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STRATEGIC AREA: LEGISLATION AND REGULATION

Recommendation 1: Adopt the *Legislative and Regulatory Framework for NPs in Canada*.

NOTE: In a many instances, the timeline reflects the reality of the current state of nurse practitioner legislation in Canada and takes into consideration the time required for changing legislation.

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
Role Clarity				
1.Enact and implement a broad scope of practice for nurse practitioners based on pan-Canadian core competencies.	High	2006 – 2007	P/T regulatory bodies P/T governments	F/P/T employers; F/P/T Principal Nursing Advisors; Professional nursing associations; Nursing unions; Interprofessional associations (e.g. CMA); Educational institutions; NP Associations; Association of Chief Executives in Nursing; CASN.
2. Adopt the recommended NP definition.	Medium	2006 – 2011	CNA P/T regulatory bodies	P/T governments; Professional nursing associations; NP associations; FNIHB; Department of National Defence; Nursing unions.
3. Protect the Nurse Practitioner title and designation in legislation in all Canadian jurisdictions.	High	2006 – 2011	P/T governments P/T regulatory bodies	CNA; Professional nursing associations; NP associations; F/P/T employers; Nursing unions.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
4. Adopt a mandatory requirement for a minimum of $5 million of professional liability protection for nurse practitioners in Canada.	Medium	2006	Canadian Nurses Protective Society P/T regulatory bodies	F/P/T employers; F/P/T governments; Professional nursing associations; NP associations; CNA.
5. Expand the national registered nurses database (CIHI) to include relevant information on nurse practitioners.	Low	2006	CIHI CNA	F/P/T governments; F/P/T employers; Educational institutions; CASN.
6. Include public membership/participation on all nursing regulatory boards/councils and their statutory committees.	Low	2006	P/T nursing regulatory bodies P/T governments	F/P/T employers; Consumer groups; Professional nursing associations; NP associations.
7. Provide information about the role of the nurse practitioner to consumers.	Medium	Ongoing	P/T nursing regulatory bodies CNA	Professional nursing associations; F/P/T employers; NP associations.
Initial and Continued Competency				
8. Adopt the *Canadian Nurse Practitioner Core Competency Framework (2005).*	High	2006	P/T regulatory bodies P/T educators	Professional nursing associations; NP associations; Educational institutions; CNA; CASN.
9. Adopt standardized requirements for registration/licensure of nurse practitioners.	High	2006	P/T regulatory bodies	F/P/T governments; CNA; Professional nursing associations; NP associations; Educational institutions.
10. Adopt the Canadian Nurse Practitioner Examination.	High	2006-2007	P/T regulatory bodies	F/P/T governments; CNA; Professional nursing associations; NP associations; Educational institutions.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
11. Adopt the Competence Assessment Framework for Nurse Practitioners in Canada.	High	2006 – 2007	P/T regulatory bodies Educational institutions	F/P/T governments; CNA; CASN; NP associations; CNA; CASN.
Employment Mobility				
12. Develop and implement a mutual recognition agreement for nurse practitioners.	Medium	2006 – 2007	P/T nursing regulatory bodies Human Resources and Social Development Canada	CNA; F/P/T governments; F/P/T employers.
13. Reduce unnecessary barriers to Canadian and internationally educated nurse practitioners applying for registration/licensure.	High	2006 – 2007	P/T nursing regulatory bodies P/T governments	CNA ;F/P/T employers; NP associations; CASN.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
Regulatory Effectiveness				
14. Adopt the 10 underlying principles as the basis for nurse practitioner legislative and regulatory processes.	Medium	2006 – 2011	P/T regulatory bodies CNA	P/T governments; Professional nursing associations; NP associations.
15. Amend existing F/P/T statutes to be consistent with nurse practitioner practice.	Medium	2006 – 2011	F/P/T governments P/T regulatory bodies	F/P/T employers; NPs and NP associations; CNA.
16. Apply the professional conduct mechanisms and processes of RN legislation and regulation to nurse practitioners.	Low	2006	P/T regulatory bodies P/T governments	F/P/T employers; NP associations; Professional nursing associations.
17. Engage the public and other stakeholders in the development of legislative and regulatory processes for nurse practitioners.	Low	2006	P/T nursing regulatory bodies P/T governments	F/P/T employers; F/P/T regulatory bodies; NP associations.
18. Develop and adopt a pan-Canadian evaluation framework to assess the effectiveness of nurse practitioner regulatory mechanisms and processes.	Medium	2006 – 2007	P/T governments P/T nursing regulatory bodies	CNA; Professional nursing associations; NP associations; F/P/T employers.

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Key Actions	Priority	Timeline	Lead/Co-Lead	Key Supporting Stakeholder Groups
Extended/Expanded RN Role				
19. Develop and implement a framework to facilitate the practice of extended/expanded role registered nurses.	Medium	2006 – 2007	CNA FNIHB	P/T regulatory bodies; HC Office of Nursing Policy; F/P/T governments; F/P/T employers; Provincial nursing associations.
20. Establish consensus on standardized mechanisms to support the practice of Registered Nurses in the extended/expanded role.	Medium	2006 – 2008	P/T regulatory bodies FNIHB	F/P/T governments; F/P/T employers; CNA; CASN; Provincial nursing associations; Registered nurses.

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STRATEGIC AREA: PRACTICE

Recommendation 2: Adopt *the Practice Framework for Nurse Practitioners in Canada* in order to facilitate consistency in F/P/T approaches to practice.

Key Actions	Priority	Timeline	Lead/Co-Lead	Key Supporting Stakeholder Groups
Role Clarity				
21. Adopt the CNPI NP role description.	High	2006 – 2008	CNA P/T Regulatory Bodies	PNAs; NPCC, CAAPN; NPPN; Employers.
Interprofessional Collaborative Practice				
22. Develop and implement clear policy direction for models of interprofessional PHC service delivery and a supportive change management strategy.	Medium – High	2006 – onward	CNA Employers	Government regulatory bodies; NPs; NPCC; CAPPN; Physicians and Pharmacist (individually and professional groups).
Liability for all health care professionals including nurse practitioners				
23. Ensure all health professionals have liability insurance protection. - Explore interprofessional team liability coverage.	Medium – High	2006	CNPS CIC	CMPA; Employers, Governments; Other Health Professionals and their professional associations; NPCC.

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Key Actions	Priority	Timeline	Lead/Co-Lead	Key Supporting Stakeholder Groups
24. P/T governments cover the costs of professional practice and liability protection as is done for other professionals in the province.	Medium – High	2006	P/T Governments	Government regulatory bodies; Employers; NPs; HIROC; CNPS.
25. Establish a national voluntary database to track claims and payments made against health providers, including NPs.	High	2006	CNPS	OIIQ; CIC (BC); CIHI; Employers; CACHC; Government regulatory bodies.

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STRATEGIC AREA: HEALTH HUMAN RESOURCE PLANNING

Recommendation 3: Conduct needs based HHRP for NPs using a pan-Canadian, interprofessional approach that is based on a conceptual framework. To support this planning, use the *Health Human Resources Planning Simulation Model for Nurse Practitioners in Primary Health Care*™

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
26. Secure long-term sustainable investment for the development of comprehensive' valid and reliable data to support HHR planning.	High	2006 – 2010	ACHDHR	CNA; Stats Canada; F/P/T governments.
27. Develop minimum data set to use Model.	Medium	2006 – 2007	CNA	

Recommendation 4: Adopt funding models for primary health care services that reflect a needs-based system (including health status) that supports interprofessional practice and incorporates population health outcomes.

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
28. Develop and disseminate toolkit on organizational and funding model options.	Medium	2007	CNA	Health Canada; ACHDHR; CHA; Conference Board of Canada.

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Recommendation 5 : Remunerate NPs to reflect their scope of practice, responsibility and accountability, and standardize the remuneration to address:

- Salary/benefit discrepancies (within provinces and territories);
- Yearly cost of living expenses;
- Incentives and supports to recruit NPs to difficult to recruit areas; and
- Additional overhead/operating/infrastructure expenses.

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
29. Develop and distribute remuneration guide for NPs/employers as supplement to Implementation and Evaluation Toolkit for NPs in Canada.	Medium	2007 – onward	CNA	CFNU, professional associations, NP associations, employers; P/T governments.

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Recommendation 6: Utilize NPs across all health care settings in urban, and rural/remote/isolated areas. NP practice should be a blend of individual and family visits, population health activities, and other advanced practice activities (research, leadership, collaboration and change agent).

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
30. Advocate to employers/governments for use of NPs in all settings using NP in homecare and long-term care fact sheets.	Medium	2006 – onward	CNA	NP associations; CHA; P/T governments.
31. Amend labour contracts to protect time for all activities.	Medium	2007 – onward	CFNU	CNA; CAAPN; F/P/T governments.
32. Create centralized web-based location for posting of available NP positions.	Medium	2007 – onward	CHA CNA	F/P/T governments; CAAPN; NP associations.
33. Educate employers on requirements for licensure in terms of all activities.	Medium;	2006 – onward	P/T regulatory bodies	CHA; F/P/T governments; CNA.

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Recommendation 7: Create healthy work environments for NPs that support positive client, provider and system outcomes.

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
34. Raise awareness and seek commitment from ACHDHR on need for workload measurement methodologies.	Medium	2007 – onward	CNA Health Canada	CAAPN; employers; F/P/T governments; NP associations.
35. Promote infrastructure/technologies to support distance education.	Medium	2007 – onward	CNA CASN	Health Infoway; F/P/T governments.
36. Develop or strengthen existing F/P/T NP associations to provide professional networks and mentorship programs.	Medium	2007 – onward	CNA CAAPN	Regulatory bodies; Professional associations; NP associations.
37. Encourage the development of incentives, supports and innovative learning approaches to support the initial and continuing education of NPs, including in urban, rural/remote/isolated, and Aboriginal communities.	Medium	2006 – onward	NP associations CNA	CASN; F/P/T governments; Employers.

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STRATEGIC AREA: EDUCATION

Recommendation 8: Adopt the *Education Framework for Nurse Practitioners in Canada*.

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
Guiding Philosophy, Assumptions and Values				
38. Reflect the Guiding Philosophy, Assumptions, and Values found in the Education Framework for Nurse Practitioners in Canada.	High	2006 – onward	Schools of nursing	CASN; P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
Entry to Nurse Practitioner Educational Programs				
39. Establish admission criteria that include an active RN designation and a minimum of 2 years of full-time equivalent clinical nursing experience.	High	2006 – onward	Schools of nursing	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
40. Adopt and apply the principles found in the *Prior Learning Assessment and Recognition Framework for Nurse Practitioner Education and Regulation in Canada* (2006).	High	2006 – onward	Schools of nursing	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
41. Establish a pan-Canadian approach to transfer of credits.	Low	2006 – onward	Schools of nursing CASN	P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
42. Allow for the transfer of credits between educational institutions subject to maximums established by the institutions.	Medium	2006 – onward	Schools of nursing[1]	P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
Curriculum Alignment and Linkages				
43. Develop philosophy, mission and goal statements that are aligned with pan-Canadian frameworks governing NP education and periodically assess and review them.	Low	2006 – onward	Schools of nursing[2]	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
44. Establish and promote participation in a pan-Canadian accreditation process for NP educational programs.	High	2007 – onward	CASN Schools of nursing	P/T regulatory bodies; Employers; NP associations; Aboriginal communities; Students.
45. Develop linkages between accreditation and approval processes.	High	2007 – onward	CASN P/T regulatory bodies	Employers; NP associations; Aboriginal communities; Students.
46. Be responsive to broadly defined, evidence-based stakeholder needs.	Medium	2006 – onward	Schools of nursing CASN	P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.

[1] This action could also be a standard of the approval/accreditation process.
[2] Ibid.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
47. Be consistent with the *Canadian Nurse Practitioner Core Competency Framework* (2005) and the standards inherent in the NP program approval process.	High	2006 – onward	Schools of nursing[3]	CASN; P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
48. Adopt the master's degree (MN / MScN) as the required exit credential ideally by 2010 but no later than 2015.	High	2010 – 2015	Schools of nursing (not at a masters currently) P/T regulatory bodies	F/P/T groups responsible for the credential process.
49. Develop and institute bridging mechanisms to support program transition to a graduate degree (MN / MScN) as the standardized exit credential.	High	2010 – 2015	Schools of nursing[4] P/T regulatory bodies	Other universities that can provide support or collaboration; CASN to facilitate.
50. Develop and institute bridging mechanisms to support an individual's transition to a graduate degree.	High	2010 –2015	Schools of nursing CASN	P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.

[3] This action could also be a standard of the approval/accreditation process.
[4] Those schools not currently at a masters level.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
Nurse Practitioner Education Delivery				
51. Where practical, designate PhD prepared practicing NPs to teach NP-specific courses. Where limited: facilitate access to PhD preparation; engage qualified masters prepared NPs or non-NPs; and / or use team teaching or shared resource models.	Medium	2007 – onward	Schools of nursing[5]	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
52. Recognize NP faculty clinical hours as teaching hours.	Medium	2007 – onward	Schools of nursing[6]	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
53. Establish and monitor guidelines governing NP educational program faculty-student ratios.	Low	2006 – onward	Schools of nursing[7]	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
54. Establish 700 hours as the standard minimum number of clinical practice hours.	Medium	2006 – onward	Schools of nursing[8]	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.

[5] This action could also be a standard of the approval/accreditation process.
[6] Ibid.
[7] Ibid
[8] Ibid.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
55. Require clinical preceptors to be an NP, or an advanced practice nurse or equivalent subject matter expert in a relevant professional discipline with a sound understanding of the NP role.	Medium	2006 – 2007	Schools of nursing[9]	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
56. Initiate a coordinated effort to sustain and increase the supply of available preceptors.	Medium	2007 – onward	Employers Schools of nursing	CASN; NP associations; Clients; Students
57. Develop preceptor preparation programs.	Medium	2007 – onward	Employers Schools of nursing	CASN; NP associations; Clients; Students
58. Develop pan-Canadian standards for NP distance education.	High	2007 – onward	Schools of nursing CASN	P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
59. Develop and deliver distance education courses for NPs.	High	2007 – onward	Schools of nursing[10]	CASN; P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.

[9] This action could also be a standard of the approval/accreditation process.
[10] Ibid.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
60. Develop innovative approaches to support collaborative programming and pursue and implement funding for collaborative programming approaches.	High	2006	Schools of nursing CASN	
61. Develop and offer interprofessional courses.	Medium	2007 – onward	Schools of nursing Other relevant faculties	CASN; Employers; CNA; Professional educational associations for the relevant faculties.
62. Implement evidence-based student evaluation and testing methodologies.	Low	2007 – onward	Schools of nursing	CASN; P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
63. Establish a pan-Canadian resource bank, including approaches and tools.	Low	2007 – onward	Schools of nursing facilitated by CASN	P/T regulatory bodies; CNA; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
Licensure to Practice				
64. Implement cross-jurisdictional collaboration among schools and regulatory bodies to ensure that the licensure to practice process for NP students is supported by NP educational program content and teaching and learning processes.	High	2006 – onward	Schools of nursing[11]	CASN; P/T regulatory bodies; Employers; NP associations; Federal government; Aboriginal communities; Clients; Students.
Transition to the Workplace				
65. Develop and implement processes and structures to facilitate the transition of NPs from their educational program to the workplace and from novice to expert.	Medium	2007 – onward	Employers Schools of nursing	CCHSA; NP associations; Aboriginal communities; Clients; Students.
66. Establish mentorship and a mentorship culture as standard features of the NP learning experience.	Low	2007 – onward	Schools of nursing[12]	CCHSA; CASN; Employers; NP associations; Aboriginal communities; Clients; Students.

[11] This action could also be a standard of the approval/accreditation process.
[12] Ibid.

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Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
67. Develop pan-Canadian mentorship tools and promote their use across all NP educational programs and in the workplace.	Low	2007 – onward	Employers Schools of nursing	CASN; NP associations; Aboriginal communities; Clients; Students.
68. Create and support a culture of continuous learning among students and practicing NPs.	Low	2007 – onward	Employers	Schools of nursing; NP associations; Clients; Students.
69. Remove potential barriers to continuing education, including funding, time off, and access to learning opportunities.	Low	2007 – onward	Employers	Schools of nursing; NP associations; Clients; Students.
70. Develop refresher training programs as required for re-entry to practice.	Medium	2007 – onward	P/T regulatory bodies Schools of nursing	Employers.

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STRATEGIC AREA: STRATEGIC COMMUNICATIONS, CHANGE MANAGEMENT AND SOCIAL MARKETING

Recommendation 9: Change Management – Disseminate and promote understanding, acceptance and utilization of the *Implementation and Evaluation Tool Kit for Nurse Practitioners in Canada* and the *Health Human Resources Planning Simulation Model for Nurse Practitioners in Primary Health Care*™.

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
71. Develop and implement a communications/marketing plan to generate understanding and utilization of the *NP Implementation and Evaluation Toolkit for Nurse Practitioners in Canada*.	High	2006 – onward	CNA	CNA; P/T jurisdictional PR counterparts; NP national and P/T associations; NP Champions.
72. Adapt the *NP Implementation and Evaluation Toolkit for Nurse Practitioners in Canada* to reflect appropriate culture and language of the First Nations, Inuit and Métis communities.	High	2007	Aboriginal Nurses Association of Canada First Nations and Health Inuit Branch, Health Canada	Office of Nursing Policy; Health Canada; Nunavut Government; NWT Government; Yukon Government; Regulatory bodies/nursing associations in Nunavut, NWT and Yukon.
73. Develop and implement a communications/marketing plan to generate understanding, acceptance and utilization of the *HHRP Simulation Model for NPs in Primary Health Care*™.	High	2006	CNA	P/T regulatory bodies; NP champions; Canadian Healthcare Association.

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Recommendation 10: Social Marketing – Continue and further develop and implement a five-year pan-Canadian social marketing campaign to promote interprofessional collaborative care and practice and the NP role as part of the solution to access and wait times.

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
74. Build a consortium/coalition to seek funding for a sustained social marketing campaign.	Medium	2006	CNA and CMA	P/T regulatory bodies; Office of Nursing Policy, Health Canada; CAAPN; NPCC; HEAL members.
75. Implement a five-year social marketing campaign.	Medium	2007 – 2009	CNA and CMA	P/T regulatory bodies; Office of Nursing Policy, Health Canada; CAAPN; NPCC; HEAL members; F/P/T governments.

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Recommendation 11: Strategic Communications – Develop and implement a pan-Canadian coordinating mechanism to facilitate the ongoing dissemination of existing and new NP information.

Key Actions	Priority	Timeline	Lead/Co-lead	Key Supporting Stakeholder Groups
76. Maintain the existing database of stakeholders.	Medium	2006 – onward	CNA	
77. Maintain and populate the existing CNPI web site - Toolkit - Centralized location for posting of available NP positions	Medium	2006 – onward	CNA	NP Implementation Secretariat; CAAPN; NPCC; CASN; CNA P/T NP Nursing Associations; Canadian Nursing Students Association; NP champions.
78. Provide information link to salaries for unionized NPs on CNPI website or CNA portal.	Medium	2006 – onward	CNA AND CFNU	P/T governments; Employers.
79. Encourage stakeholders and partners to use the existing promotion tools/materials developed during the CNPI.	Medium	2006 – onward	CNA	CNA P/T jurisdictional members; CAAPN; NPCC; CASN; CNA P/T NP Nursing Associations; Canadian Nursing Students Association; NP champions.
80. Seek partnerships with stakeholders to disseminate information to their members/stakeholder groups.	Medium	2006 – onward	CNA	CNA P/T jurisdictional members; CAAPN; NPCC; CASN; CNA P/T NP Nursing Associations; Canadian Nursing Students Association; NP champions.
81. Develop and disseminate new and relevant information and tools (e.g., NP profiles, fact sheets, etc.).	Medium	2007	CNA	P/T jurisdictional members; CAAPN; NPCC; CASN; Nurse researchers; NP champions.

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STRATEGIC AREA: EVALUATION

Recommendation 12: Adopt the *Implementation and Evaluation Toolkit for Nurse Practitioners in Canada* as a national guide to support the ongoing implementation of NP roles in different settings.

Key Actions	Priority and Sequence	Timeline	Lead/Co-Lead	Key Supporting Stakeholder Groups
82. Develop linkages to universities, government, practitioners and health care networks to continually update the tools and resources section of the Toolkit.	Medium – High	2006	CNA (establish relationship with CASN and CHSRF/CIHR Chair for ANP)	CASN; CHSRF/CIHI Chair for ANP; NP Associations/ CAAPN; NPCC; Employers.
83. Promote the use of the Toolkit to researchers to encourage standardized approach and comparison of results overtime.	Medium – High	June 2006	NP Secretariat (Note: proposal has been put in for an NP Secretariat) ANP	CASN; CHSRF/CIHI Chair for ANP; PNAs; jurisdictional members; NPs; NPCC and jurisdictional NP Association; CAAPN; Employers.

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STRATEGIC AREA: GOVERNANCE

Recommendation 13: Establish a National Coordinating Committee to work with provincial and territorial representatives and federal partners to implement system-wide change.

Key Actions	Priority and Sequence	Timeline	Lead/Co-Lead	Key Supporting Stakeholder Groups
84. Establish a Steering Committee to begin work on the terms of reference, membership and a work plan for the Coordinating Committee.	High	2006	Office of Nursing Policy; P/T PNAs	CNA; CASN; NPPN; Employers; Regulatory bodies; Educators; NPs; CAAPN; NPCC; P/T Governments