These were the issues identified and discussed during the Georgia Nurse's Leadership Coalition meeting, which I attended on 9/21/2015. Keynote Speakers were Mary Chesney, PhD, CPNP, who helped her home State of Minnesota gain full practice authority in 2014, and Barbara Safriet, JD, a legal expert and advocate for APRN practice. I have included some of my own research on these topics, with references listed at the end.

Julie Hannah, FNP-C, President-elect Gwinnett/Forsyth Chapter of UAPRN.

SHORTAGE OF PRIMARY CARE PROVIDERS –

Over a million Georgia residents are living in Health Professional Shortage Areas (HPSAs), where they face a lack of primary care providers. Even more PCPs will be required as a third of aging family physicians retire in the next decade, and fewer medical students (about 25%) choose primary care, which offers the lowest compensation and highest patient loads of all the medical specialties. APRNs could be incentivized to serve these areas through offers of student loan repayment and removal of State practice restrictions.

LIMITATIONS OF APRN EDUCATION –

Thousands of qualified applicants are turned away from masters and doctoral programs in nursing every year due to shortages of 1) faculty and 2) appropriate clinical sites and preceptors. The faculty shortage is attributed to the opening of many new (mostly online) graduate nursing programs, along with the retirement of aging faculty members. In addition, most nursing schools require a doctorate for faculty positions. The few APRNs who obtain a DNP or PhD choose jobs in the private sector, where the compensation is up to $20,000 more annually. Graduate nursing programs rarely financially compensate clinical sites and/or preceptors, despite steadily increasing their tuition costs. According to the 2013 *Multi-Discipline Clerkship/Clinical Training Site Survey*, only 4% of nursing schools with an NP program reported paying a fee per student for clinical sites. Other health professional schools in the same geographical location make the competition for clinical sites more difficult, especially since their programs often do compensate for this service (MDs 16%, DOs 71%, PAs 20%). This has delayed the graduation of many APRN students, who complain of "substandard" preceptorships that don't prepare them adequately for practice.

LIMITATIONS OF APRN FINANCIAL AID –

For five decades, the Title VIII Nursing Workforce Development program has been the largest source of funding to Georgia Colleges of Nursing. Since these

programs help finance nurse education from entry-level through graduate study, only a small portion goes towards APRN education. In fiscal year 2014, total Title VIII funding to Georgia was $4,702,573. The National Institute of Nursing Research (NINR) offers funding, but it is geared more towards doctoral students and faculty engaged in research projects. In fiscal year 2014, NINR funding to Georgia was $4,367,398. There is a huge disparity in Federal and State taxpayer funds subsidizing the education for APRNs vs. medical residents that needs to be addressed by our legislators.

A PRIMARILY RN GROUP WANTING TO SPEAK FOR APRNs –

The Georgia Nurses Association (GNA) has recently created an APRN Council. GNA has indicated that they want to displace CAPRN as the sole voice of APRNs in the Georgia legislature, in the name of "nursing unity." As Mary Chesney pointed out during this meeting, the States in which APRNs gained full practice authority had a politically-active, APRN-only group that was **separate from** the State's Nursing Association. Currently, there are 157,740 RNs and LPNs licensed in Georgia, and 10,401 APRNs. How much can we expect the GNA to invest in only 6% of their membership? The GNA's two lobbyists answer only to the CEO (who is not an APRN) – the APRN council will not be allowed to direct those lobbyists. GNA might get some token bill passed, such as removing the restriction on ordering CTs and MRIs in non-emergent situations, so they can say "See, we represented you! Keep sending us your annual dues!" But considering how cozy they are with some physician groups, don't count on substantial legislation after that. Georgia already has an organization that includes all the various NP, CNS, CRNA, and CNM professional organizations in the State – that is CAPRN, which successfully lobbied for us since 2010. Although GNA is one of the founding members, they have not participated in CAPRN's meetings for some time. We should still collaborate with GNA whenever possible, but depending on them to be our sole representative in the legislature would be unwise.

A LACK OF WILL AND PARTICIPATION BY GEORGIA APRNs –

What we truly need is not another council, but more participation in the groups that already represent APRNs, and coordination between those groups. If there was less apathy and more involvement, we could change the fact that Georgia is one of the worst states for health outcomes and provider access. We could join the momentum of progress that has led to 21 States and the District of Columbia passing laws granting independent practice authority, with a resultant increase in access to low-cost, quality primary care to those who need it most.

To accomplish this, we need: 1) coordination of communications so that all APRN groups get a consistent message in a timely manner, 2) a full-time lobbyist, paid for by (and representing) all the APRN groups in Georgia, and 3) a commitment by all APRN group members to participate fully in CAPRN, empowering that body to speak on their behalf. As Mary Chesney told us, it was the petty differences, ego battles, and fragmentation of communication among the APRN groups in her State that enabled their opponents and delayed their progress for 15 years. Let's not let that happen in Georgia!

References

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