyle management, treatment adherence and disease self-care for decades. First described 25 years ago, motivational interviewing (MI) remains the most effective, cohesive approach for engaging individuals and facilitating behavior change.[23] There have been over 300 rigorous clinical trials demonstrating its efficacy across settings, cultures and presenting medical, psychological and substance abuse concerns. It is an approach that works best for individuals who are described as "resistant." Today MI is taught in over 40 languages and being adapted by health care organizations and practitioners around the world.

MI is also ideal for training health care practitioners and health coaches as there are validated steps and tools for building and measuring proficiency in the approach. With MI we not only have outcomes demonstrating its efficacy, we have data from numerous studies showing the type and intensive of training required to build proficiency, and the proficiency level required to improve patient level outcomes. While MI

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requires a complex skill-set, through a combination of traditional knowledge-building methods, practice activities and feedback based on recorded samples of the practitioner's work with a patient, proficiency in MI can be developed. For more information comparing and contrasting various health coaching approaches, please see a special health coaching report: http://infocus.healthsciences.org/. For a review of MI outcome studies visit: http://motivationalinterviewing.org/.

A Credential for the Interdisciplinary Health Care Workforce: CCP Health Coach

In 2003, following a state pilot funded by the Minnesota Department of Human Services, the first national interdisciplinary certification program—the Chronic Care Professional or CCP Health Coaching program was first delivered across a large network of health plan, government and provider organizations in Minnesota. Based on the recommendations of the Institute of Medicine and the World Health Organization, CCP serves as the core curriculum in a career ladder model that has been linked with improved proficiency in evidence-based health coaching and better patient-level engagement in independent studies[24] and organization outcome studies by Kaiser Permanente, Capital Blue Cross and Nationwide Better Health, among others.

CCP includes four modules as described below:

Module 1: Population Health Improvement (PHI)
The New Health Care Environment
Assessing & Improving Health Care Quality
Chronic Care Improvement
Wellness, Disease Management & Care Management Practice

Module 2: Chronic Conditions
The Big Five Chronic Conditions
Key Chronic Conditions
Issues of Late-Life

Module 3: Lifestyle Management
Diet & Nutrition
Weight Management & Bariatric Surgery
Fitness, Physical Activity & Mind/Body Health
Stress Management
Tobacco Cessation

Module 4: Health Coaching
Behavior Change Theory, Science & Practice Applications
Miller & Rollnick MI Health Coaching Framework
MI Health Coaching Patient Challenges
MI Individual & Team Skill-Building Activities

CCP is completed through an online learning center. The 40-hour program includes a comprehensive learning and reference manual, skill-building activities and patient case studies, and expert presentations on key topics in population health, disease management, lifestyle management support, and MI health coaching, from HealthSciences Institute's faculty from organizations including the Mayo Clinic, Cleveland Clinic, Harvard, and Johns Hopkins. To date over 5,000 nurses, advanced practice nurses, pharmacists, physicians, and other health care team members have completed CCP. In many health care organizations, it is a job requirement. In some states CCP or RHC are required by state wellness, disease management or care management contractors.

CCP has been selected by over 25 Blue Cross Blue Shield affiliates for delivery to wellness, disease management or care management staff, leading health systems, the Veterans Administration, the U.S. Air Force, and top-ten Patient-Centered Home State Collaboratives. The CCP program materials are currently being translated by the Chinese Hospital Association for delivery to health care practitioners in China. Health coaching is also one of the fastest growing fields in health care for practitioners interested in growing job opportunities in community, hospital, health plan, corporate settings.

Achieving Proficiency in MI Health Coaching: Registered Health Coach (RHC)®

The more advanced Registered Health Coach (RHC) credential builds on CCP by adding advanced training in MI health coaching, practice and expert feedback. There are three levels of RHC certification. To achieve RHC-I, practitioners must complete CCP, the MI Intensive learning program and submit a recording of a health coaching encounter that is evaluated using a standardized, validated rating tool (the Health Coaching Performance Assessment). Practitioners must achieve RHC-I level of proficiency on the HCPA to be awarded RHC-I. RHC-II requires two additional HCPA evaluations and demonstration of specialist-level proficiency on the HCPA. RHC-III requires completion of a four-hour mentor training program and expert-level proficiency on the HCPA. After each HCPA evaluation, individuals receive a written report and feedback from a Motivational Interviewing Network of Trainers (MINT) member and RHC-III specializing in health care. RHC is the only nationally recognized certification and credential in MI health coaching.

CCP and/or RHC have been recognized by all key industry and professional associations in the field of population health management, chronic care and clinical health coaching including Care Continuum

Alliance, the National Association of Disease Management & Wellness Professionals, the Case Management Society of America and top-ten Patient Centered Medical Home Collaboratives including Medical Advantage Group. Further, CCP or RHC are required or recommended credentials for staff at many organizations. States including Montana require CCP for practitioners in their state Medicaid program and RHC has been required for Medicaid population health vendors by the State of Oklahoma. Individuals who have achieved either CCP or RHC are listed in a National Health Coach Registry that is accessible to payers, health employers and consumers. Learn more at: http://www.healthcoachregistry.org/. View the Health Coach Career Ladder at: http://healthsciences.org/registered-health-coach.

Conclusion

The U.S. spends nearly twice what other developed countries spend on health care; yet, the U.S. has poorer health and health care outcomes than most other developed countries, in addition to nearly 50 million citizens with no insurance or access to health care. To address these gaps, government and employer purchasers are pushing for sweeping changes to health care delivery and reimbursement that are focused on better patient value. The Affordable Care Act of 2010 aims to improve access to care and new programs are being tested and implemented widely across the U.S. Many major health systems and physician groups are already participating in bundled reimbursement programs or competing with other providers in local markers based on delivery of value. There are a number of new care models for improving health care. In primary care, the Chronic Care Model and the Patient-Centered Medical Home have proven popular alternatives to usual care. One of the most important steps for improving care quality is preparing the health care workforce in the new competencies required for success.

Guided by the recommendations of the Institute of Medicine, the World Health Organization and peer-reviewed studies, the Chronic Care Professional (CCP) Health Coach program is being used by leading health care organizations to build key competencies for success in the new health care environment where chronic, not acute, conditions are the main threats to public health and sustainable health care spending. A Registered Health Coach (RHC) follows CCP, offering a pathway to proficiency in motivational interviewing or MI—an approach to patient engagement and health behavior change that is being used around the world and is supported by over 300 rigorous clinical trials. The new health care environment presents a number of opportunities to not only create a sustainable health care system, but one that can improve outcomes to its most frequent customers: individuals who are at risk of, or affected by, chronic conditions.

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Health Coaching and Motivational Interviewing

HealthSciences Institute (HSI) is a strategic partner with The NPA and is offering a discount of 25% to all NPA members.

HealthSciences Institute prepares health care professionals in the use of brief, highly effective approaches for partnering with people for better health and independence. The Chronic Care Professional Training & Certification Program (CCP) from HealthSciences Institute is the only nationally accredited program for self-management support. The qualification criteria and vision for the Chronic Care Professional (CCP) certification is based on the World Health Organization, the Institute of Medicine, and leading Consumer Advocacy Groups, which emphasize that chronic care improvement and patient-centered care require a shared vision and active engagement of professionals from many disciplines.

Eligibility: Any person who works with patients is eligible to take the course, including nurses, physicians and non-clinical staff.

Course: This 40-hour online course may be completed at your own pace. You must pass a 100-item exam within one year of registration.

Certification: CCP certification is valid for 3 years.

Tuition: CCP Program tuition for NPA members is offered at a 25% discount, $1046.00.

HSI HEALTHSCIENCES INSTITUTE

CCP CERTIFIED HEALTH COACH

Tuition Includes:

- 40-hour core CCP online learning program
- CCP learning and reference text
- CCP national certification exam and CCP national certification
- CE certificate
- Unlimited access to online learning center with motivational interviewing videos
- Monthly skill-building webinars

Additional Information:

The program is self-paced and you have one year to complete the training and examination. Most professionals working full-time jobs finish within two to four months of registration. The national CCP certification and training program is pre-approved for 40 hours for nurse practitioners through ANCC. In addition, participants have access to all CCP Motivational Training (MI) videos, monthly CE events, and the online learning collaborative community. The program includes access to more than 90 hours of combined CE focused on chronic care management and behavior change skill-building materials.

Go to The NPA website www.TheNPA.org under the Education tab – Online Learning to learn more.

Why One New York Nurse Practitioner Joined the One & Only Campaign

Kim James, NP, of Brookdale University Hospital and Medical Center in Brooklyn, NY, was initially trying to raise awareness at her facility about needlestick injuries to professionals. As she did her research, checking information from the federal Centers for Disease Control and Prevention (CDC), she discovered the website of the *One & Only Campaign* and realized there was a related issue—even bigger than she imagined—regarding unsafe injections in healthcare.

After reading about incidents of *preventable* transmission of disease due to unsafe injection practices, James said to herself, "Oh my goodness, how can I not participate in this?"

The more James' eyes were opened by reports of lapses in infection control by healthcare providers, the more determined she became to spread the *Campaign's* message: *"One Needle, One Syringe, Only One Time." The One & Only Campaign* is a public health awareness campaign aimed at both healthcare providers and patients, with the intent of ensuring that all injections in healthcare are given safely. It is led by the Safe Injection Practices Coalition (SIPC), which counts the CDC among its members, including other professional healthcare organizations, patient safety groups and industry partners.

James was surprised to learn that after multiple CDC investigations, the SIPC determined that since 2001, over 150,000 patients have been potentially exposed to bloodborne pathogens, like hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV), due to lapses in basic infection control.

That number only represents the incidents CDC knows about. That could just be a fraction of actual cases, as exposure is often difficult to trace back to a healthcare setting. Patients have not only been exposed to viral infections due to unsafe injection practices, but also to serious bacterial infections, as outlined in this 2012 *Morbidity and Mortality Weekly Review (MMWR)* article. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6127a1.htm?s_cid=mm6127a1_w

"Somehow, this is personal for me," James says, when she thinks of patients who have either been potentially exposed or actually harmed.

National news headlines from 2013 underscore her concern. One physician is convicted of murder after the death of a former patient who contracted hepatitis C; prosecutors say unsafe injections were the cause. A hospital worker pleads guilty to infecting patients after authorities say he self-injected painkillers then left tainted syringes to be used on subsequent patients. Several hospitals notify thousands of patients that they might be at risk for exposure to disease because insulin pens may have been reused on patients at those facilities.

All of these incidents indicate that unsafe injections are an unfortunate reality in the nation's healthcare system. Here is how some providers may spread disease through unsafe injections:

- Direct transmission, where a provider reuses needles/syringes from patient to patient
- Indirect transmission (more common), where a healthcare provider inserts a used syringe (even if the needle has been changed) back into a multi-dose vial of medication, thus contaminating the entire vial of medicine if it is used for other patients. This practice is commonly referred to as "double-dipping"
- Using bags or bottles of intravenous solution as a common source of supply for more than one patient (unless individual doses are prepared in a pharmacy)
- Mistakenly believing it is safe to reuse syringes if the injection is administered through an intervening length of tubing
- Mishandling a single-dose vial, typically free of preservatives, in order to administer doses to multiple patients

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Correct procedures are outlined in CDC's "Standard Precautions" issued in 2007. http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Since her discovery, James has joined the national and New York Campaigns (New York's Campaign is funded by a CDC grant and directed by the New York State Department of Health-DOH), and has become a tireless advocate of both needle stick and injection safety in her hospital. She holds informational sessions with staff, asked administrators to put injection safety tips in electronic staff bulletins, displays educational materials and recently visited the United Kingdom, where she shared details about the One & Only Campaign with British and Caribbean healthcare professionals.

At one talk, James says, a provider admitted, "We still double dip," suggesting that there is still much work to do in convincing some providers to follow correct procedures at all times.

Please consider joining the Campaign either as an individual or a facility. You can find out more at http://www.oneandonlycampaign.org

Also, consider training your staff with the New York *One & Only Campaign*'s archived "train-the-trainer" webcast on injection safety, which offers **free** CME/CNE/CHES credit, through the University at Albany School of Public Health/Empire State Public Health Training Center.

http://www.albany.edu/sph/cphce/esphtc_injection_safety_webcast.shtml

State of New York

Executive Chamber

Proclamation

Whereas, the Empire State places the highest priority on quality health care for all of our residents and appreciates the many professionals who contribute to our state's excellent system of healthcare, including nurse practitioners, who work in a variety of settings, ranging from outpatient clinics, hospitals and nursing homes, to schools and private offices; and

Whereas, nurse practitioner programs serve as a bridge within the healthcare community, having first been developed in the 1960s by public health pioneers Dr. Henry K. Silver and Dr. Loretta Ford as a means of offering primary healthcare in under-populated and rural areas; and

Whereas, in response to the need for more physicians, Drs. Silver and Ford acted to make healthcare accessible to all people, establishing the first Nurse Practitioner Program, which gave registered nurses the capability to offer specified primary healthcare services; and

Whereas, the success of the Nurse Practitioner Program was immediate and the movement grew; today, advanced educational programs give many nurses the opportunity to increase their medical knowledge and fill crucial healthcare needs within our society; and

Whereas, this year marks the 25th anniversary of the enactment of Chapter 257 of the New York Laws of 1988 – the legislation that recognizes and licenses certified nurse practitioners and broadens the scope of services they perform, enabling them to act as healthcare providers in various capacities; and

Whereas, throughout this state, more than 15,000 nurse practitioners serve as an integral component of our healthcare system, focusing on prevention as well as treatment of health problems, and it is fitting that we recognize these professionals for their dedication, compassion and significant contributions to the health and well-being of New Yorkers;

Now, Therefore, I, Andrew M. Cuomo, Governor of the State of New York, do hereby proclaim November 10-16, 2013 as

NURSE PRACTITIONER WEEK

in the Empire State.

Given under my hand and the Privy Seal of the State at the Capitol in the City of Albany this fourth day of November in the year two thousand thirteen.

Governor

Secretary to the Governor

NPs Celebrate NP Week 2013 in NY & Beyond

Governor Andrew Cuomo along with governors from 27 other states issued proclamations to designate November 10th – 16th, 2013, "Nurse Practitioner Week." Many institutions held events to recognize the important contributions and impact that nurse practitioners have in the health care system. In addition, The NPAs Mohawk Valley Chapter Vice President Deanna Brady and NPA Executive Director Stephen Ferrara appeared on YNNs Capital Tonight with host Liz Benjamin to discuss NP Week and how NPs will play even greater roles in health care with the implementation of the Affordable Care Act – as long as unnecessary regulatory barriers are removed from current practice. Finally, our national organization, the American Association of Nurse Practitioners (AANP) launched a public awareness campaign during NP Week that included television, radio, and print media. To view these materials, go to: http://www.aanp.org/all-about-nps/awareness-campaign. We look forward to an even greater response for NP Week 2014 (November 9th – 15th) and encourage NPA members to begin the planning process now.

Helping Children, Protecting Childhood - We call it Love to the rescue

Susan Tapases, RN BSN
Professional Liaison
Shriners Hospitals for Children – Springfield, MA

In 1922, the Shriners fraternity opened the first of 22 Shriners Hospitals for Children in Shreveport, Louisiana to treat children afflicted with the orthopaedic manifestations of polio. In subsequent years, the Shriners organization opened additional hospitals throughout North America and expanded the service line to include burn care, spinal cord injury and cleft lip and palate.

Since that time, the organization has grown both in size and mission. Today, there are 22 Shriners Hospitals across North America which provide world-class care to children with a wide variety of special health care needs, regardless of the families' ability to pay. The vast majority of Shriners Hospitals care for children with congenital and acquired orthopaedic conditions, while others care for children with burns, spinal cord injuries and cleft lip/palate.

For almost 90 years, the Shriners Hospitals for Children located in Springfield, Massachusetts has proudly served families from throughout New England, upstate New York and abroad primarily with orthopaedic, rheumatologic, cleft lip/palate and chest wall deformities. All care is provided in a loving, supportive and family centered environment. Because children deserve the expertise of those specifically trained in pediatrics, our team of professionals conduct outreach clinics in Western Mass and Albany, New York.

Quality care often requires the close collaboration of specialists, integration of therapeutic modalities, and timely communication back to the primary care provider. At Shriners Hospitals for Children, it is commonplace to see more than one physician specialist and/or therapist in one day—convenient for our many families that travel from throughout New York for this expertise and care.

For example, there are many syndromes, which have functional manifestations and growth disorders with long term implications that are cared for by the Orthopaedics Department, in conjunction with the expertise of Endocrinology, Genetics, Urology, Neurosurgery and Physiatry. Likewise, our Cleft Lip and Palate team includes Plastic Surgery, Genetics, Otolaryngology, Dentistry, Orthodontics, Speech Pathology, Occupational Therapy, Nutrition Services, and Family Services.

Ancillary services include Physical Therapy, Occupational Therapy, Orthotics, Prosthetics and Motion Analysis, where state-of-the-art technology serves to objectively measure muscle activity with ambulation.

Combined expertise of a biomechanical engineer, physical therapist and orthopaedic surgeon interpret the 3-D computer analysis, which informs surgical decision-making and measures outcomes.

If interested in any further education around Shriners Hospital services, clinical information regarding conditions treated, or to initiate a referral, please contact Susan Tapases, RN at 413.787.2047 or stapases@shrinenet.org.

For information regarding our Boston facility, which specializes in acute burn care and reconstructive services, please contact Susan McQuaid at 617.371.4889.

Amy Atwell

Chapter: Chautauqua-Cattaraugus

Amy Atwell, FNP, is a member of The NPA Chautauqua-Cattaraugus Chapter. She has been a nurse practitioner for the past eight years, and is currently employed by Optum, a division of United Healthcare in Chautauqua County. She resides in Gerry, NY with her husband Paul of 24 years, and her two sons, Jacob (19) and Joshua (17). Amy enjoys reading, movies, shooting, hunting and playing Euchre. She is a member of the Gerry Free Methodist Church, the Missions Committee, and the Gerry Volunteer Fire Department's Auxiliary.

MEMBER SPOTLIGHT

Why did you join The NPA? I joined The NPA to keep informed of legal issues affecting the nurse practitioner profession. I have been a member of the state and local association for many years.

What are some of your interests/hobbies? I participated in the American Cancer Society's Relay for Life over the past three years, and became involved after my mother-in-law was affected with breast cancer. I turned the loss of my mother-in-law from grief into hope by raising funds for research while helping prevent others from losing a loved one to cancer. Earlier this year, I organized a local team for the Relay for Life in Chautauqua County, and also organized numerous related activities that raised money on behalf of my team. My team and I raised over $8,000!

Tina Traber, president of the Chautauqua-Cattaraugus chapter recently stated, "the spirit that was required to propel Amy through these community-wide activities is immense, and a reflection of the care for others that is inherent within nurses."

Novlet Davis

Chapter: Long Island

Novlet Davis, MSN, RN, ANP-C, was born in Jamaica, one of twelve children. She came to the US in 1987, seeking a better life for herself which would enable her to help her family. Novlet earned her BSN from Molloy College in 1996. As a registered nurse, Novlet worked on telemetry and the CTICU at St. Francis Hospital in Roslyn, N.Y. Novlet was a preceptor for nursing students and new hires.

Wanting to contribute more to the nursing profession, Novlet returned to school to become an Adult Nurse Practitioner. In 2008, Novlet earned her NP degree and received certification through the American Academy of Nurse Practitioners. Her love for mentoring new nurses led to her position as an adjunct professor at Molloy College. Two years later, Novlet became the first NP to be hired in the cardiothoracic department at St. Francis Hospital. This year, Novlet received the MLP Humanitarian Award at St. Francis. Novlet is married and has 3 daughters, one a RN going to school to become a NP.

MEMBER SPOTLIGHT

Why did you join The NPA? I joined the NPA because I want to keep abreast of all the changes occurring in the healthcare arena. The meetings are a great way to network with people who share similar values.

What are some of your hobbies/interests? In 2012, I founded the LJDR Davis Foundation in memory of four siblings; Loretta, Jacqueline, Donald and Rohan Davis. The Foundation's first medical mission took place this past July. We recruited 39 people who traveled to Jamaica where over 600 patients were treated (go to www.ljdrdavisfoundation.org for more information). Some of my hobbies include dancing, traveling and spending time with my grandson.

Linda Aumock, president of the Long Island chapter recently stated, "Novlet is an inspiration to us all for her industrious undertaking! The Long Island Chapter of The NPA is proud to have such an outstanding Nurse Practitioner in our organization!"

As of the publication of this issue of the JNPA we received and answered in excess of 220 practice issues year to date.

PRACTICE

ISSUES

Question presented: Has the Medicare law changed regarding NP's and first visits at a patients home? Does it have to be a physician for the first visit for reimbursement?"?

Response: The physician is not required to make that first visit and may sign based upon the face to face encounter of an allowed non-physician provider. A review of the most current Medicare Benefits Policy Manual Chapter 7 (which appears to have been last modified in 2011) referring to Home Health Services available from CMS indicates that the face to face encounter may be done by an allowed Non Physician Provider however the physician must sign the documentation that the event occurred and the clinical findings and sign the certification. We have included this link to the Policy Manual here so you have all the relevant sections available to review: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

Question presented: A NP has been told that she will now need to be a Certified Medical Examiner in order to continue to perform DOT physicals. Is this correct?

Response: YES. So long as you are registered at the Federal Motor Carrier Safety Administration (FMCSA) website as a Medical Examiner you may continue to perform DOT physicals until the new standard becomes effective. The new Certified Medical Examiner # requirement becomes effective 5/21/2014 to provide time for you to take the training and become certified under this new requirement. You must register at the FMCSA website, www.fmcsa.dot.gov in the FMCSA Medical Programs section and you then must take the training and pass the testing requirement to receive your Certified Medical Examiner number. A link to the new National Registry of Certified Medical Examiners is located here: https://nationalregistry.fmcsa.dot.gov/NRPublicUI/home.seam

Question presented: Are NPs required to participate in the I-STOP Prescription Monitoring Program (PMP)? What can happen if a NP does not comply with the requirements and participate in the PMP?

Response: YES. As prescribers in New York NPs are required to participate in the PMP and must check the registry no more than 24 hours prior to writing a prescription for a schedule II – IV drug. There are serious penalties for non-compliance with the I-STOP PMP program. These can include fines and criminal charges as well as professional misconduct charges against a practitioner who fails to comply.

Question presented: Can a NP write a Non Patient Specific order for flu vaccines?

Response: YES. Non patient specific orders for flu vaccine administration are within the scope of a NP and authorized by NYS. The only prohibition is that the order is only valid for a pharmacy within the same county as the NP or MD, or an adjacent county if the population of that county is less than 75,000.

Question presented: Can a NP prescribe medications without having a written collaborative practice agreement with a physician?

Response: No. A NP may not treat any patient in any manner as a NP without a written collaborative practice agreement with a physician. This includes writing prescriptions, ordering tests, signing death certificates or any other function of a NP.

Question presented: May a FNP provide low risk patients who are pregnant with prenatal care such as assessing if the patients pregnancy appears to be progressing normally?

Response: YES, with education and competence provided that this is contemplated by the written collaborative practice agreement.

Question presented: What happens if a NP lets National Certification lapse beyond any allowed reinstatement period?

Response: If a NP allows her national certification to lapse she will need to take the examination for that national certification. To be able to do so the NP will be required to meet the current requirements of eligibility to be permitted take that certification exam and become certified again. This can require an already licensed NP to have to return to school to acquire the requisite number of classroom and clinical hours and course material to meet those current national certification requirements. So long as a NP maintains their existing national certification by recertifying as required by the certifying body they do not need to meet the then current requirements to become nationally certified.

Question presented: May a NP write a prescription for herself?

Response: It is not recommended that a NP prescribe for herself. It is required that a patient chart exist for anyone the NP writes a prescription for. It is difficult for the NP to maintain an appropriate patient chart on herself. Therefore the best practice is to not self-prescribe.

The NPA is 700+ Student Members Strong…

The NPA has a long history of supporting NP Students, NPs, and the NP profession.

We Keep You Informed!

When there is news or change that affects you, we will provide you with the information, forms, links and other specifics to keep you up to date. These include: regulatory, scope of practice, educational and career opportunities and more!

You will receive this journal, the JNPA, four times a year; Insights, our monthly e-news and immediate notification of crucial or time sensitive information.

The Student Transition Guide

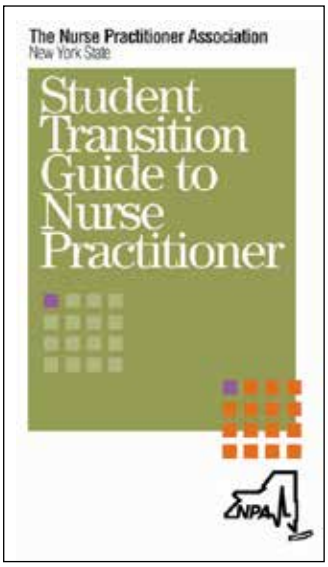
You may not need this yet, but you will!

This valuable resource will assist you as you transition from a student to a practicing Nurse Practitioner. Here is some of the information included:

- NP Licensure
- DEA Number
- National Certification
- Practice Protocols
- Collaborative Agreement
- Applications
- Prescribing Forms
- And much more!

Includes: NYS forms, applications, web links, phone numbers, references, quick tips and explanations.

Members can download this publication from our website.



Sprint Wireless Discount New Member Benefit!

Whether you are a new or existing customer with Sprint, NPA members can receive a 19% discount on Sprint services. See the homepage of our website for information and for the discount eligibility form.

NPA Continues Visits to NP Schools

In a continuation of our robust schedule for visiting NP schools (16 to date) across New York, The NPA was warmly received at a recent visit to the College of Staten Island NP program. We met with NP students as well as some CNS students to discuss The NPA, the professional climate for NPs in New York State and the work being done by The NPA every day to bring about change. A lively discussion occurred about many aspects of The NPA legislative agenda and what individual NP students (and NPs) can do to help! The attendees were very interested to gain timely information about different practice issues such as the I-STOP prescription monitoring program as well as the changing environment for NPs and future considerations. Six (6) NP students joined that day! Thank you to Dr. Patricia Given and the college for such an excellent meeting.

15% Discount for NPA Members

Fitzgerald Health Education Associates

FHEA offers a 15% discount to NPA members. To take advantage of this discount you must enter FHEA website via the link on The NPA website.

FHEA offers a highly regarded national certification review course as well as many other educational opportunities.

NPA Accomplishments and Milestones

- 1988 - Landmark legislation authorizing title and scope of practice for NPs
- 1992 - NPs acquired full DEA prescriptive authority
- 1992 - Emergency room practice and hospital coverage rights enacted
- 1993 - NP have ability to make referrals for physical and occupational therapy
- 1997 - Medicare reimbursement at 85% of the physician's rate enacted
- 1998 - Association forms a Political Action Committee (PAC)
- 2002 - The Practice Area Bill is passed, becoming Chapter 600 of the Laws of 2002
- 2003 - Respiratory Therapists can now accept orders from NPs
- 2004 - Clinical Lab Bill is passed
- 2006 - Medical Emergency Utility Svc. Bill and Handicap License Plates Bill signed into law
- 2008 - NPA Introduces legislation to remove Statutory Collaboration (Nurse Practitioners Modernization Act)

We Value and Support Our Student Members!

NPA Preceptor Finder Program

We can help you find a Preceptor using our online Program! It's available on our website in the Student section.

Tips for Using the Preceptor Finder

We recommend you use the broadest search possible, such as by specialty only, search through the list and then telephone those listed that you deem appropriate. In addition you may wish to contact members of your Chapter who are in your specialty to inquire if they would be able and willing to precept.

Preceptors Needed!

Some of our student members are in need of a preceptor to complete their educational requirements. Please go to our website for more information or to sign up to become a preceptor. A preceptor can receive credit towards their national recertification. Check with your certifying body for details.

Your Local NPA Chapter

When you join The NPA you also become a member of a local NPA Chapter of your choice. There are twenty-one chapters throughout New York State to serve our members on a local level. The chapters are staffed by nurse practitioners whom are NPA members that volunteer their time to provide leadership, education, meetings, teaching events and more.

Networking brings about many possibilities!

- Meetings
- Teaching Days
- Conferences
- Network to find a preceptor
- Learn about a job opportunities
- and much more…….

Student Transition Membership

Getting Ready to Graduate?

To assist you in your progression from Student to NP graduate we offer a special Student Transition membership rate to newly graduated NP's who are NPA student members.

One Year for $90……...or Two Years for $160

To qualify for the transition rate you must be a current student member in good standing.

NPA Career Center

Searching for a job or posting your resume is free on The NPA Career Center. It's a Member Benefit! www.The NPA.org

We are proud of our work for the advancement of nurse practitioners!

- 2010 - NPs authorized to conduct eye examinations and complete loss of consciousness with NYS DMV
- 2011 - NPA Death Certificate bill signed into law
- 2011 - NPs included in NYSHIP Empire Plan providing 121,000 state employees and families with access to NPs
- 2011 - NPs to participate in Medical Home demonstration programs
- 2011 - Governor's Medicaid Redesign Team (MRT) begins work plan, NPA was asked to assist
- 2011 - NPA proposal to remove statutory collaboration recognized by the MRT
- 2012 - NPA introduces Mental Health legislation
- 2012 - Nurse Practitioners Modernization Act passed by Assembly
- 2012 - NPA asked to participate on one of Health Benefit Exchange Regional Advisory Committees
- 2013 - Governor Cuomo introduced budgetary language that would eliminate the written practice agreement for NPs practicing in "...only primary care."

Chautauqua-Cattaraugus Chapter
Tina Traber, ANP, AOCNP, Chapter President

CHAPTER NOTES

The Chautauqua-Cattaraugus Chapter has had successful chapter meetings as we have incorporated a collegial format where members are presenting rather than pharmaceutical endorsed speakers. These meetings have been very popular, and resulted in higher attendance than past pharmaceutical-sponsored programs. The higher attendance is also likely related to a decreased number of chapter meetings. This is a reflection of today's busy lifestyle and limited extra time for activities such as professional organization participation. I am glad that the efforts of the chapter to improve attendance appear to be well received.

Our chapter has established a collaborative relationship with Hospice Chautauqua County. The 10th Annual NPA Region One conference is scheduled for Saturday, April 5, 2014 at Holiday Valley Mountain Resort and Conference Center in Ellicottville NY. Stephen Ferrara, Executive Director of The NPA, will be the keynote speaker. We are excited to have Stephen visit our region, and look forward to his keynote address. Chapter member Jennifer Hewson, ANP will also be speaking on cardiology related topics. Other topics include chronic care planning, women's health issues, and complimentary therapies all designed to improve the day to day care of our patients.

The current term of office for board members ends December 31st, and we are currently in the midst of board elections as of the writing of this article. The new officers will be announced in January.

Our chapter has joined the enpnetwork this year, and our website is https://npaccc.enpnetwork.com/. Chapter members are encouraged to join as "followers" to assure that they receive notice of updates, chapter meetings, job postings, etc.

As the holidays are quickly approaching, I hope that we all recognize the gifts in our lives, and that we take the time to spend time with family and friends amidst all of the holiday chaos.

Happy Holidays to all!

Greater Newburg Chapter
Michelle Appelbaum, PhD, FNP, PNP, Chapter President

Happy Holidays to all!

Congratulations to chapter members Dr. Alisha Fuller and Alice Looney for working to make the 2013 NPA Conference such a success. Twenty members of our Chapter attended the conference and enjoyed learning in the lovely surroundings. Our Chapter sponsored both a member and a student member to attend the conference.

Charlene Riach put together a clever and unique money tree for our chapter's contribution to the Silent Auction at the Conference.

Uloma Ijomah and Edith Onua joined me and attended the Hispanic Latina Day at the Middletown, NY YMCA on September 21. We measured blood pressures, talked about diet and exercise, and promoted the NP role.

Karen Doll and Alice Looney have been spearheading our food drive. Members bring in canned foods to each meeting.

Karen Doll has set up excellent programs for our meetings. In September the program was Juxtapid and MTP Inhibition --Clinical trials to clinical practice. The October meeting program was Xarel for Atrial fibrillation, PE and DVT. During November we heard about Invonka--a new type of diabetes type 2 treatment. The December meeting was about what's different in the treatment for acute coronary syndrome.

We look forward to the New Year as many interesting meetings are planned. We continue to welcome new members and new student members to the chapter. Best wishes for a happy new year to all!

Susquehanna Chapter
Scott Rosman, NP, Chapter President-Elect

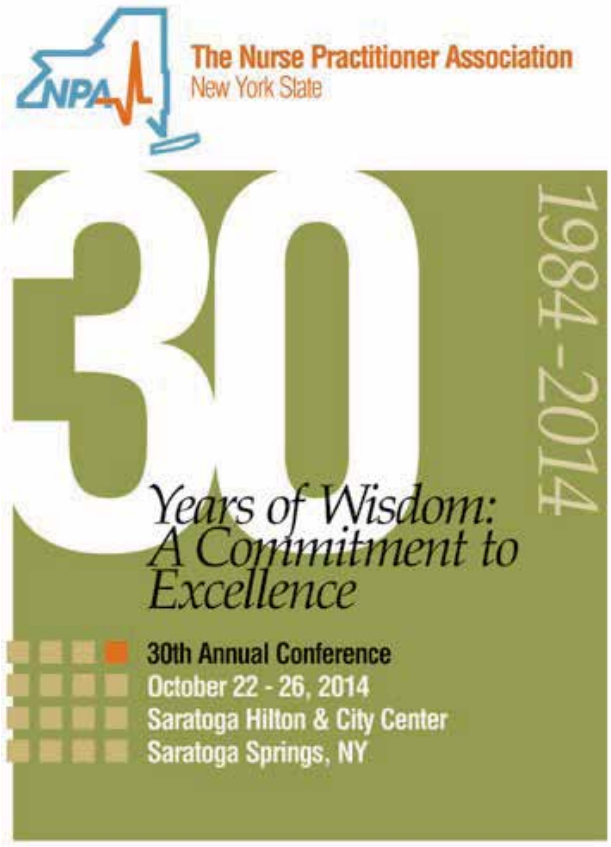
The Susquehanna Chapter held its quarterly meeting on November 13 and every member brought a non-perishable food item to be donated to a local food pantry, Community Hunger Outreach Warehouse – CHOW, in Broome County. Members felt that as nurse practitioners they should do everything they can to help those who are facing difficult times especially as the holiday season approaches.

First row left to right: Jennifer LaVare, Scott Rosman, Chris Honnick, Maureen McPhee

Second row: Trichelle Kirchner, Shannan Leonard, Courtney Ellis, Kelly Miller, Nancy Wolf, Laurie Van Ingen, Pat Curry-Wilson, Meghan Laing

Third row: Becky Christophersen, Jeffrey Hum, Kim McHenry, Cariann Brady, Brenda Carr, Melissa Skiadas, Ben Landry, Kelly Storrs, Kathy Olbrys, Marie Williams, Jennifer Shattuck, Kathy Verdin, Laure Weaver, Jean Howard

SAVE THE DATE



Western New York Chapter
Chris Rizzone, ANP, APRN-C, Chapter President

The Board of the Western New York met on November 12, 2013. Several members had participated in The NPA 29th Annual Conference. Our newest member, introduced at our October dinner meeting, Patricia Wagner, was an attendee.

One of our Board members, Lana M Pasek, ANP-BC , presented a Poster Presentation entitled "Patient Care Outcomes of In-Patients with Strokes/Transient Ischemic Attacks (TIA) at a New York State Designated Stroke Center Utilizing NP-Led Multidisciplinary Stroke Rounds". This study was supported by a 2012 community research grant from Gamma Kappa Chapter at the University of Buffalo of Sigma Theta Tau International.

This was a retrospective descriptive study of quality stroke indicator data, length of stay, mortality, stroke round procedures, and nursing length of service among three NYS designated stroke centers with center 'B' having an Adult NP leading multidisciplinary stroke rounds with the unit nursing staff. There were 5 improved Patient outcomes at center 'B' for the years 2007, 2008, 2009 and 2010 with improved scores in:

1. National Institute of Health Stroke Score (NIHSS) done on admission

2. Dysphagia screening done prior to any oral intake

3. Stroke education completion

4. More patients being discharged on cholesterol-reducing medication

5. Lowest average mortality among the 3 centers

Center 'B' also had the highest number of RN's with over 20 years of length of service.

Her study showed that NPs can expertly lead a multidisciplinary group and positively influence the care of patients. Her poster was concise and displayed the information in an attractive display that captured the main points.

Our chapter congratulates Ms. Pasek on a job well done!

Future activities of the Western New York Chapter are to encourage membership and attendance at the monthly dinner meetings, to seek out new members by presenting the benefits of membership at Schools of Nurse Practitioners and facilities in the area who employ Nurse Practitioners.

Future plans for 2014 are to develop chapter –sponsored dinners with continuing education credits, especially in Pharmacology credits.

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The Benefits of Membership in the NPA

Political Representation - We are the only state-wide association working to advance and protect your practice in New York. Through our National affiliations we help resolve Federal barriers to practice.

We Keep You Informed - When there are changes or news that affects you, if applicable we provide you with forms, links and other specific information. News and updates include political and regulatory, scope of practice, educational events, career opportunities and more! Receive the JNPA, our journal, four times a year.

Education - The NPA offers conferences, events and meetings at state, local and regional levels. You can learn, network and earn CEUs. Our annual educational conference is attended by hundreds of NPs! Discounts are also available to our members through our strategic partners on educational products and services.

Practice Issue Assistance - Available to our members with questions or issues including scope of practice, management advice, risk management, collaborative agreements and more.

Networking Opportunities - Connect with NPs and others at our state conference, regional conferences, chapter meetings, Facebook and Twitter.

Local Chapter Membership - Membership includes a local chapter of your choice. The NPA has 21 chapters throughout the state to provide you with local events, education, and networking.

Preceptor and Mentor Programs - Whether you're looking to become a preceptor or mentor or are looking to find one, we have a program for that!

Student Transition Guide - This is an extensive guide for students who are preparing for NP licensing. Topics include: national certification, licensure, collaborative agreement, DEA numbers, professional conduct and more. It's a good reference guide for practicing NPs as well.

NP Resource Guide - Information includes scope of practice, reimbursement guidelines, collaboration, certification, and more.

NPA Career Center - Search for a job, post your resume or post a job opening on our online Career Center! Members receive a discounted rate from our Human Resource Consultant when specific advice and expertise is needed.

24 Hour Access to Information, Resources, News and Updates - When you have a question or need information after business hours, our website is still working for you with 24 hour access.

NSO Professional Liability Insurance - In our effort to provide our members with valuable products and service, The NPA endorses NSO for professional liability insurance.

Join National Professional Organizations - Mention your NPA membership and you will receive $10 off your annual dues in the American Association of Nurse Practitioners (AANP).