Here are my responses to questions about safe prescribing that have been put forth by NPs entering into practice.

Question:
How do you handle the issue looking up medication information during an office visit? I feel uncomfortable investigating a drug dose or adverse reaction in front of the patient and family.

Answer:
A mark of a confident clinician is one who has no problem telling a patient that he/she wants to check a fact or look up information about a medication. I do this frequently. Usually I say to the patient, “I want to make sure this antibiotic will not cause any problems with the other medications you are taking” or “I need a minute or two to check on the use of this medication for a person who has your health condition,” and then I share the information I found with the patient. By doing this, the patient gains knowledge. The NP shows the patient that he/she is a safe, cautious and caring prescriber.

I see children as part of my practice. Sometimes the exam room is particularly noisy, especially when this is a pediatric sick visit and an ill child feels miserable and is fussy.

(Safe Prescriptive Practice: Continued on page 8)
Narcolepsy can be challenging to treat in women who are pregnant or breastfeeding. This condition affects as many as 200,000 Americans, although fewer than 50,000 are diagnosed. Unfortunately, narcolepsy is a disease that is not well understood. Oftentimes, the condition is mistaken for depression, epilepsy or even an adverse side effect from medication. Narcolepsy can affect both men and women at any age, but is diagnosed most often between 35 and 45 years of age. This debilitating disease has been seen in children from age 3 years through teens. There is no research establishing narcolepsy as a hereditary condition, however, approximately 8-12% of people diagnosed also have a close relative with the disease.

The primary symptom of narcolepsy is excessive and overwhelming daytime sleepiness that occurs even after adequate nighttime sleep. Cataplexy, sleep paralysis and hypnagogic hallucination are also characteristic symptoms of the condition, though these symptoms are not always present in every case. Cataplexy is a sudden episode of loss of muscle function, which could range from mild weakness to a complete body collapse. Sudden emotional reactions like laughter, anger or fear can trigger these episodes, which can last a few seconds or several minutes. Sleep paralysis is a temporary inability to talk or move when falling asleep or waking up. Hypnagogic hallucinations are vivid dreams that are often frightening and occur when falling asleep.

There is currently no cure for narcolepsy, but the primary method of treatment is with medications that help control the symptoms. The control of these maternal symptoms is very important as narcolepsy poses possible safety risks for both mothers and their infants, including falling asleep during breastfeeding and dropping the newborn. Central nervous system stimulants such as methylphenidate, amphetamine salts, modafinil, antidepressants, or sodium oxybate are often used for treatment. During pregnancy, these medications are usually discontinued unless risks of foregoing treatment outweigh the risks of exposing the fetus to such medications. Amphetamines used during pregnancy can lead to premature delivery, congenital malformations and low birthweight. Following birth, infants whose mothers were prescribed amphetamines during pregnancy need to be monitored for withdrawal symptoms such as jitteriness, respiratory distress or drowsiness. Most women resume their narcolepsy treatment after delivery in an effort to prevent symptoms and ensure that they can care for their newborn.

If a mother with narcolepsy chooses to breastfeed, some medications are better than others based on how much of the drug is transferred into mother’s breast milk. Modafinil use is not advised in breastfeeding mothers. While there is no data on the use of this medication during breastfeeding, based on modafinil’s molecular size and lipid solubility, the drug will likely be excreted in breast milk. Also, this medication could prevent the release of oxytocin in the mother which inhibits let-down of her milk. A better alternative is methylphenidate, which has a relatively small dose that transfers to mother’s milk. There is no data on the use of this medication during breastfeeding, but based on methylphenidate’s molecular size and lipid solubility, the drug will likely be excreted in breast milk. Also, this medication could prevent the release of oxytocin in the mother which inhibits let-down of her milk. A better alternative is methylphenidate, which has a relatively small dose that transfers to mother’s milk. No adverse effects have been seen in infants exposed to this medication during breastfeeding. However, these infants should be monitored for symptoms of agitation and adequate weight gain.

References:
**New Jersey Lawmakers Review Bill for NP Autonomy**

New Jersey legislators are reviewing a potential law proposing to remove scope of practice barriers for advanced practice registered nurses (APRNs) to allow them to practice independently. The current joint protocol rules in New Jersey allow nurse practitioners (NPs) to prescribe freely under the condition that a collaborating physician is available for consultation and reviews at least one patient chart per year. Many APRNs state-wide believe joint protocol laws are unnecessary. Under the new legislation, NPs would be allowed to establish independent practices. Advocates of the new bill are pleased that lawmakers and healthcare professionals are concentrating on the issue of improving access to quality primary care providers, particularly before the Affordable Healthcare Act takes effect. APRNs with less than 2 years of experience or 2,400 licensed hours of advanced nursing practice would be subject to joint protocol practice under the new bill.

**CDC: Study of Flu Vaccination in Healthcare Professionals**

Despite recommendations from the Advisory Committee on Immunization Practices (ACIP), a study conducted in April 2012 for the 2011-2012 flu season revealed that flu vaccination among healthcare professionals varied greatly by occupation and work setting. The United States (US) Centers for Disease Control and Prevention (CDC) surveyed 2,348 healthcare workers, of which 73.4% were clinicians and 26.6% were other healthcare workers. The study defined other healthcare workers as those who held a position as an assistant, aide, administrator, clerical support worker, janitor, food service worker, or in housekeeping. Data by occupation showed that physicians had the highest rate of flu vaccination at 85.6%. Nurses had rate of 77.9% and all other healthcare professionals had a rate of 68.8%. By work setting, data showed the vaccination rate of healthcare workers in hospitals was 76.9%, in private practices 67.7% and 52.4% among those working at long-term healthcare facilities. The CDC study revealed that 33.1% of healthcare workers chose not to receive the flu vaccine, of which 28.1% said they believed they did not need it, 26.4% thought the vaccine would not be effective, and 25.1% were concerned about potential side effects.

**FDA Advises Against Pradaxa Use in Patients with Mechanical Heart Valves**

The United States (US) Food and Drug Administration (FDA) recently issued an advisory for healthcare providers against the use of the anticoagulant Pradaxa (dabigatran etexilate mesylate) in patients with mechanical prosthetic heart valves. The blood thinner has shown to significantly increase the occurrence of strokes, heart attacks and blood clots in patients with mechanical prosthetic heart valves. Pradaxa can cause an increase in bleeding post-valve surgery. Healthcare providers should immediately replace medication for all patients who have mechanical heart valves and are taking Pradaxa. FDA recommends that patients with any type of prosthetic heart valves who are taking Pradaxa should consult their healthcare provider to determine the best course of treatment. Pradaxa is not approved for use in patients with atrial fibrillation caused by heart problems. The potential contraindication of Pradaxa in patients with bioprosthetic valves has not yet been determined.

**NP and PA Career Opportunities are on the Rise**

The number of job opportunities available for nurse practitioners (NPs) and physician assistants (PAs) has increased over the past year, according to research released by healthcare recruiters, HealthECareers. Since the third quarter of 2011, career opportunities for NPs increased 35% while opportunities for PAs increased 22%. HealthECareers attributes the increased availability of positions for NPs and PAs to the shortage of primary care providers in the United States. NPs and PAs continue to provide high-quality, cost-effective care even as studies report that the average annual salary for both providers continues to increase.
Jordan Hopchik, MSN, FNP-BC, CGRN, Creator of the Philadelphia VAMC’s First NP Colonoscopy Training Fellowship and the First NP in Pennsylvania to Become an Endoscopist

by Jaclyn Fitzgerald, Editor

Often times, being proactive is not only the key to realizing one’s own success but to helping others meet their goals as well. This is the case for Jordan Hopchik, MSN, FNP-BC, CGRN, who has dedicated his nurse practitioner (NP) career to providing quality gastrointestinal (GI) care to patients at the Philadelphia Veteran Affairs Medical Center (VAMC). Hard work and perseverance led him to gain approval to implement the Philadelphia VAMC’s first NP colonoscopy training fellowship and become the first NP in his state to practice as an endoscopist.

Hopchik has been an NP for approximately 13 years and has spent the past 10 years in the GI setting, beginning his career at the Philadelphia VAMC in 2003. Not long after, he noticed a discrepancy in the number of patients in need of colonoscopy and the resources available to complete these procedures in a timely manner. According to Hopchik, patients were often wait-listed or referred out to private healthcare facilities for this procedure. As a result, he took it upon himself to devise a plan that would allow NPs at the Philadelphia VAMC to aid in accommodating the needs of these patients.

After doing some research, Hopchik found that few NPs or physician assistants (PAs) were qualified to perform colonoscopies in the Veterans Affairs Healthcare System and he was determined to change that. He presented an NP colonoscopy training fellowship proposal to the Philadelphia VAMC in 2005. The proposal was approved and Hopchik was able to begin the training that would prepare him to perform colonoscopies and become a credentialed endoscopist.

It took Hopchik nearly 4 years to complete his NP colonoscopy training fellowship, which he said was modeled after the American Society for Gastrointestinal Endoscopy guidelines and involved performing at least 140 supervised colonoscopies and learning to remove various polyps. He said that his particular training took an extended amount of time because of certain obstacles like his schedule at the Philadelphia VAMC, which only provided him with enough time to perform six supervised colonoscopies per week. In addition, the original supervising physician that Hopchik practiced with was unable to see him through the entirety of his training, which led him to take a year and a half training hiatus. Ideally, future NPs and PAs will be able to complete this training in 1-2 years.

In 2007, while working towards his fellowship, Hopchik achieved credentialing as a certified gastroenterology registered nurse (CGRN) with the Society of Gastroenterology Nurses and Associates (SGNA). He completed his fellowship in April 2009 after carrying out more than 325 colonoscopies and more than 150 polypectomies. At last, he became a credentialed endoscopist and was able to perform these procedures independently and in collaboration with his physician colleagues at the Philadelphia VAMC.

According to Hopchik, his patients at the Philadelphia VAMC are satisfied with the care he provides and are grateful for his services. He said that because of his ability to perform a colonoscopy he has not only helped the Philadelphia VAMC save money and decrease the number of Veterans referred out for colonoscopy, but he has also helped save lives. While there are other means of colorectal cancer (CRC) screening available, Hopchik maintains that a colonoscopy is the primary means of CRC screening. Patients with abnormal results on other CRC screening tests such as sigmoidoscopy, barium enema or stool cards, require a colonoscopy for diagnostic and therapeutic measure.

Currently, there are no other NPs or PAs at the Philadelphia

(NP Firsts: Continued on page 7)
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.

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- 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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**FHEA 25th Anniversary Caribbean Cruise**
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**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)
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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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- 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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| April 11-14, 2013 | National Organization of Nurse Practitioner Faculties 39th Annual Meeting  
Pittsburgh, Pennsylvania                      |
| April 17-20, 2013 | Kentucky Coalition of Nurse Practitioners and Nurse Midwives  
Lexington, Kentucky                                           |
| May 1-4, 2013    | National Conference for Nurse Practitioners Annual Meeting  
Nashville, Tennessee                                        |

A Sample of Dr. Fitzgerald’s Upcoming Speaking Engagements

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| Jan. 17-18, 2013 | FHEA Pharmacology Update  
Grand Summit Resort Hotel & Conference Center  
89 Grand Summit Way  
Mount Snow, VT 05356 |
| Feb. 11-12, 2013 | FHEA Pharmacology Update  
Sheraton Maui Resort & Spa  
2605 Ka’anapali Parkway  
Lahaina, HI 96761    |
| March 9-13, 2013 | Clinical Update Caribbean Cruise  
Celebrity Cruise  
San Juan, Puerto Rico |
(NP Firsts: Continued from page 4)

VAMC who have completed the NP colonoscopy training fellowship or achieved the designation a credentialed endoscopist. However, there are other VAMC locations where NPs and PAs practice in the same or a similar manner as Hopchik. He is hopeful that more NPs and PAs will follow the path that he has chosen. His goals for his own future include completing his doctor of nursing practice degree at La Salle University, Philadelphia, Pennsylvania in 2014 and taking on a full colonoscopy schedule at the Philadelphia VAMC.

The following is a question and answer session with Jordan Hopchik, MSN, FNP-BC, CGRN.

**Question:** How did you come up with the idea to become a credentialed endoscopist?

**Answer:** We had a high demand for colonoscopy with a low supply of gastroenterologists to meet the demand. I have always loved doing technical aspects of healthcare and was tired of seeing hundreds of thousands of taxpayer dollars being spent on private-sector endoscopy. I thought we had to come up with a better idea to get urgently needed colonoscopy performed to prevent and detect early colorectal cancer. I initially contacted other Veterans Healthcare Administration facilities to find out if other NPs or PAs were trained to perform colonoscopy. I learned a few were. Then I put together a training proposal at my facility that eventually got approved. I became credentialed as a nationally certified gastroenterology nurse through the Society of Gastroenterology Nurses and Associates (SGNA) based in Chicago in 2007.

**Question:** What does it mean to you to be the first NP to become a credentialed endoscopist in Pennsylvania?

**Answer:** I’m proud to be the first and I want to inspire other NPs to trail blaze their dreams. Taking chances and being a role model to other nurses is so important. The only way we will advance our profession in the eyes of patients, insurance companies, politicians, and policy makers is by pushing the envelope, asserting ourselves, fighting for improved patient access and creative quality of care delivery systems.

**Question:** What sort of feedback regarding the training program have you received from patients and colleagues?

**Answer:** Patients are very pleased and once they’ve had me perform their procedure, they only want me to do their next one. Most nurses, technicians and doctors are impressed and congratulatory. However, when I was training, a number of them questioned why I should be able to train and there was a lot of resistance.

**Question:** What are your goals for the future of the NP colonoscopy training program at the VAMC?

**Answer:** I hope to resume a full colonoscopy schedule once we get our third procedure room redesigned and get more staff. I also hope to get intimately involved with a non-physician endoscopy pilot that I hope will get approved next year to train more NPs and PAs to do colonoscopy in the VA System. I am completing my DNP at La Salle University in 2014. As an adjunct to the non-physician endoscopy pilot and for my doctoral capstone thesis project, I will be starting up a GI Virtual Community of Practice to enable NPs, PAs and novice trainees to connect with each other on knowledge-sharing and expertise.

**Question:** What advice do you have for NPs who are trying to break the mold in their field?

**Answer:** Keep taking chances and stick your neck out. Don’t give up. Network and fight for the causes you believe in. Seek out others who have successfully carved out niches and find out what they did to make their dream a reality. When you hit a roadblock, find a way around it. There will always be detours. Stay focused and on track with your envisioned goals and aspirations.

Jordan Hopchik, MSN, FNP-BC, CGRN, welcomes FHEA News readers to contact him via e-mail at jhopchik@aol.com with any questions or comments.
Creating an environment that is not conducive to concentration on calculating a drug dose or looking up information critical to safe practice. If this is the case, I will usually excuse myself and go to my desk. I will share with the patient why I am leaving with a comment like, “It is a bit noisy in here right now. I am going to go to my desk to complete her prescriptions so I can better concentrate on what I am doing.” I do not point out that the child is the reason for the noise, as is usually the case, since the little one’s fussiness is often quite warranted.

**Question:**
I have seen some clinicians discontinue statins when placing a patient on an antibiotic. When is it advisable to discontinue a statin for the duration of antibiotic therapy?

**Answer:**
If the clinician is stopping all statins on all patients on antibiotics, that is likely unnecessary and perhaps even harmful. The real deal here with the antibiotic-statin interaction is at the core of all drug interactions. Is the antibiotic a significant CYP450 inhibitor? Is the statin significantly biotransformed or metabolized by CYP450 3A4 (i.e. a CYP450 isoenzyme substrate)? Clarithromycin, erythromycin and the seldom used telithromycin are CYP450 3A4 inhibitors. Given that =>50% of all prescription medications are 3A4 substrates, the risk of drug interaction with the use of these antibiotics is significant. (See [www.drug-interactions.com](http://www.drug-interactions.com), accessed 1.8.13. For more information review the recording Drug-drug and Drug-nutrient Interactions: A Focus on Avoiding Common Problems by Dr. Fitzgerald, available [here](http://www.drug-interactions.com)). As a result, when using the aforementioned antibiotics, discontinuing a statin that is a CYP 3A4 substrate (i.e. atorvastatin, lovastatin, simvastatin) is likely warranted, particularly if the statin dose is high. Here are two examples to provide perspective on this issue:

When clarithromycin is co-administered with atorvastatin, atorvastatin peak plasma concentrations are increased by 56%. Rosuvastatin (Crestor®), pitavastatin (Livalo®) and pravastatin (Pravachol®) are not CYP450 3A4 substrates, thus will not interact with the aforementioned macrolides. Azithromycin, also a macrolide, does not inhibit CYP450 3A4 and does not interact with simva-, lova- or atorvastatin. As a result, the practice of discontinuing all statins with any antimicrobial therapy is not therapeutically warranted or scientifically sound. The alternative, to have the patient discontinue use of one of the problematic statins during select macrolide therapy is certainly an option. At the same time, what if the patient is unclear which of his/her meds is the statin? What if the patient fails to stop the use of the interacting statin? What if the patient does not resume the statin use post antibiotic therapy? Best practice, to my thought, is to avoid the use of clarithro- and erythromycin. If an antimicrobial with a similar spectrum of antibacterial activity is needed for the treatment of a bacterial respiratory tract infection, treatment with doxycycline or azithromycin use should be considered.

**Question:**
How do you proceed with the patient who reports being allergic to virtually every antibiotic?

**Answer:**
Please consider referring a patient who reports multiple antibiotic allergies to an allergist for appropriate testing. You do not want to be in the situation where this patient becomes seriously ill and you are left wondering what will antibiotic will be both effective and safe. Many times, I have found that a patient is confused about what antibiotic caused what problem. I recently saw a patient who reported allergic reaction to virtually every antibiotic except the amnoglycosides. Reviewing past records shed little light upon the situation. The results of allergy testing demonstrated that she is truly beta-lactam (penicillin and cephalosporin) allergic, but has no other antibiotic allergies. That said, up to 4% of patients with a negative skin test will develop non-life-threatening allergic reactions if they take penicillin again.

**References:**

**Important System Update Information**
Routine maintenance is scheduled for January 19, 2013. 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.
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.
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- Monitor deadlines and CE requirements for multiple agencies.
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What our Customers Say...

“Dear Dr. Fitzgerald—It was great to see you this week and I am happy that my niece, Alana, was able to come and experience you for herself. I know you meet thousands of people each year, but the impact you have on so many NPs in this country is amazing. Even after all of these years, I still remember things from my board review (in 1998). The fact that Alana is able to learn from you means so much to me. I know she will be successful from having been in your review course. I look forward to seeing you soon at one of your workshops or presentations!”

— Vanessa Pomarico-Denino, MSN, FNP-BC, APRN

Meaningful Use of EHR Study

Editor’s Note: FHEA is committed to supporting the nurse practitioner in all aspects of healthcare, including facilitating research. We are pleased to support Patty Koyl, MSN, ARNP-BC, and her Meaningful Use of EHR Study.

Title: Are you Participating in the Meaningful Use Incentive Program? How Confident are you Using Health Information Technology in Practice?

Introduction: At the heart of the United States government’s efforts to improve healthcare and lower its cost is the adoption and meaningful use of Electronic Health Records (EHRs). The recent passage of the American Recovery and Reinvestment Act (2009) includes $19 billion for the advancement and exchange of Health Information Technology and includes the use of EHRs. Incentive programs to encourage eligible professionals to adopt and meaningfully use certified EHRs have recently been implemented by the Center for Medicare and Medicaid Services (CMS, 2010). The Meaningful Use Incentive Program (MUIP) is the new, federally funded program designed to encourage those who provide care to Medicare or Medicaid recipients to utilize EHRs in practice.

Much work has been done to evaluate the barriers encountered by physicians as they incorporate EHRs into practice. However, no primary studies exist that examine the challenges faced by nurse practitioners or nurse midwives as they seek to incorporate EHRs into practice or participate in the MUIP.

The aim of this study is to determine knowledge levels advanced practice nurses (APNs) have for the MUIP, to determine the extent in which APNs are participating in the program, and to identify confidence APNs have for utilizing Health Information Technology (HIT) in practice.

Results from this survey may help policy makers, nursing educators and nurse practitioners gain a better understanding of the contribution APNs make at delivering care through use of EHRs and Health Information Technology.

Please help us in determining the extent to which APNs are using EHRs and how confident they are in using HIT in practice by taking the following survey. It will take only 15 to 20 minutes to complete this important survey.

Survey Link: https://www.surveymonkey.com/s/XMS57MV

Thank you so very much for your contribution to this important issue facing APNs.

Patty Koyl, MSN, ARNP-BC
Doctor of Nursing Practice (DNP) Candidate at Case Western Reserve University
NP Scope of Practice Laws by State

The image below provides a state-by-state breakdown of the scope of practice laws for nurse practitioners.

This information was reprinted with permission from Barton Associates. For more information, please visit http://www.bartonassociates.com/. 
Since 2004, Yates has been presenting the FHEA Nurse Practitioner Certification Exam Review and Advanced Practice Update, which has successfully prepared more than 65,000 NPs for certification. She also presents several programs for FHEA on topics that include New Developments in the Assessment & Treatment of Allergic Rhinitis and Conjunctivitis, Assessment and Intervention of Acute Asthma and Acute Bronchitis and Cardiac Rhythms: A 5-Step Approach to Accurate Interpretation, among others.

Yates is certified as a family nurse practitioner (FNP) by the AANP and the American Nurses Credentialing Center (ANCC). She is also certified as an asthma educator by the National Asthma Educator Certification Board. She practices as an FNP full-time at Family Allergy and Asthma in Louisville, Kentucky. For more than 12 years, Yates worked part-time as a primary care provider at a community family practice center in Kentucky, in addition to her specialty in allergy, asthma, immunology, and cardiac rhythms.

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It’s DDx To Go! This unique format gives you a completely portable, uniquely convenient diagnostic tool. Essentially a deck of laminated cards linked together at one corner, much like a collection of color samples, the DDxDeck allows you to compare potential diagnoses visually, side by side, without the need to flip back and forth between different pages. Each card includes a full color image and information about a particular diagnosis, as well as cross references (DDx-refS) to other potential diagnoses. Small enough to fit in your pocket, this is the perfect reference for those on the front line of dermatological diagnosis. You can purchase the Dermatology DDx Deck, 2nd Edition, through our web store.
The Art of Wound Repair: Suturing for NPs and PAs

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

January 31, 2013
New York's Hotel Pennsylvania
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Earn 6 Contact Hours!
The art of suturing is the process of preparation, thinking, documentation, taking a good history and physical examination, immunizing our patient, delivering proper local anesthesia, in addition to performing a professional suture. This full-day course features the utilization of a pig's foot, anesthesia tips, 4-0 nylon suture, and a disposable stapler. Dermabond and other products will be covered. We will start with the keystone stitch, and 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.

Clinical Pharmacology for NPs and Advanced Practice Clinicians

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

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April 18-19, 2013
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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. A personal laptop or tablet equipped with Microsoft PowerPoint is required. This course is limited to 20 participants.

Advanced Pathophysiology for NPs and Advanced Practice Clinicians

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

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

Clinical Pharmacology for NPs and Advanced Practice Clinicians

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Sally K. Miller, PhD, ACNP-BC, ANP-BC, FNP-BC, GNP-BC, CNE, FAANP

March 18-23, 2013
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