



THE JOURNAL

of the New York State Nurses Association

VOLUME 42, NUMBERS 1 & 2

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- Barriers to Practice and Impact on Care: An Analysis of the Psychiatric Mental Health Nurse Practitioner Role
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of the New York State Nurses Association

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EDITORIAL

Join in to make change

This issue of the *Journal of the New York State Nurses Association* contains two articles that address the role of the nurse practitioner (NP) and pose solutions to the growing shortage, which is a particular issue in underserved areas of New York State. A third article highlights a current health concern, obesity in adolescent girls, which is also identified specifically in these areas.

Pericak outlines the need for removal of the requirement that NPs practice in collaboration with a licensed physician. NP shortages exist in New York and throughout the United States, and statutory collaboration restricts the areas in which they can practice. In 2010, the President signed into law comprehensive healthcare legislation called the Affordable Care Act, which represents the broadest changes to the American healthcare system since the 1965 development of the Medicare and Medicaid programs. With the enactment of these laws, the United States has the opportunity to transform its healthcare system and provide higher quality, safer, more affordable, and more accessible care than ever before. Realizing the vision of the Affordable Healthcare Act, however, will require a transformation of many aspects of our healthcare system, most notably pertaining to advanced practice registered nurses (APRNs).

There are far more people in need of primary care than there are primary care providers. Limited research suggests that NPs, as well as physician assistants and family physicians, are more likely to care for low-income patients or the underserved. Pericak maintains that NPs need to advocate for their autonomy by educating and convincing legislators to remove this barrier to practice. Unfortunately, fewer than 20% of NPs in New York State are members of their professional organizations, which focus on legislative action and education. In addition, each state independently determines the APRN legal scope of practice and the criteria for entry into advanced practice. This inconsistency has created a significant barrier preventing APRNs from easily moving from state to state and has had the overall effect of decreased access to care for patients.

Muxworthy and Bowllan reviewed the literature on barriers to practice for the psychiatric mental health NP role and found that this specialty faces similar barriers related to statutory collaboration. A rising need for mental health care reveals the impact of demands that exceed available providers, especially for the indigent and uninsured. Not only does statutory collaboration diminish the NP role, it is complicated by the rules of managed care and insurance companies that impose additional practice restrictions that support the collaboration agreement. There is hope, however, since New York State legislators Gottfried and Young have co-sponsored the NP Modernization Act (2011), which, in essence, amends the education law to allow NPs the right to practice without statutory collaboration.

In another article, Groth and Morrison-Beedy explore the obesity epidemic in minority adolescent girls. The negative impact of unhealthy dietary patterns over time has a significant effect in this population. More than 70% of these young women are considered impoverished, leading this group to fall into the underserved category referenced in the two other articles featured here.

The takeaway message of this issue is that NPs are appropriate providers to attend to and educate about multiple healthy behaviors that are indicated for underserved populations. It is important and necessary to know that, in order to make changes in how and where care is provided, nurses need to be involved. This action begins with belonging to our professional organizations. If you have been putting it off, please take the plunge and join your state nursing organization *today*.

We hope that the research presented here is interesting and inspiring. Perhaps you are considering submitting a manuscript for publication in *Journal*. The editorial board would be happy to support your effort through constructive feedback and guidance. For information and author guidelines, go to the publications area of www.nysna.org.

Ann Cella, MA, MEd, RN

Meredith King-Jensen, MSN, MA, RN

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Increased Autonomy for Nurse Practitioners as a Solution to the Physician Shortage

Arlene Pericak, FNP-BC, DA

Abstract

In this paper, the author addresses decreased access to health care in underserved areas and the shortage of primary care physicians and how nurse practitioners (NPs) can fill this void. In order to make up for the lack of primary care doctors, NPs need to be politically involved in fighting for their autonomy; specifically, they must work toward removal of the statutory requirement that NPs practice in collaboration with a physician. NP associations need to increase membership, encourage members' political involvement, and move legislative agendas to bring about change. Although this paper focuses mainly on New York, it does highlight NP legislative agendas and how they were used to fight for autonomy in other states.

Throughout the United States, the shortage of primary care physicians, particularly in rural and low income areas, stands as a barrier to the goal of delivering adequate health care to all Americans. According to the physician workforce study survey conducted by the Healthcare Association of New York State (HANYS) in 2008, New York State has a severe and worsening shortage of physicians, which is affecting access to care.

Thomas Nicotera, MHHA, JD, director of membership and public affairs at the Nurse Practitioner Association New York State (NPANYS), reports that almost every county

in New York is listed as being underserved (T. Nicotera, personal communication, July 6, 2009). This shortage of physicians is secondary to changing societal and healthcare needs. Primary care in our healthcare system is in crisis because there are far more people in need of primary care than there are primary care providers. The initiation of the Affordable Care Act, signed into law in March 2010, has compounded this issue. This act promises to provide insurance to 32 million Americans (Fairman, Rowe, Hassmiller, & Shalala, 2011).

Cooper (2004) notes that "physician shortages are emerging" and posits that, "by

2020 or 2025, the deficit could be as great as 200,000 physicians or 20% of the workforce needed" (p. 705). This undersupply of providers is due largely to the static growth of physicians every year, along with low numbers of physicians selecting primary care as a specialty (Hooker, 2006; Sheldon et al., 2008, Lakhan & Laird, 2009).

While it is certainly possible to devote greater resources to recruiting applicants for medical school who would commit to primary care, as Weiner (2002) argues, educating more physicians might not be a cost-effective use of our tax dollars. The cost and time to educate a

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NP and nursing associations need to increase membership, encourage members' political involvement, and move legislative agendas to bring about this and other needed change.

nurse practitioner (NP) is significantly less than that required to educate a physician. One goal advocated by the HANYS survey is to increase usage of mid-level providers, which includes NPs (2008).

Healthy People 2020

Healthy People 2020 is a multiyear public agenda that has established a roster of national health objectives. These determinants align with the achievement of long and healthy lives for all people across the life span (U.S. Department of Health and Human Services, 2011). Determinants of health as outlined by Healthy People 2020 include "policymaking, social factors, health services, individual behaviors, and biology and genetics." NPs are educated to address individuals in light of the social, economic, and environmental factors that influence their health—in close keeping with the recommendations of Healthy People 2020.

NPs filling the void

According to the Center for Health Workforce Studies (2004):

The largest number of NPs (32%) work in suburban areas, but almost as many (31%) practice in an inner-city area, while another 15% practice in a rural area or small town. Sixty-seven percent of rural NPs provide primary care (p. 3).

Brock (2008) notes that NPs are filling a huge void as they provide primary care in the North Country area of New York's St. Lawrence county. This medically underserved area has a lack of primary care doctors and specialists. A report published in the *American Academy of Family Physicians* commented on the primary care physician shortage and noted that healthcare access is the most challenging problem facing our healthcare system, especially in underserved and low-income areas (Arvantes, 2008). In this same article, the author commented that increased healthcare access needs to be addressed not only by more physicians, but also with the help of NPs and physician assistants. In fact, NPs are more likely than

physicians to provide care to those who are underprivileged and live in rural, underserved areas (Hooker, 2006). This is evident in New York where 14% of the MD workforce practices in Health Professional Shortage Areas as compared to 26% of the state NP workforce (Increasing access, 2007). Grumbach, Hart, Mertz, Coffman, and Palazzi (2003) emphasize that "limited research suggests that family physicians, nurse practitioners, and physician assistants are especially likely to practice in rural communities and might be more likely to care for low-income patients" (Introduction, para. 3). Furthermore, no study has extensively compared the geographic spread of clinicians in different primary care disciplines (Grumbach et al., 2003).

"Forty million Americans have no health insurance of any kind," according to Woods (2006, p. 150). Nurses need to find ways to help with President's Obama's initiated Affordable Care Act, which promises to bring equality to a healthcare delivery system that includes uninsured Americans.

Join state associations

NPs need to advocate for their autonomy and must strive to educate and convince legislators to remove barriers to their practice. There are no studies to support that, with newfound autonomy, NPs will magically appear in underserved rural and inner city areas. Clearly, however, under statutory collaboration, NPs are often restricted from practice in these areas because they lack a physician with which to collaborate. NP and nursing associations need to increase membership, encourage members' political involvement, and move legislative agendas to bring about this and other needed change. The first priorities are to understand the legislative requirements in each state that affect an NP's scope of practice and how the scope of practice in turn affects the delivery of health care.

New York is one of the 24 states that require physician involvement for diagnosing and treating patients with required written documentation (Pearson, 2009). According to

the director of Membership and Public Affairs at the NPANYS, "There are less than 20% or 2,600 nurse practitioner members in New York's nurse practitioner association, and the State Education Department certifies about 14,000 NPs" (T. Nicotera, personal communication, July 6, 2009). In other words, less than 20% of the 14,000 NPs in New York State are members of the NPANYS, the official state organization for NPs (Pericak, 2009).

According to Nicotera:

We need more members and, in addition, more political involvement from the members would help to move the legislative agenda. We are still overcoming these barriers, but barriers can be overcome with continuous attention to the legislative agenda. Political involvement from nurse practitioners includes financial support around organized lobbying activity, legislative visits, [and] letter or e-mail writing, both will make a difference to move legislative agendas. Nurse practitioners should meet key legislators in their home offices because the power of being a constituent is very effective. The NPANYS supports its legislative agenda in part through the organization's Political Action Committee. In addition, the NPANYS has established the Legacy Fund, which supports public relations activities (T. Nicotera, July 6, 2009, personal communication).

NPs, with support from their state organizations, need to continue to educate legislators about the importance of NPs in the healthcare arena. Clarin (2007) suggests that physicians lack knowledge of NPs' scope of practice and have had little or no formal education about collaboration with NPs.

Educate legislators, promote activism

According to Philips, Harper, Wakefield, Green, and Fryer (2002), turf battles interfere with MDs' and NPs' healthcare goals. Even though NPs and MDs practice well together, it is at the policy level where doors are closed

to healthcare access. Education is an important step when it comes to moving legislative agendas. Legislators and community members need to be educated on both the economic and societal value of care provided by NPs. In New York, educating members of the state legislature and other key stakeholders about the NP role needs to continue. To facilitate passage of crucial legislation, NPs need to lobby their legislators, and educate physicians, lawmakers, and consumers about the removal of statutory collaboration and the need to obtain third-party reimbursement to allow access to care for patients.

Political activism can move legislative agendas for NPs and can be in the form of providing education about the role of the NP to legislators and members of the community, as well as to members of the medical society. NPs have power in numbers and related to their knowledge of the healthcare system in America. The healthcare system would collapse without nurses, and a crisis in health care would result due to absent NPs. NPs can be powerful by using their voices to make significant changes in the healthcare environment. Beginning steps for every NP are to understand the relevant state legislative agenda and how it affects the NP scope of practice.

NPs are in a unique position to work with their state associations to expand their scope of practice. By opening up their scope of practice, they will have more autonomy, which will translate into improved access to care for patients. In other words, NPs need to fight for their autonomy, no matter how long it takes. NPs in the District of Columbia and the state of New Hampshire were consistent in their fight for autonomy, and they were able to remove statutory collaboration and can now practice autonomously. New York State NPs should model their fight on what these NPs did and what their predecessors did in the NPANYS to gain their legal title and scope in 1988. Another example of patience and perseverance in New York was the death certificate bill signed into city law by Governor Cuomo on July 20, 2011, allowing NPs to sign death certificates in the same manner and with the same responsibilities as physicians. In addition, NPs should examine how nurse midwives in the state of New York lobbied with the help of their patients to remove statutory collaboration in 2010.

Examples to follow

According to Karen V. Scipio-Skinner, RN, MSN, executive director of the District of Columbia Board of Nursing, “NPs in Washington, DC, were able to be free of a mandated collaborative practice because they had key legislators working with them. The NPs were united with other advanced practice registered nurses (certified midwives, clinical nurse specialists, and certified registered nurse anesthetists), which made them politically powerful, and they all worked toward the same goal” (K. Scipio-Skinner, personal communication, June 17, 2009).

According to Lisah Carpenter, BSN, JD, executive director of the New Hampshire Nurse Practitioner Association, “New Hampshire NPs were persistent in their legislative struggles. This proved successful because they are free of mandated statutory collaboration” (L. Carpenter, personal communication, June 13, 2009). NPs in New Hampshire can enjoy their own private practices independent of physician oversight. According to

Sampson (2006), it was the long and hard fight and the alliance with professional and community networks that made a difference in New Hampshire.

According to Lynda Woolbert, MSN, RN, PNP, executive director of the Texas-based Coalition for Nurses in Advanced Practice:

The Texas APRNs are challenged with a very strong medical society, the strongest in the nation. APRNs in Texas do not have removal of statutory collaboration; in addition, they have stricter regulations than New York. Furthermore, APRNs in Texas practice with supervision that is complex and greatly restricts the scope of practice. For example, NPs cannot make medical diagnoses or treat medically. It was clear, though, that once NPs educated the legislators, agendas were easier to get passed. For example, in the last 4-5 years, the APRNs have been very active in rural east Texas educating their legislators about the role of the NP. Because of their persistence and involvement, they were able to procure legislative support for prescriptive authority under nursing.

Woolbert concludes, “NPs need to work together and must realize it may take a long time to get legislation passed, but persistence is the key and involvement makes a big difference” (L. Woolbert, personal communication, July 1, 2009).

New York NPs should be encouraged by the efforts of Texas NPs. That state has stricter regulations than New York, and, in spite of this, changes are being made. Focusing on social advocacy, staying united, and becoming active in professional organizations are all ways that NPs can use their power to influence legislative agendas.

Fight for autonomy

NPs need to shift their focus from individualism to social advocacy and solidarity. If nurses in general, including NPs, could widen their lens to include the social, economic, and political barriers to health care, they would be in a better position to influence public policy (Kos-Munson, 1993). Nurses are influential when they come together to form a group committed to an issue. Peters (2002) stresses the importance of nursing leaders becoming active in issue networks. More nurses need to join their state associations or coalitions, with the main objective of advocating for their profession. In order for a nurse to reach full potential, legislative action is needed. Nurses and NPs need to be more involved in policy making, which influences the delivery of care. Philips and colleagues (2002) agree that NPs in particular need to be consistent in their fight for autonomy.

Conclusion

Our healthcare system is in need of change, and a start would be for NPs to become politically involved. NPs in New York can be successful in passing the removal of statutory collaboration if they are persistent, connect with key legislators, join their state NP or nursing associations, and work together toward common goals. The current and future needs of our population must be met by a healthcare system that is affordable and sustainable, and one that can provide access to high quality services to all Americans, including the 48 million who are uninsured. NPs can literally be the change that they want to see in the existing American healthcare system.

Related CE activity on page 24.

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Barriers to Practice and Impact on Care: An Analysis of the Psychiatric Mental Health Nurse Practitioner Role

Heather Muxworthy, DNP, PMHNP-BC
Nancy Bowllan, EdD, MS, RN

Abstract

This paper is a retrospective review of the literature analyzing the role of the psychiatric mental health nurse practitioner in the community. Presented here is an appraisal of national and state mental health initiatives. Professional nursing regulations are reviewed, focusing on New York State advanced practice nursing. Barriers to practice are assessed with discussion on how barriers, such as statutory collaboration, impede access to treatment in the community for mentally ill psychiatric patients. The current New York State legislative agenda is featured. Clinical vignettes from a nurse practitioner's private community practice are presented to introduce and conclude how clinical practice barriers impede autonomous practice.

Clinical vignette (2007)

An advanced practice psychiatric mental health nurse practitioner (APRN-PMHNP) provides mental health services within a small community based private practice. The New York State Nurse Practice Act mandates that a psychiatric nurse practitioner (NP) maintain a statutory collaborative agreement with a collaborating psychiatrist in order to provide comprehensive mental health services. Although some third-party insurance companies authorize APRN-PMHNPs on panels, a collaborative agreement must be established with a psychiatrist from each insurance panel. This becomes a critical issue

when the collaborative psychiatrist decided to close his practice and abruptly discontinued the collaborative agreement. In order to prevent discontinuity in care, the APRN-PMHNP needed to establish a collaborative agreement with another psychiatrist and develop a practice agreement (Form 4NP) based on protocols established by the State of New York. This time-consuming process resulted in a disruption in treatment for several patients. The APRN-PMHNP managing this case reported a major incident by a high-risk patient that occurred as a result of this disruption in continuity of care. This case vignette highlights the potential negative consequences related to statutory

collaborative agreements as well as the ability of an APRN-PMHNP to provide effective, safe, and consistent care.

Introduction

Several national initiatives in the past decade have identified mental healthcare indicators that address system issues and the efficiency of access to mental health treatment by consumers within the community. Healthy People 2010, Healthy People 2020, and the National Consensus Statement on Mental Health Recovery are only a few of the national initiatives that recognize the lack of access and need for more mental health

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providers. The National Business Group on Health is a health non-profit membership organization that includes 60 Fortune 100 companies, and employs 55 million workers. This organization recognized a need and set a goal to improve delivery of behavioral health care in general medical and mental health sectors (U.S. Department of Health and Human Services, 2007). In addition to the above, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2003) recognized the need to provide more mental health research and to place more providers trained in evidence-based practice into the community. SAMHSA is the largest supporter of mental health grant opportunities for mental health innovation and demonstration programs (SAMHSA, 2003).

APRN-PMHNPs are registered nurses with advanced master's and/or doctoral degrees in psychiatric mental health nursing. Though psychiatric NPs are recognized as a clinical resource, multiple authors suggest that they are underutilized as mental health providers (Feldman, Bachman, Cuffel, Friesen, & McCabe, 2003). Furthermore, according to the American Association of Colleges of Nursing, underutilization of NPs, of all specialties, has been estimated to drive healthcare spending to near \$9 billion annually (Rosseter, 2000). Barriers such as physician dominance, restrictions on reimbursement, state regulations, and scope of practice issues are further noted in the literature as interfering with the autonomy needed to fully utilize NPs of all specialties (Wortans, Happell, & Johnstone, 2006; Elsom, Happell, & Manias, 2005; Feldman et al., 2003; Staten et al., 2005; Baradell & Bordeaux, 2001; Drew & Delaney, 2009). The author of this article explores the current role of the community based psychiatric NP in New York State. The author also addresses barriers to practice that interfere and disrupt the continuity of care and place mentally ill patients at high risk within the community.

National statistics

At the state and national level, there is increasing pressure to re-evaluate the limitations of statutory collaborative agreements on the role of the advanced practice nurse, including the psychiatric NP, with the goal to provide more access to

treatment providers for those in need (Agency for Healthcare Research and Quality, 2008). The 2008 National Healthcare Quality Report provided statistical data that highlights significant mental healthcare needs within the United States (see Table 1). Other studies have provided further insights into the demographics and impact of mental illness patients and providers. Walker (2010) reported that over 30 million Americans are indigent and currently uninsured. Of these 30 million, 7.6 million Americans will require some form of mental health care. The National Council for Community Based Healthcare further noted the substantial need for mental health services has resulted in a 15 to 17% increase in caseloads in community mental health centers (Walker, 2010). Additionally, the National Association of State Mental Health Program Directors, Medical Directors Council (2006) reported that individuals with serious and persistent mental illness have higher morbidity and mortality rates secondary to co-morbid chronic illnesses. Patients with mental illness have a lifespan on average 25 years shorter than those of healthy patients (Mazade & Glover, 2007).

Psychiatric mental health NPs are better equipped to assess, diagnose, and treat mental illness than primary care providers. As an advanced practice nurse, the psychiatric NP is educated in many types of nursing and other healthcare theories. Psychiatric NPs are also educated in the chronic care model, which provides a clinical framework for addressing the multidimensional nature of complex chronic illness (Boville et al., 2007). The psychiatric NP manages the patient's psychosocial and lifestyle issues, in addition to complex physical problems that often co-exist with mental illness. As an advanced practice nurse, the psychiatric mental health NP spends more time with patients, provides more education, and seeks consultation around more complex patients (Wortans et al., 2006; Elsom et al., 2005; Staten et al., 2005; Feldman et al., 2003). Therefore, the psychiatric NP is the natural provider to bridge the gap of access to mental health treatment within the community.

Reports provided by behavioral health managed care companies have noted that major segments of the U.S. population

Table 1.
National statistics regarding mental illness

Adults that suffer from mental illness	1:4
Adults with at least one episode of mental illness or substance abuse in 2006	32%
Americans with serious and persistent mental illness	6%
Americans over age 18 with major depressive disorder	15.8 million
Hospital- or office-based provider visits for mental disorder treatment annually	130 million
Primary care physicians who fail to properly diagnose depression	30-50%
Completed suicides in 2005	32,637
Largest age group increase in suicide	Ages 45-64
Percentage of completed suicides who had seen a primary care provider within 24 hours	40%

Note: Adapted from Feldman, Bachman, Cuffel, Friesen, & McCabe, 2003; Agency for Healthcare Research and Quality, 2008, 2009; Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007; Hogan, 2003.

lack access to clinicians who can properly evaluate the need for, prescribe, and monitor psychotropic medications (Christian, Dower, & O’Neil, 2007). Feldman and colleagues (2003) further found that patient access numbers increase with those who require both psychotherapy and psychopharmacology from the same provider. With only 14.2 psychiatrists per 100,000 people in the United States, and declining numbers of psychiatric mental health NPs, there will continue to be a lack of access to treatment and fewer incentives to enter into community practice if barriers to treatment are not addressed (Feldman et al., 2003).

Growing numbers of children and adults are being forced to receive mental health treatment from pediatricians and primary care physicians even though the data substantiates that these clinicians are not skilled to provide accurate care. Thirty to fifty percent of PCPs fail to properly diagnose depressed patients (Feldman et al., 2003). The APRN-PMHNP is the logical provider that can offer access to treatment in the community for the patient or family that is wary of the stigma associated with mental health care and chooses to not attend treatment at the community mental health clinic.

Healthcare reform overview

In each state, a nurse practice act defines the scope of practice for advanced practice nurses. Within the scope of practice are the practice privilege parameters of the advanced practice nurse. Scope of practice and practice privileges determine where the practice will occur, and include the name of the designated location or facility. Scope of practice also includes the exceptions to the certified scope of practice, as agreed upon with the undersigned parties of the agreement (NYSED, 2011b).

As the Federal government looks at healthcare reform on a national level, individual states are also considering change. The Board of Nursing and APRNs in each state, New York included, have favored laws to expand the NP scope of practice to allow autonomous practice and permit expanding scope of practice. According to the Pearson Report (2009), there are now 15 states that have converted to independent practice for NPs. In 2008, 22 states expanded their legislative or regulatory NP scope of practice. This is an increase of three states compared to 2007. Further expansion of state nurse practice acts would position psychiatric

NPs to more effectively address the critical need for more community-based mental health providers. Groups, such as the Board of Medicine and psychiatrists, argue that psychiatric NPs are not qualified to practice independently, lacking sufficient education and training (Christian et al., 2007; Ginsburg, Taylor, & Barr, 2009). The thought is that those who oppose expansion of the NP scope of practice are doing it out of concern for public protection. However, there are also those who believe that the opposing groups are doing this out of competitive self-interest (Christian et al., 2007).

NP education, certification requirements, and legal scope of practice are state-specific and vary considerably (Christian et al., 2007). In New York State, NPs have been authorized by statute to practice since 1988 (Elwell, 2007). Lugo, O’Grady, Hodnicki, and Hanson (2007) analyzed the Pearson National Nurse Practitioner study that measured and ranked each state based on the regulatory practices for NPs. Each year the Pearson study analyzes patient access to NP practices. Three dimensions are explored: 1) environments affecting consumers’ access to NP providers, 2) environments affecting reimbursement and NPs’ patients’ access to related healthcare services, and 3) environments affecting NPs’ patients’ access to prescription medications. New York State was ranked 14 out of the 51 states; Arizona was ranked first and came in as the least restrictive, and Alabama, at 51, was listed as the most restrictive (Lugo et al., 2007).

Wing, O’Grady, and Langelier (as cited in Lugo et al., 2007) developed a Nurse Practitioner Professional Practice Index based on the categories of legal authority, reimbursement, and prescriptive authority. In New York State, legal capacity, defined as scope of practice, was expanded, but NPs were still underutilized due to regulatory limitations (based on the index): New York State scored 21 out of a potential score of 30. The study ranked NP patient access to services as 37 out of 40 and patient access to prescriptions as 27 out of 40. The overall ranking for the state was 85 out of 100. New York received a letter grade of B for having a partial restrictive environment. This means that patients are able to access treatment, but there are barriers that interfere and delay access to the above services (Lugo et al., 2007).

As of January 2011, there were 1,060 advanced practice psychiatric nurses registered by NYSED (NYSED, 2010). Current statistics on the demographics of psychiatric mental health NPs and psychiatric clinical nurse specialists in both the adult and child/adolescent specialty area are displayed in Table 2. The data signifies that there is a trend of an aging workforce and a diminishing number of providers. There has been a 15% reduction of advanced practice psychiatric nurses between 1988 and 2003 (Staten et al., 2005). The 2005 legislative update conducted by the American Psychiatric Nurses Association reported that by the year 2013 the psychiatric nurse workforce is

Table 2.
Characteristics of the psychiatric nurse practitioner

Characteristics	Statistics
N = 2,195 respondents	
Average age (females)	55 years old (95% of workforce)
Average age (males)	44 years old (4% of workforce)
APRN-PMH (1988)	18% of nationally certified NPs
APRN-PMH (2003)	3% of nationally certified NPs
Estimated workforce size change by 2013	Reduced by 50% of current workforce
<i>Note: Adapted from Staten et al., 2005.</i>	

expected to be reduced by as much as 50% due to nurses reaching retirement age (Staten et al., 2005).

The Nurse Practitioner Association New York State (NPANYS) collected current data on the scope of practice and barriers to practice using the psychiatric mental health survey (2009b). Fifty-one percent of the respondents had been in practice between 1 and 10 years. Another 28% had between 11 and 15 years of service, and another 17% had 16 to over 20 years of experience. Thirty-seven percent of the respondents operated an individual private practice, and 45% were employed at an institutional or university based community practice setting. The survey asked if respondents who were not currently in community based private practice would consider employment at that type of practice in the future. Only 31% of respondents said yes, and 69% responded that they would not consider their own practice. Eighty-one percent of respondents stated practice barriers impeded the ability to provide optimum patient care. In the survey, 62% of comments addressed issues with either the collaborating psychiatrist or the requirement of a psychiatrist signature on insurance forms and disability paperwork. The NPANYS survey listed reimbursement and empanelment (together scored 28%) as the number one priority issue for survey respondents. The second most frequently identified priority (22%) was the OMH mandate that the APRN-PMHNP is required to have a psychiatrist sign the treatment plan, and the third most frequent priority (22%) was salary ranking (NPANYS, 2009b).

Barriers to practice

Although the regulations differ from state to state, in New York the statutory collaborative agreement requires that collaborating physicians complete retrospective quarterly record reviews to ensure that NP practice reflects accepted standards of medical practice and that NP practice is within the scope of practice (Zittel, 2006).

The Center for Health Workforce Studies (2004) at the University of Albany conducted a survey of all licensed NP specialties in New York State. Survey results showed variability in how often charts were reviewed. However, the majority of respondents, 78%, reported meeting weekly to daily with their

collaborating physician, reflecting that the majority of NPs in New York still undergo review and meet with physician colleagues on a regular basis. The specialties were not categorized so there is no data to support how psychiatric NPs received chart reviews by psychiatrists (Center for Health Workforce Studies, 2004). Financial arrangements with collaborating physicians are another barrier to community based independent practice. Most psychiatric NPs that have a private practice within the community pay for the physician's time to honor the statutory collaboration agreement, including the initial negotiating of the practice protocols, yearly updates of the practice agreement/protocols, and quarterly record reviews. An example, in New York State, is Part 29 of Regents Rules that describes

**The statutory
collaborative
agreement serves
no public purpose,
nor is it a substitute
for professional
judgment.**

professional misconduct. Section 29.1 (b) (3) of the Rules states that unprofessional conduct shall include: "directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services" (NYSE, 2010). The NYSED Office of Professions interpreted this rule to mean that the NP can pay for collaboration but only within the fair market value of services to be provided. Dr. Susan Apold, immediate past chairwoman of the NPANYS, reported that there are cases around the state where the Regents Rule has not been observed (personal communication, November 17, 2009).

Support for barrier removal

Statutory collaboration creates artificial barriers to care (NPANYS, 2009a). Dr. Joy Elwell, chairperson of the Government Affairs Committee, and others in the NPANYS organization believe that the collaboration agreement is a mechanism to control the practice of NPs (Elwell, 2007). An NP's practice is not determined by the collaboration agreement. It is the scope of practice that determines how the NP practices. Yet the education law determines that NPs must have a statutory collaboration agreement with a physician/psychiatrist. Within the collaboration agreement, parameters of practice are negotiated between the psychiatrist and the NP. For example, the author's preference was to offer her specialty of dialectical behavior therapy to 11- to 18-year-old adolescents. This work did not include prescriptive authority of this age group, as she is adult-trained. The collaborating psychiatrist would not allow the NP to work with adolescents younger than 14 years old, and they had to be of adult height and weight. The clause in the education law states that if there is a disagreement between the NP and the physician, the physician's preference takes precedence in spite of the NP's educational level or years of experience (NPANYS, 2009a). Twenty years ago, statutory collaboration was developed as a political compromise. The statutory collaborative agreement serves no public purpose, nor is it a substitute for professional judgment. Healthcare professionals are responsible for knowing their respective scope of practice and safely practicing within that parameter. Professional judgment is a requirement of NP practice and an expectation of the public (NPANYS, 2009a).

Managed care organizations have dominated healthcare delivery over the past two decades. These companies have become multi-state corporations that establish their own set of rules. These rules exclude NPs as providers on the insurance company panels and impose additional practice restrictions, such as mandating a statutory collaboration agreement with an empanelled physician. In addition to insurance company restriction, organized medicine has launched an aggressive campaign to further restrict scope of practice of APRNs through federal

Psychiatric NPs are the logical alternative to continue to allow open access to high quality mental health care.

and state legislation that would give physicians more power and control over nursing practice (American Nurses Association, 2009).

There are few studies in the literature addressing the statutory collaboration, reimbursement, and access to treatment as barriers to treatment (Elsom et al., 2005; Feldman et al., 2003; Staten et al., 2005; Pearson, 2009; Weiland, 2008; Lugo et al., 2007). An extensive literature review by United Behavioral Healthcare, as cited in Feldman and colleagues (2003), was conducted from 1997 to 2001. This review accounted for identified barriers to providing treatment, such as prescriptive authority, including lack of interest in the addition of prescriptive authority, work-setting limitations, personal comfort with prescribing, ability to develop a collaboration agreement with a physician, fees, legislative and statutory obstacles, and obtaining a Drug Enforcement Agency number (Feldman et al., 2003).

In 2001, United Behavioral Healthcare conducted a national survey to better understand barriers to prescriptive privileges and availability of APRN-PMHNPs (as cited in Feldman et al., 2003). United Behavioral Healthcare surveyed the availability of a group of nurses and psychiatrists and the ability to receive patient referrals. Fifty-eight percent of the nurses had prescriptive authority but did not work in private practices. Of the 58% of nurses, only 16% had a strong desire to have a private practice regardless of the prescriptive authority. The most significant barriers to establishing a private practice included: billing and administrative burdens, the cost of malpractice insurance, the demands of current jobs, and difficulty obtaining referrals (Feldman et al., 2003).

The quality of the collaborative relationship between the nurse and physician was cited as another potential barrier to practice patterns. NPs cited concerns around the prescriptive practice agreement with physicians. Three cited barriers were: physician concerns about liability (24%), physicians' choices of different drugs rather than supporting those selected by the NP (20%), and physician reluctance to prescribe medications selected by the NPs (20%) (Kaplan & Brown, 2004).

New York State legislation

In New York State, Assemblyman Gottfried and Senator Young have sponsored legislation known as the NP Modernization Act (2011) to amend the education law to allow NPs the right to practice without the statutory collaboration agreement. This bill would also provide direct and equitable insurance reimbursement to the NP for the same services performed by the physician. If approved, the NP Modernization Act will also establish an NP advisory panel, recommended by the State Board of Regents. The fiscal implications of this bill are to reduce the administrative costs for NYSED. This bill will also cut costs for institutions, since the institutions are currently charged with paying

the cost of the supervision for the statutory collaborative agreement (T. Nicotera, personal communication, May 5, 2011). However, it is unclear who will fund the administrative costs of the advisory board that is to be recommended by the State Board of Regents.

The NP Modernization Act is necessary, as statutory collaboration serves no clinical purpose. It does not establish the quality of the care provided by the NP. It does not serve a purpose for access to care; if anything, statutory collaboration limits access to care. In addition, statutory collaboration does not speak to the level of education of NP or the national certification of the psychiatric nurse specialty. Statutory collaboration does not speak to the NP's years of clinical expertise in the field of psychiatry.

The American Medical Association would disagree with the above comments by the author, firmly asserting that a physician needs to supervise the NP to provide safe, high-quality care. However, NP associations across the country, and in particular in New York State, have fired back at the American Medical Association. The American Nurses Association, the American Academy of Nurse Practitioners, the American College of Nurse Practitioners, and the National Council of State Boards of Nursing have all published position statements indicating that modification of state NP legislation is essential in allowing NPs full access to provide the care that they are trained to deliver. The American College of Physicians (ACP) presented its position on NPs as primary care providers (Ginsberg, Taylor & Barr, 2009). The ACP speaks in terms of collaboration and each discipline having special skill sets that complement one another. The ACP position calls for NPs and physicians to work together in partnerships to provide high-quality care. The ACP position asks to not limit access to care, but to use all providers and their special skill sets to keep access to care open on an ongoing basis. The ACP's position is that with the impending primary care shortages expected in the future, there is a need to look at all potential providers and how each discipline can assist in the care of patients (ACP, 2009). In 2011, the American Psychiatric Association announced that there are diminishing numbers of psychiatric residents. According to Vine (2009), there are currently 38,000 psychiatrists in the United States. An additional 5,450 practitioners are needed to bring the ratio to one psychiatrist for every 10,000 people. Armstrong and Forte (2010) completed exit interviews with psychiatric residents. In New York State, there were 230 psychiatric residents and 53 child and adolescent residents that left residency in that year. Of those reported, 48% planned to work in urban areas, and only 4% planned to practice in rural areas (Armstrong & Forte, 2010). Psychiatric NPs are the logical alternative to continue to allow open access to high quality mental health care.

Removal of barriers to treatment through passage of the NP Modernization Act will streamline access to treatment. Currently, there is a lack of access to appropriate services for patients with major mental illness (Feldman et al., 2003). Once NP provider barriers are removed, patients will be able to access treatment more freely. The NP Modernization Act will position psychiatric NPs as a source for mental health care within the community, whether it is through a private office practice or within a public health clinic setting. In addition, the bill will potentially allow psychiatric NPs to open nurse-run mental healthcare clinics and offer cost-effective care that could save the state millions of dollars.

Additional proposed legislation addresses insurance payment for acknowledgement of NP services. Assemblyman Gottfried and Senator Duane have initiated the Reimbursement Assurance Bill (2009), which will assure that health plans do not deny reimbursement for services rendered by NPs acting within their lawful scope of practice. The Access Protection Bill (2010), also by Gottfried and Duane, will prohibit health plans from excluding NPs from their provider networks and to insure that reimbursement rates are reasonable. The hope is that this bill will promote practice opportunities for NPs.

Opposition

Major opposition to the NP Modernization Act comes from the insurance companies who set up barriers for empanelment based on the statutory collaborative agreements (Elwell, 2007). Most insurance companies only allow the NP empanelment if they are in a collaborative agreement with a paneled physician. If the paneled physician terminates with the insurance company, due to reduced reimbursement rates or changes to the insurance company policies, the NP must also terminate. The NP is then left to find another physician on the panel to engage in the collaborative relationship. This can be a complicated and cumbersome process for the NP. Another example is when the physician is investigated by the insurance company or has practice privileges suspended by the Office of Professional Practice. The APRN is then dually unable to practice or bill the insurance company due to the requirement that the collaborating physician must remain on the panel. These barriers have a serious impact; they can disrupt the continuity of care and put patients at risk, especially those patients that are considered part of vulnerable populations, such as the mentally ill (NPANYS, 2010).

Clinical vignette (2010)

An APRN-PMH in private practice is notified that her collaborating psychiatrist is involved in a complicated and potentially career-paralyzing

incident. The psychiatric NP consulted her own legal counsel due to the established statutory collaboration mandates with this psychiatrist. A recommendation was made to break ties with the psychiatrist and find a replacement. Unfortunately, a replacement was not accessible and led to an immediate need to close the NP's private practice due to loss of the statutory collaborative agreement. This led to a rapid transition and termination for 70 patients. The incident resulted in a major disruption of care and a difficult transition for all patients involved.

Discussion

There are a number of barriers that impede the APRN-PMH from being able to provide care to the full extent of her scope of practice. These barriers provide a disincentive for psychiatric NPs to set up practice in the community, including rural communities. As the primary care provider shortage continues, so does the shortage of psychiatrists and psychiatric NPs. With the slow decline of psychiatric NPs, the concern is that barriers create a lack of motivation for the psychiatric nurse to enter the advanced practice field of nursing and pursue independent practice.

Licensed healthcare providers, such as advanced practice NPs, have been discriminated against despite state scope of practice laws that allow for this practice (Elwell, 2007; Safreit, 2002). NPs have been restricted from leading demonstration projects, pilot programs, and incentive programs, and remain restricted on insurance reimbursement policies. The advanced practice nurse, in any specialty practice, needs to be recognized as a provider qualified to lead a nurse-managed healthcare center for disease management for the vulnerable, underserved patient population (American Nurses Association, 2009).

Psychiatric NPs, and all NPs, must learn to advocate for healthcare policy changes. NPs must get more involved in state and national associations that lobby to remove these statutory limitations of practice and encourage equity of reimbursement. In New York State, there are over 14,000 NPs (NPANYS, 2010), and only a little over 2,000 are represented through the NPANYS.

In conclusion, APRN-PMHNPs are appropriate caregivers to help protect, promote, and restore the health of the mentally ill population. The APRN-PMH is the provider that is knowledgeable about evidence-based practice. Resolving statutory and regulatory barriers to practice seems to be the natural solution to the current mental healthcare crisis, which then would authorize APRN-PMHNPs to follow through on their role in the community setting.

Related CE activity on page 25.

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Obesity Risk in Urban Adolescent Girls: Nutritional Intentions and Health Behavior Correlates

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Abstract

Obesity is an expanding epidemic and minority adolescent girls are at high risk. One way to tailor interventions for obesity prevention is to target intention to engage in particular behaviors. Data collected from adolescent girls' intentions and behaviors regarding nutrition, physical activity, and sleep patterns were used to examine nutritional intentions in relation to healthy behaviors. Adolescent girls reported behaviors that increased their risks for obesity. Nutritional intentions were significantly associated with physical activity and sleep. These results suggest that healthy behaviors tend to occur in clusters, possibly extending the theory of planned behavior beyond individual behaviors to groups of related behaviors. Nurses can intervene with high-risk adolescent girls by promoting healthy diets, recommended levels of physical activity, and adequate sleep.

Overweight and obesity have reached epidemic levels in adolescent minority females (12-19 years of age). Public health and practitioner interventions to modify teens' diet and exercise behaviors have not yet proven effective in reversing this epidemic. It is very difficult to change an individual's lifestyle, developed over a lifetime of choices based on family and personal preferences, and reinforced by habit and culture.

Obesity is a growing epidemic in adolescent girls. Of all adolescent girls, 32% are obese

(body mass index [BMI] > 95th percentile) or overweight (BMI between 85th and 95th percentile) (Ogden et al., 2006). This problem is even more pronounced for Black girls, 42% of whom are obese or overweight and 25% obese. This epidemic among teens is particularly troubling because adolescent girls who become obese are more likely to remain obese as adults and experience a higher level of morbidity and mortality than the general population (Singh, Mulder, Twisk, van Mechelen, & Chinapaw, 2008). This increased

risk and its negative consequences could be counteracted by lifestyle changes during the adolescent years.

Unhealthy dietary patterns clearly influence adolescent overweight. Adolescent girls typically consume a diet heavy in high fat foods, refined grains, and sweetened drinks, foods that are related to increasing adiposity in Black adolescent girls (Ritchie et al., 2007). Adolescent girls have a tendency to decrease their fruit and vegetable intake over time, compounding the problem of already

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suboptimal diets, and they rarely include healthy choices such as low-fat or whole-grain items, or fruits and legumes (Larson, Neumark-Sztainer, Hannan, & Story, 2007).

In addition to the negative effects of diet, the problem is exacerbated by decreasing levels of physical activity that occur as girls age (Belanger, Gray-Donald, O'Loughlin, Paradis, & Hanley, 2009; Singh, Kogan, Siahpush, & van Dyck, 2008). In particular, and despite its health benefits, vigorous aerobic activity that increases the heart rate becomes less frequent in the teen years (Belanger et al., 2009). Inactive girls at all economic levels have higher levels of obesity than girls who are physically active (Singh, Kogan, et al., 2008); however, according to the Centers for Disease Control and Prevention (CDC), Black girls are more likely to be inactive than others (CDC, 2009).

Recent data also suggest that obesity risk is correlated with behaviors less well documented than diet and physical activity. Laboratory studies suggest that reduced duration of sleep up-regulates appetite by a reduction in leptin, an increase in ghrelin, and a reduction in insulin sensitivity; these changes increase the risk for obesity (Van Cauter & Knutson, 2008). Adolescent girls experience weight gain when they have insufficient sleep, especially if they sleep less than 6 hours per night (Berkey, Rockett, & Colditz, 2008).

In addition to diet, physical activity, and sleep patterns, population-based risk factors for obesity include poverty, lack of higher education, and race/ethnicity (Singh, Kogan, et al., 2008). Race/ethnicity, poverty, and sedentary lifestyle are independently related to obesity in adolescents, and in addition, there are multiple interactive or joint effects among these factors. Poor, Black adolescent girls are at risk by virtue of their minority status, and also because minorities are over-represented in impoverished populations (Mather, 2007). Furthermore, individuals under 18 are in the age group with the highest prevalence of poverty, and females under age 18 are 27% more likely to live in poverty than males.

Obesity can be tackled by targeting personal choice through designing more effective interventions, such as addressing the individual's intention to engage in a particular behavior. This approach is central

to the theory of planned behavior (Ajzen, 1991), which includes the construct of one's intention to participate in a particular behavior. The theory of planned behavior specifies that attitude, subjective norm, and perception of behavioral control are the three components that contribute to formation of behavioral intention (Ajzen, 2002). If a person has a positive attitude toward a behavior and a sense of social pressure to carry out the behavior, and in addition they perceive that they are able to perform that behavior, then they are more likely to carry it out. A central proposition in this theory is that the stronger a person's intention to perform a particular behavior, the more likely she will, but only if she has control over the behavior (Ajzen, 1991). In other words, assuming that control over the behavior is possible, intention is an antecedent to performance.

Obesity can be tackled by targeting personal choice through designing more effective interventions, such as addressing the individual's intention to engage in a particular behavior.

Nutritional intentions, measured in both adolescent and adult populations, are predictive of healthy dietary behaviors (Backman, Haddad, Lee, Johnston, & Hodgkin, 2002; Blue & Marrero, 2006; Conner, Norman, & Bell, 2002). Thus, an adolescent's intention to engage in a healthy behavior, such as eating a healthy diet, is highly correlated with actual diet (Backman et al., 2002). However, it has not been shown whether intention to engage in one health behavior, such as healthy eating, is reflective of overall engagement in good health practices in adolescents.

Adolescent girls are at risk for obesity because of factors that include both life circumstances, which are difficult to modify, and lifestyle factors such as poor patterns of sleep, high-fat diets, and low levels of physical activity that offer potential for intervention. The purpose of this secondary analysis was to describe the nutrition intentions, levels of physical activity and sleep patterns of Black adolescent girls and explore the relationship between nutritional intentions, levels of physical activity, and sleep patterns. The authors used data that were collected at baseline in an HIV prevention intervention with adolescent girls on the girls' intentions and behaviors regarding nutrition, physical activity, and sleep patterns (Morrison-Beedy, Carey, Crean, & Jones, 2010). We hypothesized that intention to engage in healthy behaviors, such as healthy eating, would be correlated with other healthy behaviors, thus generalizing the behavior models beyond a single intention and behavior. Extension of the theory of planned behavior could lead to better interventions to decrease risk of obesity.

Method Sample

For the original study (Morrison-Beedy et al., 2010), urban adolescent girls were recruited by direct and word of mouth recruitment from primary health and reproductive care clinics and from youth development programs in Western New York. Inclusion criteria for the HIV prevention intervention were: (1) female gender, (2) 15-19 years of age, and (3) sexually active with a male partner within the past 3 months. Exclusion criteria were: (1) married status, (2) pregnant, (3) delivered a child within the past 3 months, (4) anticipated relocating within the next year, (5) mentally impaired, or (6) unable to read or speak English adequately to participate in the intervention. This study was approved by the institutional review boards of the University of Rochester and Syracuse University. The protocol was reviewed and approved by the national office of Planned Parenthood. Consent was obtained from girls who were ≥ 18 years of age; girls under 18 provided assent. Parental consent was not required by the institutional review boards because the study included testing for sexually transmitted infections, which

is protected health information under the reproductive rights laws in New York State.

Procedures

Participants were initially screened for age, and eligible girls completed additional screening questions in a private location at the recruitment site. Recruitment occurred between December 2004 and April 2008. Of 1,778 girls screened for the study, 765 were eligible. The primary reason for ineligibility was that they had not been sexually active within the past 3 months. A total of 748 eligible girls were interested in participating, gave consent or assent, and provided baseline data. The majority of girls who chose not to participate cited a lack of time to fully participate in the study as their reason for refusal. Immediately upon completion of the assent/consent process, girls completed an audio computer-assisted self-interview (ACASI).

Measures

Using the ACASI, a variety of measures were used to collect data from all participants at baseline: sociodemographic characteristics, nutritional intentions, and health behaviors such as physical activity and hours of sleep. The following baseline data points were used for this secondary analysis.

- *Sociodemographic characteristics.* Information was collected on age, race, ethnicity, free lunch status (proxy for income level), and living situation.
- *Nutritional intentions.* Four questions were developed to measure nutritional intentions, using a method in accord with the theory of planned behavior, and previously used in other, similar studies (Backman et al., 2002; Blue & Marrero, 2006; Conner, Norman, & Bell, 2002). Questions pertaining to intention to behave a certain way have been found to predict the actual behavior. The four questions assessed intentions to consume dairy products, eat fresh fruits and vegetables, include fiber in the diet, and avoid fried food. The responses were self-ratings on a 4-point Likert scale ranging from 'definitely will do' to 'definitely will not do.' Each item was examined independently to describe specific nutritional intentions and a summative score was created to assess overall nutritional intentions.

- *Health-related behaviors.* Physical activity was measured with one question asking "how many days out of the week did you get 30 or more minutes of physical activity that increased your heart rate (such as walking briskly or exercising)?" Amount of sleep was measured with one question that asked "during the past week, how many nights did you sleep 7 to 9 hours per night?" A summative health behavior variable was created that included both physical activity and hours of sleep. One other health behavior measured in this sample was the use of contraceptive measures, which, in sexually active girls would be considered a healthy behavior, as would condom use. Alternatively, if we examine behaviors such as cigarette smoking, alcohol use, or illicit drug use, those would be considered unhealthy behaviors for teens and should then be negatively correlated with healthy intentions.

Data analysis

Baseline data were analyzed using descriptive statistics, including means and standard deviations, frequencies and percentages. To evaluate the relationship between variables, further analyses were conducted using linear regression and Student's t-test. The girls who met the American Heart Association (AHA) recommendations for physical activity were compared to those who did not meet recommendations. SPSS version 17.0 was used for all analyses.

Results

Baseline data for the variables included in this analysis were available for the 511 girls who self-identified as African American or Black of the 748 girls who consented to participate in the study. Their average age was 16.5 years, with a range of 15-19 years (See Table 1). Over 70% reported that they participated in the free/reduced lunch government program, which indicated that they lived in poverty. It is likely that even more of them were impoverished, since high school students often do not participate in the federal lunch program, even when eligible (Gleason, 1995).

Table 1.
Demographic and health behavior characteristics of adolescent girls

Sample size	(n = 742)
Age	16.52 (+1.27)
Race	
Black	512 (69%)
Mixed/multiracial	80 (11%)
White	67 (9%)
Other	83 (11%)
Ethnicity	
Hispanic	126 (17%)
Living situation	
Family apartment/home	618 (83%)
Own apartment	53 (7%)
Other	71 (10%)
Poverty (reduced/free lunch participation)	516 (70%)
Days/week > 30 mins of physical activity	3.03 + 2.42
Nights/week got 7-9 hours of sleep/night	3.92 + 2.39
Nutritional intention (score range = 4-16)	10.45 + 2.64

Table 2.
Nutritional intentions of adolescent girls

Nutritional intentions	Responses to nutritional intention questions (%) (n = 742)			
	Definitely will do	Somewhat likely to do	Somewhat unlikely to do	Definitely will not do
Consume dairy products	35	35	17	13
Consume fresh fruit and vegetables	20	36	32	12
Consume fiber	22	39	28	11
Avoid fried foods	8	31	30	31

Health behaviors

The AHA recommends that adolescents participate in 30 minutes of regular physical activity daily (CDC, 1999; Singh, Kogan, et al., 2008). Fourteen percent of participants (n = 72) reported that during the past week they had met this physical activity recommendation. Thirty percent reported 30 minutes of physical activity 2-3 days out of the week, while more than 24% reported no physical activity.

Less than one-quarter of the sample (22%) met the criteria of 7-9 hours of sleep each night of the week. Five nights out of seven could be considered ‘school nights’ and 46% of the girls reported 7-9 hours of sleep for at least 5 days per week, while 12% reported less than 7 hours of sleep for all nights in the previous week.

Nutritional intentions

The four questions on nutritional intentions asked the girls about their intake of: (1) dairy products, (2) fruits and vegetables, (3) fiber, and (4) fried foods. Slightly more than one-third of the girls indicated they would definitely consume dairy products, although some indicated they definitely would not (See Table 2). Intention to include fruits, vegetables, and whole grains in their diets was even lower than intention for dairy intake. Avoidance of fried foods was not a priority for these adolescent girls.

Effect on healthy behaviors

Nutritional intentions were positively associated with level of physical activity and amount of sleep (see Table 3). As intentions to eat healthy foods increased, physical activity and hours of sleep also increased. Nutritional intentions were correlated with healthy behavior overall, and 6% of the variance for these healthy behaviors were accounted for by nutritional intentions ($R^2 = .06$).

The girls who met the AHA recommendations for physical activity had significantly more sleep ($p < .001$) and overall healthy behaviors ($p < .001$) compared to those who did not meet the recommendations.

Discussion

The majority of girls in this sample did not meet the recommendations for regular physical activity nor sleep, and did not intend to eat a healthy diet. All three factors increase their risk of obesity. The nutritional

Table 3.
Prediction of behaviors by nutritional intentions

	b	p
Physical activity	.183	< .001
Sleep	.154	< .001
Seatbelt use	.066	< .001
Healthy behaviors (summative)	.337	< .001

intentions of these Black, low-income adolescent girls were correlated with their other health-related behaviors. If these girls had intentions to eat healthy food, they also had higher amounts of physical activity and sleep. These results supported the authors’ hypothesis that it was possible to generalize beyond a single intention and behavior, and show that one intention was related to other behaviors. These findings suggest that the construct of intention may have a broader application beyond its common use, where one intention is related to one kind of behavior.

The correlation of a healthy intention to two health-related behaviors makes sense, since we would expect that people who engage in one healthy behavior are likely to engage in other such behaviors. For these adolescent girls, these healthy behaviors appear to occur as a cluster. Although the findings cannot be extended beyond these specific behaviors, the results suggest that behavioral theories of intention may be applied more generally to design interventions that address the “root cause,” which appears to drive all behaviors in a cluster—this application of the theory of planned behavior requires further study.

Lack of physical inactivity compounds the risk for obesity faced by these girls. In this study, the majority of girls were not physically active with nearly one-fourth reporting no activity at all. Even more concerning, only 14% met the AHA recommendations for physical activity, a finding consistent with other reports that adolescent girls have low levels of physical activity (CDC, 1999; Singh, Kogan, et al., 2008). Given the decrease in activity level that occurs with age (Belanger

et al., 2009), it is likely that obesity risk will escalate as these girls, who had a mean age of 16.5 years, approach adulthood. The reason for inactivity is unknown—it could be related to neighborhood safety (Bennett et al., 2007), or it could be reflective of gender expectations and peer practices.

The recommendation that adolescents get 7-9 hours of sleep per night was met by less than one-fourth of the girls in this study, although 46% reported getting adequate sleep five out of seven nights. This finding for the latter group could mean that participants had adequate sleep during the school week and just not on weekends, or it could mean that some got more sleep on the weekends. Nonetheless, over 50% are not getting adequate sleep most days of the week, which contributes to their obesity risk (Berkey et al., 2008; Van Cauter & Knutson, 2008).

The nutritional intentions reported by these adolescent girls were not protective against obesity; rather, they likely contributed to weight gain (Ritchie et al., 2007). These girls reported weak intentions of eating whole grains, fruits, and vegetables, in conjunction with almost no intention to avoid fried foods. Even with dairy products, the dietary item that more girls reported they would definitely consume, two-thirds of the girls were not confident they would. However, it is possible that this lack of confidence is related to lactose intolerance common to African Americans: More than 70% of African Americans have the potential for experiencing symptoms of intolerance, although average-size servings are often not problematic (Byers & Savaiano, 2005). These eating intentions are consistent with actual eating behaviors that have been reported in the literature. A dietary pattern that includes low fruit and vegetable intake, minimal whole grains, and fatty and/or fried foods is common in adolescent girls (Ritchie et al., 2007).

Nearly 80% of these girls did not definitely intend to include fruits and vegetables in their diet. If these intentions are predictive of actual intake, this is very concerning, because adolescent girls have a tendency to decrease fruit and vegetable intake as they get older (Larson et al., 2007), and it has been documented that these foods help individuals to manage their weight (Weinsier, Johnston, Doleys, & Bacon, 1982).

Compounding the issues of inactivity, inadequate sleep, and poor nutritional intentions, these adolescent girls faced an increased risk for obesity due to several demographic characteristics: They were predominantly impoverished (of low socioeconomic status), of African American race, female, and less than 18 years of age. Intentions to engage in healthy eating are also limited by opportunity to obtain healthy foods and poverty can exacerbate this risk. In a 2007 survey of convenience stores located in the area of the city where many of these girls lived, it was found that 85% of the surveyed stores did not sell fresh fruits or vegetables, 76% sold white bread only, and if milk was sold, it was whole milk only (University of Rochester Medical Center, 2007).

Although the findings of this study are not strong enough to definitively determine that one health intention is predictive of other health related behaviors, the findings about the behaviors and intentions of adolescent girls are very worrisome. Nurses have a responsibility to assess the individual risk in any girls they provide care for—their intentions for healthy eating and their levels of physical

activity and sleep. The challenge to nurses is to develop creative ways to encourage girls to adopt healthy behaviors. Nurses can intervene by promoting healthy diets, recommended levels of physical activity, and adequate sleep. Furthermore, nurses can become active at the local, regional, and statewide level to promote access to healthy foods and safe environments that promote healthy lifestyles.

This study had some limitations. First, all data were based on self-report, which can be subject to both recall and social desirability bias. Second, the measurements we had were limited to one time point, so intentions and later behaviors in the same domain could not be measured. The sample was limited to sexually active girls who represent a high-risk group of black adolescents, which limits generalizability. There was no self-report of actual dietary behaviors to link to report of, nor were there intentions for physical activity or sleep to link to report of these actual behaviors. Nevertheless, this study of a large sample of impoverished adolescent girls provided a unique opportunity to examine the health behaviors of this at-risk population and gain some understanding of interrelationships among these behaviors.

Black adolescent girls as a group face multiple health challenges connected to obesity and overweight. Interventions that help these girls overcome these challenges are critically needed, so they and the healthcare system are not forced to contend with the even more overwhelming challenges of the obesity epidemic when these adolescents become adults. The girls in this study were at risk for obesity by virtue of their age, race/ethnicity, gender, and socioeconomic status. Furthermore, there is a lack of intention to engage in behaviors that might reduce that risk, as well as their self-reported suboptimal sleep and physical activity, all of which compound the chance that their future will be spent battling obesity.

Implications

The collection of risk factors for obesity in this population represents a high level of disparity that deserves further research to create interventions tailored for this population. Our findings suggest that interventions require a multifaceted approach that incorporates lifestyle changes around physical activity, diet, and sleep as well as consideration of access to healthy foods. Healthcare providers have the opportunity to assess risk and counsel patients about healthy diet, physical activity, and sleep habits. However, such counseling is time consuming and often not effective. Programs are needed to promote healthy behaviors that extend beyond obesity prevention, and address the adolescent's intention to embrace a healthy life by adopting a full repertoire of interrelated healthy behaviors

If, as our data suggest, healthy behaviors tend to occur in clusters, then adolescent girls who engage in, or intend to engage in, one set of healthy behaviors may also engage in others. Further research is needed to clarify if behavioral theories can be extended to predict constellations or clusters of health behaviors from a single related behavioral intention. Extension of these theories to look at clusters of behaviors could enhance both practice and research that examines intentions to engage in behaviors and actual behaviors.

Related CE activity on page 26.

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BOOK REVIEW

Jeanine Seguin Santelli, PhD, ANP-C/GNP-C

Vance, C. (2011). *Fast facts for career success in nursing: Making the most of mentoring in a nutshell*. New York: Springer Publishing.

This book is a quick read with short, well-defined chapters and inspirational quotations. Each chapter is set up with a thumbnail introduction and objectives. Sprinkled throughout the text are “Fast Facts in a Nutshell.” Also included in this book are self-reflection exercises to identify mentoring needs and mentor fit and an extensive list of resources and references.

There are four parts to the book, each part containing two or three chapters. The first part discusses “Navigating a Successful Nursing Career.” It includes professional role, standards of practice, and career trajectory. The role of the mentor and the ebb and flow of mentors throughout one’s career are presented. Also included is the historical perspective on mentoring.

Part two is called “The ABCs of Mentoring.” Here, ABC is an acronym for the steps to mentorship: “**A**ssess your mentor intelligence” walks the reader through an exercise in determining readiness for a mentoring experience. “**B**uild your mentor connections” provides steps to developing a mentoring plan. This plan can be established whether mentees and mentors are chosen or matched. “**C**ultivate your potential and talent for success” unveils the good, the bad, and the ugly potentials of mentoring relationships and provides constructive responses to both mentee and mentor.

“Making the ‘Mentor Match’” is the title of part three. The author covers networking, negotiating, and troubleshooting strategies. She also discusses the potential roadblocks of unrealistic expectations, personal and professional mismatches, power and control issues, excessive competitiveness, “cloning,” communication, and dependence, along with avoidance/correction strategies that can help.

The last part of the book is “Career Success and the Mentor Connection.” This section transitions the reader from the role of mentee to the role of mentor.

Although the book is written for student and novice nurses, I feel that it would also be valuable to seasoned nurses who may be considering or refreshing a mentoring role. I could see this text being used as a workbook for a newly developed mentoring relationship, employing the chapters and exercises as talking points to help the mentee and mentor get to know each other. If you like structure and are interested in learning more about nursing mentorship, you’ll enjoy this book. It is a well-constructed recipe for a successful mentoring experience for all parties involved.

WHAT’S NEW IN THE HEALTHCARE LITERATURE

Elder abuse

Natan, M. B., & Lowenstein, A. (2010). Study of factors that affect abuse of older people in nursing homes. *Nursing Management*, 17(8), 20-24.

Elder abuse is a recognized phenomenon occurring in long-term care facilities. Abuse is classified as psychological, physical, financial, or sexual mistreatment, or neglect. Data regarding elder abuse is inadequate, as witnesses are unlikely to report cases even though it is mandated. Literature has suggested the incidence of elder abuse is higher in for-profit organizations and facilities with higher bed capacities, higher nurse-to-patient ratios, and decreased nurse satisfaction. The purpose of this research was to determine if these factors also increased elder abuse in Israel.

The facilities for this quantitative, descriptive study were randomly selected from each region of Israel. With approval from local ethics committees, the Iowa Dependent Adult Abuse Nursing Home Questionnaire was given to participants, and anonymity was assured. The response rate was 85%. The questionnaire investigated demographic data about each facility and the maltreatment that the nurses witnessed or conducted within the past year.

Fifty-four percent reported performing an act of maltreatment within the last year totaling 513 incidents. Sixty-four percent recorded at least 16 episodes of physical neglect occurring yearly. The most frequent forms of maltreatment were mental neglect at 34% and physical neglect at 30%. Elder abuse had a significant positive correlation with an increasing number of beds and high nurse turnover rates demonstrated by a Spearman test. Increased nurse-to-patient ratios led to significant increases in mental and physical neglect and the overall incidence of abuse. No findings suggested that for-profit organizations have higher rates of elder abuse.

Overall, rates of neglect were higher in this study than in previous studies. The researchers suggest that nurses were more likely to report neglect when it was viewed as a system failure instead of due to malicious intent. Nurses and healthcare institutions must be educated that staffing and worker satisfaction have global significance in the prediction of elder abuse. Healthcare providers can visit the National Center on Elder Abuse at www.ncea.aoa.gov to learn how to increase awareness of and prevent elder abuse.

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(continued)

WHAT'S NEW IN THE HEALTHCARE LITERATURE (continued)

Multiple sclerosis

■ Ferrandi, C., Richard, F., Tavano, P., Hauben, E., Barbie, V., Gotteland, J., ... Zaratini, P. F. (2011). Characterization of immune cell subsets during the active phase of multiple sclerosis reveals disease and c-Jun N-terminal kinase pathway biomarkers. *Multiple Sclerosis Journal*, 17(1), 43-56.

Multiple sclerosis (MS) is an inflammatory demyelinating disease of the central nervous system. Programmed death (apoptosis) of lymphocytes is essential for the immune system to function. A defect in the cycle of activated T lymphocyte death is involved in the pathology of MS. The purpose of this study was to identify the potential role of the c-Jun N-terminal kinase (JNK) pathway in regulating these T cell responses in people diagnosed with MS. Blood samples were obtained from healthy volunteers. Blood and urine samples plus other data including demographics, medical history, current medications, and 12-lead electrocardiogram were obtained from MS patients with the relapsing-remitting form of the disease.

The researchers were able to identify a gene expression signature that can correlate with disease status and differentiate the active from stable phases of MS. The researchers highlighted that the JNK/inflammation/apoptosis pathway plays a significant role in MS, and the information can be used to design a prognostic/diagnostic gene card for MS patient stratification and ultimately improved patient outcomes.

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Collaboration

■ Churchman, J., & Doherty, C. (2010). Nurses' views on challenging doctors' practice in an acute hospital. *Nursing Standard*, 24(40), 42-47.

Despite the shift in women's roles in the workforce into areas of skilled employment, studies have shown that subordination of nurses still exists. In general, subordination of nurses is not viewed as a problem; however, studies show that a lack of interdisciplinary cooperation and collaboration and poor communication contribute to harm occurring to patients in the hospital setting. This study looked to evaluate the willingness of nurses to challenge physicians' practice in the acute care setting. Of the 55 nurses invited to participate only 12 volunteered. All participants were female with the mean age of 47 years, and the youngest was 34 years old. The self-selected purposive sample was from a 400-bed acute care hospital in the South of England.

This study used a qualitative approach employing in-depth recorded interviews asking participants to identify an occasion in which they challenged physician practice or a situation in which they did not challenge a physician's practice, but wish that they had. A thematic approach identified core themes, subtexts, and repetitive words. Through thorough analysis, two main themes were identified: "the battle of challenging" and "playing games." Participants described "the battle of challenging" as a psychological process protecting them from the "uphill battle" of challenging physicians. Nurses felt intimidated by aggressive actions of physicians and felt that their opinions were not being heard. "Playing games" involved manipulation especially through charm and flirting to subtly insinuate ideas. "Playing games" allowed nurses to influence patient care without "ruffling the fragile ego of physicians." Nurses stated a belief in their assertiveness, but

observation of their practice contradicts this statement. Quality and Safety Education for Nurses, a program funded by the Robert Wood Johnson Foundation, highlights the same occupational hierarchy for nurses here in the United States. The program has created an initiative promoting education and strategies in interdisciplinary collaboration and communication through encouraging confidence in knowledge, skill, and ability to challenge physicians.

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Moral distress

■ Rice, E. M., Rady, M. Y., Hamrick, A., Verheijde, J. L., & Pendergast, D. K. (2008). Determinants of moral distress in medical and surgical nurses at an adult acute tertiary care hospital. *Journal of Nursing Management*, 16, 360-373.

Nurses in all clinical settings confront ethical issues that frequently lead to moral distress. Most studies on moral distress have been directed in the critical care environments, mostly due to the widespread use of advanced medical technology at the end of life. The aim of this study was to determine the prevalence and contributing factors of moral distress in medical surgical nurses in adult acute care units.

The study design was a prospective cross-sectional survey of nurses who cared for different patient populations including general medicine, surgical, cardiac, neurologic, and oncologic at an adult acute tertiary care hospital. The study used the moral distress scale, a validated survey instrument to measure moral distress. Institutional Review Board approval was obtained. The survey was administered to all medical and surgical nurses by the principal investigator, and consisted of 38 situations that can generate ethical conflicts and moral distress in customary hospital practice. The nurses were instructed to give consideration to experiences throughout their entire career when responding to the survey.

The moral distress scale measures perceptions of nurses on two dimensions of each situation: (1) intensity of moral distress and (2) frequency of the encounter of that particular situation using a 0-6 Likert scale. The survey situations were in six categories. Categorical variables were analyzed by the chi-squared test. The sum of moral distress and encounter frequency scores for each of the categories was examined with Wilcoxon/Kruskal-Wallis tests. Multiple regression analysis was used to identify independent predictors for the sum scores of encounter frequencies to different categories of situations. All statistical tests were two-tailed and statistical significance was accepted at $P < 0.05$.

In total, 260 nurses completed the survey for a 92% response rate. The main findings from the survey were: (1) the intensity of moral distress was uniformly high across the six categories of situations, (2) there was a variability of encounter frequencies among the different categories of situations, (3) futile care situations had the highest moral distress and encounters in the study cohort, and (4) years of nursing experience and caring for oncology patients were significantly associated with encounter frequencies of moral distress situations.

The study further identified inadequate pain control for the terminally ill and dying patients as an important cause of moral distress in medical and surgical nurses. Additionally, nurses who provided care to oncology patients had much higher exposures to situations causing moral distress

than those who cared for patients with other illnesses. Lastly, the nurses' comfort level with staffing and competence of other nurses and physicians as healthcare providers was also cited as a potential contributor to moral distress.

The implications for this study are profound. Effective communication among healthcare providers, patients, and families must take place to achieve the desired goals of medical care, including sound patient-care decisions. Improved communication and collaboration among nurses and physicians can be crucial for providing moral support of nurses when encountering situations containing ethical conflict and distress. Patient-care conferences and open group discussion of issues surrounding ethical conflicts can be both educational and beneficial. Nurse administrators are encouraged to develop programs to facilitate communication, interdisciplinary collaboration, and discussions among pertinent disciplines and with adherence to palliative care principles.

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Traumatic injury

■ Roberts, I., Shakur, H., Ker, K., & Coats, T., on behalf of the CRASH-2 Trial collaborators. (2011). Antifibrinolytic drugs for acute traumatic injury. *Cochrane Database of Systematic Reviews*, 1. DOI: 10.1002/14651858.CD004896.pub3

Every year trauma accounts for 1 in 10 deaths worldwide. Bleeding, directly or indirectly, causes 39% of these deaths. Complicating this issue is the global shortage of safe blood for transfusions. Antifibrinolytic agents are used in patients undergoing major surgery in order to prevent fibrinolysis and minimize blood loss. New evidence shows that the use of antifibrinolytics in patients with traumatic bleeding offers a quick, inexpensive intervention to save lives from hemorrhage and conserve precious blood products.

An updated Cochrane review from November 2011 addresses the effects of antifibrinolytic agents on mortality and transfusion requirements in trauma patients with significant hemorrhage. Twelve electronic databases including PubMed and Medline were searched from 1966 to the present. All four studies in this review were randomized controlled trials. The purpose of the review was to examine the effects of antifibrinolytic drugs in trauma patients with bleeding or risk for bleeding. The primary outcome was mortality, and secondary outcomes were adverse events, unexpected surgical intervention, blood transfusions, and volume of blood transfused.

The reviewers concluded that the antifibrinolytic drug, tranexamic acid (TXA), reduces all-cause mortality in bleeding trauma patients. There was no apparent increase in the risk of vascular occlusive events or in the risk of receiving one or more surgical interventions. TXA administration was not associated with a reduction in either number of blood transfusions or volume of blood transfused. The CRASH-2 study authors suggest that these findings could relate either to decisions to transfuse made early in the patients' treatment or to the fact that reduced mortality in the intervention group led to increased stays during which transfusions could be given. Statistical evidence demonstrated reduction in mortality from hemorrhage by about one-sixth.

Future research should explore how TXA may also be used in other scenarios where bleeding is life threatening or disabling and what effects it may have on disability in patients with isolated traumatic brain injury.

Based on this evidence, the British military has started saving wounded soldiers with TXA in Afghanistan, and civilian trauma centers globally are adopting TXA protocols.

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Advanced practice nursing

■ Newhouse, R., Stanik-Hutt, J., White, K., Jogantgen, M., Bass, E., Zangaro, G., . . . Weiner, J. (2011). Advanced practice nurse outcomes 1990-2008: A systematic review. *Nursing Economics*, 29(5), 1-21.

The Affordable Care Act of 2010 will enable 32 million more Americans to access health care, increasing the need for providers. Currently, the number of nurse practitioners (NPs) is increasing and the number of physicians choosing to practice in the primary care setting is decreasing (Institute of Medicine, 2011). This data supports the need to continue educating advanced practice nurses (APN) to meet the healthcare needs of Americans. Furthermore, the data reflects four key messages stated by the Institute of Medicine, suggesting that nurses should practice within their full scope of practice, continue in the lifelong education path, be full partners in the restructuring of the American healthcare system, and advocate in the planning and policy of data collection and information infrastructure.

A systematic review published in *Nursing Economics* compared healthcare providers' patient outcomes. The authors searched PubMed, the Cumulative Index to Nursing and Allied Health Literature, and Proquest databases for each APN group: NP, clinical nurse specialist, certified nurse midwife (CNM), and certified registered nurse anesthetist. The team identified 69 randomized controlled trials and 49 observational studies conducted in the United States between 1990 and 2008.

An APN technical expert panel identified pertinent systematic review studies and rated the studies. Two evaluators independently rated each article for outcomes in each APN group. A minimum of three studies with a similar outcome was required for inclusion. The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) tool was used to aggregate the outcomes. Effect size was not calculated but significance was identified.

The NP evidence was rated high with outcomes equivalent to medical doctor outcomes. The clinical nurse specialist evidence was high to moderate, and the outcomes reflect lower patient care cost, shorter hospital length of stay, better patient satisfaction, and fewer patient complications. The CNM aggregate evidence was rated high to moderate, and outcomes noted lower rates of caesarean sections, epidurals, and episiotomies, less analgesia used on labor patients, and fewer third- and fourth-degree perineal lacerations. The CNM outcomes comparable to other providers include rates of low Apgar scores, low birth weight, labor augmentation, and labor induction. The CRNA studies did not meet the criteria and were not included.

The systematic review demonstrates that APNs provide safe, quality patient care and supports the role of APNs as equal partners in healthcare reform. APNs must continue, however, to demonstrate effective practice with continued clinical research.

REFERENCES

Institute of Medicine. (2011). *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press.

Joyce Scarpinato, SUNY Upstate Medical University, Syracuse, NY

CE Activity: Increased Autonomy for Nurse Practitioners as a Solution to the Physician Shortage

Thank you for your participation in Increased Autonomy for Nurse Practitioners as a Solution to the Physician Shortage, a new 0.7-hour CE activity offered by NYSNA. NYSNA members and non-members are invited to take part in this activity, and you do not need to be a resident of New York State.

GOAL:

To increase awareness of the importance of nurse practitioners to be politically involved and move legislative agendas to bring about change.

OBJECTIVES:

By completion of the article, the reader should be able to:

1. Identify what will keep people healthy across the life span.
2. Recall what the Affordable Care Act will promise.
3. List how nurse practitioners can influence health care.
4. Discuss the scope of practice for nurse practitioners in New York.

Please answer the questions below. Remember to complete the answer sheet on page 27 by putting the letter of your corresponding answer next to the question number. Each question has only one correct answer. A score of 80% is needed to successfully pass this posttest.

The 0.7 contact hours for this program will be offered until October 16, 2014.

1. What will keep people in the United States healthy across the life span?
 - (a) More students being admitted to medical school.
 - (b) Increased number of nurse practitioners.
 - (c) Increased number of primary care providers.
 - (d) Distribution of the document *Healthy People 2020*.
2. What does the Affordable Care Act promise?
 - (a) Equality to a healthcare delivery system.
 - (b) Solve our healthcare problems.
 - (c) Free medication.
 - (d) More primary care providers.
3. Why is it important to understand legislative requirements in each state that affect a nurse practitioner's scope of practice?
 - (a) To understand how this scope of practice in turn affects the delivery of health care.
 - (b) To move legislative agendas to bring about healthcare change.
 - (c) To shift attention away from clinical issues.
 - (d) a and b.
4. New York State requires physician involvement for diagnosing and treating patients with a required written documentation for nurse practitioners. This statement is indicative of a collaborative model that best describes:
 - (a) Educational preparation for nurse practitioners.
 - (b) A way to address emerging physician shortages.
 - (c) Scope of practice for nurse practitioners.
 - (d) An agreement that is required only for the nurse practitioner's first 2 years of practice.
5. How can nurse practitioners influence the delivery of health care?
 - (a) Shift their focus from individualism to social advocacy and solidarity.
 - (b) Join their state associations and become politically involved.
 - (c) Be consistent in working towards legislative goals.
 - (d) All of the above.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

NYSNA has nothing to declare related to this educational activity. NYSNA wishes to disclose that no commercial support was received for this educational activity.

All planners/authors involved with the development of this independent study have declared that they have no vested interest.

CE Activity: Barriers to Practice and Impact on Care: An Analysis of the Psychiatric Mental Health Nurse Practitioner Role

Thank you for your participation in Barriers to Practice and Impact on Care: An Analysis of the Psychiatric Mental Health Nurse Practitioner Role, a new 0.7-hour CE activity offered by NYSNA. NYSNA members and non-members are invited to take part in this activity, and you do not need to be a resident of New York State.

GOAL:

To inform the reader of the latest developments in barriers to practice for nurse practitioners in New York State.

OBJECTIVES:

By completion of the article, the reader should be able to:

1. Identify specific barriers to practice for nurse practitioners.
2. Discuss the opposition that exists around changes of statutory collaboration.
3. Report and discuss the implications for practice once the Nurse Practitioner Modernization Bill passes.

Please answer the questions below. Remember to complete the answer sheet on page 27 by putting the letter of your corresponding answer next to the question number. Each question has only one correct answer. A score of 80% is needed to successfully pass this posttest.

The 0.7 contact hours for this program will be offered until October 16, 2014.

1. Give three examples of barriers to practice for the nurse practitioner:
 - (a) Staffing ratios, complicated diagnostic tasks, lack of physician availability.
 - (b) State's scope of practice issues, restrictions on reimbursement, physician dominance.
 - (c) Physician's recommendations of practice, prescribing practices, availability of NP partners.
 - (d) Nurse Practitioner Modernization Bill, changing education law, the Nurse Practitioner Professional Association.
2. The name of the current New York State Nurse Practitioner Association Bill that would allow for removal of collaboration agreements:
 - (a) Removal of Statutory Collaboration Bill
 - (b) Global Signature Bill
 - (c) Mental Health Bill
 - (d) Nurse Practitioner Modernization Bill
3. A nurse practitioner (NP) can become involved in healthcare policy change by:
 - (a) Writing letters to legislators and asking patients to write letters in support of NP practice.
 - (b) Make visits to local and state legislator's offices to explain NP practice.
 - (c) Join a professional organization that offers political lobbying for the profession.
 - (d) All of the above.
4. Nurse practitioners are allowed to set up independent practices in New York State. True or False?
 - (a) False – A nurse practitioner cannot set up an independent practice.
 - (b) True – Nurse practitioners can set up an independent practice, with a collaborating physician practice agreement, meeting with the physician once a quarter for chart reviews.
 - (c) True – Nurse practitioners can set up an independent practice, with a collaborating physician that is available to the NP for quarterly record reviews, and for consultation at the request of the NP throughout practice.
 - (d) True – Nurse practitioners can set up an independent practice in New York State with a supervising physician.
5. Enrollment in psychiatric residency and nurse practitioners specializing in psychiatric mental health nursing have been on a steady increase in the past 5 years.
 - (a) True
 - (b) False

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NYSNA has nothing to declare related to this educational activity. NYSNA wishes to disclose that no commercial support was received for this educational activity.

All planners/authors involved with the development of this independent study have declared that they have no vested interest.

CE Activity: Obesity Risk in Urban Adolescent Girls: Nutritional Intentions and Health Behavior Correlates

Thank you for your participation in Obesity Risk in Urban Adolescent Girls: Nutritional Intentions and Health Behavior Correlates a new 0.7-hour CE activity offered by NYSNA. NYSNA members and non-members are invited to take part in this activity, and you do not need to be a resident of New York State.

GOAL:

To increase awareness of the obesity risks of urban adolescent girls.

OBJECTIVES:

By completion of the article, the reader should be able to:

1. Describe the factors that contribute to the risk of obesity in urban adolescent girls.
2. Identify the components that contribute to formation of behavior intention.
3. Describe the challenges to promoting healthy behaviors in urban adolescent girls.

Please answer the questions below. Remember to complete the answer sheet on page 27 by putting the letter of your corresponding answer next to the question number. Each question has only one correct answer. A score of 80% is needed to successfully pass this posttest.

The 0.7 contact hours for this program will be offered until October 16, 2014.

1. Factors that increase the risk of obesity in urban adolescent girls include:
 - (a) Low levels of physical activity.
 - (b) Poor sleep patterns.
 - (c) Poverty.
 - (d) All of the above.
2. All of the following are central to the theory of planned behavior except:
 - (a) Attitude contributes to the formation of behavior intention.
 - (b) A sense of control is not integral to behavior intention.
 - (c) Subjective norm contributes to behavior intention.
 - (d) Stronger intention increases the chance of engaging in a behavior.
3. The percentage of girls who reported meeting the AHA recommendations for physical activity was:
 - (a) 10%
 - (b) 14%
 - (c) 24%
 - (d) 30%
4. Nutrition intentions of adolescent girls were related to the other health behaviors of being active and getting adequate sleep.
 - (a) True
 - (b) False
5. Interventions to encourage urban adolescent girls to adopt healthy behaviors should include:
 - (a) Promote increased sleep and physical activity.
 - (b) Active engagement in local, regional, and state-wide levels.
 - (c) Tell girls what they must eat to be healthy.
 - (d) a and b.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

NYSNA has nothing to declare related to this educational activity. NYSNA wishes to disclose that no commercial support was received for this educational activity.

All planners/authors involved with the development of this independent study have declared that they have no vested interest.

The Journal of the New York State Nurses Association, Vol. 42, No. 1 & 2
Answer Sheet

Please print legibly and verify that all information is correct.

First Name: _____ MI: _____ Last Name: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Daytime Phone Number (include area code): (_____) _____
 Profession: _____ Currently Licensed in NY State? Yes / No (circle one)
 NYSNA Member # (if applicable): _____ License #: _____ License State: _____

ACTIVITY FEE: (Per activity) \$5 NYSNA members/\$10 non-members
Special pricing! Complete two *Journal* activities and get the third for free.

PAYMENT METHOD

Check—payable to New York State Nurses Association (please include “Journal CE” on your check)
 Credit card: Mastercard Visa Discover American Express
 Card Number: _____ Expiration Date: ____/____/____ CVV# _____
 Name: _____ Signature: _____
 Date: ____/____/____

The contact hours for these CE activities will be offered until October 16, 2014.

Please print your answers in the spaces provided below. **There is only one answer for each question.**

Increased Autonomy for Nurse Practitioners as a Solution to the Physician Shortage

1. _____
2. _____
3. _____
4. _____
5. _____

Barriers to Practice and Impact on Care: An Analysis of the Psychiatric Mental Health Nurse Practitioner Role

1. _____
2. _____
3. _____
4. _____
5. _____

Obesity Risk in Urban Adolescent Girls: Nutritional Intentions and Health Behavior Correlates

1. _____
2. _____
3. _____
4. _____
5. _____

Submit both the answer sheet and course evaluation form along with the activity fee for processing.

Mail to:
 NYSNA, attn EPR
 11 Cornell Rd.
 Latham, NY 12110

Or fax to:
 (518) 782-9533

Course Evaluation

Increased Autonomy for Nurse Practitioners as a Solution to the Physician Shortage

	Poor	Fair	Good	Very Good	Excellent
1. The content fulfills the overall purpose of the course.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The content fulfills each of the course objectives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The course subject matter is current and accurate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The material presented is clear and understandable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The teaching/learning method is effective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The test is clear and the answers are appropriately covered in the course.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How would you rate this course overall?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Time to complete the entire course and the test?	_____ Hours (enter 0-99)		_____ Minutes (enter 0-59)		
9. Was this course fair, balanced, and free of commercial bias?	Yes / No (circle one)				
10. Comments:	_____				
11. Do you have any suggestions about how we can improve this course?	_____				

Barriers to Practice and Impact on Care: An Analysis of the Psychiatric Mental Health Nurse Practitioner Role

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5. The teaching/learning method is effective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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10. Comments:	_____				
11. Do you have any suggestions about how we can improve this course?	_____				

Obesity Risk in Urban Adolescent Girls: Nutritional Intentions and Health Behavior Correlates

	Poor	Fair	Good	Very Good	Excellent
1. The content fulfills the overall purpose of the course.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The content fulfills each of the course objectives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The course subject matter is current and accurate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The material presented is clear and understandable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The teaching/learning method is effective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The test is clear and the answers are appropriately covered in the course.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How would you rate this course overall?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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10. Comments:	_____				
11. Do you have any suggestions about how we can improve this course?	_____				

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