You are completing your nurse practitioner (NP) education, likely one of the most challenging tasks you have ever undertaken. Now, NP certification and licensure loom in your future. You probably have spoken to a number of certified and practicing NPs about these issues. Much of the information shared is helpful. However, there is also a good deal of inaccurate information circulating. Here are some common myths and realities about these important subjects.

**Myth:** Once I am nationally certified, I am also licensed to practice as an NP.

**Reality:** In nearly all states, achievement of national certification is one of a number of requirements to obtain a license as a nurse practitioner. Nurse practitioner licensure is handled at the state level through the board of nursing. Information about your state’s NP practice act can be obtained by contacting your state board of nursing. Links to all of these state agencies can be found at [www.ncsbn.org/boards.htm](http://www.ncsbn.org/boards.htm). (Accessed 9.20.12)

**Myth:** Once I am a certified NP and licensed to practice in one state, I will be able to practice in every state.

**Reality:** NP licensure is handled at the state level and regulations vary from state to state. As a result, you must meet the requirements for, and obtain a license in, every state where you practice.

**Myth:** From state to state, NP practice acts are quite similar.

**Reality:** State NP practice acts differ significantly in a number of ways. For example, in some states, an NP must have a physician collaborator to obtain prescriptive authority. Other states do not have this requirement and NPs are able to prescribe without physician oversight.

In certain states, state law mandates third-party reimbursement to NPs (this rate of reimbursement can vary significantly). While NPs have the authority to prescribe controlled substances in all but two states, the prescriptions permitted range from schedules II through V in some states.

(Myths and realities: Continued on page 9)
Breastfeeding News

Breastfeeding Appears to Decrease Risk for Ovarian Cancer
by Marie L. Bosco, BSN, RNC, IBCLC

Research reveals that there are numerous benefits of breastfeeding for both mothers and infants. One such benefit is a decrease in ovarian cancer in mothers who have breastfed. In the United States (US), nearly 20,000 cases of ovarian cancer are reported annually and more than 90% of all cases arise in the epithelium of the ovary. Evidence suggests that ovulation or associated reproductive hormones play a role in the development of epithelial ovarian cancer. Breastfeeding alters these hormones and may influence ovarian cancer risk.

The journal Cancer Causes and Control recently published the paper “Breast-feeding and risk of epithelial ovarian cancer” by S. J. Jordan, et al. In this paper, researchers reported data that supported the idea that there was a decreased risk of epithelial ovarian cancer in mothers who choose to breastfeed. Studies published prior to this have suggested that women who have ever breastfed have a 30% reduction in risk of ovarian cancer. However, it is unclear how the duration of breastfeeding or the timing of introduction of supplementary feedings alters the risk.

In this study, which included participants from Washington state, 881 women who had at least one birth were assessed for relationship between breastfeeding and ovarian cancer. These women were diagnosed with primary invasive or borderline epithelial ovarian tumors from 2002-2007. Case women were identified through the cancer surveillance system that is part of the US National Cancer Institute. The control women were gathered through random digit dialing (1,345 cases). This study was limited to women who had at least one live birth. Among these women, those who had breastfed a child for at least 2 weeks had a 22% reduction in risk of ovarian cancer compared to those who never breastfed. The risk reduction also seemed to decrease with longer durations of breastfeeding per child. Those who had breastfed at least one child for 18 months or more had a 43% reduction in risk compared to those who never breastfed. Women who breastfed each child for 18 months or more had a 44% reduction in risk of ovarian cancer compared to those who never breastfed. Women with only one live birth who breastfed for 18 months or more had nearly 70% reduction in ovarian cancer risk. Finally, an average of 6 months or more of breastfeeding per child was associated with a 27-35% reduction in ovarian cancer. The introduction of supplementary foods or drinks did not significantly alter the benefit results.

According to the study, the reason for this cancer risk reduction could be related to the fact that breastfeeding suppresses gonadotropin hormones, which decrease estrogen levels. This decrease in estrogen prevents ovulation, and when breastfeeding, is referred to as lactational amenorrhea. Estrogens are known causes of certain types of ovarian cancer, thus decreasing these levels through breastfeeding provides protection among women who choose to breastfeed.

References:

What Our Friends Say on Facebook

Amy
I passed my AANP exam yesterday after taking the FHEA Review Course in February and using your review book. Thank you Margaret and FHEA for helping me be well-prepared!
Like · Comment · September 28 at 4:40pm

Ashley
Took the ANP review course w/Louise McDevitt in ATL 2 wks ago, passed my boards today! I can’t say enough good things about the course & the quality of FHEA instruction materials & have encouraged all of my classmates who graduate after me to take a review course. FHEA made such a great impression, it will be my 1st choice for all pharm & non-specialty CEUs in the future! Thank You!
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Boston Hospital Named Top IT Innovator in US
Beath Israel Deaconess Medical Center, Boston, Massachusetts, (BIDMC) has taken the top spot on this year’s InformationWeek’s 500 list of innovators for business technology for 2012. BIDMC has been a pioneer in incorporating technology into their every day work for years, but it is their most recent program, Clinical Query, that helped the hospital beat out the other 499 companies for the top spot on this year's list. Clinical Query is an internal search engine that gives hospital employees the chance to see any correlations between a given condition and the factors that may have caused it. It is connected to detailed medical records of over 2 million patients. Essentially, the software acts as an investigative tool to develop and prove theories of a given health condition by drawing relationships between certain healthcare factors and a disease. If a formal clinical trial should be pursued, Clinical Query automatically sends a letter of request to the patient’s primary care providers (PCPs). This software allows providers to treat larger populations of people which, in turn, cuts costs and provides quality care to both an individual patient and the community. The information technology team at BIDMC, led by Chief Information Officer John Halamka, has always considered technology in healthcare to be a priority. The hospital has been using electronic health records (EHRs) since 1985 and started using iPads in their emergency room just one hour after the product was launched in stores. Hamalka is currently working on expanding the Clinical Query database to include EHRs from private healthcare practices and other clinics in the community to better manage the health of larger populations.

Read more

WV NP Urges Lawmakers to Remove Scope of Practice Barriers
Family nurse practitioner (FNP) and owner of Health Thru Care, LLC in Morgantown, West Virginia, Toni DiChiacchio spoke to West Virginia lawmakers last month in effort to change the state’s collaborative practice laws and allow nurse practitioners (NPs) to practice independently and with prescriptive authority. According to DiChiacchio, 40% of patients at Mon General Hospital in Morgantown, West Virginia, do not have a primary care provider (PCP). Also, many physicians have been heading into specialty fields, causing a shortage in primary care physicians. This means that patients being discharged from Mon General Hospital are not able to see a physician for follow-up appointments because their schedules are too full. According to DiChiacchio, allowing advanced practice registered nurses (APRNs) to practice autonomously would fill the gap in West Virginia and provide patients across the state with better access to PCPs. Also, APRNs would allow patients living in rural areas convenient access to healthcare. Dr. Hoyt Burdick, president of the West Virginia Medical Association, told legislators that removing collaborative practice agreements would not benefit patients since the new approach to healthcare is team-based with a physician leading the team. According to Burdick, patients prefer to know that a physician is involved in their treatment. DiChiacchio told the legislative panel that NPs have been seeing patients for more than 40 years and research shows no negative implications when NPs practice autonomously.

Read more

PAs Form New Professional Group
A small group of physician assistants (PAs) have announced the launch of a new professional organization, PAs for Tomorrow (PAFT), dedicated to advancing the role of the PA and promoting awareness of the PAs as autonomous and competent medical care providers. The new organization aims to develop a new definition of PAs, increase research performed on the profession and work to remove scope of practice barriers, among other goals. Several members of other PA professional organizations have agreed that PAs should change their formal title to "physician associate," to more accurately portray their skill level. Also, after the results from the Institute of Medicine’s (IOM) study on the Future of Nursing have proven to be effective in advancing the role of nurse practitioners (NPs), PAFT hopes to have a similar study conducted by the IOM on the future of PAs. PAFT is a membership organization and features five tiers of membership including an Affiliate Membership for NPs or other clinicians that believe in the PAFT mission. Students looking to enroll into a PA program can also become members of PAFT.

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Since becoming a family nurse practitioner (FNP) more than 32 years ago, Margaret Flinter, PhD, FNP-BC, FAANP, has been a prime example of an NP leader within a federally qualified health center (FQHC) practice setting. In 1980, Dr. Flinter became the first NP to work for Community Health Center, Inc. (CHC), a FQHC with 13 locations in Connecticut. She is currently the senior vice president and clinical director for CHC and is also the founder and director of the clinic’s center for research and development, the Weitzman Center for Innovation in Community Health and Primary Care. Five years ago, she established the first primary care NP residency program in the nation, which operates out of CHC and has paved the way for similar programs. The latter accomplishment has resulted in national recognition for Dr. Flinter and her NP residency program model.

In September 2007, Dr. Flinter and her colleagues at CHC welcomed four NP residents to the first NP residency program in the United States (US). The program, which is 12 months full-time, is open to board certified FNPs who are licensed to practice and prescribe in Connecticut and have completed their graduate education at the master’s or doctoral level within 18 months of applying. Residents in pairs of two join a team comprised of NPs, medical doctors (MD), medical assistants, and primary care nurses at one of four CHC locations qualified to host the program.

The CHC residency program model begins with a 4-week orientation. The overall program structure includes four main elements: precepted clinics, specialty rotations, didactic sessions, and independent clinics. Residents spend 40% of each week practicing alongside an NP or MD preceptor at CHC, during which time they amass a patient panel that consists of those who are new to the clinic. Each resident spends 12 hours a week in a 10-month specialty rotation, which is intended to provide knowledge of areas of practice that would often be referred out of primary care. Once a week, residents partake in a didactic session on clinical challenges that are encountered in FQHCs. Case studies are presented by residents as part of these sessions. Twice a week, they practice with patients of their primary care provider colleagues to increase their understanding of episodic and acute care problems. Other elements include an on-call rotation with back-up, participation in quality improvement initiatives and in clinic and community events and meetings.

The effort that Dr. Flinter has put into CHC’s NP residency program has not gone unnoticed. Section 5316 of the Patient Protection and Affordable Care Act (PPACA) authorized the US Health Resources and Services Administration to create a 3-year demonstration program for NP residencies in FQHCs and nurse-managed health clinics. Today, eight organizations in six states offer NP residency programs based on Dr. Flinter’s model (See Figure 1 below). These organizations have incorporated an orientation, precepted clinic and didactic sessions into their program. All but one has included specialty rotations and all but two have included specialty clinics.

(NP Firsts: Continued on page 6)
FHEA 25th Anniversary Resort Destinations

Learn about the latest in drug therapy with Dr. Margaret A. Fitzgerald as she presents the FHEA Pharmacology Update in desirable resort settings.

Topics Include:
- Drug Update: New products, new indications, new warnings
- Pharmacogenomics: Exploring genetic variations in drug metabolism
- Antimicrobial Update: A focus on treatment recommendations in urinary tract infections (UTI)
- Prescribing in the Presence of Impaired Renal Function
- Depression: A primary care approach to assessment and intervention
- As Seen on TV: What's in the OTC and Herbal Products Your Patients Are Taking?

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January 17-18, 2013

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Falmouth, Cape Cod, Massachusetts
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September 13-20, 2013

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FHEA 25th Anniversary Caribbean Cruise
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March 8-16, 2013
Earn 9 Contact Hours!

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- A sightseeing tour in San Juan with pickup at hotel and drop off at the ship (includes gratuities)
- Luggage transfer from hotel to ship
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This course begins at port on the afternoon of March 9th. Booking your travel arrangements through University at Sea is the only way to ensure early boarding to attend the first day of class. Course registration must be completed through FHEA.

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The number of residents practicing at one time varies from one to four for each organization as does the length of the orientation. (See Figure 2) By December 2012, a total of 12 organizations will have implemented residency programs based on Dr. Flinter’s model.

Since its inception, the most significant change that the CHC residency program has undergone has been in terms of growth. This year will mark the first time that CHC will accept eight residents, rather than four. Dr. Flinter’s future goals include continuing to support the adoption of her residency model, further researching the impact of the program and securing long-term funding and authorization for NP residency programs.

The following is a question and answer session with Margaret Flinter, PhD, FNP-BC, FAANP.

**Question:** What do you hope to accomplish through the creation of your residency model?

**Answer:** We have an immediate and long-term need for primary care providers in the United States; primary care providers who are expertly educated and trained to the full spectrum from prevention and health promotion to chronic disease management and acute care, and who understand how to do this in the context of managing a panel and a population while engaging with the neighborhood and community in which their patients and families live, work and study. This is how we are going to improve health outcomes and transform communities in America. The national policy debate continues to place enormous emphasis on creating incentives and strategies to entice physicians to choose primary care. While I support those efforts, I also insist that we ask the question: “Who wants to be a primary care provider? What resources and strategies do we need to put in place to support them?” NPs overwhelmingly express a preference for primary care as their practice specialty area, and my goal in creating the residency is to give them the support and training they need to enter practice successfully and build vibrant careers as primary care providers, particularly in the nation’s safety net [FQHCs]. And while I haven’t discussed the Affordable Care Act yet, of course this becomes ever more urgent as millions of Americans become insured for the first time and seek previously deferred primary care and a primary care provider.

**Question:** What are your thoughts on Amendment 5316 of the PPACA? How do you think it will impact NP practice?

**Answer:** Section 5316 of the ACA is a brilliant amendment in search of the funding to make it happen! The quick story behind it is that my colleagues at CHC and I have worked very hard since 2007 to educate Congress about these issues we have discussed here, and the need for and benefits of developing residency training for NPs. We were invited to do a Capitol Hill briefing in 2009, and a Health Policy Fellow, Dr. Jacqueline Rychnovsky, also an NP, was inspired to take this issue up. She was instrumental in getting support from key members of Congress, particularly Senator Chris Dodd and Senator Daniel Inouye. It was passed as part of the ACA but without a specific funding authorization, and we have continued to fight for funding for the past 2 years. The obvious benefit of funding Amendment 5316 would be to allow a number of community health centers as well as nurse-managed health centers to get programs up and running, in a fairly consistent and standardized way. That’s how we are going to move forward as a national model that ultimately secures a sustainable funding stream whether through GME [graduate medical education], Medicaid GME, or some other funding vehicle.

**NP Firsts: Continued from page 4**

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**NP Residency Program Expansion 2007-2012**

<table>
<thead>
<tr>
<th>Year</th>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Middlesex, CT</td>
<td>Community Health Center, Inc. establishes the first NP Residency (4 residents)</td>
</tr>
<tr>
<td>2009</td>
<td>Worcester, MA</td>
<td>Family Health Center of Worcester (2 residents)</td>
</tr>
<tr>
<td>2011</td>
<td>Philadelphia, PA</td>
<td>Puentes de Salud (1 resident)</td>
</tr>
<tr>
<td>2011</td>
<td>Austin, TX</td>
<td>CommunityCare and University of Texas, Austin School of Nursing (2 residents)</td>
</tr>
<tr>
<td>2012</td>
<td>Bangor, ME</td>
<td>Penobscot Community Health Care (2 residents)</td>
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<tr>
<td>2012</td>
<td>Los Angeles, CA</td>
<td>Union Rescue Mission Health Center and UCLA (2 residents)</td>
</tr>
<tr>
<td>2012</td>
<td>San Francisco, CA</td>
<td>Glide Health Services and UCSF School of Nursing (2 Residents)</td>
</tr>
<tr>
<td>2012</td>
<td>Santa Rosa, CA</td>
<td>Santa Rosa Community Health Centers (4 residents)</td>
</tr>
<tr>
<td>2012</td>
<td>Tacoma, WA</td>
<td>Community Health Care (4 residents)</td>
</tr>
</tbody>
</table>

**Figure 2:** Courtesy of Amber Richert and Nicole Seagriff, CHC FNP Residents

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Question: Do you believe that NP residency programs should be mandatory? Why or why not?
Answer: NP's practice in an enormous variety of settings. I don't presume to have the answer for the entire field. I look to my colleagues in all the other areas to share their thoughts on the need for residency training. However, in the area in which I do consider myself an expert, I would say every new primary care NP should have access to a formal post-graduate residency training program in an organization that offers training to a high performance model of care. This is a point I would like to stress. When we accept NP residents, we are not doing this as "pre-employment" training or preparation for employment at CHC. There is no commitment on our part to hire them or on their part to remain, though I am delighted if they do! An organization has to make a huge contribution in that setting.

Question: What are your future goals with regards to NP residency programs nationally and at CHC?
Answer: Our goals center on refinement, scalability, replication, and sustainability. We have completed one formal research study (case study) but are ready for a full-scale evaluation of the past 5 years, expanding to include the new NP residency programs now operating. As we move forward, we are thinking about the issue of accreditation or certification as we begin to reach a critical mass—we aren’t there yet, but that is likely coming in the future and of course, sustainability and funding remains the biggest obstacle to widespread development of NP residency programs. On that front, I continue to work through the legislative process on funding Section 5316, to dialogue with my national colleagues in community health centers about expanding the Teaching Health Center initiative to include NP residency, and to urge state Medicaid leaders to consider using the option of Medicaid GME funding as a vehicle for development and sustainability, as Medicaid is perhaps the most direct payor beneficiary of the benefits of an expert primary care provider workforce in community health centers. In all of this, I am deeply grateful for the support of so many individuals and organizations, from Capitol Hill to national, state, and local organizations, to my own incredible team of colleagues at CHC and of course, to that initial class of residents in 2007 and the subsequent classes that have followed. They are the ones who inspire us to continue this exciting and innovative work.

For more information on the CHC NP residency program, please visit: www.npresidency.com.

FHEA Raffle Winners

Fitzgerald Health Education Associates, Inc., recently held a raffle drawing at the 24th Annual Texas Nurse Practitioner Conference in Austin, Texas. We would like to congratulate Gail Messner for winning Nurse Practitioner Certification Examination and Practice Preparation, 3rd edition, by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC. We would also like to congratulate Michelle Butaud for winning the boxed book set of four Cherry Ames Nursing Stories, by Helen Wells. Raffles are held at all of our exhibit locations. For a list of upcoming FHEA exhibit locations, please turn to page 8.
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Dr. Fitzgerald’s Upcoming Speaking Engagements

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<th>Date</th>
<th>Location</th>
<th>Topics</th>
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<tr>
<td>Oct. 29-30, 2012</td>
<td>Iowa Nurse Practitioner Society 14th Annual Conference West Des Moines, Iowa</td>
<td>Iowa Nurse Practitioner Society 14th Annual Conference West Des Moines Marriott Hotel 1250 Jordan Creek Parkway West Des Moines, IA 50266 More information here</td>
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Come see FHEA in person!
FHEA will be exhibiting at the following locations:

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<th>Date</th>
<th>Location</th>
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<tr>
<td>Oct. 11-13, 2012</td>
<td>American Academy of Nursing 39th Annual Conference Washington, DC</td>
</tr>
<tr>
<td>Oct. 29-30, 2012</td>
<td>Iowa Nurse Practitioner Society 14th Annual Conference West Des Moines, Iowa</td>
</tr>
</tbody>
</table>
(Myths and realities: Continued from page 1)

to II to V only in others. Make sure you are aware of the scope of NP practice and particulars of the NP practice act in each state where you are licensed.

Myth: You should have at least 6 months of NP practice experience prior to sitting for the certification exam.
Reality: The certification examination content is primarily focused on entry-level NP knowledge. As adult learners, NPs tend to feel more ownership of information that has been used in clinical practice. As a result, you might feel more comfortable sitting for the examination after a few months of practice. However, some states limit the length of time or put other restrictions on NP practice prior to obtaining certification. In addition, you cannot apply for reimbursement by Medicare and some private insurers until certified. As a result, a potential employer could require certification as a condition of employment.

Myth: The content of the test tends to be limited to a few areas.
Reality: Examination content tends to be broad, reflecting the depth and breadth of NP practice, representing the array of patients seen in the average NP’s practice over an extended period of time, such as a year, rather than the mix seen in an average day. The examination candidate who reports that the test content was narrowly focused likely can only recall the areas in which he or she had the most difficulty.

Myth: The test questions are presented in topic groups.
Reality: The topics covered in the exam are presented in random order. For example, a family nurse practitioner candidate could face a question about a middle-aged man with diabetes mellitus followed by one about a child with a fever, followed by one about prescribing an antimicrobial for a pregnant woman with a urinary tract infection. The acute care NP candidate might face a question about a person with altered mental status followed by a question about a person presenting with chest pain.

Myth: On the computer-based tests, you cannot go back to change an answer or review a question.
Reality: The computer-based NP exams do have a mechanism for flagging questions for review. You can also change an answer prior to signing off.

Myth: Many certification candidates run out of time and are unable to complete the test.
Reality: The length of time provided to complete the examinations is sufficient for most candidates, allowing for both answering the questions and review of difficult items. The American Nurses Credentialing Center allocates 3 1/2 hours for a 175-item test and 4 hours for a 200 item, (ANCC; Web site at www.nursecredentialing.org) while the American Academy of Nurse Practitioners allows 3 hours for a 150-item test (AANP; Web site at www.aanpcertification.org). The National Certification Corporation allocates 3 hours for a 160-item test (NCC; Web site at www.nccwebsite.org), while the Pediatric Nursing Certification Board allows 3 hours for a 175-item test (PNB; Web site at www.pncb.org).

Myth: Practice tests represent the best way to prepare for the NP boards.
Reality: While practice tests are a helpful study aid, this method is best used to finish, not start, your study. Your study time is best spent developing a deep understanding of the nature of NP practice. Knowing what to expect on the exam will help you prepare for the test as well as for clinical practice.

Click here for Fitzgerald Health Education Associates, Inc. NP Certification Review and Advanced Practice Update live courses dates.

What our Customers Say...

“I attended the FNP certification review class taught by Christy Yates in Oakbrook, Illinois, in September and wanted to say how helpful I found the review class. I passed the ANCC-FNP exam and felt really prepared and comfortable with the questions. The on-line tutorials were really helpful and provided pertinent information that helped supplement the live class. Christy was an excellent speaker and teacher.”
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- Testing can be timed.
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  - **Report II** includes a detailed report of how each test taker scored on each topic area covered in the given test.

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Letters to FHEA

Editor’s Note: FHEA welcomes feedback from our customers about our products and our publications. To submit feedback about our products, e-mail cs@fhea.com. To submit feedback on our newsletter, please e-mail newsletter@fhea.com.

Dear Dr. Fitzgerald and FHEA Staff,

I would like to take a moment to personally thank you for your help and dedication to the students of Concordia University of Wisconsin Doctor of Nursing Practice (DNP) Program. As part of the DNP program I am attending, Family Nurse Practitioner (FNP) students are trained to practice at the highest level of independent nursing practice through multiple courses including a clinical residency course. During the DNP’s clinical residency, advanced application of clinical problem-solving is facilitated through complex case studies, lectures on how to care for complex patients with multiple co-morbidities, and utilization of evidence-based practices.

When planning my week to facilitate advanced patient management, I contacted your office to ask permission to utilize a lecture on anemia. I wanted to utilize Dr. Fitzgerald’s lecture because she goes beyond the basics, utilizing a variety of complex patient scenarios to teach principles of laboratory analysis. Further, she breaks down complex concepts that are often overlooked and not taught in MSN programs. This lecture has allowed for better understanding of interpretation of basic and advanced lab indices, evidence-based recommendations in treating a variety of anemias, and most importantly how to communicate with hematologists and specialists in advanced cases of blood dyscrasias.

Dr. Fitzgerald, you have certainly demonstrated your commitment to advancing the profession of the nurse practitioner, and the DNP students of Concordia University of Wisconsin sincerely thank you and your team for making this lecture available to our class. I would recommend, without hesitation, your lectures to any advanced practice nurse wanting to increase their clinical knowledge. Further, I plan to work with you and your staff in the future when teaching in the college arena! Thank you so much!

-Ryan Mallo DNPc, FNP-C, RN

Contact Hour Tracker

Never lose track of your certification, professional license and contact hour data again!

Thousands of your colleagues have already discovered this time-saving tool. Contact Hour Tracker is a no-cost internet service available on FHEA’s NP Expert website.

- Store all your certification and license documentation dates and CE requirements.
- Keep track of all your continuing education hours as they occur.
- Contact Hour Tracker logs FHEA earned contact hours automatically.
- Enter contact hours from any CE provider.
- Monitor deadlines and CE requirements for multiple agencies.
- Track your progress toward contact hour goals.
- Set up electronic “alarm clocks” to receive automatic e-mail reminders for all upcoming license and certification renewal dates.
- Print contact hour summaries by category and source to help complete certification and license renewal paperwork.

Go to www.npexpert.com to register.

Need a Speaker?

If you are interested in having Dr. Fitzgerald or one of our other talented associates speak at your school, local, regional or national conference, please e-mail: services@fhea.com for more information. Conference administrative services are also available.

Important System Update Information

Routine maintenance is scheduled for October 20, 2012. FHEA is committed to providing our customers maximum uptime, reliability and security for our On-line Testing and Learning Site, www.npexpert.com. Regular system maintenance is critical to achieving this goal and is normally performed the third Saturday of each month.
Earn 6 Contact Hours!

Wound repair is a necessary skill for all NPs and PAs. The art of suturing is the process of preparation, thinking, documentation, taking a good history and physical examination, immunizing your patient, delivering the proper type of anesthesia, and performing a professional suture. This workshop will be a full day course with the utilization of a pig’s foot, anesthesia tips, 4-0 nylon suture, and a disposable stapler. Dermabond and other newer products will be covered as an introduction to the use of a bio-adhesive in the care of lacerations. We will start with the “keystone stitch,” which is the simple suture. We will move on to running sutures, horizontal mattress sutures, vertical mattress sutures, and running intra-cuticular stitches. Malpractice prevention techniques will help secure your future.

The Art of Wound Repair:
Suturing for NPs and PAs

January 31, 2013
Manhattan, New York

June 15, 2013
Milwaukee, Wisconsin

Presented by:
Robert Blumm, MA, PA-C, DFAAPA

Clinical Pharmacology for NPs and Advanced Practice Clinicians

October 15-20, 2012
Holiday Inn Express Downtown
920 Broadway
Nashville, TN 37203

March 18-23, 2013
Crowne Plaza Atlanta Perimeter At Ravinia
4355 Ashford-Dunwoody Rd
Atlanta, GA 30346

Presented by:
Margaret A. Fitzgerald,
DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC
Sally K. Miller,
PhD, ACNP-BC, APN-BC, FNP-BC, GNP-BC, CNE, FAANP

Earn 45 Contact Hours!

This 5 ¼ day course addresses the growing need for a thorough course in the principles of pharmacotherapeutics. Prescribing has become a major part of the role of advanced practice nurses while at the same time, prescribing has become more complex and polypharmacy is more prevalent with the possibility of adverse interactions. Thus, a course of this caliber is critical to the preparation of advanced practice nurses. Because states’ requirements vary, it is important that you contact your state board of nursing for details regarding educational requirements for prescriptive authority. This course is also available on-line. (Contact hours differ from the live course.)

Margaret A. Fitzgerald’s Speaker School

April 18-19, 2013
Fitzgerald Health Education Associates, Inc.
85 Flagship Dr.
North Andover, MA 01845

Presented by:
Margaret A. Fitzgerald,
DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC
Marc W. Comstock, MBA

Earn 13 Contact Hours!

If you have ever wanted to share your practice expertise by speaking to other providers, or if you just want to improve your “platform skills,” this is the seminar for you! This intensive workshop will be led by Dr. Margaret A. Fitzgerald, one of the most experienced, well-known, and skilled NP speakers in the country. She has been widely recognized for her dynamic presentations. Hands-on presentation preparation and slide development techniques will be covered. Also learn how to improve your ”speaking voice.”

The workshop is limited to 20 participants. A personal laptop or tablet equipped with Microsoft PowerPoint will be required.

Advanced Pathophysiology for NPs and Advanced Practice Clinicians

March 25-30, 2013
Oak Brook, Illinois

This course is scheduled live annually and is also available on-line.

Presented by:
Sally K. Miller,
PhD, ACNP-BC, ANP-BC, FNP-BC, GNP-BC, CNE, FAANP
Margaret A. Fitzgerald,
DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC

Earn 45 Contact Hours!

This 5 ¼ day course is presented by highly acclaimed clinician-educators who currently maintain clinical practice, thus bringing clinical relevance to the classroom in addition to their knowledge and teaching skills in pathophysiology. FHEA instructors consistently rank at the top of speaker ratings at national conferences. Both the course material and testing material are kept up-to-date on subject matter. The electronic components of this program are updated as needed to reflect the current state of practice. This course is also available on-line. (Contact hours differ from the live course.)

Click here for more information about these and other courses