

**Evolution of the  
Gerontological Nurse Practitioner  
and the  
Gerontological  
Advanced Practice Nurses  
Association  
1981–2020**

care • continuity • connection





**Evolution of the  
Gerontological Nurse Practitioner  
and the  
Gerontological Advanced Practice  
Nurses Association:  
1981–2011**

**Compiled by the  
GAPNA Historical Committee  
2012**

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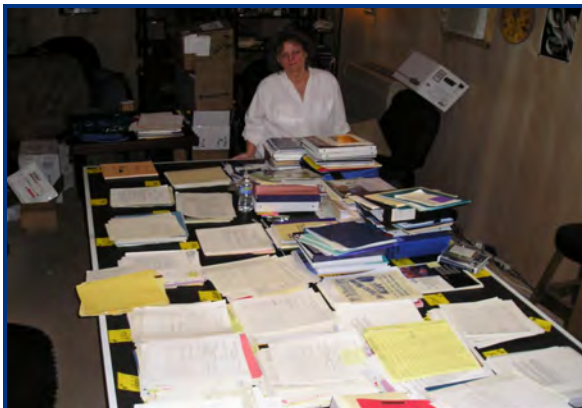
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"The Shed"

Virginia, Kathy, & Trudy

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# Chapter 1

## Geriatric Nursing: The Early Years

### Introduction

The Gerontological Advanced Practice Nurses Association (GAPNA), is the only national organization of advanced practice nurses (APNs) working with older adults, and includes Gerontological Nurse Practitioners (GNPs), Adult Nurse Practitioners (ANPs), Family Nurse Practitioners (FNPs), and Clinical Nurse Specialists (CNSs). In honor of the organization's 30th anniversary, this publication was compiled for two purposes. First, the evolution of Gerontological Advanced Practice Nurse (GAPN) role and this organization is reviewed within the context of nursing and health care of older adults from 1981 to 2011. Second, the future of the Gerontological Advanced Practice Nurse (GAPN) role and GAPNA is considered within the context of dynamic health and social policies and a rapidly aging population.

Specifically, the evolution from the National Conference of Gerontological Nurse Practitioner (NCGNP) to GAPNA is outlined by year and summarized by decade in each of three chapters. The national forces in health care and nursing that shaped the GNP role during these 30 years also are examined in three articles about each decade reprinted from the GAPNA Section of *Geriatric Nursing*. Finally, the current status of the GAPN role and implications for the future of GAPNA are considered in the last chapter and *GN* article.

The role of the GNP was impacted significantly in 2008 when the National Council of State Boards of Nursing (NCSBN) issued "The Consensus Model for APRN Regulation,"<sup>21</sup> uniform guidelines for advanced nursing practice which blended the GNP and ANP roles into the Adult-Gerontology NP (A/GNP) as a population focus for APRN licensure, and made the care of older adults a specialty linked to health care needs. The target for this integration of GNP and ANP roles is 2015. During this period of dynamic changes in APN roles, the contributions of GNPs and of this organization to advanced practice nursing care of older adults are especially appreciated. To all of these GAPNs and their contributions to the unique population of older adults across America this publication is dedicated.

## 1904–1980 Nursing Care for Older Adults

- 1902 *American Journal of Nursing* (AJN) published the first article on care of the aged written by an MD; the first article written by an RN was published in 1904.<sup>1</sup>
- 1925 Geriatric nursing was considered as a possible specialty in nursing in AJN.
- 1941 AJN published an article on restraint reduction at the Cuyahoga Nursing Home.
- 1950 C.V. Mosby published the first geriatric nursing text, *Geriatric Nursing*, by Kathleen Newton and Helen Anderson.  
First master's thesis in geriatric nursing was completed by Eleanor Pingrey.
- 1962 American Nurses Association (ANA) convened the first Conference Group on Geriatric Nursing, in Detroit, Michigan, with 70 attendees.
- 1965 Under President Lyndon Johnson, the Social Security Amendments of 1965 created Medicare and Medicaid, and the Older Americans Act of 1965 provided comprehensive services for older adults.
- 1966 ANA established the Division of Geriatric Nursing Practice.  
First Geriatric Clinical Nurse Specialist master's program established at Duke University.
- 1970 ANA published the first *Standards for Geriatric Nursing Practice*.<sup>2</sup>
- 1974 ANA began offering generalist certification in geriatric nursing practice (74 certified).
- 1975 Slack began publishing *Journal of Gerontological Nursing*; the first editor was Edna Stilwell.
- 1976 ANA changed the title of the Division to Gerontological Nursing Practice, updated the *Standards of Gerontological Nursing Practice*,<sup>3</sup> and began certifying Geriatric Nurse Practitioners.
- 1976 McGraw-Hill published *Nursing and the Aged*, by Irene M. Burnside.
- 1977 Kellogg Foundation began funding Geriatric Nurse Practitioner certificate education. First gerontological nursing track was funded by the Division of Nursing at the University of Kansas.
- 1979 Lippincott published *Geriatric Clinical Protocols* by Linda J. Pearson and M. Ernestine Kotthoff; contributors were largely the first cohort of Mountain States Health Corporation (MSHC) graduates who also were founding members of Western Conference of Geriatric Nurse Practitioners (WCGNP), including: Beverly Bakkum, Ruth Broderick, Gail de la Cruz, and Joyce Gill.
- 1980 ANA published *Nursing: A Social Policy Statement*,<sup>4</sup> including „Specialization;“ began publishing *Geriatric Nursing with* Cynthia Kelly as the first editor; and established the Council of Long Term Care Nurses.  
The National Organization of Nurse Practitioner Faculties (NONPF) was organized, including Geriatric Nurse Practitioners.





## 1975-1985 Mountain States Health Corporation



"The GNP project is progressing on schedule. As we plan for the evaluation of the GNP we find high interest from federal and private organizations. The concept of using GNP's has stimulated a great deal of interest." Pricilla Ebersole, Field Director

1975 -1978 The Mountain States Health Corporation (MSHC), based in Boise ID, received an initial 3-year grant from the Robert Wood Johnson Foundation to educate 25 RNs working in Skilled Nursing Facilities in medically underserved areas to become Geriatric Nurse Practitioners (GNPs).

1978-1990 MSHC was awarded a series of W. K. Kellogg Foundation grants to recruit geriatric nurse practitioner candidates from 11 Western states. The goal was to improve primary care in rural skilled nursing facilities. Registered Nurses (RNs) working in long term care facilities with 100 beds or more were to be trained to provide primary care. These nurses would be called Geriatric Nurse Practitioners much like the newly emerged Pediatric Nurse Practitioners.

- Experienced registered nurses working in nursing homes in underserved Western states were encouraged to apply.
- Three films were produced on the role of the GNP (two films are available).
- Annual meetings of MSHC program graduates were held to facilitate networking. These meetings evolved into an annual conference: The Western Conference of GNPs (WCGNP).

1978 The first phase of Montana GNPs graduated, followed by three additional phases of candidates from Idaho, Arizona, California, Colorado, Idaho, Montana, Oregon, Washington, and Wyoming. They were educated at SUNY-Syracuse, University of Colorado, and Cornell. Doris Schwartz, co-director of the earlier Primex program at Cornell, had experience developing an appropriate curriculum for continuing education programs at those universities. Drs. John Gerdes and Sidney Pratt, the visionaries who wrote the initial grant, mentored and supported these fledgling healthcare providers through their networking efforts with colleges of nursing and nursing home employers under the auspices of the MSHC grant. Pricilla Ebersole, on sabbatical from San Francisco State University, became the Field Director from 1981 to 1985.

1980 At a resort on Lake Coeur d' Alene, Idaho, MSHC hosted a gathering of 25 GNPs to determine opportunities for educational and professional development. Attendees helped set up a network of support and continuing education. The keynote speaker was Mary Opal Wolanin RN, BA, MPA, an early pioneer in geriatric nursing.

## Chapter 2

# The Geriatric Nurse Practitioner and NCGNP: The First Decade, 1981-1991

Trudy Keltz, GNP-BC

### WCGNP 1981

The Western Conference of Geriatric Nurse Practitioners (WCGNP) was formed in May, 1981, at Mount Angel Abbey, Oregon. This first conference, "Effect of Nutrition on Health in Later Years," had 25 attendees.



Mount Angel Abby, St. Benedict OR



MSHC continued to support WCGNP by publishing the newsletter, Pricilla Ebersole, Editor, and funding the conferences and other expenses through 1985.

Nationally in 1981, C.V. Mosby published the 1st edition of *Toward Healthy Aging* by Pricilla Ebersole and Patricia Hess and in March, the American Nurses Association (ANA) published "A Statement on the Scope of Gerontological Nursing Practice."<sup>5</sup> Hartford Foundation founded the Hospital Outcomes Program for the Elderly (HOPE) featuring a Geriatric Resource Nurse (GRN) model.

### Founding Members of WCGNP

Darlene Anderson, MT  
Beverly Bakkum, MT  
Sue Balint, OR  
Beverly Bradford  
Colleen Ruth Broderick, MT  
Lorraine Carter, OR  
Ruth Crosby Walkup, SD  
Gail de la Cruz, NM  
Sister James (Donna) Edgell, OR  
Joyce Gill, MT  
Shirley Kontos, MT

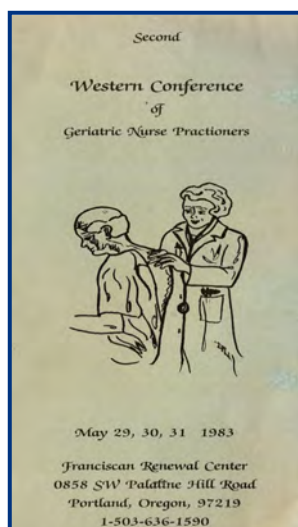
Mary Ann Laubacacher, OR  
Ruth Lueck, OR  
Barbara Lewis, ID  
Susan McDermott, ID  
Della Park, OR  
Carole Schaffer, OR  
Helen Shewmaker  
Audrey Smith, ID  
Alice Stoner  
Shirley Thennis, MT  
Sharon Western

## WCGNP 1982

The WCGNP conference was not held in 1982 because of a lack of volunteers.

Nationally in 1982, ANA reported 41 certified GNPs, and several GNP programs were started at universities across the country. New Medicaid regulations, "Improving the Quality of Life through Geriatric Nurse Practitioners," favored the use of GNPs in long term care.

## WCGNP 1983



The "2nd Western States Conference of GNP's" was held in May, 1983, at the Franciscan Renewal Center, Portland Oregon, with 66 attendees from across the country. Registration was \$100 for 30 contact hours; room/board was \$15 per night. Della Park rang a bell to alert attendees at the start of a session and no one was admitted after a session began. The WCGNP name was changed to the National Conference of Geriatric Nurse Practitioners (NCGNP) to reflect its membership from across the country. The membership established articles of incorporation as a non-profit, by-laws, a philosophy statement, organizational goals, and dues at \$15 per year.



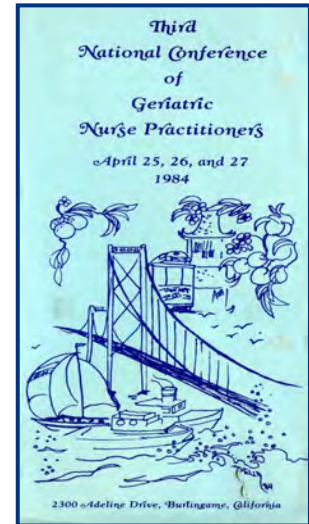
1st Officers elected were: President, Della Park; Vice President, Sue McDermott; and Secretary/Treasurer, Sister James (Donna) Edgell.

"The Western Conference of GNP's Inc established as a non-profit corporation held it's second conference in Portland, Oregon. Many thanks go to Della Park for her energy and enthusiasm for a job well done." Sister James Edgell, Oregon, June 1983 Newsletter

Nationally in 1983, ANA reported 165 certified GNP's. WCGNP obtained this list and contacted these GNPs to invite them to join and attend the conference. The Institute of Medicine (IOM) report stressed geriatric nursing education. The first endowed chair in gerontological nursing was established at Case Western Reserve University in honor of Florence Cellar.

## NCGNP 1983-1984

The 3rd NCGNP conference, "Emergency Care of the Older Adult," was held in April, 1984, at the Mercy Center Convent in Burlingame, California, with 72 attendees; registration was \$85 for 21 contact hours. Sessions started at 7 am and ended at 9 pm. Job descriptions for officers and organizational policies and procedures were developed. The GNP Newsletter circulation was 2,169 at a cost of \$1,400 per quarterly issue. NCGNP leadership contacted other organizations and professional groups such as the National Association of Pediatric Nurse Practitioners (NAPNAP), assisted living, home health and hospice.



"84-'85 Officers elected were: President, Ruth Lueck; President Elect, Sally Nail; Vice President, Susan McDermott; Secretary, Sharon Ferris; and Treasurer, Gayle Stewart.



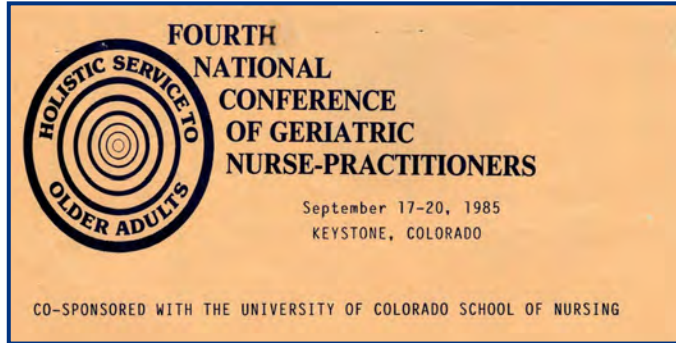
"At the 1983 conference the GNP's in attendance voted to create an official organization with the following goals: provide continuing education, maintain an open forum, create and distribute to the public and private industry the role of NP's in LTC, advocate at the local and national level for health needs of older Americans."

Ruth Lueck, Oregon (Spring 1985 Newsletter)

Nationally in 1984, GNPs struggled for 3rd party reimbursement and for recognition and autonomy as health care providers. The Rand Corporation, under the direction of Robert Kane, was granted funds to study the cost and quality effectiveness of GNPs working in nursing homes. This study was ultimately funded by the Health Care Financing Administration (HCFA), US Department of Health and Human Services (DHHS), Robert Wood Johnson Foundation, and W. K. Kellogg Foundation. The Little Hoover Commission urged greater use of GNPs in long term care and reimbursement for these services. Nursing programs in the United States included 8 GNP certificate and 16 GNP graduate programs. The National Gerontological Nurses Association (NGNA) was established for the clinical care of older adults across diverse care settings. The ANA Division of Gerontological Nursing Practice became a Council on Gerontological Nursing Practice.



## NCGNP 1984-1985



The 4th Conference, "Care of the Older Adult is Multidimensional," co-sponsored with the University of Colorado School of Nursing, was held in September, 1985, at Keystone, Colorado, with 68 attendees; registration was \$100 for 18 contact hours.

The membership was at 185; funds on hand were \$4,022. MSHC support of NCGNP conferences ended; dues were increased from \$15 to \$20 per year. A NCGNP logo, "Holistic Services to Older Adults," was introduced and the first GNP newsletter was published with a 1-year, \$10,000 grant from Mead Johnson; Arlene Woodson was the first editor briefly, then Jessie Bryant. NCGNP participated in the National Nurse Practitioner Forum.

"85-'86 Officers elected were: President, Sally Nail; President Elect, Bernie Gorek; Vice President, Sue McDermott; Secretary, Sharon Ferris; and Treasurer, Gayle Stewart.

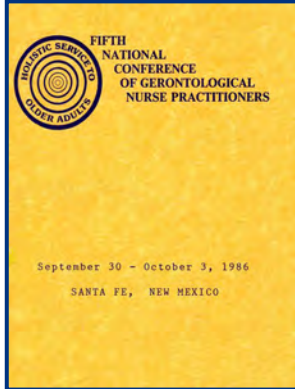
"NCGNP is leading the way in providing an avenue to meet these challenges. Our Organizations cooperative dynamics ensures that all members of the group participate in making decisions, thereby guaranteeing the continued participation and commitment of all."

Sally Nail, Colorado (Fall/Winter 1985 Newsletter)



Nationally in 1985, the American Academy of Nurse Practitioners (AANP) was formed to lead NPs in transforming patient centered health care. Hildegard Peplau published a warning in the February issue of the American Journal of Nursing (AJN), "Is Nursing's self regulatory power being eroded?"<sup>6</sup> She was concerned over the loss of nursing self regulation as a result of the American Medical Association (AMA) position that physician supervision of NPs was necessary.

## NCGNP 1985-1986



The 5th Conference, "Care to the Caregivers," was held at Sweaney Conference Center and La Fonda Hotel, in Santa Fe, New Mexico, with 80 attendees; registration was \$110 for 18 contact hours.



Susan McDermott, Sharon Farris and Nancy Trego depict "JOY" in dance therapy session.

Membership reached 206; funds on hand were \$8,480. Dues were increased from \$20 to \$40 per year. Vendor guidelines and policies and procedures for the GNP Newsletter were developed; the newsletter editors became Carol Weir and Lorraine Olson. Carol Weir conducted a NCGNP salary survey of GNPs. The Board of Directors meeting was funded by NCGNP for the first time (prior to this point the officers paid all their own expenses). NCGNP joined the National Alliance of Nurse Practitioners (NAPN), representing 7 NP organizations and 14,000 nurse practitioners, to be informed and involved in legislative issues with the potential for impacting clinical practice. NPs finally had a voice that was heard in the US Congress and the regulatory agencies.

"86-"87 Officers elected were: President, Bernie Gorek; President Elect, Carol Gustafson; Vice President, Susan McDermott; Secretary, Nancy Trego; Treasurer, Gayle Stewart.

"The NCGNP believes: gerontology is a unique field, high quality continuing education is beneficial; in networking and communications, a holistic approach is necessary, older adults are entitled to encompassing care, quality affordable services for all older adults."  
Bernie Gorek, Colorado (Summer 1987 Newsletter)

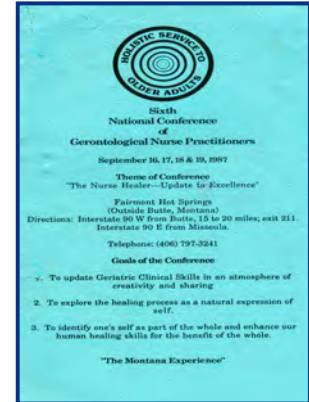


Nationally in 1986, the National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC) was organized as an advocate and educational organization for Directors of Nursing (DONs), Assistant Directors of Nursing (ADONs) and RNs in Long Term Care (LTC).

## NCGNP 1986-1987

The 6th Conference, "The Nurse Healer: Update to Excellence," was held at the Fairmont Hot Springs Resort, Anaconda, Montana, with 50 attendees for 17 contact hours.

Membership was at 167. Ross Labs began funding for printing and distribution of the GNP Newsletter; their grants covered 44 issues over the next 12 years. Lorraine Olson became the newsletter editor. A central office located in Fort Collins, Colorado, was established for the first time, staffed part-time by Yvonne O'Brien. NCGNP bought its first computer and a small amount was budgeted for committee work.



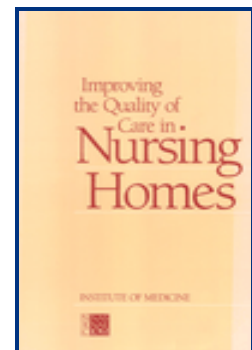
'87-'88 Officers elected were: President, Carol Gustafson; President Elect, C. Ruth Broderick; Vice President, Barbara Benzaquen; Secretary, Nancy Trego; Treasurer, Jessie Bryant.



"The Montana experience reminded me of the reason that I joined NCGNP: to share ideas and experiences with other GNP's. I returned from Montana with new ideas and renewed enthusiasm."  
Carol Gustafson, Montana (Fall 1987 Newsletter)



Nationally, following the Institute of Medicine report of March, 1986, "Improving the quality of care in nursing homes,"<sup>7</sup> in 1987, the American College of Health Care Administrators (ACHCA) conducted a study of NP and physician assistant (PA) performance in skilled nursing facilities demonstrating a high quality of care with outcomes comparable to physicians. Lobbied by NANP, including NCGNP, in December, President Ronald Reagan signed into law from the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), which included the Federal Nursing Home Reform Act. As the first major revision of the federal standards for nursing home care since the creation of both Medicare and Medicaid in 1965, this landmark legislation required long term care facilities wanting Medicare or Medicaid funding to provide services so that each resident can "attain and maintain her highest practicable physical, mental, and psycho-social well-being," and required facilities to decrease the use of physical and chemical restraints, which NCGNP helped to implement.

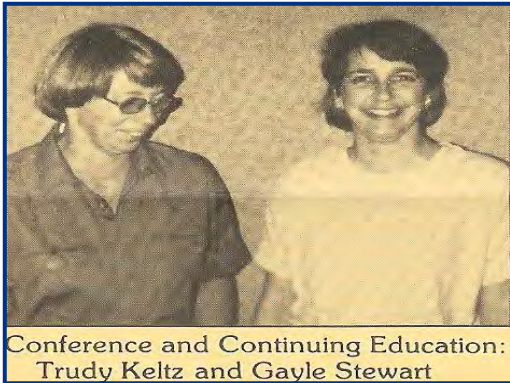


The ANA Council on Gerontological Nursing published *Standards and Scope of Gerontological Nursing Practice*.<sup>8</sup> The National Council on Aging requested a list of NCGNP membership.

## NCGNP 1987-1988

The 7th Conference, "Diversity: A Conference for Nurses in Gerontology," was held at the Miyako Hotel in San Francisco California, with 68 attendees; registration was \$150 for 21 contact hours.

Membership was at 178; the budget was \$12,600. Chapter rules and procedures were adopted. Conference planning committee for 1989 was funded \$1,000. Lorraine Olson was unable to be President Elect; Bernie Gorek was appointed to this position.



Conference and Continuing Education:  
Trudy Keltz and Gayle Stewart

This conference took place when another group backed out and the San Francisco committee chairs, Gayle Stewart and Trudy Keltz, were approached and said, "Sure, why not?" The GNPs from San Francisco hosted the conference four times: in 1984, 1988, 1997, and 2001.

"88-'89 Officers elected were: President, C. Ruth Broderick; President Elect, Lorraine Olson; Vice President, Barb Benzaquen; Secretary, Norma Lundy; and Treasurer, Jessie Bryant.

"I believe my excitement is optimistically based on the predictable evolution of NCGNP. I, for one, do not believe in laying dinosaur eggs (the fruition of plans that never materialize)."  
Ruth Broderick, Montana (Fall 1988 Newsletter)



Nationally in 1988, ANA reported 922 certified GNP's. The American Geriatrics Society (AGS) asked for the NCGNP membership list and the US Special Commission on Aging requested the NCGNP newsletter. Case Western Reserve University established the first PhD program in gerontological nursing.



## NCGNP 1988-1989



The 8th Conference, "Gaining New Perspectives," was held at the Elms Resort in Excelsior Springs, Missouri, with 135 attendees and 20 contact hours.

Membership was at 188 and funds on hand were \$5,050. NCGNP partnered with National Geriatric Nurses Association (NGNA), National Association of Directors of Nursing Administration (NADONA), National Alliance of Nurse Practitioners (NANP), and the ANA Council to organize the Gerontological Nursing Forum and was represented at a review of the Healthy People 2000 objectives.

"89-"90 Officers elected were: President, Bernie Gorek; President Elect, Linda Grisom; Vice President, Connie Gresham; Secretary, Norma Lundy; and Treasurer, Jessie Bryant.

"For the first time NP's from four national organizations concerned with gerontological nursing met. Each organization meets a specific need and has a somewhat different focus. This doesn't mean we must be antagonistic. We support one another whenever possible." Bernie Gorek, Colorado (Spring 1989 Newsletter)

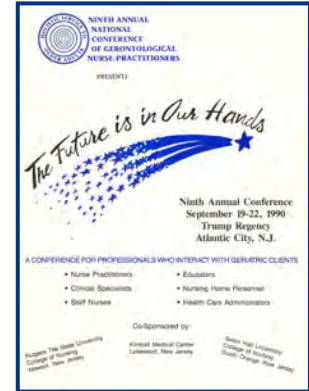


Nationally in 1989, ANA began certifying Gerontological Clinical Nurse Specialists. A major victory for NPs was passage of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), signed by George H. W. Bush, which provided reimbursement for Medicare and Medicaid; the Physician Payment Review System (PPRS) also was established.



## NCGNP 1989-1990

The 9th Conference, "The Future is in Our Hands," was held at the Trump Regency in Atlantic City, New Jersey; registration is \$169 for 14.2 contact hours.



Membership was at 170 and the budget for 1990 was \$12,800. A new central office secretary, Pam Timms, was hired to work out of her home in Fort Collins, Colorado. Pam continued to work with NCGNP for the next 10 years while also working as a preschool teacher. She often said there was not a lot of difference in her jobs: NCGNP members were just older.

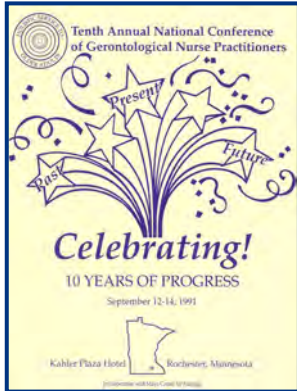
"90-'91 Officers elected were: President, Linda Grissom; President Elect, Norma Small; Vice President, Connie Gresham; Secretary, Norma Richards; and Treasurer, Jessie Bryant.

"At the tenth anniversary celebration banquet we will hear about the history of the NCGNP. Past and present leaders will be in attendance to help us celebrate." Linda Grissom, Arizona (Summer 1991 Newsletter)



Nationally in 1990, ANA established the Division of Long-Term Care within the Council of Gerontological Nursing.

## NCGNP 1990-1991



The 10th Conference, "Celebrating 10 Years of Progress," was held at the Kahler Plaza in Rochester, Minnesota; registration was \$150 for 18 contact hours. Membership dues increased from \$25 to \$40 per year.

Joe Caraway resigned as President Elect; Phyllis Freeman was appointed to this position. Rose Schmidt became the GNP Newsletter editor; under her leadership, over 1,200 copies of the newsletter were distributed four times a year. The first official NCGNP chapter was formed in Puget Sound, Washington.

ton.

"91-"92 Officers elected were: President, Norma Small; President Elect, Joe Caraway; Vice President, Phyllis Freeman; Secretary, Norma Richards; and Treasurer, Carol Wooden.

"It is a great honor to become President of NCGNP at it's 10th Anniversary Conference. The accomplishments have only been possible because of the VISION of GNP's and their dedication."  
 Norma Small, Pennsylvania (Fall 1991 Newsletter )

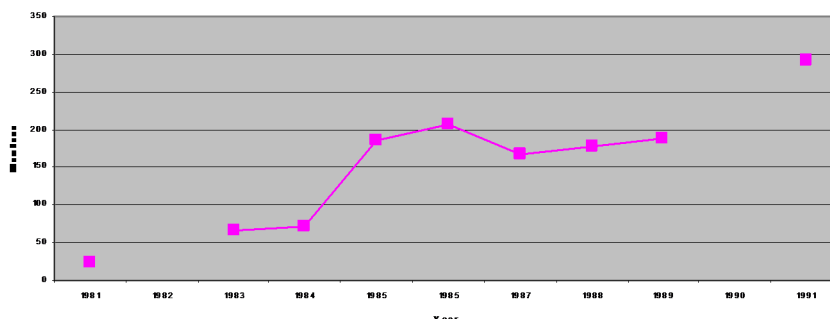


In this first decade, 1981-1991, NCGNP was focused on development as an organization for education, networking, and enhancement of the roles of NPs working with older adults. Several member surveys collected data on work sites, salaries, and other practice data. Membership grew to from 25 to 292; a 10-year increase of 116.8%. Nationally, NPs gained greater acceptance as "mid-level providers" from Medicare/Medicaid, Joint Commission on Accreditation of Hospitals (JCAH), and others. The GAPN roles of GNPs and GCNSs matured and expanded across the nation.



Past Presidents from 1981-1991 at the 10th Anniversary Celebration: Norma Small, Linda Grissom, C. Ruth Broderick, Bernie Gorek, Sally Nail, Ruth Lueck (not pictured Della Park and Carol Gustafson)

NCGNP Members 1981-1991



## **The Evolution of the Geriatric Nurse Practitioner – NCGNP The First 10 years**

C. Ruth Broderick, ANP/C,GNP,MSN, and Trudy A. Keltz, GNP-C\*

In 1976, Mountain States Health Corporation based in Boise, ID was awarded a Robert Wood Johnson grant to recruit geriatric nurse practitioner (GNP) candidates in the western United States. The goal was to improve primary care in rural skilled nursing facilities. RNs working in long term care were to be trained to provide primary care. They would be called GNPs much like the newly emerged Pediatric Nurse Practitioners. The first phase of Montana GNP's graduated in 1978 followed by three additional phases of candidates from Idaho, Arizona, Colorado, California, Oregon and Washington. Drs. John Gerdes and Sidney Pratt, the visionaries who wrote the grant, mentored and supported these fledgling healthcare providers through their networking efforts with colleges of nursing and nursing home employers under the auspices of the Mountain States grant.

At the end of the first grant phase, The Mountain State Health Corporation hosted a final gathering to sponsor an opportunity for GNPs to determine how we would support our education and professional development. At a resort on Lake Coeur d' Alene, Idaho, in 1980, 25 GNP graduates gathered to help set up a network of support and continuing education. The keynote speaker was Mary Opal Wolanin RN, BA, MPA, an early pioneer in geriatric nursing. In 1981 our first conference was held at Mount Angel Abbey in Oregon. In 1981 The Western States Conference of Geriatric Nurse Practitioners was formed. By 1983, the group's name would change to the National Conference of Geriatric Nurse Practitioners (NCGNP) with a final change substituting "Gerontological" for "Geriatric" Nurse Practitioners a few years later.

Publications specific to delivery of geriatric primary care as well as standards of geriatric care were scarce. At the time, GNPs could see that the medical model would not necessarily serve our elderly population or our nursing philosophy. Concerted efforts by geriatric nurse leaders began to disseminate best nursing practice in the specialty began to fill in the gaps began with the publication of the 1970 ANA paper "Standards of Geriatric Nursing." A series of publications followed including "Nursing and the Aged" by Irene Burnside in 1976; "Geriatric Clinical Protocols" edited by Linda Pearson and Ernestine Kolthoff in 1979; and "Toward Healthy Aging" by Priscilla Ebersole and Patricia Hess in 1981. These early authors began to build the foundation of theory for geriatric best practices and standards of care.

The daunting task of teaching the public who we were and gaining physician acceptance was difficult. We had only begun to realize who this new GNP was. There were no role models; although we had new skills, we were not sure where we fit in the paradigm. We knew we were not doctors and intuitively knew our nursing model was different. Organizations like the American Medical Association and local Medical Boards pressed for sanctions against NP practice, supporting over-the-shoulder supervision and prescribing restrictions. The lack of acceptance from our nursing peers presented challenges which further obstructed the GNPs' ability to deliver primary care. Often they would not accept our orders and in some states legally could not take orders from GNP's. The battle to get prescriptive authority and develop our scope of practice has evolved in a piecemeal fashion ever since, causing a significantly different scope of practice for every state. However, by 1982, new Medicaid regulations favored the use of GNP's in long term care and New Mexico authorized reimbursement. The following year, Arizona granted NP prescriptive privileges thanks to the strong NP advocacy of Audrey Rath, Director of the Board of Nursing at the time. Meanwhile, Mountain States had developed a GNP directory and a salary survey had been conducted by NCGNP member, Carol Weir. We had received endorsement from the Hoover commission for the role of the GNP.

## The Evolution of the Geriatric Nurse Practitioner –NCGNP The First 10 years—conclusion

By 1987, American College of Health Care Administrators had completed a study of NP/Physicians Assistant performance in skilled nursing facilities demonstrating a high quality of care with outcomes comparable to physicians. The American Nurses Association Council on Gerontological Nurse Practice published “Standards and Scope of Gerontological Nursing Practice.”

In 1986, the NCGNP (now known as the Gerontological Advanced Practice Nurses Association; GAPNA) took a step which gave us a national presence. We joined the National Alliance for Nurse Practitioners (NANP), a lobbying organization that formulated and monitored national policy for reimbursement of NP providers. Linda Grissom represented us for several years and was an aggressive and effective player in the NANP organization. For the first time, the organization had a pipeline to access emerging national policy for NP reimbursement. By 1989, we began to partner with NANP, NADONA and the ANA Council on Gerontological Nursing and the National Association of Director’s of Nursing in Long Term Care (NADNLTC) as a member of the Gerontological Nursing Forum. We all had a stake in the improvement of care for the frail elderly as well as the need for reimbursement. By national networking we were able to get a national audience and voice.

By 1987, NCGNP had a part-time national office in Colorado, 188 members, and had developed a structure for forming local chapters. Colorado became our first chapter with 31 members. These activities enabled us to jump from the west coast to the east coast, finally having a national presence. By 1988, ANA reported that 922 GNP’s were certified.

NCGNP was growing too. Our newsletter was edited by Loraine Olson and Carol Weir. During that time we developed vendor guidelines that restricted advertising and implemented new policy and procedures for the newsletter. In 1987, Ross Laboratory agreed to sponsor our publication, printing and distributing the newsletter for years.

Our 10<sup>th</sup> birthday was celebrated in Rochester, Minnesota. It was a joyous occasion for both new and old friends with the theme “Celebrating 10 years of Progress.” We all realized the most powerful part of the organization was the love and commitment of those who joined their friendship with each other with the determination to make the health care of older adults dignified, expert and respected. *GN*

\* Reprinted from the GAPNA Section, *Geriatric Nursing*, 33(2), pp. 150-152. Used with permission of Elsevier Health.

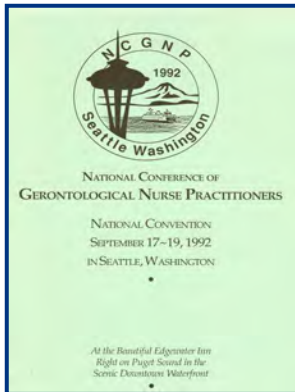


# Chapter 3

## The Gerontological Nurse Practitioner and NCGNP: The Second Decade, 1991-2001

Kathleen Fletcher, DNP, GNP-BC, FAAN

### NCGNP 1991-1992



The 11th Conference, "Frontiers of Aging," was held at the Edgewater Inn in Seattle, Washington, with 80 attendees; registration \$160 for 21 hours of continuing education.

The 10th Anniversary issue of the GNP Newsletter provided a synopsis of the early years and founding members. Membership reached 328; bylaws were streamlined and history, research, practice, and education committees were created. The Board of Directors started a savings account for a contingency fund and a telephone tree was organized for quicker response for actions on legislative issues. NCGNP collaborated with Nurse Practitioner Associates for Continuing Education (NPACE) to co-sponsor a 1993 conference, "Clinical issues of

older adults and mental health in the adult population," and worked with Health Care Financing Administration (HCFA) and National Coalition on Nursing Home Reform on "A guide for residents, families, and friends on avoiding drugs used as chemical restraints: new standards of care."



**Chapters.** The Board appointed Lynn Jensen from Puget Sound to be the first chair of Chapter Development. She created "Guidelines for NCGNP Chapter Development" and, over the next 20 years, 19 states formed Chapters. Several of them were active and then disbanded and later became active again. A few states formed more than one chapter (Florida, Tennessee, Texas) and some states combined chapters (Delaware/Pennsylvania and Louisiana/Mississippi).



'92-'93 Officers elected were: President, Phyllis Freeman; President Elect, Norma Richards; Secretary, Karen Wilson; and Treasurer, Carol Wooden.

"Change, challenge, renewal - all active words which aptly describe NCGNP. I am excited about the changes in and challenges to NCGNP as we position ourselves to be a positive influence in affecting change for the health care needs of older persons." Phyllis Freeman, Minnesota (Fall 1992 Newsletter)



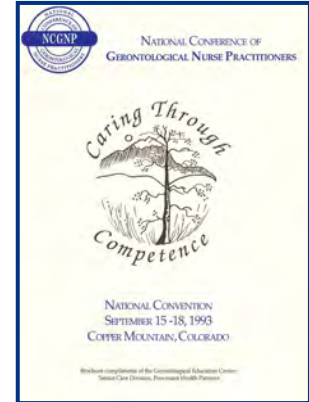
Nationally in the early 1990s, as the health care system responded to the concept of managed care, the merger of Nurse Practitioner and Clinical Nurse Specialist roles was being questioned with the Case Manager role suggested as an answer to this merger. In 1992, the John A. Hartford Foundation funded a major initiative to improve care of hospitalized older adults: Nurses Improving Care for Health System Elders (NICHE). The National Organization of Nurse Practitioner Faculties (NONPF) revised curriculum guidelines to reflect graduate education for NPs.



## NCGNP 1992-1993

The 12th Conference, "Caring Through Competence," was held in Copper Mountain, Colorado.

Membership was at 350. NCGNP pins became available for sale, the publication name was changed from the GNP Newsletter to the NCGNP Newsletter, and the philosophy statement was revised to include human rights—cultural diversity, sexual preference, and disability. Norma Small, Immediate Past President of NCGNP, became chair of the National Alliance of Nurse Practitioners (NANP). NCGNP was approached by CV Mosby to consider contracting with them as a management company—NCGNP declined.



'93-'94 Officers elected were: President, Norma Richards; President Elect, Jewel Winter; Secretary, Karen Wilson; Treasurer, Kathy Fletcher; and Board Member at Large, Connie Gresham.



"Over the years many members have come and gone. There are many APN's who work with the aging population who have yet to join. We must join together or we lose."

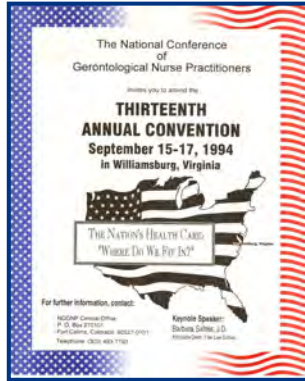
Norma Richards, Washington (Fall 1993 Newsletter)

Nationally in 1993, the American College of Nurse Practitioners (ACNP) was formed with a focus on a solid policy and regulatory foundation that enabled NPs to provide accessible, high quality healthcare to all peoples.



The National Council of State Boards of Nursing (NCSBN) questioned the need for a second licensure for Advanced Practice Nurses (APNs); NCGNP supported the American Nurses Association (ANA) stance for a single licensure for RNs.

## NCGNP 1993-1994



The 13th Conference, "The Nation's Health Care: "Where Do We Fit In?" was held in Williamsburg, Virginia.

Membership reached 375; bylaws revisions added Resource Development, History, and Bylaws as standing committees, a new logo was adopted, operating guidelines were developed for all of the committees, and the Research Committee became active under Norma Pinkerton. NCGNP financial records became computerized, and a FAX machine and a copier were ordered for Central Office. Sally Nail became Historical Committee chair and Lovenia Carter became NCGNP Newsletter

Editor. Laurie Kennedy-Malone reported to the membership on implications of proposed Health Care Reform for GNPs.



Old and New NCGNP logos

'94-'95 Officers elected were: President, Jewel Winter; President Elect, Barbara Brant; Secretary, Margaret Sackmann; Treasurer, Kathleen Fletcher; and Board Member at Large, Connie Gresham.

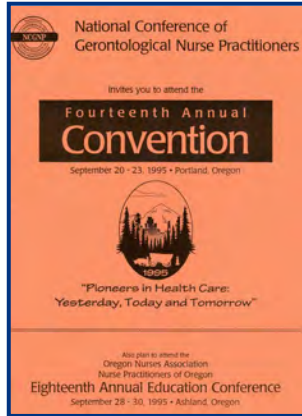
"My desire for NCGNP this year is to reflect the theme of next years conference: Pioneers on Health Care: Yesterday, Today and Tomorrow."  
Jewel Winter, Colorado (Fall 1994 Newsletter)



Nationally, the American Medical Directors Association (AMDA, formed in 1978) was interested in forming an alliance with NCGNP and two other organizations; the National NP Coalition and the National Alliance for Nurse Practitioners, which vied to be the legislative arm of NP's.



## NCGNP 1994-1995



The 14th Conference, "Pioneers in Health Care: Yesterday, Today, and Tomorrow," was held at the Red Lion Inn in Portland, Oregon.

Resource development became an active committee. Lovenia Carter became editor of the NCGNP Newsletter.

'95-'96 Officers elected were: President, Barbara Brant; President Elect, Kathy Fletcher; Secretary, Peggy Sackmann; Treasurer, Anne Marie Drexler; and Board Member at Large, Liz von Wellsheim.

"You can make a difference. Please lend your support through recruitment to membership and by serving on a committee of your interest. In doing so we can ready ourselves for a quantum leap into an exciting future."  
Barbara Brant Virginia (Fall 1995 Newsletter)



Nationally in June, 1995, ANA published the 2nd edition of *Scope and Standards of Gerontological Nursing*,<sup>9</sup> including the role of the APN in gerontological nursing, and NCGNP adopted these positions. NCGNP decided not to belong to the new American College of Nurse Practitioners but retained its membership in the National Alliance of Nurse Practitioners for legislative support. The World Wide Web was becoming an influence for APNs (e.g., NPINFO [1984], NP Central, and other list serves on the Internet).

## NCGNP 1995-1996

The 15th Conference, "Celebrating Diversity!" was held in Houston, Texas.

The membership reached 457; membership dues increased from \$40 to \$55 per year. An 800 telephone number was established at the NCGNP office in Fort Collins. The first audit of NCGNP financial records was completed; the Internal Revenue Service fined the organization for late filing, NCGNP appealed, and IRS waived the fee.

'96-'97 Officers elected were: President, Kathy Fletcher; President Elect, Laurie Kennedy Malone; Secretary, Peggy Sackmann; Treasurer, Ann Marie Drexler; Board Member at Large, Liz von Wellsheim.



"My individuals goals reflect the organization goals. I want to maintain cohesiveness and uniqueness, continue financial solvency, re-examine goals and priorities and to laugh more."

Kathy Fletcher, Virginia (Fall 1996 Newsletter)



Nationally in 1996, the Hartford Institute for Geriatric Nursing (HIGN) was founded with the goal of shaping the quality of health care older Americans receive by promoting the highest level of geriatric nursing competence. NCGNP opposed the National Council of State Boards of Nursing (NCSBN) proposal for another certification exam for NPs.

## NCGNP 1996-1997

The 16th Conference, "Care for the Caregivers," was held at the Miyako Hotel held in San Francisco, California.

A site visit to central office in Fort Collins CO was made to review inventory and hire a part-time bookkeeper. Liaison relationships were formed with American Medical Directors Association (AMDA) and the American Society of Consulting Pharmacists (ASCP).



'97-'98 Officers elected were: President, Laurie Kennedy Malone; President Elect, Mary Doucette; Secretary, Peggy Sackmann; Treasurer, Joyce Meador; and Board Member at Large, Liz von Wellsheim.



"I was ecstatic when congress passed the direct Medicare reimbursement bill in August. I want to thank all NCGNP members who over the years have supported grass roots efforts to make this possible."

Laurie Kennedy-Malone North Carolina (Fall 1997 Newsletter)

Nationally in 1997, an expansion of Medicare reimbursement for NPs became a reality when President Clinton signed the Balanced Budget Act on August 5th, which NCGNP supported vigorously.

## NCGNP 1997-1998

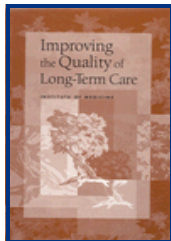


The 17th Conference, "Providing Holistic Health Care," was held at Embassy Suites in Greensboro, North Carolina, with 165 attendees. Significant financial loss was experienced at the this conference due to decreased attendance; CD's were cashed to cover these expenses.

Virginia Lee became NCGNP Newsletter Editor. The first NCGNP website was created and launched by Laurie and Chris Malone.

'98-'99 Officers elected were: President, Mary Doucette; President Elect, Liz von Wellsheim; Secretary, Virginia Lee Cora; Treasurer, Joyce Meador; and Board Member at Large, Carol Ann Mitchell.

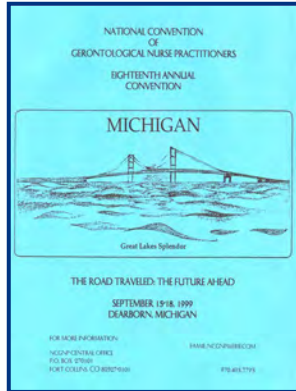
"Dynamic people make up the leadership team of this organization as a whole and you are a part of this group; a group that continues to impress me with its compassion, commitment, and strength." Mary Doucette, Minnesota (Fall 1998 Newsletter)



Nationally in 1998, the Balanced Budget Act of 1997 went into effect on January 1st. In March, NCGNP's President Laurie Kennedy-Malone testified at the Institute of Medicine (IOM) concerning, "Improving the Quality of Long-Term Care."<sup>10</sup>



## NCGNP 1998-1999



The 18th Conference, "The Road Traveled: The Future Ahead," was held in Dearborn, Michigan, with 155 attendees and 22.8 contact hours. Charged with the need to make a profit by the Board, the registration fee was raised for the first time in several years to \$340.00. In addition, 28 exhibitors and 8 sponsors were solicited. The convention was the most profitable in NCGNP history, netting over \$10,000 which enabled the organization to remain viable. Vendors would no longer be so difficult to secure as they were already signed up for next year.

Communication issues between the board, central office, and convention planning committee were attributed in part to their great geographic distances. The NCGNP Board decided to relocate the national office from Fort Collins, Colorado, to the Washington DC area. Pam Timms was thanked for her 10 years of service to NCGNP, and Kim Quimby was hired as part-time Administrative Assistant, working from her home in Centreville, Virginia.



Kim Quimby

'99-'00 Officers elected were: President, Liz von Wellsheim; President Elect, Mary Pat Rapp; Secretary, Virginia Lee Cora; Treasurer, Joyce Meador; and Board Member at Large: Carol Ann Mitchell.



"Our presence in the Washington DC area and our increased collaboration with numerous health care and consumer organizations will allow us to continue our goals of improving health care for all older adults and advancing our professional scope of practice."

Liz von Wellsheim, Oregon (Fall 1999 Newsletter)

Nationally in 1999, NCGNP dropped membership in the National Alliance of Nurse Practitioners and elected to have membership in the American College of Nurse Practitioners to help support legislative activity for APNs.

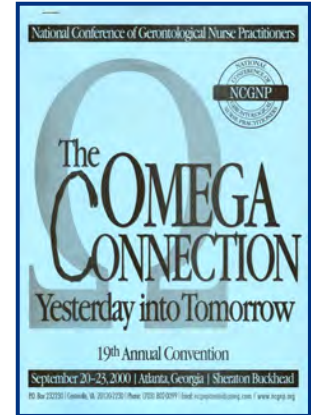
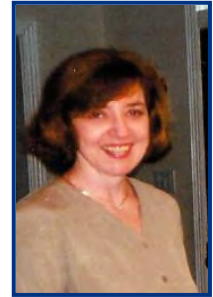
## NCGNP 1999-2000

The 19th Conference, "The Omega Connection: Yesterday into Tomorrow," was held in Atlanta, Georgia, with 200 attendees and a significant profit was realized.

Membership reached 619 and finances were improved due to the successful 1999 NCGNP conference in Michigan. The Board developed a 3-year strategic planning process with three primary goals: enhance health care to elders, improve the practice of GNPs, and strengthen NCGNP. The first NCGNP membership directory with 609 members was published. Norma Small became Historical Committee chair and Milbrey Raney became NCGNP Newsletter Editor. With the organization's increasing size and complexity, the Board began to solicit proposals from association management companies and for further web development.

'00-'01 Officers elected were: President, Mary Pat Rapp; President Elect, Virginia Lee Cora; Secretary, Nancy Wilens; Treasurer, Joyce Meador; and Board Member at Large, MJ Henderson.

"NCGNP is well on its way towards recognition by healthcare and consumer organizations devoted to the care of older adults."  
Mary Pat Rapp, Texas (Fall 2000 Newsletter)



Nationally in 2000, the John A. Hartford Foundation and the American Academy of Nursing launched the Building Academic Geriatric Nursing Capacity (BAGNC) program to produce experts who will provide leadership and improve the care of older adults.



## NCGNP 2000-2001

The 20th Conference, "2001: The Odyssey of Aging," was at the Holiday Inn Golden Gate in San Francisco, California.

Only 1 week after the tragic events of the September 11th terrorist attacks, 180 of the 230 registrants (78%) attended this conference. Several speakers had to cancel, including the keynote, but the planning committee quickly secured appropriate replacements. Preconference sessions focused on geriatric syndromes.



'01-'02 Officers elected were: President, Virginia Lee Cora;



President Elect, Barbara Resnick; Past President, Mary Pat Rapp; Secretary, Nancy Wilens; Treasurer, Caroline Duquette; and Board Member at Large, MJ Henderson.

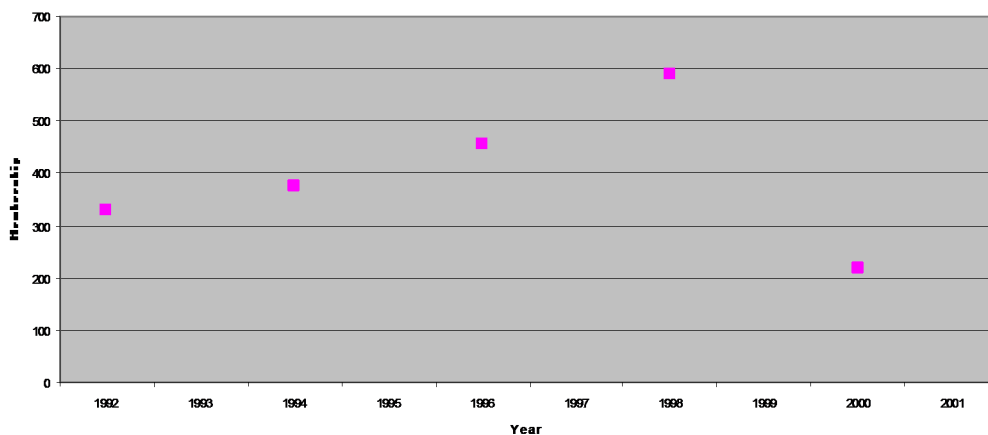
"NCGNP has been discovered! We have come from a small organization who volunteered their services to nearly 800 members, nine chapters throughout the nation, and we are growing."

Virginia Lee Cora, Mississippi (Winter 2002 Newsletter)

Nationally in June, 2001, the Department of Health and Human Services (DHHS) issued a report by the Office of Inspector General (OIG), "Medicare Coverage of Non-Physician Practitioner Services."<sup>11</sup>

In this second decade, 1991-2001, NCGNP was focused on issues arising from the complexities of increasing membership, involvement with other organizations, and national legislation and regulations influencing NP practice. The National Office relocated from its origins in the western states to the Washington DC area. Membership over these 10 years ranged from 328 to 589, an increase of 56%.

NCGNP Membership 1992-2001



## The Evolution of the GNP-NCGNP, the Second Decade—the 1990's

Kathleen Fletcher and Laurie Kennedy Malone\*

In 1991, National Conference of Gerontological Nurse Practitioners (NCGNP) celebrated its first decade of progress in Rochester, Minnesota. With a growth in membership from 25 to 292, the growth and accomplishments of the organization were dramatic during the first 10 years, and the participants celebrated the past, reveled in the moment, and planned for the future. The second decade of NCGNP history (1990-2000) would prove to be no less remarkable.

The early 1990s reflected significant growth of advanced practice nursing (APN) programs and organizations (nurse practitioner [NP] and clinical nurse specialist [CNS]) in the United States and greater clarity and understanding of the role and unique contributions of APNs. Although NP programs primarily prepared the APN in primary and specialty care, the CNS preparation was focused on populations of patients and improving care largely through consultation and education of care providers. Recognizing that there was considerable overlap in these respective roles, role merger was discussed in the literature and at nursing organizational forums—including NCGNP.

Nationally a new organization was formed, the American College of Nurse Practitioners (ACNP), in an attempt to bring some cohesiveness and legislative muscle to the growing number of NP specialty organizations. Looming on the horizon were legislative and reimbursement issues influencing NP practice. We were honored that one of our own, Norma Small, was elected as President of the National Alliance of Nurse Practitioners (NANP). In early 1990, NCGNP decided not to belong to the ACNP but to continue membership in the NANP for legislative support.

NCGNP was increasingly being recognized for their expertise in the care of elders. The Omnibus Budget Reconciliation Act (Nursing Home Reform) had been passed in 1987, requiring that nursing homes decrease the use of physical and chemical restraints, and NCGNP was called upon by HCFA and NCNHR to help lead the way in restraint reduction. In 1995, the ANA invited NCGNP to be represented on an expert panel to revise the Scope and Standards of Gerontological Nursing and for the first time the role of the APN in gerontological nursing was included in the second edition of this publication.

Following the lead of NCGNP leaders of the first decade, members continued to disseminate their expertise in geriatric best practices through publication. The second edition of *Towards Health Aging* (Ebersole and Hess) was released in 1998, and a new publication, *Management Guidelines for Gerontological Nurse Practitioners* (Kennedy-Malone and Fletcher and Plank) in 1999.

As NCGNP exerted its influence nationally, the organization continued to thrive. The by-laws of the organization were streamlined and modified. As membership in NCGNP and vendor sponsorship of NCGNP grew, the organization established a contingency fund to provide for greater financial stability. Acceptance of diversity was reflected in a revised philosophy statement.

Still, NCGNP was experiencing growing pains-- by 1994 membership was approaching 400. Although financial records were computerized, the hours for the part-time administrative assistant in the Central Office in Fort Collins were increased, and a FAX and copier were purchased, it was difficult for the all-volunteer board of GNPs to continue to keep up with needs. NCGNP was fined by the IRS for a late filing of taxes, appealed, and thanks to “fancy foot work” by our leaders at the time, the IRS waived the fee.



## The Evolution of the GNP-NCGNP, the Second Decade—the 1990’s—conclusion

The late 1990s marked one of the most monumental events in the history of the NP movement and the NCGNP. The collective legislative efforts of the NCGNP, the NANP, and the ACNP were rewarded when President Clinton signed the Budget Consolidation Act in 1997. Medicare reimbursement for NP’s was now a reality. NCGNP entered the internet age with the launching of its first web page in 1998.

Collaborations with other organizations continued through the late 1990s. The Hartford Institute of Geriatric Nursing formed a Gerontological Nursing Consortium recognizing the need for discussion and partnerships between the nursing organizations that had a focus on older adults, and NCGNP was invited to the table with the National Gerontological Nursing Association (NGNA) and the National Association of Directors of Nursing in Long Term Care (NADONA). During this time NCGNP started forming relationships with allied inter-professional groups such as the American Medical Directors Association (AMDA) and the American Society of Consulting Pharmacists (ASCP). In 1998, a representative from NCGNP, Laurie Kennedy-Malone who was at that time serving as president of the organization, was invited to testify at a public meeting held by the Institute of Medicine in preparation for the report “Improving the Quality of Long-Term Care,” which was published in 2001. She emphasized the need for all nurses employed in long-term care to have educational preparation in gerontological nursing and the vital role that GNPs play in managing the care of residents in long-term care.<sup>1</sup>

Internally, at NCGNP this was a time of growth, strategic planning, and change. Membership was over 600, and a 3-year strategic plan was created. Citing geographical and communication issues, the board decided to move the central office to DC, and a new administrative assistant was hired. At the end of the second decade NCGNP began to explore contracting for management and web development services.

In 2001, the 20<sup>th</sup> anniversary of NCGNP was celebrated in one of our favorite conference locations: San Francisco. It occurred just 1 week after the tragic events of the September 11 terrorist attacks, and the nation was still stunned, mourning, and fearful. A few speakers cancelled at the last minute, but the California planning committee did a masterful job finding expert replacements. Demonstrating the commitment to the organization, 78% of the registered participants attended a highly successful 20<sup>th</sup> conference and helped shape the future of our organization as we moved into our third decade. GN

<sup>1</sup> Kennedy-Malone, L. (2007). A NCGNP pioneer in legislation/reimbursement. *Geriatric Nursing*, 28 (4): 232.

\* Reprinted from the GAPNA Section, *Geriatric Nursing*, 33(3), pp. 235-236. Used with permission of Elsevier Health.

# Chapter 4

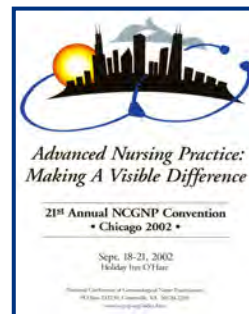
## The Gerontological Nurse Practitioner and GAPNA: The Third Decade, 2001-2011

Virginia Lee Cora, DSN, A/GNP retired, FAANP

### NCGNP 2001-2002

The 21st Conference, "Advanced Nursing Practice: Making a Visible Difference," was held at Holiday Inn O'Hare in Chicago, Illinois.

Membership was at 998. Guidelines were established for liaison representatives (e.g., AANP, ACNP, AGS, AMDA, ANCC, NGNA, NADONA, NCGN, NONPF, AARP). In June, NCGNP members met in Houston, Texas, to develop a Core Curriculum for FNP, ANPs, and CNSs working with older adults with three foci: long term care, ambulatory/home care, acute care. Thereafter, these foci were presented as a series pre-conference sessions at annual meetings. The website was enhanced by Mary Pat Rapp. The first awards and research presentations were given at annual conference. The Board met for the first time with the Board of a national pharmaceutical company, Johnson & Johnson LTC, in Titusville, New Jersey. A \$10,000 grant for a GNP career enhancement program to include a member survey, profile, data base, and speakers bureau, was awarded to Laurie Kennedy-Malone and financed jointly by the GMR Group Inc., Horsham PA (Barry Ginetti), \$7,500 and NCGNP, \$2,500.<sup>12</sup> Ann Luggen became NCGNP Newsletter Editor. Lynn Chilton became the American College of Nurse Practitioners (ACNP) National Affiliate Representative; MJ Henderson became chairperson of the very successful \$120,000 NP National Marketing Campaign; and Valisa Saunders was appointed to the American Geriatrics Society (AGS) panel on Mental Health in Nursing Homes.



"02-"03 Officers elected were: President, Barbara Resnick; President Elect, M.J. Henderson; Past President, Virginia Lee Cora; Secretary, Nancy Wilens; Treasurer, Caroline Duquette; and Board Member at Large, Valerie Matthiesen.

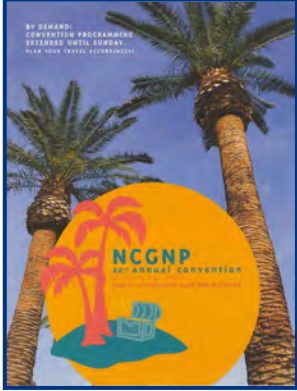


"So where are we now and where are we going? Onward and upward to improve the care provided to all older adults."

Barbara Resnick, Maryland (Fall 2002 Newsletter)

Nationally in 2001, the American Nurses Association (ANA) published *Scope and Standards of Gerontological Nursing Practice*, 2nd edition,<sup>13</sup> which was written in collaboration with the National Gerontological Nurses Association (NGNA), National Association of Directors of Nursing Administration/Long Term Care (NADONA/LTC), and NCGNP. In April, 2002, the Department of Health and Human Services (DHHS) and National Organization of Nurse Practitioner Faculties (NONPF) published *Nurse Practitioner Primary Care Competencies in Specialty Areas*,<sup>14</sup> including 48 competencies for GNPs; NCGNP provided endorsement only. The Office of the Inspector General further opened the Centers for Medicare and Medicaid Services (CMS; named HCFA prior to July 1, 2001) regulations for the clinical practice of NPs. With more nurses working with older adults in multiple settings, in 2002, ANA/ANF, American Nurses Credentialing Center (ANCC), and Hartford Geriatric Nursing Institute (HGNI) launched "Nurse Competence in Aging (NCA),"<sup>15</sup> a 5-year initiative to work with specialty nursing associations to encourage nurses to gain dual expertise in geriatrics with their other specialty. This initiative continues to support geronurseonline; gerontological nursing certifications and Specialty Nursing Association Partners in Geriatrics.

## NCGNP 2002-2003



The 22nd Conference, "Creating Our Legacy," was held at Marriott in West Palm Beach, Florida, with over 300 attendees.

Membership reached 1,140; dues were increased from \$55 to \$75 per year. Kelly Reddy-Heffner of Simpatico became convention planner, Barbara Resnick became NCGNP Newsletter Editor, and a resolution concerning Gerontological Advanced Practice Nurses (GAPNs) interactions with industry/pharma representatives was adopted.

"03-"04 Officers elected were: President, M.J. Henderson; President Elect, Barbara Phillips; Past President, Barbara Resnick; Secretary, Nancy Wilens; Treasurer, Caroline Duquette; and Board Member at Large, Valerie Matthiesen.

"As your new President I have a goal to increase our presence on the international scene. If you have colleagues outside the USA please invite them to join the NCGNP family. Take good care of yourself and remember, the beat goes on." MJ Henderson, California (Fall 2003 Newsletter)



Nationally in 2003, in response to multiple challenges by state boards of nursing concerning GNP's scope of practice, NCGNP issued its first position paper, "Clinical Practice of Gerontological Nurse Practitioners."<sup>16</sup>

Pricilla Ebersole, *GN* Editor, initiated a NCGNP section with Ann Luggen and Barbara Resnick as its first co-section editors.

**GERIATRIC  
NURSING**

## NCGNP 2003-2004

The 23rd Conference, "The Art of Aging: Weaving a Tapestry of Culture and Grace," was held at Pointe Hilton Tapatio Cliffs Resort in Phoenix, Arizona, with 450 attendees.

Membership was at 1,141; Sharon Stentz, RN, MSN, became the first Executive Director of NCGNP and the National Office was relocated from Centreville, Virginia, to Bethesda, Maryland. NCGNP's first organizational chart was approved. ANCC accredited the NCGNP Continuing Education Approver and Provider units lead by Virginia Lee Cora and Sandy Kamp respectively (the Provider Unit was dissolved in 2010). Abbott awarded a \$15,000 grant for publication and distribution of the NCGNP Newsletter, and ANA awarded a \$12,000 grant written by Barbara Resnick for NCGNP to publish a mental health tool kit.



Sharon Stentz



"04"05 Officers elected were: President, Barbara Phillips; President Elect, Sharon Maguire; Past President, M.J. Henderson; Secretary, Lynn Chilton; Treasurer, Caroline Duquette; and Board Member at Large, Sue Meiner.

"NCGNP has had a busy and productive year. Our membership has grown to more than 1,200. Because we are the premier organization for GAPN's many of our members have been invited to participate on local, state and national committees." Barbara Phillips, Florida (Fall 2004 Newsletter)

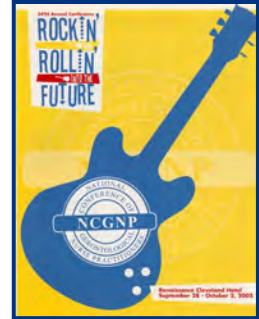


Nationally in March, 2004, American Association of Colleges of Nursing (AACN)/HGNI published *Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care*,<sup>17</sup> 47 gerontological nursing competencies for all APNs; NCGNP was on Validation Panel only. In June, an APN Consensus Conference called by the National Council of State Boards of Nursing (NCSBN) was held in Washington, DC, to which 50 organizations were invited and 32 attended. NCGNP was invited to this conference, but did not attend (In 2008, this group issued the Consensus Model of APRN Regulation, see below). ANA published *Nursing: Scope and Standards of Practice*<sup>18</sup> which referenced for all RNs to include care of older adults. In October, the AACN issued their *Position Statement on the Practice Doctorate in Nursing*.<sup>19</sup>

## NCGNP 2004-2005

The 24th Conference, "Rockin" and Rollin" into the Future," was held at Renaissance Hotel in Cleveland, Ohio, with over 400 attendees.

Membership reached 1,300. Simpatico resigned and Guiffrida became the convention planner; Kathleen Jett became NCGNP Newsletter Editor. Ortho-Biotech awarded NCGNP a grant for an Anemia Management monograph. NCGNP gave Priscilla Ebersole a Lifetime Achievement Award and NCGNPF gave a memorial tribute to David Butler of J&J LTC for his enthusiastic support of APNs and NCGNP.



"05-'06 Officers elected were: President, Sharon Maguire; President Elect, Anna Treinkman; Past President, Barbara Phillips; Secretary, Lynn Chilton; Treasurer, Debra Bakerjain; and Board Member at Large, Sue Meiner.



"As we prepare to celebrate our success of the past 25 years, lets be forever forward thinking and continue our legacy of leadership and clinical excellence."

Sharon Maguire, Wisconsin (Fall 2005 Newsletter)

**Foundation.** In September, 2005, The NCGNP Foundation (NCGNPF) was founded by three past presidents: Chair, Barbara Phillips; Vice Chair, Barbara Resnick; and Secretary-Treasurer, Mary Pat Rapp. The mission was to promote leadership and scholarship in advanced nursing practice, education, and research and to enhance the health for older adults through resource development, scholarly activities, and fund-raising. Founding donors included four chapters and eight members. In 2006, NCGNPF began sponsoring an annual Golf tournament, the Fun-Run, and a tour or event to raise funds. In 2007, the first annual research and student travel grants and a special "Spirit" award in the name of Dave Butler were awarded. In 2008, the NCGNPF name was changed to the Gerontological Advanced Practice Nurses Association Foundation (GAPNAF).



### Donors:

- Platinum Level (\$2,000+)
- Gold Level (\$1,000-\$1,999)
- Silver Level (\$500-\$999)
- Bronze Level (\$101-\$499)
- Friends of the Foundation (\$25-\$100)

Nationally in 2006, NCGNP joined with 48 organizations on the Americans for Nursing Shortage Relief (ANSR) Alliance. Barbara Resnick became Editor-in-Chief of *GN*, and Ann Luggen remained *GN* NCGNP Section Editor.



## NCGNP 2005-2006



The 25th Conference, "Celebrate with Us at Sawgrass," was held at Sawgrass Marriott Resort & Spa in Verde Beach, Florida.

Membership was at 818. NCGNP began offering five annual awards for Excellence, and the first GNP certification review course was offered at the annual conference. Kathleen Fletcher and Trudy Keltz became Historical Committee co-chairs. Sharon Stentz was terminated and later filed suit against NCGNP. Belinda Puetz, MSN, owner of Puetz Association Management Company, became Executive Director and the National Office was relocated from Bethesda, Maryland, to Pensacola, Florida. Kathleen Jett became *GN*

Section Editor.

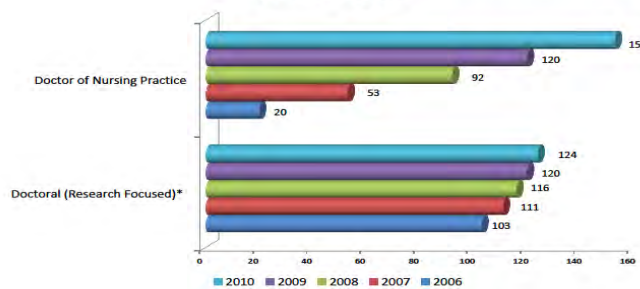
"06-"07 Officers elected were: President, Anna Treinkman; President Elect, Lynn Chilton; Past President, Sharon Maguire; Secretary, Charlotte Kelley; Treasurer, Debra Bakerjain; and Board Member at Large, Sandra Kemp.



"I want you to know that I take this responsibility very seriously. My vision for NCGNP is that we are the premier organization for APN's caring for older adults." Anna Treinkman, Illinois (Winter 2006 Newsletter)

Nationally in 2006, ANCC reported 3,704 certified GNPs. AACN published *Essentials of Doctoral Education for Advanced Nursing Practice*.<sup>20</sup>

**Growth in Doctoral Nursing Programs:  
2006-2010**



AACN, 2006<sup>20</sup>

In December, the Tax Relief and Health Care Act of 2006 was signed into law by President George W. Bush with Title III Health Savings Accounts which significantly influenced APN clinical practice by creating the CMS Physicians Quality Reporting Initiative (PQRI), the National Provider Identifier (NPI), and the Electronic Prescribing Incentive Program (eRx).



## NCGNP 2006-2007

The 26th Conference, "Charting the Course with Excellence in Elder Care," was held at Sheraton Hotel & Marina in San Diego, California.

Membership was at 968. Lynn Chilton resigned as President Elect because of health problems; members elected Debra Bakerjian, President, and Sue Mullaney, President-Elect. A second Member at Large was added to the Board of Directors.



Harriet McClung

Evercare became the first group membership. Shelley Huffstutler-Hawkins became NCGNP Newsletter Editor. Belinda Puetz sold her association management company to Jon Dancy and, in 2007, Harriet McClung became the NCGNP Executive Director.



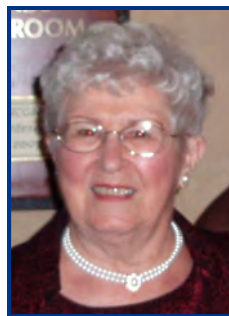
"07-"08 Officers elected were: President, Debra Bakerjian; President Elect, Sue Mullaney; Past President, Anna Treinkman; Secretary, Charlotte Kelley; Treasurer, Marianne Shaughnessy; and Board Members at Large, Sandra Kamp and Evelyn Duffy.

"I am truly honored to have been elected as President-elect. I know I speak for everyone when I say our hearts continue to be with Lynn Chilton who was elected to be this years President."

Debra Bakerjian, California (Winter 2007 Newsletter)

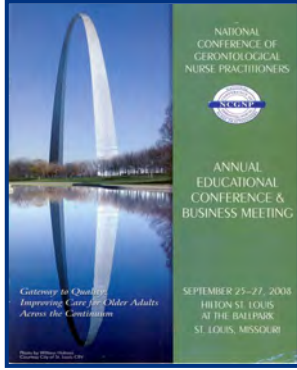


Nationally in 2007, Debra Bakerjian represented NCGNP with 28 other organizations to Advancing Excellence in America's Nursing Homes campaign. The American Academy of Nurse Practitioners (AANP) initiated certification for GNPs.



Loretta Ford,  
Keynote Speaker

## NCGNP 2007-2008



The 27th Conference, "Gateway to Quality: Improving Care for Older Adults Across the Continuum," was held at Hilton at the Ballpark in St. Louis, Missouri.

Membership reached 1,779; the first gold corporate member was Evercare. Lisa Byrd became *GN* NCGNP Section Editor. The organization's name was changed from NCGNP to the Gerontological Advanced Practice Nurses Association (GAPNA).

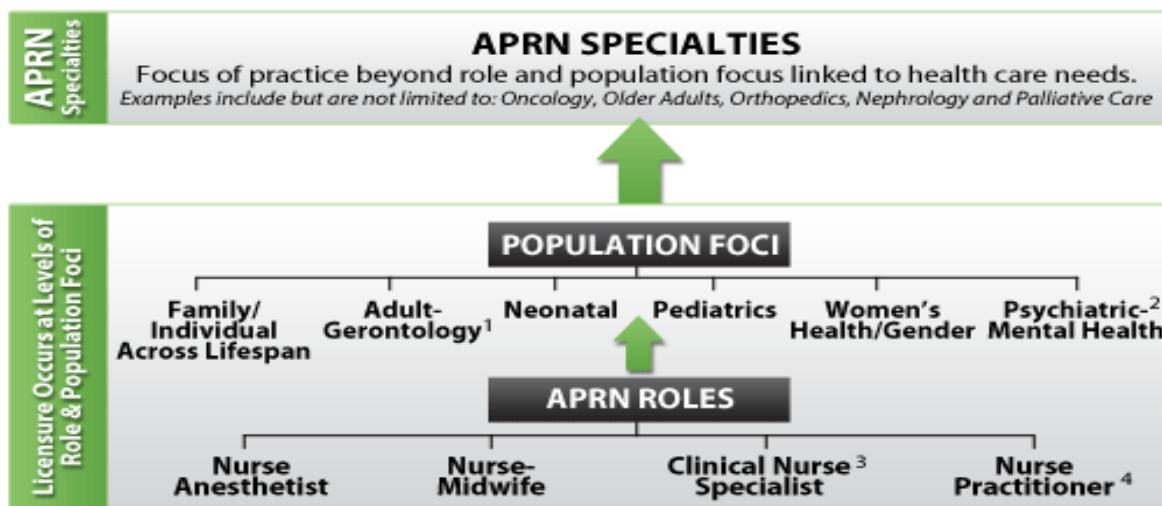
"08-"09 Officers elected were: President, Sue Mullaney; President Elect, Pat Kappas-Larson; Past President, Debra Bakerjain; Secretary, Charlotte Kelley; Treasurer, Marianne Shaughnessy; and Board Members at Large, Evelyn Duffy and Alice Bonner.



"Moving forward NCGNP will be known as GAPNA. Although the name has changed the mission and the vision have stayed the same."  
Sue Mullaney, Massachusetts (Spring 2009 Newsletter)

Nationally in 2008, *Research in Gerontological Nursing* was launched by Slack with Kitty Buckwalter, Editor. In July, NCSBN issued "The Consensus Model for APRN Regulation,"<sup>21</sup> uniform guidelines for advanced nursing practice which blended the GNP and ANP roles into the Adult-Gerontology NP (A/GNP) as a population foci for Advanced Practice Registered Nurse (APRN) licensure, and made the care of older adults a specialty linked to health care needs. The target date for full implementation of this model and its provisions for licensure, accreditation, certification, and education (LACE) was 2015.

### APRN REGULATORY MODEL



NCSBN, 2008<sup>21</sup>

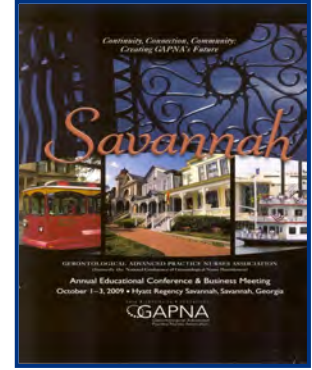


## GAPNA 2008-2009

The 28th Conference, "Continuity, Connection, Community: Creating GAPNA's Future," was held at Hyatt Regency in Savannah, Georgia.

Membership was at 1,736; Evercare became the first platinum membership. In January, the new GAPNA name and logo went online. The first GAPNA Special Interest Groups were organized. After spirited discussions of the blended ANP/GNP issue, GAPNA endorsed the APRN Consensus Model in a letter to the Advisory Committee.

care • continuity • connection



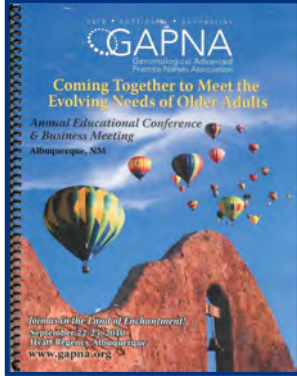
"09-"10 Officers elected were: President, Pat Kappas-Larson; President Elect, Evelyn Duffy; Past President, Sue Mullaney; Secretary, Charlotte Kelley; Treasurer, Marianne Shaughnessy; and Board Members at Large, Alice Bonner and James Lawrence.



"Our charge for the upcoming year and into the near future is to meet the demand for the infusion of gerontology across the health care continuum."  
Pat Kappas-Larson, Minnesota (Winter 2009 Newsletter)

Nationally in 2009, ANCC published *Role Delineation Study: GNP 2008*,<sup>22</sup> with 418 APNs responding to 128 behaviors. GAPNA representatives were increasingly active with AACN, AANP, ACNP, NONPF, and numerous other nursing and health care organizations.

## GAPNA 2009-2010



The 29th Conference, "Coming Together to Meet the Evolving Needs of Older Adults," was held at Hyatt Regency in Albuquerque, New Mexico

Membership reached 1,840. Dues were increased from \$75 to \$100 per year. Anthony J. Jannetti became GAPNA's association management company with Michael Brennan, Executive Director, and Sherry Dzurko, Administrative Assistant; the National Office was relocated from Pensacola, Florida, to Pitman, New Jersey.



Sherry & Michael

Debra Bakerjian was reappointed as GAPNA representative to Advancing Excellence in America's Nursing Homes campaign – Phase 2. GAPNA participated in NP Roundtable. Alice Bonner was appointed to direct CMS Division of Nursing Homes and Barbara Resnick was elected AGS President.

"10-11 Officers elected were: President, Evelyn Duffy; President Elect, Beth Galik; Past President, Pat Kappas-Larson; Secretary, Nikki Davis; Treasurer, Marianne Shaughnessy; and Board Members at Large: James Lawrence and Alice Early.

"APNs with expertise in the care of older adults are being sought for input in many different areas. Health care reform, Medicare, HRSA, LACE, the DNP each brings it's opportunities and challenges."

Evelyn Duffy, Ohio (Winter 2010 Newsletter)



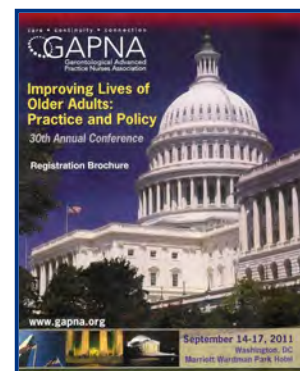
Nationally in March, 2010, AACN published *Adult-Gerontology Primary Care Nurse Practitioner Competencies*,<sup>23</sup> 75 competencies for A/GNPs; Evelyn Duffy was GAPNA's representative. AACN also published *Adult-Gerontology Clinical Nurse Specialist Competencies*,<sup>24</sup> 50 competencies for A/GCNSs; GAPNA provided endorsement only. (Note: in February, 2012, AACN published *Adult-Gerontological Acute Care Nurse Practitioner Competencies*,<sup>25</sup> 110 competencies for A/GNPs; GAPNA was not represented). An ANSR Consensus statement was published, which also included GAPNA. GAPNA collaborated with AMDA to publish a Consensus Paper on MD/NP collaboration in skilled nursing care in LTC facilities which was published in both *GN* and *Journal of the American Medical Directors Association*.<sup>26</sup> In September, ANCC/HIGN published *Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults*<sup>27</sup> with 19 competencies, which may encourage future RNs to pursue APN roles in gerontological nursing. Finally, on March 23rd and 30th, the Patient Protection and Affordable Care Act of 2010 (PPACA „10) and the Health Care and Education Reconciliation Act were passed and signed into law by President Barak Obama. Commonly called "Obamacare," this health care reform was the most significant overhaul of federal regulations since the passage of Medicare and Medicaid in 1965, and it will be a major influence on the roles of GAPNs on into the future.



## GAPNA 2010-2011

The 30th Conference, "Improving the Lives of Older Adults: Practice and Policy," was held at Marriott Wardman Park in Washington DC.

Membership was at 1,760+. The GAPNA Strategic Plan addressed the changes and challenges presented by implementation of the APRN Consensus Model's Licensure, Accreditation, Certification, Education recommendations, attacks on entitlements in DC, and opportunities presented by the enactment of Health Care Reforms. Pat Kappas-Larson led efforts to establish Leadership training for members to increase their leadership skills and create a pipeline for future leadership for GAPNA; Patty Kang was the first recipient of this Health Affairs Scholarship.



In 2011, GAPNA representatives participated in the AANP Professional Roundtable to address the changes related to Pharma support, the ACNP National Nurse Practitioner Policy Summit, the ANCC Expert Panels to develop the new Adult-Gerontology Certification exams, the Nurse Practitioner Roundtable, the Advancing Excellence Campaign, and HIGNs Coalition of Geriatric Nursing Organizations (CGNO), et al. GAPNA had 17 active chapters and 3 inactive chapters.

"11-12 Officers elected were: President, Beth Galik; President Elect, Marianne Shaughnessy; Past President Evelyn Duffy; Secretary, Nikki Davis; Treasurer, Kathyne Barnoski; and Board Members at Large, Alice Early and Patty Kang.

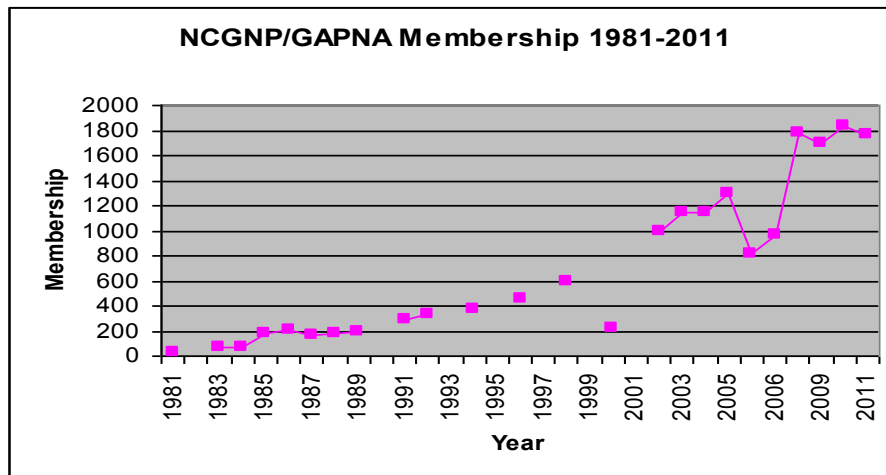


Nationally in October, 2010, ANA published *Scope and Standards of Gerontological Nursing Practice*, 3rd edition.<sup>28</sup> In April, 2011, NONPF published *Nurse Practitioner Core Competencies*,<sup>29</sup> including MSN and DNP independent practice; Evelyn Duffy represented GAPNA. In October, the Institute of Medicine (IOM) published *Future of Nursing*,<sup>30</sup> a 2-year initiative funded by the Robert Wood Johnson Foundation. As health care moves into the 2010s, the eight recommendations have significant implications for APNs, including removing barriers to practice and doubling the number of nurses with doctorates.

## NCGNP/GAPNA 2001-2011

In this third decade, GAPNA established national visibility as experts in gerontological advanced practice nursing; significantly enhanced political involvement with nursing and health care organizations; and strengthened leadership for gero APN education, practice, and research within the organization. However, GAPNA also struggled with organizational management. Between 2001 and 2011, the national office leadership changed four times and physically relocated three times.

During the 2000's, Advanced Practice Nursing organizations sharpened educational requirements and role competencies relative to advanced practice nursing with older adults and blended the gerontological APN role with the adult APN role. On the national scene, health and social policy institutions struggled with demands for accessible, affordable, quality health care, especially concerning Medicare/Medicaid; and strengthened monitoring and regulation of individual health care providers, including gero APNs.



## Evolution of the GNP and NCGNP/GAPNA: 2000s, The Third Decade

Virginia Lee Cora and Debra Bakerjian\*

Only 1 week after the tragic events of September 11, 2001, the National Conference of Gerontological Nurse Practitioners (NCGNP) entered its 3<sup>rd</sup> decade in a time of tumultuous changes. For Gerontological Advanced Practice Nurses (GAPNs), these changes were reflected in the evolution of the organization and in the enactment of the role within the dynamic arena of advanced nursing practice and health care.

### **The NCGNP/GAPNA Organization**

In 2001, the GNP role had been established for over 20 years, and the NCGNP membership had grown from 25 to almost 1,000 advanced practice nurses (APNs) working with older adults, but their roles in health care facilities were not described clearly. A grant was funded jointly by GMR (The GMR Group, Inc., Horsham, PA) (\$7,500) and NCGNP (\$2,500) to survey the membership and create a member profile and data base.<sup>12</sup> Laurie Kennedy-Malone reported that of the certified GNPs surveyed and only half of the 472 responders were working full time as GNPs and 56% of respondents indicated that they were the first GNP in the position.

To further delineate educational activities for GAPNs, in 2002, NCGNP members developed a core curriculum with three foci: long-term care, acute care, and ambulatory/home care; subsequently, pre-conference and conference continuing education activities have been offered in these areas. NCGNP developed Continuing Education Approver and Provider Units which earned initial accreditation by American Nurses Credentialing Center (ANCC) in 2004. However, the Provider Unit was dissolved in 2010; the Approver Unit remains active.

The quarterly *NCGNP Newsletter* evolved to full color, then went totally online in 2009. In 2003, the bimonthly *Geriatric Nursing* journal became the official publication of NCGNP, and the organization was given a section with an editor for brief articles and news items related to the organization. The NCGNP website was updated several times and expanded its Clinical Practice Links to include practical information for NPs working with nursing homes and assisted living facilities. The NCGNP Foundation was chartered in 2005 with annual fund raising events and a growing scholarship program which now awards annually over \$5,000 in scholarships.

In line with the recognition of NCGNP members' expertise in the care of older adults, in 2002, the Board of Directors was invited to meet with the Board of Directors of Johnson & Johnson Long Term Care; conference support and a caregiver program resulted from these liaisons. Subsequently, the organization became more involved with industry-sponsored activities offered by many pharmaceutical companies. In 2004, NCGNP received a \$12,000 grant from American Nurses Association (ANA) to develop a Mental Health Tool Kit for APNs working with Older Adults; in 2005, Ortho-Biotech provided a grant for a monograph on management of anemia in older adults; and in 2009, Takeda gave a substantial grant to develop and present regional training on management of constipation. However, with changes in federal regulations concerning pharmaceutical representative interactions with health care providers, pharmaceutical educational grants became more difficult to achieve, leading to new methods of support through company-sponsored speaker programs and product theaters.

Throughout the third decade, NCGNP experienced multiple growing pains as the central office staff and location changed several times from Kim Quimby, Centreville VA (1999-2004); to Sharon Stentz, MSN and others, Bethesda MD (2004-2006); to Belinda Puetz, Jon Dancy, and Harriet McClung, Pensacola FL (2006-2010); and finally to Michael Brennan and Sherry Dzurko of



## Evolution of the GNP and NCGNP/GAPNA: 2000s, The Third Decade—continued

Anthony J. Jannetti, Pitman NJ (2010–present). Even with all these changes, between 2001 and 2011, membership doubled from 998 to 1,840 with several group and corporate memberships; chapters increased from 7 to 17; 6 Special Interest Groups (SIGs) were organized, and 7 categories of awards now are given by the organization. As work of the organization expanded across these years, dues increased from \$55 to \$75 in 2003, then to \$100 in 2010. In an effort to strengthen the financial stability of GAPNA, the Board developed an investment strategy and opened an investment account with Edward Jones with a substantial portfolio designed to provide ongoing funding in case of future financial challenges. Finally, after years of debate, in 2008, the name of the organization was changed from NCGNP to Gerontological Advanced Practice Nurses Association (GAPNA), a name that was more inclusive of all advanced practice nurses working with older adults and was more reflective of the organization's membership. Subsequently, in 2009 the membership approved a new logo, "Care, Continuity, Connection," to develop our brand name in health care.

### The GAPN Role in Advanced Practice Nursing Education and Certification

In efforts to delineate the roles and competencies of advanced practice nurses in specialty areas, a series of documents were published in this third decade. In 2001, the ANA included gerontological advanced practice nurses in, *Scope and Standards of Gerontological Nursing Practice*, 2<sup>nd</sup> edition;<sup>13</sup> the 3<sup>rd</sup> edition<sup>28</sup> was published in October, 2011. However, some state boards of nursing challenged the scope of practice of GNPs. To clarify this issue, in 2003, NCGNP adopted its first position paper, "Clinical Practice of Gerontological Nurse Practitioners."<sup>16</sup> In 2002, as 1 of 5 NP roles in primary health care, the Department of Health and Human Services and NONPF published *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health*,<sup>14</sup> with 48 competencies for GNPs (NCGNP was not represented on the National Expert Panel but was on the Validation Panel). With more nurses working with older adults in multiple settings, in 2002, ANA, ANCC, and Hartford Geriatric Nursing Initiative (HGNI) launched "Nurse Competence in Aging,"<sup>15</sup> a 5-year initiative to work with specialty nursing associations to encourage nurses to gain dual expertise in geriatrics with their other specialty. Subsequently, in 2004, the American Association of Colleges of Nursing (ANCC) and HGNI published *Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care*,<sup>17</sup> with 47 competencies for older adult care by all NPs and CNSs (NCGNP was represented on only the Validation Panel).

Concurrently, in 2004, the National Council of State Boards of Nursing (NCSBN) held an Advanced Practice Nursing Consensus Conference to which 50 nursing organizations were invited and 32 organizations attended; although invited to this meeting, NCGNP was not in attendance. From this consensus work group and the NCSBN Advanced Practice Registered Nurse (APRN) Advisory Committee, the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education*<sup>21</sup> was published in 2008. Identified in the consensus model were 4 APRN roles (i.e., CRNA, CNW, CNS, & NP) and 6 population foci, including adult-gerontology, with the scope of practice of primary care and acute care based on patient care needs, not specific settings; older adults were not recognized as a unique population at this level. The Specialties were focused on practice beyond role and population focus and were linked to health care needs, including older adults as an area of specialty practice. Thus, the GNP role is to become the Adult Gerontology Nurse Practitioner role by 2015. In 2008, GAPNA convened a group of its leaders to discuss the blended ANP/GNP issue of the Consensus Model. A spirited discussion of the pros and cons of the new role resulted in GAPNA endorsing the Consensus Model through a letter to Advisory Committee.



## Evolution of the GNP and NCGNP/GAPNA: 2000s, The Third Decade—conclusion

Meanwhile, AACN had adopted “Position Statement on the Practice Doctorate in Nursing,”<sup>19</sup> moving the level of preparation for an APN from the master’s degree to the doctorate, also by 2015. In 2010, NONPF published *Nurse Practitioner Core Competencies*,<sup>29</sup> which included 44 MSN and DNP competencies for full scope of practice as a licensed independent practitioner (GAPNA was represented on these panels). In 2007, American Academy of Nurse Practitioners (AANP) initiated certification for GNPs. However, both ANCC, which began GNP certification in 1976, and AANP will cease certifying new GNPs after 2015; future certifications will be for A/GNPs. In 2008, ANCC conducted a national survey, “Role Delineation Study of GNPs,”<sup>22</sup> with 418 APNs responding to 128 behaviors. In 2010, AACN, HGNI and NONPF published *Adult-Gerontology Primary Care Nurse Practitioners Competencies*,<sup>23</sup> with 75 competencies for A/GNPs (GAPNA was represented on both the National Panel and the Validation Panel). In 2012, AACN, HGNI, and NONPF published *Adult-Gerontology Acute Care Nurse Practitioner Competencies*,<sup>25</sup> with 110 competencies for A/GNPs (GAPNA was not represented on either the National Panel or the Validation Panel).

### NCGNP/GAPNA Work with Other Health Care Organizations

During these 10 years, NCGNP/GAPNA established or strengthen liaisons with many other APN and health care groups. Nursing groups include AANP Roundtables, American College of Nurse Practitioners Policy Summits, NONPF, ANCC, Coalition of Geriatric Nursing Organizations, National Gerontological Nurses Association, National Association of Directors of Nursing Administration/Long Term Care, National Coalition of Geriatric Nursing, Nurse Practitioner National Marketing Campaign, Americans for Nursing Shortage Relief, and others.

GAPNA also made significant strides in collaboration with physician colleagues and other geriatric groups, including members filling prominent roles in American Medical Director’s Association (AMDA) and American Geriatric Society (AGS). In 2010, a group of GAPNA leaders collaborated with AMDA and other physician groups to address the challenging issue of MD/NP supervision and collaboration in skilled nursing care. This work led to a Consensus Paper<sup>26</sup> that was published in both *GN* and the *Journal of the American Medical Directors Association*, an unusual event. GAPNA members also have made significant contributions to AMDA’s Clinical Practice Guidelines and have participated in many AGS board committees including their quality measures and Mental Health in Long Term Care Panels. GAPNA members are now members of important interprofessional national work including National Quality Forum, Eldercare Workforce Alliance, Advancing Excellence in America’s Nursing Homes, and American Association of Retired Persons.

### The 2000s

In summary, between 2001 and 2011, NCGNP/GAPNA strengthened its leadership within the organization for education, practice and research; enhanced its political involvement with other nursing and health care organizations; and established its national visibility as experts in gerontological advanced practice nursing. Despite the organizational struggles with association management problems (4 changes in the national office leadership and 3 relocations of its office), in this past decade the organization was able to double membership and significantly increase financial reserves.

On the national level, the licensure, accreditation, certification, and education requirements relative to advanced practice nursing with older adults were sharpened and the Gerontological APN role was blended with the Adult APN role. Concurrently, the education of future APRNs moved from the master’s to the doctoral level with GAPN seen as a specialty practice beyond the initial APRN degree. How these changes evolve in the dynamics of health care reforms will energize the organization and the GAPN role as we move into future decades. *GN*

\* Reprinted from the GAPNA Section, *Geriatric Nursing*, 33(4), 321-324. Used with permission of Elsevier Health.

## Chapter 5

# The Future of the Gerontological Nurse Practitioner and GAPNA: 2011 and Beyond

Evelyn Duffy, DNP, ANP/GNP-BC, FAANP



GAPNA is not alone—an increasing need exists for this organization to work with many other organizations; nursing organizations, such as the American Nurses Association (ANA), American Academy of Nurse Practitioners (AANP), American College of Nurse Practitioners (ACNP), American Academy of Nursing (AAN), National Organization of Nurse Practitioner Faculties (NONPF), and American Association of Colleges of Nursing (AACN); geriatric professional organizations, such as the National Gerontological Nurses Association (NGNA), American Geriatrics Society (AGS), Geriatrics Society of America (GSA), American Medical Directors Association (AMDA), and Hartford Institute for Geriatric Nursing (HIGN); and older adult organizations, such as the American Association of Retired Persons (AARP). Multiple forces are shaping the future of Gerontological Advanced Practice Nursing: Education, Certification, Licensure, Accreditation, and Policy.

With regard to education, the Advanced Practice Registered Nurse (APRN) Consensus Model will change education from ANP and GNP programs to A-GNP programs for entry into practice. With regard to certification, exams will prepare the A-GNP in the future ANP and GNP exams will be eliminated by 2015. With regard to licensure, States Boards of Nursing will address the changes in APN education and practice—some states will be early adopters, some states will change in a longer time frame, and some states may not change. With regard to accreditation, these bodies will evaluate APN programs based on the APRN Consensus Model. The Doctor of Nursing Practice (DNP) degree as entry into practice was not included in the Consensus Model, but the new NONPF NP Core Competencies assume DNP preparation. With regard to policy, the need exists for increased input from APRNs with expertise in the care of older adults in the community, acute care, and long term care, and for changes in the roles of APRNs caring for older adults with increased autonomy and equity in reimbursement. Medicare and Medicaid are under attack as entitlements with the likelihood of decreasing in funding to these programs and decreasing government support for older adults as the numbers of this elderly population are increasing.

The role for GAPNA in the future is to increase our presence at the tables influencing licensure, accreditation, certification, education, and policy. The organization must play a leading role in defining health care for older adults in the “Top of the Consensus Model Pyramid.” Taking liberty with a quotation from Henry Wallace: The only certainty in this life is change, but change can be directed toward a constructive end. The future offers opportunities for GAPNA to increase our influence and ensure that the health care provided to older adults continues to be excellent.

## The Future of the Gerontological Nurse Practitioner and GAPNA

Evelyn G. Duffy, DNP, G/ANP-BC, FAANP\*

What is in the future for the Gerontological Nurse Practitioner Association (GAPNA) and for the Gerontological Nurse Practitioner (GNP)? In my crystal ball I see multiple opportunities for both GAPNA and GNPs. The “Silver Tsunami” (Maples, 2002) that has been widely discussed for the past four decades is now imminent. The first wave of the baby boom generation, generally defined as those born from 1946 to 1964 and the largest age cohort in history, began to turn 65 in 2011. The impact of this large number of older adults on Health Policy and Social Policy is already being felt. The expertise of the membership of GAPNA is receiving increasing recognition both within our profession as well as in the public arena. Policy makers at the national, state, and local level are seeking the input of our membership as they address the needs of older adults. GAPNA has increased its visibility in organizations that support policy that improves our practice as well as the care of older adults such as the Nurse Practitioner Round Table, Coalition of Geriatric Nursing Organizations, The Nursing Community, Advancing Excellence in America’s Nursing Homes Campaign, and the Advanced Practice Registered Nurse Work Group convened by AARP to identify barriers to our practice.

Preparing the next generation of APNs to care for those of us in the “Silver Tsunami” is another opportunity for GAPNA and for GNPs. During the past 3 decades many philanthropic organizations committed millions of dollars to prepare experts, including Gerontological Nurse Practitioners, to provide health care to the growing older adult population. In spite of this investment Nurse Practitioners certified as GNPs grew only slightly in number and recently have been on the decline. The lack of interest in pursuing an MSN with the narrow focus of GNP resulted in a concomitant decline in academic programs offering this specialty. The membership of GAPNA also reflects this trend. While initially an organization for GNPs, less than half of the current membership has only GNP certification. GAPNA has demonstrated willingness to adapt to the changes in our organization as well as to embrace the opportunities to improve the care of older adults. The name change at the 2008 Annual Conference from National Conference of Gerontological Nurse Practitioners (NCGNP) to Gerontological Advanced Practice Nurses Association is evidence of this flexibility.

Some would say the greatest challenges to the future of GAPNA and the GNP are the changes resulting from the Consensus Model for APRN Regulation (2008). Against the background of a rise in demand for older adult care and a decrease in experts prepared to provide this care, the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee developed a model that would seek to improve uniformity and portability of Advanced Nursing Practice from state to state and to assure public safety. As Advanced Practice Nurses increased in number, the variability of preparation and licensure was a mounting concern. The group defined four roles that were directly responsible for patient care: Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS), Certified Nurse-Midwives (CNM), and Certified Registered Nurse Anesthetists (CRNA) (Consensus Model for APRN Regulation, 2008). By far the most challenging decision was to identify which of the many academic majors preparing CNPs and CNSs would be accepted as basic preparation for licensure described in the model as “Population Foci”. In the final Consensus Document the new population that reflected the merger of the unique preparations of Adult and Gerontological APNs was labeled “Adult-Gerontology”. This decision has been perceived by some as representing the “death of the Gerontological Nurse Practitioner” (Villars, 2012). That perspective ignores the opportunities that the Consensus Model provides not only for those passionate about the care of older adults, but also for GAPNA.

## The Future of the Gerontological Nurse Practitioner and GAPNA—continued

By making the decision to merge Adult and Gerontology the committee that prepared the Consensus Model for APRN Regulation recognized the need for expertise in the care of older adults. New competencies were written to reflect the marriage of these two majors and prevent the possibility of the new preparation being “Gero Lite” (AACN, 2010). Furthermore the model requires enhanced gerontology content in all programs. From the Consensus Model for APRN Regulation (2008, pg. 10).

The population focus, “adult gerontology” encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population (e.g., family or gender specific) must be prepared to meet the needs of the expanding older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

As both the ANP and GNP certification exams are scheduled to be retired in the future and both ANCC and AANP are scheduling their first A-GNP exams in early 2013, schools of nursing are working rapidly to make changes in their adult and gerontological APN programs to reflect the new competencies and create a new Adult-Gerontology APN major. This change affects both Acute and Primary Care programs. For schools that offered only Adult programs in the past, there may not be faculty to address the more in-depth gerontology content. GAPNA members can identify themselves to schools of nursing as Content Experts that are available to advise faculty regarding inclusion of gerontology in the curriculum and offer their expertise in the presentation of gerontology content to their students. GAPNA members can also contribute to this new generation of APNs by providing clinical sites to meet the demand for “clinical education experiences” in older adult settings required by the Consensus Model.

With the retirement of the ANP and GNP exams, APNs who are currently certified in these roles will be challenged to maintain their certification or be prepared to expand their preparation to include the full scope of the new A-GNP. Because there are exponentially more ANPs in practice than GNPs there is the potential for a much greater demand for post masters preparation of the ANP to include gerontological content. This likely trend is another opportunity for current GNPs and schools of nursing with faculty who have that expertise as well as for GAPNA to be proactive in developing programs to meet that future demand.

The Gerontological NP expert is *not* dead. The opportunity to continue to prepare experts in the care of the older adult continues to exist; the consensus model recognizes the need for specialization, to quote the Committee report:

APRNs may specialize but they cannot be licensed solely within a specialty area. In addition, specialties can provide depth in one’s practice within the established population foci. Education and assessment strategies for specialty areas will be developed by the nursing profession, i.e., nursing organizations and special interest groups. Education for a specialty can occur concurrently with APRN education required for licensure or through post-graduate education. Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by the professional organizations. (Consensus Model for APRN Regulation, 2008, pg 6)



## The Future of the Gerontological Nurse Practitioner and GAPNA—conclusion

GAPNA identifies itself as “the organization of choice for advanced practice nurses who want to pursue continuing education in gerontological care and who seek peer support from experienced clinicians.” (About GAPNA, 2012) As the only Gerontological Nursing Organization specifically for Advanced Practice Nurses, GAPNA has a challenge to meet the requirement of defining the specialty as identified by the Consensus Model, often called the “Top of the Pyramid” for this model. It would be unrealistic to think we could take on that responsibility without including other stake holders in nursing as well as our colleagues in other professions caring for older adults. While the new Adult Gerontology Competencies were intended to marry the expertise of both groups, it would be impossible to include the depth provided in a GNP program in an A-GNP program within the same time frame and similar number of credits. An important first step will be a practice analysis to define the knowledge that is necessary for the expert and is not represented in the current Adult-Gerontology competencies. The Education Committee of GAPNA is in the process of holding focus groups to develop a questionnaire as a first step in that process.

Who will GAPNA attract as members in the future? As we have seen in this series of articles we have experienced many changes over the past three decades of our existence. Our growing diversity in areas of expertise as well as our expanding influence opens many avenues for growth. The GNP specialization could be acquired by any of the four APRN roles as well as any population foci who care for older adults. Offering these professionals the opportunity for membership in GAPNA and providing them with the expertise to become a specialist in the care of older adults is a vision for the future of our organization. My crystal ball is glowing. Rather than mourning the Death of the GNP we need to embrace the many opportunities these changes provide to enhance the quality of care received by older adults as well as the way our membership and our organization can grab the brass ring and catapult into the future of Advanced Practice Nursing. *GN*

About GAPNA: who we are. <https://www.gapna.org/about-gapna>

American Association of Colleges of Nursing. 2010. Adult-gerontology primary care nurse practitioner competencies. <http://www.aacn.nche.edu/geriatric-nursing/adultgeroprimcareNPcomp.pdf>

APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee. Consensus model for APRN regulation: licensure, accreditation, certification & education. July 7, 2008. <http://www.aacn.nche.edu/education-resources/APRNReport.pdf>

Maples, M. (2007). “Spirituality, wellness and the ‘Silver Tsunami’: implications for counseling” VISTAS: <http://counselingoutfitters.com/vistas/vistas07/Maples.htm>

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\* Reprinted from the GAPNA Section, *Geriatric Nursing*, 33(5),410-421. Used with permission of Elsevier Health.

**Addendum  
for the  
35<sup>th</sup> Anniversary  
of the  
Gerontological Advanced Practice Nurses Association  
2011-2016**



**Compiled by the  
GAPNA Historical Committee, 2016-2018**

**2016**

Kathleen Fletcher, Co-Chair  
Trudy Keltz, Co-Chair  
Linda Keilman, Board Liaison  
Maureen Beck  
Marianne Boettger  
Virginia Lee Cora  
Cynthia Gerstenlauer  
Elizabeth Rochford  
Marianne Shaughnessy\*  
Colleen Wojciechowski

**2018**

Cindy Gerstenlauer, Chair  
Deborah Dunn, Board Liaison  
Maureen Beck  
Marianne Boettger  
Virginia Lee Cora\*  
Kathleen Fletcher\*  
Trudy Keltz\*  
Michelle Longley  
Elizabeth Rochford  
Colleen Wojciechowski



\*Panels by Marianne



\*Narrative by Kathy, Trudy, and Virginia

## GAPNA 2011 – 2012



31<sup>st</sup> Conference, “Promoting Clinical Excellence Through Vision, Vitality & Visibility” was held September 19 – 22, 2012, at the Red Rock Hotel and Casino in Las Vegas, NV.



**'11-'12 Officers:** Secretary Nikki Davis, Treasurer Kathyne Barnoski, President Elect Marianne Shaughnessy, Past President Evelyn Duffy, President Beth Galik, Board Members at Large Patty Kang and Alice Early.

GAPNA membership for 2012 was 2062. The Board of Directors updated the 2003 position statement on the GNP role in clinical practice and posted it on the GAPNA website. The ANCC Approver Unit was retired. The GAPNA member renewal survey was updated to assist in identifying clinical interest/expertise of members. Special Interest Group awards were added to recognize accomplishments by these APRN groups.

The Board allocated start-up funding for archiving historical materials at the University of Virginia School of Nursing History Museum. The History Committee solicited additional archival funds from individuals, chapters, and monograph sales. Recognizing the need for pharmacological hours focused on older adults, the Education Committee organized a Pharmacology preconference session for APRN certification renewal. The Health Affairs Committee represented GAPNA on the Nurse Practitioner Roundtable and Coalition of Geriatric Nursing Organizations and other groups. The Research Committee developed a section on the website to advertise consultation services to members. A 3-year LGBT Focus Group was created to educate the APRN membership about health-related issues of LGBT older adults and their families.



Nationally, GAPNA's expert opinion was sought by the American Geriatrics Society and the Centers for Medicaid and Medicare on clinical topics including the Beer's List revisions, management of older adults with multiple medical co-morbidities, and initiatives to improve behavioral health for nursing home residents. Sue Mullaney replaced Debra Bakerjian on the Advancing Excellence Campaign to pursue quality of care and of life for nursing home residents. Laurie Kennedy-Malone represented GAPNA on the NONPF validation panel for updated population-focused APRN competencies.



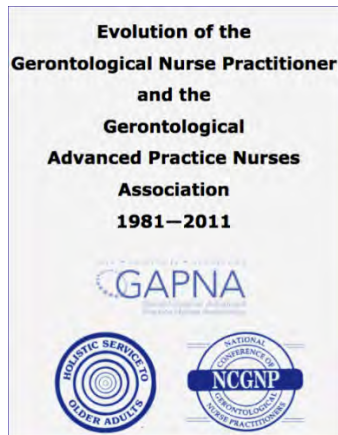
## GAPNA 2012 – 2013

32nd Conference, “Enhancing Access, Promoting Quality Care and Improving Outcomes for Older Adults,” was held September 18 – 21, 2013, the Sheraton Chicago Hotel & Towers in Chicago, IL.



**'12-'13 Officers:** Past-President Beth Galik, Secretary Jennifer Serafin, Board Member at Large Patty Kang, Treasurer Kathryn Barnoski, President Marianne Shaughnessy, President-Elect Lisa Byrd, Board Member at Large Laurie Kennedy-Malone.

GAPNA membership for 2013 was 2246. In response to the APRN Consensus Model and the need to define the gerontological nursing specialty (i.e., the 'top of the pyramid'), the Board of Directors sponsored a 'practice analysis' to define knowledge necessary for the gero expert. A 153-item Advanced Practice Nurse Managing the Care of Older Adults Practice Profile Questionnaire surveyed online GAPRN practice patterns across health care systems and settings. Almost 1,300 responses from certified ANPs, FNPs, GNPs, and CNSs provided information on 61 GAPRN professional activities. With survey results in hand, GAPNA hosted 22 gerontological nursing leaders from within and outside the membership at a consensus conference to develop proficiencies beyond entry-level competencies for the gerontological advanced practice nursing specialist. Twelve proficiency statements were agreed upon by this consensus panel. Subsequently, two task forces were deployed – a Writers Group to develop supporting paragraphs for the 12 proficiency statements and professional activities and a Work Group to examine market demand for such a gerontological specialist credential.



The Historical Committee published a 30-year monograph available for purchase on Amazon.com (initially \$25; later online free for GAPNA members). Decade summaries also were shared in a series of articles published in *Geriatric Nursing*. The Central Office modified the GAPNA website to a more responsive design, enabling members to access and read posted content using mobile devices. The Communications Committee established a Community Forum on the website and a social media presence on Facebook. The Health Affairs Committee added “Ask a Question” and “Hot Topics” sections to the GAPNA website. The Education Committee provided a GAPNA toolbox of resources for A/GNP preceptors in older adult settings. The LGBT Focus Group published an article in *Geriatric Nursing* and a LGBT resource list was provided online for member clinicians. “Ask Me About My SIG” buttons appeared on many conference attendees to stimulate interest in the Special Interest Groups.

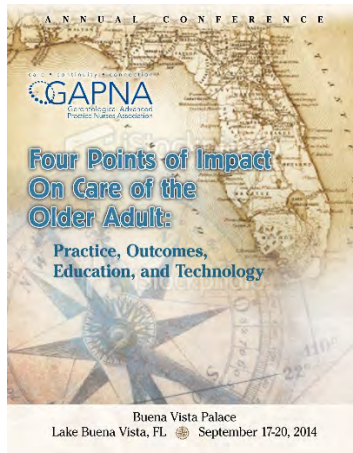
The GAPNA Foundation challenged chapters to donate themed baskets to raise funds for annual awards and scholarships. The Brooklyn Home for Aged Men donated \$10,000 to award two \$5,000 scholarships to GNP students. GAPNAF developed an application process and awarded the scholarships at the annual meeting.

Nationally, GAPNA representatives (Evelyn Duffy, Nikki Davis, Laurie Kennedy-Malone) joined the ongoing LACE (Licensure, Accreditation, Certification and Education) APRN Network to discern specifics on implementation of the Consensus Model for Advanced Practice Nursing. The American Academy of NPs and the American College of NPs combined to become the American Association of NPs. The American Medical Directors Association added the Society for Post-Acute and Long-Term Care Medicine to its name and granted membership with full voting rights to nurse members.





## GAPNA 2013 – 2014



The 33<sup>rd</sup> Conference, “Four Points of Impact on Care of the Older Adult: Practice, Outcomes, Education and Technology,” was held September 17 – 20, 2014, at the Buena Vista Palace Hotel and Spa in Orlando, FL.

**'13-'14 Officers:** President Lisa Byrd, President-Elect Pam Cacchione, Past President Marianne Shaughnessy, Secretary Jennifer Serafin, Treasurer George Peraza-Smith, Board Members at Large Laurie Kennedy-Malone and Patty Kang.



GAPNA membership for 2014 was 2392. The Board of Directors retired the ANCC Provider Unit. Plans began for an annual mid-year GAPNA conference focused specifically on pharmacological issues relevant to older adults initially to be held in Spring 2015 in Philadelphia PA. The 2013 gero expert panel reconvened for validation and endorsement for the GAPNA Consensus Statement on Proficiencies for the APRN Gerontological Specialist. The Board approved a 3-year 'silver' membership with the *Nursing Community*, a coalition of 60 national professional nursing organizations working toward a common advocacy agenda with input on policy development from GAPNA concerning issues affecting the care of older adults. GAPNA supported AMDAs attending physician competencies for post-acute/long-term care of older adults.

The Education Committee invited educational research posters for display at the annual conference poster session with GAPNAF support for their awards. A Gero-Psych Focus Group was developed for gero resources for mental health problems in older adults and their families. The Historical Committee archived four banker boxes of GAPNA materials at the University of Virginia Eleanor Crowder Bjoring Center for Nursing Historical Inquiry.



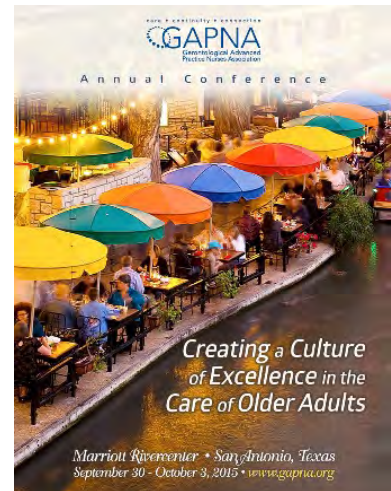


Arlene Keeling and Kathy Fletcher  
UVA Center for Nursing History

The Centers for Medicare and Medicaid Services (CMS) consulted GAPNA to advertise new initiatives surrounding the use of antipsychotics in long term care facilities. AMDA asked GAPNA to collaborate on new Guidelines for Collaborative Practice in Long-Term Care. Affordable Care Act expanded Medicare coverage to more low-income Americans. Advanced practice nurses are in the news as potential solutions to the provider shortage problem.

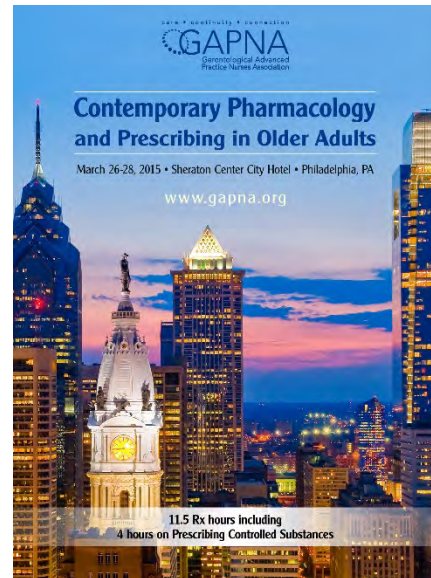
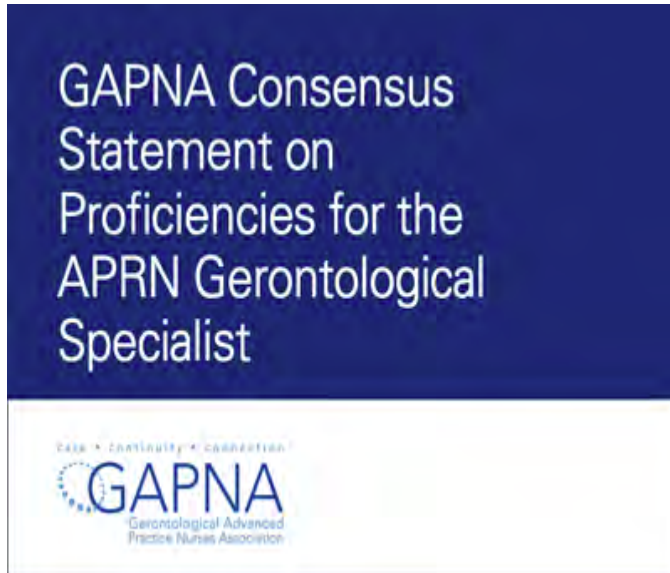
## GAPNA 2014 – 2015

The 34th Conference, “Creating a Culture of Excellence in the Care of Older Adults,” was held September 30 – October 3, 2015, at the Marriott Rivercenter in San Antonio, TX.



**‘14-‘15 Officers:** President-Elect Carolyn Clevenger, Secretary Dawn-Marie Roudybush, Past President Lisa Byrd, President Pam Cacchione, Treasurer George Peraza-Smith, Board Members at Large Linda Keilman and Patty Kang. Also pictured in 2<sup>nd</sup> row, Michael Brennan, Executive Director, Anthony J. Jannetti.

GAPNA membership for 2015 was 2528. GAPNA published a 21-page white paper, *GAPNA Consensus Statement on the Proficiencies for the APRN Gerontological Specialist*, with differences between competencies and proficiencies and development of Gerontological Specialist as top tier of the APRN Consensus Model pyramid. Validation surveys were completed and endorsements from professional organizations were sought.



The 1<sup>st</sup> GAPNA Geriatric Pharmacology Conference, was held on March 27-28, 2015, in Philadelphia PA with 324 attendees from 35 states. “GAPNA Gives Back” initiative was launched at this spring conference with collection of toiletries and personal items distributed by the Twilight Foundation to elders in need.

The Health Affairs committee launched a Medicaid Dual Eligibility Task Force to disseminate Information about access to this program. The LGBT Focus Group developed and posted on the website a position statement on care of the LGBT community.

## GAPNA 2015 – 2016



The 35<sup>th</sup> Annual Conference, The premier conference for gerontological advanced practice nurses, was held September 21 – 24, 2016, at the Arizona Grand Resort, Phoenix AZ.



**'15-'16 Officers:** Secretary Dawn-Marie Roudybush, Treasurer Michele Pic, Board Member at Large Valerie Sabol, President Carolyn Clevenger, Board Member at Large Linda Keilman, Past President Pam Cacchione, President-Elect Katherine Evans.

GAPNA membership for 2016 was 3402. The 2<sup>nd</sup> pharmacology conference, "Contemporary Pharmacology and Prescribing for Older Adults," is held March 31 – April 2, 2016, in Atlanta GA.

Contemporary Pharmacology  
and Prescribing in Older Adults



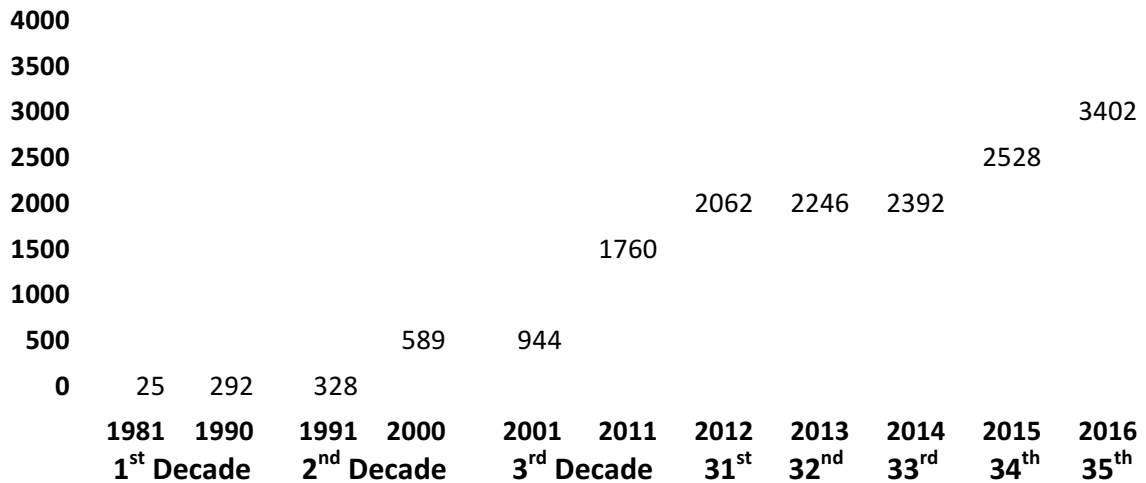
Grand Hyatt Atlanta in Buckhead  
Atlanta, GA • April 1-2, 2016



The Board appointed a Professional Recognition Task Force, an item-writing committee with 26 gero experts to develop and validate the APRN Gerontological Specialist certification exam. GAPNA initiated a quarterly *Rising Star* award to specialty expertise and organizational leadership; Megan Simmons was the first recipient. The LGBT Focus Group evolved into the Cross-Cultural Caring SIG to include ethnic minorities and other groups. Great Lakes chapter celebrated their 30<sup>th</sup> anniversary with a monograph of their activities.

Nationally, the Veterans Administration initiated ‘full practice authority’ for all APRNs. In response to the 2010 IOM report on the *Future of Nursing*, the Robert Wood Johnson Foundation and AARP launched the *Future of Nursing: Campaign fir Action*.

### GAPNA Membership 1981 – 2016





### GAPNA Conferences by Year

Year	GAPNA Year	Annual Conference	GAPNA Year	Pharmacological Conference
2011	30 <sup>th</sup>	Washington DC	---	---
2012	31 <sup>st</sup>	Las Vegas, NV	---	---
2013	32 <sup>nd</sup>	Chicago, IL	---	---
2014	33 <sup>rd</sup>	Orlando, FL	---	---
2015	34 <sup>th</sup>	San Antonio, TX	1 <sup>st</sup>	Philadelphia, PA
2016	35 <sup>th</sup>	Phoenix, AZ	2 <sup>nd</sup>	Atlanta, GA
2017	36 <sup>th</sup>	Nashville, TN	3 <sup>rd</sup>	San Francisco, CA
2018	37 <sup>th</sup>	Washington DC	4 <sup>th</sup>	Boston, MA
2019	38 <sup>th</sup>	Las Vegas, NV	5 <sup>th</sup>	Chicago, IL
2020	39 <sup>th</sup>	Virtual due to COVID-19	---	Canceled due to COVID-19
2021	40 <sup>th</sup>	San Diego, CA	6 <sup>th</sup>	Virtual due to COVID-19

### GAPNA Chapters by Year

Start Date	State	Dissolved
1991	Puget Sound Washington	1999
1993	Chicagoland Illinois	1995
1998	Northern California	
1998	Chicagoland Illinois	
1998	Great Lakes Michigan	
2001	Florida Gulf Coast	
2001	Ohio	
2001	Gulf Coast Texas	
2003	Rochester New York	2007
2003	Phoenix Arizona	2006
2005	Lone Star Texas	2010
2005	Maryland MD	
2006	Delaware Valley: DE, PA	
2006	New England: RI, NH, CT, VT, ME, MA	
2006	North Carolina Triad NC	
2006	Southeast Wisconsin WI	
2007	Sonaran AZ	
2007	Georgia GA	
2007	Magnolia: MS, LA, AL	2015
2007	Middle Tennessee TN	
2008	Mid-South TN	
2010	FL-GAPNA Florida	
2013	Southern California CA	

Start Date	State	Dissolved
2014	Liberty Pennsylvania	
2015	Heartland: KS, NB, MO	
2015	Central Virginia VA	
2016	Seattle Washington	
2020	New York & North Jersey: NY, NJ	
<b>Current Total Official Active Chapters:</b>		<b>22</b>

**Addendum  
for the  
40<sup>th</sup> Anniversary  
of the  
Gerontological Advanced Practice  
Nurses Association  
2016 – 2020**



**Compiled by the  
GAPNA Historical Committee, 2019 – 2021**

Cynthia (Cindy) Gerstenlauer, Chair

Deborah (Deb) Dunn, Board Liaison

Maureen Beck

Marianne Boettger

Linda Keilman

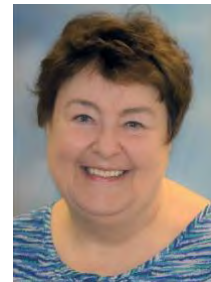
Trudy Keltz (not pictured)

Michelle Longley

Elizabeth (Beth) Rochford



Maureen Beck, Kathy Fletcher, Cindy Gerstenlauer, Marianne Boettger, Beth Rochford, Deb Dunn; GAPNA Fall Conference 2017



Linda Keilman



Michelle Longley

## GAPNA 2016 – 2017



The 36<sup>th</sup> Annual Conference was held October 4-7, 2017, at the Gaylord Opryland Resort and Convention Center, Nashville, TN

This was the highest attended meeting with 674 attendees at the preconference and 627 at the regular conference.

GAPNA Gives Back: Fifty Forward in Nashville. GAPNA contributed 560 pairs of socks and \$210 in cash and gift cards for the Adult Day Services program.



**Officers** (as pictured): Deborah Dunn, Director-at-Large; Natalie Baker, Secretary; Carolyn Clevenger, Past-President; Katherine Evans, President; Joan Michelle Moccia, President-elect; Michele Pirc, Treasurer; Valerie Sabol, Director-at-Large (not pictured).

The 3<sup>rd</sup> Annual GAPNA Pharmacology Conference, *Contemporary Pharmacology and Prescribing in Older Adults*, was held on March 24-25, 2017, at the Hyatt Regency San Francisco, CA.

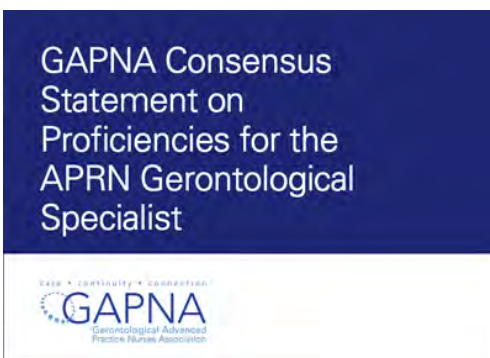
There were 345 attendees. GAPNA Gives Back: Mabuhay Health Center. GAPNA donated funds, gift cards, and toiletries.





GAPNA membership for 2017 was 3,402, which increased due to Optum members offering a GAPNA membership as a benefit. *The GAPNA Consensus Statement on Proficiencies for the APRN Gerontological Specialist* now had 22 endorsements. GAPNA's leadership team worked closely with The Society for Post-Acute and Long-Term Care (AMDA) to develop a collaborative relationship. GAPNA members were now eligible for a significant AMDA membership discount. All conference sessions were now available in the GAPNA Online Library after the conference, to both attendees and non-attendees. The Board started using video conferencing for meetings. The Online *Gerontology Resources for APRN Preceptors and Students Toolkit*, 4th edition, was updated to make geriatric and gerontological content accessible to those caring for older adults. The Professional Development Task Force developed a new APRN Gerontology Certification Exam, with two pilot exams offered at the fall 2017 conference. An *In Memoriam* column came to the GAPNA Newsletter. GAPNA developed a health policy statement which focused on home care for the website. The Leadership SIG worked on a Leadership Toolkit, and developed a conference session with the Health Affairs Committee, to help GAPNA develop new leadership and become more diverse. As a result of completing the *Membership Profile and Survey*, a new acute care SIG was formed after the 2017 fall conference. The Communications Committee made changes to the GAPNA website to improve function, and determined a total redesign was needed. GAPNA's emphasis on health policy kept the team busy moving the organization forward with the development and dissemination of GAPNA's Policy Perspectives. The Research Committee facilitated the "Cash Cab," to interact with participants in the exhibit hall at the fall conference. The GeroPsych Nursing SIG published an online position paper on geropsychiatric nursing as a subspecialty. GAPNA had 21 chapters.

On December 14, 2016, the U.S. Department of Veterans Affairs (VA) published a final rule granting veterans direct access to care by nurse practitioners (NPs), certified nurse midwives (CNMs) and clinical nurse specialists (CNSs) who work in the VA health system. A landmark ruling from the VA allowed these APRNs to practice to the fullest extent of their education, training, and certification.



## GAPNA 2017 – 2018



The 37<sup>th</sup> Annual Conference was held September 26 – 29, 2018, at the Marriott Wardman Park Hotel in Washington D.C.

An Acute Care Tract was held for the first time.

There were 485 attendees. GAPNA Gives Back: IONA Senior Services. GAPNA donated \$315 in gift cards & toiletries.

In 2018, Erin Macartney became the Association Services Manager.



**Officers** (as pictured): Jennifer Kim, Treasurer; Joan Michelle Moccia, President; Valerie Sabol, President-elect; Deborah Dunn, Director-at-Large; Katherine Evans, Past President; Natalie Baker, Secretary; Sherry Greenberg, Director-at-Large.

The 4<sup>th</sup> Annual Pharmacology Conference, *Contemporary Pharmacology and Prescribing in Older Adults*, was held on March 16-17, 2018 at the Boston Park Plaza, MA.

There were 325 attendees. GAPNA Gives Back: Little Brothers – Friends of the Elderly, Boston. Gift cards and staples were given.



GAPNA membership for 2018 was 3,740. GAPNA's first live educational Webinar was, *Best Practices in Diabetes Management and Optimizing Insulin Delivery in Older Adults*. GAPNA released, *Gerontology Resources for APRNs in Acute and Emergent Care Settings* (1<sup>st</sup> edition), and *Gerontology Resources for APRN Preceptors and Students* (6<sup>th</sup> edition). The GAPNA Consensus Statement on Proficiencies for the APRN Gerontological Specialist was disseminated to schools of nursing, geriatric nursing publications, and related conferences. GAPNA partnered with *Age Friendly Health System*, an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association and the Catholic Health Association of the U.S. (CHA). A Care Plan Oversight Toolkit was put in the GAPNA Online library. Military discount for GAPNA membership was approved for 10% discount. Any healthcare worker interested in gerontology is now eligible for associate membership. An Anniversary Committee was formed to facilitate a Chapter anniversary table to recognize 10 and 20 years of Chapter Excellence. The Awards Committee added a new Emerging Chapter Excellence Award. The Health Affairs Committee developed a preconference on health policy and advocacy, which included a visit to the Capital. The Chapter Leadership Committee now uses Zoom for their meetings. The Acute Care SIG published the Online *Gerontology Resources for APRNs in Acute and Emergent Care Settings*. The Gerontological Nursing Certification Commission administered the initial APRN Gerontological Specialist Certification exam in Boston, which was a paper/pencil test. GAPNA and the Hartford Institute for Geriatric Nursing developed 9 CE educational modules for the Dementia Care Specialist. GAPNA had 21 chapters.

A need was identified for the APRN Nursing Licensure Compact. The Institute of Medicine's Future of Nursing 2018 report reveals that as of 2017, there are 28,000 nurses in the workplace with doctorates, and 22 states and Washington D.C. have full access to nurse practitioners. To respond to the national opioid epidemic, 11 states enacted statutory or adopted regulatory changes restricting prescribing of certain controlled substances (CSs), requirements to review and monitor the state's prescription drug monitoring program (PDMP) prior to prescribing CSs, and/or authorization for APRNs to prescribe or dispense buprenorphine as part of the Medication Assistance Programs. These statutory and regulatory changes apply to all APRNs authorized to prescribe CSs, regardless of licensure category.



1st Edition

→  
Marianne Boettger created a beautiful quilt that was auctioned at the conference to benefit the GAPNA archiving efforts.





## GAPNA 2018 – 2019



The 38<sup>th</sup> Annual Conference was held on October 3-5, 2019, at the Paris Las Vegas, NV.

There were 498 registrants. The first Dementia Care Specialist (DCS) Skills Training was offered as a Pre-Conference Workshop. Completing the DCS course available in the GAPNA Online Library first was encouraged.



**Officers** (as pictured): Sherry Greenberg, Director-at-Large; Natalie Baker, Secretary; Valerie Sabol, President; Joan Michelle Moccia, Past President; Deborah Dunn, President-Elect; Jennifer Kim, Treasurer; Sharon Bronner, Director-at-Large.

The 5<sup>th</sup> Annual Pharmacology conference, *Pharmacology and Prescribing in Older Adults*, was held on March 28 – 30, 2019 at the Chicago Hilton, IL.

There were 347 attendees. GAPNA Gives Back: Little Brothers – Friends of the Elderly – Chicago. GAPNA contributed \$400 in gift cards and donations.



GAPNA membership for 2019 was 2,520, which dropped due to Optum offering members a choice between a GAPNA or AANP membership. The GAPNA Leadership Institute (GLI) was launched at the fall conference to develop support and enrich skills of a select group of APRNs to prepare for leadership roles. Four GLI fellows were selected for the 9-month structured program, led by a GAPNA leadership team.

GAPNA's Social Media helped members stay connected: Website <https://www.gapna.org>, Facebook <https://www.facebook.com/GAPNA>, twitter @GAPNA\_HQ, LinkedIn <https://www.linkedin.com/company/gerontological-advanced-practice-nurses-association-gapna->

GAPNA formed a new partnership with UnitedHealth Group (UHG) to benefit the aging population and workforce.

The GAPNA Exchange was launched in 2019 as an online private, secure community, designed to help members connect, communicate, and collaborate with their gerontology-focused colleagues.

GAPNA partnered with the UCLA Alzheimer's and Dementia Care (ADC) program, and The John A. Hartford Foundation to provide continuing professional development in dementia care and train APRNs as DCS. DCS Modules (9 contact hours) were offered to GAPNA members free initially, then for a fee for members and non-members. The DCS Curriculum contains 22 modules, housed in the GAPNA Online Library.

A two-phase Website Redesign was approved, with the Communications Committee charged with oversight. The Gerontological Nursing Certification Commission (GNCC) offered the Gerontological Specialist Certification (GSC) exam to 45 candidates, with 64 certified now. With leadership from the Education Committee (EC), GNCC GSC Study Guide was completed. The EC also completed a position paper on long term care as an appropriate APRN student clinical site. The House Calls SIG developed an educational video about Home-Based Primary Care and House Calls. GAPNA had 21 Chapters.



A major theme in the 2019 legislative and regulatory sessions was the continued focus on controlled substances prescribing for all authorized healthcare providers. The National Council of State Boards of Nursing now showed 100% implementation of the APRN Consensus Model recommendations in 18 states.



## GAPNA 2019 – 2020



The 39<sup>th</sup> Annual GAPNA Fall Conference, *The Strength of Nursing*, was changed from New Orleans to the first ever virtual conference, due to the COVID-19 Pandemic, declared on 3/11/20 by the World Health Organization (WHO).

It was held on September 24-26, 2020 with 527 registrants. Live-streamed sessions and on-demand content were available. Conference sessions were recorded and were available in the GAPNA Online Library. The Dementia Care Specialist (DCS) Skills Training and the new Gerontological Specialist Certification Exam Review pre-cons had 72 attendees each.

The 6<sup>th</sup> Spring Geriatric Pharmacology Conference scheduled for April 14-18, 2020 at the Hilton Hawaiian Village, Honolulu, HA, was canceled due to the pandemic, and rescheduled for April 20-23, 2021 at the same location.



**Officers** (as pictured): Sherry Greenberg, President-elect; Sharon Bronner, Director-at-Large; Stacey Chapman, Director-at-Large; Deborah Dunn, President; Valerie Sabol, Past President; Jennifer Kim, Treasurer; Natalie Baker, Secretary.

GAPNA Membership for 2020 was 2,776. In addition to the monthly meetings, the GAPNA Board convened two additional emergency board meetings early in the COVID-19 pandemic crisis to address the important issues of newly implemented travel restrictions, social distancing, and the anticipated intensified healthcare needs of the public, and how these events would impact the members. These deliberations led to the important conclusion that GAPNA needed to do all that it could for the health and safety of its members, and that it needed to support its members as they navigated the uncharted waters that would lie ahead. The actions taken were to reschedule the pharmacology conference, to encourage cancellation of face-to-face chapter annual conferences, and quickly establish a COVID-19 resource webpage on the GAPNA website.

A new video series, *Facing Forward*, was posted where GAPNA members were interviewed to provide insights and tips as they adjusted to providing care during the pandemic. Both the GAPNA Exchange and its social media allowed members to access the latest news, and share helpful information on senior care, APRN resources, and practice issues. The Health Affairs Committee was incredibly active and responsive to the need to advocate for policies that promote access to APRNs and reduce barriers to practice and provide safe work environments.

GAPNA members are highly sought for their expertise in care of the older adults. Members were represented at many professional meetings, like LACE, NONPF, National Council of State Boards of Nursing APRN Compact Stakeholder meeting, AMDA, and the Coalition to Transform Advanced Care National Summit on Advanced Illness Care. Members also provided interviews, presentations, op-eds, and articles to a variety of organizations. GAPNA leaders were interviewed in many nursing, healthcare, and major media publications and websites including American Nurse Journal, The Washington Post, US News and World Report, Monster.com, and more. Journalists and other publications sought out GAPNA to provide insights on optimizing care for older adults during the COVID crisis.

GAPNA released the 7<sup>th</sup> edition of *Gerontology Resources for APRN Preceptors and Students toolkit*, to make geriatric and gerontological content accessible to those caring for older adults. GAPNA announced that 23 of its members received recognition as a Distinguished Educator in Gerontological Nursing Program from the National Hartford Center of Gerontological Nursing Excellence. GAPNA and UHF briefed the Senate Special Committee on Aging on America's Health Rankings Senior Report. GAPNA now had 22 chapters with the addition of the New York and North Jersey Chapter in January.

The Gerontological Nursing Certification Commission has now certified 69. The pandemic had significant impact on test takers and the testing sites. The GAPNA Leadership Institute had its second class of fellows starting in January.

By 2019, 28 states had full practice authority for NPs. The WHO, as a credit to the pivotal role of nurses in the pandemic, and in celebration of the 200<sup>th</sup> anniversary of Florence Nightingale's birth, designated 2020 as the *International Year of the Nurse and Midwife*. This was endorsed by the American Nurses Association.



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GAPNA Section

## A historical look at men's involvement in nursing and leadership in GAPNA



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## ABSTRACT

The role of men in nursing is not always evident. Men have been care takers in early societies, military health care, and the religious sector. The perception of men in nursing, however, took a shift from one of honor to one of deviance and failure from medical school. As the contributions of historical men in nursing, such as Walt Whitman, are brought to light, so are the contributions of select men within the Gerontological Advanced Practice Nurses Association (GAPNA). Dr. George Peraza-Smith provides an exclusive interview, shares his dedication and contributions to the care of the aging adult, and provides words of wisdom to those wanting to impact the care of geriatric nursing.

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The discipline of nursing is currently identified as a predominately female profession.<sup>1</sup> However, this has not always been the case. In fact, men have had major contributions throughout time which have not only led to the advancement and progression of the nursing profession but have also made significant contributions to the fields of mental health, critical care, emergency care, the operating theater, and military nursing.<sup>1</sup>

The presence of men in nursing can be traced back to the profession's infancy. It continued despite adversity and negative public perception through current day. In many societies and ancient tribes, care of the sick was a role assigned to medicine men, shamans, or other male tribe members.<sup>2</sup> Other early records of men in nursing document their workforce presence in areas such as asylums, workhouse infirmaries, military services, and private associations.<sup>3</sup> Men have often been attracted to these hospital environments based on an assumption that a greater degree of technical competence required for the job. Less often, men have been observed migrating to more intimate care areas, such as hospice, community health, or geriatrics.<sup>4</sup>

War efforts during the middle ages created a need for men to provide nursing care. The Knight Hospitallers of St. John of Jerusalem were founded in 1080 in order to provide care to pilgrims traveling to

the Holy Land during the Great Crusades. Comprised mostly of military men, the Hospitallers as they were called, were responsible for eventually running most of the hospitals in the Holy Land as well as in some parts of Europe.<sup>5</sup> During this same time period, another military order, the Knights of Lazarus, were founded around the 1140s. This military order was compromised almost entirely of men and was charged to care for lepers as well as battle victims during the crusades.<sup>6</sup>

Historic records from the monastic movement detail the contributions men made to healthcare. It was during this period that early accounts of religious sectors of male nurses are first described. In 1095 AD, Gaston de Dauphine founded the Antonines, or Hospital Order of St. Anthony, who dedicated their work to providing for the care of sick and afflicted individuals. The Antonines remained a major contributor to healthcare until they merged with the Knights of Malta in 1775. Other religious orders of men during this time were also devoted to delivering nursing care. These included, but were not limited to, the Order of the Holy Ghost and several branches of the Third Order of St. Francis.<sup>7</sup>

During the era of Florence Nightingale, her trained nurses, known as the 'reformed nurses' introduced a non-religious nursing sisterhood. This movement allowed little to no room for men in nursing within the general or voluntary hospital sector.<sup>3</sup> It was thought that the delivery of nursing care was a role that was more appropriate to be assigned to female members of the community. Much of this shift

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assumed that it was natural for nursing to be performed by women because they traditionally provided nurturance to their own infants. It was therefore assumed these same caring approaches could be extended to both the sick and the injured members of the community.<sup>2</sup> Therefore, women became the predominate caretakers and men began to shift into other areas of nursing such as private nursing, or Navy and Army nursing, as well as moving out of nursing altogether and into other professions.<sup>2</sup>

In the United States, famed poet Walt Whitman was best known for his great American poetry accomplishments. He is less known for his role as a nurse during the American Civil War. It was here that he volunteered as a nurse in a Union military hospital in Washington D.C.<sup>2</sup> This volunteer role came about after his brother sustained a combat injury. Whitman became intrigued by nursing and served for seven years as a nurse in a voluntary role.<sup>8</sup> Many of Whitman's works at the time detail how he role as a male nurse enabled him to connect with the soldiers he was treating. One such example comes from the "Hospital Visits" chapter of his 1865 book *The Wound Dresser*: "I sat down by him without any fuss; talked a little; soon saw that it did him good. . . . He told me I had saved his life. He was in the deepest earnest about it."<sup>9</sup>

Following the Civil War, public perception of the role of men in nursing did not remain positive. Studies conducted during the 1970s and 1980s in the United States, revealed that men in nursing was perceived less positively.<sup>10,11</sup> Additionally, men were less likely to want to be a nurse when compared to other professions, such as law, medicine, physics, or English. It was also the public perception that men who entered nursing did so not out of desire, but were deviant, odd, or did so due to an inability to successfully complete medical school and therefore were seen as failures by the general community.<sup>12,13</sup>

The current state of male enrollment, involvement and contributions of men in nursing as reported by the American Academy of Colleges of Nursing, reports the number of male nursing students enrolled in baccalaureate programs is around 11.7%.<sup>14</sup> Though these statistics have gradually increasing over the years, current numbers have yet to show the type of growth needed to support a more diversified nursing workforce that better mirrors our population. The lack of a significant increase in male enrollment in Schools of Nursing may be due to poor support to enter into nursing, as well as attrition due to lack of mentors, negative stereotypes, challenging clinical placements, limited mentorship by other men in the profession.<sup>1,15</sup>

### Men's involvement in GAPNA

Within the organization, Gerontological Advanced Practice Nurses Association (GAPNA), the presence of male involvement was initially not very robust. According to the historical records from GAPNA,<sup>16</sup> there was no male involvement in the Association in the early years. In 1991, at the 10th Annual National Conference of GAPNA, the first man, Joe Caraway, was elected as President Elect. Sadly, Mr. Caraway resigned from his position before assuming the presidency.<sup>16</sup>

Over the next 17 years, men gradually started to become member of GAPNA and attend the annual conferences. It was not until the 28th Annual National Conference that the next man was elected to the Board of Directors as a Member at Large.<sup>16</sup> This gentleman as James Lawrence. He served for the 2008–2009 period and again as Board Member at Large from 2009–2010. Men continued to increase in presence over the next several years as both GAPNA members and committee members until the 33rd Annual Conference in 2013 when George Peraza-Smith was elected to the board position of treasurer and served two years.

### Exclusive interview with Dr. George Peraza-Smith

An exclusive interview with Dr. George Peraza-Smith provided amazing insight into his history, current roles, and advise for men with

a desire to serve. Dr. Peraza-Smith currently serves as the Department Chair for the online Doctor of Nursing Practice and Advanced Practice Nursing programs at South University. His involvement in GAPNA began around 2008. As a psych-mental health nurse and gerontological nurse practitioner, he became active with the Gerontology Psychiatric Special Interest Group (GeroPsych SIG). He has served on the GeroPsych's leadership team as secretary and chair. Dr. Peraza-Smith served as Treasurer from 2013 to 2015 and continued to be involved in many other committees within GAPNA. Dr. Peraza-Smith also chaired the Professional Recognition Task Force that was the predecessor to the Gerontology Nurse Certification Commission (GNCC). The GNCC released the first Advanced Practice Registered Nurse (APRN) Specialty Certification in Gerontology in 2018. This specialty certification is a way to distinguish APRNs who demonstrate expert knowledge, experience, and skill in managing the complex health needs of older adults.

Finally, Dr. Peraza-Smith represented GAPNA on the 2018–2019 American Nurses Association Gerontological Nurse Scopes and Standards Committee. It is these standards which outline the services a qualified health professional is deemed competent to perform, in keeping with the terms of their professional license.

Dr. Peraza-Smith had words of wisdom for not only men in nursing, but all men wanting to impact the progression of geriatric nursing and GAPNA:

- Be willing to be gender neutral: All must be involved and work towards the same common goal;
- Be passionate: Find something that interests you and be willing to do the work for that cause;
- Be willing to honor others: It's not about you being a shining star but rather honoring other's contributions;
- Get involved: Go to conferences, be on committees, and share your voice.

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GAPNA Section

## Evolution of the adult/gerontological APRN and GAPNA: The fourth decade, 2011–2021



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The 40th anniversary gemstone is traditionally a ruby – the stone of kings and queens. The Latin derivative is “ruber” which means red (the deep color of the stone). Rubies are thought to have an eternal inner flame or fire that in many global cultures symbolizes nobility, purity, and passion. The ruby is believed to promote health and knowledge as well as love and compassion. It has also been connected to improved energy, creativity, motivation, and goal setting. Does this sound like the GAPNA mission, vision, goals, and experience you know? A gathering of inspired and dedicated gerontological nurses founded this organization in 1981 and it has been growing stronger and burning brighter with recognized influence every year. This article highlights the last decade of work and accomplishments that have occurred from the passion of individuals working with older adults. GAPNA has forged ahead as visionary leaders in the care of older adults; creative in approaches to meeting the needs through certification and leadership opportunities. Health policy is a dedicated advocacy focus for advanced practice nursing and older adults, making the world a better place for aging and quality health care access and equity. This article will remind you or acquaint you with some of the accomplishments in the last decade. The authors hope the outcome of reading the article will delight you, but also motivate you to become actively engaged with the organization in the next years as GAPNA heads toward becoming golden.

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## Introduction

The Gerontological Advanced Practice Nurses Association (GAPNA) is the premiere and only gerontological nursing organization specifically for advanced practice registered nurses (APRNs). After the National Gerontological Nursing Organization (NGNO) dissolved in 2018, GAPNA began offering associate membership for any healthcare worker interested in gerontology and the care of older adults (OA). Membership in the last decade increased by 48%, from 1723 to 2554 members. GAPNA's mission is to promote excellence in advanced practice nursing (APN) for the ultimate outcome of well-being and quality of life (QoL) for OA. The vision for GAPNA is trusted leaders for the expert, safe care of OA. GAPNA's goals and priorities include:

- (1) Advocate quality care for older adults.
- (2) Promote professional development.
- (3) Provide continuing gerontological education.
- (4) Enhance communication and professional collaboration among health care providers.
- (5) Educate consumers regarding issues of aging.

The strategic initiatives include continuing education (CE), member engagement, strategic collaboration that advances full practice authority, improved online presence, and an increase in diversity and inclusiveness.

GAPNA offers live and virtual CE and other educational opportunities via on-demand sessions available through the Online Library. The fall 2020 annual conference was the first time a hybrid approach was offered. This change was due to the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) which was declared the COVID-19 global pandemic by the World Health Organization (WHO) on

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March 11, 2020. Given the global travel and quarantine restrictions, a virtual approach was continued with both 2021 conferences. An annual *Pharmacology and Prescribing in Older Adults* conference premiered in 2015 to meet the need for APRN pharmacology credits and information applicable to care of OA. This has been an increasingly popular conference with over 650 virtual attendees in 2021.

### Communication strategies

GAPNA is focused on improving communication and increasing organizational presence to gerontological APRNs. GAPNA provides many opportunities for member engagement; networking, and personal and professional growth. GAPNA's vast social media presence allows members to stay connected, updated and includes a newly designed *Webpage*, *Facebook*, *Twitter* pages, and a *LinkedIn* account. The semi-annual conferences provide speaking and networking opportunities; submission of research, clinical, and education posters; opportunities for travel, awards, scholarships; giving back to the conference site regional community; and fund-raising.

GAPNA has a board of directors, nine committees, six special interest groups (SIGS), and 22 Chapters where members can be active participants in achieving and living GAPNA's goals and initiatives. The *GAPNA Exchange* was launched in 2019 as an online community designed to help members connect, communicate, consult, and collaborate with their gerontology-focused colleagues. The Exchange is a private, secure community for members to share ideas, ask questions, lend expertise, and network with peers. The Exchange was especially timely with the anxiety, uncertainty, and urgency surrounding the pandemic. GAPNA's **e-Alerts** share important communications, legislative and policy news, chapter events, and timely topics of interest. The e-Alerts are being archived for easy reference. The quarterly online *GAPNA Newsletter* and the official *journal*, *Geriatric Nursing* (GN), allow publication and dissemination opportunities.

### Diversity and inclusivity

Increasing organization diversity and inclusiveness is a GAPNA priority. A 1993 philosophy statement was revised to include human rights, cultural diversity, sexual preference, and disability. Annual conference themes in 1988 and 1996 were inclusive of diversity. The

LGBTQ+ Focus Group (FG) existed from 2011 to 2015 to help address the needs of the vulnerable OA LGBTQ+ population. FG members wrote an article for GN and created an online resource list of LGBTQ+ quality, informational websites. At the 2014 annual conference, a documentary film about OA, *Gen Silent*, was presented with the producer/author in attendance. This film was extremely impactful as it poignantly illustrated the difficulties facing LGBTQ+ OA; many GAPNA chapters across the country shared this film. The FG evolved into the Cross-Cultural SIG from 2015–2019 and group members created and presented the following conference sessions: *End-of-Life Issues for Older Chinese Individuals*, *Older Adults with Lifelong Intellectual and Developmental Disorders*, and *Cultural Perspectives on End-of-Life Care*. The SIG also published articles in GN and the newsletter on various cultural topics. The American Geriatrics Society (AGS) position statement *Care of Lesbian, Gay, Bisexual, and Transgender Older Adults* was endorsed by GAPNA in 2015. To continue the GAPNA mission of diversity, the GAPNA board authored a statement on Social Justice in 2020 that is posted on the website. GAPNA remains committed to promoting excellence in APRNs that enhances the well-being of all OA regardless of race, ethnicity, gender identity, religion/fait, socioeconomic status, and sexual preference.

### Online resources

GAPNA has many online resources that contain materials of value to APRNs in gerontology (Table 1). The resources have been produced by GAPNA, third parties, or are a collaborative effort by both. Resources indicate whether they are available to members only or to the public, and whether there is a cost involved. Members also have access to several outside publications (listed on website). GAPNA's position statement on Long-Term Care (LTC) sites for APN student clinicals was endorsed by the Commission on Collegiate Nursing Education (CCNE) and poster on their website, as well as Licensure Accreditation Certification and Education (LACE) member organizations. This prestigious endorsement and dissemination are a tribute to the work of GAPNA to promote NP preparation and expertise in care of LTC residents. GAPNA's proficiency statements have been endorsed by over 22 organizations. The geropsychiatric nursing (GPN) position statement was developed to create and sustain a vision for the nursing profession that positively impacts and improves the care of OA with comorbid psychiatric/substance misuse

**Table 1**  
GAPNA online resources.

<b>Position Statements</b>	<ul style="list-style-type: none"> <li>• <i>Addressing Nursing Home Safety During the COVID-19 Pandemic and Beyond</i> (2020)</li> <li>• <i>GAPNA Geropsychiatric Nursing Position Statement: Supporting Evidence for Geropsychiatric Nursing as a Subspecialty of Gerontological Advanced Practice Nursing</i> (2020)</li> <li>• <i>Primary Care in Long-Term Care Sites: Long-Term Care Sites as Appropriate Clinical Placements for Primary Care Nurse Practitioner Students</i> (2020)</li> <li>• <i>GAPNA Consensus Statement on Proficiencies for the APRN Gerontological Specialist</i> (2015)</li> <li>• <i>Clinical Practice of GNP's</i> (updated 2012)</li> <li>• <i>Joint Summary Statement – Diagnosing Schizophrenia in Skilled Nursing Centers</i> (2017)</li> <li>• <i>Nurse Practitioner DNP Education, Certification and Titling: A Unified Statement</i> (2008)</li> </ul>
<b>Toolkits</b>	<ul style="list-style-type: none"> <li>• Gerontology Resources for APRN Preceptors and Students Toolkit, (7th ed., 2020)</li> <li>• Gerontology Resources for APRNs in Acute and Emergent Care Settings (2nd ed., 2021)</li> <li>• <i>Care Plan Oversight – Home Health Care: The NP Role</i> (2018)</li> </ul>
<b>Educational Video</b>	<ul style="list-style-type: none"> <li>• Home-Based Primary Care and House Calls</li> </ul>
<b>GAPNA Online Library</b>	<ul style="list-style-type: none"> <li>• Conference Materials               <ul style="list-style-type: none"> <li>◦ On Demand</li> <li>◦ Nursing Continuing Professional Development (NCPD)</li> </ul> </li> </ul>
<b>Online Course</b>	<ul style="list-style-type: none"> <li>• Dementia Care Specialist (DCS) Skills Training (9.0 contact hours)</li> </ul>
<b>GAPNA Newsletter</b>	<ul style="list-style-type: none"> <li>• Quarterly</li> <li>• Available online since 2015</li> <li>• Downloadable issues available back to 2008</li> </ul>
<b>Geriatric Nursing (GN) Journal</b>	<ul style="list-style-type: none"> <li>• Bimonthly</li> <li>• Members receive printed copies as benefit</li> <li>• Available online</li> </ul>

disorder. The statement has been disseminated to multiple nursing organizations, has received numerous endorsements, and is also available on numerous health care websites.

### Advocacy and legislation

GAPNA's Health Affairs Committee tracks and promotes legislation and policies that advocate for APRN practice and quality care for OA. Efforts provide an avenue to improve and strengthen coordination with key national organizations. GAPNA is a member of the Nursing Community Coalition (NCC) which includes national professional nursing associations dedicated to building consensus and advocating on a wide variety of healthcare issues including practice, education, research, and regulation. The NCC is committed to improving the health and health care of the nation.

GAPNA provided input and celebrated the 2016 landmark ruling of the United States (U.S.) Department of Veterans Affairs final rule granting veterans direct access to care by NPs, certified nurse midwives, and CNS employed within the VA health system. This ruling allowed APRNs in the VA system to fully practice to the level of their education, training, and certification. GAPNA applauded the 2019 Executive Order, *Protecting and Improving Medicare for our Nation's Seniors*, which mandated the U.S. Department of Health and Human Services (DHHS) look at the care provided by NPs and allow them to practice at the full extent of their licensure.<sup>1</sup> This order will hopefully remove the current outdated barriers to APRN practice that impede OA access to high-quality health care. The Health Affairs Committee was successful during the COVID-19 pandemic in advocating for appropriate care of OA and actively advocated for policies that promoted access to APRNs and reducing barriers to APRN practice within safe work environments. One example is the Coronavirus Aid Relief and Economic Security (CARES) Act, made into law on March 3, 2020.<sup>2</sup> The Act should modernize Medicare and allow APPs to certify home health contracts which will provide more timely services to patients and their families.

In 2012, GAPNA's Historical Committee published a 30-year monograph, *Evolution of the Gerontological Nurse Practitioner and the Gerontological Advanced Practice Nurses Association 1981–2011*. Available originally through Amazon, it is currently posted on GAPNA's website. Two addendums were added: 2011–2016 and 2016–2020. In 2014, the Historical Committee submitted GAPNA records from 1981 to 2011 for archiving at the University of Virginia's Eleanor Crowder Bjoring Center for Nursing Historical Inquiry. Archiving was completed in 2016. Access to the records are available in person or by appointment.

### Partnerships

GAPNA continues to strengthen liaisons with many other APRN and health care groups such as the National Organization of Nurse Practitioner Faculties (NONPF), LACE, Nursing Community, American Association of Retired Persons (AARP), National Council of State Boards of Nursing APRN Compact, and the U.S. Public Health Service. GAPNA became a member of the National Hartford Center for Gerontological Excellence (HCGNE) in 2016 and worked collaboratively with them on nine continuing education modules on Dementia Care Specialist (DCS) skills training. GAPNA began working with the University of California, Los Angeles (UCLA) in 2018 through a grant to fund DCS Curriculum training. The curriculum contains 22 modules that provide basic knowledge for APRNs who are looking to advance their expertise in caring for individuals with dementia and their dyad partners (caregivers). GAPNA is housing the DCS curriculum in the GAPNA Online Library.

In 2019, GAPNA developed a partnership with United Health Group (UHG) to identify and address the aging population needs,

strengthen the national gerontology-focused workforce, educate legislators and regulators on the importance of gerontology-focused education to new and existing NPs, and address the shortage of NP faculty who lack gerontology expertise. In 2019, GAPNA joined the National Task Force (NTF) on Quality NP Education which provided the opportunity to give input on the revision of the NTF criteria. GAPNA conveyed the pressing need for adequate numbers of gerontological APRN faculty to teach current and future generations of APRNs and stressed the need to deliver adequate breadth and depth of gerontology content in program curricula. In 2019, GAPNA partnered with Clinical Care Options to offer an ongoing series of free CE programs available to GAPNA members.

GAPNA also continues to make significant strides in collaboration with physician colleagues and other geriatric/gerontology groups. GAPNA partnered with the American Geriatrics Society (AGS) and the Centers for Medicare & Medicaid Services (CMS) on the *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults* revisions, management of OA with multiple medical co-morbidities, and initiatives to improve behavioral health for LTC residents. GAPNA developed a collaborative relationship with The Society for Post-Acute and Long-Term Care Medicine (PALTC/AMDA), to have an APRN presence at conferences, to promote interprofessional team care, to participate in the National Leaders Forum, sit on committees and task force groups, and assisted in developing attending physician competencies for post-acute/long-term care of OA. GAPNA's members are now eligible for a significant PALTC membership and conference discount.

### Adult/gerontological advanced practice nursing education and certification

The National Conference on State Boards of Nursing (NCSBN) at the 2008 National APRN Consensus Model gave recommendations for national regulatory standards for APRN LACE with the goal of implementation by 2015.<sup>3</sup> The American Association of Nurse Practitioners (AANP) encouraged all state boards to adopt the Consensus Model to increase health care quality among underserved populations.<sup>4</sup> The NCSBN reported 100% implementation of the Consensus Model recommendations in 18 states.<sup>5</sup> The Model requires APRN education and certification to be in alignment, and to meet the requirements of the model's regulations for the adult/gerontology population foci. Adult and gerontology graduate educational programs for APRNs have fully transitioned to Adult-Gerontology (A-G) APRN programs with the option to specialize in acute or primary care.

Despite the 2004 AACN endorsement of the Doctor of Nursing Practice (DNP) being the single-entry degree for APRNs beginning in 2015, there are still both master's and DNP A-G programs available. All adult and gerontological NP and CNS national certifications were retired by 2016, although those certified as such are eligible to recertify by professional development and clinical practice requirements. Various A-G primary and acute care NP and A-G acute care CNS certifications exams are offered by AANP and the American Nurses Credentialing Center (ANCC) through the American Nurses Association (ANA). Currently, 7% of NPs are certified as A-G primary care NPs, and 2.9% are A-G acute care NPs.<sup>6</sup>

### APRNs as primary care providers

The Patient Protection and Affordable Care Act (ACA) of 2010, implemented in 2012, created Accountable Care Organizations (ACO).<sup>7</sup> An ACO refers to a group of providers and suppliers of services that work together to coordinate care for the patients they serve who are beneficiaries of Medicare. The goal was to deliver seamless, high quality patient-centered care instead of the fragmented care that has so often been part of fee-for-service health care. The ACA enabled millions of uninsured Americans to gain health insurance



and created a need for, but also a shortage of, primary care providers (PCP). The ACA defined a PCP as “a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services (p. 532).”<sup>7</sup> However, the initial proposed rules only acknowledged physicians as PCP that patients could access within an ACO. This act failed to recognize APPs as PCP and gave the ultimate authority for determining who is a PCP to state licensing and regulatory authorities.

GAPNA, in partnership with other APRN groups in the Nurse Practitioner Roundtable (NPRt) group, requested CMS modify the rule to include APRNs as ACO professionals to fulfill the real intent of the ACA. Health policy experts agreed with this need. In 2015, The Institute of Medicine (IOM) stated,

The Affordable Care Act created new health care delivery and payment models that emphasize teamwork, care coordination, value, and prevention: models in which nurses can contribute a great deal of knowledge and skill. Indeed, the nursing profession is making a wide-reaching impact by providing quality, patient-centered, accessible, and affordable care (p. 16).<sup>8</sup>

Numerous studies attest to the quality-of-care APRNs provide. Quality includes the fact that NPs prescribe medications and follow clinical care guidelines as well as physicians and are well-suited for providing preventive education and chronic illness care.<sup>9,10</sup> The final ACO rules did adopt nursing leader recommendations and NPs were authorized to be participating ACO professionals.<sup>11</sup> Medicare beneficiaries who got most of their primary care from APRNs were able to continue that primary care relationship within the ACO which promoted continuity of care and honored patients’ rights to choose their providers. However, NP patients could not be recognized as beneficiaries of the ACO if most of their visits were with an APRN.<sup>12</sup> While this was later modified to include patients that had been seen at least once in the year with a primary care physician, it still created a barrier for NPs. Large practices could usually accommodate this ruling but NP practices without physician participants were eliminated; smaller physician practices prevented NPs from forming their own ACOs.<sup>12</sup>

NPs are important contributors to the primary care of patients of all ages, genders, races, and socioeconomic status in the US. In 2018, 1.06 billion patient visits in the US were attributed to NPs.<sup>13</sup> In 2020, 89% of NPs were certified in general primary care; 70% of all NPs deliver primary care.<sup>6</sup> As of 2021 there are more than 325,000 NPs licensed in the US.<sup>14</sup> The US is in the midst of a significant shortage in the provision of primary care, jeopardizing millions of Americans’ access to the most basic health care.<sup>13,15</sup> Greater use of NPs could allay a significant portion of this shortage.

### Barriers to APRN practice

Significant barriers continue to prevent APRNs from practicing to their full potential. The greatest barrier is the many scope-of-practice regulations from state licensing boards, Medicaid agencies, and individual hospitals. A 2010 IOM report concluded that such regulations have failed to keep pace with the evolution of advanced practice nursing over the past 40 years.<sup>15</sup> A 2012 study from the National Governors Association found significant differences in NP scope of practice requirements among states. Historically, most states have limited the practice of APRNs to a role that involved physician collaboration or supervision.<sup>16</sup>

The Federal Trade Commission (2014) worked to remove barriers to APRN full practice through the production of documents and the provision of testimony in several states citing concerns that

mandatory physician supervision and collaborative practice agreement requirements are likely to impede competition among

health care providers and restrict APRNs’ ability to practice independently, leading to decreased access to health care services, higher health care costs, reduced quality of care, and less innovation in health care delivery. For these reasons, we suggest that state legislators view APRN supervision requirements carefully. Empirical research and on-the-ground experience demonstrate that APRNs provide safe and effective care within the scope of their training, certification, and licensure (p. 38).<sup>17</sup>

While funding for grants and demonstration projects provided in the ACA makes a start toward greater use of NPs, risks to funding and disparate scope of practice regulations throughout the country provide significant barriers to their use.

Another barrier to the full use of NPs is significant reimbursement limitations on directly reimbursing for NP-provided care. Even in states that mandate direct reimbursement for NP services provided in Medicaid programs, the total reimbursement is often less than that provided for a physician’s services. AANP maintains that providers should be reimbursed equitably when they provide the same services as other providers, and there should not be reimbursement differentials based on a provider’s licensure.<sup>4</sup> Reimbursement may change going forward, however, as value-based reimbursement introduced by CMS replaces the traditional fee-for-service system and as team-based care becomes the norm. Value-based care ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness, as opposed to the quantity of care under fee-for-service.<sup>18</sup>

The COVID-19 pandemic prompted some state governors to temporarily remove unnecessary restrictions on APRNs. Lifting these barriers allowed APRNs to practice across state lines to meet the need for health care providers in surging virus areas. When regulatory requirements differ from state to state, each border represents an obstacle to license portability – potentially preventing access to APRN professionals and the high-quality care they provide.

### The APRN compact model

The APRN Compact Model by the National Council of State Boards of Nursing (NCSBN) was adopted August 12, 2020.<sup>19</sup> The Model allows an APRN to hold one multistate license with privilege to practice in other compact states. It assures safe and quality care provided by APRNs across states, and uniform licensure requirements. This model facilitates online education, is cost effective, and increases access to care by facilitating APRNs to:

- Cross state borders for relocation.
- Change employment.
- Provide telehealth for patients across the country.

The APRN Compact will be implemented when seven states enact the legislation. Currently, three states have the APRN Compact: North Dakota, Delaware and Ohio. The AANP did not endorse this model as 2080 practice hours are a prerequisite for this licensure. AANP’s position is that evidence clearly shows that APRNs are prepared for safe entry into practice at the point of graduation from an accredited graduate program and after successful passage of a national certification board examination. AANP determined this requirement creates unnecessary and costly regulations for all states.<sup>20</sup>

### Gerontological specialist certification

In 2018, GAPNA created the separately incorporated Gerontology Nursing Certification Commission (GNCC) to develop and implement a specialty certification examination to distinguish APRNs who possess



expert knowledge, experience, and skill in managing the complex health needs of OA. The GNCC is working collaboratively with the Center for Nursing Education and Testing (C-NET) in examination development, test administration and evaluation. The Gerontological Specialist-Certification (GS-C) is endorsed by GAPNA. The purpose of certification is to validate clinical knowledge at the proficient level of practice in managing complex OA. As of 2021, there are 121 individuals with the GS-C earned credential.<sup>21</sup> For more information, check out the GNCC webpage at <https://www.gapna.org/certification/faq>.

### Leadership institute

The GAPNA Leadership Institute (GLI) was established in 2019 to prepare the next generation of leaders in gerontological nursing. The Fellowship is a year-long structured program, online synchronous and face-to-face encounters, during which an experienced and nationally recognized nurse leader facilitates the curriculum and leadership. Fellows work one-on-one with mentors, all of whom have held leadership positions within GAPNA. The GLI provides opportunities to: (1) gain an enhanced understanding of GAPNA's mission, organizational infrastructure, and strategic plan, (2) develop leadership skills to foster collaboration with stakeholders to improve healthcare of OA through practice, education and advocacy, (3) study and understand leadership qualities needed to affect widespread change, (4) model the principles, qualities, and responsibilities of effective leadership, and (5) develop communication strategies essential for all leaders. To find more information on eligibility and an application visit <https://www.gapna.org/learning/leadership-institute>.

### The future

GAPNA is THE premier professional organization that represents the interests of advanced practice nurses, other clinicians, educators, and researchers involved in the practice or advancement of caring for OA. Members are active in academia, research, and a variety of health care settings including primary care, acute care, post-acute care, specialty care, home care, hospice/palliative care, and LTC. The vision is to continue to be the trusted leaders for the expert care of OA. That brings us to the future and how will GAPNA continue to thrive as an organization?

With the global increase in aging demographics and rising burden of chronic disease, there is an unmet need for healthcare professionals with experience and knowledge in the care of OA. Cultural, racial, and ethnic diversity is exploding in the US, especially in the older population. Are nurses understanding the impact of social determinants of health (SDOH) on the values, needs and goals of OA? Are the individuals pursuing education in gerontology culturally, racially, ethnically, and sexual preference diverse? If not – why not? How can GAPNA speak to the non-white and LGBTQ+ individuals that is so desperately needed in health care? With a positive record to date, GAPNA should be able to market and welcome minority and vulnerable populations to the organization so they can be prepared to provide the holistic, culturally appropriate care that is lacking in US health care.

The COVID pandemic heightened awareness of the inequities, disparities, and racism that is predominant in American health care. How will GAPNA work to solve these issues and help create access and quality for OA in health care? With GAPNA's ability to reach out and partner with world-class organizations and agencies, it seems obvious that networking with minority and specialty health care organizations will be an obvious move to help educate and empower diverse APRNs to care for diverse populations.

The pandemic has highlighted the caregiver burden experienced by families and friends providing care for loved ones. When one looks at dementia statistics, the increase in people living with dementia (PLWD) is overwhelming. As of 2021, the Alzheimer's Association

reports approximately 6.2 million Americans over the age of 65 living with Alzheimer's dementia.<sup>22</sup> This number does not consider the other diseases of dementia or other chronic conditions requiring expert aging knowledge of the disease and the individual. Additionally, there were an estimated 9.5 million family caregivers (1:5 Americans) documented between 2015 and 2020 by the National Alliance for Caregiving.<sup>23</sup> This means that APRNs providing care for OA also need to be concerned about the health and well-being of partner dyads as well as including them in the care-team. One of GAPNA's role for the future can be to produce educational videos and handouts especially created for helping care-partners to understand disease states and maintain their own QoL as well as their partners. Currently members of the GPN SIG are creating and recording online videos for APRNs and care-partners related to the neuropsychiatric symptoms of dementia. This is a start for reaching out to care-partners, but the sky is the limit. GAPNA can investigate and reach out to funding agencies to determine if there are possibilities for more educational program productions in the future.

GAPNA will need to continue to advocate for not only OA but for APRNs as well. The *National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021* include the following initiatives for OA:

- (1) Create an adequately prepared workforce.
- (2) Strengthen the role of public health.
- (3) Remediate disparities and inequities.
- (4) Develop, evaluate, and implement new approaches to care delivery.
- (5) Allocate resources to achieve patient-centered care and outcomes including palliative and end-of-life care, and
- (6) Redesign the structure and financing of long-term services and supports.<sup>24</sup>

Can you envision that GAPNA is already well-suited to be involved in these initiatives to ensure that outcomes are achieved? GAPNA has a strong legacy of advocacy, education, partnership, and research. Members are experts in their academic institutions, healthcare organizations and agencies. There are an army of GAPNA members across the country ready, willing, and able to fulfill these initiatives as well as the OA objectives for Healthy People 2030.<sup>25</sup> GAPNA leaders and members have a positive, enthusiastic, successful track record that shines, and will continue to shine, as the future unfolds!

### Conclusion

GAPNA is celebrating a 40th anniversary. The ruby is the third hardest gemstone; not easily broken. Some believe the ruby stimulates the heart chakra and brings spiritual wisdom to the group.<sup>26</sup> We are the organization that can and will put a spotlight on OA and the talented and compassionate APRNs who care for them. We can take up the battle cry to change the way health care is delivered in the US through demonstrating excellent care provided to OA from all races, ethnicities, genders, religions/faiths, and sexual preference. We will be delighted by the GAPNA leadership in the next 40 years and are thankful and appreciative of everything the organization has accomplished, with the assistance and support of the Anthony J. Jannetti, Incorporated team. Thank you for the last 40 years, we are looking forward to future decades!

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