

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: November 20, 2014

ACTION REQUESTED: Information: Nurse Practitioner National Certification

REQUESTED BY: Trande Phillips, RN, Chairperson
Nursing Practice Committee

BACKGROUND: National Certification Organizations that meet the certification requirement for Nurse Practitioner Equivalency by the Board of Registered Nursing

1. American Academy of Nurse Practitioners
2. American Nurses Credentialing Center
3. Pediatric Nursing Certification Board
4. National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty
5. American Association of Critical-Care Nurses (AACN)

Attachment: degree required certification & renewal fees, renewal requirements, accreditation & affiliation and testing services.

Committee requested return of the national certification document, specifically wanting detail from American Nurses Association-American Nurses Credentialing Center (AACN) renewal requirements

<http://www.nursecredentialing.org/CertificationHandbook.aspx> and American Association of Critical-Care Nurses (AACN) nursing concentration on Adult-Gerontology Acute Care Nurse Practitioner <http://www.aacn.org/wd/certifications/docs/acnpc-ag-exam-handbook.pdf>

RESOURCES:

American Academy of Nurse Practitioners National Certification Program(AANPCP)

<https://www.aanpcert.org/ptistore/control/index>

[http://www.aanpcert.org/ptistore/resource/documents/2013%20CandidateRenewalHandbook%20-Rev%2011%2025%202013%20forNCCA\(FINAL\).pdf](http://www.aanpcert.org/ptistore/resource/documents/2013%20CandidateRenewalHandbook%20-Rev%2011%2025%202013%20forNCCA(FINAL).pdf)

<http://www.aanpcert.org/ptistore/control/recert/qualifications>

American Nurses Credentialing Center (ANCC) <http://www.nursecredentialing.org/Certification>

<http://www.nursecredentialing.org/AcuteCareNP-Eligibility.aspx>

<http://www.nursecredentialing.org/RenewalRequirements.aspx>

<http://www.nursecredentialing.org/CertificationHandbook.aspx>

Pediatric Nursing Certification Board (PNCB)

<http://www.pncb.org/ptistore/control/exams/cpen/fees>

http://www.pncb.org/ptistore/control/resource/content/certs/PC_CPNP_Recert_Guide.pdf

http://www.pncb.org/ptistore/control/about/about_exams

National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty (NCC)

<http://www.nccwebsite.org/resources/docs/2013-exam-core.pdf>

<http://www.nccwebsite.org/resources/docs/2014-exam-np-bc.pdf>

<https://www.nccwebsite.org/resources/docs/2014-maintenance-core.pdf>

<http://www.nccwebsite.org/Certification/HowdoIapply.aspx#how-computer-testing-works>

American Association of Critical-Care Nurses (AACN)

<http://www.aacn.org/wd/certifications/content/initial-acnpc-certification.pcms?menu=certification>

<http://www.aacn.org/WD/Certifications/Content/ccrnrenewal.pcms?menu=Certification>

<http://www.aacn.org/wd/certifications/docs/acnpc-renewal-handbook.pdf>

https://www.pncb.org/ptistore/control/resource/content/certs/CPN_Recert_Guide.pdf

<http://www.aacn.org/wd/certifications/content/certcorpinfo.pcms?menu=certification&lastmenu=>

<http://www.aacn.org/wd/certifications/docs/cert-policy-hndbk.pdf>

<http://www.aacn.org/wd/certifications/docs/acnpc-ag-exam-handbook.pdf>

NEXT STEPS:

Place on Board agenda.

FISCAL IMPACT, IF ANY:

None

PERSON TO CONTACT:

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Certification Requirements

Provider	Degree	Certification	Certification Renewal	Renewal Requirements	Accreditation & Affiliation	Testing Service
<p>American Academy of Nurse Practitioners Certification Program (AANPCP) https://www.aanpcert.org/ptistore/control/index</p>	<p>Offered to graduates of a nationally-accredited graduate, post-graduate, and doctoral level adult, adult-gerontology, and family nurse practitioner programs in the U.S.A. and Canada http://www.aanpcert.org/ptistore/resource/documents/2013%20CandidateRenewalHandbook%20Rev%2011%2025%202013%20forNCCA(FINAL).pdf</p>	<p>Active RN license AANP member \$240 non-AANP member \$315</p>	<p>Every 5 years Recertification by Examination AANP Member \$240, Non-Member \$315 Recert by Practice Hours & CE: AANP Member \$120, Non-Members \$195 Recert by Practice Hours & CE: AANP Member \$120, Non-Members \$195</p>	<p>Active RN license Option 1: 1000 clinical hours as NP 75 CE applicable to population focus within 5 years Option 2: take the national certification examination http://www.aanpcert.org/ptistore/control/recert/qualifications</p>	<p>Accredited by the National Commission for Certifying Agencies (NCCA) & the Accreditation Board for Specialty Nursing Certification (ABSNC). AANPCP is an independent, separately incorporated, nonprofit organization. The Certification Program is affiliated with the national professional membership organization, the American Association of Nurse Practitioners (AANP). Membership with AANP is not a requirement for certification with AANPCP.</p>	<p>Professional Examination Service (ProService). AANPCP's National Certification Examinations are developed in cooperation with Professional Examination Service (ProExam, formerly known as PES), a not-for-profit testing company founded in 1941. Examinations are developed in conformity with standards established by the Institute of Credentialing Excellence (ICE), American Psychological Association, American Educational Research Association, National Council on Measurement in Education, and the U.S. Equal Employment Opportunity Commission</p>
<p>American Nurses Association- American Nurses Credentialing Center (ANCC) http://www.nursecredentialing.org/</p>	<p>Offered to graduates of a nationally-accredited master's, postgraduate, or doctoral level acute care, adult, adult-gerontology acute care, adult-gerontology primary care, adult psychiatric-mental health care, family, gerontological, pediatric primary care, & psychiatric-mental</p>	<p>Active RN license ANA Members \$270 American Psychiatric Nurses Association Members - For Psychiatric Exams Only \$290 Discount Rate Organizations* \$340 http://www.nursecredentialing.org/Certification/ExamResources/ExamFees/Organizations</p>	<p>Every 5 years ANA member \$200 Non-ANA member \$350 http://www.nursecredentialing.org/RenewalRequirements.aspx</p>	<p>Active RN license Current certification Option A: Professional Development Plus Practice Hours Option B: Professional Development Plus Testing Category 1 (75 continuing education hours) plus one additional category. (Candidates are allowed to double Category 1, submitting a total of 150</p>	<p>Accredited by the National Commission for Certifying Agencies (NCCA) & the Accreditation Board for Specialty Nursing Certification (ABSNC). American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA). Membership with ANA is not a requirement for certification with ANCC.</p>	<p>The ANCC certification examinations are developed consistent with the technical guidelines recommended by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education (AERA, APA, NCME; 1999). Additionally, the ANCC certification examinations meet accreditation standards of the Accreditation Board for Specialty Nursing Certification (ABSNC) and the National Commission for Certifying Agencies (NCCA).</p>

<p>Pediatric Nursing Certification Board (PNCB) http://www.pncb.org/ptistore/control/index</p>	<p>Offered to graduates of a nationally-accredited master's or doctoral level pediatric primary care nurse practitioner or pediatric acute care nurse practitioner program. http://www.pncb.org/ptistore/resource/content/exams/Prometric_Handbook.pdf</p>	<p>Active RN license \$385 http://www.pncb.org/ptistore/control/exams/pnp/fees</p>	<p>Every 7 years \$85 per module 2 PNCB Pediatric Updates Modules If purchased individually, the total cost is \$170. If two modules are purchased at the same time, the cost is \$160. There is no cost to apply previously purchased modules to your Recert application. \$130 1 PNCB Pediatric Updates module + 7.5 contact hours of other accepted activity You pay \$85 to order the module in advance of recertifying. You pay \$45 to document the other 7.5 hours of activity on the Recert application. There is no cost to apply previously purchased modules to your Recert application.</p>	<p>Active RN license each year complete 15 contact hours or equivalent activities accepted by PNCB over a period of 7 years, complete required PNCB pediatric update 6 modules (2 Primary Care modules, 2 Pharmacology, and 2 modules of their choice) 2015 requirement: 15 contact hours of pediatric pharmacology</p>	<p>Accredited by The National Commission for Certifying Agencies (NCCA). PNCB certification programs are recognized by the National Council of State Boards of Nursing (NCSBN) and individual state boards of nursing. The PNCB is also a member of the American Board of Nursing Specialties (ABNS). PNCB is an independent, non-profit organization and is not affiliated with a professional association and no membership is required.</p>	<p>PNCB utilizes the services of Prometric to assist in the administration, scoring, and analysis of the PNCB's CPN, CPNP and PMHS exams. Prometric is an independent testing agency and the leading provider of testing services and solutions for corporate, academic, government, financial and professional service clients. Our national exams are unique in that they are the only certification exams collaboratively designed by CPNPs®, CPNs®, and pediatricians. http://www.pncb.org/ptistore/control/about/about_exams</p>
<p>National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty (NCC) http://www.nccwebsite.org/default.aspx</p>	<p>Offered to graduates of a nationally-accredited masters, post-masters, or DNP level women's health care nurse practitioner or neonatal nurse practitioner program. http://www.nccwebsite.org/resources/docs/2014-exam-np-bc.pdf</p>	<p>Active RN license Exam fee \$325 Examination must be taken within 8 years of graduation date.</p>	<p>every three years Maintenance- Maintenance fee \$100 + \$70 if 15 CEU completed \$60 if 30 CEU completed \$50 if 45 CEU completed using the NCC online modules Alternatives to Professional Development Certification Maintenance Program \$175 https://www.nccwebsite.org/resources/docs/2014-maintenance-core.pdf</p>	<p>Active RN license Professional Development Certification Maintenance Program Assessment to identify strengths & knowledge gaps to build educational plan + CEU Due March 31, 2014: Use credit earned from the day you take your Stage 2 Assessment to 3/31/14 Due June 30, 2014: Use credit earned from the day you take your Stage 2 Assessment to 6/30/14 Due September 30, 2014: Use credit earned from the day you take your Stage 2 Assessment to 9/30/14 Due December 31, 2014: Use credit earned from the</p>	<p>Accredited by the National Commission for Certifying Agencies (NCCA), the accreditation body of the National Organization for Competency Assurance (NOCA). NCC is a not for profit organization that provides a national credentialing program for nurses, physicians and other licensed health care personnel. NCC is an independent, not for profit national certification organization and is not affiliated with a professional association and no membership is required.</p>	<p>NCC uses the services of testing vendor, Applied Measurement Professional, Inc (AMP) to assist in administration, scoring and analysis of the NCC's WHNP and NNP exams. http://www.nccwebsite.org/Certification/HowdoIapply.aspx#how-computer-testing-works</p>

<p>AACN Certification Corporation http://www.aacn.org/dm/mainpages/certificationhome.aspx</p>	<p>Offered to graduates of a nationally-accredited master's degree or higher level adult-gerontology acute care nurse practitioner program. http://www.aacn.org/wd/certifications/content/documentsandhandbooks.pcms?menu=certification&lastmenu=</p>	<p>Active RN license AACN Members \$245 Nonmembers \$350</p>	<p>every 5 years Synergy Continuing Education Recognition Point (CERPs) AACN Members \$120 Nonmembers \$200 CCRN Renewal by Exam AACN Members \$170 Nonmembers \$275 http://www.aacn.org/WD/Certifications/Content/ccrnrenewal.pcms?menu=Certification</p>	<p>Active RN license Option 1 - Practice Hours and CE Points minimum of 1,000 practice hours 150 CE Renewal Points, 75 of which must be in Category I - Acute Care Education Programs. Option 2 - Practice Hours and Exam minimum of 1,000 practice hours meeting the hour requirement + the certification exam Option 3 - CE Points and Exam</p>	<p>Commission for Certifying Agencies (NCCA). AACN Certification Corporation is a separately incorporated organization from the American Association of Critical Care Nurses. The Certification Corporation is not a membership organization. It is a certifying organization dedicated to consumer protection through certifying and recertifying nurses. Membership in the American Association of Critical-Care Nurses is not an eligibility requirement for AACN Certification programs. http://www.aacn.org/wd/certifications/content/certcorpinfo.pcms?menu=</p>	<p>The certification programs are administered by AACN Certification Corporation. The certification exams are conducted in cooperation with applied Measurement Professionals, Inc. (AMP). AACM Certification Corporation develops ACNPC and ACNPC-AG*specialty exams. http://www.aacn.org/wd/certifications/docs/cert-policy-hndbk.pdf</p>
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BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.2
DATE: November 20, 2014

ACTION REQUESTED: Review and Vote on Whether to Approve: Update to Frequently Asked Questions Regarding Nurse Practitioner Practice

REQUESTED BY: Trande Phillips, RN
Practice Committee Chair

BACKGROUND:

Request to bring back for review and vote on Frequently Asked Questions Regarding Nurse Practitioner Practice which is updated to include current laws and regulation changes that have occurred since the last update in 2004. The updated version includes Nursing Practice Act, (NPA) Section 2725.2 Dispensing of self-administered hormonal contraceptives by approved standardized procedures and Section 2725.4, Abortion by aspiration techniques; Requirements. NPA Section 2835.7 Authorized Standardized Procedures for ordering durable medical equipment, certifying disability in consultation with the physician pursuant to Unemployment Insurance Code, and plan of treatment or plan of care for home health in consultation with the physician. Other related changes that relate to nurse practitioner practice.

The Practice Committee at its August 7, 2014 meeting requested return of the update to Frequently Asked Questions Regarding Nurse Practitioner Practice to the October 2014 meeting for further review and discussion.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: None

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FREQUENTLY ASKED QUESTIONS REGARDING NURSE PRACTITIONER PRACTICE

Practice Questions

Added
Oct. 9, 2014

Can a Registered Nurse dispense self-administered hormonal contraceptives and contraceptive injections?

Yes, a Registered Nurse may dispense self-administered hormonal contraceptives and may administer injections of hormonal contraceptives approved by the Federal Food & Drug Administration (FDA) in strict adherence to standardized procedures. Standardized procedure shall include minimum training requirements outlined in Section 2725.2 including examination that is consistent with Centers for Disease Control & Prevention (CDC) and the United States Medical Eligibility Criteria for Contraceptive Use guidelines, educating patients on medical standards for women's health, referral criteria for patients with contraindications for hormonal contraceptives and follow-up visits, physician and surgeon supervision requirements, periodic review of nurses competence including frequency and person conducting the review. A patient seen exclusively by an RN for three consecutive years, prior to continuing dispensing or administering of hormonal contraceptives, shall be evaluated by physician, nurse practitioner, certified nurse midwife, or physician assistant.

(AB 2348 effective January 1, 2013)

Added
Oct. 9, 2014

Can a nurse practitioner with Schedule III-V furnishing privileges obtain Schedule II furnishing privileges to meet the rescheduling Hydrocodone Combination Products (HCP) legislation?

Yes, Nurse practitioners with Schedule III-V furnishing privileges already will need to take a continuing education course for Controlled Substances (CS) II Nurse Practitioners will need to complete a BRN-Approved CS II Authority Continuing Education Course.

Please mail to: Board of Registered Nursing
Advanced Practice Unit
1747 North Market Blvd., Suite 150
Sacramento, CA. 95834

Added

Can a nurse practitioner function in the emergency department?

Yes. Nurse practitioners are permitted to perform consultation and treatment in an emergency department under certain conditions. Section 1317.1 of the Health and Safety Code, relating to emergency services was repealed and amended September 26, 2011, changing definition of emergency service and care to include appropriately licensed persons, nurse practitioners and physician assistants, under the supervision of a physician and surgeon, to include medical screening, examination, and evaluation by a physician, or to the extent permitted by applicable law, by other appropriate personnel (NP&PA) under the supervision of a physician and surgeon, to determine care, treatment, and surgery by physician necessary to

relieve or eliminate the emergency medical condition or active labor, within the capability of the facility.
(SB 233, ch 333. (Pavley), Statutes of 2011)

Added ***Can nurse practitioners authorize durable medical equipment, certify disability and approve, sign, or modify care for home health services within the standardized procedure?***

Yes. (SB 819 ch 158 (Bass) Statutes 2009)

Added ***Can a nurse practitioner authorize disability benefits?***

Yes, the Unemployment Insurance Code was updated to reflect nurse practitioners' authority to authorize disability benefits. (AB 2188 ch 378, (Bradford and Niello) Statutes of 2009)

Added ***Can nurse practitioners obtain consent for blood transfusions?***

Yes, nurse practitioners are clearly authorized to obtain consent for autologous blood and direct/non-direct homologous blood transfusions. (SB 102 ch 719 Statutes of 2007).

Added ***Can nurse practitioners sign DMV physical exams for school bus drivers?***

Yes, nurse practitioners have the ability to sign DMV physical exams for drivers of school buses, school pupil activity buses, youth buses, general paratransit vehicles, and farm-labor vehicles. (AB 139, ch 158, Statutes of 2007)

Added ***Can nurse practitioners certify disability for purpose of persons obtaining a disability placard or disability car license plate?***

Yes, a nurse practitioner is authorized to certify disability for purposes of a disability placard or disability license plate. (AB 2120, ch 116 (Liu) Statutes of 2007)

Do my patient charts need to be countersigned by a physician?

The Nursing Practice Act (NPA) does not require physician countersignature of nurse practitioner charts. However, other statutes or regulations, such as those for third party reimbursement, may require the physician countersignature. Additionally, some malpractice insurance carriers require physicians to sign NP charts as a condition of participation. Standardized procedures may also be written to require physicians to countersign charts.

Can a nurse practitioner dispense medications? If so, what laws should the nurse practitioner know about to perform this function?

Business and Professions (B&P) Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication, except controlled substances, upon the valid order of a physician in primary, community and free clinics.

AB 1545, Chaptered 914 (Correa) amended Section 2725.1 to enable NPs to dispense drugs, including controlled substances, pursuant to a standardized procedure or protocol in primary, community and free clinics. Pharmacy law, Business and Professions Code, Section 4076 was amended to include NPs dispensing using required pharmacy containers and labeling. This law became effective January 1, 2000.

Is a nurse practitioner practicing illegally when the physician supervisor is more than 50 miles away?

The mileage between the nurse practitioner and the supervising physician is not specifically addressed in the NPA. However, the physician should be within a geographical distance, which enables her/him to effectively supervise the nurse practitioner in the performance of the standardized procedure functions.

Does the nurse practitioner need a physician supervisor who is approved by the medical board?

No. Nurse practitioner laws do not require that the physician supervisor be approved by the Medical Board.

I am a pediatric nurse practitioner and the physician wants me to start treating adults. I feel comfortable treating adults, so can we develop standardized procedures to cover this new population, diagnosis/treatments and furnishing?

You must first be clinically competent to provide care to this new patient population. Clinically competent is defined in California Code of Regulations (CCR) Section 1480(c) as "...to possess and exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice.". In this instance, you would have to demonstrate knowledge and skills comparable to those of an adult nurse practitioner. Clinical competence in this new specialty can be achieved by successful completion of theory course(s) and a supervised clinical practicum at an advanced level for the new patient population.

Once competencies are achieved for the adult population, and as required by the Standardized Procedure Guidelines (CCR 1474), the standardized procedures for the adult population must specify the experience, training, and/or education, (Section 1474 (4)) which enables the NP to diagnose and treat the adult population. The standardized procedures must identify the method used to establish initial and continuing evaluation of your competence to perform the standardized procedure functions (Section 1474 (5)).

How often do my standardized procedures need updating?

The standardized procedures should be updated frequently enough to ensure that patients are receiving appropriate care. Factors to consider in making the determination to update the standardized procedures include, but are not limited to, patient population and acuity, treatment modalities, and advances in pharmacology and diagnostic technology.

Can I adopt my nurse practitioner program's standardized procedures as my own when I go out into practice?

Yes, if the nurse practitioner program's standardized procedures meet the requirements of the Standardized Procedure Guidelines (CCR 1474) and are approved by the organized health care system including nursing, administration, and medicine.

I am a geriatric nurse practitioner and work with a physician who has patients in a number of long term health care facilities. We have developed standardized procedures for the medical care I will be providing in these facilities. Do the standardized procedures have to be approved by each facility?

Yes. Standardized procedures are agency specific and must be approved by nursing, administration and medicine in the agency in which they are used.

What are the requirements for Nurse practitioner practice in a long term care facility?

Delegation of duties to nurse practitioner in long-term health care facilities

Section 14111 Welfare and Institutions Code describes delegation of duties to nurse practitioners in long term health care facility.

(a) As permitted by federal law or regulation, for health care services provided in a long-term health facility that are reimbursed by Medicare, a physician and surgeon may delegate any of the following to a nurse practitioner:

(1) Alternating visits required by federal law and regulation with a physician and surgeon.

(2) Any duties consistent with federal law and regulation within the scope of practice of nurse practitioner so long as all the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual facility.

(B) The medical care of each resident is supervised by a physician and surgeon.

(C) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal law or regulation.

(c) All responsibilities delegated to a nurse practitioner pursuant to this section shall be performed under the supervision of the physician and surgeon and pursuant to standardized procedures among the physician and surgeon, nurse practitioner, and facility.

(d) No task that is required by federal law or regulated to be performed personally by a physician may be delegated to a nurse practitioner.

(e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and within the scope of practice of a nurse practitioner.

Added Stats 1992 ch 1048 § 2(AB 2849). Amended States 1994 ch 646 § 1(AB 2879)

Tasks of nurse practitioner in long-term health care facility

(a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed under this chapter, a nurse practitioner may, to the extent consistent with his or her scope of practice , perform any of the following tasks otherwise required of a physician and surgeon:

(1) With respect to visits required by federal law or regulations, making alternating visits, or more frequent visits if the physician and surgeon is not available.

(2) Any duty or task that is consistent with federal law or regulation within the scope of practice of nurse practitioners, so long as all of the following conditions are met.

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

(B) The medical care of each resident is supervised by a physician and surgeon.

(C) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by visits.

- (c) All responsibilities undertaken by a nurse practitioner pursuant to this section shall be performed in collaboration with the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.
- (d) Except as provided in subdivisions (a) to (c), inclusive, any task that is required by federal law or regulation to be performed personally by a physician may be delegated to a nurse practitioner who is not an employee of the long-term health care facility.
- (e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and with the scope of practice of a nurse practitioner

Added Stats 1992 ch 1048 § 3 (AB 2849). Amended Stats 1994 ch 646 § 2 (AB 2879); Stats 1995 ch 91 § 186 (SB 975)

I am certified as a nurse practitioner by a national certifying body. Do I need to apply to the BRN for a nurse practitioner certificate?

Yes, you do if you use the title “Nurse Practitioner” (NP) because BRN certification is required if you “hold out” as an NP in California. You also need to apply to the BRN for a certificate if you are certified in another state as an NP and wish to use that title in California.

Can a nurse practitioner develop and use standardized procedures with a chiropractor? Can the nurse practitioner furnish drugs and devices to these patients?

No. The law restricts use of standardized procedures to performance of medical functions; therefore, the standardized procedures cannot be developed by the nurse practitioner and chiropractor (BPC 2725 (c))

No. The nurse practitioner cannot furnish drugs and devices for the chiropractor’s patients. The furnishing law, BPC 2836.1, the drugs and devices are furnished or ordered by a nurse practitioner in accord with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon, when the drugs or devices furnished or ordered are consistent with the practitioner educational preparation or for which clinical competency has been established and maintained.

May I call myself a nurse practitioner once I have completed my nurse practitioner program?

No. You cannot use the title nurse practitioner until you have been certified by the BRN as a nurse practitioner. Furthermore, registered nurses who use the title NP without BRN certification may subject their RN license to possible discipline.

I am a nurse practitioner and I do not have a nurse practitioner furnishing number. Can I still “furnish” medications for patients using a standardized procedure?

No. There is explicit statutory language, BPC 2836.1 related to furnishing of drugs and devices by nurse practitioners. The furnishing of drugs and devices by nurse practitioners is conditional on issuance of a furnishing number to the nurse

practitioner by the BRN. The furnishing number must be included on all nurse practitioner prescriptions transmittal order forms.

Added

Nurse Practitioner and Medicare Information: Required Qualifications.

A NP must be a registered professional nurse authorized by the State in which services are furnished by the NP in accordance with state law: Obtain Medicare billing privileges as a NP for the first time on or after January 1, 2003, and:

- Is certified as a NP by a recognized national certification body that has established standards for NPs; and has a Master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.
- Obtain Medicare billing privilege as a NP for the first time before January 1, 2003, and meets the certification requirements described above, or
- Obtained Medicare billing privileges as a NP for the first time before January 1, 2001

(Department of Health and Human Services, Centers for Medicare and Medicaid Services)

Added

Nurse Practitioner and Medi-Cal Billing: Required Qualifications.

Section 14132.41 Welfare and Institutions Code (a) Services provided by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a certified nurse practitioner to bill Medi-Cal independently for his or her services; the department shall make payments directly to the certified nurse practitioner. For purposes of this section, "certified" means a nationally board certified in a recognized specialty. (AB 1591 chapter 719 Chan medical: nurse practitioners)

What are the provisions of the Therapeutic Abortion Act that nurse practitioners need to know?

The Reproductive Privacy Act deletes the provisions of the Therapeutic Abortion Act, among other things including the name of the act. The changes are found in Business and Professions Code Section 2253 and allow registered nurses, certified nurse practitioners, and certified nurse midwives to assist in the performance of a surgical abortion and to assist in performance of a non-surgical abortion. (SB 1301 Kuehl, Chapter 385, effective September 5, 2002).

The nurse practitioner may perform or assist in performing functions necessary for non-surgical abortion by furnishing or ordering medications in accordance with approved standardized procedures. (SB 1301 Kuehl, Chapter 385 effective September 5, 2002)

Added

What does the nurse practitioner need to know about the January 1, 2014 legislation adding Section 2725.4 Abortion by aspiration techniques, requirements?

Section 2725.4 states in order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or certified nurse-midwife shall complete training recognized by the Board of Registered Nursing. Beginning January 1, 2014, and until January 1, 2016, the competency-based training protocols established by Health Work-force Pilot Project (HWPP) No 171 through the Office of Statewide Health Planning and Development will be used. (added Stats 2013 ch 662 § 2 (AB154), effective January 1, 2014)

Can a nurse practitioner request and sign for complimentary samples of dangerous drugs and devices from a manufacture's sales representative?

Yes, the certified nurse practitioner and the certified nurse midwife may sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocol that has been approved by the physician. (SB 1558, Figueroa Chapter 263 effective August 24, 2002).

Can the certified nurse practitioner and the certified nurse midwife supervise Medical Assistants?

Yes, the supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instruction to be followed by a medical assistant in performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, physician assistant within the standardized procedures or protocol, and that task may be performed when the supervising physician and surgeon is not onsite. The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined in BPC Section 2725 or protocol. The standardized procedure, including instruction for specific authorization, shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife. (amended Section 2069 of BPC related to healing arts: SB 352 (Pavely) Chapter 286, approved by the Governor September 09, 2013)

Can the nurse practitioner cosign worker's compensation claimant report?

Yes, Section 3209.10 of the Labor Code gives nurse practitioners the ability to cosign Doctor's First Report of Occupational injury or illness for a worker's compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedure or protocols. The treating physician is required to sign the report and to make any determination of any temporary disability. (AB 1194 ch229 (Correa) effective 1, 2001 and AB 2919 (Ridley –Thomas) effective January 1, 2005 extends the operation of this provision indefinitely)

Furnishing Questions

What is a formulary?

A pharmacy formulary is generally regarded as a drug compendium reference utilized by facilities or health plans as a reference. The drug name, dosage, clinical indications, and complications/adverse reactions are generally included. It is most common for the health insurer to identify by means of a formulary those drugs and devices covered by the plan. Nurse practitioners using furnishing numbers can identify a formulary(ies) in their furnishing standardized procedure.

What is the physician supervision requirement for when obtaining a furnishing number from the BRN?

Business and Professions Code Section 2836.1 (g) (2) amendment authorizes a physician and surgeon to determine the extent of the supervision necessary pursuant to this section in furnishing or ordering of drugs and devices. (SB 1524 ch 796 (Hernandez) effective January 1, 2013)

After January 1, 2013 Nurse Practitioners are no longer required to have six (6) months physician-supervised furnishing experience prior to receiving a furnishing number from the Board of Registered Nursing.

What are the requirements for an NP to furnish or order Schedule II controlled substances?

The NPs standardized procedure and protocols address the diagnosis of illness, injury or condition for which the Schedule II controlled substance is to be furnished. The standardized procedure or protocol for Schedule II contains patient-specific protocol approved by the treating physician. The NP with a current furnishing number, and DEA registration, completes as a part of his or her continuing education requirement, a course including Schedule II controlled substances based on the standards developed by the BRN. (AB 1196 [Montañez](#) Chapter 748 1/2004)

What is a “patient-specific protocol” for Schedule II and III, controlled substances?

The patient-specific protocol required for nurse practitioners to furnish Schedule II and III controlled substances, as defined in Health and Safety Code 11055 and 11056, in a protocol, contained within the standardized procedure or protocols, that specifies which categories of patients may be furnished this class of drugs. The protocol may state other limitations, such as the amount of substance to be furnished, and/or criteria for consultation. (AB 1196 [Montañez](#) Chapter 748 1/2004)

In my furnishing procedure, do I need to list the drugs and devices that can be furnished or can I use categories of drugs?

The nurse practitioner cannot use a category of drug to meet the furnishing requirements

The law BPC 2836.1 Furnishing or ordering of drugs and devices by a nurse practitioner requires the identification of the drugs and devices in standardized procedure or protocol (BCP Section 2836.1 (c) (1).

The standardized procedures or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish drugs or devices, **which drugs or devices may be furnished**, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner’s competence, including peer review, and review of the provisions of the standardized procedures. (NPA, Section 2836.1) (Emphasis added.)

How many nurse practitioners, with a furnishing number, may a physician supervise at one time within a medical practice?

The furnishing law requires that the physician supervise no more than four nurse practitioners at a time. If the nurse practitioners are not furnishing, there are no limitations on the number of nurse practitioners the physician may supervise.

(BCP Code Section 2836.1 (e))

I am certified as both a nurse practitioner and a nurse midwife. Do I need to have two furnishing numbers?

The BRN does not require you to maintain two furnishing numbers. NPs and CNMs are required to have approved furnishing standardized procedures. However, the furnishing laws are different in their authorizations.

DEA Questions

The DEA application asks for “State License No.”. Which number, RN license number or NPF number, should the NP put on the application?

The DEA requires the RN license number and the NPF number.

The DEA application asks for a business address. Can the NP use a work address or personal address?

The DEA requires a business address that is the physician’s address or clinic’s address for the DEA Registration Number. The DEA Number is clinic site specific for dispensing, prescribing and administering purposes. If you leave your place of employment, you must submit written notification to the DEA Office with a copy of your DEA Number, the California RN license and the NP Furnishing Number certificate. If you go to another clinic, you must submit a written request for change of address to the DEA. If the physician or office clinic has two locations (business addresses), the primary clinical site should be referenced for the DEA Registration Number.

Does the NP need a furnishing number issued by the BRN to obtain a DEA number?

Yes, an nurse practitioner furnishing number is required to obtain a DEA number for Schedule II through V Controlled Substances. (AB 1196 [Montañez](#) Chapter 748 1/2004 added Schedule II controlled substances)

The provisions of SB 816 added “order” to Business and Professions Code, Section 2836.1. SB 816 did not change the requirement to furnish using standardized procedures for controlled substances, Schedule III, IV, and V.

Does having a DEA number eliminate the need for a furnishing number?

No, the DEA number only allows NPs to write and or “order” controlled substances, Schedule II, III, IV, and V. NPs are required to have a furnishing number to make drugs and devices available to their patients using a transmittal form (prescription pad) and are to be furnished pursuant to approved standardized procedures. DEA registration numbers are site specific and used by the DEA for tracking prescribing of controlled substances.

On the DEA application, it asks “Administer, Dispense, Prescribe”. Can an NP as a result SB 816 and now 1/2004 AB 1196 [Montañez](#) Chapter 748 prescribe?

Yes, the B&P Code refers to furnishing or ordering a Schedule II through V controlled substance for the purposes of obtaining DEA registration.

Are NPs now considered “prescribers”?

For the purpose of obtaining a DEA number for (ordering) Schedule II, III, IV, V the NP with a furnishing number is considered by the DEA to be a prescriber.

Can the NP with a furnishing number use the physician’s DEA number?

No, the NP with a furnishing number may not use the physician’s DEA number. The new law requires the nurse practitioner with the furnishing number to obtain his or her own DEA number to furnish controlled substances.

What is required to be printed on the prescription pad/transmittal order/drug order for Schedule II through V?

When furnishing a controlled substance, Schedule II, III, IV, or V, write the “order” and include your name, title, furnishing number, and DEA number.

How long is a controlled substance prescription (Schedule II –V) valid?

The controlled substance prescription is valid for 6 months from the date of issuance. (SB 151 Burton Chapter 406 1/2004)

Do nurse practitioners have prescriptive authority and can nurse practitioners get DEA numbers?

Furnishing is a delegated authority and is done in accordance with approved standardized procedures. Physician supervision is required and the physician must be available, at least by telephonic means, at the time the nurse practitioner examines the patient. (BCP 2836.1(d))

History of laws related to Furnishing schedule III-V and schedule II controlled substances

SB 816, Chapter 749, (Escutia), effective January 1, 2000, authorizes NPs with furnishing certificates to apply for a DEA number and furnish or order Schedule III-V controlled substances. The new law added “order” and “drug order” to Section 2836.1. The intent of this legislation is furnishing can now be known as an “order”, and can be considered the same as an “order” initiated by the physician.

AB 1196 Montañez Chapter 748 1/2004 expands NP furnishing to Schedule II controlled substances that requires a United States Drug Enforcement Registration in addition to the Schedule III through V. This law requires NPs to use the new controlled substance prescription forms for Schedule II controlled substances prescriptions. January 1, 2005, triplicate prescription forms are no longer valid and all written controlled substance prescriptions (oral or faxed for Schedule II through V are permitted) shall be on controlled substance prescription forms. (SB 151, Burton 406 1/2004).

The Drug Enforcement Agency (DEA) monitors all prescribers who write for controlled substances. NPs, pursuant to Section 2836.1 of the Business and Professions Code, are legally authorized to furnish and “order” controlled substances, Schedule II, III, IV, V.

Where can a nurse practitioner find information on controlled substances such as the Drug Enforcement Administration (DEA) and pharmacy laws? Phone numbers subject to change.

DEA Main office, San Francisco: 1-888-304-3251

DEA Field office, San Diego: (858) 616-4329

DEA Field office, Los Angeles: (213) 621-6960

Board of Pharmacy: (916) 445-5014

Web: www.deadiversion.usdoj.gov

I am here today to provide information and discussion to the practice committee about CNM practice and practice standards, in particular as related to home birth.

According to the CDC, the rate of home births has increased in the US every year since 2004 (0.56%). The rate is currently 1.36% in 2012.

Midwifery has a long home birth tradition. When birth moved from primarily taking place in homes to hospitals, nurse-midwives followed. Today in California, only 1.3% of CNM-attended births take place in the home.

There is much confusion that licensed midwives only attend home births and CNMs only attend hospital births.

BRN regulations stipulate that midwifery education programs include in their curriculum "All aspects of the management of normal pregnancy, labor and delivery, postpartum period, newborn care, family planning and/or routine gynecological care in alternative birth centers, homes and hospitals."

1. OOH CNM Practice and physician supervision
 - a. It is exceedingly difficult for OOH CNMs to find physician who will be "supervisor"
 - b. The MBC acknowledged this and stopped investigating home birth LMs for supervision, prior to recommending that supervision be removed for LMs altogether.
 - c. I would like to ask the Practice Committee to investigate this further and make a recommendation to the full board to take similar action until a legislative fix can be achieved.
 - d. Keep in mind that not having a "supervisor" does not remove the responsibility of the CNM to provide safe care by consulting, collaborating, and referring as needed. "We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits."
 - e. CNMA, like ACOG, respects the right of a woman to make a medically informed decision. Every woman has a right to an informed choice regarding place of birth and access to safe home birth services.
2. Location of suturing and protection of the public
 - a. A very specific point in home birth practice that is challenging is repair of lacerations
 - b. Statute is silent on whether lacerations can be repaired in the home. It specifically states that a CNM may repair lacerations in the hospital or birth

presented by Kim Q Paul CNM

center, but does not specifically exclude laceration repair in the home. The BRN is disciplining CNMs for repairing lacerations in the home.

- c. Laceration repair is within the scope of practice of a CNM.
 - d. Transferring a patient to the hospital for repair of a laceration is a time-consuming affair that can increase the risk of hemorrhage, infection and disrupt the neonatal and maternal bonding that is essential for breastfeeding and bonding.
 - e. I would suggest that it is within the power of the BRN to consider the implications of this on protection of the public. Ask the BRN practice committee to look at standards of care in other states and re-consider these charges given that the law is silent on the home setting.
3. Standardized Procedures and ACNM Core Competencies
 - a. Laceration repair falls under ACNM Core Competencies
 4. Home Birth CNMs held to unknown definitions of normal
 - a. No NMAC, we are happy to provide national standards and do research for the BRN on home birth practice standards, as this is a very midwifery specific practice.
 - b. Home Birth transfer guidelines
 5. Definition of supervision.
 - a. The BRN is accusing CNMs of working without supervision without clear guidance as to what supervision entails. (distance of physician)

A. The BRN has adopted a definition of supervising physician as follows:

22. Thus, the phrase “physician supervision” is a term of art; it has different meanings depending on the function performed by the certified nurse-midwife. Accordingly, consistent with the language contained in California Code of Regulations, title 16, section 1463, when nurse-midwives perform routine functions, such as those set forth in Business and Professions Code section 2746.5, subdivision(a), the term physician supervision includes consultation and collaboration, as needed to ensure the welfare of the mother or child. In contrast, when a nurse midwife performs functions that overlap with the practice of medicine, such as prescribing medication or performing an episiotomy or laceration repair, the role of the supervising physician

expands to include development and approval of standardized procedures. (Bus. & Prof. Code §§ 2746.51 & 2746.52.)

2746.52. Episiotomies; Repair of Lacerations of the Perineum

Notwithstanding Section 2746.5, the certificate to practice nurse-midwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum, in a licensed acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, and a licensed alternate birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, but only if all of the following conditions are met:

Standardized Procedures related to the American College of
Nurse-Midwives' Core Competencies for Basic Midwifery
Practice



As acknowledged by the BRN Advisory on Standardized Procedures (SP), the Legislature recognized that nursing is a dynamic field, continually evolving to include more sophisticated patient care activities. In Section 2725(a), the Legislature expressly declared its intent to provide clear legal authority for functions and procedures which have common acceptance and usage. Registered nurses must recognize that the application of nursing process functions is common nursing practice which **does not** require a standardized procedure. In Section 2725(a), the Legislature referred to the dynamic quality of the nursing profession. This means, among other things, that some functions which today are considered medical practice will become common nursing practice and no longer require standardized procedures.

As an example – In 1988 at many hospitals in Orange County there was requirement of SP for nurses in L&D to be able to perform vaginal examination for cervical checks. It was determined with consult of the BRN that vaginal exams were part of the core education of registered nurses at the time of graduation. The SPs were eliminated because vaginal exams had become common nursing practice.

Since the enabling statute for nurse-midwifery, there are many clinical practices that have evolved and have become common midwifery practice. The document that describes common practice for midwifery is the ACNM core competencies for basic midwifery practice. It is a dynamic document reviewed and updated every five years and depicts the evolution of midwifery practice as a dynamic field in an ever-fluctuating health care setting.

The practice of nurse-midwifery is well-defined by the national core competencies set forth by the American College of Nurse-Midwives. This document is clearly recognized by the State as students that graduate from programs in California must meet the Core Competencies. Therefore the national Core Competencies should be the foundation for standard practice of nurse-midwifery in California, utilizing the workforce to full extent of their preparation and not promoting activities outside their preparation.



CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE

The *Core Competencies for Basic Midwifery Practice* include the fundamental knowledge, skills, and behaviors expected of a new practitioner. Accordingly, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy makers and constitute the basic requisites for graduates of all nurse-midwifery and midwifery education programs accredited/preaccredited by the Accreditation Commission for Midwifery Education (ACME), formerly the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA).

Midwifery practice is based on the *Core Competencies for Basic Midwifery Practice*, the *Standards for the Practice of Midwifery*, the *Philosophy of the ACNM*, and the *Code of Ethics* promulgated by the ACNM. Certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the ACNM or the American Midwifery Certification Board (AMCB), formerly the ACNM Certification Council, Inc. (ACC), assume responsibility and accountability for their practice as primary health care providers for women and newborns.

The scope of midwifery practice may be expanded beyond the core competencies to incorporate additional skills and procedures that improve care for women and their families. Following basic midwifery education, midwives may choose to expand their practice following the guidelines outlined in Standard VIII of the *Standards for the Practice of Midwifery*.

Midwifery education is based on an understanding of health sciences theory and clinical preparation that shapes knowledge, judgment, and skills deemed necessary to provide primary health care management to women and newborns. Midwives provide health care that incorporates appropriate medical consultation, collaborative management, or referral. Each education program is encouraged to develop its own method of addressing health care issues beyond the scope of the current core competencies, and each graduate is responsible for complying with the laws of the jurisdiction where midwifery is practiced and the ACNM *Standards for the Practice of Midwifery*.

ACNM defines the midwife's role in primary health care based on the Institute of Medicine's report, *Primary Care: America's Health Care in a New Era*,¹ the *Philosophy of the ACNM*,² and the ACNM position statement, "Midwives are Primary Care Providers and Leaders of Maternity Care Homes."³ Primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of health care needs, developing a sustained partnership with patients, and practicing within the context of family and community. As primary health care providers, CNMs and CMs assume responsibility for the provision of and referral to appropriate health care services, including prescribing, administering and dispensing of pharmacologic agents. The concepts, skills, and midwifery management processes identified

below form the foundation upon which practice guidelines and educational curricula are built. The core competencies are reviewed and revised regularly to incorporate changing trends in midwifery practice. This document must be adhered to in its entirety and applies to all settings for midwifery care, including hospitals, ambulatory care settings, birth centers, and homes.

I. Hallmarks of Midwifery

The art and science of midwifery are characterized by the following hallmarks:

- A. Recognition of menarche, pregnancy, birth, and menopause as normal physiologic and developmental processes
- B. Advocacy of non-intervention in normal processes in the absence of complications
- C. Incorporation of scientific evidence into clinical practice
- D. Promotion of woman- and family-centered care
- E. Empowerment of women as partners in health care
- F. Facilitation of healthy family and interpersonal relationships
- G. Promotion of continuity of care
- H. Health promotion, disease prevention, and health education
- I. Promotion of a public health care perspective
- J. Care to vulnerable populations
- K. Advocacy for informed choice, shared decision making, and the right to self-determination
- L. Integration of cultural humility
- M. Incorporation of evidence-based complementary and alternative therapies in education and practice
- N. Skillful communication, guidance, and counseling
- O. Therapeutic value of human presence
- P. Collaboration with other members of the interprofessional health care team

II. Components of Midwifery Care: Professional Responsibilities of CNMs and CMs

The professional responsibilities of CNMs and CMs include but are not limited to the following components:

- A. Promotion of the hallmarks of midwifery
- B. Knowledge of the history of midwifery
- C. Knowledge of the legal basis for practice
- D. Knowledge of national and international issues and trends in women's health and maternal/newborn care
- E. Support of legislation and policy initiatives that promote quality health care
- F. Knowledge of issues and trends in health care policy and systems
- G. Knowledge of information systems and other technologies to improve the quality and safety of health care
- H. Broad understanding of the bioethics related to the care of women, newborns, and families
- I. Practice in accordance with the ACNM Philosophy, Standards, and Code of Ethics
- J. Ability to evaluate, apply, interpret, and collaborate in research

- K. Participation in self-evaluation, peer review, lifelong learning, and other activities that ensure and validate quality practice
- L. Development of leadership skills
- M. Knowledge of licensure, clinical privileges, and credentialing

- N. Knowledge of practice management and finances
- O. Promotion of the profession of midwifery, including participation in the professional organization at the local and national level
- P. Support of the profession's growth through participation in midwifery education
- Q. Knowledge of the structure and function of ACNM

III. Components of Midwifery Care: Midwifery Management Process

The midwifery management process is used for all areas of clinical care and consists of the following steps:

- A. Investigate by obtaining all necessary data for the complete evaluation of the woman or newborn.
- B. Identify problems or diagnoses and health care needs based on correct interpretation of the subjective and objective data.
- C. Anticipate potential problems or diagnoses that may be expected based on the identified problems or diagnoses.
- D. Evaluate the need for immediate intervention and/or consultation, collaborative management, or referral with other health care team members as dictated by the condition of the woman, fetus, or newborn.
- E. In partnership with the woman, develop a comprehensive plan of care that is supported by a valid rationale, is based on the preceding steps, and includes therapeutics as indicated.
- F. Assume responsibility for the safe and efficient implementation of a plan of care that includes the provision of treatments and interventions as indicated.
- G. Evaluate the effectiveness of the care given, recycling appropriately through the management process for any aspect of care that has been ineffective.

IV. Components of Midwifery Care: Fundamentals

- A. Anatomy and physiology, including pathophysiology
- B. Normal growth and development
- C. Psychosocial, sexual, and behavioral development
- D. Basic epidemiology
- E. Nutrition
- F. Pharmacokinetics and pharmacotherapeutics
- G. Principles of individual and group health education
- H. Bioethics related to the care of women, newborns, and families
- I. Clinical genetics and genomics

V. Components of Midwifery Care of Women

Independently manages primary health screening, health promotion, and care of women from the peri-menarcheal period through the lifespan using the midwifery management process. While the woman's life is a continuum, midwifery care of women can be divided into primary, preconception, gynecologic, antepartum, intrapartum, and post-pregnancy care.

A. Applies knowledge, skills, and abilities in primary care that include but are not limited to the following:

1. Nationally defined goals and objectives for health promotion and disease prevention
2. Parameters for assessment of physical, mental, and social health
3. Nationally defined screening and immunization recommendations to promote health and to detect and prevent disease
4. Management strategies and therapeutics to facilitate health and promote healthy behaviors
5. Identification of normal and deviations from normal in the following areas:
 - a. Cardiovascular and hematologic
 - b. Dermatologic
 - c. Endocrine
 - d. Eye, ear, nose, and throat
 - e. Gastrointestinal
 - f. Mental health
 - g. Musculoskeletal
 - h. Neurologic
 - i. Respiratory
 - j. Renal
6. Management strategies and therapeutics for the treatment of common health problems and deviations from normal of women, including infections, self-limited conditions, and mild and/or stable presentations of chronic conditions, utilizing consultation, collaboration, and/or referral to appropriate health care services as indicated.

B. Applies knowledge, skills, and abilities in the preconception period that include but are not limited to the following:

1. Individual and family readiness for pregnancy, including physical, emotional, psychosocial, and sexual factors including
 - a. Non-modifiable factors such as family and genetic/genomic risk
 - b. Modifiable factors such as environmental and occupational factors, nutrition, medications, and maternal lifestyle
2. Health and laboratory screening
3. Fertility awareness, cycle charting, signs and symptoms of pregnancy, and pregnancy spacing

C. Applies knowledge, skills, and abilities in gynecologic care that include but are not limited to the following:

1. Human sexuality, including biological sex, gender identities and roles, sexual orientation, eroticism, intimacy, and reproduction
2. Common screening tools and diagnostic tests
3. Common gynecologic and urogynecologic problems
4. All available contraceptive methods
5. Sexually transmitted infections including indicated partner evaluation, treatment, or referral
6. Counseling for sexual behaviors that promote health and prevent disease
7. Counseling, clinical interventions, and/or referral for unplanned or undesired pregnancies, sexual and gender concerns, and infertility
8. Identification of deviations from normal and appropriate interventions, including management of complications and emergencies utilizing consultation, collaboration, and/or referral as indicated

D. Applies knowledge, skills, and abilities in the perimenopausal and postmenopausal periods that include but are not limited to the following:

1. Effects of menopause on physical, mental, and sexual health
2. Identification of deviations from normal
3. Counseling and education for health maintenance and promotion
4. Initiation or referral for age/risk appropriate periodic health screening
5. Management and therapeutics for alleviation of common discomforts

E. Applies knowledge, skills and abilities in the antepartum period that include but are not limited to the following:

1. Epidemiology of maternal and perinatal morbidity and mortality
2. Confirmation and dating of pregnancy
3. Promotion of normal pregnancy using management strategies and therapeutics as indicated
4. Common discomforts of pregnancy
5. Influence of environmental, cultural and occupational factors, health habits, and maternal behaviors on pregnancy outcomes
6. Health risks, including but not limited to domestic violence, infections, and substance use/abuse
7. Emotional, psychosocial, and sexual changes during pregnancy
8. Anticipatory guidance related to birth, breastfeeding, parenthood, and change in the family constellation
9. Deviations from normal and appropriate interventions, including management of complications and emergencies
10. Placental physiology, embryology, fetal development, and indicators of fetal well-being

F. Applies knowledge, skills, and abilities in the intrapartum period that include but are not limited to the following:

1. Confirmation and assessment of labor and its progress
2. Maternal and fetal status
3. Deviations from normal and appropriate interventions, including management of complications, abnormal intrapartum events, and emergencies
4. Facilitation of physiologic labor progress
5. Measures to support psychosocial needs during labor and birth
6. Labor pain and coping
7. Pharmacologic and non-pharmacologic strategies to facilitate maternal coping
8. Techniques for
 - a. administration of local anesthesia
 - b. spontaneous vaginal birth
 - c. third stage management
 - d. performance of episiotomy repair of episiotomy and 1st and 2nd degree lacerations

G. Applies knowledge, skills, and abilities in the period following pregnancy that include but are not limited to the following:

1. Physical involution following pregnancy ending in spontaneous or induced abortion, preterm birth, or term birth
2. Management strategies and therapeutics to facilitate a healthy puerperium
3. Discomforts of the puerperium
4. Self-care
5. Psychosocial coping and healing following pregnancy
6. Readjustment of significant relationships and roles
7. Facilitation of the initiation, establishment, and continuation of lactation where indicated
8. Resumption of sexual activity, contraception, and pregnancy spacing
9. Deviations from normal and appropriate interventions including management of complications and emergencies

VI. Components of Midwifery Care of the Newborn

Independently manages the care of the newborn immediately after birth and continues to provide care to well newborns up to 28 days of life utilizing the midwifery management process and consultation, collaboration, and/or referral to appropriate health care services as indicated.

A. Applies knowledge, skills, and abilities to the newborn that include but are not limited to the following:

1. Effect of maternal and fetal history and risk factors on the newborn
2. Preparation and planning for birth based on ongoing assessment of maternal and fetal status
3. Methods to facilitate physiologic transition to extrauterine life that includes but is not limited to the following:

- a. Establishment of respiration
 - b. Cardiac and hematologic stabilization including cord clamping and cutting
 - c. Thermoregulation
 - d. Establishment of feeding and maintenance of normoglycemia
 - e. Bonding and attachment through prolonged contact with neonate.
 - f. Identification of deviations from normal and their management.
 - g. Emergency management including resuscitation, stabilization, and consultation and referral as needed
4. Evaluation of the newborn:
 - a. Initial physical and behavioral assessment for term and preterm infants
 - b. Gestational age assessment
 - c. Ongoing assessment and management for term, well newborns during first 28 days
 - d. Identification of deviations from normal and consultation, and/or referral to appropriate health services as indicated
 5. Develops a plan in conjunction with the woman and family for care of the newborn for the first 28 days of life, including nationally defined goals and objectives for health promotion and disease prevention:
 - a. Teaching regarding normal behaviors and development to promote attachment
 - b. Feeding and weight gain including management of common breastfeeding problems
 - c. Normal daily care, interaction, and activity including sleep practice and creating a safe environment
 - d. Provision of preventative care that includes but is not limited to
 - (1) Therapeutics including eye ointment, vitamin K, and others as appropriate by local or national guidelines
 - (2) Testing and screening according to local and national guidelines
 - (3) Need for ongoing preventative health care with pediatric care providers
 - e. Safe integration of the newborn into the family and cultural unit
 - f. Appropriate interventions and referrals for abnormal conditions:
 - (1) Minor and severe congenital malformations
 - (2) Poor transition to extrauterine life
 - (3) Symptoms of infection
 - (4) Infants born to mothers with infections
 - (5) Postpartum depression and its effect on the newborn
 - (6) End-of-life care for stillbirth and conditions incompatible with life
 - g. Health education specific to the infant and woman's needs:
 - (1) Care of multiple children including siblings and multiple births
 - (2) Available community resources

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Source: Basic Competency Section, Division of Education

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(Supersedes all previous *ACNM Core Competencies for Basic Midwifery Practice*)

*A report to Senate Business, Professions
and Economic Development Committee*

MEDICAL BOARD OF CALIFORNIA

SUNSET REVIEW REPORT 2012

VOLUME I

Edmund G. Brown Jr., Governor
Sharon Levine, M.D., President, Medical Board of California
Linda K. Whitney, Executive Director, Medical Board of California



Appendix I

Midwifery Program

- Background and Description of Midwifery Program
- Performance Measures and Customer Satisfaction Surveys
- Fiscal and Staff Issues
- Licensing Program
- Enforcement Program
- Public Information Policies
- Online Practice Issues
- Workforce Development and Job Creation
- Current Issues
- Board Action and Response to Prior Sunset Issues
- New Issues
- Attachments



Section 11 – New Issues

Physician Supervision

Section 2057 of the B&P Code authorizes a licensed midwife, *under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics*, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother and immediate care for the newborn. B&P Code section 2507(f) requires the Board *by July 1, 2003* to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery. Due to the inability to reach consensus on the supervision issue, the Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery (CCR section 1379.19). Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful due to the widely divergent opinions of interested parties and their inability to reach consensus.

Although required by law, physician supervision is essentially unavailable to licensed midwives performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of licensed midwives who perform home births. According to these companies if they supervise, or participate, in a home birth they will lose their insurance coverage resulting in loss of hospital privileges. The physician supervision requirement creates numerous barriers to care, in that if the licensed midwife needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a licensed midwife as the primary provider who does not have a supervising physician. California is currently the only state that requires physician supervision of licensed midwives. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician. For example, in New York, licensed midwives are required to establish and maintain a collaborative relationship with a physician. The midwife is required to maintain documentation of such collaborative relationships and make information about such collaborative relationships available to his or her patients. However, documentation of the collaborative relationship does not have to be submitted to the licensing authority.

In New Jersey, the licensed midwife is required to establish written clinical guidelines with the affiliated physician which outlines the licensee's scope of practice, circumstances under which consultation, collaborative management, referral and transfer of care of women between the licensee and the affiliated physician are to take place. These clinical guidelines must include provisions for periodic conferences with the affiliated physician for review of patient records and for quality improvements. The licensed midwife is required to provide this information to the licensing authority upon request. It is considered professional misconduct to practice without established clinical guidelines.

States such as Arkansas and South Carolina provide a very detailed list of situations where physician intervention or referral is required. Other states, such as Virginia and New Mexico, have laws requiring collaboration between a physician and a midwife, but limit physician liability, stating that any consultative relationship with a physician does not by itself provide the basis for finding a physician liable for any acts or omissions by a licensed midwife. New Mexico law requires that each woman

accepted for care must be referred at least once to a duly licensed physician within four (4) weeks of her initial midwifery visit. The referral must be documented in the chart.

The Board, through the Midwifery Advisory Council has held many meetings regarding physician supervision of licensed midwives and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with licensed midwives expressing concern with any limits being placed on their ability to practice independently. The physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of midwives to refer patients when the situation warrants referral or transfer of care. It appears the physician supervision requirement needs to be addressed through the legislative process.

Lab Orders and Obtaining Medical Supplies

Licensed midwives have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, licensed midwives are not able to obtain the medical supplies they have been trained and are expected to use: oxygen, necessary medications, and medical supplies that are included in approved licensed midwifery school curriculum (CCR section 1379.30). The inability for a licensed midwife to order lab tests often means the patient will not obtain the necessary tests to help the midwife monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the licensed midwife's patient and child.

The Board, through the Midwifery Advisory Council held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties it appears the lab order and medical supplies/medication issues will need to be addressed through the legislative process.

Midwife Students, Apprentices and Assistants

Section 2514 of the B&P Code authorizes a "bona fide student" who is enrolled or participating in a midwifery education program or who is enrolled in a program of supervised clinical training to engage in the practice of midwifery as part of her course of study if: 1) the student is under the supervision of a physician or a licensed midwife who holds a clear and unrestricted California Midwife License and that midwife is present on the premises at all times client services are provided; and 2) the client is informed of the student's status. There has been disagreement between the Board and some members of the midwifery community regarding what constitutes a "bona fide student". However, the current statute is very clear regarding a student midwife.

Some members of the midwifery community hold that an individual who has executed a formal agreement to be supervised by a licensed midwife but is not formally enrolled in any approved midwifery education program qualifies the individual as a student in apprenticeship training. Many midwives consider that an individual may follow an "apprenticeship pathway" to licensure. The original legislation of the Midwifery Practice Act, included the option to gain midwifery experience that will then allow them to pursue licensure via the "Challenge Mechanism" detailed in B&P Code section 2513(a) which allows an approved midwifery education program to offer the opportunity for students



History of the Nurse-Midwifery Advisory Committee to the California Board of Registered Nursing, 1978-1995

The following is a summarized transcription of materials received from the California Board of Registered Nursing (BRN) regarding the Nurse-Midwife Advisory Committee (NMAC), including meeting minutes, lists of committee members, correspondence and related materials during the active years of NMAC (1978-1995). The materials were summarized and placed in chronological order to give an overview of the activities of the committee. Not all forms were summarized such as curriculum vitae, individual applications, forms for applicants, guidelines for curricula, etc.

The California Nurse-Midwives Association (CNMA) urges the BRN to reconvene the NMAC. NMAC was composed of at least one nurse-midwife knowledgeable about nurse-midwifery practice and education, one physician who practices obstetrics, one RN familiar with nurse-midwifery practice, and one public member. It is authorized by statute under *B&P Section 2746.2* and *California Code of Regulations, Title 16, section 1461*: "The board shall appoint a committee comprised of at least one nurse-midwife and one physician... [whose] purpose is to advise the board on all matters pertaining to nurse-midwifery as established by the board."

=====

1978 NMAC Members

Doreen Chan RN N.E.C
Julia O'Bosky RN, Supervising NEC
Kathleen Miller RN, NEC
Maggie Secretary

Peggy Emrey CNM, Dept. of Health, Maternal and Infant Health Section
Connie Ament CNM
Carmella Caverio CNM
Sister Ann Keating CNM
Karen Laing CNM
Vanda Lops CNM
Wanda Mulder CNM
Patricia O'Malley NP
Richard Sweet MD
Ezra Davidson MD
Irene Matousek

9/20-21 1979 BRN meeting

Under other business:

Old – committees: Nurse Midwife and Nurse Practitioner Committee: Board approve the Nurse Midwifery report, including the test plan and the suggested evaluation tool

That the board approve the report of the NP Committee, that the staff continue developing the evaluation position that is outlined in the report and that Patty Majcher participate in the evaluation process

Nurse Midwife, Implementation of Regulations, effective 5/7/1979:

Step by step instructions for reviewing applications for certification

1. Valid current RN from CA and graduated from approved program will be certified sec. 1460 (a) (1) (a&b)
2. Valid current RN in CA, program not on list of approved programs but certified and NM by national or state organization whose standards deemed acceptable to BRN, certificate issued (sec. 1460 (a) (2) (b))
3. If 1 or 2 are not met, clerical staff to compare transcripts submitted with application to curriculum checklist on evaluation form (A) and identify areas of deficiency. Candidate would be notified and given options:
 - a. Option 1: candidate to provide official transcripts of work completed to correct deficiencies from Board approved NM program
 - b. Option 2: provides evidence of successful challenge of Board approved program's curriculum and verification of clinical competency by board approved CNMs/physician
 - c. Option 3: candidate who has post-licensure training and experience in maternal and child care (OB/GYN NP provide evidence of remediation of areas of deficiency in a board approved NM program
 - d. Option 4: completion of examination provided by Board with a satisfactory passing score and completion/verification of clinical competency by Board approved CNMs/physician
4. Application abandoned if not achieved within 2 years of initial application

Attached are case summary for each applicant, form letters when criteria not met

1/4/1980 Memorandum

To: Members of BRN

From: BRN – Antonia Gifford RN, Nursing Education Consultant

Subject Final Report: Nurse Midwifery Committee

NMC has completed the preparation of lists and evaluation tools as directed by Board at 9/20, 21 1979 board meeting

1. list of board approved programs in nurse-midwifery
2. process for evaluating nurse-midwife applicants for deficiencies
3. list of national and state organizations certifying nurse-midwives which meet board standards
4. adoption of examination
5. develop mechanism for determining competency

- a. following persons contacted and asked to submit curriculum vitae to serve as a committee for evaluation of applications:
 - i. Connie Ament RN, CNM
 - ii. Sister Ann Keating RN CNMM
 - iii. Jane Sievers Netz
 - iv. Dr. Green MD
 - v. Dr. Jane Patterson MD

Submitted by Nurse Midwife and Nurse Practitioner Committee:

Tomas Long RN, Chairman

Sister Ann Keating RN CNM

Virginia Cassidy-Brinn, RN

Patricia Majcher RN

Michael Buggy RN

Julia O'Bosky RN

Kathleen Miller RN, Carol Henriksen RN

Antonia Gifford, RN

Attachment I:

Schools compliant with standards specified in Section 1462, Title XVI of California Administrative Code

1. Columbia University Graduate Program in Maternity Nursing and Nurse-Midwifery
2. Frontier School of Midwifery and Family Nursing
3. Georgetown University School of Nursing
4. The Johns Hopkins University
5. Medical University of South Carolina
6. Meharry Medical College
7. St. Louis University
8. State University of New York
9. United States Air Force
10. University of California at San Diego
11. UCSF
12. University of Illinois at the Medical Center
13. University of Kentucky
14. University of Miami
15. University of Mississippi
16. University of Utah
17. College of Medicine and Dentistry of New Jersey

Approved refresher programs

1. Booth Maternity Center
2. University of Mississippi

Attachment II: Approved organizations or agencies for certification:

American College of Nurse Midwives

State boards of nursing: Alabama, Alaska, Arizona, Georgia, Idaho, Louisiana, Massachusetts, Montana, North Carolina, South Carolina

Attachment III: Clinical Performance Evaluation

7/17/1980 NMAC Meeting Minutes

Members Present: Patricia Majcher, RN, President, Ginny Cassidy-Brinn, RN, Chairperson, Abby Haight Board member, Sister Ann Keating RN, CNM, Gary Richwald MD, David Hoskinson, Nancy Yagi, Eric Werner, Manager, Central Testing Unit, Carol Henriksen, RN, NEC, Kathleen Miller RN NEC

1. Comments and observations on proposals submitted for the development of a valid midwifery exam
2. PSI (Psychological Services Inc.), AR (applied Research Consultants) Sacramento, NES (National Evaluation Systems), PES (Professional Examination Service), SCC (Selection Consulting Center), PC (Psychological Corporation)
3. Budget
4. Test developed by BRN and CTU
5. Negotiation of Contract
6. Publicity
7. Discussion of Concerns
8. Refining
9. Job Analysis
10. Committee for Job Analysis
11. Job Analysis Committee Meeting
12. Date for Meeting of Item Writers
13. Place to Meet
14. Payment for Item Writers and Job Analysis Experts

10/20/1980 Memorandum

To: Virginia Cassidy-Brinn

From: BRN – Antonia J Gifford, RN, Nursing Education Consultant

Subject Nurse Practitioner Evaluation

- Copy of letter written to UCSF in September 1980, updated report on status of NP evaluations, listing of schools meeting the standards of section 1484 and organizations which certify NPs and meet standards
- Process of evaluation
- Worksheet for NP minimum training standards, NP program evaluation

1981 Board of Directors of the Consortium for Nurse Midwifery, Inc.

President: Sister Ann Keating CNM

Vice-President: Kenneth E. Bell MD

Secretary: Renee Halstead CNM

Treasurer: Margie Downing, CNM

Diane Angelini CNM

Shirley Fischer CNM

R. Marshall Jelderks MD

Peggy Kaiser

Jane Meier
Howard Mitchel MD, MPH
Elysa Parra CCE
Mary Ann Rhode CNM
Barbara Sinclair RN, MPH
Wendy Wayn, RN, MPH
Consultants: Peggy Emrey CNM, Carmela Cavero

1/13/1981 Memorandum

From: BRN/Nurse Practitioner/Nurse Midwife Committee

Subject: Nurse Practitioner Evaluation Process – proposed procedure

1/14/1981 Memorandum

To: Members of BRN

From: BRN Antonia Gifford RN Nursing Education consultant

Subject: Report Regarding Evaluation of Nurse Practitioners

- Report on applications for practicing as NP, types of specialty areas requested, curriculum of programs evaluated
-

2/6/1981 NMAC Meeting Minutes

Present: Abby Haight, Chairperson, Ginny Cassidy-Brinn, Board Member, Carol Henriksen RN, Nursing Education Consultant, Mary Ann Rhode, Ann Keating, Nancy Yagi, Gary Richwald, David Hoskinson

1. NMAC Purpose
 - a. BRNs' purpose in appointing the Advisory Committee needs clarification
 - i. The charge to the advisory committee is to advise the BRN on: Implementation of midwifery law/regulation, promotion of midwifery services
 - ii. Objectives: coordinate BRN activities with those of other concerned groups and in the community to publicize BRN action and identify problems which the BRN might assist in solving
2. BRN Communication with Advisory Committee Members
3. Standardized Procedures
 - a. Use of standardized procedures by RNs to practice midwifery
 - b. Recommendation for the BRN: That the BRN assess the area of standardized procedures in relation to maternity care in California and provide a statement for appropriate public bodies
4. Agencies with whom BRN might coordinate some activities
 - a. DCAs Midwifery Advisory Council
 - b. The Consortium for Nurse-Midwifery, Inc (CNMI)
5. Keene Midwifery Bill to be written

6. Obstacles to Consumer Access to Midwifery Services
 - a. CMA is expressing its intent to oppose lay midwifery, homebirths, specific use of standardized procedures by RNs for practice of midwifery
 - b. Few midwives are being granted hospital privileges
 - c. Insurance companies do not provide reimbursement for midwifery care
 7. Public Hearings to Identify Obstacles and Consumer Access to Midwifery
 - a. At its' 1/1981 meeting the BRN voted "that the nurse midwifery advisory committee hold meetings in several areas of state and present a structured report to the BRN on problems in consumer access to midwifery services
 8. Co-Sponsors of Hearings
 9. Access Issues
 - a. Hospital privileges for NMs, reimbursement, restrictions in hospitals, out of hospital practice and MD back-up, denial of malpractice insurance to supportive MDs, limitations on the number of nurse midwives who can be taught, federal agencies, violations of FTC, title XXII-Hill Burton, UC Health Plan and HAS
 10. New West Magazine Article
 11. Next Meetings of NMAC
-

3/10/1981 Letter

- BRN Department of Consumer Affairs: Letter to Editor of New West Magazine commending magazine for article by Mark Hunter, Mothers and Outlaws (December 22, 1980). Abby Haight Public Member Board of Registered Nursing
-

3/27/1981 BRN NMAC Minutes(subcommittee of Nursing Practice Committee)

Advisory Members Present: L. Bennett, A Keating, M. Rhode, G Richwald,
Board Members Present: G. Cassidy-Brinn, Co-Chairperson, A. Haight, Co-Chairperson

Staff Attending: C. Henriksen

1. Nurse Midwife Exam
 - a. Work started on preparing exam March 12 and will meet again April 22
2. Medi-Cal Reimbursement
 - a. BRN voted to adopt the committee's 2/6/1981 recommendation to write to Beverlee Myers urging implementation of regulations that permit Med-Cal Reimbursement to midwives
3. State Insurance Commissioner
 - a. BRN voted to adopt the committee's 2/6/1981 recommendations to request the State Insurance Commissioner to Report to the BRN on

- the status of reimbursement for nurse-midwives and its rationale for non-reimbursement
- b. Letter to be written to insurance commissioner regarding this subject
4. Letter of appreciation to New West Magazine
 5. Nurse-midwifery Hearings
 - a. "Nurse midwifery advisory council members are the logical choice to act as a response to panel for the hearings"
 - b. Testimony at the hearings to be solicited regarding issues in access to midwifery services suggested in committee minutes 26/1981 p 4, 5. Revised and more clearly defined: hospital privileges; restrictions in hospitals; out of hospital practice with physician back up – question arises is nurse-midwife an employee of physician or an independent practitioner?; limits on number of nurse-midwives who can be educated/insufficient obstetrical facilities, faculty, lack of funding;
 - c. Issues in reimbursement for nurse midwives
 - d. Malpractice insurance issues
 - e. Can any Hill-Burton funded hospital legally deny privileges to nurse-midwives
 - f. Have health services agencies played a role in development of nurse-midwife services
 6. AB 1592 – Moorhead
 - a. Bill introduced on 3/25/1981 to revise definition of midwifery by deleting supervision by a physician. Weaken position of standardized procedures by putting into law functions which already can be done by RNs under standardized procedures, permits erection of an artificial barrier to nurse-midwives obtaining staff privileges in a clinical teaching facility in that it states that it does not prohibit the facility from requiring that a nurse-midwife have a faculty teaching appointment as a condition for eligibility for staff privileges in that facility
 - b. Also incorporates AB 370 which prohibits insurance plans from excluding the services of a CNM
 - c. AB 1592 and SB 670 should be supported together
 - d. Title XXII should be amended to state that facilities "cannot deny the nurse-midwife privileges."
 - e. Abby Haight to take to Legislative Committee the above and:
 - i. Faculty requirement for a midwife in a clinical teaching facility
 - ii. Effect on standardized procedures of putting into nurse-midwife law, functions which are already standardized procedures
 - iii. Definition of high-risk pregnancy
 - iv. Effect on present midwifery practice if the law is re-opened
 - v. Possibility of amending NPA regulation 1464 to delete the requirement for MD supervision
-

April 9, 1981 Update- Nurse Practitioners

- Approx. 408 requests received from RNs for evaluation since initiate of evaluation program in fall of 1979. AJG: drk

4/10/1981

List of programs offering curriculum for the preparation of nurse practitioners which met the standards specified in Title XVI, Chapter 14, Section 1484:

FNP/Primary Care NP/Associate:

CSU, Sonoma; UCSF; CSU, Fresno; UC Davis; Stanford; CSU, Long Beach; UCSD; UCLA
Medical NP/Adult NP:

CSU, Long Beach; UCSD; Loma Linda University; UCLA; UCSF; Sothern California
Permanente Medical Group

Pediatric NP:

CSU, Fresno; Valley Medical Center; CSU, Long Beach; UCSD; Loma Linda University;
UCLA; LAC – University of Southern California; UCSF

Neonatal NP:

County of Ventura- General Hospital

OBGYN NP/Maternity/Family Planning:

UCSD; UCLA – Harbor General Hospital; Southern California Permanente Medical
Group; UCSF

Geriatric Nurse Practitioner:

Spinal Cord Injury NP:

Psychiatric/Mental Health NP:

CSU, Long Beach

NP for Faculty:

UCLA

College Health NP:

UCLA

Programs no longer being offered but graduates meet criteria:

CSU, Chico – FNP; CSU, Long Beach – Primary Care NP; CSULA, Olive View Medical
Center – FNP; Northern California Permanente Medical Group – Medical NP,
Pediatric NP, OBGYN NP; Southern California Permanente Medical Group – Pediatric
NP; CSULA, Martin Luther King - Adult NP; Cal Poly, San Luis Obispo

Out of State:

Brigham young University – Primary Care NP, College Health NP; Texas Women’s
University – Geriatric NP; University of Miami – Geriatric NP, Family NP, Pediatric
NP; Linehard School of Nursing – Primary Care NP; University of Rochester – Family
Health NP; New York University – FNP; University of Kentucky – FNP; University of
Arizona – FNP; University of Colorado – Adult/Geriatric NP, Pediatric NP, FNP,
School NP

Certification by State Boards accepted: Arkansas, Florida, New Mexico

Certification by national organizations accepted: NAPNAP, NAACOG, ANA – Adult
NP, Pediatric NP, FNP

4/10/1981 Letter

To: California State Insurance Commissioner

Attn: J. Sandoval, Press Officer

From: Abby Haight

- Regarding insurers reimbursement of nurse-midwives and requesting information
 - o Laws/regulations pertinent to issue of reimbursement
 - o Names of all insurers and of those insurers which have provisions for direct reimbursement of NMs
 - o Methods for requiring private insurers to reimburse NMs
 - o Policies of insurers of state, county, and municipal employees regarding reimbursement of NMs and influence the State Insurance Commissioner
 - o Information concerning denial of malpractice insurance to NMs and/or physicians associated with nurse midwives
 - o Also invited representative from office to report on above items to NMAC meeting 5/22/1981
-

5/22/1981 NMAC Meeting Minutes

Members Present: D. Hoskinson, A Keating, G Richwald

Board Members: G. Cassidy-Brinn

Staff: C. Henriksen

1. Issues in Reimbursement of Nurse- Midwives
 2. Medi-Cal Regulations and Reimbursement of Midwives
 3. Nurse Midwifery Hearings
 4. Issues in Access to Midwifery Services
 5. Consultant for Hearings
 6. AB 1592 – develop recommendation for BRN consideration
 - a. Committee supports and recommends the BRN support
 - b. Invite Assemblywoman Jean Moorhead to next meeting
 7. Nurse Midwifery Equivalency Examination Development
-

5/26/1981 Letter

To: Beverlee Myers, Director of Department of Health Services

From: Ginny Cassidey-Brinn, Vice-President of BRN

- Regarding direct reimbursement to nurse-midwives under Medicaid
- Rapid implementation of Federal Public Law 96-499 (budget reconciliation act)
- Request a representative at NMAC in Sacramento July 17, 1981

Response:

- Clarifies that PL 96-499 mandates provision of midwifery services but does not require direct payment to the midwife, but does allow it

- Confirming this with Ms. Jean Hoodwin of Health Care Financing Administration
 - States a mechanism for direct payment to midwives under Medi-Cal would be difficult and costly to implement, require extensive changes in regulations and to contract with Computer Sciences Corporation
 - Happy to send representative from Benefits Branch, Jennifer Tachera for July 17.
 - May contact Elisabeth H. Lyman, Deputy Director From Beverlee A. Myers, Director
-

7/17/1981 NMAC Meeting Minutes

Board Members: A. Haight

Advisory Members: D. Hoskinson, A Keating, G. Richwald

Guests: Jennifer Tachera, Medi-Cal Policy Analyst, Peggy Emrey CNM DHS, Tom Green Attorney, DCA Legislative Office, Laura Kaplan Attorney DCA, Division of Consumer Services

1. Medi-Cal Regulations and Reimbursement of Midwives
 2. Nurse-Midwifery Hearings – Planning
 - a. Purpose of hearings is to assist in implementing the nurse-midwife law
 3. Insurance
 4. Nurse Midwife Exam
 5. Clinical Performance for Nurse-Midwife Equivalency
-

8/21/1981 NMAC Meeting Minutes

Board Members: G. Cassidy-Brinn, A. Haight

Advisory Members: D. Hoskinson, G. Richwald, N. Yagi, MA Rhode

Staff: J. O'Bosky, supervising NEC, C. Henriksen NEC, Liaison

Invited Guest: Cheryl Mahaffey, Psychological Services, Inc.

1. Nurse Midwife Equivalency Exam
-

10/19/1981 NMAC Members

Linda Bennett

David Hoskinson

Sr. Ann Keating

Gary Richwald

Nancy Yagi

Mary Ann Rhode

Ginny Cassidy-Brinn

Abby Haight

Carol Henriksen, Liaison

10/30/1981 NMAC Meeting Minutes 10/30/1981

Board Members: A. Haight, Chairperson

Advisory Members: D. Hoskinson, A. Keating, MA Rhode, G Richwald

BRN Staff: C. Henriksen, NEC, Committee Liaison

1. Nurse Midwife Equivalency Exam
 2. Midwifery Hearings
 3. Midwife Reimbursement
 - a. Questionnaire for insurance companies on midwife reimbursement
 - b. Medi-Cal Reimbursement for NMWs
 - c. PERS
-

NMAC Minutes 12/4/1981

Board Members: A. Haight, Chairperson

Advisor Members : D. Hoskinson, A. Keating, N. Yagi, G. Richwald

BRN staff: C. Henriksen, NEC Committee Liaison

Invited Guest: William Anderson of PERS

1. Nursing Midwifery Hearings
 2. Midwife Reimbursement
 - a. Anderson presented information from PERS regarding reimbursement
 - b. Committee agreed a letter to be sent to Bob Wilson, Health Benefits Committee Chief requesting time on agenda for NMWAC (NMAC)
 - c. Questionnaires for insurance companies on midwife reimbursement
 - d. UC system insurance plans
 3. "Guidelines for Evaluation of Clinical Performance – Nurse Midwifery"
 - a. Tool given final consideration for making changes/recommendations to Nursing Practice Committee
 4. NMW Exam Development – PSI
 5. Goals and Activities of the NMWAC (NMAC)
-

12/31/1981 Letter

To: Abby Haight

From: DH Marshall Assistant Chief, Health Benefits Division

- Regarding meeting time for health benefits committee/agenda
-

1/6/1982 Memorandum

To: NMAC members

From: BRN, Carol Henriksen RN, NEC

Subject: 1/15 meeting

- 1/15 meeting cancelled d/t no major progress reported on items from 12/4 meeting
- Meeting will be scheduled when there are matters which require the attention of the committee

2/10/1982 Memorandum
To: NMAC Members
From: BRN, Carol Henriksen RN, NEC
Subject: NMAC will meet in LA 4/5

3/29/1982 Memorandum
To: NMAC Members
From: BRN, Carol Henriksen RN NEC, Committee Liaison
Subject: Cancellation of April 5 Meeting

- Due to orders to reduce travel and other expenses to minimum as well as other state agencies

No Date, Announcement
To: nurse-midwives, physicians familiar with midwifery and consumer needs, members of the public interested in midwifery
From: BRN
Subject Selection of Nurse-Midwifery Committee (as required by section 1461)

- "BRN is now taking applications from nurse-midwives, physicians and members of the public to comprise a nurse- midwifery committee
- The committee's purpose shall be to evaluate applications for registered nurses for eligibility for the certification or examination for nurse-midwives and submit recommendations to the BRN

No Date Announcement

- April, 1982 is the target date for the first administration for the California Nurse-Midwifery Examination for nurses seeking to qualify for certification via an equivalency route.
- If you or a qualified...
- Members of the Nurse-Midwifery Committee will be reimbursed at prevailing State rates for authorized travel and per diem expenses

7/15/1982 Memorandum
To: NMAC Members
From: Carol Henriksen
Subject: Meeting

- First meeting of NMAC will be held 9/14/1982

8/17/1982 Memorandum
To: NMAC Members

From: Carol Henriksen

Subject: Meeting Announcement: 9/14/1982

- Reviewed pay, reimbursement, transportation for meeting

Attached: Nurse-midwifery examination announcement/info; application for nurse-midwife certification by examination; curriculum for nurse midwifery programs

9/14/1982 NMAC Meeting Minutes

Board members: Abby Haight, chairperson; Ginney Cassidy-Brinn RN

Staff: Barbara Brusstar, Carol Henriksen

Members of Committee: CNMs: Lorie Brilliner, Mary Colton, Tertia Heath, Ann Keating, Tekoa Lee King
Physicians: George Kibler, Joel T. O'Rea, Gary Richwald,
RNs: Mary Mangini, Debbie Stuart-Smalley, Frances Wright
Public Members: Edith Berg, Francis Hornstein, David Hoskinson

1. Self introductions
 2. Review of law, regulations, history pertaining to nurse-midwifery in CA
 3. Charge to the committee
 4. Explanation of regulations and process of applying for certifications by various methods
 5. Guidelines for make-up courses in family planning/genetics developed by staff for foreign-trained midwives seeking to remediate deficiencies
 6. Correspondence between BRN and Department of Health Services regarding reimbursement of CNMs by Medi-Cal
 7. Process of reviewing applications of persons applying for certification by method 6 discussed:
 - a. Passing California BRN Nurse- Midwife Examination
 - b. Documenting advanced training and education beyond basic nursing
 - c. Certification of clinical competency by CNM and physician
 - d. After completion of these requirements, a quorum (2 CNMs, 1 physician, 1 RN) will meet to evaluate their files/make recommendations to Nursing Practice Committee regarding certification
 8. Review of per diem and expense forms for committee members
-

2/4/1983 Goals and Objectives of the Nursing Practice Committee

1. Certified nurse-midwife attended birth, in any setting, will be a feasible choice for the consumer with a normal pregnancy
 - a. Amend nurse-midwifery regulations taking into consideration the nurse-midwifery job analysis, deleting any program standards and practice requirements which are not related to competence, and requiring experience in a variety of settings including homes
 - b. Specify content of required nurse-midwifery courses
 - c. Work with perinatal regionalization project planners to include nurse-midwives in the plan

- d. Deal with restraint-to-trade violations committed by MDs against CNMs
 - e. Provide a means of informing public regarding availability and appropriate use of nurse-midwifery services and how to locate such services in their areas
 - f. Develop a contact system between providers of NMW courses and RNs requiring remediation courses
 - g. Encourage California nurse-midwifery programs to cooperate with equivalency applicants requiring make-up courses
 - h. Work with DHS to influence development of Medi-Cal Reimbursement of CNMs
 - i. Develop and implement a system for evaluating California nurse-midwifery programs
 - j. Conduct no-expense hearings on nurse-midwifery where needs arise
2. The law enforcement program will be revised to be more efficient and to be fair and respectful to registered nurses involved in the process
 3. Consumers will have access to those medications which registered nurses are authorized by standardized procedures to manage and to transmit to pharmacies
 4. The evaluation procedure for NPs will be developed more completely and as system for gathering data about NPs will be devised

Instructions for applying for certification as a nurse midwife

- A. The completed applications form
- B. A photocopy of your California RN license
- C. The fee of \$
- D. Documentations, depending on the method by which you are qualifying
 - Method 1: a. official transcript of program
 - Method 2: a. official transcript of program
 - b. official transcript of courses taken to correct deficiencies or official transcript showing successful completion of courses approved by Board
 - Method 3: a. letter of verification of certification by certifying organization
 - Method 4: a. official transcript of courses successfully challenged in Board approved program
 - Method 5: a. BRN form "post-licensure training and Practice in Maternal and Child Care"
 - b. official transcript of courses taken to correct deficiencies
 - Method 6: a. completed BRN form "post-licensure training and practice in maternal and child care"
 - b. verification by a CNM and by a physician of applicant's clinical competency in management of normal labor and delivery "evaluation of Midwifery Clinical Competency"

c. successful completion of California BRN's exam in Nurse-Midwifery

Curriculum for Nurse-Midwifery Programs

Post-Licensure Training and Practice in Maternal and Child Care

Evaluation of Midwifery Clinical Competency

6/10/1983 Letter

To: Kristie Brandt

From: Frances Wright RN, Nursing Education Consultant from BRN

- Regarding applications for certification

No Date: NMAC Members

CNMs: Lorie Brillinger, Mary M Colton, E. Tertia Heath, Ann Keating, Tekoa Lee King, Karen M Laing

Physicians: George K. Kibler, Joel T. O'Rea, Gary Richwald

Public: Edith Berg, Francie Hornstein, David Hoskinson

RNs: Maria V. Mangini, Debbie Stuart Smalley, Frances Wright

Board Staff: Abby Haight, Barbara M. Brusstar, Carol Henriksen

7/2/1984 NMAC Meeting Minutes

Board Members: Abby Haight, Patricia Hunter

Committee Members: Karen Laing, CNM, Debbie Stuart Smalley, CNM, Gary Richwald MD, Edith Berg, Public Member, George Kibler, MD, Martha Hall Stewart RN

1. Introduction and explanation of the procedure to be followed
 2. Files of applicants for certification considered by Committee: 4 certified, 1 needed further evaluation/f/u
 3. Recency Issue: when requirements met but have not practiced x 15-20 years
 4. Refresher/Remediation Issue
 - a. Lack of such courses
-

8/20/1985 NMAC Meeting Minutes

Members: Karen Laing, CNM, Suellen Miller CNM, Francie Hornstein, public member, Lori Nairne, RN

1. Approval of minutes of 6/26/1985

2. Consideration of candidates for certification by equivalency
 - a. Of note applications from Ethiopian Nurse Midwife Refugee
 - b. Decision that she needed remediation of fetal monitoring and be allowed to sit for California Nurse- Midwife Examination and certified if pass
 3. Malpractice insurance crisis
 4. Deletion of Sections 1464 and 1465 regarding supervising physician
 5. Availability of Medi-Cal Provider numbers to CNMs
 6. Budget constraints prevent convening the entire committee
-

1989-1990, An Introduction to Continuing Competency Assessment Program

- Core Competencies in Nurse-Midwifery
 - Criteria for Pre-accreditation of basic certificate, basic graduate and precertification nurse midwifery education programs, Revised 4/1988
 - Guidelines for documenting Criteria for Pre-accreditation of basic certificate, basic graduate and precertification nurse midwifery education programs, Revised 4/1988
-

3/1990 BRN Meeting

- 7.1 approve/not approve that the Nurse Midwifery Certification Exam be given once a year
 - 3.0 NMAC – approval of applicants for membership
-

3/9/1990

To: Catherine Puri

From: Carol Henriksen

Subject: Logistics of CNM Exam Administration

5/21/1990 Letter

To: Marcia Manley of BRN Specialized Licensing Section

From: Maria Bedroni RN of BRN

- in response to her letter 5/15/1990 regarding clarification of lay midwifery (illegal) and investigations into lay midwifery by medical board if lay person and by BRN if RN
 - Attached: "How to find a Real Midwife with Real training and a real license" by Best Start Birth Center, San Diego CA
-

7/19/1990 NMAC Meeting Minutes

Committee Members: Susan Detwiler RN, George Kibler MD, Karen Laing CNM, Maria Mangini CNM, Suellen Miller CNM

Staff: Maria Bedroni, Carol Henriksen, Janette Wackerly, Gabrielle Underwood, Usrah Claar-Rice

1. Announcements: travel reimbursement, alternate committee members
 2. Standard of Practice for treating vaginal beta-hemolytic streptococcus at 3 months gestation (question asked to committee members)
 3. Guidelines for evaluation of clinical performance
 4. California educational requirements for Nurse-midwifery program
 5. Remediation guidelines
 6. Suggestions for updating the reference list on the applications for nurse midwifery certifications were received
 7. A draft of a BRN position paper titled “ Midwifery Practice Under Standardized Procedures Prohibited” was presented to the Advisory committee by Carol Henriksen
-

Standards for the Practice of Nurse-Midwifery

1. Nurse-midwifery care is provided by qualified practitioners
2. Nurse-midwifery care supports individual rights and self-determination within boundaries of safety
3. Nurse midwifery care is comprised of knowledge, skills, and judgments that foster the delivery of safe and satisfying care
4. Nurse midwifery care is based upon knowledge, skills and judgments which are reflected in written policies
5. Nurse-midwifery care is provided in a safe environment
6. Nurse-midwifery care occurs interdependently within the healthcare system of the community, using appropriate resources for referrals to meet psychosocial, economic and culture or family needs
7. Nurse-midwifery care is documented in legible, complete health records
8. Nurse midwifery care is evaluated according to an established program for quality assessment that includes a plan to identify and resolve problems

Criteria for pre-accreditation of Basic Certificate, Basic Graduate, and Pre-Certifications Nurse Midwifery Education Programs Revised April 1988

7/1991

Charge to NMAC

Purpose: Committee is appointed to advise the BRN on matters relating to nurse-midwifery, develop necessary standards related to educational requirements and provide such assistance as may be required in the evaluation of applications for nurse-midwifery certification

Authority: Section 2742.2 of B&P Code

Membership: 6 CNMs, 1 physician, 1 RN, 1 member of the public

Terms: 3 years

Relationships: committee is advisory to BRN through Nursing Practice Committee, reports from NMAC will be submitted to Nursing Practice Committee

Quorum: 5 committee members, 2 of which are CNMs

5/26/1993 Memorandum
To: NMAC members
From: Alice Takahashi
Subject: June Committee Meeting
Scheduled 6/8/1993

Agenda:

1. Review charge to committee
2. Consider method six applicants (2)
3. Consider foreign applicant for method 3
4. Review and revise guidelines for remediation
5. Review/revise management of routine gynecological care and family planning
6. Member terms, next meeting
7. Other

Attachments:

1. Charge to the NMAC:
 - Purpose: advise the board on matters relating to nurse-midwifery, develop the necessary standards related to educational requirements, and to provide such assistance as may be required in the evaluation of applications for nurse- midwifery certification
 - Authority: Section 2742.2 of Business and Professions Code
 - Membership: 6 CNMs, 1 physician, 1 RN, 1 member of the public
 - Term: 3 years
 - Relationships: advisory to the Board through its Nursing Practice Committee, reports from NMAC sent to Nursing Practice Committee
 - Meetings: meet as necessary to carry out its assigned tasks
 - Quorum: 5 committee members, 2 of which are nurse-midwives
2. California Educational Requirements for Nurse- Midwifery Programs
3. Administration of Perineal Anesthesia Remediation Guidelines
4. Episiotomy Remediation Guidelines
5. Remediation Guidelines for Courses in Family Planning
6. Nurse Midwifery Management Process: Remediation Guidelines
7. Repair of episiotomy and Lacerations Remediation Guidelines
8. Remediation Guidelines for Courses in Genetics

6/8/1993 BRN, NMAC Agenda Item Summaries

- California Educational Requirements for Nurse-Midwifery Programs
 - 1991 Application for Nurse-Midwife Certification
 - Subject Content of Advanced Experience in Maternal and Child Care Revised 1985
 - Evaluation of Nurse-Midwifery Clinical Competency
 - Guidelines for Evaluation of Clinical Performance –Nurse Midwifery
-

6/8/1993 NMAC Minutes

Attending: Gretchen Andrews, IBCLC- The Lactation Connection, Susan Detwiler, RN, Ilene Gelbaum CNM, Laura Romero CNM, Gwen Spears CNM

Staff: Maria Bedroni, Alice Takahashi

Agenda:

1. Review charge to the NMAC
2. Credential review of applicant "A" for certification as a nurse-midwife through equivalency method six
3. Credential review of foreign applicants "B", "C" and "D" for certification as a nurse-midwife through equivalency method 2
4. Review and update section (E) of California education requirements for nurse midwifery programs, " Management of Routine Gynecological Care and Family Planning"
5. Update on use board approved nurse-midwifery exam as equivalency exam: information only
Attachments: Remediation guide Nurse-midwifery management process, guidelines for evaluation for clinical performance nurse midwifery, remediation guidelines: administration of perineal anesthesia, episiotomy, repair of episiotomy and lacerations, family planning, genetics

6/18/1993 Memorandum

To: NMAC

From: Alice Takahashi

- Enclosed minutes from 6/8/1993 meeting, revised remediation guidelines, clinical performance evaluation

No Date: NMAC List

Gretchen Andrews – public member; term expires 9/1994

Sue Detwiler, RN; term expires 9/1992

Ilene Gelbaum, CNM; term expires 9/1994

George Kibler, MD; term expires 9/1994

Karen Laing, CNM; term expires 9/1992

Maria Victoria Mangini, CNM; term expires 9/1993

Suellen Miller, CNM; term expires 9/1992

Laura Romero, CNM; term expires 9/1994

Gwendolyn V. Spears, CNM; term expires 9/1994

9/1993 NMAC Member List:

Gretchen Andrews – public member; term expires 9/1994

Sue Detwiler, RN; term expires 9/1992

Ilene Gelbaum, CNM; term expires 9/1994

George Kibler, MD; term expires 9/1994

Andrea Dixon, CNM; term expires 9/1996

Linda Johnson, CNM; term expires 9/1996
Claire Westdahl, CNM; term expires 9/1996
Laura Romero, CNM; term expires 9/1994
Gwendolyn V. Spears, CNM; term expires 9/1994

6/30/1994 NMAC Minutes

Attending: Ilene Gelbaum, CNM, Lindy Johnson, CNM, George Kibler, MD, Laura Romero, CNM, Susan Detwiler, RN, Gwendolyn Spears, CNM, Gretchen Andrews, public members

Staff: Maria Bedroni, Alice Takahashi, Marlene Bowman, Gabriele Underwood

Others; Todd Gastal, DC

Lynette Allen, Student NMW

1. Review charge to the NMAC
 2. Review minutes of 6/8/1993
 3. Review methods of certification for nurse-midwives
 4. Review and update remediation guidelines
 5. Review and recommend changes if appropriate to California education requirements for nurse-midwifery program listing
 6. Information only: discuss SB 305, Killia's Licensed Midwifery Act and its relation to RNs
 - a. Passed 1/1/1994
 - b. View of NMAC that it does not relate to RNs d/t law requires nurses who are midwives to be CNMs
 7. Discussion on future direction of nurse-midwifery
 - a. Reimbursement
 - b. Physician supervision
 - c. Difficulty in obtaining hospital privileges
 8. Information only: Review term expirations
- Attachments: Remediation Guidelines, Clinical Evaluations, California Educational Requirements for Nurse-Midwifery Programs
-

1/1995

Charge to the NMAC

Purpose: committee is appointed to advise the Board on matters relating to nurse-midwifery, develop necessary standards related to educational requirements and to provide such assistance as may be required in the evaluation of applications for nurse-midwifery certification

Authority: section 2746.2 of business and professions code

Membership: committee shall be composed of 6 CNMs, 1 physician, 1 RN, 1 member of the public

Term: 3 years

Relationships: committee is advisory to the Board through its education/licensing committee. Reports of n NMAC will be submitted to the education/licensing committee

Meetings: Shall meet as necessary to carry out its assigned tasks
Quorum: 5 committee members, 2 shall be CNMs

1995 NMAC List of Members

Gretchen Andrews – public member; term expires 1/1/1998
Sue Detwiler, RN; term expires 1/1/1996
Andrea Dixon CNM; term expires 1/1/1997
Ilene Gelbaum, CNM; term expires 1/1/1998
Betsy Greulich, CNM term expires 1/1/1998
Lauren Hunter CNM; term expires 1/1/1998
Linda Johnson, CNM; term expires 1/1/1997
George Kibler, MD; term expires 1/1/1997
Jeanne Rous, CNM term expires 1/1/1997

6/15/1995 NMAC Meeting Minutes

Members: Susan Detweiler RN, Ilene, Gelbaum CNM, Betsy Greulich CNM, Lindy Johnson CNM, Jeanne Rous CNM

Staff: Alice Takahashi, Janette Wackerly, Cindy Flores

1. Approval of 6/30/1994 minutes
 2. Review of charge to NMAC
 - a. Change: make recommendations through education/licensing committee d/t majority of items referred to education issues, matters regarding practice can still go t the nursing practice committee
 3. Discussion of results of BRN CNM questionnaire
 - a. Recurring issues found: reimbursement, restraint of trade, physician supervision, malpractice insurance, hospital admitting privileges, changes practice from nurse midwifery to increasing area of women's health
 4. Action items for discussion
 - a. Revision of remediation guidelines
 - b. Approve proposed new guidelines for gynecology fetal well being, laboratory, and diagnostic tests
 5. Policy
-

10/14/1995 NMAC Meeting Minutes

Members: Andrea Dixon CNM, Ilene Gelbaum CNM, Betsy Greulich CNM, Lauren Hunter CNM, George Kibler MD, Geanne Rouse CNM, Gretchen Andrews public members, Sue Detweiler RN, Lindy Johnson CNM

Staff: Alice Takahashi, Janette Wackerly, Gabriele Underwood, Maria Bedroni, Usrah Claar-Rice

1. Approval of 6/10/1995 minutes
2. Discussion of attorney general opinion 94-1011, performance of an episiotomy by a CNM

- a. Concluded 7/31/1995 that a nurse midwife may not perform an episiotomy pursuant to a standardized procedure, and it is not within scope of practice of CNM
 - b. Stated for CNMs to lawfully perform episiotomy, statute requires amendment
 3. Remediation guidelines update; guidelines for a CNM on probation
 4. Discuss the CNMs role in primary care
 5. Review existing statutes and regulations for nurse-midwifery, recommend additions, revisions
 - a. Title protection
 - b. Episiotomy
 - c. Qualifications for certification
 - i. decision to retain methods 1,2,3 and delete 4,5,6
 - d. standards for education
 - i. revisions and proposed changes will be place din appropriate format by staff and prepared for Board approval process
-

10/23/1995 Letter

To: Alice Takahashi

From: Betsy Greulich

1. Request for NMAC Members
2. Reports at last chapter meeting and CNMA board meeting NPA should not be changed
3. Deadline for deletion of method 6 d/t nurse wanting to be certified through this method

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.4
DATE: November 20, 2014

ACTION REQUESTED: Information: Drug Enforcement Administration Publishes Final Rule Rescheduling Hydrocodone Combination Products from Schedule III to Schedule II Controlled Substances

REQUESTED BY: Trande Phillips, RN
Chair Practice Committee

BACKGROUND:

The Drug Enforcement Administration will publish in the Federal Register the Final Rule moving hydrocodone combination products (HCPs) from Schedule III to more restrictive Schedule II as recommended by the Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS). The Federal Register has made the Final Rule available for preview on its website <http://go.usa.gov/mc8d>

The BRN has been contacted by nurse practitioners who have Schedule III-V Controlled Substances DEA registration. If a NP wants the to prescribe Schedule II, there is an additional requirement for education which must be met

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY:

PERSON TO CONTACT: Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Phone: (916) 574-7686
Email: janette.wackerly@dca.ca.gov

HEADQUARTERS NEWS

August 21, 2014
Contact: DEA Public Affairs
(202) 307-7977

DEA to Publish Final Rule Rescheduling Hydrocodone Combination Products

AUG 21 (WASHINGTON)—On Friday the U. S. Drug Enforcement Administration (DEA) will publish in the *Federal Register* the Final Rule moving hydrocodone combination products (HCPs) from Schedule III to the more-restrictive Schedule II, as recommended by the Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS) and as supported by the DEA's own evaluation of relevant data. The *Federal Register* has made the Final Rule available for preview on its website today at <http://go.usa.gov/mc8d>.

This Final Rule imposes the regulatory controls and sanctions applicable to Schedule II substances on those who handle or propose to handle HCPs. It goes into effect in 45 days.

The Controlled Substances Act (CSA) places substances with accepted medical uses into one of four schedules, with the substances with the highest potential for harm and abuse being placed in Schedule II, and substances with progressively less potential for harm and abuse being placed in Schedules III through V. (Schedule I is reserved for those controlled substances with no currently accepted medical use and lack of accepted safety for use.)

HCPs are drugs that contain both hydrocodone, which by itself is a Schedule II drug, and specified amounts of other substances, such as acetaminophen or aspirin.

"Almost seven million Americans abuse controlled-substance prescription medications, including opioid painkillers, resulting in more deaths from prescription drug overdoses than auto accidents," said DEA Administrator Michele Leonhart, "Today's action recognizes that these products are some of the most addictive and potentially dangerous prescription medications available."

When Congress passed the CSA in 1970, it placed HCPs in Schedule III even though it had placed hydrocodone itself in Schedule II. The current analysis of HCPs by HHS and the DEA shows they have a high potential for abuse, and abuse may lead to severe psychological or physical dependence. Adding nonnarcotic substances like acetaminophen to hydrocodone does not diminish its abuse potential. The many findings by the DEA and HHS and the data that support these findings are presented in detail in the Final Rule on the website. Data and surveys from multiple federal and non-federal agencies show the extent of abuse of HCPs. For example, Monitoring the Future surveys of 8th, 10th, and 12th graders from 2002 to 2011 found that twice as many high school seniors used Vicodin®, an HCP, nonmedically as used OxyContin®, a Schedule II substance, which is more tightly controlled.

In general, substances placed under the control of the CSA since it was passed by Congress in 1970 are scheduled or rescheduled by the DEA, as required by the CSA and its implementing regulations, found in Title 21 of the Code of Federal Regulations. Scheduling or rescheduling of a substance can be initiated by the DEA, by the HHS Assistant Secretary of Health, or on the petition of any interested party. (Detailed information on the scheduling and rescheduling process can be found beginning on page 8 of *Drugs of Abuse* on the DEA's website at http://www.justice.gov/dea/pr/multimedia-library/publications/drug_of_abuse.pdf.)

The rescheduling of HCPs was initiated by a petition from a physician in 1999. The DEA submitted a request to HHS for a scientific and medical evaluation of HCPs and a scheduling recommendation. In 2013, the U. S. Food and Drug Administration held a public Advisory Committee meeting on the matter, and the committee voted to recommend rescheduling HCPs from Schedule III to Schedule II by a vote of 19 to 10. Consistent with the outcome of that vote, in December of 2013 HHS sent such a recommendation to the DEA. Two months later, on February 27, the DEA informed Americans of its intent to move HCPs from Schedule III to Schedule II by publishing a Notice of Proposed Rulemaking in the *Federal Register*, outlining its rationale and the proposed changes in detail and soliciting public comments on the proposal, of which almost 600 were received. A small majority of the commenters supported the proposed change.

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.5
DATE: November 20, 2014

ACTION REQUESTED: Community Paramedicine- Office of Statewide Planning and Development Pilot Project 173

REQUESTED BY: Trande Phillips, RN, Chairperson
Nursing Practice Committee

BACKGROUND:

Emergency Medical Services Authority (EMSA) submitted a proposal for community paramedicine projects to the Office of Statewide Planning & Development (OSHPD). The proposal details plans to conduct 12 community paramedicine (CP) projects across California to test a new health care delivery model which will expand the paramedic scope of practice. Selected paramedics will receive additional training to provide services beyond their customary roles in emergency response and transport. Tentative date for the decision will be October/November.

Dr. Kizer, Director, Institute for Population Health Improvement, UC Davis Health System, Dr. Shore, Senior Policy Analyst, Institute for Population Health Improvement, UC Davis Health System, and Dr. Moulin, Assistant Professor, Department of Emergency Medicine, UC Davis School of Medicine authors of the *Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care* report (2013). Community paramedicine pre-hospital and post-hospital or community health services include the following six components:

1. Transport patients with specified conditions not needing emergency care to non-ED locations (“alternate locations”)
2. After assessing and treating as needed, determine whether it is appropriate to refer or release an individual at the scene of an emergency response rather than transport the person to a hospital ED
3. Assist frequent 911 callers or frequent visitors to EDs to access primary care and other social services
4. Provide support for persons who have been recently discharged from the hospital and are at increased risk of a return visit to the ED or readmission to the hospital.
5. Provide support for persons who have been recently discharged from the hospital and are at increased risk of a return visit to the ED or readmission to the hospital.
6. Partner with community health workers and primary care providers in underserved areas to provide preventive care

RESOURCES:

Office of Statewide Health Planning & Development (OSHPD) Community Paramedicine Pilot Project (2014) http://www.oshpd.ca.gov/HWDD/pdfs/HWPP/CP_OSHPD_Community_Paramedicine_App.pdf
Kizer, K., Shore, K., & Moulin, A. (2013) *Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care*
http://www.ucdmc.ucdavis.edu/iphi/Programs/CAHPF/resources/IPHI_CommunityParamedicineReport_Final%20070913.pdf

NEXT STEPS:

Place on Board agenda.

FISCAL IMPACT, IF ANY:

None

PERSON TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Phone: (916) 574-7686
Email: janette.wackerly@dca.ca.gov

**Nursing Practice Committee Meeting
October 9, 2014
Community Paramedicine Project Briefs
Project Briefs**

1. Transport patients with specified conditions to alternate locations that can be managed in health care settings other than an acute care emergency department, such as an urgent care or general medical clinic.
2. Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments by helping them access primary care and other social or psychological services.
3. Provide short-term home follow-up care for persons recently discharged from the hospital and at increased risk of a return visit to the emergency department or readmission to the hospital with referral from the hospital, clinic, or medical provider.
4. Provide short-term home support for persons with diabetes, asthma, congestive heart failure, AMI, Sepsis or multiple chronic conditions with referral and under protocol from the medical home clinic or provider.
5. Partner with public health, community health workers, and primary care providers in underserved areas to provide preventive care.

Pilot Concepts	Pilot #
Alternate Destination	CP001, CP003, CP009
Alternate Destination: Mental Health	CP011
Post-hospital discharge follow-up	CP002, CP004, CP008, CP011, CP012
Post-hospital discharge & frequent 911 callers	CP007
Frequent 911 callers	CP010
Direct observed therapy	CP005
Hospice support	CP006

1. **CP 001** Proposal for alternate transport destination for communities in **Los Angeles County**. This proposal will allow paramedics to transport patients with a specified conditions not needing emergency care to alternate, non-emergency department locations.

2. **CP 002** Proposal is for Paramedics in **Glendale & Burbank** to reduce heart failure readmissions. The proposal is for post-hospital follow-up care for chronic conditions. Paramedics will determine whether patients are within individualized clinical benchmarks and can wait their follow-up office visit, demonstrating sign/symptoms suggesting the need for same-day physician consultation/intervention or showing signs of imminent decompensation requiring urgent transportation for medical intervention.

3. **CP 003** Proposal is for Paramedics in **Orange County** to triage and transport patients to alternative destinations. The paramedic is to determine the acuity status and potential for transportation to an alternate location such as urgent care clinics or mental health clinics.

4. **CP 004** Proposal is for Paramedics in **Butte County** to assess the safety and value of modifying the Paramedic Scope of Practice. To achieve this, paramedics will provide follow-up

assistance for patients with a post hospital discharge diagnosis of Acute Myocardial Infarction or Heart Failure and care for chronic conditions to reinforce primary care provider instructions for patients with heart failure. Paramedics will provide a follow-up telephone within 48 hours of discharge to obtain a status report on their current medical condition.

5. **CP 005** Proposal is for Paramedics in **Ventura County** to expand their services to Direct Observed Therapy (DOT) to administer TB medications, assess patients for disease progression or medication reaction and to treat reactions with Diphenhydramine, Ondansetron, or other medications.

6. **CP 006** Proposal is for paramedics in **Santa Barbara and Ventura County** to provide hospice comfort and supportive care and administer medications, provide grief and crisis support for patient, family and friends until the hospice clinicians can take over.

7. **CP 007** Proposal is for paramedics in **Alameda County** to connect patients with their primary health care providers proactively and avoid unnecessary EMS transports, ED visits, and hospitalizations. According to the proposal, there is no service that provides this level of pre-hospital assessment and care for non-acute medical conditions.

8. **CP 008** Proposal is for paramedics in **San Bernardino County** to provide follow-up post-hospital or emergency department discharge to augment discharge planning and promote treatment plan compliance by identifying these patients who do not have access to home health or other discharge follow-up.

9. **CP 009** Proposal is for paramedics in **Carlsbad** to transport patients with specified conditions not needing emergency care to alternate, non-emergency department locations such as local medical offices.

10. **CP 010** Proposal is for paramedics in **San Diego** to manage frequent 911 callers, assess, treat and refer after appropriate assessment and treatment, transport to alternate locations, post-hospital or emergency department follow-up, care for chronic conditions- reinforce primary care provider instructions.

11. **CP 011** Proposal is for paramedics in **Stanislaus County** to assess, treat, and transport behavioral health patients to appropriate alternate care at behavioral health treatment facilities.

12. **CC 012** Proposal is for paramedics in **Solano County** to provide post-hospital discharge follow-up, treatment and referral of patients with a confirmed diagnosis of chronic obstructive pulmonary disease, congestive heart failure, or at risk of medical, non-compliance, or rapid decompensation by providing post-hospital discharge home visits coordination of follow-up care necessary/appropriate transportation and medication reconciliation and make referrals to a licensed healthcare provider when an intervention could prevent an exacerbation of a medical condition.