

**SB 1217**

**PRESENTATION OF THE  
BOARD OF NURSING**

TO THE SENATE COMMITTEE ON HEALTH

TWENTY-FIFTH LEGISLATURE  
Regular Session of 2009

Wednesday, February 11, 2009  
3:00 p.m.

**TESTIMONY ON SENATE BILL NO. 1217, RELATING TO HEALTH CARE  
PROFESSIONALS.**

TO THE HONORABLE DAVID Y. IGE, CHAIR,  
AND MEMBERS OF THE COMMITTEE:

My name is Kathy Yokouchi. I am the Executive Officer of the Board of Nursing ("Board"). I appreciate the opportunity to present testimony on behalf of the Board in support of Senate Bill No. 1217.

The purpose of this measure is to allow advanced practice registered nurses ("APRNs") to sign certain medical certification forms for their patients applicable to the care provided within each practitioner's scope of practice.

Authorizing APRNs to sign certain forms which are appropriate and within the parameters of their work will reduce costs and hardships due to delays in starts of services, and will help APRNs to provide timely care and support to their clients.

The Board requests that this Committee pass this measure unamended.

Thank you for the opportunity to testify on Senate Bill No. 1217.

Testimony of  
Frank P. Richardson  
Vice President and Regional Counsel

Before:  
Senate Committee on Health  
The Honorable David Y. Ige, Chair  
The Honorable Josh Green, M.D., Vice Chair

February 11, 2009  
3:00 pm  
Conference Room 016

**SB 1217 RELATING TO HEALTH CARE PROFESSIONALS**

Chair, Vice Chair, and committee members, thank you for this opportunity to provide testimony on SB1217 that would allow an advanced practice registered nurse who provides care to a patient requesting medical certification forms, the authority to sign certifications applicable to the care provided within the advanced practice registered nurse's scope of practice.

**Kaiser Permanente Hawaii supports this bill.**

Kaiser Permanente supports the concept of APRNs completing and signing forms regarding patients they have evaluated and provided care for, for the conditions they are treating them for, within their scope of practice.

Thank you for the opportunity to comment.



## Hawai'i Primary Care Association

345 Queen Street | Suite 601 | Honolulu, HI 96813-4718 | Tel: 808.536.8442 | Fax: 808.524.0347  
www.hawaiipca.net

To: **The Senate Committee on Health**  
The Hon. David Y. Ige, Chair  
The Hon. Josh Green, MD, Vice Chair

**Testimony in Support of Senate Bill 1217**  
**Relating to Health Care Professionals**  
**Submitted by Beth Giesting, CEO**  
**February 11, 2009, 3:00 p.m. agenda, Room 016**

The Hawaii Primary Care Association asks your support for this bill which would allow nurse practitioners to complete fairly routine paperwork for patients, thus making them much more useful as providers in primary care and other settings.

We find that nurse practitioners are excellent clinicians who earn very high marks for clinical quality and patient satisfaction. In addition, with shortages in physicians and financial resources, Hawaii would be well-served to allow NPs to take on the responsibilities outlined in the bill as a regular part of their work.

Thank you for the opportunity to add our support to this measure.



# UNIVERSITY OF HAWAII SYSTEM

## Legislative Testimony

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Written Testimony Presented Before the  
Senate Committee on Health  
February 11, 2009, 3:00 p.m.

by

Virginia S. Hinshaw, Chancellor  
and

Mary G. Boland, DrPH, RN, FAAN  
Dean and Professor

School of Nursing and Dental Hygiene  
University of Hawai'i at Mānoa

### SB 1217 RELATING TO HEALTH CARE PROFESSIONALS

Chair Ige, Vice Chair Green, and members of the Senate Committee on Health, thank you for this opportunity to provide testimony in support of SB 1217 to permit advanced practice nurses to sign certification forms for their patients, if not already included in SB 1045 relating to Advanced Practice Registered Nurses (APRN).

Access to available and quality health care is a national and state priority to ensure protection of consumers of care. Updating statutes to reflect signature authority by APRNs will help to address the provider shortage and ensure quality care delivery.

In order to effectively and efficiently implement the APRN role, APRNs must have the ability to sign the multiple forms required to document services. The scope of an APRN includes, but is not limited to, performing acts of advanced assessment and diagnosing. Expanding signature rights to APRNs will streamline the process at the health care system level by providing point-of-contact service to clients. Clear bill language will allow APRNs global signature rights relative to health care for their patients to further address this ongoing need. For example, the APRN signature will be accepted by insurers on the forms required for school physicals, durable medical equipment such as wheelchairs and walkers, and many other consumer needs.

The University of Hawai'i Mānoa and the School of Nursing and Dental Hygiene supports a collaborative approach to addressing the healthcare provider needs of Hawai'i and looks forward to our continued partnership with the legislature and community.

Thank you for the opportunity to testify.

# *Hawai`i Association of Professional Nurses*

*P.O. Box 4314  
Honolulu, HI 96812  
HAPN.org*

Aloha Legislators,

Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists, collectively known as Advanced Practice Registered Nurses are licensed by statute and regulation to deliver health care in the State of Hawai`i. These professionals are often asked by their patients to complete and sign medical certification forms for a variety of purposes including but not limited to physical exams, handicapped parking passes, physical and speech therapy, and Aid to Financially Dependent Children certification forms. As currently written, Hawai`i Revised Statutes and Hawai`i Administrative Rules do not authorize non-physician health professionals to sign these many documents attesting to their patients' health, capabilities or medical needs. Instead, a physician colleague, who has not provided the care, must be found to complete the form. In some instances there is not a physician present to sign medical certification documents at the point of care.

We would like the Hawai`i State Legislature to enact legislation that eliminates barriers to necessary services by allowing Advanced Practice Nurses to sign all medical certification documents applicable to care provided within our scope of practice as defined by Hawai`i statute and administrative rules.

This legislation will permit licensed Advanced Practice Registered Nurses to sign medical certification forms including, but not limited to the certification of the needs of children to receive Aid For Financially Dependent Children, evaluation forms for Hansen's Disease patients, physical therapy orders and plans of care, pharmacist orders to assist in monitoring and management of anticoagulation, anemia and atrial fibrillation, speech therapy orders and plans of care, compassionate care only bracelet applications, foster home admissions, dietary consults, handicap parking passes, and Medicaid forms for nursing care facilities. Such legislation would allow the health care provider who has performed the evaluation or examination upon which an attestation is made to sign the form enabling the required services.



**HAWAII GOVERNMENT EMPLOYEES ASSOCIATION**  
AFSCME Local 152, AFL-CIO

**RANDY PERREIRA**  
*Executive Director*  
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The Twenty-Fifth Legislature, State of Hawaii  
Hawaii State Senate  
Committee on Health

Testimony by  
Hawaii Government Employees Association  
February 11, 2009

**S.B. 1217 – RELATING TO**  
**HEALTH CARE**  
**PROFESSIONALS**

The Hawaii Government Employees Association supports the purpose and intent of S.B. 1217. The bill allows an advanced practice registered nurse who provides care to a patient requesting medical certification forms, the authority to sign certifications applicable to the care provided within the advanced practice registered nurse's scope of practice.

The proposed legislation will benefit the patient by expediting the processing of paperwork and provide optimal care at the first point of access, especially in rural and underserved areas.

Thank you for the opportunity to testify in support of S.B. 1217.

Respectfully submitted

Nora A. Nomura  
Deputy Executive Director

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**From:** mailinglist@capitol.hawaii.gov  
**Sent:** Monday, February 09, 2009 10:16 PM  
**To:** HTHTestimony  
**Cc:** muraiz3@aol.com  
**Subject:** Testimony for SB1217 on 2/11/2009 3:00:00 PM

**Categories:** Green Category, Blue Category

Testimony for HTH 2/11/2009 3:00:00 PM SB1217

Conference room: 016  
Testifier position: support  
Testifier will be present: No  
Submitted by: Amy Stone Murai  
Organization: Individual  
Address: 1308 Al Hoku Place Honolulu, HI  
Phone: 808-833-1842  
E-mail: [muraiz3@aol.com](mailto:muraiz3@aol.com)  
Submitted on: 2/9/2009

**Comments:**

Consider adding the phrase, " Not withstanding any other law to the contrary," to cover situations where law or regulation of the various agencies that originate these certifications do not prevent the intent of this bill.



Cynthia Stuhlmiller  
7007 Hawaii Kai Drive A15  
Honolulu, 97825

February 8, 2009  
The Senate Committee on Health  
Twenty-fifth Legislative Session  
State of Hawaii  
RE: SB 1217, Relating to Health Care Professionals  
2/11/2009 at 3:00 pm  
Conference Room 16

Senators Ige, Green, and Members of the Committee. I am urging **support of SB 1217**, relating to Health Care Professionals.

My name is Cynthia Stuhlmiller. I am an APRN, professor at the University of Hawaii, consultant with the MedQUEST Division, and board member of numerous professional organizations. Streamlining delivery of health care is of utmost importance to cutting costs and reducing needless wastage of professional time. This bill is one clear example will reduce a needless step between point of contact and delivery of service.

**Please support SB 1217.**

Dr. Cynthia Stuhlmiller, RN, MS, DNSc.

Dennis B. Lind, M.D.  
615 Piikoi St., Suite 1509  
Honolulu, HI 96814

Re: SB1217, Relating to Health Care Professionals

Good afternoon, Senators Ige, Green, and Members of the Committee. I am a psychiatrist in private practice, and I've read this bill. I am in favor of APRNs being granted authority to sign any documents substantiating the care they render. It is redundant and costly to refer to physicians or psychologists to validate the care they have rendered to their patients when the state requires such signed documentation. If the APRNs perform the same kind of examination that a physician or doctoral level person performs, then it is obvious that they should be allowed to sign the proper documentation, rather than have the patient find a physician or psychologist to do the same thing. Obviously, if the APRN is not qualified to perform the required evaluation or treatment, then they will refer to someone who is so qualified.

Sincerely,

Dennis B. Lind, M.D.

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**From:** mailinglist@capitol.hawaii.gov  
**Sent:** Wednesday, February 11, 2009 8:15 AM  
**To:** HTHTestimony  
**Cc:** geesey@hawaii.edu  
**Subject:** Testimony for SB1217 on 2/11/2009 3:00:00 PM  
**Attachments:** HAPN test SB 1217.doc

Testimony for HTH 2/11/2009 3:00:00 PM SB1217

Conference room: 016  
Testifier position: support  
Testifier will be present: Yes  
Submitted by: Yvonne Geesey  
Organization: Hawaii Association of Professional Nurses  
Address: PO Box 62245 HI  
Phone: (808) 227-9361  
E-mail: [geesey@hawaii.edu](mailto:geesey@hawaii.edu)  
Submitted on: 2/11/2009

Comments:  
Amended

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**From:** mailinglist@capitol.hawaii.gov  
**Sent:** Monday, February 09, 2009 3:17 PM  
**To:** HTHTestimony  
**Cc:** kohala123@msn.com  
**Subject:** Testimony for SB1217 on 2/11/2009 3:00:00 PM

**Categories:** Blue Category

Testimony for HTH 2/11/2009 3:00:00 PM SB1217

Conference room: 016  
Testifier position: support  
Testifier will be present: No  
Submitted by: Elizabeth Bush  
Organization: Dept. of Veteran's Affairs  
Address: 459 Patterson Rd Honolulu, HI  
Phone: 808-329-0774  
E-mail: [kohala123@msn.com](mailto:kohala123@msn.com)  
Submitted on: 2/9/2009

**Comments:**

APRNS traditionally serve underserved and rural populations.

In almost all states, we have the privilege of unobstructed, autonomous practice, including the right to act as sole signatory on disability claims; prescriptions; WC, SS, DHS and other documents verifying medical necessity of treatments; time off; functional disability. etc.

I personally care for over 400 psychiatrically disabled veterans and my patients would benefit from removal of current restrictions to APRN practice.

O au me ka ha`a ha`a (I am humbly yours),

Elizabeth Bush, MSN, APRN, CARN-AP, CSAC Board Certified Psychiatric Advanced Practice Nurse (NP and CNS) Certified Addiction Registered Nurse, Advanced Practice Certified Substance Abuse Counselor

"You must be the change you wish to see in the world." - Mahatma Gandhi

<http://addictionsprofessional.com>

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Wailua Brandman APRN-Rx BC  
Ke'ena Mauliola Nele Paia, LLC  
615 Piikoi Street, Suite 1509  
Honolulu, HI 96814

February 8, 2009

THE SENATE  
THE TWENTY-FIFTH LEGISLATURE  
REGULAR SESSION OF 2009

COMMITTEE ON HEALTH

Senator David Ige, Chair  
Senator Josh Green, MD, Vice Chair  
and Members of the Committee

RE: SB1217  
DATE: Wednesday, February 11, 2009  
TIME: 3:00 p.m.  
PLACE: Conference Room 016

Good Morning, Senators Ige, Green and Members of the Committee. My name is Wailua Brandman. Thank you for the opportunity to present testimony, as an individual, in strong support of SB 1217, relating to Advance Practice Registered Nurses (APRNs). I am an APRN in private practice in Honolulu. My specialty is Adult Psychiatric Mental Health Nursing. I am the President of the Hawai'i Association of Professional Nurses. My other professional responsibilities include being the O'ahu Board Member-at-Large of the American Psychiatric Nurses Association Hawai'i Chapter, and I am a committee member of the APRN Advisory Committee to the Hawai'i Board of Nursing (Board).

This is an excellent bill which would acknowledge APRNs for their Scopes of Practice, reduce redundancies in the process of health care, improve access to care for consumers and reduce the cost of health care in Hawai'i. As you may be aware, APRNs are educated to provide primary care, which includes preventative teaching and care, promotes self-care when indicated, and referrals to other providers when the needed care lies outside the APRNs scope of practice. APRNs are generally reimbursed at 85% of the Physician's Medicare Fee Schedule. By statute, the nursing profession in Hawai'i is an autonomous health care profession, regulated by nurses through the State Board of Nursing. APRNs should be granted authority to sign any documents substantiating the care they render. It is redundant and costly to require them to refer to physicians or psychologists to validate the care they have rendered to their patients when the State requires such signed documentation. APRNs perform the same kinds of evaluations, treatment plans and treatments but are compelled by State law to find a physician or psychologist to sign the APRNs work, most times when the MD or PhD has no experience or relationship with the APRNs patient. If the APRN is not qualified to perform the required evaluation or treatment, they refer the patient to a provider who is so qualified.

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Note that the professional literature has for many years recommended the removal of the barriers to APRN practice as an improvement to the health care delivery system in the United States (The Institute of Medicine's *The Quality Chasm*, and Barbara Safriet JD's article Health Care Dollars and Regulatory Sense, in the Yale Law Journal, to name a couple).

Many of my patients do not see another health care provider because of the stigma of mental illness and the fear that they will not be treated like other patients by a general practitioner or family practice. They rely on me to monitor their overall health status, which I do with an initial history, review of systems, and when needed a limited physical examination. I also order initial baseline laboratory studies to screen for overall pathology. When I find abnormalities, I refer them, with encouragement and instilling confidence in the referral provider to deliver the quality of care they deserve. I also provide a great deal of case management to steer my patients through the delivery system, helping them make the appropriate phone calls, coaching them on pertinent questions to ask, and educating them as to the sequella they can expect if they ignore their pathology. Being acknowledged as a Primary Mental Health Care Provider would facilitate consumers' navigation through the health care system.

Once again, thank you for this opportunity to testify in **strong support** of SB1217, with the noted amendment.

Sincerely, and with  
Warmest Aloha,

*Wailua Brandman MSN APRN CSNP*

Wailua Brandman APRN-Rx BC

Wailua Brandman APRN-Rx BC  
Psychiatric Mental Health Nurse Practitioner  
Ke`ena Mauliola Nele Paia LLC  
615 Piikoi, Suite 1509  
Honolulu, HI 96814

February 7, 2009

The Senate Committee on Health  
Twenty-fifth Legislative Session  
State of Hawaii

RE: SB 1217, Relating to Health Care Professionals

2/11/2009 at 3:00 pm  
Conference Room 16

Good afternoon, Senators Ige, Green, and Members of the Committee. My name is Wailua Brandman. Thank you for the opportunity to present testimony, as an individual, **in strong support of SB 1217**, relating to Health Care Professionals. I am an APRN in private practice in Honolulu. My specialty is Adult Psychiatric Mental Health Nursing. I am the President of the Hawai'i Association of Professional Nurses. My other professional responsibilities include being the O'ahu Board Member-at-Large of the American Psychiatric Nurses Association Hawai'i Chapter, and I am a committee member of the APRN Advisory Committee to the Hawai'i Board of Nursing (Board).

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Note that the professional literature has for many years recommended the removal of the barriers to APRN practice as an improvement to the health care delivery system in the United States (The Institute of Medicine's *The Quality Chasm*, and Barbara Safriet JD's article Health Care Dollars and Regulatory Sense, in the Yale Law Journal, to name a couple).

Many of my patients do not see another health care provider because of the stigma of mental illness and the fear that they will not be treated like other patients by a general practitioner or family practice. They rely on me to monitor their overall health status, which I do with an initial history, review of systems, and when needed a limited physical examination. I also order initial baseline laboratory studies to screen for overall pathology. When I find abnormalities, I refer them, with encouragement and instilling confidence in the referral provider to deliver the quality of care they deserve. I also provide a great deal of case management to steer my patients through the delivery system, helping them make the appropriate phone calls, coaching them on pertinent questions to ask, and educating them as to the sequella they can expect if they ignore their pathology. Being acknowledged as a Primary Mental Health Care Provider would facilitate consumers' navigation through the health care system.

Once again, thank you for this opportunity to testify in **strong support** of SB 1217.

Sincerely, and with Warmest Aloha,

A handwritten signature in cursive script that reads "W. Brandman APRN-Rx BC".

Wailua Brandman APRN-Rx BC



**Are Advanced Practice Psychiatric  
Nurses a Solution to Rural Mental  
Health Workforce Shortages?**

Working Paper #31 April 2004



UNIVERSITY OF  
SOUTHERN MAINE

**Are Advanced Practice Psychiatric Nurses  
a Solution to  
Rural Mental Health Workforce Shortages?**

**Working Paper # 31**

**April 2004**

David Hartley, PhD, MHA  
Valerie Hart, PhD, MSN  
Nancy Hanrahan, PhD, MS  
Stephenie Loux, MS

Maine Rural Health Research Center  
Institute for Health Policy  
Edmund S. Muskie School of Public Service  
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This study was funded by a grant from the federal Office of Rural Health Policy, Health Resources and Services Administration, DHHS (Grant #4 UIC RH 00013-04-05). The conclusions and opinions expressed in the paper are the authors' and no endorsement by the University of Southern Maine or the funding source is intended or should be inferred.

# **Are Advanced Practice Psychiatric Nurses a Solution to Rural Mental Health Workforce Shortages?**

## ***Executive Summary***

Advanced practice nurses specializing in mental health are typically referred to as advanced practice psychiatric nurses (APPNs). Clinical outcomes for these professionals have been found to be of high quality, as indicated by skill in diagnosis and treatment of mental illness (Merwin & Mauck, 1995). With an established scope of practice, including prescribing privileges, and with increasing numbers of APPNs seeking independent practice settings, it would appear that these mental health professionals may be an ideal mental health generalist for rural areas. This paper presents data on the geographic distribution of APPNs, and investigates the content of their training curriculum to determine what role this profession might play in addressing chronic shortages of mental health professionals in rural areas.

We find that training programs do not explicitly identify rural practice as a target for their curricula, but that the curriculum content of these programs is appropriate preparation for rural practice. More specifically, many programs focus on outreach to those with poor access to mental health services, which we believe is a key to effective rural practice. Unlike other mental health professions, without a background in advanced physical assessment skills, the APPN is equipped to provide a *full range* of services to clients, combining psychiatric assessment skills with primary care and medication management. This efficiency of personnel is most appealing in a rural setting, where there is a chronic shortage of psychiatric clinicians of any sort and particularly those who can treat the patient in a holistic fashion. It is this holistic framework that is evident in the program and course description of many of the programs analyzed in this study.

We find that significant numbers of APPNs are choosing rural practice. While nationally only thirteen percent of credentialed APPNs are located in rural areas, twenty states have at least 20 percent of their APPNs in rural practice. Many of these are states with a small total number of APPNs, however, a few, such as Iowa, Kentucky, Maine, New Hampshire, Oregon and Vermont, have significant numbers as well as percentages practicing in rural communities.

Unfortunately, psychiatric nursing accounts for a very small portion of the total mental health workforce. Nationally there are 3.11 APPNs per 100,000. However, in rural Maine, rural New Hampshire, and rural Vermont, we estimate ratios of APPNs per 100,000 to be 9.6, 8.7 and 10.4 respectively. While these numbers fall short of the national ratio for psychiatrists, the

preference of that profession for urban practice results in an estimated 3.9 psychiatrists per 100,000 in rural America (Hartley et al., 1999). Thus, in a few states at least, APPNs have become more prevalent than psychiatrists in rural areas. Moreover, psychiatric nursing continues to grow as a profession, and if APPNs continue to choose rural practice at the current rate, these provider to population ratios will grow in rural areas. Since 1995, the profession has grown at a rate of approximately 300 nurses per year. If that rate continues, the national ratio of providers per 100,000 in rural areas will be roughly the same for APPNs and psychiatrists by 2010.

### **Recommendations**

1. To increase the proportion of APPNs choosing rural practice, financial incentives must be considered. These could include a reimbursement differential under Medicare and Medicaid for those practicing in designated mental health Health Professional Shortage Areas, and loan repayment programs under the National Health Service Corps or similar state programs.
2. Some states require that APPNs have a “collaborative relationship” with a physician. In rural areas the only physician available for such collaboration may be a family practitioner, who is unlikely to have sufficient psychiatric training to be appropriate for such clinical oversight. While a psychiatrist might be a more appropriate collaborator, most rural areas have none. Thus, those states that require such collaborations should consider peer-to-peer clinical supervision as an alternative to collaboration or supervision requirements currently designating a physician as the partnering clinician.
3. Currently, the Bureau of Primary Health Care is facilitating an expansion of Community Health Center sites, funding both new sites and satellite expansions of existing sites. Under this initiative, The BPHC should consider incentives for these Federally Qualified Health Centers to add APPNs to their clinical staffs.
4. The Health Resources and Services Administration currently offers a number of funding mechanisms for health professions training. Some of these existing programs could be modified to create incentives for training programs to be more explicit about preparing advanced practice nursing students for rural practice. The Quentin Burdick program has done this by funding curricula that use new and innovative methods to train health care practitioners to provide services in rural areas. It may be a good model for other incentives to university training programs.

## ***Are Advanced Practice Psychiatric Nurses a Solution to Rural Mental Health Workforce Shortages?***

Psychiatric Nursing is a growing profession that holds promise for relieving chronic shortages of mental health providers in rural areas, and for improving access to and quality of care for a range of mental health needs. Combining prescriptive authority and familiarity with an ever-changing psycho-pharmacy formulary with an array of physical and mental health diagnostic and treatment skills, these professionals may be the ideal mental health generalist for rural areas. This paper summarizes the clinical skills and prescriptive authority of Advanced Practice Psychiatric Nurses, and investigates current trends in their geographic distribution to determine what their future role may be in addressing rural mental health needs.

### **Background**

Rural communities suffer from a shortage of mental health professionals (Knesper, Wheeler, & Pagnucco, 1984; Lambert & Agger, 1995; Stuve, Beeson, & Hartig, 1989). As of September 1999, over 85 percent of the designated Mental Health Professional Shortage Areas in the United States were located in non-metropolitan (rural) counties. These areas are home to roughly 57 percent of the country's rural population (Bird, Dempsey & Hartley, 2001). Variations in the supply of mental health professionals may be an important factor in explaining persistent differences observed in access to and use of mental health services in rural versus urban areas (Lambert & Agger, 1995).

A number of studies have demonstrated that mental health professionals are differentially distributed in rural and urban areas, with psychiatrists and Ph.D. level psychologists tending to practice in urban and suburban areas, leaving mental health professionals with master's level preparation or less as the most readily available mental health providers in most rural areas (Hartley, Bird, & Dempsey, 1999; Holzer, Goldsmith and Ciarlo, 1998; Goldsmith, Wagenfel, Manderscheid, & Stiles, 1997). For example, the supply of psychiatrists is 14.6 per 100,000 in urban areas as compared with 3.9 per 100,000 in rural areas (Hartley et al., 1999).<sup>1</sup>

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<sup>1</sup> While national data for urban and rural supply of psychologists are not available, the most rural states have, on average, about 25% fewer psychologists per capita than the national average of 20 per 100,000 (Hartley, Bird and Dempsey 1999).

Due to these shortages of mental health specialty providers, it is generally accepted that at least half of the mental health services in rural areas are provided by primary care practitioners (Norquist & Regier, 1996). Typically, these PCPs are prescribing anti-depressants and other psychoactive medications because there are no psychiatrists practicing in rural areas, but, as generalists, most of these PCPs have difficulty keeping up with current drugs and current protocols (Rost et al., 2000).

With one recent exception, advanced practice psychiatric nurses (APPNs) are currently the only non-physician providers of mental health services licensed to prescribe medications.<sup>2</sup> Advanced Practice Registered Nurses are registered nurses who hold a minimum of a master's degree in an area of nursing specialization and have received supervised clinical experience in their specialty. Clinical Nurse Specialists and Nurse Practitioners are two common titles used by psychiatric nurses (Ivey, Scheffler, & Zazzali, 1998). Collectively, advanced practice nurses specializing in mental health are typically referred to as advanced practice psychiatric nurses (APPNs). Clinical outcomes for these professionals have been found to be of high quality, as indicated by skill in diagnosis and clinical results in the inpatient setting (Merwin & Mauck, 1995). The scope of clinical duties for these specialties often includes; 1) assessment, 2) diagnosis, 3) outcome identification, 4) planning, 5) implementation of treatment plan including psychotherapy, 6) case management, 7) consultation, 8) health promotion and maintenance, 9) prescriptive authority, and 10) referral. Typically, CNSs are trained in psychotherapy, and do not have prescriptive authority, while NPs place more emphasis on the biological model, including medications. In fact, NPs prescribe prescriptions quite frequently and the majority feel they have the knowledge to choose the most effective form of pharmacological treatment (Shell, 2001). Whether, and which APPNs can be granted prescriptive privileges varies by state, by training program, and by title. Current licensing laws in most states address APPN privileges in a general way, without addressing privileges granted to each respective specialty.

Certification of APPNs is done at the national level, by taking a certifying examination, administered by the American Nurses Credentialing Center. Until recently, there was only one national certifying exam, which was given to Clinical Nurse Specialists (CNSs). Technically, this left MH Nurse Practitioners with no official credential to practice. There is now a second national certification exam for NPs. Since the scope of practice of APPNs varies, and could

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<sup>2</sup> Prescriptive authority has been approved for PhD Psychologists in New Mexico.

change for an individual practitioner over the course of his or her career, many APPNs are taking both exams.

Beyond the explicit privileges granted by national certification, state licensure, or effectively granted by the policies of third party payers, other factors are likely to determine the extent to which APPNs can relieve the shortages of other mental health providers. For example, despite federal incentives encouraging mid-level primary care practitioners to practice in rural areas, it has been observed that only 15-20 percent of nurse practitioners choose such practice settings (Lin, Burns, & Nochajski, 1997; Baer & Smith, 1999). Also, in some states, APPNs are required to have some kind of collaborative or supervisory relationship with an MD, limiting their ability to practice autonomously in remote areas. It should be noted, however, that voluntary collaboration appears to be chosen in many cases without a legal mandate (Talley & Richens, 2001).

Some training programs place more emphasis on psychotherapy, while others place more emphasis on a biological model of treatment, including medication management. It is not clear whether graduates of some programs can meet the spectrum of needs for outpatient counseling, case management, and medication management now in such short supply in our most rural areas. Moreover, providing all of these services in a small independent practice, and taking on the risks associated with treating those with serious mental illness, may be too much to expect of this emerging profession. Practice settings that provide collaborative relationships with other clinicians, on an equal basis, overcoming traditional clinical role relationships, are needed.

Despite considerable state-to-state variation in titles and supervision/collaboration requirements, the national credentialing exams offer some assurance that the scope of practice for APPNs may be more uniform than that of some other mental health professions (Haber et al., 2003, Hartley, Ziller, Lambert, Loux, & Bird, 2002). With an established scope of practice, including prescribing privileges, and with increasing numbers of APPNs seeking independent practice settings, it would appear that these mental health professionals may be an ideal mental health generalist for rural areas. This paper seeks to determine the extent to which APPNs should be viewed as a potential key component of the rural mental health system.

We examine this question from two perspectives that can be expressed as two questions:

1. Are APPNs clinically prepared to address mental health needs in rural areas?

2. Are APPNs choosing rural practice in sufficient numbers to represent a meaningful addition to the rural mental health workforce?

#### Research Questions:

1. Which states grant prescriptive authority to APPNs? To which titles of APPN do they grant such authority?
2. How many APPNs are now practicing in the US, state-by-state? Do we know how many of them are practicing in rural areas?
3. To what extent are APPN academic programs preparing graduates for rural practice? What proportion of recent graduates are choosing rural practice?
4. How does the curriculum content (and practice content) of MH CNS academic programs differ from that of MH NPs?
5. Are both the MH NP and the MH CNS appropriate for some rural settings, or is one of these significantly more promising for meeting rural needs?
6. To what extent can we look to APPNs to address the shortages of mental health services and practitioners in rural areas?

#### State Licensure and Prescriptive Authority

In 1999 the American Psychiatric Nurses Association conducted a study of licensure and prescribing laws and rules in all states. This study found that the titles recognized by statute vary from state to state, as do the prescribing privileges, and the extent to which APPNs are allowed to prescribe independently (American Psychiatric Nurses Association, 2001). That study has recently been updated, and recent findings are included here (Table 1) as part of this project (Haber et al., 2003). (See Appendix A for our methodology in summarizing that study.)

Table 1 illustrates that Psychiatric Nurse Practitioners are licensed and have prescriptive privileges in all 50 states, with the exception of Georgia, where their prescriptive authority is limited to protocols overseen by a physician. Florida also requires the use of protocols, but the requirement of physician oversight is less explicit. Clinical Nurse Specialists are licensed in 43 states, and may be granted some level of prescribing privileges in 32 states. While these data would seem to suggest that the CNS license might be less preferable for an independent rural practice, our findings on current trends in training programs suggest that many with the CNS



license are taking the NP exam and being granted prescriptive privileges. For that reason, we do not feel that the distinction between the CNS and NP licenses will be a determining factor in the ability of APPNs to provide needed services in rural areas.

### **Geographic Distribution of Advanced Practice Psychiatric Nurses**

Using data from the American Nurses Credentialing Center, we assigned each APPN who is credentialed under any of the current exams to one of four categories on an urban – rural continuum. This continuum was developed using Rural Urban Commuting Areas (RUCA), as developed by the USDA and the WWAMI research center. RUCAs are based on census data, and use patterns of commuting to determine the extent to which census tracts are linked to urban or suburban areas, or to rural towns. Although the RUCA continuum includes 10 levels of urbanization, with several sub-categories based on the percentage of the population that is linked to a more urbanized area, a simplified approach has been suggested that collapses multiple RUCA categories into four levels: urban core, suburban, large town and small town/rural (The use of RUCAs in health care, 2002).

In addition, although the RUCA coding system is based on census tracts, WWAMI has developed a file that assigns RUCA codes to zip codes for use when the census tract is not known. Using the zip code file and the four-level RUCA-based continuum, we assigned each nurse in the ANCC dataset to one of the four levels. The results are shown in Table 2. Unfortunately, these data do not indicate how many of the nurses have prescribing privileges. However, for purposes of this investigation, the data are useful in indicating how many APPNs are choosing rural practice. With data from all states, it is also possible to identify states in which a greater proportion of APPNs are choosing rural practice.

What is apparent from the data presented in Table 2 is that significant numbers of APPNs are choosing rural practice. While nationally only thirteen percent of credentialed APPNs are located in rural areas, twenty states have at least 20 percent of their APPNs in rural practice. While many of these are states with a small total number of APPNs, a few, such as Iowa, Kentucky, Maine, New Hampshire, Oregon and Vermont, have significant numbers as well as percentages practicing in rural communities.

## **Training Programs in Psychiatric Nursing**

The trend in Advanced Practice Psychiatric Nursing over the past decade has been to develop a new role for the profession, that of the Psychiatric Nurse Practitioner. This role emerged in response to a variety of changes in health care including: managed care demands; the shift to a biological approach in psychiatric care; decreasing enrollment in existing graduate psychiatric nursing programs; market demand; and lack of primary care services for chronically mentally ill patients (Lego, 1996; McCabe, 2000; Moller, & Haber, 1996; Williams et al., 1998). Psychiatric nursing programs, at the masters or graduate level, historically have prepared Clinical Nurse Specialists (CNSs) who functioned as expert clinicians, nurse psychotherapists, consultants and educators. The nature of this new role is illustrated in the differences in curriculum between CNS programs and NP programs, and also by the changes within both types of degree programs in recent years.

### **How does the curriculum content of CNS academic programs differ from that of NPs?**

The core difference in curriculum for the Psychiatric Nurse Practitioner lies in the area of a biological focus, historically utilized by primary care providers. An important difference in the scope of practice is that of prescriptive authority. The American Nurses Credentialing Center (ANCC), the official credentialing body for the discipline, outlined the required coursework for CS's to be permitted to qualify for the first Psychiatric NP exam in October of 2000. The courses were: Advanced Physical Assessment, Pharmacology, and Biological Aspects of Psychiatric Care (or equivalent). These courses continue to be the cornerstone of graduate curriculum nationally for the Psychiatric NP and point to the role of providing primary care and prescriptive practice. In addition, typical other NP curriculum differences include an emphasis on case management, and cognitive or short-term therapy, or crisis intervention. Since managed care has embraced a short-term model of mental health care and sought symptom relief rather than character restructuring it has adopted such behavioral therapies as solution focused or brief therapy. A shift to short-term behavioral or cognitive therapy, more in line with crisis intervention than traditional psychotherapy, is a distinguishing feature of most Psychiatric NP programs.

In addition to the three required courses mentioned above, the psychiatric NP receives training in the assessment and management of physical symptoms not related to mental health

issues, and thereby has the skill set to make a differential diagnosis in cases where medical and psychiatric symptoms may confound the diagnosis. Not only can the NP distinguish between medical and psychiatric illness, but prescriptive practice allows for interventions in both psychotherapy and psychopharmacology. This clinician can also treat a range of ages, if trained in most programs that are certified as family nurse practitioner programs. As an NP the Psychiatric NP is capable of treating neuropsychiatric problems as well as providing primary health care for psychiatric patients.

### **To what extent are APPN academic programs preparing graduates for rural practice?**

The American Association of Colleges of Nursing reports that 69 secondary education institutions offer a psychiatric mental health program for CNSs with 450 enrolled students and 149 graduates in 2002. Another 40 schools of nursing offer a psychiatric nurse practitioner program with 480 enrolled students and 137 graduates in 2002 (Berlin, Stennett, & Bednash, 2002)

Our investigation of the curricula of these programs was limited to nine states, chosen because they have a sizable rural population, we believed they were producing significant numbers of APPNs, and because of familiarity with some of the programs in the selected states. We contacted colleges and universities with graduate programs in nursing in Alaska, Iowa, Kentucky, Maine, New Hampshire, Ohio, Oregon, Washington and Vermont, and gathered detailed information on psychiatric nursing programs in these states. The APPN programs surveyed for this project are detailed in Appendix B.

The various nursing graduate programs in psychiatric mental health nursing in the identified states were identified using a credentialing catalogue. The internet and telephone were utilized to contact college and university personnel to procure curriculum materials and an assessment was done to determine which type of program existed. Programs fell into a category of either having only CS or NP tracks or both or a combination CS/NP or dual preparation program. This was most often determined by explicit statement about what certification examination candidates would be prepared to take upon graduation. When this was not clear a closer look at the coursework made the determination obvious which preparation was the intended outcome of the program (CS or NP). Many of the programs also offer a Post-Masters

Certificate, comprised of courses related to biological aspects of mental illness, pharmacology, psychopharmacology (theory and practice), and advanced health assessment.

In reviewing the programs in this study it was clear that the tone of graduate psychiatric nursing curriculum has taken a turn in the past decade toward the biological model. The name “psychiatric nursing” is replaced with “behavioral health nursing” in some programs, further designating an emphasis on primary mental health care (University of Akron). Neurobiology and neuropsychiatric care are explicitly noted in program descriptions (Intercollegiate College). Courses like Biological Aspects of Psychosocial Disabilities (University of Washington), Biological Aspects of Mental Illness (USM), and Pathophysiology of Altered Health States (Ohio State) are examples of the emphasis on current biological/neurological research, which provide the core in the nurse practitioner curricula, and pave the way for safe prescriptive practice for these advanced practice nurses.

While the program at Husson College in Maine is the only program that specifically mentions the word “rural” in its program description (HRSA Grant funded the program) most of the programs do have a focus on reaching out to patients who do not have access. In addition, the chronically mentally ill population is mentioned frequently in the mission statements of the programs or in the descriptions of the NP programs. Williams et al. (1998) called for APPNs to meet the needs of the chronically mentally ill in primary care settings, where their psychiatric needs are often “under diagnosed and under treated”. Some programs specifically target “underserved and high-risk” psychiatric populations (University of Akron, Husson).

McCabe & Grover (1999) argue for a marriage of the psychiatric assessment skills of the CS with the primary care and medication management skills of the NP as the future role of the advanced practice psychiatric nurse. This “full-service” mental health professional is most appealing in a rural setting, where there is a chronic shortage of psychiatric clinicians of any sort and particularly those who can address both physical and psychiatric needs. While not explicitly touting “rural” as an agenda, these programs are in fact meeting a rural agenda, by way of the *type* of patient their graduates will be well trained to treat, as well as the *scope of practice* that best suits rural reality, that is one clinician to care for psychotherapy and medication needs for patients.

The reality of rural practice for the APPN is obviously one that is potentially fraught with problems, not the least of which is lack of a peer group for consultation and support, and

therefore proper methods of providing links to peers must be determined in order to bridge the isolation that is inherent in such a setting. In fact, this might be accomplished by redefining the collaborative or supervisory relationships specified in some licensure rules to encourage peer-to-peer clinical supervision.

**Are both the MH NP and the MH CNS appropriate for some rural settings?**

In general, nurse practitioner programs, with training in psychopharmacology, as well as shared curriculum with Family Practice NP programs, may better prepare students to managing a wide range of psychiatric problems. On the other hand, the literature is clear that medication in combination with counseling or other therapy, is the preferred treatment for many psychiatric problems. Moreover, many of the programs we surveyed offer both the CNS and the NP credential, and have experienced a shift in enrollment from the former to the latter, in some cases combining programs, since the introduction of the national NP examination in 2000. In addition, many graduates of CNS programs have sought additional training and taken the NP certification exam. We expect that the demand for prescriptive privileges will drive enrollment and curricula to an even greater extent in the future, making this question somewhat academic.

**To what extent can we look to APPNs to address the shortages of mental health services and practitioners in rural areas?**

Our findings contain good news and bad news. The good news is that, with nearly 9,000 APPNs practicing in the US, 1120 or about 13% are practicing in rural areas. This is in sharp contrast to 6.6% of psychiatrists (Hartley et al., 1999). Moreover, in several rural states, over 20 percent of APPNs have chosen rural practice. The scope of practice, the breadth of training, and the philosophy of the training programs all suggest that APPNs may well be the ideal rural mental health professionals, even though virtually none of the training programs we surveyed are explicit in targeting rural practice.

The bad news is that psychiatric nursing accounts for a very small portion of the total mental health workforce. For example, while our data indicate a total of 8,696 APPNs practicing in the US, there are an estimated 38,258 psychiatrists, 76,968 psychologists, and 96,268 social

workers<sup>3</sup> (West et al., 2000). To put these comparative data in another context, we are accustomed to using ratios of providers per 100,000 population as an indicator of the adequacy of the workforce. For the nation as a whole, current estimates are 11.3 psychiatrists, 27.5 psychologists and 36.2 social workers per 100,000 population. Nationally there are 3.11 APPNs per 100,000.

On the other hand, those rural states that have a larger number of APPNs with a greater proportion of them practicing in rural areas are somewhat more promising. For example, in rural Maine, rural New Hampshire, and rural Vermont, we estimate ratios of APPNs per 100,000 to be 9.6, 8.7 and 10.4 respectively. While these numbers fall short of the national ratio for psychiatrists, the preference of that profession for urban practice results in an estimated 3.9 psychiatrists per 100,000 in rural America (Hartley et al., 1999). Thus, in a few states at least, APPNs have become more prevalent than psychiatrists in rural areas. Moreover, psychiatric nursing continues to grow as a profession, and if APPNs continue to choose rural practice at the current rate, these provider to population ratios will grow in rural areas. Since 1995, the profession has grown at a rate of approximately 300 nurses per year. If that rate continues, the national ratio of providers per 100,000 in rural areas will be roughly the same for APPNs and psychiatrists by 2010.

Unfortunately, there will be increasing pressure on APPNs with prescribing privileges to become med-check mills for managed care insurers seeking a less costly alternative to psychiatrists. Already such organizations are approaching psychiatric nurses with lucrative offers (Hart, personal communication). These payers, however, are not typically interested in psychotherapy or other more time consuming (and costly) treatment regimens. They just want clinicians who are certified in psychopharmacology.

## **Recommendations**

1. To increase the proportion of APPNs choosing rural practice, financial incentives must be considered. These could include a reimbursement differential under Medicare and Medicaid for those practicing in designated mental health Health Professional Shortage

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<sup>3</sup> The number of social workers includes a significant number who do not deliver mental health services, e.g. discharge planners in general hospitals and nursing homes.

Areas, and loan repayment programs under the National Health Service Corps or similar state programs.

2. Some states require that APPNs have a “collaborative relationship” with a physician. In rural areas the only physician available for such collaboration may be a family practitioner, who is unlikely to have sufficient psychiatric training to be appropriate for clinical oversight. While a psychiatrist might be a more appropriate collaborator, most rural areas have none. Thus, those states that require such collaborations should consider peer-to-peer clinical supervision as an alternative to collaboration or supervision requirements currently designating a physician as the partnering clinician.
3. Currently, the Bureau of Primary Health Care is facilitating an expansion of Community Health Center sites, funding both new sites and satellite expansions of existing sites. Under this initiative, The BPHC should consider incentives for these Federally Qualified Health Centers to add APPNs to their clinical staffs.
4. The Health Resources and Services Administration currently offers a number of funding mechanisms for health professions training. Some of these existing programs could be modified to create incentives for training programs to be more explicit about preparing advanced practice nursing students for rural practice. The Quentin Burdick program has done this by funding curricula that use new and innovative methods to train health care practitioners to provide services in rural areas. It may be a good model for other incentives to university training programs.

### References

- American Psychiatric Nurses Association. (2001). *Advanced practice in psychiatric mental health nursing, State of the states: 2001*.
- Baer, L. D., & Smith, L. M. (1999). Non-physician professionals and rural America. In T. C. Ricketts (Ed.), *Rural Health in the United States* (pp. 52-60). New York: Oxford University Press.
- Berlin, L. E., Stennett, J., & Bednash, G. D. (2002). *Enrollment and graduations in baccalaureate and graduate programs in nursing*. (No. 01-02-01). Washington, D.C.: American Association of Colleges of Nursing.

- Bird, D. C., Dempsey, P., & Hartley, D. (2001). *Addressing mental health workforce needs in underserved rural areas: Accomplishments and challenges*. (Working Paper #23). Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy, Maine Rural Health Research Center.
- Goldsmith, H. M., Wagenfel, R., Manderscheid, & Stiles, D. (1997). Specialty mental health services in metropolitan and non-metropolitan areas, 1983 and 1990. *Administration and Policy in Mental Health, 24*(6), 475-88.
- Haber, J., Hamera, E., Hillyer, D., Limandri, B., Pagel, S., Staten, R., & Zimmerman, M. (2003). Advanced practice psychiatric nurses: 2003 legislative update. *Journal of the American Psychiatric Nurses Association, 9*(6), 205-216.
- Hartley, D., Bird, D., & Dempsey, P. (1999). Rural mental health and substance abuse. In T. C. Ricketts (Ed.), *Rural Health in the United States* (pp. 159-178). New York: Oxford University Press.
- Hartley, D., Ziller, E., Lambert, D., Loux, S., & Bird, D. (2002). *State licensure laws and the mental health professions: Implications for the rural mental health workforce*. (Working Paper #29). Portland, ME: University of Southern Maine, Rural Health Research Center.
- Holzer, C. E., Goldsmith, H. F., & Ciarlo, J. A. (1998). *The availability of health and mental health providers by population density*. (Letter to the Field No. 11). Denver: Frontier Mental Health Services Resource Network.
- Ivey, S. L., Scheffler, R., & Zazzali, J. L. (1998). Supply dynamics of the mental health workforce: Implications for health policy. *Milbank Quarterly, 76*(1), 25-57.
- Knesper, D. J., Wheeler, J. R., & Pagnucco, D. J. (1984). Mental health services providers' distribution across counties in the United States. *American Psychologist, 39*(12), 1424-1434.
- Lambert, D., & Agger, M. S. (1995). Access of rural AFDC Medicaid beneficiaries to mental health services. *Health Care Financing Review, 17*(1), 133-145.
- Lego, S. (1996). Long live the CNS and the NP in psychiatric nursing: Do not blend the roles. *Online Journal of Issues in Nursing*, Available [http://www.nursingworld.org/ojin/tpc1/tpc1\\_1.htm](http://www.nursingworld.org/ojin/tpc1/tpc1_1.htm) (Access date: July 10, 2003).
- Lin, C., Burns, P. A., & Nochajski, T. H. (1997). The geographic distribution of nurse practitioners in the United States. *Applied Geographic Studies, 1*(4), 287-301.
- McCabe, S. (2000). Bringing psychiatric nursing into the twenty-first century. *Archives of Psychiatric Nursing, 14*(3), 109-116.
- McCabe, S., & Grover, S. (1999). Psychiatric nurse practitioner versus clinical nurse specialist: Moving from debate to action on the future of advanced psychiatric nursing. *Archives of Psychiatric Nursing, 13*(3), 111-116.



- Merwin, E., & Mauck, A. (1995). Psychiatric nursing outcome research: The state of the science. *Archives of Psychiatric Nursing*, 9(6), 311-331.
- Moller, M. D., & Haber, J. (1996). Advanced practice psychiatric nursing: The need for a blended role. *Online Journal of Issues in Nursing*, Available [http://www.nursingworld.org/ojin/tpc1/tpc1\\_7.htm](http://www.nursingworld.org/ojin/tpc1/tpc1_7.htm) (Access Date: July 10, 2003).
- Norquist, G. S., & Regier, D. A. (1996). The epidemiology of psychiatric disorders and the de facto mental health care system. *Annual Review of Medicine*, 47, 473-479.
- Rost, K., Nutting, P., Smith, J., Coyne, J. C., Cooper-Patrick, L., & Rubenstein, L. (2000). The roles of competing demands in the treatment provided primary care patients with major depression. *Archives of Family Medicine*, 9(2), 150-154.
- Shell, R. C. (2001). Antidepressant prescribing practices of nurse practitioners. *The Nurse Practitioner*, 26(7), 42-47.
- Stuve, P., Beeson, P. G., & Hartig, P. (1989). Trends in the rural community mental health workforce: A case study. *Hospital and Community Psychiatry*, 40(9), 932-936.
- Talley, S., & Richens, S. (2001). Prescribing practices of advanced practice psychiatric nurses: Part I--Demographic, educational and practice characteristics. *Archives of Psychiatric Nursing*, 15(5), 205-213.
- The use of RUCAs in health care.* (2002). [Web Page]. URL [http://www.fammed.washington.edu/wwamirhrc/rucas/use\\_healthcare.html](http://www.fammed.washington.edu/wwamirhrc/rucas/use_healthcare.html) [2004, January 28].
- West, J., Kohout, J., Pion, G. M., & Wicherski, M. M. (2000). Mental health practitioners and trainees. In R. W. Manderscheid, & M. J. Henderson (Eds.), *Mental health, United States, 2000* (pp. 279-315). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Williams, C. A., Pesut, D. J., Boyd, M., Russell, S. S., Morrow, J., & Head, K. (1998). Toward an integration of competencies for advanced practice mental health nursing. *Journal of the American Psychiatric Nurses Association*, 4(2), 48-56.

**Table 1: Psychiatric Nurses and Requirements for Prescriptive Authority**

State	NP	CNS	Protocols	Collaboration
Alabama	•	o		√
Alaska	•	NA <sup>1</sup>		
Arizona	•	o		
Arkansas	•	•		√
California	•	o		√
Colorado	•	•		
Connecticut	•	•		√
Delaware	•	•		
Florida	•	•	√	√
Georgia	o <sup>f</sup>	o <sup>f</sup>	√	
Hawaii	•*	•*		
Idaho	•	•		√
Illinois	•	•*		√
Indiana	•	•		√
Iowa	•*	•*		
Kansas	•*	•*		√
Kentucky	•*	•*		√
Louisiana	•*	•*		√
Maine	•	o		
Maryland	•	o		√
Massachusetts	•	•		√
Michigan	•	NA		√
Minnesota	•	•		√
Mississippi	•	o		√
Missouri	•*	•*		√
Montana	•*	•*		
Nebraska	•*	•*		√
Nevada	•*	•*		√
New Hampshire	•	•		
New Jersey	•	•*		√
New Mexico	•	•		
New York	•	NA		√
North Carolina	•	NA		√
North Dakota	•	•		√
Ohio	•	•		√
Oklahoma	•*	•*		√
Oregon	•	o		
Pennsylvania	•	o		√
Rhode Island	•	•		√
South Carolina	•*	•*		√
South Dakota	•	o		√
Tennessee	•	NA		√
Texas	•	•		√
Utah	•*	•*		
Vermont	•*	•*		
Virginia	•	o		√
Washington	•	NA		
West Virginia	•	NA		√
Wisconsin	•	•		
Wyoming	•*	•*		

o	Licensed, but does not have prescriptive authority
•	Licensed with prescriptive authority
NA	Not licensed in the state
*	Can prescribe if licensed as an APRN
+	Licensed as an APRN only
f	May order through protocol with physician

<sup>1</sup> “CNSs from other states are eligible for certification as ANP”, Haber (2003) Table 1

Table 2. Distribution of Advanced Practice Psychiatric Nurses (APPNs) by State and Rurality<sup>1</sup>

State	Rurality				Total	% Rural Population <sup>2</sup>	% of APPNs in	
	Urban	Suburban	Large Town	Rural			Urban & Suburban <sup>3</sup>	Large Town & Rural <sup>4</sup>
AK	39	4	6	3	<b>52</b>	32.4%	82.7%	17.3%
AL	41	9	4	9	<b>63</b>	58.2%	79.4%	20.6%
AR	12	3	11	3	<b>29</b>	13.6%	51.7%	48.3%
AZ	87	10	10	6	<b>113</b>	52.9%	85.8%	14.2%
CA	315	23	8	4	<b>350</b>	3.3%	96.6%	3.4%
CO	118	13	1	14	<b>146</b>	18.6%	89.7%	10.3%
CT	315	98	9	18	<b>440</b>	8.6%	93.9%	6.1%
DC	29	0	0	0	<b>29</b>	0.0%	100.0%	0.0%
DE	23	1	0	1	<b>25</b>	20.3%	96.0%	4.0%
FL	217	28	7	8	<b>260</b>	7.0%	94.2%	5.8%
GA	181	12	17	11	<b>221</b>	30.2%	87.3%	12.7%
HI	22	16	7	5	<b>50</b>	28.0%	76.0%	24.0%
IA	39	3	7	15	<b>64</b>	54.1%	65.6%	34.4%
ID	12	1	6	2	<b>21</b>	65.4%	61.9%	38.1%
IL	152	10	8	12	<b>182</b>	14.8%	89.0%	11.0%
IN	85	21	11	2	<b>119</b>	27.5%	89.1%	10.9%
KS	73	9	11	3	<b>96</b>	42.5%	85.4%	14.6%
KY	79	15	18	18	<b>130</b>	51.1%	72.3%	27.7%
LA	25	5	4	7	<b>41</b>	24.4%	73.2%	26.8%
MA	727	93	34	47	<b>901</b>	1.5%	91.0%	9.0%
MD	328	57	23	14	<b>422</b>	7.2%	91.2%	8.8%
ME	66	44	16	49	<b>175</b>	59.8%	62.9%	37.1%
MI	157	29	17	16	<b>219</b>	17.8%	84.9%	15.1%
MN	162	14	18	26	<b>220</b>	29.2%	80.0%	20.0%
MO	106	6	7	18	<b>137</b>	32.0%	81.8%	18.3%
MS	36	5	7	6	<b>54</b>	67.4%	75.9%	24.1%
MT	5	2	8	5	<b>20</b>	76.8%	35.0%	65.0%
NC	127	19	16	18	<b>180</b>	32.0%	81.1%	18.9%
ND	13	0	7	2	<b>22</b>	54.8%	59.1%	40.9%
NE	38	4	14	1	<b>57</b>	46.6%	73.7%	26.3%
NH	44	33	22	22	<b>121</b>	37.5%	63.6%	36.4%
NJ	301	39	4	2	<b>346</b>	0.0%	98.3%	1.7%
NM	48	10	9	2	<b>69</b>	42.4%	84.1%	15.9%
NV	11	2	2	0	<b>15</b>	11.7%	86.7%	13.3%
NY	612	49	30	40	<b>731</b>	7.9%	90.4%	9.6%
OH	263	25	15	3	<b>306</b>	18.9%	94.1%	5.9%
OK	18	2	7	0	<b>27</b>	38.7%	74.1%	25.9%
OR	60	14	23	7	<b>104</b>	28.8%	71.2%	28.9%
PA	338	42	25	16	<b>421</b>	15.4%	90.3%	9.7%
RI	96	24	1	0	<b>121</b>	8.0%	99.2%	0.8%
SC	79	12	7	5	<b>103</b>	29.8%	88.4%	11.7%
SD	5	0	1	4	<b>10</b>	64.4%	50.0%	50.0%
TN	142	24	22	11	<b>199</b>	32.3%	83.4%	16.6%
TX	197	38	17	12	<b>264</b>	14.7%	89.0%	11.0%
UT	74	3	3	3	<b>83</b>	24.0%	92.8%	7.2%
VA	230	38	26	21	<b>315</b>	21.4%	85.1%	14.9%
VT	8	4	10	31	<b>53</b>	67.1%	22.6%	77.4%
WA	345	53	16	12	<b>426</b>	16.7%	93.4%	6.6%
WI	73	10	7	8	<b>98</b>	32.0%	84.7%	15.3%
WV	19	5	7	6	<b>37</b>	57.6%	64.9%	35.1%
WY	3	0	3	3	<b>9</b>	69.9%	33.3%	66.7%

State	Urban	Suburban	Large Town	Rural	Total	% Rural Population	% Urban & Suburban	% Large Town & Rural
US	6595	981	569	551	8696	19.7%	87.2%	12.9%

Source: American Nurse Credentialing Center, Center, Economic Research Service, USDA 2002

#### Four Tiered Consolidation of RUCA Codes

Consolidation Class	RUCA Codes
Urban Core Areas	1
Suburban Areas	2, 3, 4.1, 7.1, 8.1, 10.1
Large Town Areas	4, 5, 6, 7.2, 8.2, 10.2
Small Town and Isolated Rural Areas	7.0, 7.3, 7.4, 8, 8.3, 8.4, 9, 9.1, 9.2, 10, 10.3, 10.4, 10.5

<sup>1</sup> The degree of rurality was defined using the 1990 zip code version of Rural Urban Commuting Areas (RUCA) codes. We used a four tiered consolidation of the RUCA system which collapses them into urban core, suburban, large town and small town and isolated rural areas. The table shown above illustrates how each of these areas was defined.

<sup>2</sup> Percent of population living in rural areas in 2002. These data were obtained from the state fact sheets found on the USDA's Economic Research Service site, [www.ers.usda.gov/state\\_facts/](http://www.ers.usda.gov/state_facts/). Rurality was defined using Rural Urban Continuum Codes. Metropolitan counties were classified by size of MSA (using codes 0 through 3) and non-metropolitan counties were classified by degree of urbanization and proximity to metropolitan areas (using codes 4 through 9).

<sup>3</sup> Percent of mental health APRNs in urban and suburban areas.

<sup>4</sup> Percent of mental health APRNs in large town and rural areas.

## Appendix A

### *Methodology for Table 1.*

We obtained information about the status of licensure and prescriptive authority of psychiatric nurse practitioners (NPs) and clinical nurse specialists (CNSs) from a recent article addressing legislative and licensure issues. (Haber et al., 2003). The data were collected from state boards of nursing, each state's professional organization or American Psychiatric Nurses Association and national organizations. The table included in this article summarizes the authors' findings with three pieces of information for each state. First, Haber and her colleagues list the nursing titles recognized by each state. This category also included information on whether NPs or CNSs were included under the title of Advanced Practice Registered Nurse (APRN). Second, the table lists whether a CNS or NP has prescriptive authority. Lastly, for those with prescriptive authority, the table provides the type of prescriptive authority given, including collaborative, independent, or supervised.

**Appendix A**  
**Psychiatric Nursing Programs contacted for this study.**

**Alaska:**

University of Alaska- Anchorage School of Nursing

Program: Psychiatric-Mental Health Nursing- 32 cr, CS-Adult and PNP-Adult  
Program typically runs every other yr- with cohort of 5 students.

**Iowa:**

1. Allen College- is a private college for nursing and allied health professions in Waterloo, in northeast Iowa established in 1989. It developed out of the original Allen Memorial Hospital Nurses Training School (which originated in 1925). The college offers programs in nursing and radiology.

It has joint ventures with the University of Northern Iowa (Cedar Falls) and Wartburg College (Waverly) for general education instruction.

Programs: Family Nurse Practitioner program, not psychiatric. Masters of Science in Nursing with focus on Leadership or Health Education.

2. Drake University- HAD a graduate nursing program, which closed in May of 2003. It no longer has Nursing at either Grad or undergrad level.

**Kentucky:**

1. University of Kentucky- Large Graduate program (17 faculty), and there is even an Assistant Dean for Advanced Practice Nursing. There are many Master's level tracks and subspecialties including Adult Psychiatric/Mental Health Nurse Practitioner (others include Acute Care Nurse Practitioner, Adult Clinical Nurse Specialist, Parent-Child Nursing, Primary Care Nurse Practitioner, Public Health Nursing, Geriatric Nurse Practitioner, Neonatal Clinical Nurse Specialist, Public Health Clinical Specialist).

The Psych NP program identifies the severely mentally ill adult and their family as a particular focus along with those with "common problems" or acute and chronic problems and co-morbidities. The program is a total of 44 Credit Hours. It is a typical Psych NP curriculum- with Psychopharm, Pathophysiology, Health Assessment included. There is also a Post Master's Certificate Program Option-

2. Spaulding University- in Louisville- Sisters of Charity of Nazareth, both undergrad and grad liberal and professional studies- mission statement stresses an emphasis on service and promotion of "peace and justice".

School of Nursing offers a Master of Science in four tracks: Leadership in Nursing; Nurse Practitioner: Adult, Family and Pediatric. No Psychiatric Program.

3. Northern Kentucky University- Department of Nursing offers both undergrad and Grad nursing. The MSN program offers nursing administration and Primary Care Nurse Practitioner- focusing on Adult, Pediatric, Family and Geriatric. Also a post-master's certificate is offered. An on-line MSN program began Fall of 2003. No Psychiatric NP.

4. Murray State- Department of Nursing offers both undergrad and Masters Of Science in nursing- Clinical Specialist, Family Nurse Practitioner and Nurse Anesthetist. No Psychiatric program.

**Maine:**

1. Husson College – private college in Bangor.  
Programs: Advanced Practice Psychiatric Nursing, CS in Child/adolescent or Adult and PNP – 43 cr  
Typical cohort – 6 students.  
Post-Masters Certificate- (for already certified Clinical Specialists) 12-18 cr Only program that explicitly stresses rural practice.

2. University of Southern Maine - Portland  
Programs: Psychiatric-Mental Health Nursing-45 cr CS in Adult or PNP in Adult  
Post-Masters Certificate- 12 cr Total student enrollment 8-10

**New Hampshire:**

Rivier College  
Psychiatric-Mental Health NP- 43 cr, Post- Masters Certificate  
Student enrollment, approximately 5/yr

**Ohio:**

1. Kent State  
Psychiatric Mental Health Nursing, CS and CS/NP- 45, 55 cr, Post Masters- 20 cr  
Students: average 6/yr, majority are CS

2. University of Akron  
Behavioral Health Nursing, CS or NP, Adult- 49 cr  
Students: average 5students/yr

3. Ohio State  
Psychiatric Mental Health Nursing, CS or dual psych /adult NP (cert as adult NP)  
Students - currently 13

4. University of Cincinnati

Psychiatric Nursing, CS- 60 quarter cr hrs  
New program as of summer '02 currently 2 students

**Oregon:**

Oregon Health Sciences University- Large program- national leader- campuses in Ashland, Klamath Falls, LaGrande, Portland, Eugene and Bend, Tacoma WA, Bozeman MT, and Provo UT (Coursework and programs delivered online).

Programs: The NP program is offered in Ashland and La Grande as well as in Bend and Eugene. The Clinical Nurse Specialist program is also offered in Ashland and in Eugene.

The Masters program Psychiatric Mental Health Nurse Practitioner is available in Portland and Ashland, Klamath Falls and LaGrande.

The PsychNP program- stresses the role of "primary mental health care provider: and intervention with "vulnerable populations".

The curriculum is one of the longest nationally- 65 Credits

A Post-Masters Certificate is also available

(Note: University of Portland offers both undergrad and grad nursing. Graduate programs include: Family Nurse Practitioner; and Leadership in Health Care Systems. No Psych program.)

**Vermont:**

University of Vermont-

Programs: Both undergrad and grad NP programs. Grad program offers Adult Health; Community Health, Adult and Family Nurse Practitioner. No Psych program.

**Washington:**

1. Intercollegiate College of Nursing

Programs: Psychiatric-Mental Health Nursing, PNP- 47-50 cr

Students: 40 currently enrolled; 10 admitted/yr typically 3 yrs to complete program

2. Seattle University School of Nursing

Programs: Psychiatric Mental Health NP- 59-62 cr (Also eligible for addictions certification)

Students: admitted 5 in June, 2003

3. Gonzaga University

Psychiatric-Mental Health Nursing, CS or PNP- 50 cr, Post- Masters Certificate- 31 cr





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