The journey toward full practice authority in Illinois has spanned over 3 decades. Finally, in 2017, advanced practice registered nurses were successful in removing most of the barriers to practice, specifically, the requirement to work with a written collaborative agreement with a physician. Strategies for achieving this legislative achievement included garnering unprecedented unity within the nursing community, recruiting support from influential organizations, and using social media. The lessons learned may be helpful for those states still struggling to modernize restrictive practice acts.

Keywords:
- advanced practice registered nurse
- advocacy
- certified nurse practitioner
- full practice authority
- legislation
- nurse practice act

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ders by writing prescriptions with a physician and the NP

Practice Act of 1987 as a model for their NPA (eg, being willing to include written protocols that permitted phone orders or ‘verbal’ orders by writing prescriptions with a physician and the NP’s name). Unfortunately, unlike the previously mentioned CNM, neither the NPs nor their collaborating physicians escaped discipline by Illinois Department of Financial and Professional Regulation. The NPs were reprimanded, and their practices were severely restricted. The physicians were also reprimanded, and one of them also was required to pay a fine.9

The other pitfall of such obscure language was its impact on reimbursement for services, especially those of CNMs who were more likely to work in their own private practices. Insurance companies and Illinois Medicaid refused to recognize the autonomy of APRNs and would not pay for services that were billed in their names. While APRNs winced to hear it, it was obvious that the most common interpretation of the NPA, even by those who worked in state regulatory agencies, was that advanced practice nurses did not exist in Illinois.

In Illinois, most health professional practice acts “sunset” every 10 years, meaning their language must be reviewed, and possibly rewritten, to ensure the protection of the public health, safety, and welfare of the state’s citizens.7 As the sunset of the NPA drew near in 1997, the Illinois Nurses Association launched a massive campaign working with legislators, physician groups, and other stakeholders to update the NPA to unequivocally acknowledge the existence and practice of NPs, CNMs, CRNAs, and CNs. It should be noted that physicians would have had no objections if APRNs had been willing to use the Illinois Physician Assistant Practice Act of 1987 as a model for their NPA (eg, being willing to have a “supervising” vs a collaborating physician and accepting supervising physician-to-APRN ratios of 1:2). However, APRNs remained steadfast that their practice was different from that of physician assistants and were unwilling to accept those restrictions.10 The complex negotiations with the medical community were not finalized in 1997; as a result, the language of the NPA was updated to reflect contemporary practice for RNs and licensed practice nurses, but finalizing the language for APRNs was deferred until the following year.

Finally, in 1998, the existence of APRNs was clearly acknowledged by statute. This recognition took the form of a new, second license that would be available to those licensed RNs who met the educational and certification requirements as certified NPs (CNPs), CNMs, and CNs. APRN practice required a written collaborative agreement (WCA) with a physician and included prescriptive authority for legend and Schedule III to V medications. As negotiations between CRNAs and anesthesiologists were even more contentious than for other APRNs, it took 1 more year of haggling before language recognizing and defining CRNA practice was passed in 1999.

Almost every year over the next 2 decades, APRNs continued to claw their way toward increased scope of practice and recognition. Legislation was passed nearly every year after 1998 for the purpose of expanding APRN authority, often with the optimistic goal of removing the WCA requirement and allowing full prescriptive authority for schedule II to V medications. Yet as the end of each legislative session approached, it was clear that significant concessions would be necessary, otherwise there would be no movement forward (Table 1). As might be expected, this incremental approach toward FPA was met with mixed feelings. While the removal of small barriers was appreciated, many APRNs could not help being envious of the other states where FPA was already a reality.

Each year the amount of effort that would be required to pass legislation was contemplated before every session of the Illinois General Assembly. Effective advocacy always involved certain considerations: how to highlight the current factors affecting the specific health care needs of the legislators’ constituents, how to educate legislators that APRNs are a solution to those constituents’ needs, and how to motivate enough APRNs to engage in successful legislative advocacy. Despite decades of nurses trying to educate legislators about APRN practice, many in the Illinois General Assembly continued to remain uninformed regarding the breadth and depth of services that APRNs provide daily.

In 2012, a potentially dire situation raised the possibility that inaction could mean taking a step backward. A legislator introduced a bill that was directed toward restricting CRNA practice in terms of administering local anesthesia, but it became clear that it might have ramifications for other APRNs who engaged in a whole host of pain-reducing strategies. The proposed legislation underscored that there were legislators still unaware of the services that APRNs provide and many who were apprehensive at the thought of APRNs practicing without a WCA with a physician. It became clear to many APRNs that it was necessary to develop a stronger, more organized strategy that in the short-term would protect what had been gained thus far, and in the long term lead to the ultimate goal of FPA.

When the bill regarding local anesthesia restrictions was discussed at a meeting of the Illinois Society of Advanced Practice Nursing (ISAPN) and other nursing organizations, an important ally emerged. A leader in the National Association of Hispanic Nurses-Illinois Chapter volunteered to act as a liaison with the bill sponsor whom she knew well. From that day forward, a powerful alliance between National Association of Hispanic Nurses-Illinois Chapter and ISAPN was established. Several of the APRNs in the small delegation who met the very powerful bill sponsor were advocacy novices who had significant apprehension going into the meeting; however, the conversation went very well. The APRNs explained that as written, the bill would affect not just CRNA practice, but could significantly impede the pain-relief services that were delivered by other types of APRNs, such as joint injections, removing lesions, and even the care provided by CNMs during deliveries. The APRNs listened to the legislator’s doubts about APRN practice and systematically were able to alleviate her concerns. Evidence-based literature was given to the legislator that documented the safety and quality of the care of all APRN specialties, especially when delivering care to the uninsured, underinsured, and vulnerable populations, issues that resonated with many legislators. The APRNs told personal stories of what
their services meant for the elderly, chronically or terminally ill, and other underserved populations. Eventually, this legislator blocked the bill’s moving forward. After this meeting, the APRNs continued an ongoing relationship with the legislator, often sending articles or personal anecdotes of care that APRNs provided, especially to her constituents. Over time, the legislator came to appreciate APRN practice as a force in providing quality care and improving access to health care to Illinois residents and ultimately became an influential ally in getting a momentous bill passed in 2017. In 2013, ISAPN again sought FPA, thinking that if ultimate success was not achieved, at least APRNs would get closer to the goal. As anticipated, the bill that was passed was only a small step toward FPA. The compromise language clarified the absence of geographic restrictions for practice and recognized APRNs as primary care providers (Table 1).

A bill regarding FPA was not introduced in 2014. Instead, the legislative session that year was used to regroup and develop a more cohesive plan for the reintroduction of FPA in 2015. However, to continue engaging members and legislators, a bill to change language from Physician Orders for Life Sustaining Treatment to Practitioner Orders for Life Sustaining Treatment (POLST) was introduced. The new Practitioner Orders for Life Sustaining Treatment language granted APRNs the ability to order advanced directives and was unanimously adopted by the General Assembly after vigorous APRN lobbying efforts.

Also in 2015, ISAPN forged a new plan to pursue FPA. The Single Point of Contact program was created with a goal to recruit at least 1 APRN in each state Senate and House of Representatives district who would commit to visit legislators’ offices every time an issue concerning nursing needed support or opposition. The Single Point of Contact program was designed to ensure that every state legislator had an ongoing relationship with at least 1 APRN.

To expand grassroots efforts, the Single Point of Contact initiative was introduced to other nursing organizations whose members might not be APRNs themselves but were nonetheless supportive of the APRN cause. Casting a wider net of individuals to convey the FPA message turned out to be a successful approach to developing nursing unity. Soon ISAPN became a major player in the Illinois Coalition of Nursing Organizations, an organization structured to foster collaboration among nursing groups throughout Illinois. Thus, the campaign for FPA would no longer be limited to APRNs but could tap into all Illinois’ 177,000 licensed nurses.

Table 1
Illinois Advanced Practice Registered Nurses Regulatory Milestones

<table>
<thead>
<tr>
<th>Year</th>
<th>Regulatory Milestone</th>
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<tr>
<td>1994</td>
<td>FNP’s and PNP’s became eligible for Medicaid reimbursement at 70% of the physician rate.</td>
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<tr>
<td>1998</td>
<td>Licensure of certified registered nurse anesthetists added to NPA. Umbrella term “Advanced Practice Nurse” (APN) adopted.</td>
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<tr>
<td>2001</td>
<td>APNs authorized to sign school physicals.</td>
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<tr>
<td>2003</td>
<td>APNs authorized to certify eligibility for vehicle disability placards; 2) sign school employee physicals.</td>
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<tr>
<td>2004</td>
<td>APNs authorized to write referrals for physical, occupational, and speech therapy.</td>
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<tr>
<td>2006</td>
<td>All specialties of APNs, except PMH APNs became eligible for 100% Medicaid reimbursement.</td>
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<tr>
<td>2007</td>
<td>All APNs authorized to collaborate with podiatrists; 2) prescribe Schedule II medications (limited to 5 oral) if noted in WCA; WCA requirement removed for APNs practicing in hospitals and ASTCs. If so privileged, APNs could order all scheduled medications (Schedules II-V) within hospital and ASTC settings.</td>
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<tr>
<td>2009</td>
<td>PMH APNs became eligible for Medicaid reimbursement.</td>
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<tr>
<td>2011</td>
<td>Changes: (1) Prescriptive authority expanded to include topical and transdermal as well as oral forms of Schedule II thru Schedule V controlled substances if noted in WCA and if such medications are routinely used by the collaborating physician; (2) Requirement that the APN and collaborating physician meet in person monthly changed to simply “collaborate and consult on a monthly basis”; (3) Hospitals authorized to prescribe APNs to practice without a WCA in hospital affiliates; (4) Clarification added that APNs working in a hospital or ASTC did not have to have a mid-level controlled substance license to order controlled substances.</td>
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<tr>
<td>2013</td>
<td>Clarified absence of geographical restrictions for practice and recognized that APRNs might serve as primary care providers.</td>
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<tr>
<td>2014</td>
<td>Change language in law from Physician Orders for Life Sustaining Treatment to Practitioner Orders for Life Sustaining Treatment (POLST) was introduced.</td>
</tr>
<tr>
<td>2015</td>
<td>APNs allowed to practice up to 90 days without a WCA if a relationship with a collaborating physician was suddenly terminated.</td>
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<tr>
<td>2017</td>
<td>Changes: (1) Official title changed from APN to APRN; (2) CNPs, CNMs, CNSs eligible to apply for a full practice authority license by submitting an attestation statement of (a) 250 hours of CE or training in area of certification, and (b) 400 hours of practice in area of certification with WCA (this latter attestation must include signature of collaborating physician); (3) an APRN-FPA who prescribes Schedule II opioids and/or benzodiazepines must designate a physician consultant with the Illinois prescription monitoring program and discuss the condition of the patients for whom such medications are prescribed with the consulting physician on a monthly basis.</td>
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</table>

APN — advanced practice nurse; APRN — advanced practice registered nurse; ASTC — ambulatory surgical treatment center; CE — continuing education; CNM — certified nurse midwife; CNS — clinical nurse specialist; FNP — family nurse practitioner; NPA — nurse practice act; PMH: psychiatric mental health; PNP — pediatric nurse practitioner; WCA — written collaborative agreement.

Hosted Nurse Advocacy Days in the state capital that provided lobbying education and mentored legislator visits.

Distributed talking points to the member organizations of ICNO with a concise list of the advantages of FPA to the state’s entire health care system.

Grassroots efforts in 2015 made significant strides. It was a year of “all hands on deck.” The ISAPN PAC had more money than in previous years. Membership became actively involved in bringing the FPA message to their places of employment and educational institutions. The movement was on a roll... or so it was thought. Despite these coordinated efforts, NPA changes in 2015 turned out to be very disappointing. Any significant steps toward FPA were rebuffed, but a few cosmetic changes made the statute more concise. In addition, a provision was added allowing an APRN to practice up to 90 days without a WCA if the relationship with collaborating physician was suddenly terminated (Table 1).

ISAPN’s government relations leadership met to evaluate the advocacy efforts at the end of the 2015 legislative session. Despite the earnest attempts on the part of many, it would take even more effort for FPA to come to fruition; thus, there were extensive discussions to explore the strengths and shortcomings of recent attempts and to refine the plan to move forward. One weakness identified was that there was a difference of opinion regarding at what point an APRN should be allowed to apply for FPA. Historically, APRNs have felt that such authority should be upon graduation from an APRN program and certification, while other members expressed support for postgraduate, postcertification practice hours before working without the WCA. Those different perspectives were used as a springboard to educate APRNs by sharing the same data that demonstrates the safety and satisfaction of APRN practice that is given to legislators.

It was anticipated that major legislation would not be introduced in 2016. Rather, the plan was to launch a huge FPA effort the following year, when the entire NPA would sunset. The task for 2016 would be 2-fold: (1) to sustain interest in advocacy even if there was not large-scale legislation to advocate for and (2) to upgrade the entire organizational advocacy process.

In evaluating the legislative momentum of previous years, it was noted that responses to rally efforts during each legislative session tended to be short-term, with the level of eagerness dissipating at the end of each legislative session. APRNs needed to be reminded that pursuing FPA is a marathon, not a sprint. The ratio of ISAPN members who were experienced and willing to engage in legislative advocacy seemed to be shrinking compared with the political neophytes joining the organization.

It was clear that the Single Point of Contact program ISAPN had used in 2015 needed some tweaking. The Single Point of Contact title did not resonate with members; hence, the role was rebirthed into a legion of legislative captains. Furthermore, someone clearly needed to maintain the APRN-legislator database to oversee the recruitment and activities of these captains; thus, the legislative commander role was born. In fact, the role morphed into 2 co-commanders, as one of the most senior ISAPN members was joined by another member who was new to the organization but enthusiastically committed to the FPA campaign. Enlisting district captains was a continuous process, with repeated invitations via newsletters and email blasts, but often the most effective tactic was for well-known nursing leaders to entice individuals whom they knew personally.

Moreover, it became clear that there needed to be a repository of helpful, accurate legislative information that members could access at any time during their busy schedules when they wanted to understand the political process and issues that were in play at the moment. To that end, ISAPN and the American Nurses Association-Illinois found a way to share a single open advocacy portal between their respective websites so that consistent information would be readily available to any nurse who sought it.

Communication on the advocacy portal was not just a one-way information stream. All nurses who communicated with their legislators, whether it was in face-to-face meetings or telephone or email, were urged to go to a link on the portal and complete an electronic legislator contact form to document the interaction so that the co-commanders and lobbyists would know which legislators supported or opposed the APRN cause—or were still on the fence.

PAC donations were repeatedly sought during statewide and local meetings using raffles, silent auctions, pass the hat, and similar activities. Members were encouraged to donate to PAC at the time of their membership renewal; payment could be made annually or monthly via automatic bank account withdrawal. When lobbyists received invitations to legislative fundraisers, the PAC chairperson and legislative commanders quickly enlisted nurses to attend such events to make nursing’s presence known to the legislators.

The NPA Sunset in 2017 provided a unique opportunity for all nurses to work together. The ISAPN executive director was also the coordinator for Illinois Coalition of Nursing Organizations, which facilitated the coalition’s achieving consensus throughout the entire nursing community. This unity was vital, because the sunset process entailed updating the NPA to meet the needs of APRNs and non-APRNs alike. To that end, all communication about the meaning and opportunity of Sunset 2017 was endorsed by 3 nursing organizations, ISAPN, American Nurses Association-Illinois, and Illinois Coalition of Nursing Organizations, demonstrating nursing solidarity, which is always appreciated by legislators.

Furthermore, key stakeholders other than the nursing community were sought, and these stakeholders, such as AARP, hospital health systems, other organizations that employ APRNs, and organizations that care for underserved populations were apprised of the benefit of APRNs having FPA. APRNs who owned their own practices were urged to tell their unique stories about their obstacles, both as small business owners and as providers, especially those who worked in health care shortage areas or cared for patients not served by other providers. APRNs who had issues finding and paying collaborating physicians or myriad other barriers to practice were encouraged to describe these situations.

Legislators in districts that had significant gaps in health care coverage were targeted for personal visits so they could be educated about how greater APRN autonomy would improve their constituents’ access to health care. Social media was used as a method for APRNs to communicate with each other, as well as with the public and legislators. Additionally, some members wrote opinion/editorial pieces for local papers about the importance of APRNs, the unique qualities they bring to health care, and their cost savings.

A key component to our success was developing bill language and preparing for the “no-go” positions once legislative negotiations ensued with bill introduction in 2017. These preparations began in mid-to-late 2016 with regular planning meetings of the Green Team (ie, government relations leadership), ISAPN lobbyists, and executive personnel. The long history of incremental changes to the NPA had provided insight in terms of what should be expected during negotiations in the 2017 bill. Language was developed for the ideal FPA role, but with a few added reassurances for those legislators who had been skeptical in the past. These reassurances took the form of added continuing education hours and mandatory prescription drug monitoring program review before prescribing controlled substances to directly address concerns about the opioid crisis. In addition, a requirement was added that half of the pharmacology continuing education hours be dedicated to safe opioid prescribing.
Table 2
Licensure And Practice Pathways for Illinois Advanced Practice Registered Nurses

<table>
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<tr>
<th>Initial Licensure for All Illinois APRNs Begins as Follows:</th>
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<tbody>
<tr>
<td>- Graduation from an APRN program and appropriate national certification.</td>
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<tr>
<td>- Application for APRN license with specialty designation (CNP, CNS, CMN, or CRNA).</td>
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<tr>
<td>Practice with this license requires a WCA with a physician who delegates prescriptive authority, including medications Schedules II-IV. Schedule II prescribing is limited to oral, topical or transdermal routes and renewals beyond 30 days require discussion with collaborating physicians (in-person or by electronic means).</td>
</tr>
<tr>
<td>Or</td>
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<tr>
<td>Practice within a hospital or ambulatory surgical treatment center (ASTC) permitted if credentialed and privileged by that organization. In-house ordering is permitted, but prescriptive authority to outside pharmacies limited to only discharge prescriptions.</td>
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</table>

Subsequent Licensure Available to CNPs, CNMs, CNSs (but not CRNAs) “APRN-FPA” = License That Permits Practice Without a WCA

Note: The “APRN-FPA License” is a State of Illinois term, but includes a few restrictions that are not consistent with the FPA as defined by the American Association of Nurse Practitioners. APRNs are not required to apply for an APRN-FPA license; they may continue to hold and renew the license described above.

To work without a WCA, an APRN must have:

- Completed 4,000 clinical hours with a WCA or have been credentialed and privileged in a hospital or ASTC; these hours must be confirmed via an attestation statement signed by APRN and collaborating physician or physician from hospital or ASTC.
- Completed 250 hours of CE since becoming certified as an APRN.

Practice requirements to practice without a WCA:

- If prescribing opioids or benzodiazepines, APRN must designate a consulting (not collaborating) physician with the Illinois Prescription Monitoring Program and discuss such prescriptions with consulting physician monthly (in-person or by electronic means).

Regardless of type of license, APRNs are required to complete 80 hours (20 hours must be in pharmacology) within the 2-year renewal cycle. A maximum of 30 hours may be obtained by presentations in the APRN’s clinical specialty, evidence-based practice, or quality improvement project, publications, research projects, or preceptor hours.

CE = continuing education; CNM = certified nurse midwife; CNP = certified nurse practitioner; CNS = clinical nurse specialist; CRNA = certified registered nurse anesthetist; WCA = written collaborative agreement.

Noting that several of the states that had recently achieved FPA required a transition-to-practice with some type of collaborative practice preceding the acquisition of FPA status, it was understood that some form of transition-to-practice likely would end up in the final bill. Still, there were some limits to compromising the “no-go” stance. After reviewing the various APRN FPA acts throughout the country, it was determined that 5000 hours of transition-to-practice would be the stopping point, as well as no new limitations on prescriptive or signature authority that had already been achieved. Thus, the bill introduced in early 2017 reflected the ideal FPA language (eg, full scope of practice after national certification), all the while keeping the bargaining options confidential.

Once the 2017 legislative session commenced, identical bills were introduced in the Illinois Senate and the House to allow Illinois APRN to practice independently. Throughout the session, there was extensive negotiation with physician groups, with the back-and-forth discussion steered by the bill sponsors. The language in the initial bills reflected the assumption that APRNs are ready to practice independently after completion of graduate education and national certification; however, as discussion among the stakeholders ensued, it was clear that this premise of new graduate readiness would be an impediment to bill passage. Eventually, a bill passed that was not ideal, but it did remove the bulk of the barriers to practice for CNPs, CNMs, and CNSs and brought Illinois APRNs closer to the ultimate goal of true FPA.13 Eventually HB 313 made its way through both chambers of the General Assembly and became Public Act 100-0513 when signed by the governor in a public event on September 20, 2017.14 Sadly, as was the case in 1998, due to the specific issues with their scope of practice, the fight for greater CRNA autonomy would have to be waged another day, and to this day CRNAs are not yet eligible for APRN-FPA licensure in the state of Illinois.

The new practice act provides a pathway for licensed APRNs to eventually practice without a WCA once they have completed (1) 4000 hours of practice in their area of APRN certification in collaboration with a physician, and (2) 250 hours of CE or training postcertification. Once these requirements are met, regardless of work setting (hospital, health system-based, or private practice), the APRN seeking to practice without a WCA is eligible to submit an application for a new APRN license, which Illinois Department of Financial and Professional Regulation has titled “APRN-FPA.” The application for this new license must contain an attestation statement that has been signed by the APRN and the collaborating physician or a physician from hospital or ambulatory surgical treatment center (Table 2).

APRNs without a WCA will be licensed to prescribe legend medications and controlled substances, Schedule II through V without physician delegation, although there is a caveat: APRNs without WCA who prescribe Schedule II opioids or benzodiazepines must designate a physician consultant on the Illinois prescription drug monitoring program website and discuss the condition of the patients for whom such medications are prescribed with the consulting physician on a monthly basis. However, a WCA is not required. Furthermore, the previous limitation of prescribing opioids and narcotics in only oral, topical, or transdermal form remains unchanged.

Despite being signed into law, the bill’s provisions could not go into effect until administrative rules were written by the Illinois Department of Financial and Professional Regulation, 2 public hearing periods were conducted, and a review by the Joint Committee on Administrative Rules was performed. This process took nearly 2 years, but in July 2019, APRNs were finally allowed to apply for the APRN-FPA license. To be clear, upon graduation and certification, APRNs in Illinois apply for an initial license with the title, “APRN.” Once they meet the previously identified requirements, they may apply for APRN-FPA license, if they so choose.

The new law diverges from American Association of Nurse Practitioners’ definition of FPA which notes that “In Full Practice Authority (FPA) states, NP licensure is not contingent on unnecessary contracts or relationships with a physician...”15 Thus, despite significant progress, Illinois is still considered a reduced practice state, since the NPA does require consultation with a physician in very limited situations. There also are ongoing institutional barriers, such as those health systems that insist APRNs maintain formalized collaborative agreements and documentation with physicians even if they are eligible to apply for and are issued the new type of license. Furthermore, an unforeseen circumstance has now emerged; some APRNs are unable to obtain the mandated physician signature on the license application due to physicians retiring, relocating, or realizing they no longer will be compensated.
for collaboration. Finally, even an FPA license does not ensure that insurance companies will be willing to reimburse APRN services.

It is hoped that APRNs in Illinois remain committed to achieving FPA in its fullest sense. The APRNs who worked tirelessly to remove regulatory restraints to practice in Illinois are proud of their perseverance throughout this journey, proving once again that when APRNs passionately and resolutely assume the mantle of legislative advocacy, they can make historic strides in practice autonomy. APRNs must continue to strive for full autonomy over their profession, uncumbered by unnecessary regulations and policies. APRNs must continue to be involved in developing relationships with legislators and stakeholders, understanding the needs of health care in the state, enlisting the assistance of nursing colleagues, and having an ongoing presence in the state capital. APRNs must begin planning today for the challenges of tomorrow.

Acknowledgements

The authors of this article wish to acknowledge the past and continuing efforts to expand the scope of practice regulations for APRNs in Illinois. Special thanks to Dr. Susan Swart, Illinois Society for Advanced Practice Nursing (ISAPN) Executive Director, Debbie Broadfield and Sue Clark, ISAPN lobbyists, and ISAPN Board of Directors and membership, past and present, for their enduring assistance of legislative advocacy, they can make historic strides in practice autonomy. APRNs must continue to strive for full practice autonomy. APRNs must continue to strive for full autonomy over their profession, uncumbered by unnecessary regulations and policies. APRNs must continue to be involved in developing relationships with legislators and stakeholders, understanding the needs of health care in the state, enlisting the assistance of nursing colleagues, and having an ongoing presence in the state capital. APRNs must begin planning today for the challenges of tomorrow.

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Further Reading


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