The ANCC Adult-Gerontology Primary Care NP Certification Exam: An overview

by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC

Author’s note: This article focuses on the recently announced content outline for the American Nurses Credentialing Center’s (ANCC) AGPCNP certification examination. A future article will focus on the content outline of the American Academy of Nurse Practitioner’s (AANP) adult-gerontology examination, once this information is available. The Fitzgerald Health Education Associates, Inc. 2013 NP Certification Exam Review Courses are developed with these exam content updates in mind.

In keeping with the recommendations from the Consensus Model for APRN Regulation on Licensure, Accreditation, Certification & Education, the ANCC’s adult-gerontology primary care NP (AGPCNP) certification examination will be offered for the first time in early 2013. The age ranges represented on this examination include the adolescent (13 to 17 years), adult (18 to 64 years), young-old (65 to 74 years), middle-old (75 to 84 years) and oldest-old (85 years and older). The examination contains 200 questions, a 25 question increase from the current ANCC adult or gerontology NP test. Of the 200 questions, 175 are scored questions and 25 are pretest questions that are not scored; performance on the pretest questions, which are distributed throughout the test, does not contribute to or detract from the candidate’s final score. A candidate’s score is based solely on the 175 scored questions. The test consists of three domains: Foundations of Advanced Practice Nursing, Professional Roles and Independent Practice.

Below is a summary of the ANCC’s AGPCNP exam content outline.

Foundations of Advanced Practice Nursing (33%)
- Advanced Pathophysiology
  - Content example: Physiology, pathogenesis, clinical manifestations, and etiology of altered physical/psychological health/disease states across the aging continuum, differentiating between normal and abnormal physiologic changes associated with development and aging

(ANCC AGPCNP Exam: Continued on page 6)
Breastfeeding News

August: A month to celebrate breastfeeding by Marie L. Bosco, BSN, RNC, IBCLC

World Breastfeeding Week (WBW) celebrates its 20th anniversary this year from August 1-7 with the theme “Understanding the Past-Planning the Future.” The World Alliance for Breastfeeding Action (WABA) launched its first WBW celebration with the theme of “Baby Friendly Hospital Initiative” in 1992. The focus of WBW is to facilitate actions to protect, promote and support breastfeeding. During the last 10 years, WBW has focused on the Global Strategy for Infant and Young Child Feeding (GS) which was adopted by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF). The goal of this strategy is to increase breastfeeding initiation, exclusivity (for the first 6 months) and duration. The program also aims to reach the fourth Millennium Development Goal which is to decrease the mortality rate for children younger than 5 years old by two-thirds by 2015.

According to the WBW website, the objectives for WBW 2012 are:
1. “To recall what has happened in the past 20 years on infant and young child feeding (IYCF).
2. To celebrate successes and achievements nationally, regionally and globally and showcase national work at global level.
3. To assess the status of implementation of the Global Strategy for Infant and Young Child Feeding (GS).
4. To call for action to bridge the remaining gaps in policy and programmes on breastfeeding and IYCF.
5. To draw public attention on the state of policy and programmes on breastfeeding and IYCF.”

The GS was published in 2003 and has outlined 10 areas of action for implementation, which includes having national policies and programs in place such as Baby Friendly Hospital to support breastfeeding. It also includes upholding the International Code of Marketing of Breast Milk Substitutes along with supporting mother’s health and nutrition, community and informational support, and monitoring and evaluation.

(Breastfeeding: Continued on page 10)
**NP News in Brief**

**AANP and ACNP Plan to Merge**
The American Academy of Nurse Practitioners (AANP) and the American College of Nurse Practitioners (ACNP) recently announced plans to potentially merge. The proposed unification, which has been approved by the boards of directors from both organizations, would strengthen the ways in which AANP and ACNP advocate for nurse practitioners (NPs). With AANP and ACNP working together as one, they would become the largest NP professional membership organization. According to a press release from AANP, the anticipated consolidation would allow for increased growth of NP practice and policy and also bring greater awareness and understanding of the NP role and provide NPs with enhanced resources. According to ACNP, the new organization will likely adopt the structure of AANP but with some modifications. AANP and ACNP are anticipated to complete their negotiations by the end of 2012.

**Read more from AANP**
**Read more from ACNP**

**Citalopram Hydrobromide Use (Celexa) Linked to Abnormal Heart Activity**
The US Federal Drug Administration (FDA) has issued reports to clear up confusion surrounding the new dosing recommendations for citalopram hydrobromide (Celexa). Evidence that QT prolongation can result from use of high doses of the popular antidepressant led the FDA to the limit the prescribing guidelines last year to 40 mg per day compared to 60 mg per day, the standard for previous years. Citalopram is an antidepressant that is part of the class of drugs known as selective serotonin reuptake inhibitors (SSRIs). Research analyzed by the FDA showed no benefit in high doses of citalopram hydrobromide but showed QT interval increased by 18.5 ms in patients who took 60 mg of citalopram per day after 22 days. Study participants who received a 20 mg dose per day experienced a QT interval increase of 8.5 ms while those who took 40 mg per day saw an increase of 12.6 ms. According to the new guidelines, people with certain heart conditions including congenital long QT interval, bradycardia and hypomagnesemia should not take citalopram hydrobromide; the maximum recommended dose of citalopram is 20 mg per day for patients older than 60 years of age. However, the new recommendations include cautionary measures to take if these patients need to be on the drug. The drug label of citalopram hydrobromide has been changed to include more information about the risk of QT prolongation and guidelines when prescribing in high-risk patients. QT prolongation can lead to potentially fatal cardiac rhythms including Torsade de Pointes.

**Read more**

**Vitamin D Supplementation Lowers Fracture Risks in Older Adults**
Recent research published in the New England Journal of Medicine revealed that high doses of vitamin D can help reduce the risk of fracture in patients 65 years and older. The pooled analysis included 12 studies, 11 of which involved persons 65 years of age or older who took vitamin D supplements orally alone or with calcium daily, weekly or every 4 months. In 5 of the 11 groups, participants were permitted to take vitamin D supplements outside of the studies. The results of these trials were compared to participants who were taking calcium alone or were taking placebo. The researchers found that 792-2000 IU of vitamin D per day can reduce the risk of hip fracture by 30% and the risk of non-vertebral fracture by 14% regardless of whether the person resides at home or in an institution. Approximately 75% of all fractures impact people over the age of 64.
Sneak Preview of the National NP Preparedness Survey, 2012

by Ann Marie Hart, PhD, FNP-BC
Associate Professor and DNP Coordinator
Fay W. Whitney School of Nursing, University of Wyoming, Laramie, WY

Background
In 2004, the first national survey was conducted regarding nurse practitioners’ (NPs) perceived preparedness for clinical practice after completing their initial NP educational preparation. The 2012 National NP Preparedness Survey was administered in a paper format to NPs at two national conferences: the NP Symposium in Keystone, Colorado, and the annual meeting of the National Organization for Nurse Practitioner Faculties (NONPF) in San Diego, California. Results from 562 surveys revealed that while 10% of the respondents felt “very well prepared” and 38% felt “generally well prepared” for clinical practice following their basic NP educational preparation, 38% felt “somewhat prepared,” 12% felt “minimally prepared,” and 2% felt “very unprepared.” Respondents described feeling most prepared in the areas of health assessment, differential diagnosis, pathophysiology, pharmacology, and health related teaching and least prepared in coding and billing, complementary and alternative medicine, EKG and radiology interpretation, and skills such as suturing, splinting, and simple office procedures.

In terms of improving NP education, the respondents described the need for increased rigor, increased content related to skills preparation, more clinical hours, and the option of a post-graduate residency. Although the 2004 study provided valuable data regarding NP education, it was limited by the fact that many of the respondents had received their NP education long before educational competencies were standardized; some had completed their NP education 20 or more years beforehand.

Since 2004, NP practice and education have experienced many changes, including the introduction of the Doctor of Nursing Practice (DNP) degree, changes in core competencies for NP education, the APRN consensus document, and increased autonomy and scope of practice for NPs. In order to understand newer NPs’ perceptions of their preparation for clinical practice and their transition into practice, a revised survey was developed specifically for NPs who graduated between 2006 and 2011.

Procedure
The survey and its administration procedures were approved by the University of Wyoming’s Human Subjects’ Board. Survey items were based upon the initial 2004 survey. Additionally, Margaret Flinter, PhD, CRNP, senior vice president and clinical director of Community Health Center, Inc. in Middletown, Connecticut, provided feedback regarding survey items. The survey was prepared in a web-based format using Key Survey and consisted of 81 multiple-choice items, 27 demographic items and 6 open-ended items. An invitation, including a link to the survey, was graciously distributed by Fitzgerald Health Education Associates, Inc. (FHEA) to its ~51,000 electronic newsletter subscribers on April 25, 2012. The first few items of the survey were eligibility items; respondents who did not meet the eligibility criteria did not continue with the survey. These criteria included: graduating from an initial NP program between 2006 and 2011, being licensed to practice as an NP in the US and having practiced as a licensed NP in the US.

Demographics of the sample
As of July 5, 2012, surveys were completed by 723 eligible respondents who were licensed to practice in all but one of the 50 US states and the District of Columbia (D.C.). In addition, respondents had completed educational programs in D.C. and 47 of the 50 US states. Respondents ranged in age from 24-69 years (mean = 42 years); 95% were female. With the exception of neonatal nurse practitioners (NNPs, 0%), respondents represented all of the nationally recognized NP foci: family (FNPs, 68%), adult (ANPs, 21%), acute care (ACNPs, 5%), pediatric (2%), psychiatric mental health (PMHNPs, 2%), women’s health (WHNPs, 1.5%), and geriatric (GNPs, 0.5%). Thirty percent (30%) of the respondents completed their initial NP educational program in 2011, 22% in 2010, 15% in 2009, 13% in 2008, 12% in 2007, and 8% in 2006. Ninety percent (90%) of the respondents received their initial NP education at the master’s level, 8% at post-master’s certificates, and less than 2% at the DNP level or post-doctoral level. However, 4.5% of the respondents reported their highest level of education as DNP (3%) or a research doctorate in nursing (0.5%) or another field (1%).

Results
For this "sneak preview," 5 major items were reviewed:

(NP Preparedness: Continued on page 5)
(NP Preparedness: Continued from page 4)

1) Upon completion of your initial NP education program, how prepared were you for practice as an NP? (See Figure 1)
   - Very well prepared: 3.1%
   - Generally well prepared: 38.6%
   - Somewhat prepared: 43%
   - Minimally prepared: 11.5%
   - Very unprepared: 3.8%

![Figure 1](image)

2) “I was prepared for entry level NP practice” (See Figure 2)
   - Strongly agree: 17.43%
   - Agree: 54.95%
   - Neither agree or disagree: 10.34%
   - Disagree: 12.97%
   - Strongly disagree: 4.32%

![Figure 2](image)

3) “Which of the following best describes the mentoring you received during your first year of practice?” (See Figure 3)
   - I had a formal mentor or number of formal mentors: 16.32%
   - I had an informal mentor or number of informal mentors: 40.39%
   - I had both formal and informal mentors: 18.4%
   - I did not have any mentors: 24.9%

![Figure 3](image)

4) “During your first year of practice as an NP, did you ever feel you were practicing outside of your competence level?” (See Figure 4)
   - No: 51.25%
   - Yes: 48.75%

![Figure 4](image)

5) “If a formal NP residency program had been available to you after you had completed your initial NP residency program, how interested would you have been in this?” (See Figure 5)
   - Extremely interested: 58.01%
   - Somewhat interested: 31.92%
   - Neither interested or disinterested: 5.67%
   - Somewhat disinterested: 2.27%
   - Not at all interested: 2.13%

![Figure 5](image)

(NP Preparedness: Continued on page 8)
(ANCC AGPCNP Exam: Continued from page 1)

- **Advanced Pharmacology**
  - **Content example**: Pharmacotherapeutics, pharmacokinetics, pharmacodynamics, pharmacogenetics of broad categories of drugs, analyzing the relationship between pharmacological agents and physiologic/pathologic responses, impact of aging on pharmacological regimens

- **Advanced Physical Health Assessment**
  - **Content example**: Knowledge of components of history, physical, and psychosocial assessments across the aging continuum, components of history, physical, and psychosocial assessments across the aging continuum, developing a comprehensive database, including developmental/functional assessment, comprehensive or problem-focused health history, comprehensive or problem-focused physical examination, and appropriate testing

- **Theories and Frameworks**
  - **Content example**: Knowledge of theories and frameworks relevant to the adult-gerontology primary care nurse practitioner (e.g., theories of development and aging, nursing conceptual models)

- **Clinical Prevention and Population Health**
  - **Content example**: Health promotion and population-based health policy, designing and delivering clinical prevention interventions and strategies (e.g., immunizations, disaster preparedness, health screenings)

- **Management for Diverse Populations**
  - **Content example**: Cultural competencies, influence of aging, socioeconomic status, culture, gender, ethnicity, and spirituality on the mental and physical health of the individual and family in various health care settings

Professional Roles (25%)

- **Translational Science/Evidence-based Practice**
  - **Content example**: Research process, evidence-based practice, applying clinical investigative skills to practice

- **Legal and Ethical Issues/Scope and Standards/Regulation**
  - **Content example**: Ethical and legal issues, role, scope, and standards of the adult-gerontology primary care nurse practitioner

- **Quality Improvement and Safety**
  - **Content example**: Knowledge of methods, tools, performances measures, quality improvement models, culture of safety principles, and standards related to quality

- **Leadership, Advocacy, and Inter-professional Communication and Collaboration**
  - **Content example**: Leadership concepts, including interdisciplinary communication, collaboration, and coordination, advocating for the needs of patients and their families

- **Health Policy and Delivery**
  - **Content example**: Interdependence between policy and practice (e.g., health care economics, health disparity, globalization, organizational structure, federal health care policies), advocating for policies that improve health

- **Informatics and Health Care Technologies**
  - **Content example**: Legal and ethical issues related to the use of informatics and health care technologies, integrating technology systems into the delivery and coordination of care

Independent Practice (42%)

- **Advanced Patient-centered Communication**
  - **Content example**: Knowledge of adapting communications to specific patients' needs/situations across the aging continuum

- **Health Promotion and Disease Prevention**
  - **Content example**: Knowledge of anticipatory guidance, health behavior modification, patient-specific primary, secondary, and tertiary prevention, selecting interventions for the maintenance of health/wellness

- **Illness/Disease Management**
  - **Content example**: Knowledge of clinical guidelines and standards of care, risk, cost, and benefits of interventions, illness, injury, disease management, common geriatric syndromes

- **Diagnostic Reasoning/Critical Thinking**
  - **Content example**: Selecting appropriate tests and procedures, interpreting laboratory and diagnostic data, synthesizing data from multiple sources, establishing and prioritizing differential diagnoses, formulating a patient-centered, mutually acceptable plan of care

To access the full outline, please visit: [http://www.nursecredentialing.org/Documents/Certification/TestContentOutlines/AdultGeroPCNP-TC0.pdf](http://www.nursecredentialing.org/Documents/Certification/TestContentOutlines/AdultGeroPCNP-TC0.pdf)

[Click here](http://www.nursecredentialing.org/) to read an FHEA News article about the Consensus Model for APRN Regulation and NP certification examinations that will be retired in 2014. [Click here](http://www.fhea.com/) to read the FHEA News article “Frequently Asked Questions about NP Certification Exams.” Look for additional information on the changes to the AANP and ANCC certification exams in future issues of FHEA News.


**New and Updated Products**

**Assessment and Intervention of COPD: The latest treatment recommendations**

This session focuses on the assessment and intervention in the person with chronic obstructive pulmonary disease (COPD), both in acute exacerbation and long-term management. Learn about the latest recommendations for treatment of this challenging but common clinical condition in this program presented by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC. This program is available on-line and on audio CD.

**Allergic Rhinitis: A focus on assessment and intervention**

Learn the latest evidence-based guidelines for intervention in allergic rhinitis based on the Joint Task Force Practice Parameters and Allergic Rhinitis and Its Impact on Asthma Guidelines (ARIA). Hone your clinical skills in differentiating the common cold, sinusitis and allergic rhinitis. Included in the program, presented by Christy M. Yates, MS, FNP-BC, AE-C, an expert in asthma and allergy, is a detailed description of the pharmacologic agents including first and second-generation antihistamines, intranasal corticosteroids, leukotriene modifiers, decongestants, anticholinergic agents, and allergen immunotherapy. This program is available on-line and on audio CD.

**How to Study for Standardized Tests**

**Best of the $4 Drugs: Optimizing your choice of the least costly generics**

The $4 drug lists continue to grow as does our patients' need to access these low cost therapeutic options. But which of these medications is the optimal choice for the treatment of common conditions? Learn how to optimize your clinical decision making in choosing the best of the $4 drugs for the treatment of type 2 diabetes, acute bacterial sinusitis, community-acquired pneumonia, dyslipidemia, hypertension and other commonly encountered clinical conditions in this program presented by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC. This program is available on-line and on audio CD.

**Acute Asthma Exacerbations and Acute Uncomplicated Bronchitis: An evidence-based approach to management**

Learn the latest evidence-based recommendations on the assessment and intervention in acute asthma exacerbations. Christy M. Yates, MS, FNP-BC, AE-C, provides insights into the National Asthma Education Program Expert Panel-3 guidelines for determining acute asthma exacerbation severity levels and the recommended pharmacologic treatments for each level. Utilizing case studies, this seminar suggests tips for the management of acute mild to severe asthma symptoms. It also includes a detailed review of inhaled short-acting beta2-agonists, systemic corticosteroids, and inhaled anticholinergic agents. In addition, Ms. Yates concludes the seminar with a discussion of the evidence-based guidelines for the management of acute uncomplicated bronchitis. This program is available on-line and on audio CD.

**Asthma Update: An evidence-based approach to management throughout the lifespan**

Study the evidence-based guidelines for assessment and management of asthma with a NP expert. Christy M. Yates, MS, FNP-BC, AE-C, uses her extensive experience in primary and specialty asthma care in presenting guidelines for assessing and managing asthma throughout the lifespan. This program covers strategies for step-up and step-down care; appropriate use of short-acting beta2-agonists, inhaled corticosteroids, leukotriene modifiers, long-acting beta2-agonists, oral corticosteroids, and omalizumab. Ms. Yates also discusses the updated safety data on asthma medications, particularly the long-acting beta2-agonists and leukotriene modifiers. This program is available on-line and on audio CD.

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**NP Preparedness: Continued from page 8**

**Discussion**

Although the survey data are not final and participants are still being recruited, preliminary results indicate a couple of striking similarities between the 2004 and 2012 surveys, including the overall perception of preparedness for practice and interest in formal NP residency programs.

In addition, three items (items 2, 3, and 4) discussed in this “sneak preview” were not included in the 2004 survey but are definitely worthy of discussion. Although overall feelings of preparedness remain generally low, feelings of preparedness for “entry level NP practice” were higher with 72% of the respondents indicating that they “agreed” or “strongly agreed” that they were prepared for entry level NP practice. Furthermore, almost half of the respondents reported engaging in practice outside of their competence level and almost 25% reported not having a mentor during their first year of practice. Both of these findings support item 5, which revealed an overwhelming (almost 90%) interest in formal NP residency programs.

Interestingly, although similar studies with US medical and physician assistant students were not found in the published literature, results from studies conducted in the United Kingdom4,5 and Germany6 indicate that many graduating medical students also feel unprepared for the realities of practice, thus underscoring the importance of post-graduate residency training.

**Next steps**

The survey is still open, and participants are being recruited from underrepresented areas. Final results will be submitted to an NP journal at a later date. For inquiries or to learn how to participate in the survey, please contact Ann Marie Hart at: annmhart@uwyo.edu.

**References:**


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Important System Update Information

Routine maintenance is scheduled for August 18, 2012. FHEA is committed to providing our customers maximum uptime, reliability and security for our On-line Testing and Learning Site, [www.npexpert.com](http://www.npexpert.com). Regular system maintenance is critical to achieving this goal and is normally performed the third Saturday of each month.

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FHEA Raffle Winners
Fitzgerald Health Education Associates, Inc. recently held a raffle drawing at the 24th Annual Southeast Regional Nurse Practitioner Symposium in Flagstaff, Arizona. We would like to congratulate Audrey Russell-Kimble for winning *Nurse Practitioner Certification Examination and Practice Preparation, 3rd* by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC. We would also like to congratulate Mary Joyce Grubb for winning the boxed book set of four *Cherry Ames Nursing Stories*, by Helen Wells. Raffles are held at all of our exhibit locations.

(Breastfeeding: Continued from page 2)

As part of the 2012 GS objectives, review of implementation of these strategies has begun. Currently, less than 40% of the 136.7 million infants born each year globally are exclusively breastfed for the first 6 months. These rates have increased from 31% in 1990 and some countries have made marked increases in their breastfeeding rates. These achievements have been noted in developing countries in eastern and southern Africa and East Asia where the actions outlined in the GS are being put into place. The developed world including Europe and the United States has made only a modest increase in breastfeeding exclusivity for the first 6 months from 32% in 1990 to 39% in 2011.

The United States has been increasing support for breastfeeding rapidly over the past few years and has declared August as National Breastfeeding Month. The Surgeon General's Call to Action to Support Breastfeeding released in January 2011 has brought renewed enthusiasm for breastfeeding to the country. Here, 20 concrete steps were outlined to support breastfeeding and remove barriers. These steps fall into categories which include: mothers and families, communities, health care, employment, research/surveillance, and public health infrastructure.

The United States Breastfeeding Committee (USBC) has declared the theme for National Breastfeeding Month 2012 to be "Everyone Can Help Make Breastfeeding Easier": 20 Actions in 20 Days. The USBC has invited everyone to engage in conversations across social media platforms such as Twitter, Facebook and electronic newsletters through the month of August. On each weekday in August, the campaign will focus on one of the 20 steps outlined in the Surgeon General's Call to Action. Everyone can follow on Twitter (@usbreastfeeding) and on Facebook (www.facebook.com/usbreastfeeding), which will spread the word that everyone can make breastfeeding easier!

References:

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We will be exhibiting at the following locations:

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<th>Date</th>
<th>Location</th>
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| Sept. 6-9, 2012 | **Texas Nurse Practitioners 24th Annual Conference**  
Austin, Texas |
| Oct. 3-7, 2012 | **American College of Nurse Practitioners National Clinical Conference**  
Toronto, ON Canada |
| Oct. 11-13, 2012 | **American Academy of Nursing 39th Annual Conference**  
Washington, DC |

Dr. Fitzgerald's Upcoming Speaking Engagements

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<th>Date</th>
<th>Location</th>
<th>Topics</th>
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| Sept. 5-6, 2012 | **Laboratory Data Interpretation: A Case Study Approach**  
New York's Hotel Pennsylvania  
401 7th Ave, 18th Floor  
New York, NY 10001 | [More information here](#) |
| Sept. 6-9, 2012 | **Texas Nurse Practitioners 24th Annual Conference**  
9721 Arboretum Blvd  
Austin, Texas | [More information here](#) |
| Sept. 20-22, 2012 | **Alaska Nurse Practitioners 29th Annual Conference**  
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When Does a New NP Become Profitable to a Practice?

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An employer’s income may drop for about 6 months after a solo physician or practice hires a new nurse practitioner, because the practice will be paying the nurse practitioner’s salary, benefits and overhead and yet the new nurse practitioner may not have a large enough patient load to cover salary, benefits and profit for the practice. But after 6 months, the practice should break even. After 12 months, the practice should have recouped the losses of the first 6 months, and during the 2nd year of employment, the practice should be making a profit attributable to the nurse practitioner’s efforts.

Should the practice hire a physician rather than a nurse practitioner, the practice should expect to count on 9 months of losses, simply because physicians’ salaries and benefits usually are greater than nurse practitioner’s, and a new physician is not likely to be as efficient as an experienced physician nor carry a full patient load. Nevertheless, physicians who hire new physician associates usually recoup their losses and are making a profit from the associate’s work by the 2nd year of employment.

For more information on reimbursement issues affecting nurse practitioners and their employers, visit: www.buppert.com.

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Valuable Information and Advice about NP Employment

Over the years, FHEA News has published numerous articles on the topic of NP employment. Follow the links below to learn some valuable information about this topic.

- **Negotiating your NP Practice Contract: Advice from the expert and novice NP**
- **Tips for the New NP Graduate with Bruce D. Askey, MS, ANP-BC**
- **Tips for the New NP Graduate with Wendy L. Wright, MS, ANP-BC, FNP-BC, FAANP**
- **Questions to Ask a Prospective Employer Setting the Stage for Success in your New NP Role (Part 1)**
- **Setting the Stage for Success in your New NP Role (Part 2)**
- **The Practice Doctorate: Implications for advanced practice nursing**
- **How to Run your NP Business: A guide for success**
- **Q&A with Dr. Fitzgerald: Advice for the new NP**
- **Interview Questions you can Ask**

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- University faculty may choose to have a random selection of test questions, with no two exams the same, or may choose to have the same test questions presented to each test taker.
- Questions can be scrambled so that they are not presented in the same order.
- Tests are delivered using state-of-the-art on-line software that links seamlessly to most academic learning management systems.
- Testing can be secure if taken in a university computer lab.
- Testing windows can be set for multiple days or a single day, allowing scheduling flexibility.
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- Once testing is complete, university faculty will receive two distinct reports:
  - **Report I** includes a percentage score for each test taker.
  - **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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When prescribing cephalosporins to patients with a history of penicillin allergy, it is important to be cautious.

**Question:** How would you prescribe cephalosporins to patients with penicillin allergies?

**Answer:** The penicillins, including penicillin, amoxicillin, dicloxacillin, and many others, and the cephalosporins, including a number of antibiotics containing the cephalosporin prefix, share a common feature, a beta-lactam ring in their molecular structures. Additional antibiotics with this property include less commonly used products such as the carbapenems (example-imipenem, usually given with cilastatin {Primaxin}) and the monobactams (example-azetronam [Azactam]). The most common allergic reactions to antibiotics including the cephalosporins and penicillins are maculopapular skin eruptions, urticaria and pruritus; more severe reactions include respiratory and cardiovascular compromise. The reaction’s onset can occur rapidly post drug ingestion, particularly if the patient has been sensitized to the antibiotic by previous exposure; rapid onset classic symptoms including urticaria, pruritus, anaphylaxis, and bronchospasm are usually considered to be IgE-mediated Type I reactions. Less common reaction includes a hypersensitivity syndrome characterized by fever, eosinophilia, and other extracutaneous manifestations. Approximately 10% of the general population report penicillin allergy.

Conventional practice is to assume that a patient with allergy to penicillin will also exhibit this reaction to the cephalosporins. However, the assumption of a 100% cross-sensitivity rate is inaccurate, as historical data suggests that at best, approximately 8-10% of patient with penicillin allergy will exhibit cephalosporin sensitivity. Indeed, the majority of what has been reported about penicillin-cephalosporin allergy has been derived from older retrospective studies in which penicillin allergy was not routinely confirmed by skin testing. Also, many reported penicillin reactions are not allergic in nature. For example, I recall a number of times during my years of NP practice where an infant or toddler who developed candida diaper rash during amoxicillin therapy was brought in by the parents who believe that since the rash developed while taking an antibiotic, the baby must be penicillin allergic. Some post penicillin use reactions are not allergic in nature. For example, when certain penicillin forms such as ampicillin and amoxicillin are administered to a person with Epstein-Barr virus infection, the most common causative organism in mononucleosis, a cutaneous reaction nearly always occurs; this rash is thought to be the result of altered immune status during the infection and not indicative of penicillin allergy. In addition, these historic data were gathered during a time when cephalosporins were often contaminated with traces of penicillin, an obvious trigger for an allergic reaction.

More recent study supports that the rate of cross-reactivity between penicillins and cephalosporins is probably less than 1% and determined by similarity in side chains and not the beta-lactam ring structure. Simply put, the greatest rate of cross reactivity to the penicillins appears to arise from the use of the first generation cephalosporins, including cephalixin (Keflex) and cefadroxil (Duricef). As a result of Pichichero’s metaanalysis, the use of certain second, third and fourth generation cephalosporins including cefprozil (Ceftin), cefuroxime, cefpodoxime (Vantin), ceftazidime, and ceftriaxone (Rocephin) appears to result in lower allergic risk.

For patients with a history of penicillin allergy, whether to prescribe a cephalosporin or not requires careful data-gathering on the exact reaction that occurs post penicillin use. If the history is consistent with a severe, rapid onset IgE mediated-type response, referral for allergy testing is the most prudent course; this approach should also be considered if the penicillin allergy history is unclear. When testing is undertaken, confirmation of both presence of penicillin allergy as well as the presence or absence of cephalosporin sensitivity is important. This advice extends to the use of carbapenems and the monobactams. With a history of less severe reactions, clinical judgement is warranted. Additional research is needed before the recommendation to use the second, third and fourth generation cephalosporins can be routinely recommended. When seeing a patient who reports being allergic to virtually all antibiotics, referral for allergy testing is critical to confirm what medications are safe to use if the patient presents with an infectious disease where such therapy is warranted.

**References:**

The Art of Wound Repair: Suturing for NPs and PAs

September 11, 2012
DoubleTree Chicago-Oak Brook Hotel
1909 Spring Rd

January 31, 2013
Manhattan, New York

June 15, 2013
Milwaukee, Wisconsin

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

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 intracuticular stitches. Malpractice prevention techniques will help secure your future.

Laboratory Data Interpretation: A Case Study Approach

September 5-6, 2012
New York's Hotel Pennsylvania
401 7th Ave, 18th Floor
New York, NY 10001

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

Earn 12 Contact Hours!

Are you looking to improve your lab data interpretation skills? Using a case-based approach, this program is designed to help you refine your skills in ordering and analyzing the results of laboratory tests.

Topics include...
- Assessment and Intervention in Common Anemias
- Laboratory Monitoring During Drug Therapy
- Evaluation and Intervention in Thyroid Disorders
- Evaluation of Renal Function
- Assessment of Hepatic Function
- Analysis of the WBC Count and Differential
- Evaluation in Immunologic and Autoimmune Disorders
- Challenging Case Studies in Laboratory Diagnosis

Clinical Pharmacology for NPs and Advanced Practice Clinicians

October 15-20, 2012
Nashville, Tennessee

March 18-23, 2013
Atlanta, Georgia

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

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

Advanced Pathophysiology for NPs and Advanced Practice Clinicians

March 25-30, 2013
Oak Brook, Illinois

This course is presented 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

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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.)

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